KINGSWOOD HOUSE SCHOOL

FIRST AID AND ADMINISTRATION OF MEDICINES POLICY

This Policy relates to the whole school including the Early Years Foundation Stage, and is reviewed annually to ensure compliance with current regulations and law and must be read in conjunction with other relevant Kingswood House School policies.

Related Policies:

- Child Protection and Safeguarding Policy
- Low Level Concern Policy
- Special Educational Needs and Disabilities (SEND) Policy
- Positive Mental Health Policy
- Head injury and Concussion Policy (Appendix 7)
- Allergy Policy (Appendix 8)
- Asthma Policy (Appendix 9)

This list is not exhaustive.

Policy reviewed by: Emma Darbishire **Dated: 9th October 2023 (updated 9.2.24)**

Policy next review: 9 October 2024

Policy statement

In accordance with Health and Safety legislation (Health and Safety (First Aid) Regulations 1981), it is the responsibility of the Governing Body to ensure adequate and appropriate first aid provision at all times when there are people on the school premises and during off-site visits and activities.

In order to ensure adequate first aid provision, it is the School policy that:

- There are sufficient numbers of trained personnel together with appropriate equipment to ensure someone competent in basic first aid techniques can rapidly attend an incident at all times during normal school hours to ensure first aid is administrated in a timely manner.

- Appropriate first aid arrangements are made whenever staff and pupils are engaged in off-site activities and visits.

Responsibilities under the policy

The Health and Safety Inspection Committee of the School, on behalf of the Governing Body, is responsible for:

- Inspecting the School's first aid provision each term.
- Advising the Bursar of issues arising.
- Reporting to the Governing Body their recommendations.

The Health and Safety Committee of the School, on behalf of the Governing Body, is responsible for ensuring:

- First aid needs are assessed and addressed.
- Sufficient numbers of suitably qualified first aiders are available.
- The adequate provision of first aid services during school hours and for activities held on site after normal school hours.
- Appropriate first aid cover is available for off-site school organised activities.

The Bursar, on behalf of the Health and Safety Committee, is responsible for:

- Assessing the first aid needs throughout the school.
- Advising on appropriate levels of first aid provision.
- Ensuring first aid cover is available during normal school hours and for activities held on site after normal school hours.
- Identifying first aid training needs.
- Arranging training and maintaining records thereof.
- Organising provision and replenishment of first aid equipment.
- Reviewing accident forms.
- Induction of staff in first aid issues.
- Liaising with the Health and Safety Inspection/Committee on first aid issues.

Qualified First Aiders are responsible for:

- Responding promptly to calls for assistance.
- Providing first aid support within their level of competence.
- Summoning medical help as necessary.
- Recording details of treatment given.
- Maintaining accurate records of first aid treatments given.

Appointed Persons are responsible for:

- Giving assistance to the qualified first aiders.
- Taking charge when someone becomes ill.
- Ensuring that an ambulance or other professional medical help is summoned as appropriate.

Early Years First Aiders are responsible for:

- Providing first aid support within the Early Years Foundation Stage.
- Ensuring that an ambulance or other professional medical help is summoned as appropriate.

Deputy Head and Head of Sport are responsible for:

- Ensuring appropriate first aid cover is available at all out of hours sports activities.
- Ensuring appropriate first aid cover and equipment for all practice sessions and matches.
- Ensuring appropriate first aid cover and equipment for all outings and residential trips.

Parent/Guardian is responsible for:

- Completion of the medical form(s) issued by the school annually and on joining (Appendix 1). Any changes to any new or existing medical condition must be notified to the school as soon as possible.
- Providing a signed consent form for administration of medication (Appendix 2).
- Completing the Allergy and Anaphylaxis Plan if required (Appendix 3).
- Ensuring that a member of the family or other nominated person is easily contactable at all times in the event of an emergency or a child requiring to be sent home from school due to illness or injury.

First Aid risks

An assessment of first aid needs is carried out on an annual basis by the Bursar on behalf of the Health and Safety Committee. The assessment takes into account:

- Numbers of pupils, staff and visitors on site.
- Layout and location of buildings and grounds.
- Specific hazards.
- Special needs.
- Hours of work.
- Out of hours and off-site activities.

The assessment will identify:

- How many first aiders are needed during the school day.
- Out of hours and off-site arrangements.
- Back-up arrangements to cover absence of first aiders.
- Which departments require a qualified first aider.
- What equipment is needed.
- Where equipment is to be located.
- Where notices and signs are displayed.
- Good practice in record keeping.

Numbers of pupils, staff and visitors on site

During the majority of school days there are approximately 335 people, 250 pupils and 85 staff, on site. Occasionally, for school plays and concerts, this number may increase to 450 people.

Layout and location of buildings and grounds

The school site is quite compact with 6 different teaching areas. However, accidents can happen anywhere at anytime and therefore all staff should know how and when to obtain help in an emergency.

Specific hazards/lunch and breaks

Accident statistics can indicate the most common times, locations and activities involved when accidents occur at school, highlighting areas where pupils and staff may be at greater risk of injury. Injuries and accidents are most likely to occur during Games/PE lessons and matches, at break times, in the DT and Science departments, in the kitchen and maintenance departments. The Head of Science, Head of DT and Head of Catering have all completed first aid courses. Out of hours and off-site activities may present particular risks depending on the location and nature of the activity and the numbers of pupils and staff involved.

Pupils all go to the dining room for lunch with their year group, which is supervised by staff. Pupils may use the field, astro, playground and adventure trail for break and supervised by two or more staff in different areas. All staff are aware of procedures when a child is injured.

Hours of work

The Medical Room is open from 1030 to 1430 when the School Nurse will be in attendance. At all other times first aid will be provided from the School Office which is manned from 0730 to 1700 Monday to Friday during term time and a first aider is always on site from 0730 to 1800.

Out of hours and off-site activities

Some school activities take place outside of normal school hours and/or off-site. First aid provision is available at all times while people are on the school premises and when on school trips or visits. The medical file, kept in the School Office, must be taken on all off-site trips/activities together with inhalers, epi pens and medication, when necessary.

Please see the Education Visits Policy for guidance on first aid and medication on school trips.

Contractors

All contractors will be advised of our procedures for first aid. Major building projects under a JCB contract will be covered by their own health and safety regulations.

First Aid kits

First Aid kits are clearly labelled with a white cross on a green background in accordance with Health and Safety regulations. The contents of the first aid kits may vary depending on the particular needs in each location but are in accordance with guidance given in HSE doc “Basic advice on first aid at work”. The Bursar will supply first aid kits as appropriate. First aid kits are currently situated in:

- Medical room (Board room)
- School office
- PE Office (including travel bags which must be taken on school trips and other off-site activities).
- Kitchen
- DT
- Science Lab
- Reception Classroom (EYFS)

- Grounds shed
- Minibuses

The School Matron is responsible for the checking and restocking of first aid kits. This is usually carried out at the beginning of each term and as required. The School Matron should be notified when items have been used so they can be replaced without delay.

A first Aid bag or box must be taken on all trips when pupils leave the school, including sporting events.

Information

This First Aid and Administration of Medicines Policy is located on the school website and is available to parents and staff on request.

Parents are informed of our procedures for responding to children who are ill or infectious on admission to the School and these procedures are also written up in our Parents' Handbook.

New staff are briefed on the First Aid and Administration of Medicines policy and procedures as part of the induction process and new pupils are briefed by their teacher when they start school.

The briefing should include:

- Location of the School Office (first aid station)
- What to do in an emergency
- Names of first aiders and appointed persons
- Location of First Aid kits
- Administration of medicines

First aid notices are posted in most rooms around the School, including the Staff Room, School Office, Kitchen, Study Centre, upper corridor of Langlands, changing rooms, Katy Walton building, Lower Prep, Humanities, DT and Peter Brooks building. Notices give the names of First Aiders and location of first aid boxes.

There is a locked **medicine cupboard** in the Medical room and School Office where all medicines are to be stored. Keys are kept by the School Matron and office staff.

Training

A **qualified first aider** is someone who holds a valid certificate of competence in First Aid at Work. The certificate must be issued by an organisation approved by the Health and Safety Executive, such as St John's Ambulance, and must be renewed every three years. The Bursar will arrange for staff to attend the **First Aid at Work** course as required. In the school six people hold this qualification:

- Mrs Emma Darbishire, School Matron
- Mrs Karen Harding, School Secretary
- Mrs Ann Miller, Office and Admissions Administrator
- Mr L Clarke, Interim Headmaster and DSL
- Mr Ian Mitchell, Deputy Head
- Mrs Tessa Curnin, EHCP Coordinator and LSA

- Miss Nikita Patel
- Mr Jeremy Westcott

An **appointed person** is someone who has attended a minimum of 4 hours first aid training (renewable every three years) and is competent to give emergency aid until further help arrives. We have 15 qualified appointed persons.

There are five people qualified in **Early Years** / **Paediatric First Aid** who are competent to give first aid assistance to the Early Years Foundation Stage:

- Mrs Emma Darbishire, School Nurse
- Mr Liam Clarke, Interim Headmaster and DSL
- Mrs Chantel Martins

There will always be an EYFS First Aid/Paediatric trained member of staff on all site at all times whilst EYFS children are present.

Staff have inset training annually on the use of epipens, epilepsy and the management of seizures and diabetes. This training is carried out by the School Matron. Training will also be provided to staff if further medical or technical knowledge is required

First Aid and appointed person training will be refreshed every three years.

There are two trained **Mental Health aider**s in School:

- Mrs Jane Chandler – Catering Manager
- Katey Timothy – Emotional Literacy Support Assistant (ELSA)
- Mrs Emma Darbishire – School Matron

Please refer to the School's Positive Mental Health Policy for more details.

PROCEDURES

Minor Incidents/Illness

Any child sustaining an injury or suffering illness whilst at school will be treated by the school staff who will inform the parent/carer of any treatment given either by telephone, or a note sent home with the child.

All minor incidents should be treated in the Medical Room or School Office (cuts and grazes) by a qualified first aider. The wound should be cleaned with sterile water and covered with a dressing. Staff should send the casualty with an escort to the School Office or accompany them themselves if the casualty is in distress.

If a child needs to be sent home from school, he/she will remain in the School Office with a member of staff until collected by a parent/carer. The parent/carer is to collect the child as promptly as possible. A bed is kept in the Medical Room and may be used for any person requiring it. The School Matron or School Secretary will remain with the casualty at all times until they can be collected.

Major Incidents
In the case of a severe accident, severe bleeding, serious injury to legs or back, head injury, eye injuries, severe nose bleeds and seizures, the casualty must not be moved and a qualified first aider called to the scene as soon as possible.

Resuscitation Action Plan
A copy of the plan can be found in Appendix 6 attached. The school Automated External Defibrillator (AED) is located on the wall of the School Office behind the reception desk. The AED is designed for treatment of sudden cardiac arrest and should only be used to treat someone who is either unresponsive or non-breathing. The Action plan must be followed and a copy can also be found with the AED.

Head injury
The pupil will be assessed in accordance with our Head Injury policy. For incidents without side effects, a form (Appendix 7) will be given to the parent via the pupil advising them of the incident and if first aid was administered. If side effects such as outlined in the policy occur then either parent/carer will be contacted or an ambulance will be requested and parent/carer advised.

CALLING AN AMBULANCE
The School Office, School Matron, Bursar or a qualified first aider are normally responsible for summoning an ambulance (dial 999 or 112), and for escorting the pupil to hospital; but all staff are advised in their induction training that, if the above staff are unavailable, they should summon an ambulance themselves. A member of staff will always escort the child, together with a driver, and stay with them in hospital until their parents/carers have arrived.

If the emergency services are called to the school to attend to a casualty, that person must obey the advice of the attending paramedics.

Staff should ensure that other pupils are cared for during and after an incident. Extra staff may be required to help with duties and reassure the children and keep them at a respectful distance to the casualty. After the incident the children may need time to talk it through, perhaps with their form teacher, and all other staff should be informed.

Emergency Medical Treatment
In accepting a place at the school, we require parents to authorise the Headmaster, or an authorised deputy acting on his behalf, to consent on the advice of an appropriately qualified medical specialist to your child receiving emergency medical treatment, including general anesthetic and surgical procedure under the NHS, if we are unable to contact you in time.

Asthma Inhalers / Epipens
The Asthma (Appendix 8) and Allergy (Appendix 9) Policies state that inhalers and epipens (or any other treatment) must be kept in the filing cabinet in the School Office, suitably labelled.
Parents/carers should ensure that they are not out of date and replace when necessary. When used, an epipen should be safely put into a box with a lid and handed to the ambulance service.

Administering Medication at School
Medication can only be administered to children at Kingswood House School when the following conditions apply:

- Medicines should only be administered at school when it would be detrimental to a child's health or school attendance not to do so.

- No child under 16 should be given prescription or non-prescription medicines without their parent's written consent – except in exceptional circumstances where the medicine has been prescribed to the child without the knowledge of the parents. In such cases, every effort should be made to encourage the child or young person to involve their parents while respecting their right to confidentiality. Schools should set out the circumstances in which nonprescription medicines may be administered.
- A child under 16 should never be given medicine containing aspirin unless prescribed by a doctor. Medication, e.g. for pain relief, should never be administered without first checking maximum dosages and when the previous dose was taken. Parents should be informed.
- Where clinically possible, medicines should be prescribed in dose frequencies which enable them to be taken outside school hours.
- Schools should only accept prescribed medicines if these are in-date, labelled, provided in the original container as dispensed by a pharmacist and include instructions for administration, dosage and storage. The exception to this is insulin, which must still be in date, but will generally be available to schools inside an insulin pen or a pump, rather than in its original container.
- All medicines should be stored safely. Children should know where their medicines are at all times and be able to access them immediately. Where relevant, they should know who holds the key to the storage facility. Medicines and devices such as asthma inhalers, blood glucose testing meters and adrenaline pens should be always readily available to children and not locked away. This is particularly important to consider when outside of school premises, e.g. on school trips.
- When no longer required, medicines should be returned to the parent to arrange for safe disposal. Sharps boxes should always be used for the disposal of needles and other sharps.
- A child who has been prescribed a controlled drug may legally have it in their possession if they are competent to do so, but passing it to another child for use is an offence. Monitoring arrangements may be necessary. Schools should otherwise keep controlled drugs that have been prescribed for a pupil securely stored in a non-portable container and only named staff should have access. Controlled drugs should be easily accessible in an emergency. A record should be kept of any doses used and the amount of the controlled drug held.
- School staff may administer a controlled drug to the child for whom it has been prescribed. Staff administering medicines should do so in accordance with the prescriber's instructions. Schools should keep a record of all medicines administered to individual children, stating what, how and how much was administered, when and by whom. Any side effects of the medication to be administered at school should be noted in school.

Medication

Prescribed medication may be administered by staff. If a child needs to take medication whilst at school, the parent/carer should hand it in to the school office. Medication should be clearly labelled with details of the name of the medication and when and how much should be given. A medication consent form should be completed and signed giving clear instructions. Regular medications are recorded in the medication file. All medication will be stored in the locked medical cabinet in the Medical Room or School Office except for those medicines that need to be kept in the fridge in which case the fridge in the staff room should be used.

Paracetamol, Calpol, antihistamine, Ibuprofen and Nurofen are the only non-prescription medications that will be administered by school staff. These non-prescription medications can only be administered by staff if the parent/carer has provided signed written consent to do so. All parents will have the opportunity to give their consent at the time of acceptance to the school and thereafter

annually by completion of the medical consent form. Any medication given will be recorded on CPOMS and a note completed for parents.

If a parent would like the school to administer a non-prescribed medication, different to those listed above, then a consultation needs to take place with the school. This consultation will be to determine:

- If the medication was not administered at school would it be detrimental to a child's health or school attendance;
- Whether it is a licensed product, if it is unlicensed then the school would not administer it and ask the parent/carer to obtain prescribed medication from a qualified health professional;
- That it does not contain aspirin, as a child under 16 should never be given medicine containing aspirin unless prescribed by a qualified health professional; and
- If there are any risks in the child taking the medication, in which case the school would ask the parent/carer to seek medical advice from a qualified health professional to obtain prescribed medication or a safe alternative.

No child will be given any treatment or medication against his/her will.

Staff Medication and special health needs or disabilities

Staff must seek medical advice if they are taking medication which may affect their ability to care for children and the Headmaster should be informed. Any staff medication must be securely stored at all times and must never be left in handbags in the classroom. Staff may use the locked medical cupboard located in the school office. If a member of staff has a life threatening condition such as diabetes, epilepsy, asthma or allergies which could give rise to anaphylactic shock, then they must ensure staff are aware and provide details on the display board in the staff room.

Medical history/Allergies of pupils/ Special health needs

Staff must ensure that they are aware of the medical history of the children they teach. The Headmaster must ensure that such information is available to members of staff. It is also essential that staff are aware of any children suffering from potentially life-threatening conditions such as diabetes, epilepsy, asthma or allergies which could give rise to anaphylactic shock, and the action necessary to take in the event of such an attack (see Appendix 3 and 4).

An up-to-date list of medical conditions of all children by class is kept in the school office. A list of pupils with allergies is also kept in the kitchen and appropriate food arrangements made. These are updated by the school secretary each term.

Staff are informed by the Headmaster if children with serious medical problems join the school and a notice is kept on the staff room board. Parents complete a care plan if their child has a serious medical condition or allergy and these are kept in their medical files in the School Office and displayed in the staff room.

All pupil medical records are kept in locked files in the main School Office.

Children with Medical Needs or Special Education Needs or Disabilities who require special adjustments

If a child has medical needs, special education needs or requires any special adjustments, the parents will be invited to a meeting with Headmaster, form tutor and Special Education Needs Coordinator and any outside Specialist who has been involved with the care of your child, to discuss thoroughly the regime that is most appropriate for his or her individual care.

Immunisations
When advised by the community school nurses, we will arrange for parents to be informed about required immunisations for their child. These are usually HPV in Year 8 and 9 and nasal flu vaccination.

Swimming
Children with open wounds must not swim.

Matches and off-site activities
A first aid bag must be taken on all trips. Grab bags are kept in boxes in the School Office/Sports Office and must be taken on all coach trips and to matches. When travelling by car it is the responsibility of the member of staff to carry a grab bag in their vehicle.

The class list of pupils' medical conditions should also be taken on all trips together with medication/inhalers, etc.

Exclusion Illnesses
In all cases of infections the exclusions in Appendix 5 will be followed. Kingswood House School will keep up-to-date with any health alerts and respond accordingly following the recommended government and health agencies protocols. The school takes a proactive and preventive approach to the prevention and control of infections which are summarized in Appendix 5.

Body fluids
Gloves should be worn at all times if in contact with body fluids and any spillages cleaned up immediately. Vomit should be covered with absorbent deodorizing powder (kept in the School Office and Lower Prep) and then swept up using the supplied dustpan and brush. The Bursar must be informed who will contact our cleaning company to ensure that the area is cleaned properly in the evening.

If vomit is located outside, the area should be cordoned off and covered with sand. Please ensure the Bursar is informed so that the sand can be safely disposed of.

All items that come into contact with body fluids, including medi-wipes, cleaning cloths, tissues, gloves, etc. are to be disposed of in a plastic bag and tied up and placed in the pedal bin in the office which is emptied each evening.

REPORTING AND RECORD KEEPING

Accidents
All accidents should be reported immediately and recorded on CPOMS. Details to be recorded should include:

- Date and time of incident
- Name of casualty
- Details of injury/illness
- Treatment and/or advice given
- Signature or person dealing with the accident
- Whether parents have been informed
- Parents of EYFS children will be informed on the same day or as soon is reasonably practical

Accident records are reviewed by the Health & Safety Inspection Committee each term. Accident records must be kept for a minimum of three years.

Any member of staff or visitor to the school who has an accident must also complete an accident form (in the School Office) which should be passed to the Bursar for filing. Any visitor to the school who has an accident will receive a follow up call as to their welfare.

EYFS
The School will notify the local child protection agencies of any serious accident or injury to, or the death of, any child while in their care, and will act on any advice from those agencies.

RIDDOR
The School will report to the Health & Safely Executive (Tel: 0845 300 9923), under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995, any deaths, major injuries, over-three-day injuries, accidents causing injury to pupils, members of the public or other people not at work, specified dangerous occurrences, where something happened which did not result in an injury but could have done.

Medication
Any treatment or medication administered should be recorded on CPOMS and should include:

- Date and time of administration
- Name and amount of medication or treatment given
- Name of person receiving medication
- Signature of administrator

Records are kept for a minimum of five years.

Controlled Medication
- The supply and possession and administration of some medicines are controlled by the Misuse of Drugs Act and its associated regulations. Some may be prescribed as a medicine for use by children who have ADHD, such as methylphenidate.
- Any authorized or trained member of staff may administer a controlled drug to the child for whom it has been prescribed. Staff administering medicine should do so in accordance with the prescriber's instructions.
- The controlled drugs are stored in a locked medical cabinet in the office.
- All controlled drugs must be in their original packaging with a pharmacy label including name and dose.
- A Paper Controlled Drug register is kept in the locked medical cabinet in the office and keeps a record of the controlled medication received and given at Kingswood House School.

In accordance with Health and Safety law, some accidents and illnesses must be reported to the Health and Safety Executive. This is the responsibility of the Bursar.

Please note that all parents of children in the EYFS are to be informed by written note or telephone call if their child has had an accident or been administered medicine on the same day, or as soon as reasonably practicable.

Accident Investigation
All serious accidents and an injury/accident that frequently occurs should be investigated. Accident Investigation Forms are kept in the School Office and once completed should be filed with the Bursar for review by the Health and Safety Committee.

MONITORING AND REVIEW OF POLICY

First aid arrangements are reviewed annually to ensure the provision is adequate and effective. Additional reviews will take place following any significant changes in structure, such as new buildings, relocation or changes in staffing and/or pupils numbers.

Appendix 1

Pupil Health Consent Form

Last Name	
First Name	
Middle Name	

Date of Birth	
Year / Form	

Family Doctor (Name, Address & Phone)	

Child adopted / not adopted (Please circle as appropriate)	Parents living together / separated / divorced (Please circle as appropriate)
Any past events (e.g. recent deaths, traumas, etc.) which may have had an effect on your child	

Does your child have: (please tick as appropriate)		Yes	No
1. a)	Asthma		
b)	Difficulties with breathing		
c)	Diabetes		
d)	Difficulty with his eyes		
e)	Trouble with his ears / hearing		
f)	Speech difficulty		
g)	Frequent sore throats		
h)	Skin rashes		
2. Does your child suffer from any chest trouble?			
3. Do you think your child has any weight trouble?			
4. Has your child ever had any convulsions or fits?			
5. Has your child had frequent headaches in the last 12 months?			
6. Does your child have fainting attacks, blackouts or dizzy spells?			

7. Does your child have difficulty getting to sleep or sleeping?		
8. Does your child suffer from rheumatism?		
9. Does your child require an Asthma Inhaler? If yes, do your require it to be kept in the School Office?		
10. Does your child need an Epipen? Is it kept at school?		

ADDITIONAL MEDICAL CONDITION, MEDICATION OR INSTRUCTIONS

Is there any other medical condition not already detailed, additional medication to be taken or special instructions for the school?

GENERAL

Are there any other concerns / difficulties of which you would like us to be aware, which may affect your child's performance at school?

PHYSICAL

Has your child difficulties, which may affect their ability to participate in games lessons?

HOSPITAL

If your child attends hospital at present, or has attended in the last year or two, please give details.

Name of Hospital and consultant, physician or surgeon

Date(s) attended

Was he/she an in-patient, and if so, for how long?

Reason for attendance

VACCINATIONS

Has your child been vaccinated against tetanus? Yes / No (please circle)

Date of last injection …….

MEDICATION

Does your child receive regular prescription medication? Yes/No

If **yes**, Name of medication:…… Dosage: ……..

Would you like the school to administer this prescribed medication Yes/No
If so, please advise timings:…….…….

ALLERGIES

Please state if your child has any allergies:

Hayfever	Yes/No
Bites/stings	Yes/No
Plasters	Yes/No
Drugs	Yes/No
Food	Yes/No

If yes, please give the name of the food and treatment required if any:

Please provide details of any other allergies not listed…

Are any of the above life threatening? Yes/No
If **yes**, please give details…

DIETARY REQUIREMENTS

Does your child require a special diet? Yes/No
If yes, please provide details:

CONSENT 1

I do / do not consent to my child being given the non-prescribed medication listed below, as deemed appropriate, whilst they are on school premises:

Paracetamol/Calpol	Yes/No
Antihistimine	Yes/No
Ibuprofen / Nurofen	Yes/No

Signature of Parent/Guardian …….

Date ……..

CONSENT 2

In the event of the school being unable to contact myself or the emergency contact/s
I do / do not consent to an appropriate member of staff acting in the best interests of my child.

Signature of Parent/Guardian ……

Date: …….

PARENTAL CONSENT

I hereby give my consent to the attendance of my child on school visits on the understanding that the person in charge of the party of children will be a member of the teaching staff of Kingswood House. That member of staff will remain in loco parentis although, on certain visits, they may hand over the duty of care to a specialist instructor.

We further authorise the Head Teacher, or an authorised deputy acting on their behalf, to consent on the advice of an appropriately qualified medical specialist to our child receiving emergency medical treatment, including general anaesthetic and surgical procedure under the NHS, if you are unable to contact us in time.

Signature of Parent/Guardian …….

Date …….

If any of the information you have provided changes e.g. address, telephone, GP, medical conditions, you must let the school know immediately

Appendix 2

ADMINISTRATION OF MEDICINES IN SCHOOL

Child's Name: …….. Form: ……

MEDICATION

Name of medication: …….

Dosage: …….

Time of last dose: ……. Amount given: ……..

Condition of illness: …….

When/ How to administer medication:

……

……

Special Instructions: ……..

……

Does medication need to be put in fridge?: ……

Please administer the above medicine for …….. days or until further notice.

Signed: ……. Date:……..

Print Name: …….

Appendix 3

Anaphylaxis and Allergy Plan

Name…….

Date of Birth……

The above named pupil may suffer from an anaphylaxis reaction if they are exposed to:

……
……

Their usual allergic symptoms are:

……
…….

Procedure in the event of an acute allergic reaction:

Symptoms: Wheezing
Swelling of face and throat
Difficulty in breathing and swallowing
Feeling faint

Action: ***Contact ambulance service 999***

- Place child in safe, comfortable position
- Give Epipen injection (kept in bottom drawer of medical filing cupboard in office)
- Monitor closely. If no improvement, or if symptoms of floppiness or pallor develop or worsen within 10 minutes repeat if further Epipen available.
- Inform the following contact numbers in order of priority.

Contact No. 1 Name……..…
Tel. No…….….
Relationship…….

Contact No. 2 Name……..
Tel. No……
Relationship……..

In case of: Itchiness
Tingling of face and lips
Tummy cramps
Vomiting
Blotchiness of skin

Give……. (Oral antihistamine) ……... ml immediately

Inform the contact numbers as above

- It is the parents' responsibility to ensure that all medication supplied to the school is in date and clearly marked.
- It is the parents' responsibility to ensure the pupil is fully aware of the signs and symptoms of an allergic reaction.
- It is the parents' responsibility to ensure the pupil has been instructed on the administration of the necessary medication and the importance of carrying it at all times.
- All medication will be returned to the pupil/parent at the end of each half term and term.
- It is the parents' responsibility to replace any medication used.

The school will inform all relevant staff with regard to the pupil's condition and the arrangements set out in this document.

The school office, form tutor and sport's office will hold a copy of this plan.

Agreed and signed

Parent Name …… Sign …… Date ……..

Parent Name …… Sign …… Date ……..

School Bursar…… Sign …… Date ……..

Guidance on how to administer an epipen:

Sit the casualty down
Take the epipen in your dominant hand
Remove the grey cap
Plunge into the outer thigh through clothing (except heavy jeans)
Count to 10
Remove and place in a box and give to the ambulance service
Rub the area in the thigh gently

JEXT epipen (has a yellow cap):
Remove the yellow cap
Put against the leg and push hard until you hear a click.

Repeat after 10 minutes if there is no change and you have another epipen.

Appendix 4

Asthma, Seizures, Diabetes

Guidance for staff on the recognition and first aid treatment of:

Asthma Attack

In an asthma attack the muscles of the air passages in the lungs go into spasm and the linings of the airways swell. As a result, the airways become narrowed and breathing becomes difficult.

Sometimes there is a specific tripper for an attack such as:

- An allergy
- A cold
- Cigarette smoke
- Extremes of temperature
- Exercise

Recognition features

- Difficulty in breathing, with a very prolonged breathing-out phase.

There may also be:

- Wheezing as the casualty breathes out
- Difficulty speaking and whispering
- Distress and anxiety
- Coughing
- Features of hypoxia, such as a grey-blue tinge to the lips, earlobes and nailbeds

ACTION
Your aim is to ease the breathing and if necessary get medical help.

- Keep the casualty calm and reassure them
- Encourage them to use their blue inhaler if they have one. Children may have a spacer device. It should relieve the attack within a few minutes.
- Encourage the casualty to breathe slowly and deeply.
- Encourage the casualty to sit in a position that they find most comfortable, often leaning forward with arms resting on a table or the back of a chair. Do not lie the casualty down.

A mild attack should ease within three minutes but if it doesn't ask the casualty to use their inhaler again.

Caution
If this is the first attack, or if the attack is severe and any one of the following occurs:

- The inhaler has no effect after 5 minutes
- The casualty is becoming worse
- Breathlessness makes talking difficult
- The casualty becomes exhausted

Call for an ambulance.

- Encourage the casualty to use their inhaler every 5 to 10 minutes

- Monitor and record the breathing and pulse rate every 10 minutes

Seizure

A seizure or convulsion can occur at any age and is due to abnormal electrical activity in the brain resulting in uncontrollable muscular activity and loss of consciousness. There are many types of seizure, with some being relatively mild and others severe and prolonged.

The patient goes still, loses consciousness, falls to the floor and begins to jerk or convulse. They may look a little blue around their mouth from irregular breathing. Seizures can last for a few minutes.

ACTION:
Assess the situation – are they in danger of injuring themselves?
Remove any nearby objects that could cause injury.
Cushion their head to protect them from head injury.
Check the time.
Look for a medical bracelet or ID card – it may give you information about the person's seizures and what to do.
Once the seizure is over, put them on their side (in the recovery position).
Stay with them and reassure them as they come round.
Never restrain the person, put something in their mouth or try to give them food or drink.

Call for an ambulance if the casualty does not wake up within 10 minutes, is not breathing well, or it is their first seizure.

Diabetes - Hypoglycaemia and Hyperglycaemia

Hypoglycaemia is when the blood sugar level falls below normal and brain function is affected.

Recognition features:
- History of diabetes, the casualty may recognize the onset of an attack
- Weakness, faintness or hunger
- Palpitations and muscle tremors
- Strange actions or behavior
- Sweating and cold, clammy skin
- Rapid and strong pulse
- Deteriorating level of response
- Diabetic warning card, insulin, glucose get or tablets in their possession

ACTION
Aim is to raise the blood sugar as quickly as possible and obtain medical help if necessary.
- Help the casualty to sit or lie down
- Give them a sugary drink, sugar lumps or sweet food.
- Alternatively, they may take their own glucose gel

If they respond quickly
- Give them more food and drink and let them rest until feeling better
- Advise them to see their doctor

If the condition does not improve
- Monitor the level of response and consciousness

- Call for an ambulance

Hyperglycaemia

High blood sugar levels over a long period can result in unconsciousness. Usually the casualty will drift into this state over a few days. It requires urgent treatment in hospital.

Recognition features:
- Warm, dry skin
- Rapid pulse and breathing
- Fruity/sweet breath
- Excessive thirst
- If untreated, drowsiness then unconsciousness

ACTION
Aim is to arrange urgent removal to hospital. Call for an ambulance.
Monitor level of response.

Appendix 5

CONDITIONS REQUIRING EXCLUSION FROM SCHOOL

Exclusion is a necessary control measure to enforce when an individual poses a risk of infection to others and, whilst it is not always applicable in all cases of communicable disease, it is advisable that children are kept away from school when unwell, e.g. feverish, irritable, loss of concentration or are nauseous. Details of specific exclusions are listed below:

DISEASE	EXCLUSION PERIOD
Chickenpox	For 5 days from onset of rash
Cold sores	Whilst sore and discharging
Conjunctivitis	Until better or antibiotics commenced
Persistent Diarrhoea and Vomiting	Until symptoms have stopped for 48 hours
Head Lice	Until treated
Hepatitis A	Young children and those requiring supervised hand washing until 5 days from onset of jaundice or pale stools
Hepatitis B and C	No exclusion, but strict hygiene should be adhered to when handling blood or body substances
HIV / AIDS	Same as Hepatitis B and C
Impetigo	Until antibiotics commenced **and** lesions healed (crusted over)
Measles	For 5 days after onset of rash
Mumps	For 5 days after onset of swelling
Ringworm	None once treatment commenced by GP
Rubella (German Measles)	For 5 days from onset of rash
Scabies	Until treated
Scarlet Fever	For 5 days from starting antibiotics
Sore throat (Bacterial)	For 5 days from start of treatment
Tuberculosis	Until 2 weeks after start of treatment
Whooping Cough	For 5 days from commencing antibiotics

The school reserves the right to ask the parent for a doctor's letter stating that the child is fit to return to school.

INFECTION PREVENTION AND CONTROL

Hand Hygiene

Hand hygiene is one of the most important ways of controlling the spread of infections, especially those that cause diarrhoea and/or vomiting and respiratory infections.

To enable this Kingswood House school will:

Ensure all individuals have access to liquid soap, warm water, and paper towels. Bar soap should not be used. Alcohol hand gel can be used if hands are not visibly dirty. Alcohol hand gel is not effective against organisms that cause gastroenteritis, such as norovirus.

Advise all individuals to clean their hands after using the toilet, before eating or handling food, after playtime and after touching animals.

All cuts and abrasions should be covered with a waterproof dressing.

Educate children and young people on why hand hygiene is so important. Free resources to support this have been developed by the UK Health Security Agency (UKHSA) with teachers for ages 3 to 16 and are available at e-bug.eu.

Respiratory and Cough Hygiene

Coughs and sneezes spread diseases. Covering the nose and mouth when sneezing and coughing can reduce the spread of infections.

Therefore, Kingswood House School:

Discourages spitting.

Encourage all individuals, particularly those with signs and symptoms of a respiratory infection to follow the recommended respiratory and cough etiquette specifically, to:

*cover nose and mouth with a tissue when coughing and sneezing, dispose of used tissue in a waste bin, and clean hands *cough or sneeze into the inner elbow (upper sleeve) if no tissues are available, rather than into the hand *keep contaminated hands away from their eyes, mouth and nose *clean hands after contact with respiratory secretions and contaminated objects and materials

Educate children and young people on why respiratory hygiene is so important. Free resources to support this have been developed by UKHSA with teachers for ages 3 to 16 and are available at e-bug.eu.

Cleaning

Keeping settings clean, including equipment, reduces the risk of transmission. Effective cleaning and disinfection are critical in any setting, particularly when food preparation is taking place.

Cleaning with detergent and water is normally all that is needed as it removes most germs that can cause diseases.

Essential elements of a comprehensive cleaning contract include daily, weekly and periodic cleaning schedules. Further information on cleaning services is available.

In the event of an outbreak of infection at Kingswood House, UKHSA health protection team (HPT) may recommend enhanced or more frequent cleaning, to help reduce transmission. This is covered in the Managing outbreaks and incidents.

Advice may also be given to increase cleaning of areas with particular attention to hand touch surfaces that can be easily contaminated such as door handles, toilet flushes, taps and communal touch areas.

To prevent and control infections Kingswood House School ensures that

Surfaces are cleaned that people touch a lot. Regularly clean and disinfect all areas or surfaces in contact with food, dirt, or bodily fluids.

In cleaning schedules, clearly describe the activities required, the frequency of cleaning and who will carry them out.

Ensure plans for situations where additional cleaning will be required (for example in the event of an outbreak) and how the setting might carry this out.

Ensure cleaning staff are appropriately trained and have access to the appropriate personal protective equipment (PPE), such as household gloves and aprons.

Although there is no legislative requirement to use a colour-coding system, it is good practice. Use colour-coded equipment in different areas with separate equipment for kitchen, toilet, classroom, and office areas (for example, red for toilets and washrooms; yellow for hand wash basins and sinks; blue for general areas and green for kitchens).

Cleaning equipment used should be disposable or, if reusable, disinfected after each use.

Store cleaning solutions in accordance with Control of Substances of Hazardous to Health (COSHH), and change and decontaminate cleaning equipment regularly.

Nominate a member of staff to monitor cleaning standards, have a system in place for staff to report issues with cleaning standards and discuss any issues with cleaning staff, or contractors employed by the setting.

In areas where food is handles or prepared

The Food Standards Agency (FSA) strongly advises the use of either a dishwasher, a sterilising sink, or a steam cleaner to clean and disinfect equipment and utensils.

Operate and maintain equipment according to the manufacturer's instructions and include regular dishwasher interior cleaning cycles.

Follow food hygiene standards from the Food Standards Agency.

Educate children and young people on their role in improving food hygiene.

Free resources to support this have been developed by UKHSA with teachers for ages 3 to 16 and are available at e-bug.eu

Toileting and Sanitation

Good hygiene practices depend on adequate facilities and clear processes. Hand hygiene is extremely important to emphasise to individuals who are supporting children and young people with toileting.

For all individuals and staff:

Kingswood House School will ensure that

Hand wash basins are available, with warm running water along with a mild liquid soap, preferably wall-mounted with disposable cartridges.

Disposable paper towels next to basins in wall-mounted dispensers are available, together with a nearby foot-operated wastepaper bin.

Toilet paper is available in each cubicle (it is not acceptable for toilet paper to be given out on request). If settings experience problems with over-use, they could consider installing paper dispensers to manage this.

Suitable sanitary disposal facilities should be provided where there are children and young people aged 9 or over (junior and senior age groups).

Personal Protective Equipment

PPE can protect individuals and staff from contamination with blood or bodily fluids, which may contain germs that spread disease.

PPE should be used in line with risk assessments in all settings, proportionate to the risk identified.

Risk assessments look at both the risk of occurrence and the impact, and may need to be dynamic, based on the emerging situation. This ensures that all people, including those with complex or additional health needs, are supported to continue their care and education in the setting, where it is safe to do so.

One example of where this is required is an Aerosol Generating Procedure (AGP).

Kingswood House School will:

Conduct risk assessments that are dynamic and long-term.

If there is a risk of splashing or contamination with blood or bodily fluids during an activity, wear disposable gloves and plastic aprons. Gloves and aprons should be single-use disposable, non-powdered vinyl/nitrile or latex-free and CE marked.

Wear a fluid-repellent surgical facemask and eye protection if there is a risk of splashing with blood or body fluids to the face. If reusable, decontaminate prior to next use.

Safe management of the environment

Ventilation

Ventilation is the process of introducing fresh air into indoor spaces while removing stale air. Letting fresh air into indoor spaces can help dilute air that contains viral particles and reduce the spread of COVID-19 and other respiratory infections.

Kingswood House School will ensure that:

All occupied spaces are well ventilated to help reduce the number of respiratory germs. Open windows and doors as much as possible to let fresh air in (unless it is unsafe to do so, for example, do not keep fire doors open).

Try and open higher-level windows to reduce draughts, where it is safe to do.

During the colder months, you may consider opening windows more when the room is unoccupied in between lessons.

Safe management of blood and bodily fluids

Blood and bodily fluids can contain germs that cause infection. It is not always evident whether a person has an infection, and so precautions should always be taken.

Cleaning blood and bodily fluid spills

Clean any spillages of blood, faeces, saliva, vomit, nasal discharges immediately, wearing PPE.

Use gloves and an apron if you anticipate splashing and risk assess the need for facial and eye protection.

Clean using a product which combines detergent and disinfectant that is effective against both bacteria and viruses. Manufacturer's guidance should always be followed. Cleaning with detergent followed by the use of a disinfectant is also acceptable. It should be noted that some agents, such as NaDCC (Sodium Dichloroisocyanurate or Troclosene Sodium, a form of chlorine used for disinfection), cannot be used on urine.

Use disposable paper towels or cloths to clean up blood and bodily fluid spills. These should be disposed of immediately and safely after use.

A spillage kit should be available for bodily fluids like blood, vomit and urine.

Managing cuts, bites, nose bleeds and bodily fluid spills

Take standard precautions when dealing with any cuts or abrasions that involve a break in the skin or bodily fluid spills.

Be aware of the setting's health and safety policies and manage incidents such as cuts, bites, bleeds and spills accordingly.

These policies should include having nominated first aiders who are appropriately trained.

Use Standard Infection Prevention and Control (SIPC) precautions to reduce the risk of unknown (and known) disease transmission.

These include:

- wearing gloves when in contact with blood, bodily fluids, non-intact skin, eyes, mouth, or nose (washing grazes, dressing wounds, cleaning up blood after an incident) and wearing a disposable plastic apron
- carefully cleaning the wound under running water if possible or using a disposable container with water and wipes; carefully dab dry
- covering all exposed cuts and grazes with waterproof plasters
- keeping the dressing clean by changing it as often as is necessary
- managing all spillages of blood or body fluids

Safe management of waste (including sharps)

Under the waste management duty of care, Kingswood House School must ensure that all waste produced is dealt with by a licensed waste management company.

Place any used PPE in a refuse bag and dispose of as normal domestic waste. PPE should not be put in a recycling bin or dropped as litter.

Settings that generate clinical waste should continue to follow usual waste policies.

Managing prevention of exposure to infection (including needlestick or sharps injuries, and bites)

An exposure is an injury from a used needle or a bite which breaks the skin, and/or exposure of blood and body fluids onto:

- broken skin
- the eyes, nose or mouth

Human mouths are inhabited by a wide variety of organisms, some of which can be transmitted by bites. Human bites resulting in puncture or breaking of the skin are potential sources of exposure to blood borne infections, therefore, it is essential that they are managed promptly.

If someone pricks or scratches themselves with a used hypodermic needle or has a bite which breaks the skin Kingswood House School will:

- dispose of the needle safely in a sharps container to avoid the same thing happening to someone else – please contact your local authority or school nurse for help with safe disposal of discarded needles
- wash the wound thoroughly with soap and warm running water
- cover the wound with a waterproof dressing
- seek immediate medical attention or advice from your local accident and emergency department or occupational health provider
- record it in the accident book and complete the accident form

Appendix 6

RESUSCITATION ACTION PLAN

The School's Automatic External Defibrillator (AED) is located in the School Office and a copy of this plan is stored with it.

The AED is designed for the treatment of sudden cardiac arrest and should only be used to treat someone who is:

- Unresponsive
- Non-breathing

1. **Person is not responsive and no signs of life?**
   Address person and shake on shoulder.

2. **Call for help**
   - If one person is at the scene – call for help and call the emergency services then start CPR.
   - If two people are on the scene – one calls the emergency services while the other starts CPR.
   - The person administering CPR should not leave the casualty unless absolutely essential.
   - Where possible, bring the AED to the scene by someone already close to its usual location

3. **Open the airway**

4. **Check for breathing**

5. **Perform CPR (cardio pulmonary resuscitation)**
   30 compressions: 2 breaths
   Continue until an AED is available or arrival of emergency physician.

6. **Turn on AED and follow instructions:**
   Prior to using the AED please carry out the following:
   - Remove clothes to expose bare chest
   - Shave area where pads are to be applied if excessively hairy
   - Dry chest area if required
   - Paediatric pads to be used on children aged 1-8
   - Place pads in position shown on the AED
   - Do not perform chest compressions through electrodes
   - No one must be in contact with patient when a shock is delivered

   When the pads are attached correctly you will hear voice prompts:
   - "Analysing heart rhythm. Do not touch the patient."
   - "Shock advised. Charging. Do not touch the patient."
     Or
   - ""No shock advised."

7. **"Press the red flashing button now. "Deliver the shock now."**
   The AED will only administer a shock if it is needed. A voice prompt will tell you when to press the shock button.

   - √"It is safe to touch the patient."
   - "Begin CPR." (Beep), or "If needed, begin CPR." (Beep)
   - "Give two breaths."
   - "2, 3 or 5 times repeat."
   - "Stop CPR."

Appendix 7

Kingswood House School

HEAD INJURY AND CONCUSSION POLICY

Created By: Emma Darbishire (School Matron) **Reviewed: 17 November 2023**
Next Review Date: 17 November 2024

Introduction

The aim of this policy is to:

- Ensure understanding of the key terms and the link between head injury and brain injury;
- Identify sports and activities which carry a risk of head injury;
- Underscore the importance of creating suitable risk assessments for sport and other activities being under taken by the School; and
- Provide clear processes to follow when a student does sustain a head injury so that they receive the highest possible care.

This policy applies to:

- School staff (including part time or occasional employees or visiting teachers);
- Pupils of the School
- Parents of pupils at the School; and
- Any other individual participating in any capacity in a School activity. For example, this would include a contractor providing sports coaching, or a volunteer on a School trip.

This policy follows the current guidelines from

- England Rugby HEADCASE programme (2018)
- Consensus statement on concussion in sport (Patricios et al,2022)
- If In Doubt Sit Then Out – Uk Concussion Guidelines for Non-Elite (Grassroots) Sport (UK Government, 2023)
- NICE Clinical Guideline 56 – Head Injury: Triage, assessment and early management in Infants, Children and Adults (2007)

Terminology

The following terms are used in this policy:

- **Head injury**: means any trauma to the head other than superficial injuries to the face.
- **Traumatic Brain Injury (TBI**): is an injury to the brain caused by a trauma to the head (head injury).
- **Concussion**: is a type of traumatic brain injury (**TBI**) resulting in a disturbance of brain function. It usually follows a blow directly to the head, or indirectly if the head is shaken when the body is struck. All concussions are serious. Transient loss of consciousness is not a requirement for diagnosing concussion and occurs in less than 10% of concussions.
- **Transient Loss of consciousness**: is the sudden onset, complete loss of consciousness of brief duration with relatively rapid and complete recovery. It can also be referred to as 'being knocked out' or a 'blackout'.
- **Contact sport**: is any sport where physical contact is an acceptable part of play for example rugby, football and hockey.
- **Non-contact sport**: is any sport where physical contact is not an acceptable part of play but where there are nonetheless potential collisions between players and between players and the ball, for example cricket and netball.

HEAD INJURIES & CONCUSSION

Minor head injuries are a frequent occurrence in the school playground and sports field. The majority of head injuries are mild and do not lead to any complications. However, a small number are potentially dangerous and can lead to severe injury to the brain. Therefore, any head injury requires proper assessment and management. The risk of injury is dependent upon the velocity and the force of the impact, the part of the head involved in the impact and any pre-existing medical conditions. Potentially serious complications can develop up to 24 hours after an apparently minor head injury so it is important that staff and parents of Kingswood House School are all aware that symptoms such as a severe headache that persists, drowsiness, irritability, confusion, loss of concentration, vomiting, convulsions, blurred vision and weakness of limbs need are all signs of concussion that need medical assessment.

All concussions are serious, and most occur without a loss of consciousness. Transient loss of consciousness is not a requirement for diagnosing concussion and occurs in less than 10% of concussions. A head impact by either direct blow or indirect transmission of force can be associated with a serious and potentially fatal head injury. Playing contact and non-contact sport increases an individual's risk of collision with objects or other players. Therefore, concussions must be taken extremely seriously to safeguard the short and long term health and welfare of the individual, especially when considering young people. It is widely agreed that children and adolescents take longer to recover, and because their brains are still developing a more conservative approach should be taken with them.

Signs & Symptoms of Concussion

- **Balance problems**
- **Drowsiness**
- **Nausea or vomiting**

- **Loss of consciousness**
- **Seizure or convulsion**
- **Irritability**
- **Changes in mood – more emotional, irriatability, sad, nervous**
- **Memory difficulties**
- **Headache**
- **Dizziness**
- **Confusion**
- **Blurred vision**
- **Sensitivity to light and noise**
- **Difficulties concentrating**

If any "red flag" symptoms are noted the ambulance services should be called on 999

The Pocket Concussion Recognition Tool at Appendix C identifies the following red flags:

RED FLAG SYMPTOMS –CALL 999

- **Any loss of consciousness**
- **Deteriorating consciousness (becoming more drowsy)**
- **Amnesia (no memory) for events before or after the injury**
- **Increasing confusion or irritability**
- **Severe neck pain (DO NOT MOVE)**
- **Repeated vomiting**
- **Seizure**
- **Weakness or tingling/burning in arms or legs**
- **Severe or increasing headache**
- **Any suspicion of a skull fracture (eg. Cut, bruise, swelling, severe pain)**
- **Previous history of brain surgery or bleeding disorder**
- **Current blood thinning therapy**

Recovery typically follows a sequential course over a period of days or weeks, although in some cases symptoms may be prolonged. Therefore, all concussions need to be managed individually and require the full cooperation of the child, parent, school and any involved health services

Children and young adults are more susceptible to concussion than adults because their brains are not yet fully developed and thus more vulnerable to injury. The current evidence suggests that repeated episodes of concussion, even where there is no transitory loss of consciousness, can cause significant changes to the structure and function of the brain.

Prevention and Education

- The Health & Safety Committee will ensure that the environment is inspected regularly to minimise the risks for sustaining head injuries.

- The identification of a concussed player on the pitch may be difficult; concussion should be suspected if one or more of the visible clues, signs, symptoms or errors in memory questions are present. Therefore, those individuals to whom this policy applies should be aware of the symptoms of a concussion. The British Medical Journal has published a one page 'Pocket Concussion Recognition Tool' to help identify concussion in children, youth and adults. All the PE first aid boxes contain a copy of this pocket concussion assessment tool. The tool is attached at Appendix B, and is also available for download (here: https://bjsm.bmj.com/content/bjsports/47/5/267.full.pdf)

- Following a head injury, students, parents/carers are given a written form (Appendix A) informing them of the signs of concussion and follow up advice following all head injuries and the parents are called to inform them of their child's head injury.

- If a child receives a significant bump to the head but is displaying no signs of concussion when assessed school staff are informed so that the child can be monitored carefully for the rest of the school day.

- Where students are known to have a long term disability or chronic medical condition, the student should be risk assessed before taking part in sports where there is a risk of injury or concussion. It is the parents/carers responsibility to keep the school up-to-date with any medical information regarding their child.

- Academic staff are encouraged to inform the School Matron if they notice any concentration issues in any of their children.

- Any person responsible for the undertaking of a sporting activity must ensure a suitable risk assessment for the specific sport activity is created.

- A **risk assessment** should be tailored to the specific School environment and should:

- Identify the specific risks posed by the sport activity, including the risk of players sustaining head injuries;
- Identify the level of risk posed;
- State the measures and reasonable steps taken to reduce the risks and;
- Identify the level of risk posed with the measures applied.

The governing bodies of most sports played in Schools have each produced head injury guidelines (See Appendix C) that are specific to their sport. Those responsible for risk assessing sport activities in School should have regard to the relevant and latest guidelines when carrying out their risk assessment.
Potential measures to reduce the risk of players sustaining head injuries while playing sports might include:

- Structuring training and matches in accordance with current guidelines from the governing body of the relevant sport (see above);
- Removing or reducing contact elements from contact sports, for example removing 'heading' from football;
- Removing or reducing removing the contact elements of contact sports during training sessions;
- Ensuring that there is an adequate ratio of coaches to players in training;
- Ensuring that students are taught safe playing techniques;

- Ensuring that students are taught to display sportsman like conduct at all times and maintain respect for both opponents and fellow team members equally;
- Using equipment and technology to reduce the level of impact from collision with physical objects (e.g. using padding around rugby posts, using soft balls, not overinflating footballs etc.);
- Using equipment and technology to reduce the level of impact from collision between players (e.g. gum shields, helmets etc.);
- Coaching good technique in high risk situations (such as rugby tackles);
- Ensuring that the playing and training area is safe (for example, that is not frozen hard, and there are suitable run-off areas at the touchlines);
- Ensuring that a medical professional is easily accessible during training and matches.

Head injuries sustained outside of school

Repeated concussions can cause significant changes to the structure and function of the brain, in particular the child's brain. It is therefore very important that Kingswood House School, our pupils and their parents take a holistic approach to the management of head injury causing concussions and cooperate with regards to sharing information.

Where a pupil sustains a head injury which has caused a concussion whilst participating in an activity outside of the School, the parents of the pupil concerned should promptly provide ***Mrs Karen Harding, School Secretary or Emma Darbishire, School Matron,*** with sufficient details of the incident, and keep the School updated of any developments thereafter. This would apply, for example, if a pupil suffers a concussion playing rugby for an external rugby club or if a student sustains a head injury while talking part in an informal game of sport, for example in the local park.

The School will determine the appropriate way forward on receiving a notification of this nature. That might include reviewing any return to play plan already established by the external club, or if no such plan has been put in place, considering whether a return to play plan should be established under this policy.

In turn the School will inform parents where a student has sustained a head injury causing a concussion at School.

Procedure to follow where a student sustains a head injury at School

The welfare of our pupils of central importance. Any person to whom this policy applies should adopt a cautious approach if they are in any doubt as to whether a head injury has occurred and/or whether the head injury has caused a concussion.

- With any head injury the **possibility of a spinal injury** should be considered, any neck pain or tenderness, weakness in any part of the body, tingling or numbness in extremities should be dealt with caution.
- If a spinal injury is suspected the **injured person should not be moved and an ambulance called.**
- Where a pupil sustains a suspected head injury or concussion, the person supervising the activity should immediately remove the pupil from play where it is safe to do and seek appropriate medical professional ***from a qualified first aider.*** **They should not return to play in the match.**
- They will be assessed for any of the signs and symptoms of concussion discussed previously and seen in Appendix B
- Where the injury is so severe or concerning that it is clear an ambulance should be called, staff should dial 999 and seek support from the emergency services.
- If there are signs or symptoms of concussion present that are outlined in Appendix C, but it is felt that a 999 call is not immediately required, the pupil's parents should be contacted and they should be taken to A & E as soon as possible.
- If there are no signs or symptoms of concussion as outlined in Appendix C, but the force of the injury is such that a concussion is a possibility, the pupil is kept and observed for at least 30 minutes in the

medical room or office. If no symptoms develop the child can go back to class with a completed head injury form (Appendix A) to give to their parents. The parents/carers will also be called to inform them that their child has experienced a head injury as even if concussion symptoms are not present as concussion can symptoms can present 24-48 hours post head injury. They are advised If the pupil has displayed any of the signs or symptoms of concussion they should be assessed by a Healthcare professional (GP, NHS 111 or A&E) within 24 hours of the incident.

- A pupil sustaining a head injury and showed symptoms of concussion will not be allowed to travel home unaccompanied by either school or public transport, and alternate arrangements should be made.

MANAGEMENT FOLLOWING A CONCUSSION

Return to Learning

Return to education takes priority over return to sport and it is acceptable to allow pupils to return to school and school work (eg. Half days or with scheduled breaks), even if symptoms are still present, provided that symptoms are not severe or significantly worsened. It is recommended that the individual should rest and sleep as needed for the first 24-48 hours as this aids recovery. Easy activities of daily living and walking are also acceptable. But smartphones, screen and computer use should be minimised for at least the first 48 hours post injury. Each child will be treated individually but all will follow the return to learn protocol recommendations set out in the Consensus statement on concussion in sport (Patricios et al, 2022) as shown in the table below.

STEP	Mental Activity	Activity at each step	Goal
1	Daily activities that do not result in more than a mild exacerbation of symptoms related to current concussion.	Reading, minimising screen time, start with 5-15 mins at a time and increase gradually.	Gradual return to typical activities
2	School activities	Homework, reading or other cognitive activities outside of the classroom.	Increase tolerance of cognitive work.
3	Return to school part time	Gradual introduction of schoolwork. May need to start with a partial day or with greater access to rest breaks during the day.	Increase academic activities.
4	Return to school full time	Gradually progress in school activities until a full day can be tolerated without more than mild symptom exacerbation.	Return to full academic activities and catch up on missed work.

- At Kingswood House School teaching staff will be advised if a pupil has had a concussion and will be reminded that they will need to reduce the pupil's workload, reading requirements and use of screens.

- Progression through the return to learning stages is dependent upon the activity not more than mildly exacerbating symptoms.
- Where debilitating concussion-related symptoms remain present, a pupil should not be considered fit to return to learning.
- The School Matron will regularly monitor the child during their recovery and will report back to parents if there are any concerns regarding symptoms impacting on learning or it is felt concentration is worsening.
- Medical advice from the NHS via 111 should be sought if symptoms deteriorate or do not improve by 14 days after the injury. Those with symptoms after 28 days should see their GP.
- It is recognised by Kingswood House School that each child will be treated individually and that sometimes it may be necessary to reduce the pupil's workload or to allow extra time for assignments.
- The final stage of return to school is when the pupil is back to full pre-injury mental activity, and this should occur before the return to unrestricted sport is completed.

Return to Play

The RFU U19 and Below Concussion Management Guidelines state that there is good evidence that during the recovery period from concussion the brain is more vulnerable to further injury, so if they return to sport too soon they risk experiencing further concussions which may result in prolonged concussion symptoms, possible increased risk of long-term health consequences such as cognitive impairments or degenerative brain disorders later in life. Therefore, anyone with concussion should generally rest for 24-48 hours but can undertake easy activities of daily living and walking, but must avoid intense exercise, challenging work, or sport.

It is estimated that a third of adolescents with concussion, recovery can take place in 1-2 days. The majority (80-90%) of concussions resolve in a short period of 7 to 10 days but this may be longer in children and adolescents, therefore, a more conservative and cautious approach is taken regarding recovery time as their brains are susceptible to further injury. Any pupil that has suffered a head injury and showed symptoms of concussion should be subject to a graduated return to play programme (**GRTP**) recommended in the Consensus statement on concussion in sport (Patricios et al, 2022). Graduated return to sport will commence once all symptoms have resolved and needs to occur at a rate that does not, more than mildly, exacerbate existing symptoms or produce new symptoms. The very earliest return to play after concussion in a child under 19 years of age is 23 days.

The GRTP should be undertaken with the full cooperation of the player and their parents/guardians. It is important that before a child can return to graduated play they MUST:

- Have had 2 weeks rest
- Be symptom free
- Have returned to normal academic performance
- Be cleared by a doctor (it is the parents responsibility to obtain medical clearance)

Step	Exercise Strategy	Activity at Each Step	Goal
1	Symptom-limited activity	Daily activities that do not exacerbate symptoms (eg, walking)	Gradual reintroduction of school.
• **Stage 2 should only be started when the person has had 14 days rest, is symptom free, is off all medication that modifies symptoms (eg. Painkillers) and has returned to normal school work.**			
2	Aerobic exercise 2A – Light 2B - Moderate	Stationary cycling or walking at slow to medium pace. May start light resistance training that does not result in more than mild and brief exacerbation of concussion symptoms.	Increase heart rate.
3	Individual sports-specific exercise	Training away from the team environment (eg, running, change of direction and/or individual training drills. NO ACTIVITIES AT RISK OF HEAD IMPACT.	Add movement, change of direction.
Steps 4-6 should begin after the resolution of any symptoms, abnormalities in cognitive function and any other clinical findings related to current concussion, including with and after physical exertion.			
4	Non-contact training drills	Exercise to high intensity including more challenging training drills (eg. Passing drills, multiplayer training) can integrate into a team environment.	Resume usual intensity of exercise, coordination and increased thinking.
5	Full contact practice	Participate in normal training activities.	Restore confidence and assess functional skills by coaching staff.
6	Return to sport	Normal game play	
• **Progression through each step typically taking a minimum of 48 hours. If mild exacerbation of symptoms occurs during Steps 1-3, they should stop immediately and attempt again the same step the next day. If experiencing concussion-related symptoms during Steps 4-6 they should return to Step 3 to establish full resolution of symptoms with exertion before engaging in at-risk activities.**			

If any symptoms occur while progressing through this protocol then the pupil must stop for a minimum period of 48 hours rest and during this time seek further medical advice. When they are symptoms free they can return to the previous stage and attempt to progress again after 48 hours if they remain symptom free.

The GRTP should be developed in consultation with a suitably qualified medical professional and be tailored to the specific circumstances of the individual (including the type of injury sustained and the relevant sport). For an example GRTP, see the GRTP developed by England Rugby here: https://www.englandrugby.com/dxdam/04/0453acb5-5fe2-4608-91b0-a2bd191c3016/HEADCASE%20GRTP.pdf

Following a concussion it is recommended that children and young people should be reviewed/ assessed by a doctor before returning to sport. This review should be undertaken having completed the initial 14 days of relative rest and up to stage 5 of the GRTP at around 23 days post injury for children.

It is the responsibility of the parents to ensure that their child does not participate in any inappropriate physical activity outside of School whilst they are subject to a GRTP.

Breaches of this policy

The School takes its duty of care very seriously and will take appropriate action:

- if a pupil attempts to return to play in breach of their GRTP plan, the School would consider the matter under the School's Behaviour and Sanctions policy;
- if a member of staff fails to report a head injury, the School would consider the matter under the School's staff disciplinary policy; and
- if a parent fails to report to the School a head injury their child sustains outside of School, the School would consider the matter under the terms of the School parent contract.

References

Head Injury: Triage, assessment and early management of head injury in infants, children and adults, National Institute for Health and Clinical Excellence (NICE Guidelines CG56, September 2007)
Head Injury: assessment and early management, National Institute for Health and Clinical Excellence (NICE Guidelines CG176, January 2014
Management of Concussion, RFU 2015 available online at https://keepyourbootson.co.uk/wp-content/uploads/2019/04/U19-Concussion-Management-Guidelines-2018.pdf

Patricios et al (2023), Consensus statement on concussion in sport: the 6th International Conference on Concussion in Sport – Amsterdam, October 2022, British Journal of Sports Med 2023;57:695-711
UK Government, UK Concussion Guidelines for Non-Elite (Grassroots) Sport, April 2023
U19 and Below Concussion Management Guidelines (Routine), RFU 2018

Kingswood House School
Head Injury Form

This form is appendix A of the School's Head Injury and Concussion Policy which is available on request from the School Office.

Name of student	
Date of incident	
Time of incident	
Description of incident and head injury	
First Aid given	

Dear Parent/Carer

Whilst your child was at School today, they sustained a bump to their head. After initial first aid was given we allowed them to return to class, as they were not exhibiting any symptoms of concussion.

They have been kept under observation throughout the rest of the day and have **not** developed any symptoms of concussion..

If they complain of any of the following symptoms over the next 48 hours, please seek medical advice immediately either by contacting your GP or taking them to the nearest hospital for a check-up:

1. Pupil complains of neck pain;
2. Increasing confusion or irritability;
3. Repeated vomiting;
4. Seizure or convulsion;
5. Weakness or tingling/burning in arms or legs;
6. Deteriorating conscious state;
7. Severe or increasing headache;
8. Unusual behaviour change; and
9. Double vision.

We would advise against giving your child any painkillers without first seeking medical advice, as this could mask symptoms.

Appendix B - Specific Sports References

- The Sport and Recreation Alliance includes members from the major sports governing bodies, including the RFU, ECB, FE, RFL and England Hockey. Together they have produced 'Concussion Guidelines for the Education Sector', which can be viewed here: https://www.afpe.org.uk/physical-education/wp-content/uploads/Concussion_guidelines_for_the_education_sector_June2015.pdf

- Football:

  General FA concussion guidelines: https://www.thefa.com/get-involved/fa-concussion-guidelines-if-in-doubt-sit-them-outold

  FA Heading Guidance: https://www.thefa.com/news/2020/feb/24/updated-heading-guidance-announcement-240220

- Rugby:

  https://www.englandrugby.com/participation/playing/headcase/age-grade/schools-and-colleges

  RFU Graduated Return to Play guidelines: https://www.englandrugby.com/dxdam/04/0453acb5-5fe2-4608-91b0-a2bd191c3016/HEADCASE%20GRTP.pdf

- Hockey:

  GB & England Hockey Concussion Policy https://www.cuhc.org.uk/wp-content/uploads/2020/10/CUHC-Concussion-Policy-2020-21.pdf

  England Hockey 'Safe Hockey' guides https://www.englandhockey.co.uk/governance/duty-of-care-in-hockey/safe-hockey

Appendix C

Pocket CONCUSSION RECOGNITION TOOL™

To help identify concussion in children, youth and adults.

RECOGNIZE & REMOVE

Concussion should be suspected if one or more of the following visible clues, signs, symptoms or errors in memory questions are present.

Annexure 1 Visible clues of suspected concussion

Any one or more of the following visual dues can indicate a possible concussion:

- Loss of consciousness or responsiveness
- Lying motionless on ground / Slow to get up
- Unsteady on feet / Balance problems or falling over / Incoordination
- Grabbing/dutching of head Dazed, blank or vacant look
- Confused / Not aware of plays or events

Annexure 2 Signs and symptoms of suspected concussion

Presence of anyone or more of the folloving signs & symptoms may suggest a concussion:

-Loss of consciousness	- Headache
- Seizure or convulsion	- Dizziness
- Balance problems	- Confusion
- Nausea or vomiting	- Feeling slowed down
- Drowsiness	- "Pressure in head"
- More emotional	- Blurred vision
- Irritability	- Sensitivity to light
- Sachess	- Amnesia
- Fatigue or low energy	- Feeling like "In a fog"
- Nervous or anxious	- Neck Pain
- "Don't feel right"	- Sensitivity to noise
- Difficulty rem em bering	- Difficulty concentrating

Annexure 3. Memory function

Failure to answer any of these questions correctly may suggest a concussion.

"What venue are we at today?"
"Which half is it now?"
"Who scored last in this game?"
"What team did you play last week/ game?"
"Did your team win the last game?"

Any athlete with a suspected concussion should be IMMEDIATELY REMOVED FROM PLAY and should not be returned to activity until they are assessed medically. Athletes with a suspected concussion should not be left alone and should not drive a motor vehicle.

It is recommended that, in all cases of suspected concussion, the player is referred to a medical professional for diagnosis and guidance as well as return to play decisions, even if the symptoms resolve.

RED FLAGS

If ANY of the following are reported then the player should be safely and immediately removed from the field. If no qualified med ical professional is available, consider transporting by ambulance for urgent medical assessment

- Athlete complains of neck pain
- Increasing confusion or irritability
- Repeated vomiting
- Seizure or convulsion
- Weakness or tinging / burning in arms or legs
- Deteriorating conscious state
- Severe or increasing headache
- Unusual behaviour change
- Double vision -

Remember:
- In all cases, the basic principles of first aid (danger, response, airway, breathing, circulation) should be followed.

- Do not attempt to move the player (other than required for airway support) unless trained to so do.
- Do not remove helmet (if present) unless trained to do so.

from McCrory et, al, Consensus Statement on Concussion in Sport. Br J Sports Med 47 (5), 2013

KINGSWOOD HOUSE SCHOOL

ASTHMA POLICY

Policy Review date:

This Policy relates to the whole school including the Early Years Foundation Stage, and is reviewed annually to ensure compliance with current regulations and law and must be read in conjunction with other relevant Kingswood House School policies.

Related Policies:

- Child Protection and Safeguarding Policy
- First Aid and Administration of Medications Policy

Policy statement

This policy aims to minimize the risk of any pupil suffering from asthma whilst at school or attending any school related activity and to ensure staff are properly prepared to recognise and manage an asthma attack should it arise. It has been written following advice from Asthma UK and the Department of Health and reflects the requirements of two key documents: Supporting Pupils at school with medical conditions (2014) and Guidance on the use of emergency salbutamol inhalers in schools (2015).

Kingswood House School recognises that asthma and recurrent wheezing are important conditions affecting an increasing number of school age children and welcomes children with asthma.

All staff who have contact with these children are given the opportunity to receive training from the School Matron. Updates for training are offered at regular intervals and on an ad-hoc basis. Any significant changes with a child's asthma symptoms and/or management will be communicated to all staff.

Introduction

Asthma is a common, serious but manageable condition that affects the small tubes (airways) that carry air in and out of the lungs. When a person with asthma comes into contact with something that irritates their airways (an asthma trigger), such as pollen, dust, smoke, exercise etc. resulting in the muscles around the walls of the airways tightening so that the airways become narrower and the lining of the airways become inflamed and start to swell. Sometimes sticky mucous or phlegm builds

up, which can further narrow the airways. These reactions make it difficult to breathe, leading to symptoms of asthma, such as cough, wheeze, chest tightness and breathlessness. These symptoms are usually easily reversible by use of a reliever inhaler but all staff must be aware that suffers may experience an acute episode which will require rapid medical or hospital treatment.

Kingswood House School recognizes that asthma is a widespread, serious, but controllable condition and welcomes all pupils with asthma and aims to support these children in participating fully in school life. We endeavor to do this by ensuring we have:

- An asthma register
- Up-to-date asthma policy
- An asthma lead
- All pupils with immediate access to their reliever inhaler at all times
- All pupils have an up-to-date asthma action plan
- An emergency salbutamol inhaler
- Ensure all staff have regular asthma training
- Promote asthma awareness with pupils, parents and staff.

Asthma Register

Kingswood House School has an asthma register of the children within the school, which we update yearly. We do this by asking parents/carers if their child is diagnosed as an asthmatic or has been prescribed a reliever inhaler. When parents/carers have confirmed that their child is asthmatic or has been prescribed a reliever inhaler we ensure that the pupil has been added to the asthma register and has:

- An up-to-date copy of their personal asthma action plan (Appendix A)
- Their reliever (salbutamol/terbutaline) inhaler in school
- Permission from the parents/carers to use the emergency salbutamol inhaler if they require it and their own inhaler is broken, out of date, empty or has been lost (Appendix B)

Asthma Lead

Kingswood House School has an Asthma Lead, School Matron, Emma Darbishire whose responsibility is to manage the asthma register, update the asthma policy, manage emergency salbutamol inhalers (Department of Health Guidance on the use of salbutamol inhalers in schools, March 2015) and ensure measures are in place so that children have immediate access to their inhalers.

Medication and Inhalers

All children with asthma should have immediate access to their reliever (usually blue) inhaler at all times and therefore they should never be locked away. The reliever is a fast acting medication that opens up the airways and makes it easier to breathe (Asthma UK).

Some children will also have a preventer inhaler (usually brown), which is usually taken morning and night, as prescribed by the doctor/nurse. This medication needs to be taken regularly for maximum benefit. Children should not bring their preventer inhaler to school as it should be taken regularly as prescribed by their doctor/nurse at home. However, if a pupil is going on a residential trip, we are aware that they will need to take the inhaler with them so that they can continue taking their inhaler as prescribed.

Children are encourage to carry their reliever inhaler as soon as they are responsible enough to do so. We would expect this by key stage 3 (Year 7 and above). However, we will discuss this with each child's parent/carer. We recognize that all children may still need supervision in taking their inhaler.

For younger children, reliever inhalers are kept in the emergency medication drawer in the school office.

School staff are not required to administer asthma medications to pupils however many children have poor inhaler technique, or are unable to take the inhaler by themselves. Failure to receive their medication could end in hospitalization or even death. Therefore, all staff receive asthma training during medical inset so they are able to happily support children use their inhaler, which is essential for the child's well-being. If there are any concerns regarding the child's ability to use their inhaler they can be referred to the School Matron who can advise the parents/carers to arrange a review with their GP/nurse.

Asthma Action Plans

Asthma UK evidence shows that if someone with asthma uses a personal asthma action plan they are four times less likely to be admitted to hospital due to their asthma. As a school, Kingswood House recognises that having to attend hospital can cause stress for a family. Therefore, we believe it is essential that all children with asthma have a personal asthma action plan to ensure their asthma is managed effectively within the school to prevent hospital admissions. These asthma action plans are readily available for all staff to access on the shared drive in the medical file.

Staff Training

Staff will receive regular asthma updates during medical inset as well as ad-hoc training as required before residential trips for example. The triggers, signs and symptoms and treatment of an asthma attack will be covered including how to use the reliever inhaler and spacers effectively. A list of the children on the asthma register will be displayed in the staff room and be accessible on the shared drive, in the medical file. In addition, on the shared drive, in the medical file, there are additional resources about asthma, for staff to access and read. Asthma attack flow charts are on the walls in the office, staff room and medical room.

Parents are responsible for informing the school:

- That their child has asthma;
- About any medications their child require during school hours;
- Of any medications that their child requires whilst taking part in school day trips, residential trips and out of school sporting activities;
- Of any changes to their child's condition;
- If their child has been unwell which may affect symptoms;

And for ensuring:

- The school has a complete and up-to-date asthma plan for their child;
- That any medications and medical devices are clearly labelled with their child's name and date of birth;
- Their child's medication is within expiry dates;
- Their child has regular asthma reviews with their GP/Practice nurse.

School Environment

Kingswood House School does all that it can to ensure the school environment is favourable to pupils with asthma. The school has a definitive no smoking and no vaping policy. Pupil's asthma triggers

will be recorded as part of their asthma action plans and the school will ensure that pupil's will not come into contact with their triggers, where possible.

We are aware that triggers can include:

- Colds and infection
- Dust and house dust mite
- Pollen, spores and moulds
- Feathers
- Furry animals
- Exercise, laughing
- Stress
- Cold air, change in weather
- Chemicals, glue, paint, aerosols
- Food allergies
- Fumes and cigarette smoke

As part of our responsibility to ensure all children are kept safe within the school grounds and on trips away, a risk assessment will be performed by staff. These risk assessments will establish asthma triggers which the children could be exposed to and plans will be put in place to ensure these triggers are avoided, where possible.

Exercise and Activity

Taking part in sports, games and activities is an essential part of school life for all pupils. All staff will know which children in their class have asthma and all PE teachers at the Kingswood House School will be aware of which pupils have asthma from the school's asthma register which will be circulated via email as well as stored on the shared drive in the medical folder which is accessible to all staff.

Pupils with asthma are encouraged to participate fully in all activities. PE teachers will remind pupils, whose asthma is triggered by exercise, to take their reliever inhaler before the lesson, and to thoroughly warm up and down before and after the lesson. It is agreed that the pupils who are mature enough will carry their own inhaler with them. Those that are too young will have their inhaler labelled and kept in a box, which can be found in the emergency medications drawer in the office and will be taken with them when leaving the school site for training or matches. If a pupil needs to use their inhaler during a lesson, they will be encouraged to do so.

There has been a large emphasis in recent years on increasing the number of children and young people involved in exercise and sport in and outside of school. The health benefits of exercise are well documented and this is true for children and young people with asthma. It is therefore important that Kingswood House School involve pupils with asthma as much as possible in and outside of school. The same rules apply for out of hour sports, as during school hours PE.

When asthma is affecting a child's education

Kingswood House School is aware that the aim of asthma medication is to allow people with asthma to live a normal life. Therefore, if a member of staff has concerns about the progress of a child with asthma, such as impacting on their life by being unable to take part in activities, tired during the day, or falling behind in lessons, they should be encouraged to discuss this with the School Matron and parents/carers. It may simply be that the pupil needs an asthma review to review inhaler technique,

medication review or an updated Personal Asthma Action Plan to improve their symptoms. However, the school recognises that pupils with asthma could be classed as having a disability due to their asthma as defined by the Equality Act 2010, and therefore may have additional needs because of their asthma.

Emergency Salbutamol Inhaler in school

Kingswood House School are aware of the guidance 'The use of emergency inhalers in schools from the Department of Health' (March, 2015) which gives guidance on the use of emergency salbutamol inhalers in schools. The key points from this policy are below.

As a school we are able to purchase salbutamol inhalers and spacers from community pharmacists without a prescription. We have one emergency kit, which is kept on the wall in the office so that it is easy to access. The kit contains:

- A salbutamol inhaler
- Two spacers compatible with the inhaler
- Instructions on using the inhaler and spacer
- Instructions on cleaning and storing the inhaler
- A checklist of inhalers, identified by their batch number and expiry date
- List of children permitted to use the emergency inhaler
- Record of administration

We understand that salbutamol is a relatively safe medicine, particularly if inhaled, but all medicines can have some adverse effects. The adverse effects of inhaled salbutamol are well known, tend to be mild, are temporary and are not likely to cause serious harm. The child might feel a bit shaky or may tremble, or they may say they feel their heart is beating faster.

We will ensure that the emergency salbutamol inhaler is only used by children who have asthma or have been prescribed a reliever inhaler, and for whom written parental consent has been given.

The school asthma lead will ensure that:

- On a monthly basis the inhaler and spacers are present, in working order and the inhaler has a sufficient number of doses available
- Replacement inhalers are obtained when expiry dates approach
- Replacement spacers are available following use
- The plastic inhaler housing (which holds the canister) has been cleaned, dried and returned to storage following use, or that replacements are available if necessary. Before using a salbutamol inhaler for the first time, or if it has not been used for 2 weeks or more, shake and release 2 puffs of medicine into the air.

To identify when an inhaler is nearing empty each use - detailing the number of puffs taken - should be documented.

The inhaler can be reused, so long as it has not come into contact with any bodily fluids. Following use the inhaler canister will be removed and the plastic inhaler housing and cap will be washed in warm, running water, and left to dry in the air in a clean, safe place. The canister will be returned to the housing, when dry, and the cap replaced.

Spent inhalers are to be returned to the pharmacy to be recycled.
The emergency salbutamol inhaler is only to be used by children:

- Who are diagnosed with asthma and prescribed a reliever inhaler **OR** who have been prescribed a reliever inhaler;

AND

- Written parental consent for use of the emergency inhaler has been given.

The names of these children is clearly written in our emergency kit. The parents/carers are always to be informed in writing if their child has used the emergency inhaler, so this information can be passed onto the GP.

Common 'day to day' symptoms of asthma

As a school Kingswood House requires that children with asthma have a personal asthma action plan completed (Appendix A). These plans inform us of the day-to-day symptoms of each child's asthma and how to respond to them on an individual basis. We will also send home our own information and consent form for every child with asthma (Appendix B). Both these forms are also available on the school website. The forms need to be returned as soon as possible and will be kept with our asthma register.

However, we also recognise that some of the most common day-to-day symptoms of asthma are:

- Dry cough
- Wheeze often when exercising
- Shortness of breath when exposed to trigger or exercising
- Tight chest

These symptoms are usually responsive to the use of the child's inhaler and rest. As per Department of Health document; they do not usually require the child to be sent home from school or to need urgent medical attention.

Asthma Attacks

Kingswood House School recognises that if all the above are in place, we should be able to support pupils with their asthma and, hopefully, prevent them from having an asthma attack. In any event, we are prepared to deal with asthma attacks should they occur.

All staff will receive an asthma update annually as part of the medical inset. As part of this training, they are taught how to recognise an asthma attack and how to manage one. In addition, guidance will be displayed in the staff room and is accessible on the shared drive in the medical file.

The Department of Health guidance on the use of emergency salbutamol inhalers (March 2015) states that the signs of an asthma attack are:

- Persistent cough
- A wheezing sound coming from the chest (when at rest)
- Difficulty breathing (the child could be breathing fast and with effort, using all accessory muscles in the upper body)
- Nasal flaring
- Unable to talk or complete sentences (some children will go very quiet)
- May try to tell you that their chest feels tight (younger children may express this as a tummy ache)

If the child is showing these symptoms, follow the guidance for responding to an asthma attack recorded below.

Call an ambulance immediately and commence the asthma attack procedure, without delay, if the child:

- Appears exhausted
- Has blue/white tinge around lips
- Is going blue
- Has collapsed

In the event of an asthma attack:

- Keep calm and reassure the child
- Encourage the child to sit up and slightly forward
- Use the child's own inhaler – if not available, use emergency inhaler
- Remain with child while the inhaler and spacer are brought to them
- +Shake the inhaler and remove the cap
- +Place the mouthpiece between the lips with a good seal, or place the mask securely over the nose and mouth
- +Immediately help the child to take 2 puffs of salbutamol via the spacer, one at a time (1 puff to 5 breaths)
- If there is no improvement, repeat these steps + up to a maximum of 10 puffs
- Stay calm and reassure the child. Stay with the child until they feel better. The child can return to school activities when they feel better.
- If a child is treated for an asthma attack in school it is important that we inform the parents/carers and advise that they should make an appointment with their GP.
- If the child has had to take 6 puffs or more in 4 hours the parents should be made aware and they should see their doctor or asthma nurse.
- If the child does not feel any better or you are worried at ANYTIME before you have reached 10 puffs, call 999 FOR AN AMBULANCE and call the parents/carers.
- If the ambulance does not arrive in 10 minutes give another 10 puffs in the same way.
- A member of staff will always accompany a child taken to hospital by an ambulance and stay with them until a parent/carer arrives.

Appendix 1

School Asthma Card

To be filled in by the parent/carer

Child's name

Date of birth

Address

Parent/carer's name

Telephone home

Telephone mobile

Email

Doctor/nurse's name

Doctor/nurse's telephone

This card is for your child's school. **Review the card at least once a year and remember to update or exchange it for a new one if your child's treatment changes during the year.** Medicines and spacers should be clearly labelled with your child's name and kept in agreement with the school's policy.

Reliever treatment when needed

For shortness of breath, sudden tightness in the chest, wheeze or cough, help or allow my child to take the medicines below. After treatment and as soon as they feel better they can return to normal activity.

Medicine	Parent/carer's signature

If the school holds a central reliever inhaler and spacer for use in emergencies, I give permission for my child to use this.

Parent/carer's signature Date

Expiry dates of medicines

Medicine	Expiry	Date checked	Parent/carer's signature

Parent/carer's signature Date

What signs can indicate that your child is having an asthma attack?

Does your child tell you when he/she needs medicine?

☐ Yes ☐ No

Does your child need help taking his/her asthma medicines?

☐ Yes ☐ No

What are your child's triggers (things that make their asthma worse)?

☐ Pollen ☐ Stress

☐ Exercise ☐ Weather

☐ Cold/flu ☐ Air pollution

If other please list

Does your child need to take any other asthma medicines while in the school's care?

☐ Yes ☐ No

If yes please describe

Medicine	How much and when taken

Dates card checked

Date	Name	Job title	Signature / Stamp

To be completed by the GP practice

What to do if a child is having an asthma attack

1. Help them sit up straight and keep calm.
2. Help them take one puff of their reliever inhaler (usually blue) every 30–60 seconds, up to a maximum of 10 puffs.
3. **Call 999 for an ambulance if:**
   - their symptoms get worse while they're using their inhaler this could be a cough, breathlessness, wheeze, tight chest or sometimes a child will say they have a 'tummy ache'
   - they don't feel better after 10 puffs
   - you're worried at any time.
4. You can repeat step 2 if the ambulance is taking longer than 15 minutes.

asthma UK

Any asthma questions?
Call our friendly helpline nurses
0300 222 5800
(Monday-Friday, 9am-5pm)
www.asthma.org.uk

KINGSWOOD HOUSE SCHOOL

ANAPHYLAXIS POLICY

This Policy relates to the whole school including the Early Years Foundation Stage, and is reviewed annually to ensure compliance with current regulations and law and must be read in conjunction with other relevant Kingswood House School policies.

Related Policies:

- Child Protection and Safeguarding Policy
- First Aid and Administration of Medications Policy

Policy Review date:

Policy statement

This policy aims to minimize the risk of any pupil suffering a serious allergic reaction whilst at school or attending any school related activity and to ensure staff are properly prepared to recognise and manage serious allergic reactions should they arise.

1.) Introduction

An allergy is a reaction of the body's immune system to substances that are usually harmless. The reaction can cause minor symptoms such as itching, sneezing or rashes but sometimes causes a much more serious reaction called anaphylaxis.

Anaphylaxis is serious, life-threatening allergic reaction. It is at the extreme end of the allergic spectrum. The whole body is affected often within minutes of exposure to the allergen, but sometimes it can be hours later. Causes can include foods, insect stings, and drugs.

Most health care professionals consider an allergic reaction to be anaphylaxis when it involves difficulty breathing, or affects the heart rhythm or blood pressure. Anaphylaxis symptoms are often referred to as the ABC symptoms (Airway, Breathing, Circulation).

It is possible to be allergic to anything that contains a protein, however, most people will react to a fairly small group of potent allergens. Common UK allergens include (but are not limited to): Peanuts, Tree nuts, Sesame, Milk, Eggs, Fish, Latex, Insect venom, Pollen and Animal Dander.

This policy sets out how Kingswood House School will support students with allergies, to ensure they are safe and are not disadvantaged in any way whilst taking part in school life.

2.) Roles and Responsibilities

Parent Responsibilities

- On entry to the school, it is the parent's responsibility to inform the School Matron of any allergies. This information should include all previous serious allergic reactions, history of anaphylaxis and details of all prescribed medication.
- Parents are to supply a copy of their child's Allergy Action Plan to the school. See Appendix A for form.
- Parents are responsible for ensuring any required medication is supplied, in date and replaced as necessary.
- Parents are requested to keep the school up to date with any changes in allergy management. The Allergy Action Plan will be kept up to date accordingly.

Staff Responsibilities

- All staff will complete anaphylaxis training. Training is provided for all staff on a yearly basis and on an ad-hoc basis for any new members of staff.
- Staff must be aware of the pupils in their care (regular or cover lessons) who have known allergies as an allergic reaction could occur at any time and not just at mealtimes. Any food related activities must be supervised with due caution.
- Staff leading school trips will ensure they carry all relevant emergency supplies. Trip leaders will check that all pupils with medical conditions, including allergies, carry their medication. Pupils unable to produce their required medication will not be able to attend the excursion.
- School Matron will ensure that the up-to-date Allergy Action Plan is kept with the pupil's medication, is displayed on the notice board in the staff room and also available on the shared drive in the medical file.
- It is the parent's responsibility to ensure that all medication is in date however the School Matron will check medication kept at school on a termly basis and send a reminder to parents if medication is approaching expiry.
- School Matron keeps a register of pupils who have been prescribed an adrenaline auto-injector (AAI) and a record of use of any AAIs and emergency treatment given.

Pupil Responsibilities

- Pupils are encouraged to have a good awareness of their symptoms and to let an adult know as soon as they suspect they are having an allergic reaction.
- Pupils who are trained and confident to administer their own AAIs will be encouraged to take responsibility for carrying them on their person at all times.

3. Allergy Action Plans

Allergy Action Plans are designed to function as individual healthcare plans for children with allergies, providing medical and parental consent for schools to administer medicines in the event of an allergic reaction, including consent to administer a spare adrenaline auto-injector.

Kingswood House School recommends using the British Society of Allergy and Clinical Immunology (BSACI) Allergy Action Plans (Appendix A) to ensure continuity. This is a national plan that has been agreed by the BSACI, Anaphylaxis UK and Allergy UK.

It is the parent/carer's responsibility to complete the allergy action plan with help from a healthcare professional (eg. GP or Allergy Specialist) and provide this to school.

4. Emergency Treatment and Management of Anaphylaxis

What to look for:

Symptoms usually come quickly, within minutes of exposure to the allergen.

Mild to moderate allergic reaction symptoms may include:

- A red raised rash (known as hives or urticaria) anywhere on the body
- A tingling or itchy feeling in the mouth
- Swelling of lips, face or eyes
- Stomach pain or vomiting.

More serious symptoms are often referred to as the ABC symptoms and can include:

- **AIRWAY** – swelling in the throat, tongue or upper airways (tightening of the throat, hoarse voice, difficulty swallowing).
- **BREATHING** – sudden onset wheezing, difficulty breathing, noisy breathing.
- **CIRCULATION** – dizziness, feeling faint, sudden sleepiness, tiredness, confusion, pale clammy skin, loss of consciousness.

The term for this more serious reaction is anaphylaxis. In extreme cases there could be a dramatic fall in blood pressure. The person may become weak and floppy and may have a sense of something terrible happening. This may lead to collapse and unconsciousness and, on rare occasions, can be fatal.

If the pupil has been exposed to something they are known to be allergic to, then it is more likely to be an anaphylactic reaction.

Anaphylaxis can develop very rapidly, so a treatment is needed that works rapidly. **Adrenaline** is the mainstay treatment, and it starts to work within seconds.

What does adrenaline do?

- It opens up the airways
- It stops swelling
- It raises blood pressure

As soon as anaphylaxis is suspected, adrenaline must be administered without delay.

Action:

- Keep the child where they are, call for help and do not leave them unattended.
- **LIE CHILD FLAT WITH LEGS RAISED** – they can be propped up if struggling to breathe but this should be for as short a time as possible.
- **USE ADRENALINE AUTO-INJECTOR WITHOUT DELAY** and note time given. AAIs should be given into the muscle of the outer thigh. Specific instructions may vary by brand – always follow the instructions on the device.
- **CALL 999** and state **ANAPHYLAXIS (ana-fil-axis)**
- If no improvement after 5 minutes, administer a second AAI.
- If no signs of life commence CPR.
- Call parent/carer as soon as possible.

Whilst you are waiting for the ambulance, keep the child where they are. Do not stand them up, or sit them in a chair, even if they are feeling better. This could lower their blood pressure drastically, causing their heart to stop.

All pupils must go to hospital for observation after anaphylaxis even if they appear to have recovered as a reaction can reoccur after treatment.

5. Supply, Storage and Care of Medicaiton

Depending on their level of understanding and competence, pupils will be encouraged to take responsibility for and to carry their own **two** AAIs on them at all times (in a suitable bag/container).

For younger children for those not ready to take responsibility for their own medication, their emergency medication will be kept in the unlocked emergency medication drawer in the office which is **accessible to all staff.**

Medication is stored in a suitable container and clearly labelled with the pupil's name and picture. The pupil's medication storage container should contain:

- Two AAIS
- An up-to-date allergy action plan
- Antihistamine (if included on the allergy action plan)
- Spoon if required
- Asthma inhaler (if included on the allergy action plan)

It is the responsibility of the child's parents to ensure that the anaphylaxis kit is up-to-date and clearly labelled, however, the School Matron will check medication kept at school on a termly basis and send a reminder to parents if medication is approaching expiry.

Parents can subscribe to expiry alerts for the relevant AAIs their child is prescribed, to make sure they can get replacement devices in good time.

Older children and medication

Older children and teenagers should wherever possible, assume responsibility for their emergency kit under the guidance of their parents. However, symptoms of anaphylaxis can come on **very suddenly**, so school staff need to be prepared to administer medication if the young person cannot.

Storage

AAIs should be stored at room temperature, protected from direct sunlight and temperature extremes. For younger children their AAIs are accessible at all times and are stored in separate boxes with their names and photos on and are in the emergency medication drawer in the office.

Disposal

AAIs are single use only and must be disposed of as sharps. Used AAIs can be given to the ambulance paramedics on arrival.

6. Spare Adrenaline Auto-injectors in School

Kingswood House School has purchased spare **AAIs for emergency use in children who are at risk of anaphylaxis,** if their own devices are not available or not working.

These are stored in a green box clearly labelled Emergency Adrenaline Pen, on the wall in the office and is **accessible and known to all staff.**

Kingswood House School holds 3 spare pens, 2 x 300mcgs, 1 x 150 mcgs

The School Matron is responsible for checking the spare medication is in date on a monthly basis and to replace as needed.

Written parental permission for use of spare AAIs is included in the pupil's allergy action plan.

If anaphylaxis is suspected in **an undiagnosed individual** call the emergency services and state you suspect ANAPHYLAXIS. Follow advice from them as to whether the administration of the spare AAI is appropriate.

7. Staff Training

The named staff members are responsible for co-ordinating staff anaphylaxis training and the upkeep of the school's anaphylaxis policy are:-

Sally Witts

Emma Darbishire

All staff will attend an inset training session for first aid where anaphylaxis training will be included. Training is also available on an ad-hoc basis for any new members of staff.

Training includes:

- Knowing the common allergens and triggers of allergies
- Spotting the signs and symptoms of an allergic reaction and anaphylaxis. Early recognition of symptoms is key, including knowing when to call for the emergency services.
- Administering emergency treatment (including AAIs) in the event of anaphylaxis – knowing how and when to administer the medication/device
- Measures to reduce the risk of a child having an allergic reaction eg. Allergen avoidance, knowing who is responsible for what
- Managing allergy action plans and ensuring they are up-to-date
- A practical session using trainer devices

8. Inclusion and Safeguarding

Kingswood House School is committed to ensuring that all children with medical conditions, including allergies, in terms of both physical and mental health, are properly supported in school so that they can play a full and active role in school life, remain healthy and achieve their academic potential.

9. Catering

All food businesses (including school caterers) must follow the Food Information Regulations 2014 which states that allergen information relating to the 'top 14' allergens must be available for all food products.

The school menu is available for parents to view in the newsletter and on the school website.

The School Matron will inform the Catering Manager of pupils with food allergies and provides a list with photographs to ensure the catering staff can identify the pupils.

The Catering Manager is happy to meet parents to discuss their child's specific needs.

The school adheres to the following Department of Health guidance recommendations:

- Bottles and snack boxes are clearly labelled
- The pupil should check with catering staff before selecting their food choice.
- Staff should be educated about how to read food labels for food allergens and instructed about measures to prevent cross contamination during the handling, preparation and serving of food.
- Use of food in crafts, cooking classes, science experiments and special events needs to be considered and may need to be restricted/risk assessed depending on the allergies of particular children and their age.

10. School Trips

Staff leading school trips will ensure they carry all relevant emergency supplies. Trip leaders will check that all pupils with medical conditions, including allergies, carry their medication. Pupils unable to produce their required medication will not be able to attend the excursion.

All the activities on the school trip will be risk assessed to see if they pose a threat to allergic pupils and alternative activities planned to ensure inclusion.

Overnight school trips should be possible with careful planning and a meeting for parents with the lead member of staff planning the trip should be arranged. Staff at the venue for an overnight school trip should be briefed early on that an allergic child is attending and will need appropriate food.

Sporting Excursions

Allergic children should have every opportunity to attend sports trips to other schools. The school will ensure that the P.E. teachers are fully aware of the situation. The school being visited will be notified that a member of the team has an allergy when arranging the fixture. A member of staff trained in administering adrenaline will accompany the team. If another school feels that they are not equipped to cater for any food-allergic child, the school will arrange for the child to take alternative/their own food.

Most parents are keen that their children should be included in the full life of the school where possible, and the school will need their co-operation with any special arrangements required.

11. Allergy awareness and nut bans

Kingswood House School supports the approach advocated by Anaphylaxis UK towards nut bans/nut free schools. They would not necessarily support the blanket ban on any particular allergen in any establishment, including in schools. This is because nuts are only one of the many allergens that could affect pupils, and no school could truly guarantee a truly allergen free environment for a child living with food allergy. They advocate instead for schools to adopt a culture of allergy awareness and education.

A ‘whole school awareness of allergies’ is a much better approach, as it ensures teachers, pupils and all other staff are aware of what allergies are, the importance of avoiding the pupils’ allergens, the signs and symptoms, how to deal with allergic reactions and to ensure policies and procedures are in place to minimise risk.

12. Risk Assessment

Kingswood House School will conduct a detailed individual risk assessment for all new joining pupils with allergies and any pupils newly diagnosed, to help identify any gaps in our systems and processes for keeping allergic children safe.

13. Useful Links

Anaphylaxis UK Safer Schools Programme

AllergyWise for Schools (including certificate) online training

BSACI Allergy Action Plans

Spare Pens in Schools

Department of Education Supporting Pupils at school with medical conditions

Department of Health Guidance on the use of adrenaline auto-injectors in schools

Food Allergy quality standards

Anaphylaxis: assessment and referral after emergency treatment.

BSACI ALLERGY ACTION PLAN

RCPCH anaphylaxis UK AllergyUK

This child has the following allergies:

Name:

.....

DOB:

.....

Photo

Mild/moderate reaction:

- Swollen lips, face or eyes
- Itchy/tingling mouth
- Hives or itchy skin rash
- Abdominal pain or vomiting
- Sudden change in behaviour

Action to take:

- Stay with the child, call for help if necessary
- Locate adrenaline autoinjector(s)
- **Give antihistamine:**

..... (If vomited, can repeat dose)

- Phone parent/emergency contact

Watch for signs of ANAPHYLAXIS

(life-threatening allergic reaction)

Anaphylaxis may occur without skin symptoms: ALWAYS consider anaphylaxis in someone with known food allergy who has **SUDDEN BREATHING DIFFICULTY**

A AIRWAY
- **Persistent cough**
- **Hoarse voice**
- **Difficulty swallowing**
- **Swollen tongue**

B BREATHING
- **Difficult or noisy breathing**
- **Wheeze or persistent cough**

C CONSCIOUSNESS
- **Persistent dizziness**
- **Pale or floppy**
- **Suddenly sleepy**
- **Collapse/unconscious**

IF ANY ONE (OR MORE) OF THESE SIGNS ABOVE ARE PRESENT:

1. **Lie child flat with legs raised** (if breathing is difficult, allow child to sit)
2. **Immediately dial 999** for ambulance and say ANAPHYLAXIS ("ANA-FIL-AX-IS")
3. In a school with "spare" back-up adrenaline autoinjectors, **ADMINISTER the SPARE AUTOINJECTOR** if available
4. Commence CPR if there are no signs of life
5. **Stay with child** until ambulance arrives, **do NOT stand child up**
6. Phone parent/emergency contact

***** IF IN DOUBT, GIVE ADRENALINE *****

You can dial 999 from any phone, even if there is no credit left on a mobile. Medical observation in hospital is recommended after anaphylaxis. For more information about managing anaphylaxis in schools and "spare" back-up adrenaline autoinjectors, visit: **sparepensinschools.uk**

Emergency contact details:

1) Name: .....

.....

2) Name: .....

.....

Parental consent: I hereby authorise school staff to administer the medicines listed on this plan, including a 'spare' back-up adrenaline autoinjector (AAI) if available, in accordance with Department of Health Guidance on the use of AAIs in schools.

Signed: .....

Print name: .....

Date: .....

For more information about managing anaphylaxis in schools and "spare" back-up adrenaline autoinjectors, visit: sparepensinschools.uk

Additional instructions:

This BSACI Action Plan for Allergic Reactions is for children and young people with mild food allergies, who need to avoid certain allergens. For children at risk of anaphylaxis and who have been prescribed an adrenaline autoinjector device, there are BSACI Action Plans which include instructions for adrenaline autoinjectors. These can be downloaded at **bsaci.org**

For further information, consult NICE Clinical Guidance CG116 Food allergy in children and young people at **guidance.nice.org.uk/CG116**

This is a medical document that can only be completed by the child's healthcare professional. It must not be altered without their permission. This document provides medical authorisation for schools to administer a 'spare' adrenaline autoinjector in the event of the above-named child having anaphylaxis (as permitted by the Human Medicines (Amendment) Regulations 2017). The healthcare professional named below confirms that there are no medical contra-indications to the above-named child being administered an adrenaline autoinjector by school staff in an emergency. **This plan has been prepared by:**

Sign & print name: .....

Hospital/Clinic: .....

..... **Date:** .....