BEAUDESERT PARK SCHOOL

FIRST AID, ACCIDENT AND MEDICAL HEALTH POLICY

This is a whole school policy, including the EYFS.

Contents:

AIM

This policy sets out the responsibilities and methods by which Beaudesert Park School ("the School") makes provision for first aid and medical health needs.

COMMITMENT

The School is committed to providing sufficient numbers of School Nurses and First Aid personnel to deal with accidents and injuries that occur within the School and school grounds and to providing these personnel with sufficient training, retraining and equipment to ensure that they are able to carry out their duties competently.

Furthermore, the Childcare Act 2006 says childcare is 'any form of care for a child including education or any other supervised activity' and, as Early Years Registered provision is offered within our Pre-prep, our School is committed to upholding the legal requirements set out in the Statutory Framework for the Early Years Foundation Stage (2021).

This publication specifies that "at least one person who has a current paediatric first aid (PFA) certificate must be on the premises and available at all times when children are present, and must accompany children on outings." Our EYFS staff, including any assistant who might be in sole charge of the children for any period of time, hold full current PFA certificates, which are consistent with the required criteria (Appendix T) and are renewed every three years. PFA certificates are available to parents on request and a list of PFA qualified staff is displayed at the entrance to the Pre-prep and the Nursery entrance.

All appointed School Nurses and First Aiders will be briefed fully on their responsibilities and provided with information and training on first aid (and re-training) to ensure that the statutory requirements and the needs of the School are met.

We have a Surgery at the School on the first floor of the main building led by School Nurses Deanna Davies and Liz Powell.

All registered nursing staff have a professional responsibility to practice within the bounds of the Nursing and Midwifery Council (NMC) (2018) Code of Professional Conduct.

There is a qualified School Nurse on duty on the School site:

Monday – Friday, 8am – 5.30pm and Saturday mornings when the School is in session

In addition, the Matrons and House Parents who are all qualified First Aiders, are available to respond to any medical matters which arise at other times. They also take the Opus Medicines Awareness for Schools training every 2 years:

Resident House Parents –Mr and Mrs Layton - Emergency First Aid at Work (EFAW)

Resident Assistant House Parent – Mr Griffiths - EFAW

Resident Assistant Matron – Gemma Price EFAW

Non-resident Matrons:

Jackie Excell - EFAW

Allyson Owens - EFAW

Lisa Nicole - EFAW

Sally Gardiner – EFAW

Kim Thomas - EFAW

Selected members of the full-time teaching staff are qualified as First Aiders (EFAW), as well as some of the peripatetic staff. The School Nurse/Matron will administer first aid, deal with accidents and emergencies or help if someone is taken ill. In the unlikely event that neither are available, first aid trained staff will attend.

All first aid personnel receive updated training (EFAW) every 3 years.

There are paediatric first aid trained staff present in the EYFS setting and on trips with the children.

There is always a qualified School Nurse in attendance at the games field for matches.

Within the School and school grounds or sports field, the School Nurse or Matron will decide when an ambulance should be called for injuries or illness.

If the School Nurse is not in attendance, the first aiders will call an ambulance as necessary.

First aid boxes are placed in all areas of the School where an accident is considered possible or likely to happen (see pages 6 & 7) e.g., sports hall, tennis courts, DT room, Pre-prep, Performing Arts Centre, minibuses, swimming pools, laboratories.

There are three Automated External Defibrillators (AEDs) located in:

1. Main entrance lobby
2. Swimming Pool lobby
3. In the Pavilion at the playing fields.

First aid bags are always taken with groups of pupils who are going out of School on organised trips or to participate in sporting events. We keep records of all accidents/injuries and have a procedure in place for ensuring that they are reviewed regularly in order, where possible, to minimise the likelihood of recurrence.

We must notify Ofsted within 14 days of any serious accident, illness, injury or death of a child in EYFS and notify the Charity Commission via their Serious Incident reporting channel.

All medical details are entered in the child's school medical record, including treatment and medicine given and details of contact with parents.

Parents may contact the School Nurses at any time, should they wish to discuss any concern that they might have relating to their child's health.

If we believe that any child in School is suffering from a notifiable disease identified as such in The Health Protection (Notification) Regulations 2010, the School Nurses will liaise with the child's parents/guardian, registered GP Practice and local Health Protection Agency.

Severe accidents, where hospital admission or attention of a doctor is required, are reported to the Health and Safety Executive, if necessary, under RIDDOR – the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013. Under RIDDOR we are obliged to report accidents to pupils which arise out of, or in connection with, a work activity and where the child is taken directly

to hospital for treatment. The School Nurses will assess the accident or incident using a prescribed form to consider whether it was caused by:

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

For employees, the rules are slightly different. Certain specified injuries (and deaths) must be reported, as well as any accident which prevents the injured person from continuing their normal work for more than seven days.

LIAISING WITH PARENTS REGARDING MEDICAL NEEDS

The School promotes ongoing communication with parents to ensure that all of our pupils' specific medical needs are identified and met. Parents or legal guardians have primary responsibility for their child's health and are responsible for notifying the School if their child develops a medical condition which requires specific support and/or the administration of either prescription or non-prescription medication within School.

The School requests that medication is only taken into School if it is essential – where it would be detrimental to the pupil's health not to administer medication during the school day. Where possible, medicines should be taken at home before and after attending School. See also the School's Administration of Medicines Policy.

We will endeavour to contact parents/guardians by telephone or email if a child suffers anything more than a minor injury, or if a child becomes unwell, or if we have any worries or concerns about a child's health.

CHILD'S INDIVIDUALISED HEALTH CARE PLANS

Where a child has long-term or complex health needs, the School Nurse will work in partnership with parents and the child to produce an Individual Health Care Plan (IHCP) that supports their medical needs in School. This will include details of the child's medical condition, what specific support the child needs in school and when it should be provided. A copy of this will be kept within the child's school medical record.

Once in place and implemented, the School Nurse is responsible for ensuring that the IHCP is being adhered to within School.

The IHCP will be reviewed at regular intervals in agreement with the parents and child, but as a minimum at least yearly.

Parents/carers are responsible for informing the School of any medical changes so that any subsequent alterations to the IHCP can be made in a timely manner.

MEDICAL RECORDS AND CONSENT

Parents of all pupils in School are required to complete a medical questionnaire/personal data form before their child joins the School. Parents will receive a reminder email on a yearly basis requesting that they inform the School Nurse of any new medical developments or changes in their child's health, to ensure that medical records are accurate and up to date.

Parents are required to provide written parental consent for their child to receive prescription medicines, non-prescription medications and first aid whilst in the School's care.

MEDICAL & NURSING CONFIDENTIALITY

The confidentiality and rights of pupils as patients are appropriately respected by the School. This includes the right of a pupil deemed to be "Gillick Competent" to give or withhold consent for his/her own treatment. (Fraser guidelines, more commonly referred to as Gillick competence is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. A child will be Gillick competent if he or she has sufficient understanding and intelligence to understand fully what is proposed). However, in providing medical care, protection and in consideration of the welfare of the child, it is recognised that on occasions a Doctor and/or Nurse may liaise with parents/ guardians, academic staff and allied health professionals, and that information, ideally with the pupil's prior consent, will be passed on as appropriate. With all medical matters, the Doctor and Nurse will respect a pupil's confidence except on rare occasions when the Doctor or Nurse considers that it is in the child's better interests, or necessary for the protection of the wider school community, to breach confidence and pass information to a relevant person or body.

ADMINISTRATION OF MEDICINES

Please refer to the Administration of Medicines Policy, which is a whole school policy including the EYFS.

PROCEDURES FOR UNWELL BOARDERS AND DAY CHILDREN

If a child is unwell and unable to attend School:

Day Children

Parents must inform the School before 8.20am that their child will be absent.

If the child is well enough to attend School but cannot take part in games, PE or swimming, parents must notify the School, either by a note which the child can hand either to the form teacher or School Nurse, or by telephoning or emailing the School.

If a child is unable to take part in sporting activities for longer than a week, new notification will be required every Monday morning.

If a note has stated "off sport until further notice", a second note will be required when the child is to resume games.

If a child is taken ill during the school day, he/she is taken to the School Nurse/Matron who will assess them and attend to their health needs. If it is a temporary sickness, the child will remain in the sick bay until he/she recovers and then return to class. If the child continues to be unwell and is unlikely to return to class, the School Nurse/Matron will inform parents by telephone or email and discuss the possibility of the child being collected to be taken home.

In the event of both a boy and girl being unwell at the same time, provision can be made to use a dormitory, next to the Surgery, so that the different sexes can be cared for separately.

Boarders

Children will remain in the boarding house until seen by the School Nurse who will assess the child and judge whether the child needs to go home or is well enough to resume school activities.

House Parents are on call for all children in the boarding house throughout the night and can be summoned by means of the 'night-time call' button.

If the House Parents have any concerns regarding the child's health and require further medical advice/assistance, they will call 111 and act accordingly, as well as call the parents as soon as possible.

ACCIDENTS

All accidents are recorded in an accident book, with the time, date, place and nature of the accident completed by the member of staff who witnessed it or who was in charge at the time.

There is a separate accident book in the Pre-prep office.

Accident Procedure

In the event of an accident that requires a child to be taken to hospital, the following procedure will apply:

- Unless there is a threat of immediate danger to the child, where possible the child must not be moved.
- Call the School Nurse or First Aider (EFAW or Sports FA) to assess injury. Ensure airway is clear.
- If there is any indication that the injury is serious to the head, leg or spine, call for an ambulance and inform parents/guardian.
- If the School Nurse or First Aider (EFAW or Sports FA) thinks the child can be moved, accompany the child back to the school surgery for further assessment and onward referral to allied health services such as the child's GP or local Minor Injuries Unit. Inform the parent/guardian what has happened.
- Details of the accident are written up in the Accident Book. In Pre-Prep one copy is kept in the Pre-Prep office and a copy is sent home. In the Prep school the accident form is kept in the Surgery.

MEDICAL PROCEDURES

All children needing medical attention should go to the School Nurse/Matron in the Surgery.

If the School Nurse is off duty or not in the Surgery, a notice on the surgery door will denote where Matron can be located.

A list of locations for the First Aid boxes can also be found in the Surgery.

First Aid boxes are in the following locations:

1 Minibus x 9

2 Forest School – hanging in the shed

3 Games Field x 2 (in Pavilion and maintenance shed)

4 Indoor swimming pool (in the foyer area) and outdoor when open (staff take first aid kit down to the pool)

5 DT Room – hanging on wall by the sink

6 Science laboratory x 3 – in First Aid marked cupboards by the sinks

7 Lower tennis courts pavilion

8 Pre-prep x 2 – Pre-prep office in red rucksacks

9 Kitchen (responsibility of the contract caterers)

10 Sports Hall – in corridor between sports hall and swimming pool

11 Stable yard (maintenance)

12 Performing Arts Centre – in marked cupboard under sink in downstairs kitchen

13 Qube – on the wall in the (swimming pool side) entrance corridor

14 Staff kitchen opposite staff room

There is a Catastrophic Bleed Kit located in the Stable Yard maintenance shed.

These are checked by the School Nurses at the beginning of each term and re-stocked.

If any member of staff uses an item from any box, the School Nurse must be notified and restocked.

MANAGEMENT OF SPECIFIC CONDITIONS

Procedures for the management of the below conditions are included as Appendices:

NEW PROCEDURES DUE TO COVID 19

Commitment

Sealed bags containing personal protective equipment (PPE) are available within all first aid bags and with the AED (automated external defibrillators) for first aid use when required.

Staff will inform school nurses when these PPE packs have been used in order for these to be replenished.

Procedures for day children presenting with symptoms of Covid-19

If a child is taken ill during the school day, he/she is taken to the School Nurse/Matron who will assess them and attend to their health needs.

The School Nurse/Matron will follow current NHS guidance on Covid-19 symptoms, as available at:

https://www.nhs.uk/conditions/coronavirus-covid-19/symptoms/

If a child or member of staff presents with symptoms of Covid-19 the following measures will be taken:

- Parents/carers will be contacted immediately and requested to collect their child at the earliest opportunity.
- The child will be cared for in a separate isolation room, whilst awaiting collection.
- Separate toilet facilities are available for their use.
- PPE will be worn by staff caring for the child if a distance of 2 metres cannot be maintained.
- On arrival at school, parents/carers should telephone school reception and arrangements will be made for the school nurse and their child to meet at a designated area
- Government guidance on further management and testing of suspected Covid-19 can be found at the following link and will be adhered to:

  https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance/stay-at-home-guidance-for-households-with-possible-coronavirus-covid-19-infection

- Staff will also be requested to follow current Government guidance

If a child is taken ill with Covid-19 symptoms whilst boarding overnight, staff will take the same measures as stated above for a day pupil, with additional measures as follows:

Parents will be informed at the earliest opportunity and requested to collect their child as soon as possible. The School's Covid Outbreak Management Plan will be implemented as necessary if threshold outbreak levels have been triggered.

This policy can be made available in large print or other accessible format if required.

Authorised by	
	C Kay
	Chair of Governance & Compliance Committee
Date 23rd November 2021	
Approved by	
	M Pyper
	Chair of Governors
Date 23rd November 2021	
Last Reviewed	November 2020
Next Review	November 2022

APPENDIX A - Management of sports injuries (https://www.nhs.uk/conditions/sports-injuries/)

Taking part in sports, games and activities is an essential part of school life for all children. The benefits of sports and exercise far outweigh the risks, but occasionally injuries do happen.

Any part of the body can be injured, including the muscles, bones, joints and connective tissues (tendons and ligaments). The ankles and knees are particularly prone to injury.

If an injury is sustained there may be immediate pain, tenderness, swelling, bruising, and restricted movement or stiffness in the affected area. Sometimes, these symptoms may only be noticeable several hours after exercising or playing sports.

Staff will advise children to stop exercising if they feel acute pain. Continuing to exercise while injured may cause further damage and slow their recovery.

There is always a qualified School Nurse in attendance at the games field for matches. In the unlikely event that they are not available, first aid trained staff will attend to any injuries.

During the Autumn Term, sports therapists from The Prime Practice are in attendance at home rugby matches to provide additional medical support for injuries.

Treating a sports injury:

- Protection – protect the affected area from further injury
- Rest – rest the affected part of the body for the first 48-72 hours to prevent further damage
- Ice - regular application of an ice pack for 15-20 minutes every 2-3 hours to the affected area during the first 48-72 hours to reduce swelling
- Pain relief - use appropriate pain relief, such as paracetamol
- Elevation – where appropriate keep the injured body part raised above level of the heart whenever possible to help reduce swelling

Symptoms should improve within a few days. However, if symptoms do not improve, the School Nurses will reassess and if necessary, recommend further assessment by the child's GP or local Minor Injuries Unit.

APPENDIX B - Management of a head injury

(https://www.englandrugby.com/participation/playing/headcase/resources**)**

Bumps and knocks to the head are quite common, particularly among children. Most are innocent but all should be assessed by the School Nurse or a qualified first aider.

A head injury may produce concussion. Concussion is a traumatic brain injury resulting from a blow to the head or body which results in forces being transmitted to the brain. This typically presents as a rapid onset of short-lived impairment of brain function that resolves spontaneously. This impairment results from a functional disturbance, rather than a structural injury, and no abnormality is seen on standard hospital scans. A range of signs and symptoms are typically seen, affecting the player's thinking, memory, mood, behaviour, level of consciousness, and various physical effects. Clear loss of consciousness occurs in less than 10% of cases. Recovery typically follows a sequential course over a period of days or weeks, although in some cases symptoms may be prolonged.

In addition, any child with an injury to the head may also have a neck (spinal) injury and should be treated accordingly.

Minor head injury

Symptoms of a minor head injury:

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

Treatment of a minor head injury:

If a child experiences a knock, bump or blow to the head, the child must be seen by the School Nurse or a qualified First Aider.

- Sit the child down, comfort them, and make sure they rest
- Apply cold therapy to the affected area

The School Nurse or First Aider will inform the parents and written head injury advice will be given with instructions that if the child's symptoms get significantly worse, they must be taken straight to the accident and emergency (A&E) department of their nearest hospital or call 999 for an ambulance.

Major head injury

Symptoms of a severe head injury can include:

- Unconsciousness – where the child has collapsed and is unresponsive, even for a brief period of time.
- A sudden but short-lived loss of mental function that occurs after a blow or other injury to the head; the child may have a glazed look or appear confused, but won't necessarily be unconscious
- Fits or seizures
- Difficulty speaking or staying awake
- Problems with the senses – such as hearing loss or double vision
- Repeated episodes of vomiting

- Blood or clear fluid coming from the ears or nose
- Memory loss (amnesia)
- Sudden swelling or bruising around both eyes or behind the ear
- Difficulty with walking, balance or co-ordination

Treatment of a major head injury:

Severe head injuries require immediate medical attention.

The School Nurse will notify parents as soon as possible if their child experiences any of these symptoms after sustaining a head injury. A child who has been concussed will be taken to the School Surgery immediately. The child will need to be taken to the nearest accident and emergency (A&E) department for further assessment and, if appropriate, the School Nurse will dial 999 to request an ambulance.

If the pupil loses consciousness, the School Nurse should be called to come to the place of the accident and assess the child.

The School Nurse or First Aider will not move the child if unconscious (unless their airway is obstructed) and will call 999 for immediate ambulance assistance.

APPENDIX C - Management of concussion
(https://www.englandrugby.com/participation/playing/headcase/resource **)**

Concussion occurs when there has been a disturbance to the normal function of the brain without any structural damage occurring. Concussion can be caused by a direct blow to the head or if the head is shaken after the body has been struck. It is important to recognise that most people who develop concussion may not have been knocked unconscious.

Concussion can affect a child's thinking, memory, mood, behaviour and level of consciousness. The majority of children who sustain concussion do not require any treatment as they normally get better by themselves, but some children can have the symptoms of concussion for several days, weeks, or occasionally they can last longer.

Always consider concussion for anyone who gets a blow to the head or face or is involved in a collision that could cause a whiplash injury. If concussion is suspected the child should be assessed.

The School Nurse will be aware of the 4 'Rs' of concussion management and be guided by the Rugby Football Union (RFU) and NIHCE (National Institute for Health and Clinical Excellence) guidelines:

- Recognise
- Remove from play or situation that caused the blow to the head
- Let the person Recover
- Let the child Return to play if all is well and concussion has not been diagnosed

'IF IN DOUBT, SIT THEM OUT'

Signs and symptoms of concussion:

- Knocked unconscious
- Headache
- Dizziness
- Blurred vision, double vision, flashing lights
- Nausea
- Vomiting
- Feeling dazed disorientated/confusion/feeling slowed down
- Feeling in a fog
- Slurred speech
- Generally feeling unwell
- Ringing in the ears
- Sleepiness/drowsiness
- Poor co-ordination of balance
- Inappropriate emotions (laughing, crying, angry)
- Irritability
- Seizure/convulsion
- Fatigue/low energy
- Difficulty remembering/concentrating
- Pressure in head
- Amnesia
- Sensitivity to noise

IF THE CHILD IS SUSPECTED OF HAVING CONCUSSION, THE CHILD WILL BE REMOVED FROM PLAY STRAIGHT AWAY.

Playing with a concussion increases the child's risk for Second Impact Syndrome (SIS) or a more severe traumatic brain Injury.

Management of concussion:

- Remember basic first aid
- Assess at the pitch side/site of the occurrence
- If the child is conscious and has no neck injuries remove from the pitch/situation
- Sit the child down, be calm and look for obvious signs of injuries
- Apply cold therapy to the affected area
- Observe and monitor for any signs of concussion (refer to questions below).
- Reassure the child
- Do not leave alone

Checks for Cognitive/Memory function (use age and time appropriate questions – these are just a guide):

- What's your name?
- What's my name?
- Which school are we at?
- How old are you/ when is your birthday?
- Did your team win the last game?
- Which half is it now?
- Who scored last in this game?

Visiting children:

- Observe in the school Surgery or at the pitch side if appropriate
- Inform their teacher/sports coach
- Give head injury advice form to give to the child's parents/games coach or school nurse if they are a boarder.

Management in school following diagnosis of concussion:

In young players a very conservative Graduated Return to Play approach is recommended and it is advisable to extend the amount of rest and the length of the graded reintroduction of exertion, as per RFU.

On return to school:

- Children should be symptom free before they return to school
- Inform teachers to observe for any deterioration in schoolwork or concentration
- If any member of staff is concerned, the School Nurse will be contacted for advice
- The child is to remain off games until they are free of symptoms for two weeks (or following medical instruction)
- The child is to remain off contact sport for 23 days and Doctor's clearance is required before full contact sport is resumed
- The child is to be reviewed by their Doctor if there are any concerns, or before the return to sport
- The child will be required to have a phased return to games/contact sport /swimming depending on the doctor's advice

APPENDIX D - Management of away match injuries

- The member of staff in charge of an away match team is 'in loco parentis' for those children and, as such, they are the staff responsibility
- If an injury occurs during an away day, the injury can be treated by School staff who hold a valid first aid certificate. If the member of staff is unable to treat the injury, medical help must be sought. This may be from either from the away school's Surgery, other First Aid staff on duty, or by calling 999 for ambulance support.
- The staff member will ensure that the child's parents are informed as soon as possible. If the parents of the injured child are present at the away match, they assume responsibility for their child.
- The staff member will have a record of the injury and subsequent treatment and will notify the School Nurse on their return to Beaudesert so that this can be added to the child's health record.
- In all cases staff and parents should refer to medical staff.

APPENDIX E - Anaphylaxis (https://www.allergyuk.org/about-allergy/anaphylaxis/)

The School Nurse will ensure that each child with a known allergy will have an individual health care plan (IHCP). A copy of this will be kept within the child's school health record.

Training for all staff will be given annually. The School Nurse will provide new staff members with training as necessary. Staff can come to surgery at any time for refresher training, or to have a practice with the trainer adrenaline auto-injector devices (e.g., EpiPens). A record of staff training will be maintained by the Surgery.

Managing Anaphylaxis

Symptoms:

- Apprehension
- Headache
- Sweating
- Dizziness
- Feeling of faintness
- There may be a burning or tingling sensation around the mouth
- A sensation of a lump in the throat which may progress to hoarseness indicating swelling of vocal cords. Airways may be obstructed
- Hives
- Vomiting
- Swelling of the lips
- Difficulty breathing
- Sudden changes in behaviour

Immediate treatment is required:

- Give an antihistamine as prescribed in the child's care plan
- Stay calm - get help - contact a trained member of staff or School Nurse
- Lay child on floor or bed with legs raised
- Administer Adrenalin auto-injector device into thigh
- Dial 999 (or 112) for ambulance
- Stay with child until ambulance arrives
- Contact the child's parents/carer
- If no improvement after 5 minutes, give 2nd adrenaline dose using second adrenaline auto-injector device if available into other thigh
- Transfer to hospital, used auto-injector adrenaline devices to go with the child

Storage, Administration and Disposal of Adrenalin:

- School Nurse to liaise with parents to ensure that any prescribed medication (for example antihistamine medication) and two adrenaline auto-injector devices are supplied for use in school.
- All adrenaline auto-injector devices and allergy associated medications are kept either in the personalised emergency medication bag in the unlocked emergency medication cupboard in the surgery lobby or carried by the child with parental consent, as deemed necessary.A copy of the child's IHCP is also kept in this bag.

- Used adrenaline auto-injector devices must accompany the child to hospital
- Out of date adrenaline auto-injector devices are returned to the child's parents for disposal to the issuing pharmacy.

Out of school activities and trips:

The School Nurse, in conjunction with the teaching staff, is responsible for ensuring that the children's prescribed adrenaline auto-injector devices, allergy medication and IHCP are taken to the games field or on away trips and for returning them to the surgery lobby afterwards.

APPENDIX F - Asthma (https://www.asthma.org.uk/advice/)

The School recognises that asthma is a widespread, serious but manageable condition and welcomes children with asthma, encouraging these children to achieve their potential in all aspects of school life.

The School Nurse holds a register of all children who experience asthma related symptoms, copies of which are kept with the School's emergency Ventolin inhaler in the Surgery lobby area and also in the emergency asthma bag kept in the Sports Office.

Taking part in sports, games and activities is an essential part of school life for all children. Children with asthma are reminded to use their inhalers before sport (if sport is a trigger) and to take their inhalers with them to the games field a child does not have their inhaler in school, the emergency Ventolin inhaler can be used if necessary (see below).

Asthma medicines

Immediate access to reliever medicines (usually a blue Ventolin inhaler) is essential.

Parents/carers are requested to provide the School with a spare inhaler and spacer device/ aero chamber, which should be individually labelled (in their original box, as prescribed by their G.P) and handed in to the School Surgery. These are kept in named pigeon holes in the Surgery lobby and are accessible at all times.

In the Pre-Prep school and Year 3, the staff keep the children's inhalers in their classroom and assist the child with medication when necessary.

Older children are encouraged to be responsible for their own reliever medication with consent from a parent.

Children are encouraged to clean the mouth pieces and spacer devices/aero chambers after use. Inhalers located in the Surgery lobby will have their expiry dates checked each term and parents will be notified when inhalers are reaching their expiry date and are requested to collect old inhalers from the School Surgery.

The School Nurse will:

- On a termly basis check that the inhaler is present and in working order and the inhaler has sufficient number of doses available.
- Check inhaler expiry dates on a termly basis and request that replacement inhalers are replaced by parents should they be reaching their expiry date or have insufficient doses available.

Guidance for use of Emergency Ventolin (Salbutamol) Inhalers

The emergency Ventolin (Salbutamol) inhaler should only be used by children:

- Who have been diagnosed with symptoms of asthma and prescribed a reliever inhaler.
- For whom written parental consent for use of the emergency inhaler has been given.
- If the emergency inhalers are used members of staff must return these to the School Surgery so that it can be correctly cleaned to prevent cross infection between pupils.

A register of children who can have an emergency inhaler is kept by the School Nurses and copies of this are within the emergency inhaler bags.

Managing Asthma Symptoms Guidelines

At all times, stay calm and reassure the child. Help the child to breathe by loosening clothing and to sit up straight. Utilise a spacer device where possible as this helps breathing to be easier and maximises delivery and efficacy of inhaler medication. Encourage the child to take slow steady breaths. Stay with the child until the attack is resolved.

Mild/moderate attack

- the child may feel breathless
- have a cough
- may have an audible wheeze
- difficulty in breathing

These symptoms should be relieved by the use of the Ventolin (blue) inhaler, to be used as prescribed on the packaging.

*Severe attack (*https://www.nhs.uk/conditions/asthma/asthma-attack/)

- the child may be too breathless to speak and go quiet
- have tightness of the chest
- nasal flaring
- have difficulty inhaling or exhaling
- develop a blue tinge around lips
- they may also show no signs of improvement following use of blue inhaler

Repeat use of Ventolin (blue) inhaler - make sure the child takes one puff of their reliever inhaler every 30-60 seconds, up to a maximum of 10 puffs. If the child does not start to feel better after 10 puffs or you are worried or having doubts about the child's condition at any time before you have reached the 10 puffs, CALL 999 FOR AN AMBULANCE - for example the child is becoming exhausted or has blueness in face and lips. If an ambulance does not arrive within ten minutes, repeat the 10 puffs.

Parents must be contacted as soon as possible.

All staff will be given annual asthma training, enabling them to recognise the signs, symptoms and treatment of asthma. The School Nurse will provide new staff members with training as necessary. Staff can come to surgery at any time for refresher training. A record of staff training will be maintained by the Surgery.

APPENDIX G - Diabetes (https://www.nhs.uk/conditions/diabetes/)

Diabetes is a lifelong condition that causes a person's blood sugar level to become too high.

There are two main types of diabetes:

Type 1 diabetes – where the body's immune system attacks and destroys the cells that produce insulin

Type 2 diabetes – where the body doesn't produce enough insulin, or the body's cells don't react to insulin

Type 1 diabetes is the most common type in children.

Every child with diabetes will have an individualised healthcare plan (IHCP), kept in their health record in the surgery. The IHCP will include details of the child's diabetes, what specific support the child needs in school, when it should be provided and detailed treatment plans for the child.

The School Nurse will liaise closely with parents/carers regarding the child's IHCP and health, as well as with allied health professionals, such as the child's Paediatric Diabetes Specialist Nurse, to ensure the best possible healthcare support for the child.

APPENDIX H - Epilepsy (https://www.epilepsy.org.uk/info/seizures-explained)

Epilepsy is a condition that affects the brain. When someone has epilepsy, it means they have a tendency to have epileptic seizures.

Electrical activity is happening in our brain all the time, as the cells in the brain send messages to each other. A seizure happens when there is a sudden burst of intense electrical activity in the brain. This causes a temporary disruption to the way the brain normally works. The result is an epileptic seizure.

Seizures can be classed by which part or parts of the brain the epileptic activity starts in.

• Focal seizures (also called partial seizures) involve epileptic activity in just part of the brain. The child may still remain alert during this type of seizure. They may have involuntary movements or have unusual sensations or feelings. Onlookers may not be aware that they are having a seizure.

• Generalised seizures involve epileptic activity in both halves of the brain. The child usually loses consciousness during this type of seizure, but sometimes it can be so brief that no one notices. The muscles in their body may stiffen and/or jerk and they may fall down. Seizures usually last between a few seconds and several minutes. After a seizure, the child's brain and body will usually return to normal.

Epilepsy is usually only diagnosed if someone has had more than one seizure, and doctors think it is likely they could have more. Epilepsy can start at any age and there are many different types. Some types of epilepsy last for a limited time and the person eventually stops having seizures. But for many people epilepsy is a life-long condition.

The School recognises that epilepsy is one of the most common serious neurological conditions and welcomes all children with epilepsy to the School, encouraging them to achieve their full potential.

Every child with epilepsy will have an individualised healthcare plan (IHCP), kept in their school health record. The IHCP will include details of the child's epilepsy, what specific support the child needs in School, when it should be provided, and detailed management plans.

The School Nurse and class teachers will liaise closely with parents regarding the child's IHCP and health, as well as with allied health professionals such as the Paediatric Epilepsy Nurse, to ensure the best possible healthcare support for the child.

First aid
First aid for the child's seizure type will be included on their IHCP and staff will receive basic training on administering first aid relating to these seizures.

APPENDIX I - Eating disorder management (https://www.nhs.uk/mental-health/feelings-symptoms-behaviours/behaviours/eating-disorders/overview/)

Eating disorders are complex mental illnesses. Anyone, no matter what their age, gender, or background, can develop one. Some examples of eating disorders include bulimia, binge eating disorder, and anorexia. There's no single cause and people might not have all symptoms for any one eating disorder.

Possible Symptoms of an Eating Disorder

Physical signs:

- Significant loss or gain in weight
- Poor or inadequate weight gain in relation to their growth
- Dizzy spells
- Tiredness, Lethargy
- Thirsty
- Abdominal pains
- Swollen Glands
- Downy hair on the body
- Dull hair and skin
- Bruised knuckles
- Feeling cold, poor circulation
- Dry, rough or discoloured skin
- Loss of periods
- Loss of bone mass

Behavioural signs:

- Rigid or obsessive behaviour attached to eating or exercise
- Restlessness
- Wearing baggy clothes
- Vomiting or taking laxatives
- Disappearing to the toilet after meals
- Periods of fasting or skipping meals
- Secrecy and reluctance to socialise
- Shoplifting for food or spending excessive amounts of money on food
- Food disappearing unexpectedly or being hoarded

Psychological signs:

- Intense fear of weight gain
- Distorted perception of body weight or shape
- Denial of the existence of the problem
- Changes in personality and mood swings
- Becoming aware of an 'inner voice' that challenges their view of eating and exercise
- Lack of interest
- Lack of attention
- Anxiety, depression, low self-esteem, shame and guilt
- Isolation

If there are any concerns that a child may be displaying any of the above signs, staff will liaise with the School Nurse. The School Nurse will gather further information from the child and bearing in

mind the confidentiality and rights of the child, the School Nurse may advise the child that they will have to inform their parents/guardians and other professionals as appropriate.

It's usually very difficult for people with eating disorders to get better on their own, so it's important that professional help and support, for example, from the specialist eating disorder service, is sought as soon as possible in order to provide the best possible treatment and support for the child and family.

APPENDIX J – Self-harm guidelines (https://www.mind.org.uk/information-support/types-of-mental-health-problems/self-harm/about-self-harm/)

Self-harm is when somebody intentionally damages or injures their body. It's usually a way of coping with or expressing overwhelming emotional distress. Sometimes when people self-harm, they feel on some level that they intend to die. However, the intention is more often to punish themselves, express their distress or relieve unbearable tension. Sometimes the reason is a mixture of both. Self-harm can also be a cry for help.

Many children and young people describe that by deliberately hurting themselves they are temporarily able to change their state of mind to better cope with painful feelings. It is not attention seeking - it is most often carried out in secret. Self-harm provides a mechanism for dealing with intense emotional pain and it should be recognised that there may be fear that this coping strategy might be taken away.

There will need to be support and encouragement to minimise risks.

Common behaviours include:

- Cutting
- Burning
- Scalding
- Banging or scratching the body
- Breaking bones
- Hair pulling
- Ingesting toxic substances or objects
- Head banging
- Ligatures around the neck and limbs
- Object insertion
- Hitting with objects
- Pinching
- Overdose
- Other behaviours such as overeating or food restriction, excessive alcohol consumption, smoking and recreational drug use, can also be used as coping strategies giving a sense of 'control' and 'relief'

If staff suspect self-harm, they will liaise with the School Nurse. The School Nurse will gather further information from the child and bearing in mind the confidentiality and rights of the child, the School Nurse may advise the child that they will have to inform their parents/guardians and other professionals as appropriate.

In supporting the child, the School Nurse will:

- Encourage the child to talk
- Provide any first aid support if required
- Share other ways to manage distress e.g., art, music, sport, talking, TV, video games
- Distraction techniques can be beneficial e.g., ice cubes, pillow punching
- Signpost to suitable support resources

Any mention of suicidal intent will always be taken seriously and acted upon as a matter of urgency. However, self-harm is not necessarily an indicator of suicidal intention, but rather that they are trying to cope with difficult feelings by engaging in behaviour which temporarily relieves stress and anxiety, but which can become very addictive and with possibilities that life threatening mistakes can be made.

APPENDIX K - Management of infectious diseases

All information is taken from Guidance on infection control in schools and other childcare settings (https://www.publichealth.hscni.net/sites/default/files/Guidance_on_infection_control_in%20schools_poster.pdf, Public Health Agency). This is from Public Health England's Guidelines. If we believe that any child in school is suffering from a notifiable disease identified as such in the Health Protection (Notification) Regulations 2013, the School Nurse will liaise with the child's parents/guardian, registered GP Practice and the local health protection team (HPT)

Management measures:

- To monitor that both staff and children are off school until symptom free for 48 hours.
- The School Nurse will contact parents to keep children at home if there are any signs of a temperature or if their child is unwell.
- If the child becomes unwell in School and is unable to go home immediately, they are isolated in the sick room or neighbouring dormitories.
- Ensure that systems for the control of the infection within the School are put into immediate effect after consultation with the Headmaster and the HPT - consider suspending outside school activities.
- Headmaster should be responsible, in consultation with the School Nurses and the HPT for producing information either verbally or written for parents when required.
- The School will ensure that adequate hygiene facilities and appropriate practices are adhered to at all times, but especially when dealing with bodily fluids i.e., faeces, vomit, blood, urine and saliva. This is essential to reduce the spread of infection and to prevent the outbreak escalating.
- Good hygiene is maintained by washing hands frequently with soap and water to reduce the spread of infection.
- Hard surfaces (e.g., work tops, desktops, door handles, stair handrails) are cleaned frequently using normal cleaning products.

APPENDIX L - Management of needle stick injuries (https://www.nhs.uk/common-health-questions/accidents-first-aid-and-treatments/what-should-i-do-if-i-injure-myself-with-a-used-needle/#:~:text=If%20you%20pierce%20or%20puncture,while%20you're%20washing%20it)

In the event that skin is pierced or punctured with a used needle, the following guidelines must be followed immediately:

- Encourage the wound to bleed, ideally by holding it under running water
- Wash the wound using running water and plenty of soap
- Don't scrub the wound while you're washing it
- Don't suck the wound
- Dry the wound and cover it with a waterproof plaster or dressing

The School Nurse will record the incident in the accident book and if needed refer you to a Doctor.

The Surgery has a sharps bin (a specially designed rigid box with a lid) for disposal of sharps such as needles or lancets used with finger-pricking devices.

Used needles or similar medical supplies will be disposed of into the sharps bin immediately and not taken out again. Sharps bins will only be filled to the manufacturers' line and will be disposed of when full.

APPENDIX M - Head Lice (https://www.nhs.uk/conditions/head-lice-and-nits/)

Head lice and nits are very common in young children. They don't have anything to do with dirty hair and are usually picked up from head-to-head contact.

The only way to be sure someone has head lice is by finding live lice or eggs. You can do this by combing their hair with a special fine-toothed comb (detection comb). You can buy these online or at pharmacies.

Parents are requested to check their children's hair carefully once a week, and should any lice and/or eggs/nits (empty egg cases) be found, to treat as soon as possible.

Detection:

You will need a special fine-toothed detector comb (for example, the 'Nitty Gritty' comb is very effective). Wash hair using an ordinary shampoo, towel dry and apply lots of conditioner. ·Make sure you have good lighting. First, comb the hair with an ordinary comb. Then using the detecting comb, begin at the top of the head, touching the scalp and draw the comb slowly down towards the ends of the hair. Check the teeth comb carefully after each section is combed (wipe comb on a tissue or rinse in basin of clean water). Do this regularly and check all members of the family at the same time.

Treatments:

Head lice treatments are available to buy from pharmacies, supermarkets and online. You don't usually need to see your GP.

The main treatments are:

1) Lotions or sprays that kill head lice – these can be very effective, but some aren't suitable for pregnant or breastfeeding women, or for children under two. Make sure you carefully follow the instructions that come with the treatment you choose. A pharmacist can advise you about the treatments available if you're not sure which is best for you or your child.

2) Removing head lice with a specially designed fine toothed comb or 'bug busting' treatment method – this is suitable for everyone and relatively inexpensive, but needs to be repeated several times and can take a long time to do thoroughly.

Wet combing physically removes the lice from the hair, preventing them maturing and spreading. Apply conditioner and use a detector comb in the same way as for detection. It can take 20-30 minutes to remove all the lice. Make sure you use clean water for final rinse. Do wet combing on days 1, 5, 9 and 13 to catch any newly hatched head lice. Check again that everyone's hair is free of lice on day 17.

APPENDIX N - Dental Management (https://www.nhs.uk/conditions/knocked-out-tooth/)

All children who sustain injuries involving teeth are to be sent to the School Nurse for assessment in the Surgery. If appropriate, dental injuries will be referred to a dentist via parents/carers.

All whole or fragments of teeth knocked out will be placed in a labelled container with milk and sent with the child to the dentist. If milk is not available, the tooth or fragment should be wrapped into some plastic with the patient's saliva.

APPENDIX O - Tick bite management (https://www.nhs.uk/conditions/lyme-disease/); https://www.nhsinform.scot/illnesses-and-conditions/injuries/skin-injuries/tick-bites)

Ticks are small, spider-like creatures that feed on the blood of animals, including people.

Ticks can survive in many places, but prefer moist areas with dense vegetation or long grass. Ticks can be found throughout the year, but are most active between spring and autumn. Ticks don't jump or fly, but wait until an animal or person brushes past to climb on. They then bite to attach to the skin, bury their heads and mandibles into the skin and feed on blood. The first sign of their presence is an engorged body about the size of a grain of rice on the skin or in the hair.

When the children cross the common to the games field, staff will ask the children to keep to the mown paths where the grass is shorter, to reduce the risk of being bitten by a tick. The children are also encouraged to wear their long sports trousers.

Once a tick bite is detected it is important to remove the tick with a tick removal tool as soon as possible, to reduce the risk of becoming ill. It is thought only a small proportion of ticks carry the bacteria that cause Lyme disease, so being bitten by a tick does not mean you or your child/children will definitely be infected. However, it is important to be aware of the risk and seek medical advice if you or your child/children start to feel unwell.

If a child is found, or suspected, to have been bitten by a tick, the School Nurse will notify parents/carers as soon as possible.

Removal of a tick:

- Do not be tempted to pull it out because any mouthparts left in the skin can cause a local infection.

- The safest way to remove a tick is to use a pair of fine-tipped tweezers, or a tick removal tool available from pharmacies.

- Grasp the tick as close to the skin as possible and pull upwards slowly and firmly.

- Once removed, apply antiseptic to the bite area, or wash with soap and water and observe the bite area for several weeks for any changes.

- Contact GP if feeling unwell and advise them regarding recent tick bite.

Alternatively visit the local Minor Injuries Unit where the tick will be removed professionally, and the child checked for infection.

APPENDIX P - Spillage of Bodily Fluids

If an accident has occurred where body fluids have been spilt, the School Nurse/Matron/EYFS Assistant will attend.

1. Protective gloves and apron should be put on before clearing up.

2. Ready prepared single application clean up kits should be collected from the cupboard under the Surgery sink.

3. Use absorbent granules and disinfectant.

Place all fluids, soiled paper towels and cloths, gloves and apron in yellow bag and place in 'soiled dressings' bin behind the Surgery door. This bin is replaced every four weeks by a commercial waste disposal company.

APPENDIX Q – Continence (https://www.eric.org.uk/)

Bladder and bowel issues in childhood are very common. These problems can include difficulties with daytime wetting and/or soiling, constipation and night-time wetting, also known as nocturnal enuresis. Younger children are affected more than older children, but problems can happen at any age.

The School recognises that continence issues can cause significant anxiety and embarrassment for the child and their parents/carers.

The School Nurse and class teachers will work together with the parents/carers and the child regarding any continence issues and if appropriate will draw up an IHCP that fully supports the child's continence needs at school, ensuring that the best possible support is in place for the child.

Boarders with night-time wetting issues are appropriately supported in managing this common childhood problem and avoiding undue embarrassment.

The management of the enuresis is discussed with parent and child prior to his/her start of boarding and mutually agreeable support will be put in place and all boarding staff will be informed.

The School Nurses are happy to offer evidence-based advice and support on enuresis and can also provide support in referral on to the NHS Children's Continence Service in Gloucestershire via the Public Health Team (School Nurses/Health Visitors) for initial assessment and possible treatment prior to a Specialist Nurse involvement

APPENDIX R - Verruca Management (https://www.nhs.uk/conditions/warts-and-verrucas/)

Verrucae are warts on the feet usually on the sole of the foot or on the pads of the toes. They are caused by a virus. They may multiply but eventually the body will develop an immunity to them, and the verrucae will disappear. This can take a month to 2 years and sometimes more. They can be left untreated or can be treated with a variety of preparations available from the pharmacy over the counter.

If a parent wishes to purchase verruca socks for their child to wear for swimming, this is perfectly acceptable so long as the child is taught to put their own socks on and take them off.

APPENDIX S – Management of a Cardiac Arrest and use of Automated External Defibrillator

Cardiac arrest is when the heart stops pumping blood around the body. It can be triggered by a failure of the normal electrical pathway in the heart, causing it to go into an abnormal rhythm or to stop beating entirely. Oxygen will not be able to reach the brain and other vital organs. When a cardiac arrest occurs, the individual will lose consciousness and their breathing will become abnormal or stop. If basic life support is not provided immediately, the chances of survival are greatly reduced. Cardiac arrest can affect people of any age and happen without warning. When a cardiac arrest occurs, cardiopulmonary resuscitation (CPR) can help to circulate oxygen to the body's vital organs. This will help prevent further deterioration so that defibrillation can be administered.

An Automated External Defibrillator (AED) is a machine used to give an electric shock when a person is in cardiac arrest. In the event of cardiac arrest, swift action in the form of early CPR and prompt defibrillation can help save a person's life. The aim of an AED is to increase the rate of survival of people who have sudden cardiac arrests. AEDs make it possible for both trained and non-trained people to administer defibrillation prior to the arrival of Emergency Medical Services. The casualty's chance of survival falls by around 7 - 10% with every minute that defibrillation is delayed (Resuscitation Council (UK) and British Heart Foundation, 2017).

An AED is only to be applied to casualties who are unconscious, without pulse, signs of circulation and normal breathing. The AED will analyse the heart rhythm and advise the operator if a shockable rhythm is detected. If a shockable rhythm is detected, the AED will charge to the appropriate energy level and advise the operator to deliver a shock.

Location of AEDs at Beaudesert Park School:

1) Just inside main reception door in the entrance hall, wall mounted on the right-hand side as you enter through main door.
2) In the public lobby to the swimming pool
3) Inside the Pavilion at the playing fields

Procedure for cardiac arrest:

The Resuscitation Council (UK) (https://www.resus.org.uk/library/2021-resuscitation-guidelines) sets the standard for resuscitation training for both the general public as well as Health Care Professionals. These guidelines and procedures have been written in relation to these standards.

In the event of a serious incident, it is of key importance for the member of staff who remains with the casualty to:

- Keep calm, assess the situation and take charge
- Carry out immediate First Aid while waiting for help to arrive
- Leave the casualty where found, unless it is imperative that they are removed from danger
- Send bystanders away from the scene of the incident unless they are able to be of immediate help
- Reassure the casualty

For an apparently unconscious casualty:

D – Check for, and remove, sources of **Danger**

R – Can the casualty **Respond**? Are they conscious? 'Hello, can you hear me? Open your eyes'

If you are alone, and the casualty is unconscious, shout for help!

A - If unconscious, turn the casualty onto their back and open the **Airway** using head tilt and chin lift:

- Place your hand on their forehead and gently tilt their head back
- With your fingertip(s) under the point of the casualty's chin, lift the chin
- Do not push on the soft tissues under the chin as this may block the airway
- If you still have difficulty in opening the airway, try the jaw thrust method: place the first two fingers of each hand behind each side of the casualty's mandible (jaw bone) and push the jaw forward

Have a low threshold for suspecting injury to the neck. If you suspect this, try to open the airway using jaw thrust alone. If this is unsuccessful, add head tilt gradually until the airway is open. Establishing an open airway takes priority over concerns about the cervical spine.

B – Are they **Breathing**? Look, listen and feel for up to 10 seconds by putting your face close to the casualty's face and looking along the chest:

- **Look** for chest movements
- **Listen** at the casualty's nose and mouth for breath sounds
- **Feel** for air movement on your cheek

In the first few minutes after cardiac arrest the casualty may be taking infrequent, noisy gasps. Do not confuse this with normal breathing. Look, listen, and feel for *no more than* 10 seconds before deciding – if you have any doubts whether breathing is normal, act as if it is not normal.

- On confirmation of an unconscious casualty who is not breathing normally, **dial 999** stating **CARDIAC ARREST**
- Call for additional help if available and ask them to contact the main office in school to alert them of the emergency and location of unconscious casualty. Main office will assign someone to retrieve the nearest AED and bring to emergency scene.

If the casualty is breathing normally but is unconscious, without suspected spinal injury:

- Put casualty in the recovery position on their side. (For suspected spinal injury, maintain open airway in the position that the casualty has been found in).

If the casualty is not breathing and there are no Signs of Life:

C – **Circulation -** Carry out CPR as follows:

- For a young person or child, give 5 initial rescue breaths. Follow these with 30 chest compressions and 2 rescue breaths, repeating this sequence until help arrives, or the casualty's breathing restarts.
- For an adult, start 30 chest compressions, then open the airway and give 2 rescue breaths, repeating this sequence until help arrives, or the casualty's breathing restarts.

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

Procedure for use of AED:

The following sequence applies to the use of automatic AEDs in a casualty who is found to be unconscious and not breathing normally:

- Assess casualty scene safely
- Administer normal good quality CPR, as outlined above, until the AED is brought to the scene and is available for use – do not delay CPR. It is not recommended to administer CPR for a certain length of time before using the AED
- This early CPR is vital and must only be interrupted when it is necessary for the AED to analyse the rhythm and deliver the shock
- As soon as the AED arrives continue with CPR until it is switched on. If you are alone, stop CPR and switch on the AED
- Follow the voice prompts
- Attach the AED pads electrodes to the casualty's bare chest

  Placement of AED pads:

  - A picture of their correct placement is shown on the pads themselves – you must ensure though that one pad is lower than the other
  - The aim of pad placement regardless of age is to position the pads so that they deliver a shock right through the heart
  - You can use **adult** pads for a **child** less than 8 years, but you may have to apply them differently than shown on the pads: apply one on the front of the chest, the other on the back, so they do not touch
  - If positions are reversed it does not matter as removing them to replace correctly will waste time and may not adhere to skin when re-attached
  - The casualty's chest must be sufficiently exposed to enable correct pad placement – it may be necessary to shave the casualty's chest if excessively hairy. This will ensure the shock delivered is effective. Razors can be found in pack with the AED.

Ensure that nobody touches the casualty while the AED is analysing the heart's rhythm:

- If a shock is indicated – ensure nobody touches the patient whilst the AED automatically delivers the shock
- If no shock is indicated, resume CPR immediately using a ratio of 30 compressions to 2 rescue breaths and continue as directed by the voice prompts
- Continue to follow the AED prompts until qualified help arrives and takes over responsibility or the casualty starts showing signs of regaining consciousness (e.g., coughing, opening eyes, moving purposefully and starts to breathe normally)

  Defibrillation if casualty is wet:

- As long as there is no direct contact between the user and the casualty when the shock is delivered, there is no direct pathway that the electricity can take that would cause the user to experience a shock.

- Try to dry the casualty's chest so that the adhesive AED pads will stick – towel for drying can be found in the pack in the AED.
- If the casualty is in the water – lift the casualty out on to the side before attempting to use the defibrillator
- The use of an AED is NOT recommended in children aged less than 1 year

Routine maintenance and safety checks of AED:

- AEDs are located in areas that are immediately accessible to staff
- UK standardised signs as recommended by the Resuscitation Council (UK) are utilised to highlight the AED locations
- All staff know where AEDs are located as part of their induction
- Should any member of staff have any concerns regarding the AEDs they must notify the school nurses
- AEDs are maintained in accordance with the manufacturer's instructions - modern AEDs undertake regular self-tests and, if a problem is detected, will indicate this by means of a warning sign or light on the machine
- It is the responsibility of the school nurses to ensure that weekly and monthly checks of the AEDs are carried out and recorded on the AED checklist
- Most AEDs will store data, which can subsequently be used to assist with ongoing patient care. The school nurses will therefore contact the local ambulance service after an AED has been used and make arrangements for the data to be downloaded
- The school nurses will ensure that the AED is ready for use again by replacing pads and other consumables as required, and ensure that it is not displaying any warning lights or messages
- Where a cardiac arrest occurs as a result of an accident or act of physical violence arising out of or in connection with work, this may constitute a reportable incident under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)

APPENDIX T – Criteria for effective Paediatric First Aid (PFA) Training

1. Training is designed for workers caring for young children in the absence of their parents and is appropriate to the age of the children being cared for.
2. Following training an assessment of competence leads to the award of a certificate.
3. The certificate must be renewed every three years.
4. Adequate resuscitation and other equipment including baby and junior models must be provided, so that all trainees are able to practice and demonstrate techniques.
5. The **emergency PFA** course should be undertaken face-to-face[71] and last for a minimum of 6 hours (excluding breaks) and cover the following areas:
    - Be able to assess an emergency situation and prioritise what action to take
    - Help a baby or child who is unresponsive and breathing normally
    - Help a baby or child who is unresponsive and not breathing normally
    - Help a baby or child who is having a seizure
    - Help a baby or child who is choking
    - Help a baby or child who is bleeding
    - Help a baby or child who is suffering from shock caused by severe blood loss (hypovolemic shock)
6. The **full PFA** course should last for a minimum of 12 hours (excluding breaks) and cover the elements listed below in addition to the areas set out in paragraph 5 (the emergency PFA training elements outlined in paragraph 5 should be delivered face to face).
    - Help a baby or child who is suffering from anaphylactic shock
    - Help a baby or child who has had an electric shock
    - Help a baby or child who has burns or scalds
    - Help a baby or child who has a suspected fracture
    - Help a baby or child with head, neck or back injuries
    - Help a baby or child who is suspected of being poisoned
    - Help a baby or child with a foreign body in eyes, ears or nose
    - Help a baby or child with an eye injury
    - Help a baby or child with a bite or sting
    - Help a baby or child who is suffering from the effects of extreme heat or cold
    - Help a baby or child having: a diabetic emergency; an asthma attack; an allergic reaction; meningitis; and/or febrile convulsions

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    - Understand the role and responsibilities of the paediatric first aider (including appropriate contents of a first aid box and the need for recording accidents and incidents)
7. Providers should consider whether paediatric first aiders need to undertake annual refresher training, during any three year certification period to help maintain basic skills and keep up to date with any changes to PFA procedures.
