First aid policy

Christ Church CE Primary School

Approved by:	Kerry James	**Date:**	04.09.24
Last reviewed on:	4.9.24		
Next review due by:	4.9.25		

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1. Aims

The aims of our first aid policy are to:

- Ensure the health and safety of all staff, pupils and visitors
- Ensure that staff and governors are aware of their responsibilities with regards to health and safety
- Provide a framework for responding to an incident and recording and reporting the outcomes

2. Legislation and guidance

This policy is based on the Statutory Framework for the Early Years Foundation Stage, advice from the Department for Education on first aid in schools and health and safety in schools, guidance from the Health and Safety Executive (HSE) on incident reporting in schools, and the following legislation:

- The Health and Safety (First-Aid) Regulations 1981, which state that employers must provide adequate and appropriate equipment and facilities to enable first aid to be administered to employees, and qualified first aid personnel
- The Management of Health and Safety at Work Regulations 1992, which require employers to make an assessment of the risks to the health and safety of their employees
- The Management of Health and Safety at Work Regulations 1999, which require employers to carry out risk assessments, make arrangements to implement necessary measures, and arrange for appropriate information and training
- The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013, which state that some accidents must be reported to the Health and Safety Executive (HSE), and set out the timeframe for this and how long records of such accidents must be kept

- Social Security (Claims and Payments) Regulations 1979, which set out rules on the retention of accident records
- The Education (Independent School Standards) Regulations 2014, which require that suitable space is provided to cater for the medical and therapy needs of pupils
- This policy complies with our funding agreement and articles of association.

3. Roles and responsibilities

3.1 Appointed person(s) and first aiders

They are responsible for:

- Taking charge when someone is injured or becomes ill
- Ensuring there is an adequate supply of medical materials in first aid kits, and replenishing the contents of these kits
- Ensuring that an ambulance or other professional medical help is summoned when appropriate

First aiders are trained and qualified to carry out the role (see section 7) and are responsible for:

- Acting as first responders to any incidents; they will assess the situation where there is an injured or ill person, and provide immediate and appropriate treatment
- Sending pupils home to recover, where necessary
- Filling in an accident report on the same day, or as soon as is reasonably practicable, after an incident (see the template in appendix 2)
- Keeping their contact details up to date

Our school's first aiders are listed in appendix 1. Their names will also be displayed prominently around the school.

3.2 The governing board

The governing board has ultimate responsibility for health and safety matters in the school, but delegates operational matters and day-to-day tasks to the headteacher and staff members.

3.3 The headteacher

The headteacher is responsible for the implementation of this policy, including:

- Ensuring that an appropriate number of first aid trained personnel are present in the school at all times
- Ensuring that first aiders have an appropriate qualification, keep training up to date and remain competent to perform their role
- Ensuring all staff are aware of first aid procedures
- Ensuring appropriate risk assessments are completed and appropriate measures are put in place
- Undertaking, or ensuring that managers undertake, risk assessments, as appropriate, and that appropriate measures are put in place
- Ensuring that adequate space is available for catering to the medical needs of pupils
- Reporting specified incidents to EECLIVE when necessary

3.4 Staff

School staff are responsible for:

- Ensuring they follow first aid procedures
- Ensuring they know who the first aiders in school are
- Completing accident reports (see appendix 2) for all incidents they attend to where a first aider is not called
- Informing the head teacher or their line manager of any specific health conditions or first aid needs

4. First aid procedures

4.1 In-school procedures

In the event of an accident resulting in injury:

- The closest member of staff present will assess the seriousness of the injury and seek the assistance of a qualified first aider, if appropriate, who will provide the required first aid treatment
- The first aider, if called, will assess the injury and decide if further assistance is needed from a colleague or the emergency services. They will remain on the scene until help arrives
- The first aider will also decide whether the injured person should be moved or placed in a recovery position
- If the first aider judges that a pupil is too unwell to remain in school, parents will be contacted and asked to collect their child. Upon their arrival, the first aider will recommend next steps to the parents
- If emergency services are called 999 , the first aider will contact parents immediately
- The first aider will complete an accident report form on the same day or as soon as is reasonably practical after an incident resulting in an injury

There will be at least 1 person who has a current paediatric first aid (PFA) certificate on the premises at all times.

Type of Accident	Example	Action	When
Minor	Grazes Minor bumps to the head	Details logged in the First Aid book. If head a call home and a leaflet sent home with child	The same day Head – Asap to parents
Possibly requiring medical/ dental treatment	Sever cuts/lacerations Impact injury (bang or blow) to the head (Head defined as whole face, neck and head)	Details logged in first aid book Call parents to inform of the blow to the head and send home first aid report EECLIVE to be used to report the incident	The same day
Severe	Major injuries e.g. broken bones/not fingers Loss of limbs Accident resulting in over 7 day injury Where injured party leaves premises by	Details logged EECLIVE used to report the incident which will then be reported to the HSE RIDDOR.	24 hours of the incident

	ambulance Death		

4.2 Off-site procedures

When taking pupils off the school premises, staff will ensure they always have the following:

- A school mobile phone
- There will always be at least one first aid trained member of staff in the party.
- A portable first aid kit including, at minimum:
    - A leaflet giving general advice on first aid
    - 6 individually wrapped sterile adhesive dressings
    - 1 large sterile unmedicated dressing
    - 2 triangular bandages – individually wrapped and preferably sterile
    - 2 safety pins
    - Individually wrapped moist cleansing wipes
    - 2 pairs of disposable gloves
- Information about the specific medical needs of pupils
- Parents' contact details

When transporting pupils using a minibus or other large vehicle, the school will make sure the vehicle is equipped with a clearly marked first aid box.

Risk assessments will be completed by the class teacher prior to any educational visit that necessitates taking pupils off school premises, this will then be checked by the Head Teacher.

There will always be at least 1 first aider with a current paediatric first aid (PFA) certificate on school trips and visits, as required by the statutory framework for the Early Years Foundation Stage.

5. First aid equipment

A typical first aid kit in our school will include the following:

- A leaflet giving general advice on first aid
- 20 individually wrapped sterile adhesive dressings (assorted sizes)
- 2 sterile eye pads
- 2 individually wrapped triangular bandages (preferably sterile)
- 6 safety pins
- 6 medium-sized individually wrapped sterile unmedicated wound dressings
- 2 large sterile individually wrapped unmedicated wound dressings
- 3 pairs of disposable gloves

No medication is kept in first aid kits.

First aid kits are stored in:

- Year 1 cloakroom
- Year 5 cloakroom
- Activity Room
- Entrance office/foyer
- Each class has a bum bag (except Y5)

6. Record-keeping and reporting

6.1 First aid and accident record book

- An accident is logged in the folders in Year 1 and Year 5. A form will be completed by the first aider on the same day or as soon as possible after an incident resulting in an injury
- As much detail as possible should be supplied when reporting an accident, including all of the information included in the accident form at appendix 2
- An accident letter is filled in and given to the class teacher to go home with them at the end of the day. Calls are made home to parents depending on the injury.
- Records held in the first aid and accident book will be retained by the school for a minimum of 3 years, in accordance with regulation 25 of the Social Security (Claims and Payments) Regulations 1979, and then securely disposed of.

6.2 Reporting to the HSE

The head teacher will keep a record of any accident on EECLIVE which results in a reportable injury, disease, or dangerous occurrence as defined in the RIDDOR 2013 legislation (regulations 4, 5, 6 and 7). EECLIVE will then decide if the accident is reportable to the HSE as soon as the report is created and within 10 days of the incident.

Fatal and major injuries and dangerous occurrences will be reported without delay (i.e. by telephone) and followed up in writing within 10 days.

School staff: reportable injuries, diseases or dangerous occurrences

These include:

- Death
- Specified injuries, which are:
    - Fractures, other than to fingers, thumbs and toes
    - Amputations
    - Any injury likely to lead to permanent loss of sight or reduction in sight
    - Any crush injury to the head or torso causing damage to the brain or internal organs
    - Serious burns (including scalding) which:
        - Covers more than 10% of the whole body's total surface area; or

    - Causes significant damage to the eyes, respiratory system or other vital organs
  - Any scalping requiring hospital treatment
  - Any loss of consciousness caused by head injury or asphyxia
  - Any other injury arising from working in an enclosed space which leads to hypothermia or heat-induced illness, or requires resuscitation or admittance to hospital for more than 24 hours
- Work-related injuries that lead to an employee being away from work or unable to perform their normal work duties for more than 7 consecutive days (not including the day of the incident).
- Near-miss events that do not result in an injury, but could have done. Examples of near-miss events relevant to schools include, but are not limited to:
  - The collapse or failure of load-bearing parts of lifts and lifting equipment
  - The accidental release of a biological agent likely to cause severe human illness
  - The accidental release or escape of any substance that may cause a serious injury or damage to health
  - An electrical short circuit or overload causing a fire or explosion

Pupils and other people who are not at work (e.g. visitors): reportable injuries, diseases or dangerous occurrences

These include:

- Death of a person that arose from, or was in connection with, a work activity*
- An injury that arose from, or was in connection with, a work activity* and the person is taken directly from the scene of the accident to hospital for treatment

*An accident “arises out of” or is “connected with a work activity” if it was caused by:

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

6.3 Notifying parents (early years only)

The first aider or class teacher will inform parents of any accident or injury sustained by a pupil, and any first aid treatment given, on the same day, or as soon as reasonably practicable. Parents will also be informed if emergency services are called.

6.4 Reporting to Ofsted and child protection agencies (early years only)

The Head Teacher will notify Ofsted of any serious accident, illness or injury to, or death of, a pupil while in the school’s care. This will happen as soon as is reasonably practicable, and no later than 14 days after the incident.

The Head Teacher /DSL/DDSL will also notify social services of any serious accident or injury to, or the death of, a pupil while in the school’s care.

7. Training

All school staff are able to undertake first aid training if they would like to.

All first aiders must have completed a training course, and must hold a valid certificate of competence to show this. The school will keep a register of all trained first aiders, what training they have received and when this is valid until (see appendix 3).

The school will arrange for first aiders to retrain before their first aid certificates expire.

At all times, at least 1 staff member will have a current paediatric first aid (PFA) certificate which meets the requirements set out in the Early Years Foundation Stage statutory framework. The PFA certificate will be renewed every 3 years.

8. Automated external defibrillators (AEDs)

The school has procured an AED through the NHS Supply Chain, which is located in **the school office**.

Where the use of the AED is required, individuals will follow the step-by-step instructions displayed on the device. A general awareness briefing session, to promote the use of AEDs, will be provided to staff on an **annual** basis, and usually during the **first INSET session** of the academic year. Use of the AED will be promoted to pupils during **PSHE lessons**.

9. Storage of medication

Medicines will be stored securely and appropriately in accordance with individual product instructions, save where individual pupils have been given responsibility for keeping such equipment with them. Medicines will be stored in the original container in which they were dispensed, together with the prescriber's instructions for administration, and properly labelled, showing the name of the patient, the date of prescription and the date of expiry of the medicine.

Medicine brought in by pupils will be returned to their parents for safe disposal when they are no longer required or have expired.

An emergency supply of medication will be available for pupils with medical conditions that require regular medication or potentially lifesaving equipment, e.g. an EpiPen.

Parents will advise the school when a child has a chronic medical condition or severe allergy so that an IHP can be implemented and staff can be trained to deal with any emergency in an appropriate way. Examples of this include epilepsy, diabetes and anaphylaxis. A disclaimer will be signed by the parents in this regard.

Pupils will have any medication stored and, where appropriate administered, in accordance with their EHC plans and the school's Administering Medication Policy.

10. Monitoring arrangements

This policy will be reviewed by the Local Governing Board every year.

At every review, the policy will be approved by the Head Teacher and the Local Governing Board

11. Links with other policies

This first aid policy is linked to the:

- Health and safety policy
- Risk assessment policy
- Policy on supporting pupils with medical conditions

Appendix 1: list of appointed persons for first aid are:

STAFF MEMBER'S NAME	ROLE	CONTACT DETAILS
Kerry James	Head Teacher	07970742244 Kerry.james@christchurchprimaryschool.org
Rachael Clarke	Deputy Head	Rachael.clarke@christchurchprimaryschool.org
Leanne Carpenter	LSA	Leanne.carpenter@chirstchurchprimaryschool.org

Appendix 2: accident report form

NAME OF INJURED PERSON		ROLE/CLASS	
DATE AND TIME OF INCIDENT		LOCATION OF INCIDENT	
INCIDENT DETAILS			
Describe in detail what happened, how it happened and what injuries the person incurred.			
ACTION TAKEN			
Describe the steps taken in response to the incident, including any first aid treatment, and what happened to the injured person immediately afterwards.			
FOLLOW-UP ACTION REQUIRED			
Outline what steps the school will take to check on the injured person, and what it will do to reduce the risk of the incident happening again.			
NAME OF PERSON ATTENDING THE INCIDENT			
SIGNATURE		DATE	

Appendix 2: Accident Report Form Template 2

Date	Name and Class	Time	Accident and treatment	Signed

Appendix 3: first aid training log

NAME/TYPE OF TRAINING	STAFF WHO ATTENDED (INDIVIDUAL STAFF MEMBERS OR GROUPS)	DATE ATTENDED	DATE FOR TRAINING TO BE RENEWED (WHERE APPLICABLE)
Paediatric First Response And National College First AID 6 hours Person responsible for administering medicine	Kerry James	12.9.18 18.10.21 / 4.9.24 21.10.22 6.9.23	18.10.23 4.9.25 21.10.25 6.9.25
First Aid for children and adults 6 hrs	All staff apart from Heather Gregory Alison Knowles	04.1.23	04.1.26
Diabetes	Alison Thorne Claire ball Leanne Carpenter Dan Hiscox Marie Coomber Rachel Clarke Kerry James Heather Gregory		Need to refresh Sept/Oct 2023
Trachi Trained	Iwona Grzebyk	Sept / Oct 22	Annually (Not needed at present time)
Paediatric First Aid 12 hours	Leanne Carpenter Heather Gregory Beth Duffen	22.9.21 26.4.22 10.9.24	01.06.24 01.4.25 10.9.26
Persons responsible for administering medicine	Beth Duffen Kerry James Jo Baxter	09.9.23 7.9.23 16.08.23	09.9.25 7.9.25 16.08.25
Persons responsible for first aid kits	Kerry JAMES (KS2) Jo Baxter (office) Kim Poulding (KS1)		

ADDITIONAL INFORMATION

ANAPHYLAXIS AT SCHOOL

There are many hundreds of children in the nation's schools who are at risk of anaphylaxis. The vast majority of children with anaphylaxis are happily accommodated in mainstream schools, thanks to good communication and consensus between parents, schools, teachers, doctors and education authorities.

The following information is intended to assist schools who face the challenge of managing a child at risk of anaphylaxis. It is based on the good practice that exists in many schools around the country.

What is Anaphylaxis?

Anaphylaxis is an acute, severe allergic reaction needing immediate medical attention. It can be triggered by a variety of allergens, the most common of which are foods (especially peanuts, nuts, eggs, cow's milk, shellfish), certain drugs such as penicillin and the venom of stinging insects (such as bees, wasps or hornets).

In its most severe form, the condition is life-threatening.

Symptoms

Symptoms which usually occur within minutes of exposure to the causative agent may include but are not limited to the following:-

- ✓ Itching or a strange metallic taste in the mouth
- ✓ Swelling of the throat and tongue
- ✓ Difficulty in swallowing
- ✓ Hives anywhere on the body
- ✓ Generalised flushing of the skin
- ✓ Abdominal cramps and nausea
- ✓ Increased heart rate
- ✓ Sudden feeling of weakness or floppiness
- ✓ Sense of doom
- ✓ Difficulty in breathing – due to severe asthma or throat swelling
- ✓ Collapse and unconsciousness

Not all of these symptoms need to be present at the same time.

Medication

When a child is at risk of anaphylaxis, the treating doctor will prescribe medication for use in the event of an allergic reaction. These may include antihistamines, an adrenaline inhaler or an adrenaline injection.

The adrenaline injections that are most commonly prescribed are the 'Epipen' and the 'Anapen'. These devices are preloaded and simple to administer.

Working Together

When a school has a child at risk of anaphylaxis or when admission for such a child is sought, it is important to ensure that the child is treated normally and the parents'/guardians' fears are allayed by the reassurance that prompt and efficient action will be taken in accordance with medical advice and guidance.

Many schools which manage a child at risk of anaphylaxis have drawn up an individual protocol, (Health Care Plan Proforma 2) agreed by the parents/guardians, the school, the treating doctor and the education authority. The Health Care Plan deals with all of the important issues:-

- ✓ Emergency procedure
- ✓ Medication
- ✓ Food management
- ✓ Staff training
- ✓ Precautionary measures
- ✓ Professional indemnity
- ✓ Consent and agreement

This Health Care Plan forms an agreement that the best possible support is in place for both the child and the school staff.

The partnership of parents/guardians, school, medical practitioner and education authority is crucial in formulating such an agreement.

N.B. Some school caterers now exclude peanuts and peanut derivatives from their products. Parents/guardians may wish to make enquiries about the situation at their child's school.

Please see model Health Care Plan (Proforma 2) attached to this pack.

Day-to-Day Measures

Day-to-day measures are needed for food management, awareness of the child's needs in relation to the menu, individual meal requirements and snacks in school.

When school kitchen staff are employed by a separate organisation to the teaching staff, it is important to ensure that the catering supervisor is fully aware of the child's particular requirements. A code of practice can be formulated with the help of The Anaphylaxis Campaign.

Appropriate arrangements for outdoor activities and school trips should be discussed in advance by parents and the school.

Cookery and science experiments with food may present difficulties for a child at risk of anaphylaxis. Suitable alternatives can usually be agreed.

The individual child and the family have a right to confidentiality. However, the benefits of an open management policy could be considered. As with any other medical condition, privacy and the need for prompt and effective care are to be balanced with sensitivity.

Conclusion

A child at risk of anaphylaxis presents a challenge to any school. However, with sound precautionary measures and support from the staff and the doctor responsible, school life may continue as normal for all concerned.

ASTHMA AT SCHOOL

What is asthma?

Asthma, which is sometimes described as wheezing, causes the airways in the lungs to narrow, making it difficult to breathe. Sudden narrowing produces what is usually called an attack of asthma. Lesser or more persistent narrowing leads to less dramatic, but more frequent symptoms.

People with asthma have airways which are persistently inflamed (red and swollen) and therefore very sensitive to a variety of common stimuli. Asthma is not an infectious, nervous or psychological condition, although stress may sometimes make symptoms worse.

Inflamed airways are quick to react to certain triggers (irritants) that do not affect other children without asthma. Asthma triggers vary from child to child ; most children will be affected by several. Some common triggers are:

- ✓ Viral infections (especially common colds)
- ✓ Allergies (for example grass pollen, house-dust mites and furry or feathery animals)
- ✓ Exercise
- ✓ Cold weather, strong winds or sudden changes in temperature
- ✓ Excitement or prolonged laughing or crying
- ✓ Fumes and strong smells such as glue, paint, tobacco smoke and 'fresh air' aerosol sprays
- ✓ Cigarette smoke

Certain substances, which do not affect other people, can cause symptoms to develop in those with asthma. As the substance does not affect most others, it is described as an allergen.

The following are some common allergens:

- ✓ House-dust mites which live in soft furnishings, carpets and beds
- ✓ Furry or feathery animals
- ✓ Grass pollen
- ✓ In rare cases, foods like peanuts, milk and eggs

Other allergic symptoms include itching and redness of the skin (eczema), watery eyes (allergic conjunctivitis) and a runny nose or sneezing (hayfever, allergic rhinitis). These symptoms can occur with or without the symptoms of asthma.

How Asthma Affects Children

Children with asthma may have episodes (attacks) of breathlessness and coughing, and sometimes wheezing or whistling noises can be heard coming from their chest. They feel a 'tightness' inside their chest, which can be frightening and may cause great difficulty in breathing.

Individual children are affected by asthma in different ways. One child may occasionally experience minor coughing bouts and breathlessness, while another is unable to participate in games and is sometimes forced to stay off school. Sometimes a cough can be the only symptom of asthma.

Avoiding Attacks of Asthma

The use of modern treatments will help to avoid the symptoms of asthma, but it is important for individuals to be aware of their triggers so that they can avoid them or take precautions.

- ✓ Grass pollen can cause attacks from about late May to the end of July and children who are allergic to pollen may need to keep clear of flowering grass.
- ✓ Do not keep furry or feathery animals such as gerbils or hamsters in the classroom. Certain school pets can trigger a child's asthma.
- ✓ Fumes from science experiments can provoke symptoms.
- ✓ Food allergy is rare, but if the doctor asks a child to avoid certain foods it is important to follow this advice and not regard it as a 'food fad'.

When A Child With Asthma Joins Your Class

- ✓ Ask the parents/guardians about their child's asthma and current treatment. This information can be recorded on a National Asthma Campaign school card. If the child has severe asthma it may be helpful for teachers to consult either the school nurse and doctor, or the child's own GP.
- ✓ Only on agreement by Headteacher (see proforma), allow the child easy access to his or her medication: do not lock it away in the school office. Inhalers will be kept in the child's classroom in a nominated drawer / cupboard and all staff linked to the class will be informed

- ✓ Even the slightest delay in taking medication can cause unnecessary distress and can be dangerous. Ideally, children should carry their own reliever inhaler. Most children above the age of seven or eight are able to decide when they need it.

- ✓ Let the school nurse know if a child is often absent with chest problems or seems tired in class (which could result from disturbed sleep due to asthma).

- ✓ Some children need a discreet reminder to take medication (especially before exercise); it is worth remembering that some children are shy of taking medication in front of others.

- ✓ When the child is out of school on a trip, the inhaler will be taken out of storage and held by an adult attending the trip. The child will be reminded about who holds the inhaler. This will be included in information on school circulars and in advice to parents.

- ✓ Always inform the parents if the child is taking frequent reliever medication in school.

How Sport Affects Asthma

'Total normal activity' should be the goal for all but those with the most severe asthma.

Children with asthma become wheezy during exercise. After a five-minute run a child can get a severe attack of wheezing and coughing. If this happens, they must take their reliever inhaler. This type of asthma is called exercise-induced asthma. Teachers can help to identify undiagnosed asthma by spotting children who cough or wheeze a lot after exercising, especially in the winter.

The type of sport and the weather conditions are often crucial:

- ✓ Wheezing due to asthma is usually worse on cold, dry days than when the air is moist and warm.

- ✓ Prolonged spells of exercise are more likely to induce asthma than short bursts.

Swimming is an excellent form of exercise for children with asthma and seldom provokes an attack unless the water is very cold or heavily chlorinated.

The symptoms of exercise-induced asthma may be prevented if the child takes a dose of reliever bronchodilator medicine before beginning exercise. A dose of sodium cromoglycate before taking exercise may also reduce the symptoms. Children should warm up before playing games; several 30-second sprints over five to ten minutes may protect the lungs for up to an hour or so.

It is important that PE Teachers encourage children with asthma to take part in sport, to take their medication beforehand, where appropriate, and to keep it with them during the class. Children who are forced into inactivity may become psychologically and socially isolated and a child who is physically fit is probably better able to cope with an asthma attack.

Children who have lost confidence in their ability to participate should be encouraged to take part in active sports. It may help them to know that people with asthma (such as Ian Botham and Adrian Moorhouse) do succeed in competitive sports.

- No child should be forced to continue games if they say that they are too wheezy or breathless to continue.

Asthma Treatments

There are two types of treatments:

- ✓ Preventers – These medicines are usually taken twice daily outside school hours to make the airways less sensitive to the triggers. Generally speaking, preventers come in brown, orange, red and sometimes white inhalers. Preventers are rarely taken during school hours.

- ✓ Relievers – These medicines, sometimes called bronchodilators, quickly open up the narrowed airways and help the child's breathing difficulties. It is this inhaler a child needs immediately at the onset of an attack so it should never be locked away but always be accessible.

Methods of Taking Asthma Medicines

Currently, the best way of taking asthma medicines is to inhale them. Children need to use their inhalers properly to ensure that the correct doses of medicine reaches their lungs. Many children need to use a large plastic chamber called a spacer, into which the aerosol spray is released. Some children use a dry-powder device and many find this easier to take than an aerosol.

If you think that a child is having problems with taking his or her medication correctly, **please let the parents and the school nurse know**.

If another child gets hold of an inhaler and uses it, it will not cause any damage to that child. All the inhaled treatments are extremely safe.

How to help during the attack

Children with asthma learn from their past experience of attacks; they usually know just what to do and will probably 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. Taking the Reliever

Ensure that the reliever medicine is taken promptly and properly. A reliever inhaler (usually blue) should quickly open up narrowed air passages; try to make sure it is inhaled correctly. Preventer medicine is of no use during an attack; it should be used only if the child is due to take it.

2. Stay Calm

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 do not put your arm around the child's shoulder as this is restrictive.

3. Breathing

In an attack, people tend to take quick, shallow breaths, so encourage the child to try to breathe slowly and deeply. Most people find it easier to sit fairly upright or leaning forwards slightly. They

may want to rest their hands on their knees to support their chest. They must not lie flat on their back.

In addition, loosen tight clothing around the neck and offer the child a drink of warm water as the mouth becomes dry with rapid breathing.

4. Call a Doctor

A doctor should be called urgently if any of these apply:

- ✓ The reliever has no effect after five to ten minutes
- ✓ 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 not immediately available, *call an ambulance*. Repeat doses of reliever as needed (every few minutes if necessary until it takes effect) while awaiting help. Do not be afraid of causing a fuss. Doctors prefer to be called early so that they can easily alter the child's medication and make him or her well again.

5. 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 as normal.

A note will be taken of when the inhaler was used. This will be recorded in the red first aid files in class and / or the first aid book. A note will be given to parents where a significant event has occurred involving dosage and time.

Asthma Policy for Schools

This school:-

- ✓ Welcomes all pupils with asthma
- ✓ Will encourage and help children with asthma to participate fully in all aspects of school life
- ✓ Recognises that asthma is an important condition affecting many school children
- ✓ Recognises that immediate access to reliever inhalers is *vital*
- ✓ When planning activities such as PE/School trips etc. will ensure that either the medication is carried by the child, or if children are too young, teachers will carry the reliever with them.
- ✓ Will do all it can to make sure that the school environment is favourable to children with asthma
- ✓ Will ensure that other children understand asthma so that they can support their friends and so that children with asthma can avoid the stigma sometimes attached to this chronic condition
- ✓ Has a clear understanding of what to do in the event of a child having an asthma attack
- ✓ Will work in partnership with parents, school governors, health professionals, school staff and children to ensure the successful implementation of a school asthma policy.

NB. If children are too young to carry/administer their own relievers they must have access to them at all times and know where they are stored and who to go and see. Sometimes children will feel embarrassed putting their hand up to tell a teacher, they feel reluctant to draw attention to themselves. However, if this has been discussed previously with the teacher they feel comfortable coming up to the teacher or going to their drawer and fetching the inhaler.

EPILEPSY AT SCHOOL

About one in 100 children have epilepsy. In the UK around 80% live a normal life with medication, keeping their epilepsy under control.

What is Epilepsy?

Epilepsy is 'repeated seizures of primal cerebal origin'. This medical definition simply means that someone with epilepsy has a tendency to experience seizures, which originate in the brain.

Communication

The disability due to epilepsy can be substantially reduced if there is good communication between professionals, parent, the child with epilepsy and school friends. A free interchange between teachers, parent and carers is essential and parents should not be reluctant to disclose and discuss their child's epilepsy. Teachers need to know more than that a particular child 'has epilepsy', this fact alone is inadequate for correct understanding and supportive care.

Detailed information will be recorded on an individual health care plan for the pupil. (See Healthcare Plan within this pack). This will detail description of the seizures and their frequency, the normal speed of recovery, the most appropriate management for that child, any treatment and possible side effects etc.

Taking Risks

The presence of any disability in a child may alter the normal dynamics in a family, and lead to the child being over-protected. Whereas this is an understandable reaction, particularly if the seizures are accompanied by injury, it is often harmful in the long run and may lead to inappropriate behaviour and an over-dependence on the parents. In addition, parents and teachers may try to protect the child from stress if this is felt to precipitate seizures. A more productive approach is to teach the child the skills necessary to cope with stress, which is an inevitable part of everyday life.

Concern about safety may also lead to a child being barred from workshops, science labs and sporting activities. Blanket restrictions on all children with epilepsy are unacceptable and the risks to each child must be assessed individually on the basis of accurate knowledge of that child's epilepsy (information from Health Care Plan and discussions with parents).

Epilepsy manifests itself differently in people. If the seizures are completely controlled or only occur during sleep, then no restrictions are needed. Even if seizures occur during the day, almost all activities, including swimming and climbing can be undertaken providing the risks have been assessed and adequate supervision is in place.

The vast majority of children with epilepsy can watch television and use VDU's quite safely. However, it is essential to find out from parents/doctor etc. if the child is known to be sensitive to flashing lights. This should be discussed at the early stage when the Individual Health Care Plan is being drawn up.

What To Do During A Seizure

Seizures can be frightening to watch, but the child having the seizure is not in pain and will have little or no memory of what has happened. At the start of the attack, the person may cry out as the air from the lungs is expelled through the voice box. During the early phase of the seizure, breathing may stop and the child may go slightly blue. Although this looks frightening, it is to be expected until normal breathing resumes.

The attack cannot be stopped or altered so the best thing to do is follow these guidelines:-

- ✓ Call a first aider/school nurse to the scene
- ✓ Prevent others from crowding around
- ✓ Put something soft under the child's head (eg. Jacket or cardigan) to prevent injury
- ✓ Only move the child if he/she is in a dangerous place such as the top of a flight of stairs or in the road
- ✓ Remove any objects/equipment that the child is likely to bang into
- ✓ Do not attempt to restrain the convulsive movements
- ✓ Do not put anything in the child's mouth
- ✓ Check there has been no injury
- ✓ Roll the child if he/she is sick and place them in the recovery position
- ✓ Wipe away any excess saliva and if breathing is still laboured, check that nothing is blocking the airways
- ✓ Stay with the child until he/she is fully recovered
- ✓ Record how long the seizure has lasted. This can be communicated on to the parents/doctor and also importantly recorded in the pupil's Health Care Plan.

Seizures can sometimes manifest in a different way when consciousness is not lost or when the muscles stiffen and the child falls to the ground.

As these seizures can take many different forms, the response of observers will need to vary. If a person falls during a seizure you should make sure that there is no injury which needs medical attention. If prolonged confusion occurs:-

- ✓ Gently guide the child away from obvious dangers like wandering into the road
- ✓ Keep others from crowding around
- ✓ Speak gently and calmly to the child to help re-orientation to surroundings as quickly as possible.

- ✓ Remember that the child may be confused for some time after the seizure and it is better to leave well alone than to keep offering help and have it rejected with what might be misunderstood as aggression.

- ✓ Stay with the child until he/she is able to resume activities

When To Call For Help

Medical assistance should be called if any of the following have occurred:

- ✓ The child has injured themselves badly in a seizure

- ✓ The child has trouble breathing after a seizure

- ✓ One seizure is immediately followed by another, or the seizure lasts more than 5 minutes and you do not know how long they usually last

- ✓ The seizure continues for longer than usual

- ✓ If in any doubt at all call an ambulance

DIABETES AT SCHOOL

What is diabetes?

One in 700 children of school age has diabetes. It is therefore likely that staff in schools will teach or supervise a child with the condition at some time.

Diabetes cannot be cured, but it can be treated effectively. Children with diabetes will have treatment consisting of:

- ✓ Insulin injections

- ✓ Appropriate diet

The aim of this treatment is to keep the blood glucose level close to the normal range so that the blood glucose is neither too high (hyperglycaemia) nor too low (hypoglycaemia).

Insulin Injections

All children with diabetes will need injections of insulin. Insulin cannot be taken by mouth because it is destroyed by the digestive juices in the stomach.

In most cases, children will be on two injections of insulin a day. The injections will be taken at home, before breakfast and before the evening meal. When diabetes is newly diagnosed and the child and parents are learning how to do injections, they may take a little longer than expected in the mornings, this may mean that the child is occasionally late for school.

Some children will be taking more than two injections of insulin a day, in which case one of the injections may be taken at lunchtime. If a child needs to inject whilst at school, he or she will know

how to do the injection without the help of an adult. If the child injects using a disposable syringe, the school must have a safe system of work on 'disposal of sharps'. Children with diabetes need to balance their insulin with the food they eat and their level of physical activity.

Injections of insulin are given by means of a syringe or a pen device. The method used depends on the age of the child, the hospital he or she attends and the time since diagnosis. The injections of insulin will lower the blood glucose level and they need to be balanced with food intake.

If the blood glucose level is high, the child may need to pass urine frequently. If this happens regularly, the parents should be informed. It is important that requests to visit the lavatory are allowed.

Diet

An essential part of the treatment of diabetes is an appropriate diet. Food choices can help to keep the blood glucose level near normal.

The diet recommended for people with diabetes is based on the healthy, varied diet recommended for the whole population. Meals should be based on starchy foods. Food choices should be low in sugar and fat and high in fibre.

The child with diabetes will have been given guidance on food choices. These will be a balance of different foods, with particular attention being paid to carbohydrate foods, such as bread, rice, pasta, potatoes and cereals.

Snacks

Most children with diabetes will also need snacks between meals and occasionally during class time. These could be cereal bars, fruit, crisps or biscuits.

It is important to allow the child to eat snacks without hindrance or fuss. It may be worthwhile explaining to the class why this needs to be done, to prevent problems with other children.

Timing of Meals and Snacks

Equally important as the type of food eaten is timing of meals and snacks. The child with diabetes will need to eat his or her food at regular times during the day. This will help to maintain a normal blood glucose level.

Because the child needs to eat on time, he or she may need to be near the front of the queue and at the same sitting each day for the midday meal. If a meal or snack is delayed for too long, the blood glucose level could drop, causing hypoglycaemia.

HYPOGLYCAEMIA (OR HYPO)

Hypoglycaemia means low blood glucose. The possibility of a child having a hypoglycaemic episode (a hypo) is a worry to many people supervising children with diabetes. People have visions of children passing out or ending up unconscious. This is rarely the case and most hypos can be identified and treated without calling for professional medical help.

It is important to know what causes hypoglycaemia:

These are common causes of hypoglycaemia:

- ✓ A missed or delayed meal or snack
- ✓ Extra exercise (above that normally anticipated)
- ✓ Too much insulin

It has been noticed that hypoglycaemia may occur more frequently when the weather is very hot or very cold:

Symptoms can include:

- ✓ Hunger
- ✓ Glazed eyes
- ✓ Sweating
- ✓ Shaking
- ✓ Drowsiness
- ✓ Mood changes
- ✓ Pallor
- ✓ Lack of concentration

Each child's signs and symptoms will differ and the parents will be able to tell you how hypoglycaemia affects their child. This needs to be recorded in the child's Individual Health Care Plan. All staff supervising should be aware of the contents of the Health Care Plan.

If the child displays any of these signs and you are not sure whether it is hypoglycaemia, talk to the child. If you are in doubt, treat it hypoglycaemia.

How to treat Hypoglycaemia

Fast acting sugar should be given immediately. This will raise the blood glucose level. It is most important that you do not send a child who is hypo unaccompanied to get sugary food. Always make sure that he or she is accompanied.

Here are some examples of fast acting sugars:

- ✓ Lucozade
- ✓ Sugary drink, such as Coke, Fanta (not diet drinks)
- ✓ Mini chocolate bar, such as Mars, Milky Way
- ✓ Fresh fruit juice
- ✓ Glucose tablets
- ✓ Honey or jam
- ✓ 'Hypo-Stop' – a glucose gel which is available from the medical team. The child's parents will be able to provide this.

The parents will be able to tell you what is appropriate for their child, together with the quantity. Most children with diabetes have their own preferred fast acting sugars. It is important that this information is recorded on the Health Care Plan and communicated to staff. Teachers can help by having fast acting sugar in their desk and, when out of the classroom, readily available at all times.

If the child is unable to swallow, try rubbing sugary jam, honey or Hypo-Stop (a special hypo preparation described above) inside the cheek, where it can be absorbed. In the unlikely event of the child losing consciousness, place him or her in the recovery position and call an ambulance. You can rest assured that if the child does lose consciousness, he or she will come round eventually and should not come to any immediate harm.

Recovering from Hypoglycaemia

When the child recovers, he or she will need to eat some slower acting starchy food (such as a couple of biscuits and a glass of milk, or a sandwich) in order to maintain the blood glucose level until the next meal or snack.

Recovery from hypoglycaemia should take about ten to fifteen minutes. The child may feel nauseous, tired or have a headache.

Hypos are a part of living with diabetes. Isolated incidents are inevitable. However, if the child is having hypos at school, you should inform the family.

Blood Testing

Children with diabetes can check the level of glucose in their blood by means of a simple blood test. The child will have been shown how to do this.

The test involves a simple finger prick to produce a small drop of blood. The drop is put on to a prepared reactive strip, which will indicate the level of glucose in the blood. The level can be read either by sight or by a small machine. The child will have his or her own container for disposing of used blood testing equipment.

This test takes about two minutes and can be done in the classroom, on the school bus or in any other convenient place.

It is important to talk to the parents about blood testing. The frequency with which children carry out tests will vary. Depending on the child, you may or may not see a blood test carried out at school.

If the child displays any of the signs of hypoglycaemia it would be sensible to advise the child to do a blood test.