HOLLAND HOUSE SCHOOL

13a – FIRST AID POLICY

Applicable to all pupils including those in the EYFS

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

References:

A. Keeping Children Safe in Education, 2021
B. Working Together to Safeguard Children, 2018.
C. Information Sharing, March 2015.
D. RIDDOR (Reporting of Injuries, Diseases & Dangerous Occurrences Regulations), updated 2013.
E. DfE, Guidance on First Aid for Schools, February 2014.
F. DfE, Supporting Pupils at School with Medical Conditions, August 2017.
G. Public Health England – Guidance on infection control in schools and other childcare settings, dated 2017.
J. NICE, Anaphylaxis Guidelines CG134, reviewed August 2014.
K. HSE, L74 – First Aid at Work (Third Edition), April 2018.
L. HSE, OCE 23 – Cleaning up Body Fluids, dated 2011.
M. DfE Understanding and Dealing with Issues Relating to Parental Responsibility, September 2018

1. Aim.

This policy aims to ensure that the school has adequate, safe and effective first aid provision in order for every student, member of staff and visitor to be well looked after in the event of any illness, accident or injury. First Aid will be carried out in a timely and competent manner no matter how major or minor the incident.

2. Philosophy of Care.

The school provides general, non-judgemental access to healthcare, advice and education for children, parents and staff. This is delivered by paediatric trained staff. A member of staff is available to attend medical needs at all times.

3. Delegated Responsibilities and Implementation.

a. **Governance**. The Board of Governors has oversight of first aid, health and the required underpinning policies and processes; notice and no-notice checks are conducted.

b. **Headmistress**. The Governors delegate day-to-day responsibility and oversight to the Headmistress for ensuring the school has adequate and appropriate first aid equipment, facilities and trained personnel, and for ensuring that the correct medical, first aid and clinical procedures are applied.

c. **School First Aiders**. The School First Aider is based in the school medical area on the ground floor and oversees required medical routines as set out in this policy and has the delegated responsibility for drafting/reviewing related documentation. The line management of the School First Aider covers routines directly beneficial to the welfare of all pupils.

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

4. PSHE and Health.

Personal, Social and Health Education (PSHE) provides age appropriate advice and guidance on healthy eating, making healthy lifestyle choices and keeping fit. The school medical area has an open-door policy in that any child can come and discuss any concerns or queries they may have relating to their physical and mental health, and emotional wellbeing at any time.

5. Practical Arrangements at the Point of Need.

a. **Accident**. In the event of an accident or serious medical emergency the First Aider can be immediately contacted either by telephone or using one of the School's walkie-talkie radios. All staff should be prepared to contact the emergency services if required and appropriate.

b. **Capability**. School First Aiders are trained in Paediatric First Aid and attend regular additional training in more specialist areas such as adrenaline auto-injector training.

c. **Medical Area**. The school medical area is equipped with essential first aid facilities and equipment; adrenaline auto-injectors, spare inhalers, a fully stocked first aid cabinet, a wash basin and a bed sick bay.

- The Medical Area is staffed during term-time by the First Aider from 8.30am – 3.30pm Mon-Fri. At other times the Medical Area is staffed by a designated member of staff with first-aider training. Trained School Office personnel cover the first aid area during the designated staff breaks.

- Outside these times, first aid cover is provided by form teachers, Office or Welfare Staff who are also first aider trained

6. Pandemics and Infectious Diseases.

We have contingency plans in the event of a pandemic, and isolation of child/children, in the event of an outbreak of infectious disease. All infectious diseases are reportable to the Health Protection Agency.

- See **Annex A** for the Procedure in the Event of Illness Policy
- See **Annex B** for the Caring for a child who needs to be isolated

Once children have been assessed, parents are contacted by either the School Office, Headmistress or a member of the Welfare Team to come and collect their child as soon as possible. If the child is deemed to be infectious, then they are isolated until the parent can return to School. On collection of the child the parent/guardian is notified of the period of required absence. All data is collated on the child's medical file in First Aid.

7. Staff and First Aid Qualifications.

a. The First Aider holds a current Paediatric first Aid Certificate and a First Aider at Work Certificate.

b. Office staff are responsible for ensuring that members of staff have the appropriate and necessary first aid training and that they have sufficient understanding and confidence to deliver the required first aid at the point of need.

c. In the Reception Year and Pre-Prep, at least one person with a current paediatric first aid certificate is on the premises at all times when the children are present. This also applies to outings and trips.

d. In the School, most teaching staff are first aid trained and receive update training every three years.

e. List of Staff members qualified in First Aid Training:

Staff Name	Paediatric First Aid	Renewal date	Anaphylaxis	Renewal date
Emily Brown	Level 3	2nd Sept 2022	3 Hours	5th Jan 2023
Raksha Dave	Level 3	2nd Sept 2022	3 Hours	5th Jan 2023
Laura Zarandi	Level 3	8th Sept 2023	3 Hours	5th Jan 2023
Paul Longman	Level 3	6th Sept 2024	3 Hours	5th Jan 2023
Reena Damani	Level 3	2nd Sept 2022	3 Hours	5th Jan 2023
Elisavet Sotiriadou	Level 3	6th Sept 2024	3 Hours	5th Jan 2023
Mimi Ko	Level 3	2nd Sept 2022	3 Hours	5th Jan 2023
Claudia Parker	Level 3	2nd Sept 2022	3 Hours	5th Jan 2023
Paul Rowbotham	Level 3	6th Sept 2024		
Louise Wigodsky	Level 3	2nd Sept 2022	3 Hours	5th Jan 2023
Caroline Ng	Level 3	2nd Sept 2022	3 Hours	5th Jan 2023
Eleonora Salmons	Level 3	19th Apr 2022	3 Hours	5th Jan 2023
Nicola Geller	Level 3	19th Apr 2022	3 Hours	27th Jan 2023
Anne Wold	Level 3	19th Apr 2022	3 Hours	5th Jan 2023
Sally Muchmore	Level 3	6th Jan 2022	3 Hours	5th Jan 2023
Sally Muchmore	First Aid at Work Level 3 (3 Days)	12th Jan 2025		
Simon Muchmore	Level 3	6th Jan 2022	3 Hours	5th Jan 2023
Simon Muchmore	First Aid at Work Level 3 (3 Days)	12th Jan 2025		
Sujala Mehra	Level 3	6th Jan 2023	3 Hours	5th Jan 2023
Sajeda Shaikh	Level 3	6th Jan 2023	3 Hours	5th Jan 2023
Deval Shah	Level 3	6th Jan 2023	3 Hours	5th Jan 2023
Jo Conway-Boyne	Level 3	6th Jan 2023	3 Hours	5th Jan 2023
Claire Timberlake	Level 3	8th Sept 2023	3 Hours	5th Jan 2023
Michaela Kamoum	Level 3	6th Jan 2023	3 Hours	5th Jan 2023
Vivien Ho (Yuet Wan)	Level 3	6th Jan 2023	3 Hours	5th Jan 2023
David Kamoum (Chabane)	Level 3	6th Jan 2023	3 Hours	5th Jan 2023
Sue king	HABC (19th July 2015)			
Sue King	Oxygen Therapy Admin Instructor			21st Mar 2022

Sue King	Cardiopulmonary Resuscitation & External Defibrillation		Level 2	20th Mar 2022
Sue King	Anaphylaxis Instructor			21st Mar 2022
Sue King	IQL Level 2 Award in Pool Lifeguarding Intervention, Supervision & Rescue	25th Aug 2022		

8. Access to First Aid Kits.

a. First Aid kits are conspicuous and coloured green with a white cross. There is a first aid cupboard in the medical area and other first aid kits are located in the following areas: First-Aid Room, Kitchen, Reception Classroom, outside the Art Room, Staff Room and the Playground. An orange burns box is located in the playground.

b. Kits are checked termly by the First Aider and replenished as required. If a kit is used it is that person's responsibility to inform the school Office so that rapid replenishment can take place.

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

9. Arrangements for Pupils' Health and those with Particular Medical Conditions.

a. Parents are requested to complete a health questionnaire prior to starting the school and this questionnaire is renewed at the start of every school year. It consists of general medical information, immunisations, allergies and a signed consent form allowing a first aider to administer first aid to their child as necessary. It also gives permission for the first aider to give basic over the counter medications, and any prescribed medications the child may be given. Consent forms and Individual Health Care Plans for each pupil are kept locked in the School Medical Area.

- See **Annex C** for Health Records and Supporting Children with Medical Conditions Policy
- See **Annex D** for the Storage and Administration of Controlled Drugs Policy

- See **Annex E** for the Early Years Administration of Medication Policy • See **Annex F** for the General Medication Administration Policy

b. With parents' consent a 'mini list' will be available in the staff room which highlights those children who have serious medical conditions such as diabetes, epilepsy and severe allergies so that teachers and first aiders are aware. Where appropriate we have health care plans for those children with chronic illnesses or ongoing medical needs. This information will be shared on a need to know basis with respect to confidentiality and the needs of the child in school.

- See **Annex G** for the Asthma Policy
- See **Annex H** for the Anaphylaxis Policy
- See **Annex I** for Diabetes Policy

c. Where appropriate individual pupils may be given responsibility for keeping lifesaving equipment with them and their suitability for this arrangement will be reviewed regularly. For example, children who have inhalers or adrenaline autoinjectors.

- See **Annex J** for the Consent Policy

10. Hygiene Procedures for dealing with the Spillage of Body Fluids

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

b. **Procedures**. The first aider should take the following precautions to avoid risk of infection.

- Ensure a good standard of ventilation
- Wear suitable personal protective equipment such as disposable gloves and apron when dealing with blood or other bodily fluids
- Use sterile wipes and clean water to cleanse wound
- Cover any cuts and grazes with a waterproof plaster
- Use the spillage kits located in the medical area to deal with bodily fluids and scrape up residues into a closable container for safe disposal
- Bag up contaminated material that needs laundry or disposal
- Wash surfaces with detergent before disinfecting. Infection control-in health care settings we would also consider a deep clean after vomit/ blood (high risk of infection compared with urine). The Site Manager should be contacted to ensure the affected area is deep cleaned.
- Wash hands after every procedure
- If the first aider suspects that they or any other person may have been contaminated with blood or other bodily fluids, the following action should be taken:

- Wash splashes off skin with soap and running water.
  - Wash splashes out of eye with water or saline pods (in first aid kits)
- Report incident and take medical advice if appropriate
- Instruct all staff and pupils in the locality to wash before eating or drinking, and after touching any surface or object that might be contaminated

11. Accident/Injury Procedure and Guidance when to call an Ambulance

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

Danger
Response
Shout for Help
Airway
Breathing
Circulation

(1) **Assess the Situation.** Consider the following:

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

(2) **Think of Safety - Consider** the following points.

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

(3) **Treat Serious Injuries First – think Airway, Breathing, Circulation**

- In the event of an accident where more than one person has been injured, go to the quiet casualty first - they may be unconscious
- **DO NOT MOVE** the casualty if there is a risk of significant head, neck or spinal injury, unless there is immediate danger to life
- If the casualty has stopped breathing, commence chest compressions and or mouth-to-mouth resuscitation immediately (note that mouth-to-mouth is not a legal requirement)
- If the casualty is bleeding seriously then every reasonable measure must be taken to bring this under control

(4) **Get Help**

- Shout for help - someone may hear you although it may not be obvious that there are people nearby

- If there is someone with you, tell them to fetch another member of staff – telephone or radio for help
- If an ambulance is required than call 999
- Arrange for staff to meet and direct the ambulance
- Arrange for adult to accompany pupil to hospital
- Manage the emergency or incident to the best of your ability until relieved by a member of the SLT

(5) **Once Incident Stabilised**

- Communicate with a member of the SLT
- If off site, arrange for the rest of the group to return to School/safety
- Note witnesses – names and addresses. Do not discuss legal liability
- Refer any media at the scene back to the Headmistress
- Write down all details while fresh in memory - who/why/what/where/when • Complete accident form.
- The completed accident form is placed in the child's file • A copy is sent home

b. In the case of a minor accident or injury, the on-site first aider should deal with the incident appropriately. However, if there is any doubt a second opinion must be sought to either confirm the correct actions have been taken or to remove the pupil to sick bay for assessment and further treatment as necessary.

c. The school first aider is to be informed of all accidents and injuries so the child's medical records can be updated.

d. **Guidance when to call an Ambulance**. An ambulance is to be called in the following circumstances:

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

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

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

- See **Annex K** for the Taking Children to Hospital Policy

g. **Informing Parents**. Parents are informed on the day of the accident either via the home & school contact book, at pickup or if felt more immediate notification is required the parent is contacted by telephone

12. Reporting of Injuries, Disease and Dangerous Occurrences (RIDDOR)

a. All accidents, injuries and illness are to be reported to the school office.

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

c. **Staff**. Injuries to staff and visitors should also be reported to the school office.

d. **Reporting**. Using the HSE and RIDDOR guidelines, the school is legally required to report certain injuries, disease and dangerous occurrences:

- Work related accidents resulting in death or major injury will be reported immediately to the HSE
- Work related accidents which prevent the injured person from continuing with their normal work for more than seven days will also be reported to the HSE
- Certain dangerous occurrences (near misses) will be reported

e. **Accident Data**. Accident data is collated and presented to the termly H&S Committee meeting in order to review the risk, apply necessary amendments to procedures or Risk Assessments.

f. **Accident Grading System**. The following grading system for accidents is used:

1. Minor injury/accident requiring no or little intervention e.g. falls (**not including head bumps/injuries**) with no obvious injury or small graze.

A head injury or bump, no matter how minor it may appear, cannot be graded in this category.

2. Minor injury requiring some intervention e.g.; cleaning of small wound, application of ice, nose bleed. (not including head bumps/injuries)

A head injury or bump, no matter how minor it may appear, cannot be graded in this category.

3. Minor injury or accident requiring intervention, monitoring and observation e.g. **minor head injury including bumps**, sprain, significant wound. (parents to be informed-child may be sent home) An accident form should be considered so that the Headmistress is aware.

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

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

g. Accident Forms - Process

- Child assessed by First Aider – first aid and appropriate treatment given
- Decision made for required escalation of care; call parents, A&E, home, etc
- Treatment documented in individual health record
- Once child stabilised or medical diagnosis made and confirmed accident form is completed
- The accident grading is made at the initial point and updated as required if the medical diagnosis changes
- Once all facts gathered a decision regarding RIDDOR, accident investigation requirements, etc. is made
- Completed accident forms are passed to the School Office for assessment
- A copy is placed in the staff member's personnel file or child's medical records and a further copy in the Accident/incident folder held in medical area
- An overview of patterns/clusters is considered at termly H&S meetings where all accidents from the previous term are considered, lessons identified or required changes to policy or procedure agreed.

Annex A - Procedure in the Event of Illness Policy

1. If a child is unwell during lessons, then a member of staff will assess the situation and decide the next course of action. If required the child will be accompanied to the Medical Area by an adult if they have sustained a head injury, in a lot of pain, vomited or are distressed.

2. If required the First Aider will then provide first aid as required and decide when and if the child can return back to class, and whether to contact the parents.

Annex B - Caring for a child who needs to be isolated

1. **Aim**. To ensure that potential spread of viral or bacterial infections is minimised throughout the school.

2. **Process.**
   a. When in doubt isolate the child from others – then seek additional advice.

   b. Inform parents if a child needs to be isolated. Ask parents to collect them from school as soon as possible. Offer appropriate nursing advice e.g. temperature control, fluids, assessment via Family GP.

   c. Children with vomiting and/or diarrhoea should remain off school for 48 hours after the last episode.

   d. Discuss situation and numbers currently involved with the Headmistress.

   e. If more than three children, consider if there is a need to set aside a room for isolated children.

      (1) When a temporary sickbay is opened, mark the room with an 'overflow sickbay'.

      (2) Inform other staff.

   f. Document any episodes of contagious type symptoms e.g. Diarrhoea/Vomiting/Rashes/notifiable diseases to the Health Protection Agency (HPA).

   g. After an outbreak or use of a bed or sick bay by an infectious child, such as with gastroenteritis, it is best practice to perform a deep clean of the area as part of good infection control. The Site Manager is to be contacted to ensure a deep clean is carried out.

Annex C - Health Records and Supporting children with medical conditions.

1. All children have their own individual health record clearly labelled with their full name. All Individual Folders are clearly labelled to mark any medical conditions using a coloured dot to state the following:

BLUE – ASTHMA
GREEN – MEDICAL CONDITIONS SUCH AS EPILEPSY OR DIABETES RED – ANAPHYLAXIS/AUTO INJECTORS
YELLOW – ALLERGY (STATING ALLERGY)

2. Where necessary Individual Care Plans are formulated with pupils and parents and discussed with consent of parents and child with appropriate staff. Close liaison with academic, welfare and sports staff with regards to the medical management of needs and support for the child. Extra training for staff may be required depending on the individual child's need. The school office will liaise with other professionals and healthcare staff in the community to ensure we can provide a safe environment where the child can participate in all school activities as much as possible.

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

4. All records contain relevant health and welfare information provided by parents and consent for first aid treatment in school and on trips. These records include any significant known drug reactions, major allergies and notable medical conditions, and this information is available to staff likely to administer medication or treatment. All records are held in a locked cupboard.

5. Records include identification of the persons with parental responsibility, contact details for parents and any other emergency contact arrangements, and any court orders affecting parental responsibility or the care of the pupil. Medical information is stored on the school's MIS system.

6. Regular meetings take place between the Staff to discuss any children that have been identified as requiring individual support in the way of individual welfare plans or individual care plans protecting confidentially where necessary.

Annex D - The Storage and Administration of Controlled Drugs

1. **Aim**. For all such medications to be securely stored, to ensure no child or unauthorised person has access to them. **All such medication to be fully accounted for.**

2. **Procedures**.

   a. All Controlled Drugs (CDs) are to be signed in and out of the Medical Area, e.g. when being dispensed daily, taken home for holidays, returned from holidays via parents, or when repeat prescriptions being brought in from Pharmacy.

   b. For CDs to be kept locked away.

   c. For Medication sheet to clearly state the child's name and the medication to be administered and the time of administration. **Each time medication given to be dispensed and signed for by a qualified first aider.**

   d. Monthly rechecking of CDs held in Medical Area to be carried out by two First Aiders.

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

   f. For any loss of medication to be reported using a formal report and for School Office, Headmistress and Parents to be contacted ASAP.

Annex E - Early Years Administration of Medication

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

2. **Procedures**.

   a. **Prescribed Medicines**.

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

      (2) The parent will take medication to the Primary Paediatric First Aider for safe storage and to sign a consent form.

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

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

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

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

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

      (5) The parent must sign and date the 'Medication Consent form'. The dose, time and date are all recorded in the Incident Note folder in first aid and a Visit to first Aid form is sent home to parents.

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

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

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

(9) Should a child be prescribed antibiotics, they must remain at home for the first 24 hours of the course.

(10) The School reserves the right to state that they are unable to administer a prescribed medication to a child and in such cases the parent or guardian will be asked to come into school at the required time to administer the medication themselves.

b. **Emergency Paracetamol Procedures**.

(1) The reason for giving medication to be established

(2) Paracetamol may be given for a temperature over 37.5 degrees centigrade or over.

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

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

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

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

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

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

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

(10) Parents to be informed of time and dose of medication given on collection.

Annex F – General Medication Administration Policy

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

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

3. Should a child be prescribed antibiotics, they must remain at home for the first 24 hours of the course.

a. **Process**.

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

(2) Complete 'Medication Consent form" which parents sign.

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

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

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

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

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

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

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

a. **Process**

(1) Get a clear history from the child and ideally the parent to establish the health need and if medication is required.

(2) Check that the child does not have any contra-indications e.g. asthma, renal failure, not to take ibuprofen. (**These details are noted on the pupil's folder**).

(3) Check if the child has any allergies.

(4) Check medical records to see history and to check for any medication given recently.

(5) Ensure the correct dose is given at the correct time and that not more than the allowed dose is given over a 24 hour period.

(6) Document dosage/time and signature in child's records.

(7) First Aiders to review notes and pupils who require OTC medication for more than 2 days.

(8) Contact parents and/or arrange medical review as required.

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

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

6. All medication which is out of date, no longer required, or not collected by parents after an agreed time, is disposed of via the local pharmacy. Sharps Bins are given to the GP surgery to dispose of. All Stock is checked termly, replenished and disposed of as necessary.

Annex G - Asthma Policy (policy written and adapted with advice from Asthma UK)

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

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

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

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

   a. **Common Triggers:**

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

   b. **Common Signs of an Asthma Attack**.

   - Coughing
   - Shortness of breath
   - Wheezing
   - Tightness in chest
   - Being unusually quiet
   - Difficulty in speaking in full sentences
   - Sometimes young children will express feeling tight in the chest as tummy ache.

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

- **Keep calm**, send another child to get assistance
- Encourage the child or young person to sit up and slightly

- forward – do not hug or lie them down
- Make sure the child or young person takes two puffs of reliever inhaler (usually blue) immediately – preferably through a spacer

6. **How to use an inhaler**.

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

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

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

8. **If there is no immediate improvement**. Continue to make sure the child or young person takes one puff of reliever inhaler every minute for five minutes or until their symptoms improve. Call 999 or a doctor urgently if:

- No improvement after 10 puffs
- The child or young person's symptoms do not improve in 5–10 minutes
- The child or young person is too breathless or exhausted to talk
- The child or young person's lips are blue
- You are in doubt
- Ensure the child or young person takes one puff of their reliever inhaler every minute until the ambulance or doctor arrives

9. **Asthma Medicines.** The school recognises that pupils with asthma need immediate access to reliever inhaler at all times. Immediate access to reliever inhalers is essential. All children should have an inhaler at school.

10. All school staff will let pupils have access to their medicine when they need to.

    a. Spare Ventolin inhalers are kept in the medicine cupboard in Medical Area. Inhalers are also taken out to Games.

b. All inhalers and medications should be signed in and out of the medication book to enable tracking of all medication held in the Medical Area.

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

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

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

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

11. **Record Keeping**. The school keeps records of all pupils with asthma and the medicines they take. When the child joins the school, a medical questionnaire is sent out to parents. If the child is noted to have asthma then more information is asked for, initially by telephone call, followed up by a request for an Asthma UK School Card or a Care plan to be completed.

12. An Individual Health Care plan is completed for those pupils that have moderate to severe asthma, that are on a preventer and possibly been hospitalised before due to asthma.

All pupils with asthma are clearly identifiable on their notes by a blue dot on their name sticker. Care plans need to be reviewed on a yearly basis by the school first aiders and parent/carers. A central asthma register is kept and is available to all staff on the central notice board in the staff room, in all match and trip first aid kits and in the medical area.

13. **Exercise and Activity - PE and Games**. The school ensures that the whole school environment, including the physical, social, sporting and educational environment, is favourable to pupils with asthma. Taking part in sports, games and activities is an essential part of school life for all pupils. All staff know which children in their class have asthma and all PE teachers at the school are aware of which pupils have asthma from the school's Medical Form. Games teachers are to be aware of pupils that have asthma, that are going on an "away" school match and to ensure that those pupils have their inhaler and spacer with them.

14. Pupils are encouraged to participate fully in all PE lessons. PE teachers will remind pupils whose asthma is triggered by exercise or cold in the winter months to take their reliever inhaler before the lesson, and to thoroughly warm up and down before and after the lesson. All pupils need to take their inhaler down to the lesson site with them and are encouraged to use them if need be. All PE, games coaches and classroom teachers are aware of what to do in an asthma attack and received training. Classroom teachers follow the same principles as described above for games and activities involving physical activity.

15. **Roles and responsibilities**. The school will work in partnership with all interested parties including the governing body, all school staff, parents/carers, employers of school staff, doctors and nurses and pupils to ensure that the policy is planned, implemented and maintained successfully.

a. **All School Staff have a Responsibility to:**

Understand the school's asthma policy.

- Know which pupils they come into contact with asthma.
- Know what to do in an asthma attack.
- Allow pupils immediate access to their reliever inhaler.
- Inform First Aider and parents/carers if child has an asthma attack.
- Inform First Aider and parent/carers if pupils are taking more reliever inhaler than they normally would.
- Ensure that pupils have their asthma medication with them if they are going out of school on a school trip.
- Ensure pupils that have been unwell catch up on missed school work.
- Be aware that pupils may be tired due to night time symptoms.
- Keep an eye out for pupils with asthma experiencing bullying.
- To notify School Office if they require further training.

b. **PE Teachers**. PE teachers have a responsibility to:

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

c. **School First Aiders**. School First Aiders have a responsibility to:

- Help plan and update the school asthma policy.
- Provide regular updates for school staff in managing asthma.

Will ensure an up to date list of all pupils with asthma is kept in the staff room and in all match and trip kits. (Parental consent is given via medical questionnaire).

- Liaise with parents to ensure continuity of care between school and home with regards to asthma management, recognizing triggers and use of inhalers.
- Ensure that all pupils with asthma have their medical notes clearly labelled with a blue dot label to indicate that they suffer with asthma.
- Ensure that pupils know how to use their asthma inhaler (and Spacer) effectively.

Pupils. Pupils have a responsibility to:

- Treat other pupils with and without asthma fairly,
- Tell their parents/carers, teachers, PE teachers and school First Aiders when they are not feeling very well.
- Know how to take their own asthma medicines.

d. **Parents/Carers.** Parent/carers have a responsibility to:

- Inform the school on the child's admission to the school, (via a medical questionnaire) that the child has asthma.
  Inform the school if a new diagnosis of asthma is made or the child has asthma symptoms.
- Tell the school of any changes to the child's asthma medication.
- Tell the school of any change in the child's asthma symptoms.
- Ensure the child's asthma medication and spacer is labelled with their name.
- Keep the child at home if they are not well enough to attend school.
- Ensure their child has regular asthma reviews with their doctor or nurse every 6-12 months.

Annex H - Anaphylaxis

1. Anaphylaxis is an extreme allergic reaction requiring urgent medical treatment. Most common allergens are food products such as nuts, fish and dairy products. However, in some cases sufferers can be allergic to all sorts of different food produce. Other common triggers are wasp/bee stings.

2. **Signs and Symptoms**.

   - Metallic taste and itching in mouth
   - Swelling of face throat tongue or lips
   - Difficulty swallowing
   - Wheezing / difficulty breathing
   - Abdominal cramps and or nausea
   - Feeling faint
   - Flushed
   - Collapse / unconsciousness

3. **Treatment**.

   - Remain calm and stay with child
   - Call for help. Ask someone to locate adrenaline auto-injector.
   - Call 999
   - Give adrenaline injection on the outer thigh, hold in for 10 seconds (try to note the time)
   - Place the child in a comfortable position
   - Observe the child for improvement – if there is no improvement, administer a further dose of adrenaline 5-10 minutes after the first dose.
   - Await ambulance crew
   - Call parents

4. Annual anaphylaxis training given to staff.

5. Adrenaline auto-injectors are located in the Medical Area in the cupboard labelled Epi-pens. These are named with whom they belong to.

6. The children who are known to have severe reactions are known to all staff. A poster with children's names and photo is clearly displayed in the staff room. Close liaison between the welfare staff and the teachers is required and the adrenaline auto injections are made available to children going on trips and away matches.

7. Holland House School is a nut free school and the sharing of snacks is forbidden.

8. Children can bring individually portioned birthday treats (cupcakes, doughnuts etc) Parents are asked to ensure that these do not contain nuts and that they come to school in their unopened, original packaging so that teachers can check ingredients. Treats are generally distributed at the end of the school day in the playground.

9. Children with auto-injectors, are asked to wear a small red badge on their collars so that they are instantly identifiable by all members of staff.

10. The kitchen is updated as soon as the school is made aware of any allergy changes.

Annex I - Diabetes Policy

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

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

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

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

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

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

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

   a. **Food**. Children with diabetes should follow the same diet that's recommended for all children – one that's low in fat (for older children), salt and sugar and includes five

portions of fruit and veg a day. Too many sweets and chocolates aren't good for anyone, so they should be a treat rather than a regular snack. Diabetic foods are not recommended because they still affect blood glucose levels, can have a laxative effect and are expensive.

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

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

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

5. **Highs and Lows**.

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

- has had too much insulin
- hasn't had enough carbohydrate food
- has been more active than usual

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

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

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

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

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

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

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

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

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

- has missed an insulin dose or hasn't taken enough insulin
- has had a lot of sugary or starchy food
- has over-treated a hypo
- is stressed
- is unwell

- has a problem with their pump.

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

6. **School Life**.

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

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

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

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

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

c. **Overnight stays**. When staying overnight on a school trip, a child who injects will need to take insulin injections and test their blood glucose levels (which may include testing at night), even if these aren't usually done in school. If the child can't do their own injections, manage their pump or test their blood glucose levels, they'll need to be done by a trained member of staff. School staff should meet with the child's parent, carer and PDSN well in advance of the trip to discuss what help is required and who will assist the child.

Annex J - Consent Policy

1. **Medical Treatment – Seeking Consent following Accident or Injury .** Schools may experience problems when a child has had an accident and consent may be needed for emergency medical treatment. The Children Act 1989 and The Children Act 2004 provides that people who do not have parental responsibility but nonetheless have care of a child may:

   '…do what is reasonable in all the circumstances of the case for the purpose of safeguarding or promoting the child's welfare'.

This would allow schools to act 'in loco parentis', i.e. in place of a parent, or allow them to seek consent from a parent who may not hold parental responsibility. It would clearly be reasonable for a school to take a child who needs to have a wound stitched up to hospital, but the parents, including the non-resident parent who has asked to be kept informed of events involving the child, should be informed as soon as possible.

2. Gaining consent from a child is not age dependent and is based on their understanding of the treatment to be given. For minor treatments, overall consent has been gained from parents/guardian. It is good practice to gain the consent of the child through explaining what is to be done and why.

3. **Process**.

   a. **Formal** consent to routine and emergency care is **sought by parents/ guardians** on entering the school, via the medical questionnaire.

   b. That **informal** consent to treatment is gained **from the child** on a treatment to treatment basis where possible.

   c. Consent is a patient's agreement for a carer to provide care and / or treatment. Consent can be formal, informal, verbally or non-verbally from a child.

   d. Gaining consent is both good practice and a legal requirement.

   e. To give consent a child must be considered 'competent' i.e. that they 'have sufficient understanding and intelligence to enable him or her to fully understand what is proposed'. This competence is not based on age, but on understanding. **NO child under 16 is automatically deemed to be 'competent', but where possible their consent should be sought**.

   f. That unless it is an emergency situation where **no** treatment will cause harm, a child's consent should be gained prior to treatment. This can be as simple as the First Aider explaining what is to be done and the child not objecting. (With smaller children, giving a choice sometimes gets a negative response when they are frightened that treatment will hurt, this is different from a child who actively objects to treatment.)

4. **Guidelines**. Where a child is not deemed 'competent', seek the parents' consent. For day to day treatment this needs to be a formal signature from parents/ guardians. Where parents have not returned medical questionnaires, contact them by telephone in the first instance and seek verbal consent then reminders by email for the prompt return of the questionnaire and signed consent. In an emergency consent does not have to be gained from a child under 16 as this reverts to the parent/ guardian to give or deny consent. The key to gaining valid consent is that a child must be given the correct information about treatment and at an appropriate level for his/her age and ability. Where any child declines treatment for whatever reason, do not pressure the child, but do explain the consequences of not having the treatment and inform the parents if the child still declines treatment.

Annex K - Taking Children for Emergency Trips to Hospital

1. Where children need urgent medical attention, ensure they are escorted by the most appropriate member of staff and that parents are aware and updated.

2. **Process.**

   a. Assess the child in which ever place the situation necessitates. If a child cannot be fully treated at school consider where they need to be treated, e.g. parents take to GP, parents take to A&E, staff takes to A&E and for parents to meet staff and child at pre-arranged A&E department, paramedics to be called and pupil to transfer to hospital via ambulance, one member of staff to accompany, unless parents present.

   b. Administer first Aid.

   c. Inform the office and Headmistress of intention i.e. what/where/who/when.

   d. If possible, either contact parents yourself or instruct another member of staff to do so (best done in person in order to give an accurate account).

   e. Take a mobile with you and inform the office of your mobile number (ensure that your own phone is charged and switched on).

   f. If you are escorting an ill child, one member of staff will be needed to drive and another to sit in the back with the child. Take vomit bucket, tissues, old towels if necessary and child's details.

   g. Where possible, the School First Aider should stay on the premises; however, this is not always possible and they will need to discuss this with the Headmistress /Deputy Head teacher, for most appropriate escorts.

   j. Keep office at HHS informed of progress and any likely times of return for staff and pupils.

   k. When in an emergency an ambulance has been called, consider all the areas raised above and how the escort will get back from the hospital. Complete any formal reports/treatment book records, medical records.

Annex L – Procedures for Storage & Administration of Staff Medication

Directions for teachers needing to take medications during the school day:

As outlined in the Staff Handbook, the school deems it gross misconduct for any member of staff to be unfit for duty due to the use of drugs or alcohol while at work or on the school premises.

If a member of staff uses prescription drugs it is advised that they are taken before or after the school day so that they do not need to be stored on the school premises.

Any prescription drugs taken regularly by a member of staff during the school day are the responsibility of the member of staff and the following steps must be taken;

- The Headmistress must be informed of type of drug, frequency and length of need
- The Headmistress must be informed immediately if the medication impairs any aspect of the responsibilities undertaken by the member of staff

Over the counter pain relief medication is kept locked away within the medical area for staff use if required. If a member of staff brings into school any over the counter medications the following steps must be taken;

- It is the responsibility of the staff to keep any medication they may use away from the children. Staff are asked to ensure that handbags are kept closed or that meds are given to the First Aider, who will securely store them.
- The Headmistress must be informed immediately if the medication impairs any aspect of the responsibilities undertaken by the member of staff
- The staff member should consider whether they should be at school or at home recovering

Annex M – Dealing with Head bumps and injuries

A minor head injury is a frequent occurrence in the school playground and during sports. Fortunately, the majority of head injuries and bumps are mild and do not lead to complications or require hospital admission. However, in some rare occurrences, complications can occur, depending very much on the force and speed of the blow.

1. All head bumps/injuries must be seen by a member of staff in First-aid / by the member of staff leading the sports activity if out at the Park.

2. **An ice-pack should be applied** for at least 10 minutes and the child/person observed by the first aider during this time.

3. **Head bumps, however minor, cannot be classified as a group 1 or 2** injury as swelling / other complications can occur hours later. The person who has sustained the bump or injury should be monitored.

4. After any head bump or injury, even when none of the worrying signs are present, the **child's parents/carers must be informed.**

Minor injuries

The symptoms of a minor head injury are usually mild and short-lived. They may include:

- a mild headache
- nausea (feeling sick)
- mild dizziness
- mild blurred vision

If the symptoms get significantly worse, the person will need to be seen by medical professionals in hospital. Contact parents and call an ambulance if required.

Serious injuries

What to look out for: Signs of a brain injury after a head injury include:

- unconsciousness – either brief (concussion) or for a longer period of time
- fits or seizures
- problems with the senses – such as hearing loss or double vision

- memory loss (amnesia) Loss of consciousness
- Dilated pupils, or pupils of uneven size
- liquid coming out of the ears or nose
- Vision issues, such as blurred vision, double vision, light sensitivity, inability to move eyes, or blindness
- Balance problems
- Dizziness

- Respiratory failure, or problems breathing
- Slow pulse, and slow breathing rate, with an increase in blood pressure
- Inability or difficulty moving body part
- Vomiting
- Inability to respond to others, not alert
- Sluggish, sleepy, or easily fatigued
- Headache
- Confusion, or difficulty with thinking skills such as memory and judgment
- Poor attention span
- Difficulty processing thoughts, or slowed processing speed
- Ringing in the ears, or difficulty hearing
- Odd emotional responses, such as increased irritability and frustration, inappropriate anger, laughing, or crying
- Difficulty speaking or swallowing
- Numbness or tingling in body parts
- Bladder and bowel control problems

If any of these symptoms occur after a head injury, immediately call 999 and ask for an ambulance and contact parents.