First Aid Policy

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This policy applies to all sections of the school, including the Early Years Foundation stage

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Part 1: First Aid

1. Introduction

1.1 First aid can save lives and prevent minor injuries becoming major ones, especially if it is administered promptly.

1.2 This policy covers the arrangements that need to be made to ensure that appropriate treatment is given to injured or sick people, including:

- Treatment for the purpose of preserving life and minimising the consequences of injury and illness until help from a medical practitioner, paramedic or nurse can be obtained
- Treatment of minor injuries, which would not necessarily need treatment by a medical practitioner or nurse.

1.3 A first aider is someone who has successfully completed one of the following:

- First aid at work (FAW),
- Paediatric first aid,
- First aid for school,
- Sports first aid,
- First aid essentials (Educare)
- or other first aid course recognized by the Health & Safety Executive or other appropriate authority.

2. Training arrangements including Early Years Foundation Stage (EYFS)

2.1 FAW courses take three days, and the qualification must be renewed every three years. A 2-day requalification course is available for this purpose. EFAW courses take one day and must also be renewed every three years by repeating the day's training.

2.2 St John's Ambulance also offer a first aid for Schools course which is a two-day course which many of our teachers have opted to do as it is more relevant to the children.

2.3 Some members of staff hold paediatric first aid qualifications which must be renewed in accordance with the issuing authority's requirements. All staff are offered first aid at work, first aid essentials or first aid for schools' courses. We ensure we have enough staff trained in FAW to cover incidents with adults on site.

2.4 Staff with paediatric first aid training within EYFS are listed in Appendix 1. There are sufficient to ensure that at least one is with children at all times, including on school visits.

2.5 All Games staff are offered the sports first aid one-day course. These courses are valid for three years. One day or half day training is carried out on-site on school inset days where possible.

3. Provision of first aiders

3.1 First aid provision must always be available while people are on the school premises or off the premises on school visits.

3.2 The school is responsible under the Health and Safety at Work etc. Act 1974 for ensuring that first-aid provision is available for staff, pupils and visitors.

3.3 Newland House School Prep has a variety of staff trained in first aid at work, schools first aid, paediatric first aid, first aid essentials and sports first aid. In the Pre-Prep, there are more staff paediatric first aid trained to ensure that at least one is with children at all times, including school visits. All staff in the Nursery are paediatric first aid trained.

3.4 All staff are offered recognised emergency first aid courses. These may be tailored to specific groups as required for example, sports staff and those staff working with children up to 8 years old. Staff are expected to do their best at all times and particularly in emergencies, to secure the welfare of the pupils at the school, in the same way that parents might be expected to act towards their children. The consequences of taking no action are likely to be more serious than those of trying to assist in an emergency.

3.5 In September 2019 all permanent and fixed-term staff received anaphylaxis awareness training and training in the use of auto-injectors. This will be reviewed regularly.

3.6 Please see Appendix 1 for an up-to-date list of qualified members of staff.

4. First Aid information

4.1 It is the responsibility of the Head to ensure that all employees at the school are informed of the following:

- the arrangements for recording and reporting accidents
- the arrangements for first aid
- those employees with qualifications in first aid and those who have attended First Aid Courses
- the location of first aid boxes

4.2 In addition, the Head will ensure that signs are displayed throughout the school providing the following information:

- names of employees with first aid qualifications and those who have attended emergency first aid courses
- location of first aid boxes

4.3 All members of staff are made aware of the school's first aid policy which is available on the school's intranet, Firefly and on the website.

Part 2: First aid facilities and equipment

5. First aid boxes

5.1 Main areas have at least one first aid box properly marked with a white cross on a green background. There is a box readily available in higher risk areas of the school.

5.2 At Newland House first aid boxes are situated in:

Prep School

- The main hall x 1
- Kitchen x 1
- Design and technology x 1
- West wing x 2
- First aid room x 1
- Main reception x 1
- Minibuses x 1 in each of the 6 minibuses
- Sports Boys x 8
- Sports Girls x 4
- Science laboratories x 1 in each
- Information Technology Suite x 1
- Swimming x 1
- Music block x 1

Pre-Prep

- Medical room x 1
- Spill out area outside Year 1 Classrooms
- Spill out area outside Year 2 Classrooms
- Travel bags x 2

5.3 The contents of a first aid box will include:

- 20 individually wrapped sterile adhesive dressings (assorted sizes, hypoallergenic only)
  NB. blue detectable dressings should be available in food preparation areas
- 2 sterile eye pads
- 4 individually wrapped triangular bandages
- 6 medium sized individually wrapped, sterile un-medicated wound dressings (approximately 12 cm x 12 cm)
- For Pre-Prep and Prep School – 4 small sized individually wrapped, sterile un-medicated wound dressings
- 2 large sterile individually wrapped, un-medicated wound dressings (approximately 18 cm x 18 cm)
- Disposable gloves
- Where no mains water is readily available, a small supply of sterile water should be available for eye irrigation
- 1 sick bag

- 1 ice Pack
- 6 alcohol free cleansing wipes

5.4 First aid boxes must be restocked as soon as possible after use and checked at least once a term by the lead first aider. All sterile items must be in date.

5.5 Mini first aid kits are available in each classroom for teachers on request. We also have 2 defibrillators; 1 is held in the Prep medical room and the other in the Pre-Prep medical room. For children under 8 a key is inserted. Instructions are inside the case.

5.6 We have an emergency inhaler for use with disposable spacers. These can only be used on children who have been prescribed an inhaler and from whose parents we have received written consent. This would only be used if their own inhaler had run or could not be located. Please see our asthma care procedure in section 14 below for further details.

5.7 We have emergency auto injectors which can be used in the event of a prescribed auto injector being unavailable. They can also be used if instructed by 999.

6. Travelling first aid kits

6.1 Transport legislation requires that all school minibuses carry a first aid container, and all the Newland House School minibuses have a travelling First aid kit.

6.2 The container itself must be kept in good condition, be readily available for use and clearly visible as a first aid container (white cross on green background).

6.3 The first aid container should include the following items:

- 1 bottle of water
- 1 disposable bandage (not less than 7.5 cm wide)
- 2 triangular bandages
- 1 packet of 24 adhesive dressings (hypoallergenic only)
- 3 large sterile dressings (not less than 18 x 18 cm)
- 2 sterile eye pads with
- 10 alcohol free cleansing wipes
- 2 ice packs
- 2 sick bags
- disposable gloves
- tissues
- 1 pair scissors
- 1 eye and wound wash
- 1 emergency blanket

In addition, kits are in each Minibus to deal with spillages. Each kit contains:

- Disposable gloves
- Plastic bags

- Wet wipes
- Spillage powder

6.4 Tablets, medicines (for example, Dettol, Savlon) burn and sting treatments are not permitted in travel bags. These items, if administered, can under certain circumstances make a condition worse or interfere with any hospital treatment which may be required.

6.5 Medication can be given on a trip if provided by a parent with written permission for a specific ailment or illness.

7. Residential visit first aid kit

7.1 Before pupils attend residential visits, their parents are asked to complete Newland House School medical form (1V) (Appendix 5). Parents are asked to give permission for the following medication to be administered in loco parentis:

- Paracetamol tablets
- Liquid paracetamol
- Sun cream
- Antiseptic cream – for cuts, grazes etc.
- Plasters – for cuts, grazes, blisters etc. (Hypoallergenic only)
- Insect repellent cream
- Sting relief cream – for insect bites
- Antihistamine for example, cetirizine – for allergic reactions
- Travel sickness tablets
- Throat lozenges – for sore throats
- Gaviscon – upset stomach

7.2 The residential visit first aider prepares a first aid kit comprising of the above medication, together with any individual medication required (for example, an inhaler or auto injector) and gives them to the residential visit leader. They would also carry the emergency inhaler.

8. First aid room

8.1 Newland House School has provided a room / accommodation for medical treatment. This facility will contain the following:

- sink with running hot and cold water
- drinking water and disposable cups
- paper towels
- smooth-topped working surfaces
- a range of first aid equipment (at least to the standard required in first aid boxes) and proper storage
- chair
- couch or bed (with waterproof cover), blankets
- soap

- clean protective garments for first aiders
- suitable refuse container (foot operated) lined with appropriate disposable yellow plastic bags, i.e. for clinical waste
- an appropriate record-keeping facility
- a means of communication, for example, telephone.

8.2 Newland House School has a designated first aid room in Pre-Prep and the Prep. The Pre-Prep medical area has a fold down bed.

Part 3: First aid procedures

9. General statement

9.1 At Newland House School, we will support children's medical needs if at all possible and children with medical needs have the same rights of admission to school as other children.

9.2 Most children will, at some time, have short term medical needs such as finishing a course of medicine. A few children may have longer term needs and require medicine on a long-term basis to keep them well. Others may need medicines in certain circumstances, such as children with asthma or severe allergies.

9.3 A child who has a high temperature, is vomiting or has diarrhoea should stay at home until the symptoms have totally subsided (48 hours after last episode of vomiting or diarrhoea).

10. Head Injuries

10.1 If a child bumps their head at school, they will be kept in the medical room under observation. The first half an hour of observation is critical to see if there is a decline in the child's condition.

10.2 If we feel there is no decline and the child feels well, we will send them back to class. We will also issue them with a Bump on the Head letter (BOTH Letter) (see Appendix 2) to take home so that their parents are aware it has happened so if there are any delayed symptoms, they will be aware of the possible cause. They will also receive a head bump wristband (sticker in Pre-Prep) so that staff within the school are aware.

10.3 If the child does not deteriorate but is still suffering a headache, we will ring parents for permission to administer pain relief and follow our medicines procedure.

10.4 If the child does not show signs of improvement, we will contact the parents and request they collect the child and keep them under observation at home and seek further advice from a doctor. When they are collected, we will also give the parent a copy of the BOTH letter, so they know what signs and symptoms they should be looking out for and when to seek further medical advice.

10.5 If the child begins to deteriorate and we deem it necessary, we will call an ambulance and follow our emergency ambulance response procedure. The parents will then be called and informed of our action either will meet the ambulance at school, or we will advise them of the hospital the child has been taken to.

10.6 If a head injury happens on the field during a rugby match, we will follow the below guidelines. These guidelines are available for parents on Firefly in the sports section along with RFU HEADCASE Guidelines (see Appendix 11).

11. Concussion in Rugby

11.1 This is very serious situation in rugby and one that we as a school will be adhering to. Should your child have suspected concussion then:

a) He /she will be taken from the field of play and assessed by the teacher in charge of the session/match.
b) He/she will sit out the rest of the match if there is any slight indicator of concussion (see RFU HEADCASE Guidelines in Appendix 11). The parent will be informed in the form of a phone call/ email or meeting.
c) You have a responsibility to inform the school if your son or daughter sustains concussion outside of school at his rugby club. Your son should not be playing for school after a concussion at the weekend for his team.
d) If your son / daughter has concussion symptoms, then he /she /parent will be given the most up to date info pack from the RFU and instructed to report any official medical advice. (this can be found on Firefly or at RFU Resources).

12. Administering medicines procedure

12.1 This procedure applies to Prep school only. Please see Administration of medicine policy for the Nursery and Pre-Prep which includes the Early Years Foundation Stage.

Prescribed medicines

12.2 Staff are not legally required to administer medicines, but we will accept medicines that have been prescribed by a doctor, dentist, nurse prescriber or pharmacist prescriber. Medicines should be stored in their original containers and be clearly labelled with the name of the pupil, the name and dose of the drug, and the frequency of administration.

12.3 Medicines (both prescription and non-prescription) must only be administered to a child where written permission for that **particular** medicine has been obtained from the child's parent and or/carer. Providers must keep a written record each time a medicine is administered to a child and administer it at the times and in the dosage prescribed and agreed with the parent and/or carer.

12.4 Medicines containing aspirin should only be administered if prescribed by a doctor and should be in the original container as dispensed by a pharmacist and include the prescriber's instructions for administration and dosage.

12.5 It is helpful, where clinically appropriate, if medicines are prescribed in doses that can be taken outside school hours. Parents should ask the prescriber about this; providing two prescriptions, where appropriate and practicable, for a child's medicines: one for home and one for use in the school. This avoids the need for repackaging or relabelling by parents.

12.6 The medicines should be given by the parent or carer directly to the Receptionist in the medical room of the Prep school, who will ensure that they are stored correctly.

Non-prescription medicines

12.7 Non-prescription medicines are kept in the medical room and may be administered during the school day. Written consent needs to be given in advance of administration and in this instance, will be accepted via email. Non-prescription medicines will only be given when the child is suffering minor illness and it is agreed with the parent that the medication will help alleviate the symptoms, for example, headache or mild allergic reactions.

Medication may also be administered if the child is suffering a high temperature and the parent is unable to get to school quickly to take the child home. Age-appropriate liquid paracetamol (250mg per 5ml), liquid ibuprofen (100mg per 5ml), liquid chlorphenamine maleate (2mg per 5ml), cough syrup (glycerol, honey, sucrose) and sore throat lozenges, are the only non-prescription medicines that will be kept on site. Any medication that is administered will be recorded for time and dosage.

12.8 Some parents who are not always available during the working day prefer to give us ongoing permission to give certain non -prescription medication if we deem it necessary. This permission will be given in writing. In the instance that this medication is required, contact will be made either via a voicemail or email to inform the parent that medication has been given and the time and dose provided.

12.9 Non-prescription medicines will be checked once a term to ensure they are in date and will be kept in a lockable non-portable cupboard.

12.10 Staff are required to store any of their own medications in a locked cupboard or draw where access cannot be gained by a child.

Controlled drugs

12.11 In some cases, a child may be prescribed controlled drugs. These will be kept in a secure place in the school and a record of administration will be kept. Children with on-going health issues will have a care plan individually tailored to their needs. Please see our asthma care procedure (section 14) and allergy management procedure (section 13) for further details.

12.12 Children who are ill off site for example at the Bushy Park sports club, will be, where possible, sent back to school if medication is required, unless it is an emergency.

12.13 Permission slips to administer medicine are available from reception and can also be found on Firefly under 'forms' and submitted electronically.

13. Allergy management procedure

13.1 This policy is concerned with a whole school approach to the health care and management of those members of the school community suffering from specific allergies.

13.2 Newland House School's position is not to guarantee a completely allergen free environment, rather to minimise the risk of exposure, encourage self-responsibility, and plan for effective response to possible emergencies. The intent of this policy is to minimise the risk of any student suffering allergy-induced anaphylaxis whilst at school or attending any school related activity.

13.3 The common causes of allergies relevant to this policy are nuts (in particular peanuts), dairy products, eggs, wasps, bees and ants.

13.4 An allergic reaction to nuts is the most common high-risk allergy, and as such demands more rigorous controls throughout this procedure.

13.5 The underlying principles of this procedure include:

- The establishment of effective risk management practices to minimise the pupil, staff, parent and visitor exposure to known trigger foods and insects.
- Staff training and education to ensure effective emergency response to any allergic reaction situation.
- Age-appropriate pupil education on allergy awareness and self-responsibility.

13.6 This procedure applies to all members of the Newland House School community:

- School staff.
- Parents / Guardians.
- Volunteers.
- Relief staff.
- Pupils.

13.7 Definitions

Allergy - A condition in which the body has an exaggerated response to a substance (for example, food and drug). Also known as hypersensitivity.

Allergen - A normally harmless substance that triggers an allergic reaction in the immune system of a susceptible person.

Anaphylaxis - Anaphylaxis, or anaphylactic shock, is a sudden, severe and potentially life-threatening allergic reaction to food, stings, bites, or medicines.

Epipen - Brand name for an auto injector pen containing the drug adrenalin, which is ready for immediate inter-muscular administration.

Minimised Risk Environment - An environment where risk management practices (for example, Risk assessment forms) have minimised the risk of (allergen) exposure.

Individual Care Plan – A detailed document outlining an individual student's condition, treatment, and contact details of the parents. (Appendix 8)

Allergy Action Plan – A detailed document regarding a child's allergy and the action that should need to be taken in the instance of a reaction. Clear details of how to use an autoinjector and contact details for the parents.

13.8 Key Strategies

- The involvement of parents, staff and the student in establishing Individual Care Plans and allergy action plans.
- The establishment and maintenance of; practices for effectively communicating individual student medical plans to all relevant staff.
- The incorporation of allergy management strategies into the risk assessments for, all school events, excursions and sporting activities.
- All staff trained in anaphylaxis management; including awareness of triggers and first aid procedures to be followed in the event of an emergency.
- Age-appropriate education of the children with severe food allergies.
- Parents / Guardians are requested to carefully consider eliminating allergenic food stuffs from their child's lunch boxes and celebratory events.

13.9 Nut related

- The school kitchen, parent support groups and outside caterers are made aware of the allergy management procedure and requested to eliminate nuts and food items with nuts as ingredient from their operations.
- Classroom teachers promote hand washing before and after eating.
- Newland House School is committed to a no food and drink sharing policy.
- Age-appropriate education of the children with severe nut allergies.
- All parents are asked to not send foods in school snacks that contain nuts, peanuts, tree nuts or 'nut traces'.
- Newland House offers all staff in house training on how to use an autoinjector. Teaching and support staff from all three sites have been trained.

13.10 **Dairy and egg related**

- Pupils with dairy product or egg allergies are managed by the school in consultation with the parents / guardians on a case-by-case basis.
- Age-appropriate education of the children with the severe dairy/egg allergies.

13.11 Insect related

- Diligent management of wasp and ant nests on school grounds.
- Education of pupils to report significant presence of insects in play areas.
- Age-appropriate education of the children with severe insect allergies.

14. Procedures and Responsibilities for Allergy Management

14.1 Medical Information

a. Parents are responsible for providing, in writing, on-going accurate and current medical information to the school. The school will seek updated information via a pupil details form at the commencement of each academic year.

b. Furthermore, any change in a child's medical condition during the year must be reported to the school.

c. For students with an allergic condition, the school requires parents / guardians to provide written advice which explains the condition, defines the allergy triggers and any required medication.

d. The lead first aider and administration team will ensure there is an effective system for the management of medical information.

e. The lead first aider and administration team will ensure that a Health Management Plan (action plan) is established and updated for each child with a known allergy.

f. Teachers and teaching assistants of those students and key staff are required to review and familiarise themselves with the medical information.

g. Action plans with a recent photograph for any students with allergies will be posted in relevant rooms.

h. Where students with known allergies are participating in **camps and/or excursions**, the risk assessments and safety management plans for those camps and excursion will include each student's individual allergy Individual Care Plan (action plan).

i. Relevant sports coaches are provided with medical information and individual Health Management Plan for any student with known allergy prior to undertaking the activity.

j. Action plans are also provided on each minibus, so they are available when the child goes off site for games lessons or matches.

k. Action plans are also placed in the medical bags that the children carry with them when they off site.

Medical Information (Autoinjector)

14.2 Where antihistamine and / or an autoinjector (Adrenalin) is required in the allergy action plan:

a. Parents/ guardians are responsible for the provision and timely replacement of the autoinjector, in all sections of the school.

b. Children with autoinjector and/ or antihistamine are listed in the medical book. This book is kept in the medical room named 'PUPIL MEDICAL INFO'. The medical room is by reception at the main entrance of the building.

c. The school first aider must check the pupil medical info record sheet each day for each individual child to ensure their autoinjector/ antihistamine is at school.

d. If a child's autoinjector is not present a school first aider must contact the parent to alert them of this by telephone.
e. Student autoinjectors are kept in the first aid room. All teachers are required to visit the first aid room to understand where to access the autoinjector. Some students with the most severe allergies keep an autoinjector on them in bright yellow bags to enable the fastest administration, this is indicated on their care plan and on the pupil medical info sheet.
f. All children are requested to have one autoinjector in school at all times.
g. Teachers with an allergic condition that require autoinjectors are also encouraged to keep one in the medical room at all times so that they are readily available at all times to the first aider.
h. The school holds an emergency auto injector in the Prep and Pre-Prep first aid rooms.

Minimised nut environment

14.3 Newland House School will promote the following food allergy information through the school website, parent handbook, and notices around school.

Whole school - food from home

14.4 Parents are urged to pack healthy snacks such as fruit and vegetables and snacks for pupils that contain:

- No peanuts
- No nuts of any type
- No foods with peanut or nut derivative or ingredient (for example, Nutella)
- No foods that contain some traces of peanut (where possible)

14.5 Please see our Snack policy for further information.

Kitchen

14.6 Kitchen management will be consulted and work with the lead first aider and administration team in preparing foods under the following guidelines:

- No peanuts
- No nuts of any types
- No foods with peanut or nut derivative or ingredient (for example, Nutella)
- No foods that contain some traces of peanut (where possible)
- It is expected that kitchen staff are made aware of the risk of cross contamination when preparing foods.
- Parents are expected to make themselves aware of school foods and train their children to avoid any products they consider 'unsafe'.
- Specific meals will be prepared for children with multiple food allergies as appropriate. This will be agreed in conjunction with the parents and tailored menu plans will be provided.

Trips/excursions

14.7 The teacher coordinating the activity shall check with any food provider and ensure 'safe' food is provided, or that an effective control is in place to minimise risk of exposure.

14.8 Where a student is prescribed an autoinjector all staff present during the activity shall be made aware of the appropriate medical treatment as outlined in the students Individual Care Plan. (Appendix 8)

BBQ and celebrations

14.9 Where a planned BBQ or celebration is planned, the coordinating group (for example, Parents' Association) is responsible for ensuring that peanuts, peanut products or peanut oil are not used.

15. Asthma care procedure

15.1 Newland House School:

- Welcomes all pupils with asthma.
- With the involvement of parents, staff and the student will establish Individual Care Plans.
- Will establish and maintain practices for effectively communicating individual student medical plans to all relevant staff.
- Will encourage and help children with asthma to participate fully in all aspects of school life.
- Recognises that asthma is a serious condition affecting many school children.
- Recognises that immediate access to inhalers is vital.
- Will do all it can to make sure that the school environment is favourable to children with asthma.
- Will ensure that other children understand asthma so that they can support their friends; and so that children with asthma can avoid the stigma sometimes attached to this chronic condition.
- Has a clear understanding of what to do in the event of a child having an asthma attack.
- Will work in partnership with parents, school governors, health professionals, school staff and children to ensure the successful implementation of a school asthma policy.

15.2 Asthma attacks can be triggered by things that may be found in schools such as cigarette smoke, animals and chemicals. Avoiding these in the school environment can go some way to lessening the incidence of asthma attacks.

15.3 Smoking is not permitted on the school premises or in our minibuses[1]. The staff in the school work hard to ensure that pupils are never exposed to the dangers of passive smoking whilst in school.

Emergency inhalers

15.4 From 1st October 2014, the Human Medicines regulations 2012 has permitted schools to hold an emergency salbutamol inhaler for children who have either been diagnosed with asthma and prescribed an inhaler as reliever medication.

[1] It is illegal to smoke in a car (or another vehicle) with anyone under 18. The law changed on 1 October 2015, to protect children and young people from the dangers of second-hand smoke.

15.5 This change applies to all primary and secondary schools in the UK. Schools are not required by law to hold an emergency inhaler, however, Newland House School has initiated this, as keeping an inhaler for emergency use will have many benefits. It could prevent an unnecessary and traumatic trip to hospital for a child, and potentially save their life.

15.6 A child may have been prescribed an inhaler for their asthma which contains an alternative reliever medication to salbutamol (such as terbutaline). The salbutamol inhaler can still be used for a child if their own inhaler is not accessible (for example, because it is broken, empty or not available.

15.7 A child should continue to hold their own inhaler and follow Newland House School first aid policy procedures. It is important to remember that the school inhaler is only to be used for emergencies.

15.8 As part of good practice, the use of the emergency inhaler will be included in a Newland House School child's individual healthcare plan. We will require a written consent form (please see form in Appendix 7) which you will need to be completed, signed and returned to reception.

Newland House School inhaler instructions

15.9 Children with inhalers are listed in the medical book. This book is kept in the medical room named 'PUPIL MEDICAL INFO'. The medical room is by reception at the main entrance of the building.

15.10 The School first aider must check the pupil medical Info record sheet each day for each individual child to ensure their inhaler is at school.

15.11 If a child's inhaler is not present a school first aider must first check it is not being held by the child and if not, contact the parent to alert them of this by telephone.

Newland House School emergency inhaler instructions

15.12 Newland House School keep an emergency inhaler in the Prep School medical room. The lead first aider is responsible for checking that it is kept in date. We provide disposable spacers in the instance that it needs to be used to maintain hygiene.

15.13 An emergency inhaler will only be given to a child who has been prescribed an inhaler by a doctor and when their own inhaler is unavailable.

15.14 Parents must sign a consent form in addition to the 'asthma card' for an emergency inhaler to be used for their child. (Appendix 7)

15.15 An 'at a glance' record is kept in the 'pupil medical info' to check that a child is authorised by the parent to receive an emergency inhaler.

15.16 If a child's inhaler is not present at School, a School First Aider must contact the child's parents, to alert them by telephone.

16. Defibrillators Procedure

Location

16.1 Newland House School has two defibrillators, one is held in the medical room in Prep School, and one is held in the medical room in the Pre-Prep. The defibrillator and instructions are kept with the defibrillator machines. The medical room is situated behind the reception area in the Prep and Pre-Prep.

16.2 Important note: It is important to understand that survival rates for sudden cardiac arrest are directly related to how soon victims receive treatment. For every minute of delay, the chance of survival declines by 7% to 10%.

16.3 Treatment cannot assure survival. In some victims, the underlying problem causing the cardiac arrest is simply too severe.

Training

16.4 Whilst no formal training should be required, it is useful for staff and all onsite personnel to familiarise themselves with the defibrillator as it is accessible to all in an emergency. Further training can be arranged if required and you can view demonstrations on-line.

Instructions

16.5 Quick guide for child/adult:

- Check signs of sudden cardiac arrest – call 999 – The operator will ask you for your location, your contact number and details of the injury.
- Call for a second person to help
- If no heart response can be found, or is not regular, CPR should be administered immediately until the defibrillator machine is ready.
- Turn on the defibrillator machine.
- Adult - place the pads on bare chest – 2 on chest for an adult (follow instructions on the machine)
- Child under 8 – A key is inserted into the machine on the defibrillator, place one pad on the middle of the chest and one on the middle of the back

17. Disposal of body fluids

17.1 All staff must take precautions to avoid infection. Hygiene procedures must be followed. Staff should use disposable gloves and should take care when dealing with blood or other body fluids and use spillage powder where necessary. All spillage of blood and body fluids must be dealt with promptly.

17.2 Items contaminated with blood or other body fluids should be treated in the following ways:
- Disposable items must be placed in the yellow bin which is situated in the medical room.
- Clothing can be cleaned in an ordinary washing machine on the hot cycle
- Other equipment and surfaces can be cleaned using a hypochlorite solution for example, bleach (one-part bleach to ten parts water) or Milton 2.

18. Disposal of Sharps procedure

18.1 'Sharps' is any object that can be reasonably anticipated to penetrate the skin or any other part of the body and to result in an exposure incident, including a needle device, a scalpel, a lancet, a piece of broken glass etc.

18.2 The main concerns associated with discarded sharps and needle stick injuries are the potential risks for transmission of blood-borne viruses, such as hepatitis B, hepatitis C, HIV and tetanus.

18.3 In the healthcare worker setting, the risk of infection following a percutaneous injury from a needle, which has been used on an infected person, is approximately 30% for the hepatitis B virus (HBV), 3% for the hepatitis C virus (HCV) and 0.3% for HIV. Outside the healthcare setting, the risks appear to be less, because needles will often have been lying in unfavourable conditions for the survival of these viruses over long periods of time. Nevertheless, if a needle stick injury is sustained in this setting, there is still a possible risk of viral transmission.

Discarded sharps

18.4 If a discarded sharp is found in a school, the following actions should be taken:
- Contact the school office /caretaker.
- Do not handle the discarded sharp and guard the area until it is removed by a trained person with suitable equipment such as remote pickers and sharps containers. A sharps container can be found in the medical room.
- Should there be any doubt that the sharp belongs to any person that has not been identified as requiring sharps in the school it should not be handled (even with suitable equipment).
- Sharps must not be handled directly (even when heavy duty gloves are worn) and makeshift containers, such as drinks cans and coffee jars, should not be used to store them. A record should be kept of the location and the number of sharps collected.

Disposal of sharps containers

18.5 All sharps' containers must comply with the British Standard (BS7320). A sharps container is kept in the medical rooms in the Main School and the Pre-Prep.

18.6 As soon as the sharps container has been filled to the line shown on the label, it should be securely locked shut. Richmond Council must be contacted to arrange disposal when required.

Needle stick injuries

18.7 If a pupil, employee or visitor sustains an injury from a discarded sharp, the following immediate first aid measures should be applied:

- Encourage bleeding of the affected area by squeezing (do not suck).
- If possible, wash the area with soap and water.
- If eyes/mouth are involved, irrigate with a sterile saline solution or tap water for 1-2 minutes.
- Attend the nearest Accident and Emergency Department, where staff will assess the potential risk and provide the appropriate treatment.
- Persons suffering from a needle stick injury can also experience great anxiety and there may be a need to provide counselling to allay fears that have stemmed from such an incident.

19. Transport to hospital or home

19.1 Where the injury is an emergency, the first aider, using our policy on emergency ambulance response, will call an ambulance. Following which the parent will be called.

19.2 Please see the emergency ambulance response procedure below regarding the process of calling and directing the ambulance to both school buildings.

19.3 Where hospital treatment is required but is not an emergency, then the first aider will contact the parents for them to take over the responsibility of the child. If the parents cannot be contacted, then the Head may decide to make arrangements for the pupil to be transported to hospital by a responsible adult. The first aiders in the medical room must remain on site as a first aid provision for the rest of the school.

20. Emergency Ambulance Response Procedure

20.1 EMERGENCY AMBULANCE RESPONSE INFORMATION PRE-PREP
Newland House School
Pre-Prep
28 Waldegrave Park
Twickenham
TW1 4TQ
020 8865 1279

1. Position of school made clear.
2. Tell the paramedics a member of staff will be outside in a high visibility jacket.
3. Signal other members of staff. (Pre-Prep receptionist should be first response).
4. Parent is rung and Prep school rung.
5. Inform paramedics of other medication and provide with care plan if appropriate.
6. Fill in incident report.

20.2 EMERGENCY AMBULANCE RESPONSE INFORMATION PREP SCHOOL
Newland House School
32-34 Waldegrave Park
Twickenham
TW1 4TQ
020 8865 1234

1. Position of school made clear.
2. Tell the paramedics a member of staff will be outside in a high visibility jacket.
3. Signal other members of staff. (Reception should be first response).
4. Parent is rung and Pre-Prep rung.
5. Inform paramedics of other medication and provide with care plan if appropriate.
6. Fill in incident report.

21. Record keeping

21.1 All medical incidents for pupils are recorded on the computer and a report is printed off fortnightly listing all medical incidents and accidents. This list is sent to the Deputy Head (Prep) and the Bursar. The records are stored on our data system WCBS. The report requires the following information:

- Name of person treated
- Date and time of treatment
- Nature of injury or illnesses
- Treatment given/action taken
- Staff member making the record

21.2 All staff accidents are logged in an accident book that is held in the medical room.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)

21.3 All RIDDOR-reportable incidents that happen in school, or during education activities out of school, must be reported to the Health and Safety Executive (HSE). These regulations require employers and other people to report accidents and some diseases that arise out of or in connection with work. Please inform the Bursar of any incidents as soon as possible who will ensure that the incident is reported in the accident book and reported to the HSE.

21.4 Please see Appendix 10 for summary of the HSE leaflet, which gives practical advice to schools on what they need to report and how to report.

22. Additional medical forms

22.1 Included in this policy in the appendices are additional policies and forms covering all aspects of first aid:

- Bump on the Head Letter (Appendix 2)

- Minor injuries form (Appendix 3 - Pre-Prep)
- Residential visits medical form (Appendix 4)
- NHS day/Residential visit accident report form (Appendix 5)
- Pupils personal information and parental consent form (Appendix 6)
- Emergency inhaler consent form (Appendix 7)
- Individual Care Plan (Appendix 8)

23. Further information

23.1 This policy will be reviewed every academic year or sooner if changes to legislation, compliance requirements or good practice dictate.

Appendix 1 – List of all staff with first aid qualifications

All staff have completed first aid essentials online.

Paediatric First Aid	
Oliver	Foss-Smith
Hannah	Foster
Margaret	Gelderblom
Helen	Halstead
Nat	Hill
Caroline	MacDonald
Esha	Nayyar
Ellen	O'Carroll
Caroline	O'Donnabhain
Jeanette	Parker
Sarah	Pomroy
Zoe	Prindiville
Emma	Rafferty
Rebecca	Ranken
Yasemin	Sarioglu
Eve	Seall
Dawn	Singh
Maisie	Slaney
Tim	Soper
Beth	Spencer
Hannah	Taylor
Katy	Turner
Linda	Wadey
Maria	Wallace
Samantha	Wallace
Gina	Warren (nee Page)
Anna	Crowhurst
Claire	Baker
Ian	Bardgett
Bryony	Blant
Marianna	Chiavirini
Laura	Clouting
Sofia	Cookman

Appendix 2 - Head Injury letter to Parent or Guardian

Bumped Heads Letter.

Name:	
Date:	Form:

Your child has had an accident at school today.

They received a bump to the head and have had treatment from a first aider. It is important that you watch for any signs or symptoms that might indicate more serious injury than assessed at the time of the incident.

Description of Injury:
First Aid Administered:
First Aider:

Front

Back

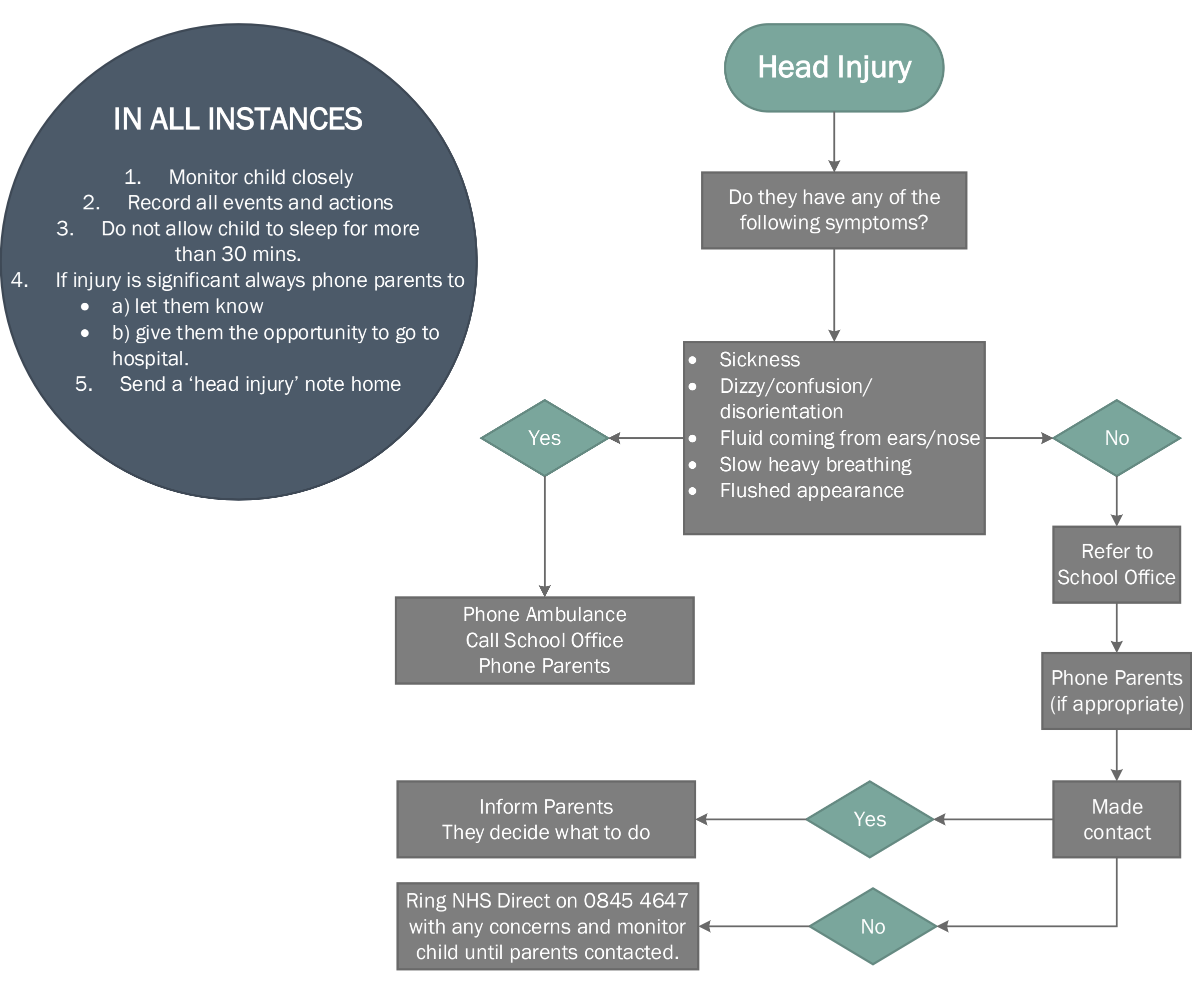
Please watch for:

- Unexpected drowsiness / sleepiness.
- Vomiting.
- Any signs of blood or fluid coming from the nose or ears.
- Any complaint of headache.
- Any complaint of seeing double / blurred vision.

If any of these signs develop, contact your GP or local A&E immediately for advice.

Form Completed by:	Date:

Appendix 2a - Head Injury Action Plan



Appendix 3 - Minor Accidents and Injuries Form for Pre-Prep

Your child had First Aid today.
Child's name……………………………………………………… Class……………………………
Location……………………………………………………………
Date/Time…………………………………………………………
Injury/accident/treatment:
………
………
………
Signed………………………………………………………………………………………………………

Appendix 4 – Residential Visits Newland House School Medical Form

Newland House School medical form

Please complete this form and return to school by: ....

SCHOOL VISIT TO...
DATES OF VISIT..
CHILD'S NAME.. FORM.........................
DATE OF BIRTH..
HOME ADDRESS ....
....
....
Telephone Number: Home.. Mobile..
EMERGENCY CONTACT:
Name...
Address..
Telephone Number: Home .... Mobile: ....
DOCTOR:
Name..
Surgery Address..
Doctor's telephone Number ....

1. Does your child have any medical condition, or has he been admitted to hospital? Yes / No
   If Yes, please give details:
   ....
   ....
2. Does your child have any allergies or phobias? Yes / No
   If yes, then please state:
   ....
3. Does your child suffer from travel sickness? Yes / No
4. Is your child currently taking any medicine(s) on a long-term basis?

   If yes, please give full details (including asthma inhalers etc.).

   ....
   ....

5. Have there been any contagious or infectious diseases suffered within the family during the last four months? Yes / No

6. Has your child suffered any other recent illnesses? Yes / No
   If 'Yes' to either question, please give full details.
   ....
   ....

7. Does your child have any night time tendencies such as sleep walking or bedwetting? Yes / No
   If 'yes' state below

   ....

8. Is your son/daughter a confident swimmer? Yes / No

9. Is your child protected against TETANUS? Yes / No

   If 'yes', please state the date of his/her last injection ....

10. Do you give permission for staff to administer the following medicines or treatments, if necessary? Please tick the appropriate box.

Medicine / treatment	Yes	No
Paracetamol tablets		
Liquid paracetamol		
Sun cream		
Antiseptic cream – for cuts, grazes etc.		
Plasters – for cuts, grazes, blisters etc.		

Insect repellent cream		
Sting Relief Cream – for Insect bites		
Antihistamine for example, cetirizine - for allergic reactions		
Travel Sickness Tablets		
Indigestion Remedy		
Cough Mixture		
Throat Lozenges – for sore throats		

11. I give my permission for members of staff to arrange any emergency medical treatment for my child, should it be necessary.

FOOD ALLERGIES

Please list below any foods that your child is ***allergic*** to (NOT THE ONES HE/SHE DOES NOT LIKE!)

……

………

SPECIAL RELIGIOUS FOOD REQUIREMENTS

If your child has any essential religious food requirements, please state them below:

………
………

PARENT/GUARDIAN'S SIGNATURE

…………………………………………………………………………………………………

DATE ……

Appendix 5 - Newland House Day/Residential Visit Accident Report Form

Name of Pupil...
Year/Class...
Pupil's home/parents mobile numbers ....
Nature of Injury ....
....
Activity - engaged when the accident occurred
....
Full description of accident
....
....
....
Did the pupil require medical treatment? Yes / No
Has the injury prevented the pupil from continuing to take part in the activities? Yes/ No
If 'Yes' period of absence: From .... To
....

When were the parents notified of the accident: Date.......................................
Time........................

How was the injury treated?
....
....
Were arrangements made to take him/her to hospital? YES/NO
Precise Location: .... Time.............................
Was the accident caused by any defect in the premises or equipment? Yes / No
If 'yes' explain
....
....
....
Treatment/Findings (if known)

....
....

If the child has to be taken to the hospital or doctor, please answer the following:
How many pupils were in the area when the accident happened?...
Which teachers were supervising the area?
....

Signed by teacher: .... **Date**: ....
If an emergency and the child needs to be taken to hospital,

1. Call for an ambulance,
2. Teacher to accompany if parents not able to do so
3. Take mobile to stay in contact with the Visit Centre and School Office.

Follow up:
Please make sure teacher in charge rings home to see how the child is if he has to return home and not continue the Visit (Day or Residential).

Appendix 6 - Pupil's personal information and parental consent form

NEWLAND HOUSE SCHOOL

PUPIL'S PERSONAL INFORMATION AND PARENTAL CONSENT FORM

This form is subject to the provisions of the Data Protection Act. Information will only be made available to those persons who require access to it while discharging their duties on behalf of the school. All forms and electronic copies are to be destroyed, either when superseded or when the child leaves Newland House School. We will contact you annually to check that the data we hold is correct, but we would strongly advise you to inform the school immediately of any significant changes.

PERSONAL INFORMATION & CONTACTS:

Child's Name .... Date of birth ....

Address .... Form ....

.... Post Code ....

Home Telephone No.................................... E-mail address ....

Emergency Contact Number **TO BE AVAILABLE AT ALL TIME** ....

Mother's Work Number .... Mobile Number ....

Father's Work Number .... Mobile Number ....

MEDICAL INFORMATION:

Doctor's Name and Telephone Number ....

Date of last tetanus injection (if applicable)...

Medical conditions (for example, allergies/asthma/dietary requirements, including foods your child may not eat). For serious conditions please give full details of **specific** medication if we are currently not in possession of this. Please also indicate if you wish your child to be treated only with hypoallergenic plasters in the event of any minor cuts or abrasions etc.

....

....

....

CONSENT:

- I agree to my child taking part in extra-curricular sports and activities, school fixtures and galas and understand that travel will be by coach, minibus or by foot. I hereby authorize members of staff during the course of these activities to approve such dental, medical or surgical treatment for my child as is deemed necessary in an emergency. **Please note: every effort will be made to obtain parental consent directly.**
- I also agree to the school using photographs of my child in the School Magazine, on the School's website or in any other material publicising the school in accordance with the school's Digital Image Policy (see overleaf). ***Please circle as appropriate*** YES/NO*

Name of Parents/Guardians (Block Capitals)

....

Signed .... (Parent/Guardian) Date ....

Signed .... (Parent/Guardian) Date ....

Please attach a passport sized photograph of your child to this form.

Appendix 7 – School Asthma Card

School Asthma Card

To be filled in by the parent/carer

Child's name

Date of birth D D / M M / Y Y

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 D D / M M / Y Y

Expiry dates of medicines

Medicine	Expiry	Date checked	Parent/carer's signature

Parent/carer's signature   Date D D / M M / Y Y

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.

The Asthma UK and British Lung Foundation Partnership is a company limited by guarantee 01863614 (England and Wales). VAT number 648 8121 18. Registered charity numbers 802364 and SCO39322
Your gift will help Asthma UK fund vital research projects and provide people with asthma with the support they need. © Asthma UK Last reviewed and updated 2020; next review 2023.

Appendix 8 – Individual Care Plan

Photo of pupil

NAME: **FORM:**

ALLERGY OR AILMENT:

SYMPTOMS/SIGNS:

WHAT TO DO?

ADMINISTRATION OF MEDICATION DETAILS:

EPIPENS HELD:

CONTACT DETAILS:

MOTHER: FATHER:

Other emergency numbers:

Appendix 9 – Allergy Action Plan

Allergy Action Plan

THIS CHILD HAS THE FOLLOWING ALLERGIES:

Name:

DOB:

Emergency contact details:

1)

2)

Child's Weight: Kg

Mild-moderate allergic reaction:

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

ACTION:

- Stay with the child, call for help if necessary
- Give antihistamine: (if vomited, can repeat dose)
- Contact parent/carer

Watch for signs of ANAPHYLAXIS
(life-threatening allergic reaction):

AIRWAY: Persistent cough, hoarse voice, difficulty swallowing, swollen tongue

BREATHING: Difficult or noisy breathing, wheeze or persistent cough

CONSCIOUSNESS: Persistent dizziness / pale or floppy suddenly sleepy, collapse, unconscious

If ANY ONE of these signs are present:

1. **Lie child flat.** If breathing is difficult, allow to sit
2. **Give EpiPen® or EpiPen® Junior**
3. **Dial 999 for an ambulance*** and say ANAPHYLAXIS ("ANA-FIL-AX-IS")

If in doubt, give EpiPen®

After giving Epipen:

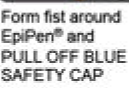
1. Stay with child, contact parent/carer
2. Commence CPR if there are no signs of life
3. If no improvement **after 5 minutes, give a further EpiPen®** or alternative adrenaline autoinjector device, if available

*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.

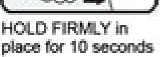
How to give EpiPen®

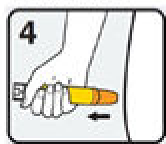
Form fist around EpiPen® and PULL OFF BLUE SAFETY CAP

SWING AND PUSH ORANGE TIP against outer thigh (with or without clothing) until a click is heard



HOLD FIRMLY in place for 10 seconds





REMOVE EpiPen®. Massage injection site for 10 seconds

Keep your EpiPen device(s) at room temperature, do not refrigerate.
For more information and to register for a free reminder alert service, go to www.epipen.co.uk
Produced in conjunction with:

The British Society for Allergy & Clinical Immunology www.bsaci.org Approved Oct 2013

Additional instructions:

This is a medical document that can only be completed by the patient's treating health professional and cannot be altered without their permission.

This plan has been prepared by: ____________

Hospital/Clinic:

Date:

Appendix 10 - HSE Leaflet Summary: EDIS1[2] (Revision 3) 10/13

Introduction

This information sheet gives guidance on how the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) apply to schools. Most incidents that happen in schools or on school trips do not need to be reported. Only in limited circumstances will an incident need notifying to the Health and Safety Executive (HSE) under RIDDOR. The information sheet gives practical guidance to schools about what they need to report and how to do it.

What needs to be reported?

RIDDOR requires employers and others in control of premises to report certain accidents, diseases and dangerous occurrences arising out of or in connection with work.

The information sheet includes examples of the incidents that sometimes result from schools' activities and are reportable under RIDDOR. The sheet contains three sections, which cover:

- injuries and ill health involving employees (Section 1);
- injuries involving pupils and other people not at work (Section 2);
- dangerous occurrences (Section 3).

Who should report?

The duty to notify and report rests with the 'responsible person'. For incidents involving pupils and school staff, this is normally the main employer at the school. The education pages on HSE's website at www.hse.gov.uk/services/education provide information about who the employer is in different types of schools. Some school employers may have centrally co-ordinated reporting procedures. In others, reporting may be delegated to the school management team. The health and safety policy should set out the responsibilities and arrangements for reporting in each school. Incidents involving contractors working on school premises are normally reportable by their employers. Contractors could be, e.g. builders, maintenance staff, cleaners or catering staff. If a self-employed contractor is working in school premises and they suffer a specified injury or an over-seven-day injury, the person in control of the premises will be the responsible person. (See HSE's RIDDOR web pages at www.hse.gov.uk/riddor for more detail on the reporting arrangements for self-employed people.)

Who do I report to?

For general advice about how to report, see HSE's RIDDOR web pages. You can report all incidents online and there is a telephone service for reporting **fatal and specified injuries only.** Reporting details for out of hours' incidents are available from HSE's out of hours' web page at www.hse.gov.uk/contact/contact.htm

For incidents on school premises involving members of staff, pupils or visitors, HSE is the enforcing authority and you should submit your reports to them. HSE is also the enforcing authority for nursery provision provided and operated by local authorities. For privately run

[2] **'Contains public sector information published by the Health and Safety Executive and licensed under the Open Government Licence'.**

nursery schools, the local authority is the enforcing authority.

What records must I keep?
You must keep records of:

- any reportable death, specified injury, disease or dangerous occurrence that requires reporting under RIDDOR;

- all occupational injuries where a worker is away from work or incapacitated for more than three consecutive days. From 6 April 2012 you don't have to report over-three-day injuries, but you must keep a record of them. Employers can record these injuries in their accident book. You must keep records for at least three years after the incident.

Section 1: Injuries and ill health to people at work

Under RIDDOR, the responsible person must report the following work-related accidents, including those caused by physical violence, if an employee is injured, wherever they are working:

- accidents which result in death or a specified injury must be reported without delay (see 'Reportable specified injuries');

- accidents which prevent the injured person from continuing their normal work for more than seven days (not counting the day of the accident, but including weekends and other rest days) must be reported within 15 days of the accident.

The responsible person must also report any case of a work-related disease, specified under RIDDOR, that affects an employee and that a doctor confirms in writing (see 'Reportable diseases'). You can find detailed guidance about RIDDOR reporting and online reporting procedures at www.hse.gov.uk/riddor/report.htm.

If you are in control of premises, you are also required to report any work-related deaths and certain injuries to self-employed people that take place while they are working at the premises.

Reportable specified injuries

These include:

- fractures, other than to fingers, thumbs and toes;
- amputations;
- any injury likely to lead to permanent loss of sight or reduction in sight;
- any crush injury to the head or torso causing damage to the brain or internal organs;
- serious burns (including scalding), which: – cover more than 10% of the body; or – cause significant damage to the eyes, respiratory system or other vital organs;
- any scalping requiring hospital treatment;
- any loss of consciousness caused by head injury or asphyxia
- any other injury arising from working in an enclosed space which:
  – leads to hypothermia or heat-induced illness; or

– requires resuscitation or admittance to hospital for more than 24 hours.

Physical violence

Some acts of non-consensual physical violence to a person at work, which result in death, a specified injury or a person being incapacitated for over seven days, are reportable. In the case of an over-seven-day injury, the incapacity must arise from a physical injury, not a psychological reaction to the act of violence.

Examples of reportable injuries from violence include an incident where a teacher sustains a specified injury because a pupil, colleague or member of the public assaults them while on school premises. This is reportable, because it arises out of or in connection with work.

Reportable occupational diseases

Employers must report occupational diseases when they receive a written diagnosis from a doctor that their employee has a reportable disease linked to occupational exposure. (See www.hse.gov.uk/riddor for details of the reporting arrangements for self-employed people.)

These include:

- carpal tunnel syndrome;
- severe cramp of the hand or forearm;
- occupational dermatitis, e.g. from work involving strong acids or alkalis, including domestic bleach;
- hand-arm vibration syndrome;
- occupational asthma, e.g. from wood dust and soldering using rosin flux;
- tendonitis or tenosynovitis of the hand or forearm;
- any occupational cancer;
- any disease attributed to an occupational exposure to a biological agent.

Stress

Work-related stress and stress-related illnesses (including post-traumatic stress disorder) are not reportable under RIDDOR. To be reportable, an injury must have resulted from an 'accident' arising out of or in connection with work.

In relation to RIDDOR, an accident is a discrete, identifiable, unintended incident which causes physical injury. Stress-related conditions usually result from a prolonged period of pressure, often from many factors, not just one distinct event.

Section 2: Incidents to pupils and other people who are not at work

Injuries to pupils and visitors who are involved in an accident at school or on an activity organised by the school are only reportable under RIDDOR if the accident results in:

- the death of the person, and arose out of or in connection with a work activity; or

- an injury that arose out of or in connection with a work activity and the person is taken directly from the scene of the accident to hospital for treatment (examinations and diagnostic tests do not constitute treatment).

The lists of specified injuries and diseases described in Section 1 only apply to employees. If a pupil injured in an incident remains at school, is taken home or is simply absent from school for a number of days, the incident is not reportable.

How do I decide whether an accident to a pupil 'arises out of or is in connection with work'? The responsible person at the school should consider whether the incident was caused by:

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

So, if a pupil is taken to hospital after breaking an arm during an ICT class, following a fall over a trailing cable, the incident would be reportable. If a pupil is taken to hospital because of a medical condition (e.g. an asthma attack or epileptic seizure) this would not be reportable, as it did not result from the work activity.

This means that many of the common incidents that cause injuries to pupils at school tend not to be reportable under RIDDOR, as they do not arise directly from the way the school undertakes a work activity. **Remember, in all these cases, you only need to consider reporting where an accident results in a pupil's death or they are taken directly from the scene of the accident to hospital for treatment. There is no need to report incidents where people are taken to hospital purely as a precaution, when no injury is apparent.**

What about accidents to pupils during sports activities?

Not all sports injuries to pupils are reportable under RIDDOR, as organised sports activities can lead to sports injuries that are not connected with how schools manage the risks from the activity.

The essential test is whether the accident was caused by the condition, design or maintenance of the premises or equipment, or because of inadequate arrangements for supervision of an activity. If an accident that results in an injury arises because of the normal rough and tumble of a game, the accident and resulting injury would not be reportable. Examples of reportable incidents include where:

- the condition of the premises or sports equipment was a factor in the incident, e.g. where a pupil slips and fractures an arm because a member of staff had polished the sports hall floor and left it too slippery for sports; or

- there was inadequate supervision to prevent an incident, or failings in the organisation and management of an event.

What about accidents to pupils in a playground?

Most playground accidents due to collisions, slips, trips and falls are not normally reportable. Incidents are only reportable where the injury results in a pupil either being killed or taken directly to a hospital for treatment. Either is only reportable if they were caused by an accident that happened from or in connection with a work activity.

This includes incidents arising because:

- the condition of the premises or equipment was poor, e.g. badly maintained play equipment; or
- the school had not provided adequate supervision, e.g. where particular risks were identified, but no action was taken to provide suitable supervision.

Physical violence

Violence between pupils is a school discipline matter and not reportable under RIDDOR, as it does not arise out of or in connection with a work activity.

Other scenarios

Injuries to pupils while travelling on a school bus If another vehicle strikes the school bus while pupils are getting on or off and pupils are injured and taken to hospital, this is normally reportable under RIDDOR.

However, you do not have to report deaths and injuries resulting from a road traffic accident involving a school vehicle travelling on the public highway under RIDDOR. These are classed as road traffic incidents and are investigated by the police.

Incidents involving pupils on overseas trips RIDDOR only applies to activities which take place in Great Britain. So, any incident overseas is not reportable to HSE.

Incidents to pupils on work experience placements If pupils are on a training scheme or work placement, they are deemed to be employees for the period of the placement. In these circumstances, the employer, as the responsible person, should report a death, injury or disease to a pupil, which arises out of or in connection with work. This means the wider range of reporting categories for employees is applicable.

Section 3: Dangerous occurrences

These are specified near-miss events, which are only reportable if listed under RIDDOR. Reportable dangerous occurrences in schools typically include:

- the collapse or failure of load-bearing parts of lifts and lifting equipment;
- the accidental release of a biological agent likely to cause severe human illness;
- the accidental release or escape of any substance that may cause a serious injury or damage to health;
- an electrical short circuit or overload causing a fire or explosion.

Supplementary information

Consultation

Under the Safety Representatives and Safety Committees Regulations 1977 and the Health and Safety (Consultation with Employees) Regulations 1996, employers must make relevant health and safety documents available to safety representatives.

This includes records kept under RIDDOR, except where they reveal personal health information about individuals. Further information is available in Consulting employees on health and safety: A brief guide to the law Leaflet INDG232(rev2) HSE Books 2013 www.hse.gov.uk/pubns/indg232.htm.

Reporting requirements of other regulators

There may be other reporting requirements placed on schools by other regulators in the education sector. The requirements of these other regulators are separate to, and distinct from, the legal duty to report incidents under RIDDOR.

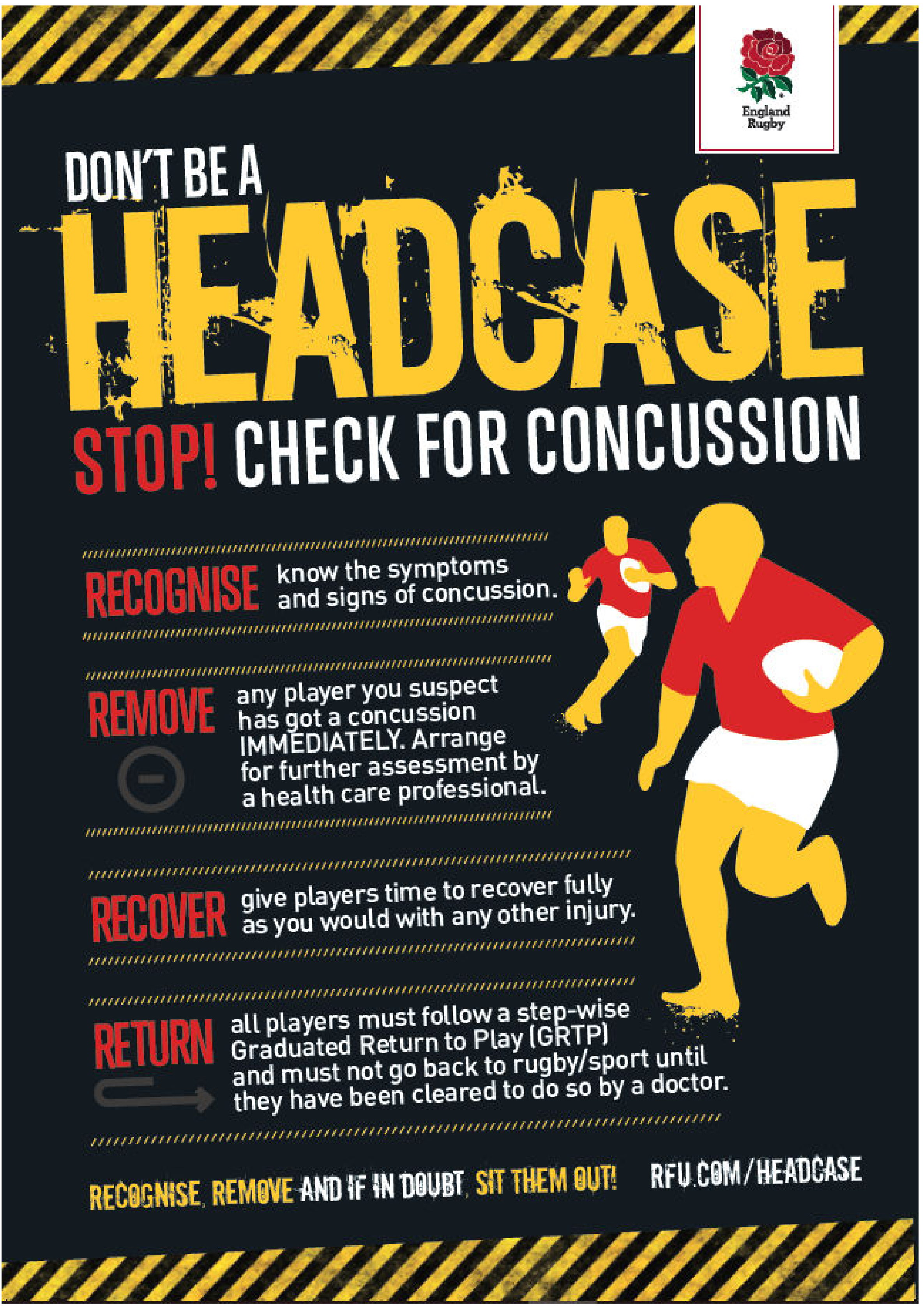
Further information

For information about health and safety, or to report inconsistencies or inaccuracies in this guidance, visit www.hse.gov.uk/. You can view HSE guidance online and order priced publications from the website. HSE priced publications are also available from bookshops.

This guidance is issued by the Health and Safety Executive. Following the guidance is not compulsory, unless specifically stated, and you are free to take other action. But if you do follow the guidance you will normally be doing enough to comply with the law. Health and safety inspectors seek to secure compliance with the law and may refer to this guidance.

This information sheet is available at: www.hse.gov.uk/pubns/edis1.htm

Appendix 11 RFU HEADCASE Guidelines



DON'T BE A HEADCASE STOP! CHECK FOR CONCUSSION

HEADACHE EMOTIONAL APPEARANCE DROWSINESS CONFUSION AGITATED SEIZURE EARS AND EYES

Return to play after concussion

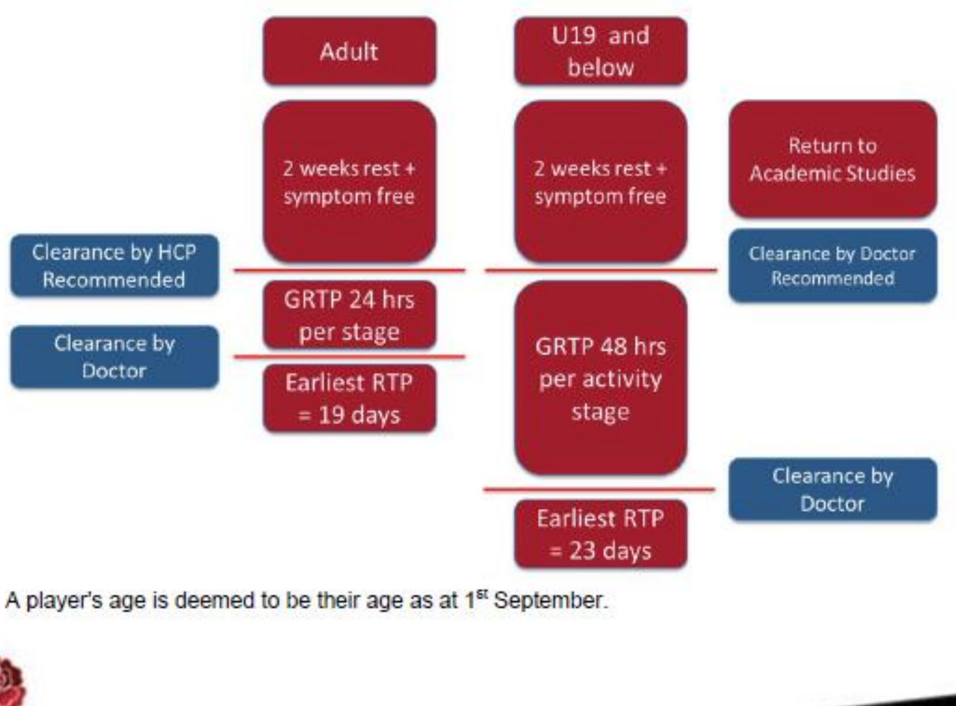
Concussion must be taken extremely seriously to safeguard the short and long term health and welfare of players, and especially young players.

The majority (80-90%) of concussions resolve in a short (7-10 days) period. This may be longer in children and adolescents and a more conservative approach should be taken with them. During this recovery time however, the brain is more vulnerable to further injury, and if a player returns too early, before they have fully recovered this may result in:

- Prolonged concussion symptoms
- Possible long term health consequences e.g. psychological and/or brain degenerative disorders
- Further concussive event being FATAL, due to severe brain swelling – known as second impact syndrome.

What should players do to return to play (RTP)?

The routine return to play pathway is shown in the diagram below:



A player's age is deemed to be their age as at 1st September.

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- Rest. Individuals should avoid the following initially and then gradually re-introduce them:
  - Reading
  - TV
  - Computer games
  - Driving
- It is reasonable for a student to miss a day or two of academic studies but extended absence is uncommon.
- Start Graduated Return to Play (GRTP) once all symptoms have resolved and cleared to do so by a healthcare professional (HCP) or doctor (for children).
- In young players a more conservative Graduated Return To Play approach is recommended, and it is advisable to extend the amount of rest (routinely this should be two weeks/14 days) and the length of the GRTP.
- As part of the process it is also prudent to consult with the young person's academic teacher(s) or tutor to ensure that their academic performance has returned to normal prior to commencing their GRTP. The school environment obviously helps with this liaison with educational experts.

It must be emphasised that these are minimum return to play times and in players who do not recover fully within these timeframes, these will need to be longer.

Graduated Return to Play (GRTP)

The GRTP should be undertaken on a case by case basis and with the full cooperation of the player and their parents/guardians.

Where a club/school has their own medical resources the GRTP process should be carried out by the club/school coach, and overseen by the club/school health care professional/doctor. Parents should where possible also be actively involved in the process.

A summary of the GRTP is shown in the following diagram.

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Stage	Rehabilitation Stage	Exercise Allowed	Objective
1	Rest	Complete physical and cognitive rest without symptoms	Recovery
2	Light aerobic exercise	Walking, swimming or stationary cycling keeping intensity, <70% maximum predicted heart rate. No resistance training.	Increase heart rate and assess recovery
3	Sport-specific exercise	Running drills. No head impact activities.	Add movement and assess recovery
4	Non-contact training drills	Progression to more complex training drills, e.g. passing drills. May start progressive resistance training.	Add exercise + coordination, and cognitive load. Assess recovery
5	Full Contact Practice	Normal training activities	Restore confidence and assess functional skills by coaching staff. Assess recovery
6	Return to Play	Player rehabilitated	Safe return to play once fully recovered.

The Pocket Concussion Recognition Tool symptom and signs check list can be used to assess players at each stage of the GRTP; this is shown below and is available to download at rfu.com/concussion.

Pocket CONCUSSION RECOGNITION TOOL™

RECOGNIZE & REMOVE

1. Visible clues of suspected concussion

2. Signs and symptoms of suspected concussion

3. Memory function

RED FLAGS

Remember:

Before a player can commence the exercise elements of the GRTP i.e. Stage 2, they must be symptom free for a period of 24 hours (adult) or 48 hours (U19) (This is Level 1)

The player can then progress through each stage as long as no symptoms or signs of concussion return. Where the player completes each stage successfully without any symptoms the player would normally proceed through each stage on successive days. In U19s, progression should take 2 days for each stage.

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If any symptoms occur while progressing through the GRTP protocol, the player must consult with their medical practitioner before returning to the previous stage and attempting to progress again after a minimum 24-hour (adult) or 48 hour (U19) period of rest, without the presence of symptoms.

If it is not feasible for the coach to conduct Levels 2 - 4, these may be done by the player in their own time or in children supervised by parents with appropriate guidance. Alternatively the protocol may simply be extended with each level being conducted by the coach at training sessions or in the school setting by other PE staff during PE lessons, when they are able

On completion of Level 4 the player may resume full contact practice (Level 5) with Medical Practitioner clearance.

It is the player's or parent's responsibility to obtain medical clearance before returning to play.

Schools and clubs are advised to keep a record of the player's or parent's confirmation that clearance has been obtained and a doctor's letter is not necessarily required.

On completion of Level 5 without the presence of symptoms, the player may return to playing in full contact rugby games (Level 6).

Note:
If a player's concussion resulted from poor tackle technique, their coach must also ensure that this is corrected before return to play.

If there are concerns about the player's behaviour and approach to the game when playing or training that appears to put them at increased risk of concussion, then this should be addressed before return to play.

Return to Play Pathway in an Enhanced Care Setting

In some circumstances (such as Professional clubs and Rugby Academies) there is a doctor with training and experience in the management of concussion/traumatic brain injury available to closely supervise the player's care and GRTP, and clear the player prior to RTP. In these instances, a shortened timeframe for RTP is possible, but only under strict supervision by the appropriate medical experts as part of a structured concussion management programme. In these circumstances **ONLY**, the following RTP pathway can be followed:

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It is recognised that players will often want to return to play as soon as possible following a concussion. Players, coaches, management, parents and teachers must exercise caution to:

a. Ensure that all symptoms have subsided before commencing GRTP.
b. Ensure that the GRTP protocol is followed.
c. Ensure that the advice of Medical Practitioners and other Healthcare Professionals is strictly adhered to.

After returning to play all involved with the player, especially coaches and parents must remain vigilant for the return of symptoms even if the GRTP has been successfully completed.

If symptoms reoccur the player must consult a Healthcare Practitioner as soon as possible as they may need referral to a specialist in concussion management.

Additional resources

- Coaches Concussion Guide rfu.com/concussion
- Pocket Concussion Recognition Tool rfu.com/concussion
- Coaches, First Aiders, Match Officials and Administrators concussion education module. www.irbplayerwelfare.com/concussion
- Club/School Health Care Professionals concussion educational module. www.irbplayerwelfare.com/concussion

These RFU Concussion resources have been developed based on the Zurich Guidelines published in the Consensus Statement on Concussion in Sport, and adapted for rugby by the International Rugby Board

The information contained in this resource is intended for educational purposes only and is not meant to be a substitute for appropriate medical advice or care. If you believe that you or someone under your care has sustained a concussion we strongly recommend that you contact a qualified health care professional for appropriate diagnosis and treatment. The authors have made responsible efforts to include accurate and timely information. However they make no representations or warranties regarding the accuracy of the information contained and specifically disclaim any liability in connection with the content on this site.

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HEADACHE EMOTIONAL APPEARANCE DROWSINESS CONFUSION AGITATED SEIZURE EARS AND EYES

What is concussion?

What is concussion?

Concussion is a traumatic brain injury resulting in a disturbance of the normal working of the brain in which typically standard brain scans are normal. It is usually the result of one of the following:

- A blow directly to the head e.g. a clash of heads or the head hitting the ground
- The head being shaken when the body is struck e.g. a high impact tackle

This disturbance results in a range of symptoms which are covered in detail on this site, some of which are very subtle, but the common ones are headache, dizziness, memory disturbance or balance problems.. The main effects that help us identify concussion are the brain's ability to process information – this is picked up by looking for symptoms and testing a player's memory and balance.

Loss of consciousness, being knocked out, occurs in less than 10% of concussions. Loss of consciousness is not needed for a diagnosis of concussion to be made.

While in most cases the onset of symptoms of concussion is immediate or within minutes of the injury, in some cases there is a delayed onset which may be up to 48 hours.

Concussion:

- Is a brain injury.
- Causes disturbance of the brains function.
- Cannot be detected using standard brain scans.
- Must be taken seriously.
- Can occur without loss of consciousness.
- Onset of symptoms may be delayed.
- Most cases recover with physical and mental rest. And takes about 7-10 days.
- In the early stages can be similar to rare but more serious structural brain injury

Young players are more susceptible to concussion and some studies suggest that females are twice as likely to sustain a concussion as males.

Headache Emotional Appearance Drowsiness Confusion Agitated Seizure Ears&eyes

Is concussion serious?

Most people who sustain a concussion do not require any treatment as they normally get better by themselves and recover quickly.

"While the medical term 'traumatic brain injury' can sound serious, the actual extent of damage to the brain is usually minimal and does not usually cause long-term problems or complications." – NHS Choices

While for most the symptoms usually last for a few days, they may last for a few weeks or in a small number of cases longer; when it may be called Post-concussion Syndrome. Research suggests that most adults recover fully by about 7 – 10 days after the initial injury.

During this recovery time however, the brain does appear to be more vulnerable and if another concussion is sustained during this time, the risk of more severe and prolonged symptoms is increased, especially in young players (see below). This is why it is so important to recognise concussion, remove the player immediately from play, and not allow them to return to play until their brain function has returned to normal and they have been medically cleared.

If managed correctly, concussion rarely has serious consequences, and full recovery can be expected. Most doctors would therefore argue that the physical benefits of taking part in contact sports outweigh the potential risks associated with concussion.

The other consideration is the importance of identifying rare but serious head injuries that may initially present in a similar way to concussion. This issue is considered further below.

Is concussion different in young players?

In young players we do need to be more cautious. Because the child and adolescent brain is still developing there is particular concern that concussion can have more of an impact on the brain function, and another concussion occurring before recovery of the first results in prolonged symptoms that can have a significant impact on the child, especially on their education.

There are also reports that in extremely rare and as yet not fully understood cases, this subsequent concussion (if in close proximity to the first, particularly in the same game) may cause potentially **FATAL** rapid brain swelling.

Young Players:

- Are more susceptible to concussion
- Take longer to recover
- Have more significant memory and mental processing issues.
- Are more susceptible to rare but potentially fatal complications of further concussions.

What is therefore of some concern is that our research in young players suggests that boys playing rugby at their school or club frequently do not admit to being concussed and continue to play and train. In our study of 16 - 18 year olds, although 66% felt a concussion was a serious injury, only 44% were aware that there were Regulations that required them to stand down from playing for a period and gain medical clearance before returning to play. Of those who felt that they had been concussed in the preceding two seasons, 66% of this group said that they did not leave the field after that concussion, and 38% said that they did not report their concussion to anyone. Only 10% said that they waited the stipulated IRB stand down period before returning to play.

Players must be encouraged to be honest with themselves, coaching and medical staff for their own protection. Our research shows that young players rely most on their coach for advice and guidance on concussion. Coaches, and other adults involved in rugby therefore

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have a pivotal role in educating young players about concussion, and in making sure it is managed properly.

Can more serious conditions appear like concussion?

Although extremely rare in sport, a blow to the head (direct or indirect) may first appear to be concussion, when in fact there is something more serious going on; such as bleeding or swelling in or around the brain. Sometimes the symptoms of a more serious brain injury do not occur for several hours or days after the initial injury has taken place. If not recognised, these injuries can have very serious consequences and can be fatal. To keep this in context, according to American data on fatal head injuries, the number of deaths in all sports added together resulting from head injury is lower than the number of deaths due to lightning strikes.

All players who are suspected of having concussion must therefore be assessed by a health care professional and children by a doctor. If there are any concerns about a more serious injury then the emergency services should be called to take the player to hospital immediately.

What about repeated concussions?

Because there is considerable variation in the initial effects of concussion, and spontaneous recovery is often rapid, this could increase the potential for players to ignore concussion symptoms at the time of injury and/or return to play prior to full recovery, as was shown in our research. There is an increasing amount of research that suggests that returning to play before complete resolution of the concussion exposes the player to the risk of recurrent concussions that can occur with ever decreasing forces, and result in chronic symptoms of Post-concussion Syndrome. There are therefore concerns that repeated concussion particularly before full recovery could shorten a player's career, significantly interfere with academic performance, and may have some potential to result in permanent neurological impairment. This emphasises the need for prevention, careful management at the time of injury, comprehensive medical assessment and structured follow-up until the concussion has fully resolved. Players who suffer two concussions in any 12 month period are at greater risk of further brain injury and slower recovery and should seek medical attention from practitioners experienced in concussion management via their GP, before return to play.

Repeated concussions:

- Have potentially serious short and long term health consequences.
- Players who suffer two concussions in any 12 month period should seek expert medical opinion before RTP