First Aid and Medical Policy

(including details of staff trained in Paediatric First Aid on page 27 and the administration of medicines on page 10))

This policy is made available to all parents, prospective parents, staff and prospective employees of Hurlingham School on our website, and a hard copy can also be viewed at our School Office.

This policy applies to all activities of Hurlingham School, including the Early Years Foundation Stage.
Children with medical needs have the same rights of admission to our school as other children.

Contents:

1. Policy Statement

1.1.The Health and Safety (First-Aid) Regulations 1981 place a duty on employers to provide adequate First Aid equipment, facilities and personnel to their employees. In its guidance, HSE strongly recommends that employers include non-employees in their assessment of First Aid needs and that they make provision for the needs of visitors to the school site.

1.2. In order to ensure that adequate First Aid provision is provided for staff, pupils, contractors and visitors to the School, it is Hurlingham School's policy that:

1.2.1. a qualified First Aider is available when pupils are present on-site;

1.2.2. sufficient numbers of trained First Aid personnel, together with appropriate equipment, are available to ensure that there is someone competent in basic First Aid techniques who can attend an incident during times when the School is occupied; and

1.2.2. appropriate First Aid arrangements are in place whenever staff and pupils are engaged in offsite activities and visits. Further information can be found in the School's Policy for Educational Visits.

1.3.Teachers' conditions of service do not include giving First Aid, although any member of staff may volunteer to undertake these tasks. The School must ensure that there are sufficiently trained staff to meet the statutory requirements and assessed needs.

2. Practical Arrangements at the Point of Need (Emergency Procedures)

2.1. Ambulance

2.1.1. If the first member of staff present at an incident judges that an ambulance should be called, he or she should do so immediately, by calling the emergency services on 999, without hesitation and without waiting for the First Aider to arrive at the scene. If necessary, a First Aider should be summoned (see 2.3 below).

2.1.2. Staff should always call an ambulance if there is:

- a serious injury or illness;
- serious breathing difficulty;
- any significant head injury;
- major bleeding;
- a period of unconsciousness (excluding a faint);
- a severe burn; or
- an obvious fracture or dislocation.

2.1.3. Whenever possible, an adult should remain with the casualty until help arrives and other staff can be called upon to help with moving away any pupils present.

2.1.4. If an ambulance is called, the receptionist should be notified immediately in order to be able to direct the ambulance crew to the casualty's location.

2.1.5.Parents/next of kin of the casualty should be notified and a responsible adult should go to hospital with the casualty.

2.2. Other Incidents

2.2.1. For all other illnesses and accidents a pupil should either be taken immediately to the Medical Room either by an adult or a responsible friend if judged appropriate by the supervising member of staff.

2.2.2. If the condition involves the pupil feeling dizzy or unstable then a first aider should be sent for. Under no circumstances should the pupil walk to the Medical Room as injury may occur on route. The pupil should be laid on the floor of the classroom with their legs raised as necessary.

2.3. Contacting a First Aider

2.3.1. The Primary First Aider (Scott Stanley) can be contacted via his mobile number 07949 167519.

2.3.2. Alternatively the member of staff should ask anther adult to make contact either in person or by telephone with the school office who will arrange for a first aider to attend.

2.3.3. In the event that there is only one adult present and that person needs to remain with the ill or injured person, they should arrange for one of the pupils to take the red 'Please Come Now' cards (located on the wall by the door of every room and detailing the location) to the school office who will arrange for help.

2.4. Informing Parents/next-of-kin

2.4.1.If an ambulance is called, parents or next-of-kin will be notified as soon as possible.

2.4.2. All serious or significant incidents are reported to the parents at the earliest opportunity by telephone where possible.

2.4.3 Minor injuries are also communicated to the parents, by email, including details of the injury and any treatment given. If a pupil receives medical attention for an injury that the first aider considers should receive further care or observation, a member of the school office staff will telephone and email the parents or carers.

2.4.3.Following a head injury (except the most minor), parents are informed by telephone as necessary and a separate head injury advice letter on adverse reactions to look out for is also sent home.

2.4.4 If any medication has been given, an email is sent to the parent giving details of the date, time and quantity of medication given as well as the person who administered it. The School will telephone parents of pupils in Reception prior to administering any O.T.C medication to confirm that they are happy for us to do so and to confirm whether or not any medication was administered at home prior to coming to school (see 8.1.3. below for administering of OTC medications).

All staff must be aware that they can call an ambulance at any time if they feel it to be appropriate irrespective of whether they are a school first aider. If they are in any doubt whatsoever about the need to do so, they should always err on the side of caution and call an ambulance.

3. Responsibility under the policy

3.1. The **Principal** (*on behalf of the Directors of the Hurlingham School Company Limited*) has overall responsibility for the First Aid Policy both within our school premises and during off-site activities or trips and for ensuring that:

- first aid is administered in a timely and competent manner;
- in line with the Health and Safety at Work Act 1974 (HSWA to ensure that a Health and Safety policy is in place and included within this are the arrangements for first aid based upon ongoing risk assessment;
- the statutory requirements for provision of first-aiders have been met, that appropriate training is provided and correct procedures are followed in line with the DfE "Guidance on First Aid".

3.1.1.The **Principal** is responsible, through the Headmaster and members of staff to whom she gives delegated authority, for:

3.1.2. putting the policy into practice and for ensuring that detailed procedures are in place;

3.1.3. ensuring that parents are aware of the school's Health and Safety Policy, including the arrangements for First Aid, by making both policies available on the school's website; and

3.1.4. overseeing the adequacy of First Aid cover including organization of qualified staff training programmes and equipment.

3.1.5. reviewing the School's First Aid Policy in consultation with the Health and Safety Committee; and

3.1.6. reviewing the operation of the First Aid Policy to determine any changes that might be required to the School's First Aid provision.

3.1.7. organising and carrying out First Aid training for staff following advice;

3.1.8. ensuring that an up to date lists of qualified First Aiders is kept at Reception and that Schedule 1 to this Policy and the relevant section of the Staff Handbook is updated regularly;

3.1.9 ensuring that Code Red posters and cards are updated and located in the Staff Room, Medical Room, Sports Office, Arts Center, Kitchen and in the individual classrooms of pupils included on the posters;

In practice, however, the Headmaster is responsible for ensuring that our First Aid Policy is put into practice and for developing detailed procedures.

3.4. The **Headmaster**, in consultation with the Principal and Health and Safety Committee is responsible for:

3.4.1. assessing the First Aid needs throughout the school;

3.4.2. deciding on First Aid issues with the Deputy Head and the Principal;

3.4.3. ensuring that suitable numbers of First Aiders are available when pupils are on-site and for events out of hours providing First Aid cover during normal school hours;

3.4.4. ensuring that appropriate arrangements are followed for off-site activities/trips and out of hours activities.

3.4.5 staff are aware of the procedures set out in this policy and, where appropriate, the location of the nearest First Aid kits; and

3.4.6. risk assessments, especially for practical work, take account of First Aid Procedures; and

3.4.7. if specified in risk assessments, emergency action such as immediate flushing and cooling for burns
is carried out without waiting for a qualified first aider to arrive on the scene.

3.4.8. making reports under RIDDOR where appropriate (see paragraph 16.3 below)

3.5 The **Appointed Person** is the School's receptionist **Christine Turner.** She is responsible for:

3.5.1. maintaining accurate records of first aid or any treatment given in the Medical Room in the accident book and entering that information into the accident record on the School Database;

3.5.2. organising the ordering, provision and replenishment of First Aid equipment to ensure that First Aid boxes and kits are adequately stocked at all times.

3.4.6. checking the off-site PE First Aid kits at the beginning of each term (the PE department are then responsible for re-stocking the kits as needed, with supplies provided by the appointed person).

3.4.7.checking the Emergency Asthma kits at the beginning of each term and after each occasion when they have been used.

3.4.8. ensuring that the Code Red Posters detailing pupils with existing conditions that require prompt action such as severe allergies, asthma, epilepsy and diabetes are kept up to date and posted on the Staff Room board and also in the kitchen area, Sports Department, Arts Centre and in the classrooms of any pupils detailed on it.
The poster must be available for staff from the beginning of term and before they meet their classes.

3.4.9. maintaining records of accidents.

3.7. **Sports Staff** are responsible for:

3.7.1. ensuring that First Aid kits are taken on all home/away matches and also during practice sessions;

3.7.2. restocking the off-site PE First Aid kits on an ongoing basis, in liaison with the Appointed Person (who will stock the kits at the start of each term and provide supplies for restocking);

3.7.3. ensuring that they have spare Epi Pens, asthma inhalers and any other medication for pupils who require them on home and away matches and checking that such pupils are also carrying their own medication where appropriate ie. asthma inhalers; and

3.7.4. liaising with the appointed person to ensure that they have up-to-date awareness and knowledge of the medical needs of the pupils they teach.

3.9.**All staff** have a duty of care towards pupils and should respond accordingly when First Aid situations arise; they should:

3.9.1.familiarise themselves with the Code Red Posters on the board in the Staff Room detailing pupils with medical needs that require the use of Epi Pens and pupils who could require First Aid due to medical conditions such as severe asthma, epilepsy, allergies and diabetes;

3.9.2. familiarise themselves with the list of qualified First Aiders kept at Reception and on the board in the Staff Room, and at Schedule 1 to this policy; and

3.9.3. understand that in general the consequences of taking no action are likely to be more serious than those of trying to assist in an emergency

4. Provision of First Aid, Appointed Persons and First Aiders

4.1. Provision of First Aid personnel

4.1.1. The School has a well-equipped Medical Room. The Medical Room is open during the school day and is fully equipped to deal with minor accidents and injuries.

4.1.2. A qualified First Aider will be on site at all times when children are present and, with regard to EYFS, a Paediatric First Aider will always be on site when children of Reception age are in the school building.

4.1.3. A Paediatric First Aider will always be present on trips involving EYFS pupils.

4.1.4. Anyone needing to contact a First Aider should contact the School office to find out their location.

4.1.5. For events held outside normal school opening hours, the event organiser must ensure that a qualified First Aider is available.

4.1.6.Appropriate First Aid arrangements are in place whenever staff and pupils are engaged in off-site activities and visits. Further information can be found in the School's Policy for Educational Visits.

4.1 Qualifications and Training

4.1.1. Primary First Aider

Our School's primary first aider is currently **Scott Stanley.**
His First Aid at Work training is valid for three years and he received refresher training and re-testing of competence up to three months *before* his certificate expire will be arranged by us.

4.1.2. First Aiders

Although most normal incidents on site during the school day are dealt with by the office staff, all members of the teaching and most of the ancillary staff also receive certified general first aid training in school every 2-3 years by an external organisation whose training and qualifications are approved by the HSE.

The purpose of this is to ensure that at any time the children are accompanied or near to someone with basic first aid skills. These include:

- what to do in an emergency
- cardio-pulmonary resuscitation (including the use of a defibrillator)
- first aid for the unconscious casualty
- first aid for the wounded or bleeding

The duties of a first aider are to:

- give immediate help to casualties with common injuries or illnesses and those arising from specific hazards at school
- ensure (when necessary) that an ambulance or other professional medical help is called.

4.1.3. Paediatric First Aiders

Members of staff who have regular contact with pupils in EYFS are trained specifically in paediatric first aid. An up-to-date list of all members of staff who hold a paediatric first aid qualification is located on the notice board in the Early Years Reception.

Please see Schedule 1 for the list of staff trained in First Aid for the current academic year.

4.2. Records

All training certificates are kept in the Staff Training file and a record of first aiders and certification dates on our School database which automatically generates an alert notice to warn of any qualifications which are due to expire.

An up-to-date list of all members of staff who hold a first aid qualification are is located on the wall in the School medical room.

Members of staff also receive additional training, when required, in order to support pupils with specific medical needs such as Diabetes.

5. First Aid Materials, Equipment and Facilities

Wherever possible, children should be treated in the Medical Room on the ground floor.
All staff should be aware that there is now a defibrillator on the rear of the medical room door with clear instructions on how to operate it contained within.

5.1. The Medical Room

The medical room is situated directly adjacent to the School office. The room contains:

- a medical examination bed, chair, small fridge
- a defibrillator
- a locked cabinet containing over the counter medication (prescription medicine is usually stored in the fridge)
- a cabinet containing first aid supplies as well as individual and spare asthma inhalers, epi-pens and insulin.
- the accident book, medical consent forms, staff medication book and 'code red' (see below) pupil information.

It has an interconnecting WC with wash-hand basin and bidet. The appointed person is responsible for ensuring that the medical room is thoroughly stocked and that it is kept clean and tidy.

5.2. Travelling First Aid Packs

Any member of staff leaving the building with children, whether to go to the park or on an outing, must take a travelling first aid pack *(available from Christine Turner in the School office).*
Travelling first aid packs must contain:

- a leaflet giving general advice on first aid;
- the school's spare asthma inhaler;
- six individually wrapped sterile adhesive dressings;
- one large (approx 18cm x 18cm)sterile individually wrapped un-medicated wound dressings;
- two triangular bandages;
- two safety pins;
- individually wrapped moist cleaning wipes;
- one pair of disposable gloves;
- one mobile telephone (teacher's own).
- **Record cards for any children who have been designated as 'code red' as a result of a medical condition with details of what to do in the event of a medical emergency.**
- **Any specific emergency medical treatment for individual children ie. epi-pens and ventolin.**

We also advise members of staff that, when going on an outing by coach, a supply of sick bags should be included in the first aid pack. An emergency first aid box is also located in the school minibus in addition to the travelling pack.

When children in the Early Years Foundation Stage (Reception) are on an outing, at least one adult accompanying the trip will hold a current paediatric first aid certificate.

5.3 First Aid boxes

Careful consideration had been given to the positioning of first aid boxes within the school.
Emergency first aid boxes are also located in the following locations:

- Box 1 : Wall adjacent to the lift at first floor
- Box 2 : Wall adjacent to the lift at second floor
- Box 3 : Wall adjacent to doors into playground in 'garden room'.
- Box 4 : School kitchen
- Box 5 : Car park lobby

6. Hygiene and Infection Control
All Parents are asked to read our Sick Child Policy prior to their child joining our School. This contains guidance about how long a child should be kept at home if they are ill to minimise the spread of the illness. If we feel that this policy has not been adhered to by a parent, and a sick or potentially infectious child is sent into School, then we will ask for the child to be collected and kept at home until it is safe for them to return. **If there is any doubt, we will request confirmation from the child's GP that there is no further risk of infection to other children or staff.**

All staff should take precautions to avoid infection and must follow basic hygiene procedures. **Staff must use single-use disposable gloves and hand washing facilities, and should take care when dealing with blood or other body fluids and when disposing of dressings or equipment.** Wherever possible, staff should also wear disposable aprons. In some circumstances, when airborne infection is a possibility (eg flu pandemic), the wearing of a mask will also be appropriate. All staff must have read and be familiar with our policy for the management of HIV/AIDS in schools. *(See our Policy for HIV/AIDS)*

Body fluid disposal packs are located in the Medical Room and should be used when dealing with the cleaning up of blood or other body fluids including vomit.

Any additional cleaning cloths used in connection with the above must be disposed of and any mop heads should be thoroughly rinsed, and soaked in Milton disinfectant. The mop and bucket for use **exclusively** in connection with body fluids and blood is **GREEN. These can be found in the staff toilets on the 1st & 2nd floors and in the laundry cupboard on the ground floor.**

Under no circumstances is the School kitchen to be used for the cleaning of or disposal of anything which has been used in connection with the above. Water in the bucket should be disposed of down the toilet and the sink in the laundry room should be used for any associated laundry.

Staff should report any highly infectious diseases (even if they are only suspected and not confirmed) to the Head and School office so that notification can be sent home to parents where appropriate or parents can be contacted and asked to collect their child and seek medical advice. *(see our 'Flu pandemic policy')*

The same applies to the discovery of head lice/nits; staff should report any suspected cases to the School office who will contact the parents. Only in serious cases, or if the parents have previously been informed of an infestation and failed to act, will they be asked to collect the child. In all other cases, parents will be contacted and asked to treat their child in the evening, before returning them to School. Parents of all children in that class will be notified via letter that a case has been identified.

7. Information

7.1 Pupil Information

7.1.1. General Medical Information
We hold medical information on all our pupils in order to ensure that we can provide appropriately for their needs, or look after them if they are injured or have an accident. All parents are required to complete a medical questionnaire **(HS MED 5)** before their child joins the school. This information is in kept in each child's folder and on our School database from which a summary card is printed and kept readily accessible in the School office. These cards list details of any pre-existing medical conditions and allergies which may need to be taken into account when assessing a child's injury or illness as well as contact details for the child's parent/guardian or named contact. Details of any specific food allergies dietary requirements are provided to the kitchen staff and relevant teaching staff.

All parents are asked to complete a First Aid Consent Form **(HS MED 4)** and Permission for Emergency Treatment Form **(HS MED 3)** prior to their child joining the school.

7.1.2. Details of Medical Conditions

Children with pre-existing medical conditions are allocated a 'traffic light system' colour code depending on the severity or potential severity of their condition.

Red - Potentially life threatening
Amber – Moderate risk
Green – low risk

All children designated 'code red' have a photographic record card which identifies their medical condition and gives basic advice on what to do in the event of a medical emergency. These are displayed on the walls of the staff room and medical room and there are also copies of these in any medical bags which accompany the children off site. These children are also clearly identified using the same traffic light system on our School database.

7.2 Staff Information

All members of staff are required to complete a pre-employment medical questionnaire. Any important medical information is then entered into the school database and also displayed on the individual staff record cards in the School Office in case of an emergency.

Staff are aware of the need to inform the School Office of any significant (life threatening) medical conditions which develop during their employment so that appropriate action can be taken in the event of a medical emergency.
All members of staff working with pupils in EYFS are also aware of their responsibility to record any medication they take, whilst in contact with pupils during the school day, in the record book retained by the Deputy Head of Lower School.

8. Medical Needs in General

Most children will at some time have **short-term medical needs**, perhaps entailing finishing a course of medicine such as antibiotics (see paragraph 8.1.4.below).

Some children, however, have **long term medical needs** and may require medicines on a long-term basis to keep them well, for example children with well-controlled epilepsy, cystic fibrosis or diabetes.
Parents are asked to inform the Headmaster of any particular needs before a child is admitted, or when a child first develops a medical need.

It is important to have sufficient information about the medical condition of any child with long-term medical needs. This is so that we can ensure that the existing staff are able to fully support that child as, if a child's medical needs are inadequately supported, this may have a significant impact on a child's experiences and the way they function in or out of school.

If a child has a medical condition which necessitates regular access to medication, or monitoring, we will always try to ensure that an appropriate regime can be devised.
It is often helpful to develop a written health care plan for such children, involving the parents and relevant health professionals as this can help staff identify the necessary safety measures to support children with medical needs, ensuring that they, and others, are not put at risk.
The Headmaster and or Principal will then ensure that the relevant academic and pastoral staff is informed, in confidence, of these medical needs and will sometimes also arrange some additional medical training for those staff.

Some medical conditions may be classed as a disability. The Headmaster will consider what arrangements can reasonably be made to help support a pupil (or prospective pupil) who has a disability. Where necessary we will seek advice from local health professionals to determine if reasonable adjustments can be made within the

existing School setting, and by utilising the existing School staff, to ensure that disabled pupils are not put at a substantial disadvantage in comparison to those who are not disabled.

Others may require medicines only in particular circumstances, such as children with severe allergies who may need an adrenaline injection. Children with severe asthma may have a need for daily inhalers and additional doses during an attack. *(see sections 11 and 14 for more details on asthma and anaphylaxis)*

Most children with medical needs are able to attend school regularly and can take part in normal activities, sometimes with some support. However, staff will need to take extra care in supervising some activities to make sure that these children, and others, are not put at risk. Our policy for Long Term Medical needs is detailed below.

8.1. Supporting Children with Short Term Medical Needs (including the Administration of Medicines)

8.1.1. If a Child Becomes Ill while in our Care:
We will always try to contact the parents if a pupil suffers anything more than a trivial injury, or if he or she becomes unwell during school day, or if we have any worries or concerns about his or her health. We will ask parents to collect their child if he or she becomes ill during the school day.

8.1.2. Emergency Medical Treatment
However, in accepting a place at the school, parents are required to authorise the Headmaster, or a senior member of staff acting on her behalf, to consent, on the advice of an appropriately qualified medical specialist, to a pupil receiving emergency medical treatment, including general anesthetic and surgical procedure under the NHS, if we are unable to contact the parents or guardians in time. .

8.1.3. Administering of Over the Counter (O.T.C.) Medicines to Pupils
With parental consent, we will apply or supervise the application of lotions, in particular sunscreens or allergy creams and an antihistamine such as Piriton to children who suffer from hay-fever.

We keep a supply of some O.T.C. medicines. **These are kept in one of the locked silver cupboards in the medical room at all times and are only administered by appointed, trained staff.**
All parents are required to complete an Authority for the Administering of O.T.C. Medicines form **(HS MED 1)** when a child joins the school. By completing this form, parents may (if they wish) give consent for office staff or teachers to administer Calpol, Nurofen and Arnica in the event that a child becomes ill (particularly with a high temperature) and only if we are unable to contact the parents or if the parents are delayed in coming to collect their child.
Completed forms are kept in Children's individual files.
A list of those children to whom we are not permitted to administer the aforementioned O.T.C.s is on the wall in the medical room and is checked prior to the administration of any medicine.
Parents will always be notified by email if their child has been given medication at school together with details of the time and amount given will be sent home with the child. The School will telephone parents of pupils in Reception (EYFS) prior to administering any O.T.C medication to confirm that they are happy for us to do so and to confirm whether or not any medication was administered at home prior to coming to school.

8.1.4. Medicines and Treatments brought to School by Pupils
Medication should only be given at school when absolutely essential.

- Cough medicines, anti-histamine and antibiotics (if prescribed by a doctor) will be administered, only when the child is otherwise fit for school.
- Parents must bring the medication to the School office and complete the relevant form **(HS MED 2)** when the child comes to school. On no account should children be given the medication to administer themselves. On no occasion will the school administer medication without the written permission from the pupil's parent or guardian.
- Parents are responsible for collecting the medication at the end of the day if it is needed.

- **Medicines that have been taken out of the container as originally dispensed will not be administered and nor will the School make changes to dosages displayed on the bottle on parental instructions.**
- If a child refuses to take medicine, staff will not force them to do so, but will note this in the records and telephone the parent / guardian.
  (See our Policy for Short Term Administration of Medicines)

8.1.5. Medicines and Treatments brought to School by Staff

- Medication may only be brought in to school if it is stored securely and out of the reach of children. If taking medication staff must seek the advice of their doctor to ensure that the medication will not impede their ability to do their job in a safe and satisfactory way.
- Staff in Reception must notify the Headmaster or Principal if they take any medication (including over-the-counter products) whilst teaching. They must also make a note of the medication taken in the medication book situated in the medical room.

8.1.6 Administration to save a life.

- In extreme emergencies e.g. an anaphylactic reaction, certain medicines can and will be given or supplied without the direction of a medical practitioner, for the purpose of saving life.
- For example, the administration of adrenaline by injection (1:1000), chlorpheniramine and hydrocortisone are among those drugs listed under Article 7 of the Prescription Only Medicines (Human Use) Order 1997 for the administration by anyone in an emergency for the purpose of saving life.
- Where there is a written protocol for dealing with an emergency, this will be followed. Epi-pens, inhalers and insulin are kept in the Medical Room as well as in the sports or outing bags.
- In the event that a child who has been prescribed Ventolin or an Epi-pen is not able to locate their device, for whatever reason, a member of staff may take the decision to administer another child's device of the same type or dosage.

8.1.7. Legal Position
Medicines Act 1968

- The Medicines Act 1968 specifies the way that medicines are prescribed, supplied and administered within the UK and places restrictions on dealings with medicinal products, including their administration. Anyone may administer a prescribed medicine, with consent, to a third party, so long as it is in accordance with the prescriber's instructions. This indicates that a medicine may only be administered to the person for whom it has been prescribed, labelled and supplied; and that no-one other than the prescriber may vary the dose and directions for administration.

- The administration of prescription-only medicine by injection may be done by any person but must be in accordance with directions made available by a doctor, dentist, nurse prescriber or pharmacist prescriber in respect of a named patient.

There is no legal or contractual duty on staff to administer medicine or supervise a child taking it. Support staff may, however, have specific duties to provide medical assistance as part of their contract. Of course, swift action needs to be taken by any member of staff to assist any child in an emergency.

Anyone caring for children including teachers and other school staff in charge of children have a common law duty of care to act like any reasonably prudent parent. Staff need to make sure that children are healthy and safe. In exceptional circumstances the duty of care could extend to administering medicine and/or taking action in an emergency. This duty also extends to staff leading activities taking place off site, such as visits, outings or field trips.

Although there is no legal requirement for schools to keep records of medicines given to pupils, and the staff involved, it is our policy to do so. Records offer protection to staff and proof that they have followed agreed procedures.

9. Supporting Children with Long Term Medical Needs

We promote inclusion and will take all reasonable steps to ensure that children with a disability or SEN are not discriminated against or treated less favourably than other pupils. We work in partnership with the family and other agencies in the best interests of the pupil and to maximise educational opportunity.

Children with complex health needs have the same rights of admission to school as other children, and cannot generally be excluded from school for health reasons. In certain circumstances, eg where there is a risk to health and safety of staff or other pupils, children can be removed from school for health reasons. This, however, is not exclusion.

Some children may have medical needs which include allergic reactions, anaphylaxis, asthma, diabetes, epilepsy, hepatitis and HIV. These pupils have complex health needs that require more support than regular medicine. We will seek medical advice about each child or young person's individual needs.

In accordance with Part 4 of the DDA, we **will not discriminate** against disabled pupils in relation to their access to education and associated care – a broad term that covers all aspects of school life including school trips and school clubs and activities.

It is our policy to make reasonable adjustments for disabled children including those with medical needs at different levels of school life, and for the individual disabled child to be considered in our School's practices, procedures and policies.

We are not required to provide auxiliary aids or services or to make changes to physical features of the School. Nevertheless, we plan strategically to increase access, over time, in the School. This includes planning to increase access to the school premises, to the curriculum and providing written material in alternative formats to ensure accessibility.

Our School is fully compliant with disability access requirements.

The Special Educational Needs (SEN) Code of Practice 2001 advises that a medical diagnosis or a disability does not necessarily imply SEN. It is the child's educational needs rather than a medical diagnosis that **must** be considered.

These factors will all be taken into consideration when determining whether or nor the school will be able to educate and develop the prospective pupil to the best of his or her potential and in line with the general standards achieved by the pupil's peers.

It is essential that we are given sufficient information about the medical condition, what signs or symptoms we should look for, if any, and how we should react.

In most cases, we are happy to administer medication in accordance with the School's Policy for Short Term Administration of Medicines.

A written record is kept each time medicines are given. Children with a health care plan will generally have their own book for recording any medication given and other observations and medical notes. Comprehensive records such as these are vital as they help demonstrate that staff have exercised a duty of care. Although not a legal requirement, we believe it is good practice to have the dosage and administration of all medicines witnessed by a second adult and staff are expected to adopt this policy unless special circumstances make it impossible to do so.

9.1. Self-Management

It is good practice to support and encourage children, who are able, to begin to take responsibility to manage their own long-term medication (eg Ventolin) from a relatively early age and our school will encourage this if we

feel that it is appropriate and does not pose a health and safety risk to that child or others. The age at which children are ready to take care of, and be responsible for, their own medicines, varies and each case will be assessed individually.

9.2. Educational Visits
Whenever we consider it practical and safe to do so, children with medical needs will be encouraged to participate in safely managed visits.

Risk assessments are carried out for all trips and the level of reasonable adjustments required to enable children with medical needs to participate fully and safely on visits will be factored in.

If necessary, additional safety measures will be taken for outside visits. It may be that an additional supervisor, a parent or another volunteer might be needed to accompany a particular child. Arrangements for taking any necessary medicines will also be taken into consideration.

Staff supervising visits are always made aware of any medical needs, and relevant emergency procedures. A copy of any health care plans is taken on visits in the event of the information being needed in an emergency. A paediatric first aider will always accompany EYFS pupils on educational visits

If staff are concerned about whether they can provide for a child's safety, or the safety of other children on a visit, they should seek parental views, medical advice and discuss all of their concerns in detail with the Headmaster and / or the Principal.

9.3. Sporting Activities
Most children with medical conditions can participate in physical activities and extra-curricular sport. There is sufficient flexibility for all children to follow in ways appropriate to their own abilities. For many, physical activity can benefit their overall social, mental and physical health and well-being. Any restrictions on a child's ability to participate in PE will be recorded in their individual health care plan.

Some children may need to take precautionary measures before or during exercise, and may also need to be allowed immediate access to their medicines such as asthma inhalers.

Staff supervising sporting activities will consider whether additional risk assessments are necessary for some children, be aware of relevant medical conditions and any preventative medicine that may need to be taken and emergency procedures.

9.4. Confidentiality regarding disabilities
In accordance with the Disability Discrimination Act, in deciding what sort of reasonable adjustments to make, we will take into account a request for confidentiality as to the nature or the existence of a child's disability, both from the child's parents; and from the child, if the school is satisfied that the child understands the nature and the effect of the request for confidentiality.

The legislation recognises that a request for confidentiality may limit the reasonable adjustments that a school can make. The child's safety will always be our first consideration. If a request for confidentiality meant that staff taking pupils on a trip could not be informed of the nature of a child's condition, and if ignorance of the child's condition could put the child at risk, we might not be able to include the pupil on that trip.

In practice, the very reasons that parents may request confidentiality relate back to concerns that information might not be used sensitively to support their child, or that their child might be singled out in some way. We recognize that parents' concerns are likely to be heightened where there is a social stigma attached to the child's health condition.

We will seek to reassure parents that information that they share with us will be handled sensitively.

In the light of the Children Act 2004, establishing protocols for sharing information with health, social care and education professionals will become routine practice. What is essential is that the issues of confidentiality, stigma, who needs to know and why, are at the forefront of any decision to share information on an HIV infection. It is paramount that the child and parents are involved in these decisions.

9.5. Roles and Responsibilities
It is important that responsibility for child safety is clearly defined and that each person involved with children with medical needs is aware of what is expected of them. Close co-operation between ourselves (the School), parents, health professionals and other agencies will help provide a suitably supportive environment for children with medical needs.

9.6. Parents and Carers
They should, jointly with the Headmaster, reach agreement on our role in supporting their child's medical needs, in accordance with our Medical Policy. Whenever practicable, the Headmaster will seek parental agreement before passing on information about their child's health to other staff, although parents should understand that there may be circumstances where this is not possible if we are to act in the best, immediate, interest of the child or others. Sharing information is important if staff and parents are to ensure the best care for a child.

9.7. The School
We will:

- support staff to use their best endeavours at all times, particularly in emergencies. In general, the consequences of taking no action are likely to be more serious than those of trying to assist in an emergency
- arrange for NHS Primary Care Trusts (PCTs) or other bodies to provide any necessary training for staff in the management of medicines and policies about administration of medicines. (Complex medical assistance is likely to mean that the staff will need more specialised training).

The Headmaster will need to agree with the parents exactly what support can be provided. Where parents' expectations appear unreasonable, the Headmaster will seek advice from the child's GP or other medical advisers. The Headmaster will be responsible for deciding if we are able to provide the appropriate support on a case by case basis.

Staff who follow documented procedures will be fully covered by our public liability insurance, should a parent make a complaint.

9.8. Teachers and Other Staff
We recognize that some staff may be naturally concerned for the health and safety of a child with a medical condition, particularly if it is potentially life threatening. Staff with children with medical needs in their class or group will be informed about the nature of the condition, and when and where the children may need extra attention. The child's parents and health professionals will be expected to provide this information and it will be included in the child's Health Care Plan**.** *(See Paragraph for guidance on Drawing up a Health Care Plan)*

All staff are made aware of the likelihood of an emergency arising and what action to take if one occurs. Back up cover is arranged for when the member of staff responsible is absent or unavailable. At different times of the day other staff may be responsible for children, such as lunchtime supervisors. They are also provided with training and advice.

9.9. School Staff Giving Medicines
We understand the importance of taking medicines as prescribed. All staff understand that there is no legal or contractual duty for any member of staff to administer medication or supervise a pupil taking medication unless they have been specifically contracted to do so. Where specific training is not required, any member of staff may administer prescribed and non-prescribed medicines to our pupils with parental consent.

Administration of medication which is defined as a controlled drug (even if the pupil can administer it themselves) should be done under the supervision of a member of staff.Any member of staff who agrees to accept responsibility for administering prescribed medicines to a child will be given appropriate training and guidance. They are also made aware of possible side effects of the medicines and what to do if they occur. The type of training necessary will depend on the individual case.

In the event that we agree to administer certain medicines on a long term basis, the Headmaster will complete a '**Confirmation of the Headmaster's agreement to administer medicine' Form (HS MED 8)**

9.10. Storage

- Children should know where their own medicines are stored and who holds the key. The Headmaster is responsible for making sure that medicines are stored safely.
- **All emergency medicines, such as asthma inhalers and adrenaline pens, should be readily available to children and should not be locked away.** In some cases, children are permitted to carry their own inhalers.
- Other non-emergency medicines should be kept in the locked cupboard in the Medical Room where they are not accessible to children.
- A few medicines need to be refrigerated. These are to be kept in the refrigerator in the Medical Room.
- It is the parent's responsibility to ensure new and in date medication comes into school on the first day of the new academic year and is replaced accordingly thereafter.

Sharps boxes are always to be used for the disposal of needles. Sharps boxes can be obtained by parents on prescription from the child's GP or pediatrician. Collection and disposal of the boxes should be arranged with the Local Authority's environmental services or with the parent.

9.11. Health Professionals

Some children with medical needs receive dedicated support from specialist nurses or community children's nurses, for instance a children's oncology nurse. These nurses often work as part of a NHS Trust or PCT and work closely with the primary health care team. They can provide advice on the medical needs of an individual child, particularly when a medical condition has just been diagnosed and the child is adjusting to new routines. We will work closely with Healthcare professionals to ensure children with long term medical needs are well supported at our School.

10. Allergies and Dietary Needs

Parents are requested to notify school of any special dietary requirements for health or religious reasons. School offers an alternative vegetarian menu.
Wherever possible, for children with other special dietary requirements, we try to provide an alternative which is prepared in the School kitchen.
School menus are displayed in the Avenue and on our School website a week in advance to help parents plan supplementary foods or alternatives to send into school on such days as the menu is unsuitable due to a child's dietary needs, in the event that we are unable to provide an alternative.

We operate a 'NO NUTS' policy and children are given a list of prescribed snacks which they are allowed to bring into school for break. The School provides a home-cooked nut-free snack for children staying to late sport. Children with specific allergies may bring in an alternative to this.

10.1. Guidance on Food Allergies

Severe allergic reactions are relatively rare and most commonly caused by only a handful of foods. The following food allergens have been identified as public health concerns in the UK:-

• Peanuts (also called ground nuts)
• Nuts (almond, hazelnut, walnut, cashew, pecan nut, Brazil nut, pistachio nut, macadamia nut and Queensland nut)
• Fish
• Shellfish

- Sesame seeds
- Eggs
- Dairy Products
- Gluten
- Soya Beans
- Celery
- Mustard
- Sulphur dioxide and Sulphites

Some people also need to avoid certain foods because of coeliac disease, a life-long auto-immune disease caused by an intolerance to gluten. At least 1 in 100 people need to avoid gluten. People with this disease need to avoid wheat, rye, barley, oats, spelt and kamult.

10.2. Guidance and Legislation

In November 2005 guidance was produced by the Food Standards Agency on allergy management and consumer information. This is the best practice guidance on managing food allergies with particular reference to avoiding cross- contamination and using appropriate advisory labelling (e.g. may contain labelling).

The Catering manager will play close attention to manufacturer's labelling regarding allergens when preparing food for pupils with allergies to certain foods.

10.3. Recognising Allergies

Allergic reactions vary. There can be an itching or swelling in the mouth, or an itchy rash all over the body. The person affected may feel sick and may actually be sick, although remember that other conditions can also cause vomiting. The initial symptoms may not be serious in themselves, but the child should be watched very carefully in case the situation becomes worse.

Symptoms usually occur after seconds or minutes, and may progress rapidly. Occasionally they begin a few hours after contact with the allergenic food or substance.

Serious symptoms include a severe drop in blood pressure, where the person affected goes weak and floppy; severe asthma; or swelling that causes the throat to close. **This is a medical emergency**.

In all cases where an allergic reaction is suspected, an ambulance must be called.

11. Asthma
What is Asthma?

Asthma is common and appears to be increasingly prevalent in children and young people. One in ten children have asthma in the UK.

The most common symptoms of asthma are coughing, wheezing or whistling noise in the chest, tight feelings in the chest or getting short of breath. Younger children may verbalise this by saying that their tummy hurts or that it feels like someone is sitting on their chest. Not everyone will get all these symptoms, and some children may only get symptoms from time to time.

However, in early years settings staff may not be able to rely on younger children being able to identify or verbalise when their symptoms are getting worse, or what medicines they should take and when. It is, therefore, imperative that early years and primary school staff, who have younger children in their classes, know how to identify when symptoms are getting worse and what to do for children with asthma when this happens. This should be supported by written asthma plans, asthma school cards provided by parents, and regular training and support for staff. Children with significant asthma should have an individual health care plan.

Medicine and Control

There are two main types of medicines used to treat asthma, relievers and preventers. Usually a child will only need a reliever during the school day. **Relievers** (blue inhalers) are medicines taken immediately to relieve asthma symptoms and are taken during an asthma attack. They are sometimes taken before exercise**.** Whilst **Preventers** (brown, red, orange inhalers, sometimes tablets) are usually used out of school hours.

Children with asthma need to have immediate access to their reliever inhalers when they need them. Inhaler devices usually deliver asthma medicines. A spacer device is used with most inhalers, and the child may need some help to do this. It is good practice to support children with asthma to take charge of and use their inhaler from an early age, and many do.

Children who are able to use their inhalers themselves should be allowed to carry them with them. If the child is too young or immature to take personal responsibility for their inhaler, staff should make sure that it is stored in a safe but readily accessible place, and clearly marked with the child's name. Inhalers should always be available during physical education, sports activities and educational visits.

For a child with severe asthma, the health care professional may prescribe a spare inhaler to be kept in the school or setting.

The signs of an asthma attack include:

- coughing
- being short of breath
- wheezy breathing
- feeling of tight chest
- being unusually quiet

When a child has an attack they should be treated according to their individual health care plan or asthma card as previously agreed. An ambulance should be called if:

- the symptoms do not improve sufficiently in 5-10 minutes
- the child is too breathless to speak
- the child is becoming exhausted
- the child looks blue

It is important to agree with parents of children with asthma how to recognise when their child's asthma gets worse and what action will be taken. An Asthma School Card (available from Asthma UK) is a useful way to store written information about the child's asthma and should include details about asthma medicines, triggers, individual symptoms and emergency contact numbers for the parent and the child's doctor.

A child should have a regular asthma review with their GP or other relevant healthcare professional. Parents should arrange the review and make sure that a copy of their child's management plan is available to the school or setting. Children should have a reliever inhaler with them when they are in school or in a setting.

Children with asthma should participate in all aspects of the school or setting 'day' including physical activities. They need to take their reliever inhaler with them on all off-site activities. Physical activity benefits children with asthma in the same way as other children. Swimming is particularly beneficial, although endurance work should be avoided. Some children may need to take their reliever asthma medicines before any physical exertion. Warm-up activities are essential before any sudden activity especially in cold weather. Particular care may be necessary in cold or wet weather.

Reluctance to participate in physical activities should be discussed with parents, staff and the child. However children with asthma should not be forced to take part if they feel unwell. Children should be encouraged to recognise when their symptoms inhibit their ability to participate.

Children with asthma may not attend on some days due to their condition, and may also at times have some sleep disturbances due to night symptoms. This may affect their concentration. Such issues should be discussed with the child's parents or attendance officers as appropriate.

All schools and settings should have an asthma policy that is an integral part of the whole school or setting policy on medicines and medical needs. The asthma section should include key information and set out specific actions to be taken (a model policy is available from Asthma UK). The school environment should be asthma friendly, by removing as many potential triggers for children with asthma as possible.

All staff, particularly PE teachers, should have training or be provided with information about asthma once a year. This should support them to feel confident about recognising worsening symptoms of asthma, knowing about asthma medicines and their delivery and what to do if a child has an asthma attack.

12. Epilepsy

What is Epilepsy?

Children with epilepsy have repeated seizures that start in the brain. An epileptic seizure, sometimes called a fit, turn or blackout can happen to anyone at any time. Seizures can happen for many reasons. At least one in 200 children have epilepsy and around 80 per cent of them attend mainstream school. Most children with diagnosed epilepsy never have a seizure during the school day. Epilepsy is a very individual condition.

Seizures can take many different forms and a wide range of terms may be used to describe the particular seizure pattern that individual children experience. Parents and health care professionals should provide information to schools, to be incorporated into the individual health care plan, setting out the particular pattern of an individual child's epilepsy. If a child does experience a seizure in a school or setting, details should be recorded and communicated to parents including:

- any factors which might possibly have acted as a trigger to the seizure – e.g. visual/auditory stimulation, emotion (anxiety, upset)
- any unusual "feelings" reported by the child prior to the seizure
- parts of the body demonstrating seizure activity e.g. limbs or facial muscles
- the timing of the seizure – when it happened and how long it lasted
- whether the child lost consciousness
- whether the child was incontinent

This will help parents to give more accurate information on seizures and seizure frequency to the child's specialist.

What the child experiences depends whether all or which part of the brain is affected. Not all seizures involve loss of consciousness. When only a part of the brain is affected, a child will remain conscious with symptoms ranging from the twitching or jerking of a limb to experiencing strange tastes or sensations such as pins and needles. Where consciousness is affected; a child may appear confused, wander around and be unaware of their surroundings. They could also behave in unusual ways such as plucking at clothes, fiddling with objects or making mumbling sounds and chewing movements. They may not respond if spoken to. Afterwards, they may have little or no memory of the seizure.

In some cases, such seizures go on to affect all of the brain and the child loses consciousness. Such seizures might start with the child crying out, then the muscles becoming stiff and rigid. The child may fall down. Then there are jerking movements as muscles relax and tighten rhythmically. During a seizure breathing may become difficult and the child's colour may change to a pale blue or grey colour around the mouth. Some children may bite their tongue or cheek and may wet themselves.

After a seizure a child may feel tired, be confused, have a headache and need time to rest or sleep. Recovery times vary. Some children feel better after a few minutes while others may need to sleep for several hours. Another type of seizure affecting all of the brain involves a loss of consciousness for a few seconds. A child may appear 'blank' or 'staring', sometimes with fluttering of the eyelids. Such absence seizures can be so subtle that they may go unnoticed. They might be mistaken for daydreaming or not paying attention in class. If such seizures happen frequently they could be a cause of deteriorating academic performance.

Medicine and Control

Most children with epilepsy take anti-epileptic medicines to stop or reduce their seizures. Regular medicine should not need to be given during school hours.

Triggers such as anxiety, stress, tiredness or being unwell may increase a child's chance of having a seizure. Flashing or flickering lights and some geometric shapes or patterns can also trigger seizures. This is called photosensitivity. It is very rare. Most children with epilepsy can use computers and watch television without any problem.

Children with epilepsy should be included in all activities. Extra care may be needed in some areas such as swimming or working in science laboratories. Concerns about safety should be discussed with the child and parents as part of the health care plan.

During a seizure it is important to make sure the child is in a safe position, not to restrict a child's movements and to allow the seizure to take its course. In a convulsive seizure putting something soft under the child's head will help to protect it. Nothing should be placed in their mouth. After a convulsive seizure has stopped, the child should be placed in the recovery position and stayed with, until they are fully recovered.
An ambulance should be called during a convulsive seizure if:

- it is the child's first seizure
- the child has injured themselves badly
- they have problems breathing after a seizure
- a seizure lasts longer than the period set out in the child's health care plan
- a seizure lasts for five minutes if you do not know how long they usually last for that child
- there are repeated seizures, unless this is usual for the child as set out in the child's health care plan

Such information should be an integral part of the school or setting's emergency procedures as discussed at paragraphs 115 - 117 but also relate specifically to the child's individual health care plan. The health care plan should clearly identify the type or types of seizures, including seizure descriptions, possible triggers and whether emergency intervention may be required.

Most seizures last for a few seconds or minutes, and stop of their own accord. Some children who have longer seizures may be prescribed diazepam for rectal administration. This is an effective emergency treatment for prolonged seizures. The epilepsy nurse or a paediatrician should provide guidance as to when to administer it and why.

Training in the administration of rectal diazepam is needed and will be available from local health services. Staying with the child afterwards is important as diazepam may cause drowsiness. Where it is considered clinically appropriate, a liquid solution midazolam, given into the mouth or intra-nasally, may be prescribed as an alternative to rectal Diazepam. Instructions for use **must** come from the prescribing doctor.

Children and young people requiring rectal diazepam will vary in age, background and ethnicity, and will have differing levels of need, ability and communication skills. If arrangements can be made for two adults, at least one of the same gender as the child, to be present for such treatment, this minimises the potential for accusations of abuse. Two adults can also often ease practical administration of treatment. Staff should protect the dignity of the child as far as possible, even in emergencies. The criteria under the national standards for under 8s day care requires the registered person to ensure the privacy of children when intimate care is being provided.

13. Diabetes
What is Diabetes?
Diabetes is a condition where the level of glucose in the blood rises. This is either due to the lack of insulin (Type 1 diabetes) or because there is insufficient insulin for the child's needs or the insulin is not working properly (Type 2 diabetes).

About one in 550 school-age children have diabetes. The majority of children have Type 1 diabetes. They normally need to have daily insulin injections, to monitor their blood glucose level and to eat regularly according to their personal dietary plan. Children with Type 2 diabetes are usually treated by diet and exercise alone.

Each child may experience different symptoms and this should be discussed when drawing up the health care plan. Greater than usual need to go to the toilet or to drink, tiredness and weight loss may indicate poor diabetic control, and staff will naturally wish to draw any such signs to the parents' attention.

Medicine and Control
The diabetes of the majority of children is controlled by injections of insulin each day. Most younger children will be on a twice a day insulin regime of a longer acting insulin and it is unlikely that these will need to be given during school hours, although for those who do it may be necessary for an adult to administer the injection. Older children may be on multiple injections and others may be controlled on an insulin pump. If doses are required at school supervision is required, and also a suitable, private place to carry it out.

Increasingly, older children are taught to count their carbohydrate intake and adjust their insulin accordingly. This means that they have a daily dose of long-acting insulin at home, usually at bedtime; and then insulin with breakfast, lunch and the evening meal, and before substantial snacks. The child is taught how much insulin to give with each meal, depending on the amount of carbohydrate eaten. They may or may not need to test blood sugar prior to the meal and to decide how much insulin to give. Diabetic specialists would only implement this type of regime when they were confident that the child was competent. The child is then responsible for the injections and the regime would be set out in the individual health care plan.

When staff agree to administer blood glucose tests or insulin injections, they should be trained by an appropriate health professional.

Children with diabetes need to be allowed to eat regularly during the day. This may include eating snacks during class-time or prior to exercise. Schools may need to make special arrangements for pupils with diabetes if the school has staggered lunchtimes. If a meal or snack is missed, or after strenuous activity, the child may experience a hypoglycemic episode (a hypo) during which blood glucose level fall too low. Staff in charge of physical education or other physical activity sessions should be aware of the need for children with diabetes to have glucose tablets or a sugary drink to hand.

Staff should be aware that the following symptoms, either individually or combined, may be indicators of low blood sugar - a **hypoglycemic reaction** (hypo) in a child with diabetes:

- hunger
- sweating
- drowsiness
- pallor
- glazed eyes
- shaking or trembling
- lack of concentration
- irritability
- headache
- mood changes, especially angry or aggressive behaviour

Each child may experience different symptoms and this should be discussed when drawing up a health care plan.

If a child has a hyperglycemia, it is very important that the child is not left alone and that a fast acting sugar, such as glucose tablets, a glucose rich gel, or a sugary drink is brought to the child and given immediately. Slower acting starchy food, such as a sandwich or two biscuits and a glass of milk, should be given once the child has recovered, some 10-15 minutes later.

An ambulance should be called if:

- the child's recovery takes longer than 10-15minutes
- the child becomes unconscious

1. Some children may experience **hyperglycemia** (high glucose level) and have a greater than usual need to go to the toilet or to drink. Tiredness and weight loss may indicate poor diabetic control, and staff will naturally wish to draw any such signs to the parents' attention. If the child is unwell, vomiting or has diarrhea this can lead to dehydration. If the child is giving off a smell of pear drops or acetone this may be a sign of ketosis and dehydration and the child will need urgent medical attention.

2. Such information should be an integral part of the school or setting's emergency procedures but also relate specifically to the child's individual health care plan.

14. Anaphylaxis

What is anaphylaxis?

Anaphylaxis is an acute, severe allergic reaction requiring immediate medical attention. It usually occurs within seconds or minutes of exposure to a certain food or substance, but on rare occasions may happen after a few hours.

Common triggers include peanuts, tree nuts, sesame, eggs, cow's milk, fish, certain fruits such as kiwifruit, and also penicillin, latex and the venom of stinging insects (such as bees, wasps or hornets).

The most severe form of allergic reaction is anaphylactic shock, when the blood pressure falls dramatically and the patient loses consciousness. Fortunately this is rare among young children below teenage years. More commonly among children there may be swelling in the throat, which can restrict the air supply, or severe asthma. Any symptoms affecting the breathing are serious.

Less severe symptoms may include tingling or itching in the mouth, hives anywhere on the body, generalised flushing of the skin or abdominal cramps, nausea and vomiting. Even where mild symptoms are present, the child should be watched carefully. They may be heralding the start of a more serious reaction.

During anaphylaxis there can be a whole range of symptoms including those described above.

Some or all of the following may be present:

- **flushing of the skin**
- **nettle rash (hives) anywhere on the body**
- **the feeling that something terrible is happening •**

  swelling in the throat or mouth
- **difficulty in swallowing or speaking**
- **alterations in heart rate**
- **severe asthma**
- **stomach pain, feeling sick and vomiting**
- **sudden feeling of weakness (drop in blood pressure)**
- **collapse and unconsciousness**

Common Conditions - Practical Advise on Asthma, Epilepsy, Diabetes and Anaphylaxis

The medical conditions in children that most commonly cause concern in schools and settings are asthma, diabetes, epilepsy and severe allergic reaction (anaphylaxis). There follows some basic information about these conditions but it is beyond its scope to provide more detailed medical advice and it is important that the needs of children are assessed on an individual basis.

Members of staff who are appointed first-aiders in our early years setting are trained to recognise and respond appropriately to the emergency needs of young children with chronic medical conditions.

Medicine and Control
The treatment for a severe allergic reaction is an injection of adrenaline (also known as epinephrine). Pre-loaded injection devices containing one measured dose of adrenaline are available on prescription. The devices are available in two strengths – adult and junior.
Should a severe allergic reaction occur, and only if an ambulance does not arrive before it is felt that there is a serious risk to the child, the adrenaline injection should be administered into the muscle of the upper outer thigh. **An ambulance should always be called.**

Staff that volunteer to be trained in the use of these devices can be reassured that they are simple to administer. Adrenaline injectors, given in accordance with the manufacturer's instructions, are a well-understood and safe delivery mechanism. It is not possible to give too large a dose using this device. The needle is not seen until after it has been withdrawn from the child's leg. In cases of doubt it is better to give the injection than to hold back.

The decision on how many adrenaline devices the school or setting should hold, and where to store them, has to be decided on an individual basis between the Headmaster, the child's parents and medical staff involved.

Where children are considered to be sufficiently responsible to carry their emergency treatment on their person, there should always be a spare set kept safely which is not locked away and is accessible to all staff. In large schools or split sites, it is often quicker for staff to use an injector that is with the child rather than taking time to collect one from a central location.

Important issues specific to anaphylaxis to be covered include:

- anaphylaxis – what may trigger it
- what to do in an emergency
- prescribed medicine
- food management
- precautionary measures

Once staff have agreed to administer medicine to an allergic child in an emergency, a training session will need to be provided by local health services. Staff should have the opportunity to practice with trainer injection devices.

Day to day policy measures are needed for food management, awareness of the child's needs in relation to the menu, individual meal requirements and snacks in school. When kitchen staff are employed by a separate organisation, it is important to ensure that the catering supervisor is fully aware of the child's particular requirements. A 'kitchen code of practice' could be put in place.

Parents often ask for the Headmaster to exclude from the premises the food to which their child is allergic. This is not always feasible, although appropriate steps to minimise any risks to allergic children should be taken.

Children who are at risk of severe allergic reactions are not ill in the usual sense. They are normal children in every respect – except that if they come into contact with a certain food or substance, they may become very unwell. It is important that these children are not stigmatised or made to feel different. It is important, too, to allay parents' fears by reassuring them that prompt and efficient action will be taken in accordance with medical advice and guidance.

Anaphylaxis is manageable. With sound precautionary measures and support from the staff, school life may continue as normal for all concerned.

15. Drawing up a Health Care Plan

Purpose of a Health Care Plan

9.1 The main purpose of an individual health care plan for a child with medical needs is to identify the level of support that is needed. Not all children who have medical needs will require an individual plan.

9.2 An individual health care plan clarifies for staff, parents and the child the help that can be provided. It is important for staff to be guided by the child's GP or pediatrician. Staff should agree with parents how often they should jointly review the health care plan. It is sensible to do this at least once a year, but much depends on the nature of the child's particular needs; some would need reviewing more frequently.

9.3 Staff should judge each child's needs individually as children and young people vary in their ability to cope with poor health or a particular medical condition.

9.4 Developing a health care plan should not be onerous, although each plan will contain different levels of detail according to the need of the individual child.

9.5 In addition to input from the child's parents, GP or other health care professionals (depending on the level of support the child needs), those who may need to contribute to a health care plan include:

- the Headmaster
- the parent or carer
- the child (if appropriate)
- the form teacher
- care assistant or support staff (if applicable)
- staff who are trained to administer medicines
- staff who are trained in emergency procedures

15.1 Co-ordinating Information

Coordinating and sharing information on an individual pupil with medical needs, can be difficult. The Headmaster will decide which member of staff has specific responsibility for this role. This person can be a first contact for parents and staff, and liaise with external agencies. If appropriate, members of staff with this role will receive training on managing medicines and drawing up policies on medicines.

15.2 Information for Staff and Others

Staff who may need to deal with an emergency will need to know about a child's medical needs. The Headmaster will ensure that supply staff know about any medical needs.

15.3. Off-site education

See our Educational Visits Policy.

15.4 Staff Training

A health care plan may reveal the need for some staff to have further information about a medical condition or specific training in administering a particular type of medicine or in dealing with emergencies. Staff should not give medicines without appropriate training from health

16. Reporting Accidents, Record Keeping and Parental Notification

16.1. Statutory Records:
Records are kept of all injuries by entry into the accident report books which are situated in the Medical Room. Additional books are also kept in the Sports medical bags and outings bags. All accident record books are numbered. In each case the following information is recorded:

- the date, time and place of the incident;
- the name (and class) of the injured or ill person;
- details of the injury/illness and what first aid was given;
- what happened to the person immediately afterwards (for example went home, resumed normal duties, went back to class, went to hospital);
- name and signature of the first-aider or person dealing with the incident.

In the event that someone is treated outside of the Medical Room using one of the emergency first aid packs, all of the information regarding the incident is entered into the accident book before the end of that day.

16.2. Accident books are retained for three years in accordance with current guidelines..
In accordance with our legal responsibility, we also maintain an additional central record which is supplementary to the accident book. All of the entries in the accident book are transferred to our School Database so that a personal accident history forms part of each child's record and so that any trends can be identified and possible causes rectified.
This information is also used to

- help us to identify accident trends and possible areas for improvement in the control of health and safety risks
- guide us in future first aid needs assessments
- assist in insurance and investigative purposes should the need arise.

16.3. Reporting Accidents to the HSE
The following accidents must be reported to the HSE:

- Accidents resulting in death or major injury
- Accidents which prevent the injured person from doing their normal work for more than three days.

For definitions of major injuries, dangerous occurrences and reportable diseases see HSE guidance on RIDDOR 1995.The following documents will need to be submitted or referred to: Form A1. RIDDOR 1995 Accident procedures guidance, Form 2508 – Report of an injury or dangerous occurrence, Form 2508A – Report of a case of disease, Form 2058A – Guidance notes.

HSE must be notified of fatal and major injuries and dangerous occurrences without delay (eg. by telephone). This must be followed up within ten days with a written report on Form 2508. Other reportable incidents do not need immediate notification, but they must be reported to the HSE within ten days on Form 2508.
An accident that happens to pupils or visitors must be reported to the HSE on Form 2508 if:

- The person involved is killed or is taken from the site of the accident to hospital; and
- The accident arises out of or in connection with work *or*
- It relates to any school activity, both on or off the premise *or*
- It relates to the way a school activity has been organised and managed *or*
- It relates to the design or condition of the premises.

Date created: Autumn 2009
Date of last review: June 2017
Date for next review: June 2018

Appendix 1

For the current academic year the members of staff trained in first aid are as follows:

First Aid at Work

Name	Requalification Date
Scott Stanley	24/05/2020

General First Aid

Name	Requalification Date
Annabel Cruickshanks	20/04/2018
Leonie Bannister	01/09/2018
Colette Barclay	01/09/2018
Jonathan Brough	01/09/2018
Jacquie Campbell	01/09/2018
Francesca Chalmers	01/09/2018
Fiona Driver	01/09/2018
Roland Devitt	01/09/2018
John Fitzgerald	01/09/2018
Deborah Flanagan	01/09/2018
Claire Glbert	01/09/2018
Isabel Gwyther	01/09/2018
Luisa Page	01/09/2018
Leanda Reeves	01/09/2018
Madeleine Sakrouge	01/09/2018
Siobhan Strutt	01/09/2018
Paul Swinden	01/09/2018
Jessica Sykes	01/09/2018
Irene Vincent	01/09/2018
Avril Walmsley	01/09/2018
Manuel Santos	26/09/2020

Staff Trained in Paediatric First Aid 2017-18

Name	Requalification Date
James Cabourn-Ford	01/09/2018
Amanda Few	01/09/2018
Ginny Houstoun	01/09/2018
Kasia Jakubus	01/09/2018
Maria Jeczen	01/09/2018
Karen Jones	01/09/2018
Rachel McDowell	01/09/2018
Katy Pickford	01/09/2018
Misty Spooner	01/09/2018
Andy Thwaite	01/09/2018
Christine Turner	01/09/2018
Georgia Hopkins	12/02/2019
Nesty Boyd	15/07/2019
Emily Cleveland	15/07/2019
Christina Costanzo	15/07/2019
Matt Curtis	15/07/2019
Katharine Geary	15/07/2019
Amelia Martel	15/07/2019
Kea Ward	15/07/2019
Christopher Iggulden	17/04/2020
Ana Barnes	17/04/2020
Stuart Harris	17/04/2020
Richard Morris	17/04/2020
Sarah Moy	17/04/2020
Sheri Patterson	17/04/2020
Holly Rakison	17/04/2020
Scott Stanley	17/04/2020
Janet Simpson	17/04/2020
Sarah Sinclair	17/04/2020
Nicky Almond	01/09/2018

Appendix 2

Emergency procedure to be followed in school

Anyone finding a collapsed individual should shout for help then:

1. Call 999 and request an ambulance (following the school procedure)
2. Send an adult or a child with a 'Please Come Now' red card to inform the school office staff.

The School Office Staff will:

1. Alert the School Primary First Aider via his extension number: 202 or his Mobile: 07949 167519
2. Alert the AED trained First Aiders (after school hours they will alert the AED trained First Aider on duty)
3. Send a runner to take the Medical Room AED to the location of the casualty
4. Appoint a member of staff to open the gates and direct the paramedics
5. Check that all the above has been carried out and that an ambulance has been dispatched!

The First Aider/s will make their way immediately to the casualty

- CPR will be started as soon as it is established that the casualty is unresponsive and non-breathing by the first trained person on the scene. The AED machine will be connected to the casualty as soon as it arrives. (See Resuscitation Council AED algorithm in schedule 3).
- Any First Aiders not directly involved with CPR will assist with:
    1. The safety of the casualty
    2. Moving away any bystanders
    3. Be ready to take over CPR if the other First Aiders become tired
    4. Organise for someone to meet the ambulance crew and direct them to the location of the casualty.

A member of the Senior Team will lead the identification of the casualty and will be responsible for contacting the next of kin as soon the situation allows.

Appendix 3

Automatic External Defibrillator (AED) Procedure

What is an Automatic External Defibrillator (AED)?
An automated external defibrillator (AED) is a portable electronic device that automatically diagnoses potentially life threatening cardiac arrhythmias in an individual and is able to treat them through defibrillation. Defibrillation is the application of electrical therapy allowing the heart to re-establish an effective rhythm.

Overview:
In the UK approximately 30,000 people sustain cardiac arrest outside hospital each year. Electrical defibrillation is well established as the only effective therapy for cardiac arrest caused by ventricular fibrillation (VF) or pulseless ventricular tachycardia (VT). The scientific evidence is overwhelming;

- the delay from collapse to delivery of the first shock is the single most important determinant of survival. If defibrillation is delivered promptly, survival rates as high as 75% have been reported;
- the chances of successful defibrillation decline at a rate of about 10% with each minute of delay;
- basic life support will help to maintain a shockable rhythm, but is not a definitive treatment.

(Resuscitation Council (UK) – The use of Automated External Defibrillators –2010).

Children:
The school AED contains pads which are suitable for an adults and child.

Training:
AED trained staff also hold a First Aid qualification (see Schedule 1 of the First Aid Policy for the current list). Annual AED training is provided for staff in conjunction with First Aid Training by the member of the Senior Management Team in charge of training.
All those trained in the use of an AED will also receive a copy and familiarize themselves with the following document:
https://www.resus.org.uk/resuscitation-guidelines/

Reception staff will be trained in their role and responsibilities within this procedure.

Location of the AED:
The School AED is located on the rear of the door in the Medical.
The AED is powered by a long life battery clearly displayed (green when the battery is fully charged, red when the battery is depleted).

The AED is checked daily during term time by the Appointed Person.

Appendix 4

HURLINGHAM SCHOOL

HIV and AIDS Policy

This policy is made available to all parents, prospective parents, staff and prospective employees of Hurlingham School on our website, and a hard copy can also be viewed at our School Office.

1. Introduction

The welfare of all of our children at Hurlingham School is our overriding priority. We understand that chronic illness such as HIV can impact on a child and their family in varying degrees, mainly on attendance, behaviour and educational attainment. We aim to create a supportive environment and we recognises that a child living with or affected by a chronic illness has the right to access education and we will provide support to the child and their family.

If a family discloses any information about illness or disability affecting the child or members of his/her family, any sharing of that information will be done on a need-to-know basis and only with the consent of the pupil and/or parent, unless there is a child protection issue.

2. Routes of HIV transmission

HIV has been known about for over 20 years and in this time the only routes of transmission in the United Kingdom have been through blood, breast milk, and seminal and vaginal fluids. Screening is in place to make blood and organs safe. Transmission of the HIV virus is only possible if there is a sufficient quantity of the virus entering the bloodstream directly.

If an infected child has a cut, this should be dealt with in the normal manner following first aid procedures and standard hygiene practices. This will be effective in preventing transmission of all blood-borne infections, including HIV.

HIV is a non-notifiable disease, which means that parents or children who are affected or infected may choose to not inform the school. This is because the infected pupil poses no risk to others.

Having an infected child in school poses no risk to staff or pupils. As stated before, there is no known case of an HIV transmission occurring in a school in the United Kingdom. No case has ever been recorded of HIV transmission from child to child by biting, fighting, playing or any other normal childhood interaction.

3. Living with HIV

Virtually all infected children are completely healthy for the majority of their school career. With regular clinical check-ups and advances in medical science and medication, the majority of infected children in the United Kingdom are reaching adulthood. They take medication at home once or twice a day and will appear as normal, healthy children. If we need to manage a pupil's medication, perhaps due to a school trip, as with any medication, a robust system will be put in place to manage it safely and confidentially (DfEE and DoH 1996).

Date created: Autumn 2009
Date of last review: June 2017
Date of next review: June 2018

Appendix 5

HURLINGHAM SCHOOL

Meningitis Policy

This policy is made available to all staff at Hurlingham School.

1. The Nature of Meningitis

Meningitis is an inflammation of the meninges which are the lining surrounding the brain and spinal cord. There are two main forms of meningitis, bacterial meningitis (i.e. spread by bacteria) and viral meningitis (i.e. spread by viruses).

Bacterial meningitis is a fairly uncommon illness, with some 2500 to 3000 reported cases each year. It is, however, extremely dangerous. It is fatal in one in 10 cases and one in seven survivors will be left with a serious disability such as deafness or brain injury. Cases of bacterial meningitis require urgent treatment with antibiotics; speed of diagnosis and treatment is crucial to increase the likelihood of recovery. Viral meningitis is more common than bacterial meningitis but is generally far less dangerous to health.

Those cases of meningitis which receive publicity and cause concern in schools are almost always of bacterial meningitis. This document therefore deals only with bacterial meningitis.

2. Transmission of Bacterial Meningitis

Those most at risk are older people, children under 5, older teenagers and young adults. At any one time, between 10 and 25 per cent of people will be carrying the bacteria which can cause meningitis without contracting the disease. The bacteria are spread between people who are in prolonged close contact and by coughing, sneezing and kissing.

Most cases are isolated incidents unrelated to others. There are, however, often well-publicised outbreaks. It is often not clear why these outbreaks have happened and they often appear unrelated to any geographical or environmental factor.

3. Types of Bacterial Meningitis

There are three main types of bacterial meningitis:

- meningococcal meningitis;
- pneumococcal meningitis; and
- haemophilus influenza B (Hib) meningitis.

Meningococcal Meningitis

Meningococcal meningitis is the most common bacterial form and accounts overall for well over half of cases of bacterial meningitis.

Two thirds of people suffering from meningococcal meningitis will also have septicaemia, an infection of the bloodstream caused by the same bacteria which is displayed in the form of a rash. Septicaemia can also be contracted in the absence of meningitis and in such cases is a more serious infection with a higher mortality rate.

Meningococcal meningitis is itself divided into types A, B and C. Type B is the most common strain and accounts for almost two-thirds of cases of meningococcal meningitis. Type C, the second most common strain, accounts for around one-third of cases. Type C has, however, caused more deaths in recent years and is particularly associated with school outbreaks whereas Type B cases are more likely to be isolated cases.

Pneumococcal Meningitis
Pneumococcal meningitis accounts for about ten per cent of bacterial meningitis cases. It usually occurs in older adults and young children, has a higher fatality rate of about 20 per cent and has a higher risk of permanent neurological damage for survivors.

Hib (Haemophilus Influenza B) Meningitis
Until 1992, Hib meningitis accounted for almost half of bacterial meningitis cases. Routine infant immunisation, however, means that it is now rare in the UK.

4. Vaccines against Meningitis
There is still no vaccine against Type B meningococcal meningitis, the most common strain of bacterial meningitis.

A new vaccine became available in 1999 against Type C meningococcal meningitis and offers effective long-term protection against this strain. A vaccination programme in schools for all school pupils in the 15 to 17 age group commenced in October 1999, to be extended to school pupils aged 5 to 14 from summer 2000. It will also become part of the infant immunisation programme. There is also an older vaccine against both Types A and C which confers protection in about 80 per cent of cases. This vaccination is encouraged by universities for all first year university students. It offers protection for about three years but is not effective for children under 18 months old.

There is also a vaccine against pneumococcal meningitis and other diseases caused by pneumococcal infection. It is recommended for the elderly and high risk groups including people with heart disease, liver disease, diabetes, and sickle cell disease or thalassemia.

5. Dealing with Cases of Meningitis
Cases of meningitis must be notified to the local health authority's Consultant in Communicable Disease Control (CCDC). The CCDC is, in particular, responsible for advice on precautions to be taken in schools with regard to cases involving school pupils.

During a meningitis outbreak, it is important that parents, pupils and staff are fully and regularly informed. It is sensible for schools to hold information on identifying cases of possible meningitis and on steps which may need to be taken if there are cases at the school. It is also sensible for each school to have a named person who will deal with this type of issue.

Meningitis is not regarded by the medical profession as highly infectious. Due to the means of transmission, only the patient's close contacts, generally family members, are at any significant risk. Contacts are usually offered antibiotics, which are intended to eliminate bacteria responsible for the infection which the contact may also be carrying. The use of antibiotics does not, however, guarantee that contacts will not contract meningitis. Contacts will also generally be offered vaccination although this offers protection only in the longer term and against only certain strains of meningitis.

Medical advice is likely to be that the risk of transmission to contacts at school is low and, therefore, that the school will not need to be closed, close contacts such as siblings will not need to be excluded and other contacts such as teachers and fellow pupils will not need treatment with antibiotics or vaccination. In general, antibiotics and mass vaccination are offered only where at least two cases occur in a school simultaneously or very close together.

The NUT has, however, generally sought in such circumstances to ensure that antibiotics and/or vaccination are made available to contacts who request them, at the very least to those teachers and pupils who have been in close contact with the person suffering from meningitis. In the event of an outbreak, the NUT believes that provision of antibiotics and vaccination should be made available to teachers. NUT members facing

difficulty in obtaining this should contact the relevant NUT Regional Office or, in Wales, the NUT Wales Office NUT Cymru.

6. Further Information

Advice in connection with any specific case of meningitis should be sought from the relevant health authority's Consultant in Communicable Disease Control. The name and contact details will be obtainable from the health authority.

General guidance, including advice leaflets and a 24 hour advice line, on the above issues and others such as symptoms and diagnosis are provided by:

National Meningitis Trust, Fern House, Bath Road, Stroud, Glos GL5 3TJ
24 hour advice line: 0845 600 0800
website: www.meningitis-trust.org.uk

Meningitis Research Foundation
24 hour advice line 0808 800 3344

General guidance relevant to school pupils, provided by the Public Health Laboratory Service in conjunction with the Department of Health, can also be accessed on the following websites:

www.wiredforhealth.gov.uk or www.phls.co.uk

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Appendix 6

Monitoring of an Individual Healthcare Plan

Parent or healthcare professional informs school that the child has been newly diagnosed, or is due to attend a new school or is due to return to school after a long-term absence or that needs have changed.

↓

Headmaster or senior member of school staff to whom this has been delegated, co-ordinates a meeting to discuss the child's medical support needs, and identifies members of school staff who will provide support to the pupil.

↓

Meeting to discuss and agree on need for IHCP to include key school staff, child, parent, relevant healthcare professional and other medical/health clinician as appropriate (or to consider written evidence by them).

↓

Develop IHCP in partnership – agree who leads on writing it. Input from healthcare professionals must be provided.

↓

School staff training needs identified.

↓

Healthcare professional commissions/delivers training and staff signed off as competent – review date agreed.

↓

IHCP implemented and circulated to all relevant staff.

↓

IHCP reviewed annually or when condition changes. Parent or healthcare professional to initiate.

Appendix 7

HURLINGHAM SCHOOL

Intimate Care Policy

This policy is made available to all staff at Hurlingham School.

Our Intimate Care Policy is part of our collective pastoral care policies. This policy is in line with multi-agency guidance as found in the Area Child Protection Committees' (ACPC) Regional Policy and Procedures (2005). It is our intention to develop independence in each child, however there will be occasions when help is required. The principles and procedures apply to everyone involved in the intimate care of children.

'Intimate care may be defined as an activity required to meet the personal care needs of each individual child in partnership with the parent, carer and the child.' (9.26, ACPC Regional Policy and Procedures). In school this may occur on a regular basis or during a one-off incident.

Hurlingham School is committed to ensuring that all staff responsible for the intimate care of children will undertake their duties in a professional manner at all times. We recognise that there is a need to treat all our children with respect when intimate care is given. No child should be attended to in a way that causes distress or pain and adults and staff must be sensitive to each child's individual needs.

Intimate care is any care which involves one of the following:
1. Assisting a child to change his/her clothes
2. Changing or washing a child who has soiled him / herself
3. Assisting with toileting issues
4. Supervising a child involved in intimate self-care
5. Providing first aid assistance
6. Providing comfort to an upset or distressed child
7. Feeding a child
8. Providing oral care to a child
9. Assisting a child who requires a specific medical procedure and who is not able to carry this out unaided. *

* In the case of a specific procedure only a person suitably trained and assessed as competent should undertake the procedure, (e.g. the administration of rectal diazepam.) Parents have the responsibility to advise the school of any known intimate care needs relating to their child

Principles of Intimate Care

The following are the fundamental principles of intimate care upon which our policy guidelines are based:

- Every child has a right to be safe;
  Every child has the right to personal privacy;
  Every child has the right to be valued as an individual;
- Every child has the right to be treated with dignity and respect;
- All children have the right to be involved and consulted in their own intimate care to the best of their abilities;
- All children have the right to express their views on their own intimate care and to have their views taken into account; and
- Every child has the right to have levels of intimate care that are appropriate and consistent.

Assisting a child to change his / her clothes

This is more common in our Foundation Stage. On occasions an individual child may require some assistance with changing if, for example, he / she has an accident at the toilet, gets wet outside, or has vomit on his / her clothes etc.

Staff will always encourage children to attempt undressing and dressing unaided. However, if assistance is required this will be given.

Staff will always ensure that they have a colleague in attendance when supporting dressing/undressing and will always give the child the opportunity to change in private, unless the child is in such distress that it is not possible to do so. If staff are concerned in any way parents will be sent for and asked to assist their child and informed if the child becomes distressed.

Changing a child who has soiled him/herself

If a child soils him/herself in school a professional judgement has to be made whether it is appropriate to change the child in school, or request the parent/carer to collect the child for changing. In either circumstance the child's needs are paramount and he/she should be comforted and reassured throughout. The following guidelines outline our procedures but we will also seek to make age-appropriate responses.

- The child will be given the opportunity to change his / her underwear in private and carry out this process themselves.
- School will have a supply of wipes, clean underwear and spare uniform for this purpose. (A supply of clean underwear and spare uniforms are available outside the Medical Room).
- If a child is not able to complete this task unaided, school staff will attempt to contact the emergency contact to inform them of the situation.
- If the emergency contact is able to come to school within an appropriate time frame, the child will be accompanied and supported by a staff member until they arrive. This avoids any further distress and preserves dignity.
- If the emergency contact cannot attend, school will seek verbal permission for staff to change the child. If none of the contacts can be reached the Headmaster or another member of the SLT team is to be consulted and the decision taken on the basis of loco-parentis and our duty of care to meet the needs of the child.

Child Protection/Safeguarding Guidelines

- Ensure that the action you are taking is necessary and try to ensure that another adult is present or in the vicinity.

Pastoral Care Procedures

- Ensure the child is happy with who is changing him / her.
- Be responsive to any distress shown.

Basic hygiene routines

- Always wear protective disposable gloves.
- Seal any soiled clothing in a plastic bag for return to parents.

In the case of children in Reception and Lower School, in order to avoid any unnecessary distress, a member of staff may assist the child, with a colleague in attendance, unless a parent has requested otherwise or if the child is reluctant. Parents will be contacted as soon as it is practical to do so.

3. Providing comfort or support to a child:

There are situations and circumstances where children seek physical comfort from staff (particularly children in Early Years). Where this happens staff need to be aware that any physical contact must be kept to a minimum. When comforting a child or giving reassurance, staff must ensure that at no time can the act be considered intimate. If physical contact is deemed to be appropriate, staff must provide care which is professionally appropriate to the age and context.

If a child touches a member of staff in a way that makes him/her feel uncomfortable this can be gently but firmly discouraged in a way which communicates that the touch, rather than the child, is unacceptable. If a child touches a member of staff, as noted above, this should be discussed, in confidence with the DMS.

4. Assisting a child who requires a specific medical procedure and who is not able to carry this out unaided.

Our administration of medications guidelines in our First Aid and Medical Policy outline arrangements for the management of the majority of medications in school.

Residential Trips

Residential educational visits are an important part of our provision. Particular care is required when supervising pupils in this less formal setting.

As with Extra-Curricular Activities, although more informal relationships in such circumstances tend to be usual, staff are still guided by our Child Protection procedures, Pastoral Care and Positive Behaviour Policies. Some specific Intimate Care issues may arise in a Residential context.

Showering
Children are entitled to respect and privacy when changing their clothes or taking a shower. However, there must be the required level of supervision to safeguard young people with regard to health and safety considerations, and to ensure that bullying, teasing or other unacceptable behaviour does not occur.

This means that staff should announce their intention of entering changing rooms, avoid remaining in changing rooms unless pupil needs require it, avoid any physical contact when children are in a state of undress and avoid any visually intrusive behaviour.

Given the vulnerabilities of the situation, it is strongly recommended that when supervising children in a state of undress, another member of staff is present. However, this may not always be possible and therefore Staff need to be vigilant about their own conduct, e.g. adults must not change in the same place as children or shower with children.

It is best practice in our school that when an incident has taken place that has necessitated a member of staff to be present when children are changing that an incident report is made.

Night Time Routines
It is established practice that the children's bedrooms are private spaces and anyone else wanting to enter the room should knock and announce their intention to enter.

At bedtime, children are given a set amount of time to change and prepare for bed and will be told when the supervising teachers will visit the rooms to check all is okay and switch off the lights. A reciprocal arrangement is in place in the mornings.

There are occasions when incidents take place during the night and the need arises to:

1. Assist a child to change his / her clothes
2. Change a child who has soiled him / herself
3. Provide comfort to an upset or distressed child
4. Assist a child who requires a specific medical procedure and who is not able to carry this out unaided.

Guidance as above will be followed with the support of an additional member of staff in attendance.

School Responsibilities

All members of staff working with children are vetted. This includes students on work placement and volunteers who may be left alone with children. Vetting includes criminal record checks and two references.

Only those members of staff who are familiar with the intimate care policy and other Pastoral Care Policies of the school are involved in the intimate care of children.

Where anticipated, intimate care arrangements are agreed between the school and parents and, when appropriate and possible, by the child. Consent forms are signed by the parent and stored in the child's file. Only in emergency would staff undertake any aspect of intimate care that has not been agreed by parents and school. Parents would then be contacted immediately.

The views of all relevant parties should be sought and considered to inform future arrangements.

If a staff member has concerns about a colleague's intimate care practice he or she must report this to the DMS.

Guidelines For Good Practice

All children have the right to be safe and to be treated with dignity and respect. These guidelines are designed to safeguard children and staff. They apply to every member of staff involved with the intimate care of children.

Young children and children with special educational needs can be especially vulnerable. Staff involved with their intimate care need to be particularly sensitive to their individual needs.

Members of staff also need to be aware that some adults may use intimate care, as an opportunity to abuse children. It is important to bear in mind that some forms of assistance can be open to misinterpretation. Adhering to the following guidelines of good practice should safeguard both children and staff.

- Involve the child in the intimate care. Try to encourage a child's independence as far as possible in his or her intimate care. Where a situation renders a child fully dependent, talk about what is going to be done and, where possible, give choices. Check your practice by asking the child or parent about any preferences while carrying out the intimate care.
- Treat every child with dignity and respect and ensure privacy appropriate to the child's age and situation. Care should not be carried out by a member of staff working alone with a child.
- Make sure practice in intimate care is consistent. As a child may have multiple carers a consistent approach to care is essential. Effective communication between all parties ensures that practice is consistent.

- Be aware of your own limitations. Only carry out activities you understand and feel competent with. If in doubt, ask. Some procedures must only be carried out by members of staff who have been formally trained and assessed.
- Promote positive self-esteem and body image. Confident, self-assured children who feel their bodies belong to them are less vulnerable to sexual abuse. The approach you take to intimate care can convey lots of messages to a child about their body worth. Your attitude to a child's intimate care is important. Keeping in mind the child's age, routine care can be both efficient and relaxed.
- If you have any concerns you must report them. If you observe any unusual markings, discolouration or swelling report it immediately to the DMS.

If a child is accidentally hurt during intimate care or misunderstands or misinterprets something, reassure the child, ensure their safety and report the incident immediately to the designated teacher. Report and record any unusual emotional or behavioural response by the child. A written record of concerns must be made available to parents and kept in the child's personal file.

Working with Children of the Opposite Sex

There is positive value in both male and female staff being involved with children. Ideally, every child should have the choice for intimate care but the current ratio of female to male staff means that assistance will more often be given by a woman. The intimate care of boys and girls can be carried out by a member of staff of the opposite sex with the following provisions:

- When intimate care is being carried out, all children have the right to dignity and privacy, i.e. they should be appropriately covered, the door closed or screens/curtains put in place;
- If the child appears distressed or uncomfortable when personal tasks are being carried out, the care should stop immediately. Try to ascertain why the child is distressed and provide reassurance;
- Report any concerns to the DSM and make a written record;
- Parents must be informed about any concerns.

Communication With Children

It is the responsibility of all staff caring for a child to ensure that they are aware of the child's method and level of communication. Depending on their maturity and levels of stress children may communicate using different methods - words, signs, symbols, body movements, eye pointing, etc. To ensure effective communication:

- Make eye contact at the child's level;
- Use simple language and repeat if necessary;
- Wait for response;
- Continue to explain to the child what is happening even if there is no response; and
- Treat the child as an individual with dignity and respect.

Date created: June 2017
Date of next review: June 2018

Appendix 8:

First Aid Arrangements for Sporting Activities

In all cases when sports activities take place off-site, at least one member of staff accompanying the group must be a qualified first aider.

Sports Staff are responsible for:

- ensuring that First Aid kits are taken on all home/away matches and also during practice sessions;
- restocking the off-site PE First Aid kits on an ongoing basis, in liaison with the Appointed Person (who will stock the kits at the start of each term and provide supplies for restocking);
- ensuring that they have spare Epi Pens, asthma inhalers and any other medication for pupils who require them on home and away matches and checking that such pupils are also carrying their own medication where appropriate ie. asthma inhalers; and
- liaising with the appointed person to ensure that they have up-to-date awareness and knowledge of the medical needs of the pupils they teach.

All of the sports kits bags contain laminated copies of the 'code red' medical cards for pupils with potentially life-threatening conditions and these give details of those conditions, the action to be taken in the event that the pupils becomes ill and contact details for the parents and any medical professionals who have oversight for their specific care.

All of the sports staff are provided with risk assessments specific to the teaching of each sport and these underpin the teaching and application of all sport at Hurlingham in order to minimize the risk of injury. Sports staff are also made aware of head injury and concussion protocol.

A charged mobile phone is always taken to any off-site sporting activity for use in case of emergency.

Any accidents or medical incidents which occur when sport is being taught both on and off site are recorded in the accident book in the medical room either at the time or as soon as is practical when the teacher returns to school in the case of off-site activities.

Sports staff and responsible for notifying the Appointed person of any first aid supplies contained within the PE First Aid kit bags which have been used off site when they return to school in order to ensure that they are re-stocked.

Parents are advised of any significant injuries or medical incidents either at the time by the member of the sports department present or by the school office as soon as is practical. In the event of any head injuries, parents are always notified by email as well as by telephone whenever possible.

An ambulance will always be called in the event of any injury or medical emergency judged to require immediate professional medical assistance. Staff are made aware of and understand their responsibility to call for an ambulance if they are in any doubt as to the severity of the situation.