First Aid and Medical Policy

Written By	**Bursar – First Aid** **Senior Matron – Medical conditions policy** **DSL – Intimate care principles**
Date of Review	**February 2022**
ISI Codes NMS	**A7, B5, E4, E5** **3 & 3.1**

FIRST AID

1. **Introduction.** Health and safety legislation places duties on employers for the health and safety of their employees and anyone else on the premises. At Sherborne Prep the governing body is responsible for Health and Safety at the School. First aid can save lives and prevent minor injuries becoming major ones. Under health and safety legislation employers have to ensure that there are adequate and appropriate equipment and facilities for providing first aid in the workplace.

2. **Responsibilities.** The Governors are held responsible for Health and Safety policy including first aid within the School. The following is delegated to:

   a. The Headmaster is responsible for putting the governing body's policy into practice and for developing detailed procedures. The Headmaster should also make sure that parents are aware of the School's health and safety policy, including arrangements for first aid.

   b. The Bursar is the School's Health and Safety Officer on behalf of the Headmaster and is responsible for the day to day supervision of the policy.

   c. Teachers and other staff in charge of pupils are expected to use their best endeavours at all times, particularly in emergencies, to secure the welfare of the pupils at the school in the same way that parents might be expected to act towards their children. In general, the consequences of taking no action are likely to be more serious than those of trying to assist in an emergency.

3. **First-aid provision.** The minimum first aid provision is:

   a. A suitably stocked first-aid container.
   b. An appointed person to take charge of first-aid arrangements.
   c. Information for employees on first-aid arrangements.
   d. A suitably qualified person on site when children are present.

Please see the appropriate policy for specific arrangements for Pre-Prep.

4. **Risk assessment.** This minimum first aid provision must be supplemented by a risk assessment, to include:

a. What size is the school and is it on split sites and/or levels?

b. Location of school, is it remote from emergency services?

c. Are there any specific hazards or risks on the site?

d. Are there staff or pupils with special health needs or disabilities?

e. What age range does the school cater for as different first-aid procedures may apply to pupils in Pre-prep and Prep.

f. Emergency procedures.

The Bursar and Matron will write the risk assessment and review annually including the laydown of qualifications. The assessment will be reviewed after any major accident/incident.

5. **Medical risk assessments.** The School will produce a risk assessment for children with medical conditions and serious allergies. Assessments will be written by a Matron in consultation with parents and reviewed at least annually.

6. **Number of first aid trained personnel.** There are no rules on exact numbers of how many first-aid trained personnel are required. By way of example, a lower risk place of work with fifty to one hundred employees should have at least one first aider. The School's first aid risk assessment defines the requirement for this policy:

Location/Activity	**Qualification**[1]	**Quantity**	**Remarks**
Prep	Emergency first aid at work	At least one in: • Blake Wing • Wessex Wing • School office	Adequate provision for lunchtimes and breaks
Pre-prep	Paediatric	At least two	
Boarding staff	Emergency first aid at work First aid at work	Boarding Master and Matrons to have First aid at work	Unless medically qualified
Sport	Emergency first aid at work	One teacher in each locality	Preferably every sports teacher and coach
Outdoor learning	Relevant accredited first aid qualification	Preferred one on site.	See risk assessments.
Science/DT	Emergency first aid at work	Both teachers	
Support staff	Emergency first aid at work	Kitchen – one each shift Grounds/maintenance team – at least one	

[1] All courses to be HSE compliant/certified.

Prep field trip	Emergency first aid	At least one	If a child with a medical condition is on the trip, a member of staff current and competent with their medication /Epipen must attend.
Pre-prep field trip	Paediatric	At least one	If a child with a medical condition is on the trip, a member of staff current and competent with their medication /Epipen must attend.

A list of first aid trained personnel in the School is held by the Bursar and will distributed regularly. At least one qualified member of staff must be on site at all times when pupils are present. In event that a member of staff is worried that there may not be a qualified person on site, they must inform the bursar or School Office.

7. **Training.** The Bursar will coordinate first aid training, usually programmed for a staff inset. All training to be conducted by a recognised and certified trainer. As training is only valid for 3 years, a rolling programme of re-validation will be organised by the Bursar.

8. **Informing staff/parents on first aid arrangements.** The Matrons will produce an A3 one-pager to inform staff of:

a. Where first aid kits are held.
b. 6-figure grid and post code of the School for first aid responders.
c. How to contact a first aider.

A format is at Annex A.

9. **Availability of information.** This policy is available in the following locations:

a. The School's website.
b. All health and safety noticeboards and the teaching and domestic staff workrooms.
c. A copy in the School Office.

10. **First aid kits.** The School has a large number of first aid kits, all held in clearly identified containers labelled first aid, green with a white cross. The following locations hold a first aid kit:

a. Sickbay.
b. Pre-Prep.
c. School Office.
d. Kitchen.
e. Netherton.
f. EYFS.
g. Science and D&T.

h. One for each Sports Coach – collected from Matron.
i. Each minibus.
j. Tractor
k. Forest School.

11. **First aid kit contents.** The School uses the HSE recommended list for all first aid boxes including: sports, PSVs and travelling kits. The Matrons are responsible for regular checks to ensure all equipment is present and in-date. They keep records of all checks.

12. **First aid accommodation.** The School has sick rooms in the boarding house. The room contains a washbasin and are close to a WC in accordance with HSE regulations and NMS.

13. **Sport matches.** When sport matches are being played on 5 Acres, a Matron with an enhanced first aid bag and mobile telephone will be on duty. Where that is not possible because of staff illness, a sports coach is to have a duty mobile to communicate to the on duty matron in Acreman.

14. **Record keeping.** The School will keep a record of any first aid treatment given to be held for 3 years. Matrons will collate and hold. It should include:

a. The date, time and place of incident.

b. The name (and class) of the injured or ill person.

c. Details of the injury/illness and what first aid was given.

d. What happened to the person immediately afterwards (for example went home, resumed normal duties, went back to class, went to hospital).

e. Name and signature of the first aider or person dealing with the incident.

In an emergency, the Headmaster or his nominated representative will contact parents to inform them of the incident. Where the Headmaster feels it appropriate, he will confirm the incident and the detail be letter.

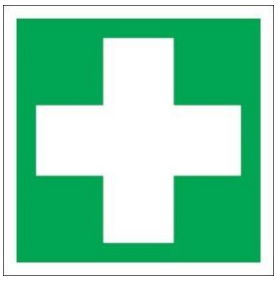
15. **Medical conditions.** See Annex B for the policy and protocols relating to medical conditions.

16. **Statutory accident records.** The Bursar is responsible for reporting all HSE reportable accidents under RIDDOR. All incidents where first aid is required are to be recorded on the relevant form and sent on to the Bursar.

Annexes:

A. First aid one-pager.
B. Medical conditions policy.

Annex A



Action to be taken - minor injury/sickness:

- Ensure the area is safe to prevent any further risk of injury.
- Phone Matron or if safe to do so escort the child or adult to sick bay.
- Submit RIDDOR/Accident Form.

Action to be taken - major injury:

- If First Aid qualified administer help. If not, send a runner/call the School Office/Matron who can get a qualified person to assist.
- Ensure the area is safe to prevent any further risk of injury.
- Shout for help/send runner to the School office for first aider.
- Phone 999 for an ambulance:
    - loss of consciousness;
    - an acute confused state;
    - fits that are not stopping;
    - persistent, severe chest pain;
    - breathing difficulties;
    - severe bleeding that cannot be stopped;
    - severe allergic reactions;
    - severe burns or scalds;
    - Traumatic injuries: breaks/significant bleeds etc
    - **Anaphylaxis** shock;
    - Asthma attacks;
    - Epileptic fit.
- Make the injured person comfortable. Place in the recovery position if unconscious.
- Phone Matron.
- Ensure or next of kin informed (through Matron) – Headmaster of representative.
- Inform Bursar.
- Complete incident form and RIDDOR/Accident Form.

First aid kit locations:

- Sickbay.
- Pre-Prep.
- School Office.
- Kitchen.
- Netherton.
- EYFS.
- Science and D&T.
- One for each Sports Coach – collected from Matron.
- Each minibus.
- Tractor.

Locations:

- Post code – DT9 3NY
- Grid references:
  School – 636166

  5-Acres- 634165

Contact details:

- Matron: 01935 812083
- Office: 01935 812097

Annex B

MEDICAL CONDITION POLICY AND PROTOCOLS

GENERAL

1. **Introduction.** The school has and implements appropriate policies for the care of day pupils and boarders who are unwell. These include first aid, care of those with chronic conditions and disabilities, dealing with medical emergencies and the use of household remedies. Sherborne Prep School addresses its pupils'[3] health and wellbeing in a number of ways. Care in respect of health and wellbeing is provided primarily within sick bay, which is staffed by the matrons. Their duties include:

a) The coordination of external appointments for boarders with medical and therapeutic services, such as physiotherapy and x-rays;

b) The oversight and monitoring of individual care plans for pupils with chronic conditions, such as Crohn's disease or diabetes:

c) The oversight and monitoring of pupils with temporary disabling conditions, including injury;

d) The organisation of routine vaccinations.

e) The education and support of pupils in respect of eg Asthma, anaphylaxis;

f) The coordination of medical support for sporting activities, as appropriate;

g) Support for house staff in respect of ongoing CPD (eg training in the use of Epipens);

h) Coordination of pupil medicals, as required, in coordination with the school doctor.

As well as medical provision on site via the School's Doctor, boarders have access to local medical, dental, optometric or specialist support, which is coordinated through the School's Matron.

2. **Referrals.** The Medical Centre can refer pupils for routine (ie non-emergency) dental, orthodontic, optometric or other specialist services. These can be accessed in the local area. Parents may choose to organise such appointments independently (particularly for ongoing treatment) and are asked to abide by the school's stipulation that appointments do not cause pupils to miss other commitments.

3. **The Storage of Medicines.** All medicines are kept there in locked cupboards and there are only two sets of keys for these cupboards. The keys are kept in a Pin-coded safe. The use of all medicines is recorded by staff in the book, and by Matron on ISAMs. All medication must be stored in the original containers with the child's name, date, dose and frequency of administration. The expiry date must be clearly visible and the information must be written in English. If a foreign child has been prescribed medication whilst at home and the information is not in English, an email or written confirmation must be obtained by the parent's or guardian in English and sent to Matron. If the medication requires to be kept in a fridge, it will be stored at the appropriate temperature and locked.
4. **Staff medication.** All staff must be responsible for their own medication and will ensure that the children are not able to access it at any time. Matron will give over the counter medication if required and will record the name of the staff member receiving it, the time and dose given in the medical book.
5. **Parental permissions.** Written parental or guardian's permission is required before the administration of any medication. Prescription medication will only be given to a child if it has been prescribed by a doctor, nurse practitioner or a dentist – this includes medications with aspirin for EYFS children. A medical permission slip must be filled in and signed for and the form will be filed in the child's medical notes.

6. **Gillick competence.** Gillick competence is the term used to decide whether a child under the age of 16 is able to consent to his or her own medical treatment without the need for parental permission. They can consent to their own treatment if they are believed to have enough intelligence, competence and understanding to fully appreciate what is involved in their treatment. Gillick Competence can only be decided by a Health Care Professional. The School's Doctor is the only person responsible for this decision at Sherborne Prep School. Matron would arrange a suitable time, allowing sufficient time for a full assessment to ensure the child fully understands the nature and consequence of the proposed treatment and is mature enough to take account of broader health and social factors when making their decision.

7. **Counselling Service.** The school has a system whereby any child who wishes to talk to an independent adult can do so. There are currently two adults who have taken up this role and their details are displayed in the boarding houses. This is a confidential system and the independent visitors are under no obligation to inform the school of any calls. The school also has access to a local school counsellor.

MEDICAL POLICY

8. **The school doctor.** The nominated Medical Officer is provided by The Grove Medical Centre. Upon entry to the school the parents of all children complete a medical questionnaire outlining any medical problems, current ones, present treatment, allergies etc. Permission will be sought from parents at this time for permission to administer non-prescribed drugs, as appropriate. All boarders are then registered with the School's doctor.

9. **Procedures for doctor visits**. The doctor visits the school each week. The duty Matron oversees her visits and ensures that the necessary children are there. Following the consultation, the doctor enters notes into the surgery's medical files. Matron enters notes in the medical book and on iSAMS. These records are kept by the matrons in Sick Bay. Where necessary, the matron will contact the parents regarding treatment of boarders. At other times the doctor can be contacted at his surgery or at home, either by the Housemaster/Matron. All boarders are made aware that they may make an appointment to see the school doctor to discuss any concerns that they have. Boarders may request to see a doctor of the same sex.

10. **Record keeping.** All minor cuts and injuries (along with non-prescribed medicine) are recorded in the Medication Book in Sick Bay and then onto ISAMs. Any issues with the administration of medicines must be discussed with the parents of the pupil concerned on the same day, or as quickly as practicable, for both Pre Prep and Prep. Any serious injuries such as a suspected fracture, head injuries, any incident when a doctor is called out or a pupil is taken to hospital, or any accidents must be recorded a RIDDOR form. Parents of children who have been entered into the Accident Book must be informed the same day or as quickly as practicable, for both Pre Prep and Prep. All relevant staff must be informed of the incident, its ongoing management and any constraints regarding sport/lessons.

11. **Treatment of Conditions.** The Matrons will ensure that a pupil's House Master/Mistress is made aware of the identity of pupils in their houses with medical conditions, or social information of a sensitive nature that may be of relevance in their dealings with them in the boarding house, or when arranging trips and visits. The office staff will insert an electronic "flag" onto the school database, and annotate the pupil's file, so that the teaching staff will know that they should consult the School Nurse and House Master/Mistress about a particular individual when arranging an activity. The Head Chef holds the names of pupils with food allergies.

12. **Action in the Event of Infectious Disease.** Where a common infectious ailment such as chicken pox is identified or where concern persists without identification of the infection, the parents and/or guardians will be contacted by telephone. If the diagnosis takes place when away from school, parents and

guardians must advise the school. The matter will be discussed and the parent and/or guardian should be advised to seek immediate medical advice, if not done so already, and to contact the matrons either before the child returns or upon return if advised to do so by the doctor. The following is a common list of infectious diseases where some form of action may be required (it is not exhaustive):

a. Amoebiasis (Entamoeba histolytica)
b. Campylobacter
c. Chickenpox
d. Conjunctivitis
e. Diarrhoea
f. Diphtheria
g. Hand, Foot and Mouth disease
h. Haemophilus influenzae type b (Hib)
i. Hepatitis A, B or C, Herpes (cold sores)
j. Impetigo
k. Influenza and influenza like illnesses
l. Measles
m. Meningitis (bacteria —other than meningococcal meningitis)
n. Meningococcal infection
o. Mumps
p. Pertussis (Whooping cough)
q. Poliomyelitis
r. Ringworm
s. Scabies
t. Pediculosis (head lice)
u. Rubella (German measles)
v. Salmonella
w. Shigella
x. Severe Acute Respiratory Syndrome (SARS)
y. Streptococcal infection (including scarlet fever)

z. Verotoxin producing Escherichia coli (VTEC)

aa. Worms.

To avoid passing infections in a close community, **the School's policy is to follow the NHS' guidance; parents will be asked to keep children at home in line with that advice.**

POLICY FOR ADMINISTRATION OF MEDICINE

13. **Non-prescribed/Over the Counter Medicines (OCMs).** Homely remedies, including OCMs such as painkillers, can be provided by matrons and boarding staff. The procedure is detailed at Appendix 1. If a child visits matron and is given a non-prescribed medicine, it is recorded in the Medication Book that is kept in Sick Bay. The duty matron will then follow the procedure outlined below if further treatment or observation is required:

a. Day Children: A note will be sent home, or a phone call made, to the parents from the matron detailing treatment, times of administration and any further action. This includes all EYFS children.
b. Boarders: A record is made in the medical book and is recorded on iSAMS.

14. **Prescribed**. All medicine that is brought into school must be handed to the matron and recorded on the Medicine Chart. The matron will then oversee the administration of the medicine. As the medicine is administered, the Matron or duty house staff will record the date and time given in the medical book and on iSAMS.

15. **Storage of medication.** All non-prescribed medication is kept in a locked cupboard in Sick Bay. Regular medication for children is kept in a locked cupboard and there is also a locked box in the refrigerator should any medication need to be kept cool. Sick Bay itself is locked when not in use. Keys for the medicine are kept in a pin-coded wall safe.

16. **Immunisation** The school adheres to strict guidelines set down by the school doctor. Prior to immunisations a letter or an email will be sent to all parents of children who may receive an immunisation. The replies are then collated and the matron organises the immunisation in conjunction with the school doctor.

17. **Dental care.** The school does not make appointments for dental care unless it is an emergency. It is the responsibility of the child's parents or guardian to do this.

18. **Staff Support.** All members of staff who routinely deal with pupils are made aware of those pupils who have potentially life-threatening conditions and this information is also available, under confidential cover, in the Staff Room. The "need to know" in these cases, in the best interests of pupil welfare, is considered to be such that it overrides ordinary medical confidentiality. For example, this occurs where children may require an epi-pen, or are allergic to specific substances, or are diabetic and may require additional medical assistance.

19. **Dealing with Asthma, Diabetes, Allergies and Epilepsy.**
    a. Appendix 2 – Asthma
    b. Appendix 3 – Diabetes.
    c. Appendix 4 – Allergies.
    d. Appendix 5 – Epilepsy.
20. **Action in the Event of an Emergency.** For all emergency situations, when the immediate accident has been dealt with, the Headmaster, Bursar, Housemaster/mistress and Sick Bay will be informed as soon as

possible. Subsequently a RIDDOR report form must be completed and given to sickbay who will ensure it is passed to the bursary. In the event of a serious or life threatening accident where it does not seem safe and reasonable to the first member of staff on the scene for the victim to be taken to sickbay, the following routine should be employed. Help should be sought immediately as follows:

a. Phone 999 and request an Ambulance giving brief details of the injury and careful details of the site. See the Actions on in the first aid policy.

b. Inform the sickbay. They will ensure medical details of the pupil are available where necessary, and inform the School Doctor, if required.

21. **Action in the Event of Sickness during School Hours (0745am – 8.30pm).** In the event of a child becoming sick during the hours, the member of staff currently supervising the child will, depending upon the circumstances, do one of three things:

a. Escort the child to sick bay. Another teacher, in close proximity (eg teaching next door), should be alerted. Also, the School Office should be alerted if practicable. This is the appropriate procedure in all cases where the child is diabetic. They are not to go to sick bay alone.

b. Allow the child to go to sick bay with another pupil as escort. This might be done for minor ailments for the older children (for example, a Yr 8 child complaining of a sore throat).

c. Allow the child to go to sick bay on their own. This is the least acceptable course of action and should only be undertaken if there is no alternative and no member of staff who might be alerted.

d. Once at sick bay, matron will make the decision on the appropriate course of action for the child. Parents and/or guardians must be reminded that their children may not return to school within 48 hours of a vomiting or diarrhoea episode.

22. **Action in the Event of Sickness during non-School Hours (8.30pm – 07.45 am).** In the event if a child becoming sick during the night a member of the boarding staff will attend to them where necessary; parents will be contacted if it is felt necessary or is possible. If a child is extremely ill and parents are not contactable, the Housemaster – or the most senior boarding member of staff on duty - is to be informed and to make a decision on whether a child requires to see a doctor. Accommodation for boarders who are unwell is adequately staffed by appropriately qualified personnel. It is adequately separated from other boarders and provides separate accommodation for male and female boarders where this is necessary. Parents and/or guardians must be reminded that their children may not return to school within 48 hours of a vomiting or diarrhoea episode.

BODILY FLUIDS PROTOCOL

23. **General.** This protocol covers the precautions to be taken when dealing with body fluids. All body fluids potentially carry transmittable disease, the biggest risk being Hepatitis B, which is difficult to destroy and is carried by up to 20% of the population, Hepatitis C, D and G can also be carried in the blood. HIV can be present in freshly spilt blood, but does not survive outside the body for more than a few seconds. It is not possible to identify all risks so **ALL** body fluids should be regarded as potentially infectious.

24. **Treatment guidelines.** Use the following treatment guidelines:

a. Always use disposable gloves.

b. Always use disposable cloths.

c. Encourage children to clean their own wounds, as appropriate.

d. Always cover a wound.

e. Ensure that wounds are covered during contact sports.

f. Control surface contamination by blood and bodily fluids through containment and appropriate decontamination procedures.

Note that kitchen staff are not permitted to clean up bodily fluid spillages in the School, as to do so would increase the risk of contamination through transfer whilst serving food.

25. **Safety guidelines.** Use the following safety guidelines:

a. If a child finds a used condom, dispose of it and ensure that the child washes their hands thoroughly. The parents must be informed.

b. If a child finds a needle from a syringe, bring the sharps bin (located in the School office) and dispose of it. Ensure that the child washes their hands thoroughly. If there is broken skin, encourage the wound to bleed. The parents must be informed and it is their responsibility to seek medical advice if they believe it to be necessary.

c. Parents and/or guardians must be reminded that their children may not return to school within 48 hours of a vomiting or diarrhoea episode.

26. **Bodily fluid kits.** Matron holds bodily fluid spillage kits. A kit will be held in the Dining Room.

INOCULATION INCIDENTS

27. **Direction.** The most common inoculation incident comes from a sharps injury where a needle or other sharp contaminated with blood or other high risk body fluid penetrates the skin. However, this can also include bites from an infected person, which breaks the skin. Inoculation incidents involving the potential for injury may be caused by:

a. Needlestick or sharp injury with a used needle or instrument
b. Body Fluids entering uncovered cuts or breaks in the skin
c. Bites and scratches
d. Splashes in the eye and/or mouth.

28. **Actions.** IMMEDIATELY STOP WORK.

a. **DISPOSE** of the causative sharp safely and attend to the injury.
b. **BLEED IT** by applying gentle pressure - do not suck.
c. **WASH IT** well under running water.
d. **COVER IT** – dry and apply a waterproof plaster.

If blood and body fluids splash into the mouth, do not swallow. Rinse out the mouth several times with cold water. If blood and body fluids get into the eye, irrigate with cold water. Contact NHS or A & E for advice and or treatment.

MEDICAL FORMS

29. **Medical forms.** Copies of the School's medical forms are at:

a. Appendix 6 – Admissions Medical Form.
b. Appendix 7 – Medication chart.
c. Appendix 8 – Regular medicine chart.

IMMUNISATION PROTOCOL

30. **Protocol.** The following is the School's immunisation protocol:

a) All parents/guardians to be written to with full details of proposed immunisation with an unambiguous consent form enclosed specific to that vaccine.

b) Parents who have stated they do not want vaccination to occur on the child's records should also be written to out of courtesy to let them know that immunisation is occurring and, that if they were to wish their child to be included in this instance, to contact the School.

c) Any unreturned consent forms to be chased up by telephone by the Matron.

d) Specific lists of those to be vaccinated to be taken to the surgery.

e) Only those children who are to be vaccinated to be presented for vaccination.

f) A detailed check to be completed that the child being presented for immunisation has an appropriate consent form being sent in with that child to the person performing the immunisation.

g) The person giving the immunisation to check against the child's name and that the consent form is correctly filled in.

h) Only then can the vaccine be administered.

i) The child must be closely supervised for at least 10 minutes before being allowed to leave.

j) Full record of immunisation to be kept by the School separately and on the child's medical records.

INTIMATE CARE PRINCIPLES

31. A detailed intimate care guidance is at Appendix 9.

Appendix 10 – Epipen

Appendix 11 – Head Injuries

Appendix 1

PROTOCOL FOR ADMINISTERING OVER THE COUNTER MEDICINES (OCMs)

1. **General.** Such medicines might include simple linctus, painkillers such as paracetamol or ibuprofen, Piriton. When issuing medication the following procedure should be followed:

a. **Check:**

(1) Whether the pupil is allergic to the medication – iSAMs notes.

(2) Whether the pupil has taken any medication recently. If so, what? (NB dosage and contra-indications)

(3) That the pupil has taken the OCM before - the expiry date on the medication

b. **Administer:**

(1) The pupil should take the medication under the supervision of the person issuing it. No more than the standard recommended doses of any OCM should be administered in one twenty-four period.

(2) A pupil requiring more than the recommended doses in the same twenty-four period, or whose symptoms persist beyond twenty-four hours, should be referred to the School Doctor for treatment.

c. **Record.** The following details are to be entered into the book in full. **IT IS A DISCIPLINARY OFFENCE NOT TO DO SO:**

(1) Record the details of issue.

(2) Name of pupil – in full.

(3) Reason for issue.

(4) Name of medication and dose.

(5) Date and time.

(6) Signature.

Matron will enter the information on to iSAMs. Such a record should be kept so that an audit trail of OCM administration is possible within individual Boarding Houses. Such records are liable to inspection by ISI and by the Head of Boarding.

Appendix 2

DEALING WITH ASTHMA

1. **General.** Asthma is a common long-term condition that can cause a cough, wheezing, and breathlessness. The severity of the symptoms varies from person to person. Asthma can be controlled well in most people most of the time.

2. **What is asthma?** Asthma is caused by inflammation of the airways. These are the small tubes, called bronchi, which carry air in and out of the lungs. If you have asthma, the bronchi will be inflamed and more sensitive than normal. When you come into contact with something that irritates your lungs, known as a trigger (see below), your airways become narrow, and the muscles around them tighten and there is an increase in the production of sticky mucus (phlegm). This leads to symptoms including:

a. Difficulty breathing
b. Wheezing and coughing
c. A tight chest

A severe onset of symptoms is known as an asthma attack or an 'acute asthma exacerbation'. Asthma attacks may require hospital treatment and can sometimes be life-threatening, although this is rare. For some people with chronic (long-lasting) asthma, long-term inflammation of the airways may lead to more permanent narrowing. If you are diagnosed with asthma as a child, the symptoms may disappear during your teenage years. However, asthma can return in adulthood. Moderate to severe childhood symptoms are more likely to persist or return later in life. Although asthma does not only start in young people and can develop at any age.

3. **What causes asthma?** The cause of asthma is not fully understood, although it is known to run in families. You are more likely to have asthma if one or both of your parents has the condition.

4. **Common triggers.** A trigger is anything that irritates the airways and brings on the symptoms of asthma. These differ from person to person and people with asthma may have several triggers. Common triggers include: house dust mites, animal fur, pollen, tobacco smoke, exercise, cold air and chest infections. Asthma can also be made worse by certain activities, such as hard exercise during PE.

5. **Treating asthma.** While there is no cure for asthma, there are a number of treatments that can help effectively control the condition. Treatment is based on two important goals:

a. Relieving symptoms.
b. Preventing future symptoms and attacks from developing**.**

Treatment and prevention involves a combination of medicines, lifestyle advice, and identifying and then avoiding potential asthma triggers.

6. **Asthma attack – what to do.** Current guidelines for children and adults having an asthma attack are to:

a. Alert matron if there is time to do so – send a child or an adult as a runner.

b. Allow the pupil to use their reliever inhaler (usually blue) straight away and try to breathe deeply and steadily. IF the child is panicking ask them for it, or where it is.

c. Sit them down and loosen any tight clothing.

If the symptoms haven't improved after five minutes, or you're worried, call 999 or see a doctor urgently continue to take a puff of your reliever inhaler every minute until help arrives. Once the incident is complete, ensure that matron is aware and an Accident Report has been filled in. Matron will ensure that the parents and/or guardians are made aware.

Appendix 3

DEALING WITH DIABETES

1. **General.** Diabetes is a lifelong condition that causes a person's blood sugar level to become too high. In the UK, approximately 2.9 million people are affected by diabetes. There are also thought to be around 850,000 people with undiagnosed diabetes.

2. **Types of diabetes.** There are two main types of diabetes, referred to as type 1 and type 2:

a. Type 1 diabetes is often referred to as insulin-dependent diabetes. It is also sometimes known as juvenile diabetes or early-onset diabetes because it often develops before the age of 40, usually during the teenage years. In type 1 diabetes, the pancreas (a small gland behind the stomach) does not produce any insulin. Insulin is a hormone that regulates blood glucose levels. If the amount of glucose in the blood is too high, it can seriously damage the body's organs. If you have type 1 diabetes, you will need to take insulin injections for life. You must also make sure that your blood glucose levels stay balanced by eating a healthy diet, taking regular exercise and having regular blood tests.

b. In type 2 diabetes, the body does not produce enough insulin, or the body's cells do not react to it. This is known as insulin resistance. Type 2 diabetes is far more common than type 1 diabetes, which occurs when the body doesn't produce any insulin at all. In the UK, about 90% of all adults with diabetes have type 2 diabetes.

3. **Diabetes symptoms.** Diabetes can cause various symptoms. Symptoms common to both types of diabetes include:

a. Feeling very thirsty.

b. Urinating frequently, particularly at night.

c. Feeling very tired.

d. Weight loss and loss of muscle bulk

4. **Treating type 1 diabetes.** Diabetes cannot be cured, but treatment aims to keep your blood glucose levels as normal as possible, and control your symptoms to prevent health problems developing later. If you are diagnosed with diabetes, you will be referred to a diabetes care team for specialist treatment. Your care team will be able to explain your condition to you in detail and help you understand your treatment. They will also closely monitor your condition. As your body cannot produce any insulin, you will need to have regular insulin treatment to keep your glucose levels normal. You will need to learn how to match the insulin you inject to the food you eat, taking into account your blood glucose level and how much exercise you do. This skill needs to be practised and learnt gradually. Many centres now provide courses to teach these skills. Insulin comes in several different forms, each of which works slightly differently. For example, some last up to a whole day (long-acting), some last up to eight hours (short-acting) and some work quickly but do not last very long (rapid-acting). Your treatment may include a combination of these different insulin preparations.

5. **Treating type 2 diabetes.** Diabetes cannot be cured, but treatment aims to keep your blood glucose levels as normal as possible to control your symptoms and minimise health problems developing later. If you are diagnosed with diabetes, you may be referred to a diabetes care team for specialist treatment, or your GP surgery may provide first line diabetes care. In some cases of type 2 diabetes, it may be possible to control your symptoms by altering your lifestyle, such as eating a healthy diet (see below). However, as type 2 diabetes is a progressive condition, you may eventually need medication to keep your blood glucose at

normal levels. To start with this will usually take the form of tablets, but later on it may include injected therapies, such as insulin.

6. **What to do if someone is someone has a diabetic attack.** In most instances, the school knows who the diabetic children are, and their pictures are displayed around the school. However, a visitor to the school may also have a diabetic attack so it is sensible for all to know what to do. **Wherever possible, contact a matron first to get help from them.**

Administer Sugar. The best response to a hypoglycaemic attack is sugar. Most diabetics should carry glucose tablet with them, for just such an emergency. In the absence of glucose tablets, sweets, juice, sugary soft drinks and anything else with straight sugar will do.

Glucagon Injections. Some diabetics may have their physicians prescribe glucagon. Glucagon is a hormone, produced by the pancreas, which raises blood sugar. Glucagon is administered by injection like insulin, and the diabetic may be able to inject himself. The Glucagon may be in a tube of gel.

Call Emergency Services. If the person has lost consciousness, or if you are unable to administer sugar or glucagon, contact 999 immediately. The longer you wait, the lower the blood sugar levels will drop and the greater the risk of slipping into a coma. If the diabetic does pass out, do not administer sugar or insulin, do not inject glucagon and do not give food or liquids. Wait with her until help arrives and make her a comfortable as possible. Make note of the time of the attack because the paramedics will ask.

Once the incident is complete, ensure that matron is aware and an Accident Report has been filled in and that the parents and/or guardians are made aware.

Appendix 4

DEALING WITH ALLERGIES

1. **Food Allergies.** Food allergies are becoming increasingly common in the UK, although severe allergic reactions are relatively rare and most commonly caused by only a handful of foods. It is thought that one to two per cent of UK adults and about five to eight per cent of children are affected by food allergies. Fortunately most allergic reactions to food are relatively mild, but some reactions can be very severe. The term anaphylaxis is used to describe severe allergic reactions. For many people with food allergy, it only takes a minute amount of the allergen to trigger a reaction. The following food allergens have been identified as public health concerns in the UK:

a. Peanuts (also called groundnuts or monkey nuts);

b. Nuts (almond, hazelnut, walnut, cashew, pecan, Brazil, pistachio, macadamia and Queensland nut);

c. Fish;

d. Eggs;

e. Crustaceans (e.g. crab, lobster, langoustine, prawn, shrimp);

f. Sesame seeds;

g. Milk;

h. Soybeans;

i. Celery (including celeriac);

j. Mustard;

k. Lupin;

l. Molluscs (e.g. squid, octopus, mussels, cockles);

m. Added sulphur dioxide and sulphites at a level above 10 mg/kg; and

n. Gluten containing cereals (including wheat, barley, rye, kamut, spelt, couscous, pearl barley, semolina).

2. **Gluten.** Some people also need to avoid gluten-containing foods due to coeliac disease. Although not a food allergy, coeliac disease is a life-long auto-immune disease caused by intolerance to gluten. The only treatment is to follow a gluten-free diet for life.

3. **Guidance and legislation.** People with food allergies are well protected under existing food and consumer protection law. Under the Food Safety Act 1990 and Food Safety Regulations 1995 (Revised 2006) the Sherborne Prep kitchens must:

a. Provide essential allergen information to their staff and children of Sherborne Prep, especially on request or where foods contain a known or common allergen. Any information given by a member of staff must be accurate and properly researched.

b. Ensure that anyone involved in the preparation or serving of the food to customers understands the risks involved, how to avoid them and the importance of giving accurate information.

4. **Recognising allergies - what are the symptoms?** 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 is getting 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 – call 999.**

5. **What is anaphylaxis?** Anaphylaxis is a severe allergic reaction. A small number of people are unfortunate to suffer from a very acute allergy to food and, for these people, the issue is vital: it is literally potentially a matter of life and death, and needs to be treated quickly with adrenaline. The whole body is affected, often within minutes of exposure to the allergen but sometimes after hours. A reaction can be triggered by a wide range of foods. Theoretically almost any food may be implicated, but the most common culprits are peanuts, tree nuts, sesame seeds, fish, shellfish, eggs and dairy products. During anaphylaxis there can be a whole range of symptoms including those described above. Some or all of the following may be present:

a. Flushing of the skin;

b. Nettle rash (hives) anywhere on the body;

c. The feeling that something terrible is happening;

d. Swelling in the throat or mouth;

e. Difficulty in swallowing or speaking;

f. Alterations in heart rate;

g. Severe asthma;

h. Stomach pain, feeling sick and vomiting;

i. Sudden feeling of weakness (drop in blood pressure); and/or

j. Collapse and unconsciousness.

6. **How to minimise the risks.** The school does the following:

a. School briefs ALL staff termly at INSET about hazards of allergies, the emergency procedures to be followed in the event of someone suffering from an allergic reaction and about the identities of those known to suffer from severe food allergies.

b. Liaises with the parents of those with a food allergy to ensure that details of foods to be avoided, and for the less common allergies, menus and recipes to be followed are known. In order for the school to provide meals exempt of the identified ingredients a copy of this information must be made available to the school Catering Manager before any items are prepared and issued to the child.

c. Sources, as far as it is possible, foods from its suppliers for a child to cater for his or her particular allergy condition. The child's parent/guardian must accept that the school can only source according to the information it is provided with from suppliers. The school may need to seek advice from procurement, dietetics and the health and safety executive and provide catering staff with regular updates on allergy matters and sources/content of ingredients.

d. Ensures that catering staff can identify those with severe food allergies and ensure that they supervise the meals taken by those who are at risk.

e. Clearly indicates, as far as possible, key allergens on the menus for the pupils by clearly naming dishes and whether certain products/ingredients have been included or may be present as trace contaminants e.g. gluten, dairy or nuts in particular.

f. Train staff to negate, as far as practicable, human error in the preparation and delivery of special diets. Assess catering practices to identify areas of potential cross-contamination. For example, use separate serving utensils for products and wash hands after handling nut or milk products. Wipe up milk spillages promptly and thoroughly. Common hazards include using tongs to handle different products and using the same knife for spreading.

g. Designated trained staff should be available in school at all times in order to assist children in an emergency. The child's parents must consent to staff administering remedies. Children with allergies going on trips will be part of the risk assessment process.

h. Each child should have a protocol prepared for them by the school if there is one or more severe food allergy that results in anaphylactic conditions if they come into contact with the allergen(s).

i. In respect of pre-packaged foods, the school can only provide the information given from manufacturers. Food Labelling Regulations has expanded the food labelling requirements of manufacturers including the requirement to list common allergens in the foods.

j. The child must be taught which allergens to avoid. Teachers and the school catering staff, once aware of a child's allergy problem, can assist.

k. During childhood development, allergies and their treatment may alter. If parents are advised of changes by medical practitioners, any changes that affect diet must be notified to the Matron and the catering manager in a letter signed by the appropriate practitioner.

l. Other areas that need to be tightly managed when handling foods that 'may contain traces of nuts' are staff room biscuits, packed lunches (see below), field trip food, match teas, birthday cakes, bring and buy sales, and harvest festivals. With children with a severe anaphylactic reaction every avenue that food may be brought onto site will need to be addressed.

m. The school has a disclaimer which states:

"Some of our menu items contain nuts, seeds and other allergens. There is a small risk that tiny traces of these may be in any other dish or food served here. We understand the dangers to those with severe allergies. Please ask to speak to the Head Chef who may be able to help you to make an alternative choice".

EMERGENCY ACTIONS

7. **General.** Most allergic reactions are minor and do not require first aid or assistance. In a number of very rare cases, a person will have a serious reaction that will result in anaphylactic shock. In these cases emergency action is necessary.

8. **Trained EPIPEN User Actions.** If a matron or trained person has access to the pupil's epi-pen, they are allowed to administer it: **EPIPEN IT IS NOT TO BE ADMINISTERED BY UNTRAINED PERSONNEL.**

9. **Untrained on EPIPEN.** If an allergic pupil becomes ill, it is likely that this person - or someone with them - will say that he/she is suffering from an allergic reaction. If a trained person is unavailable, the following procedure must be followed:

Immediately send someone to **dial 999.** Remind them if they need to dial for an outside line. Tell them to give the following information:

(1) Ask for the Ambulance service.

(2) **"This is an emergency. A pupil has collapsed and we believe they are suffering from anaphylaxis - an allergic reaction"** (pronounced ana-fill-axis).

(3) Give the address and postcode of Sherborne Prep, which is Acreman Street, Sherborne, DT9 3NY - clearly enough so that the ambulance crew will know exactly where to come. Try to stay calm.

(4) Someone should be sent to stand at the entrance of the school to direct the ambulance crew to the pupil.

10. **What is the treatment and how does it work?** Adrenaline (also known as epinephrine) is the front-line treatment for anaphylaxis. During anaphylaxis, blood vessels leak, bronchial tissues swell and blood pressure drops. Adrenaline acts quickly to constrict blood vessels, relax smooth muscles in the lungs to improve breathing, stimulate the heartbeat and help to stop swelling around the face and lips. If a child is having an anaphylactic reaction, an injection of adrenaline could save their life. It is vital that an adrenaline injection is available at all times, and that family, friends and school staff are briefed about when and how it should be used. Adrenaline injection kits are available from GPs on prescription. The School should hold 2 EPIPENS per child. Adrenaline pens should only be administered by someone who is trained and authorised to do so.

11. **Post incident actions.** Once an incident has taken place, a member of the senior management team must be informed immediately and an accident report filled in. Concurrently, the parents and/or guardians should be informed.

Appendix 5

DEALING WITH EPILEPSY

1. **What is a seizure?** A seizure happens when there is a sudden burst of intense electrical activity. This is often referred to as epileptic activity. This intense electrical activity causes a temporary disruption to the way the brain normally works, meaning that the brain's messages become mixed up. The result is an epileptic seizure. The brain is responsible for all the functions of your body. What you experience during a seizure will depend on where in your brain the epileptic activity begins and how widely and rapidly it spreads. For this reason, there are many different types of seizure and each person will experience epilepsy in a way that is unique to them.

2. **Treatment of epilepsy.** Epilepsy is usually treated with epilepsy medicines. These are also referred to as anti-epileptic drugs (AEDs). Epilepsy medicines act on the brain, trying to reduce seizures or stop seizures from happening. Many people with epilepsy find that when they have the right medicine, they have fewer or no seizures. In the UK, 70 per cent (seven out of ten) of people with epilepsy could be seizure free with the right treatment.

3. **What to do if you see someone having a Seizure**

a. **Tonic-Clonic seizures.** The person goes stiff, loses consciousness and then falls to the ground. This is followed by jerking movements. A blue tinge around the mouth is likely. This is due to irregular breathing. Loss of bladder and/or bowel control may happen. After a minute or two the jerking movements should stop and consciousness may slowly return.

Do	Don't
• Protect the person from injury - (remove harmful objects from nearby) • Cushion their head • Look for an epilepsy identity card or identity jewellery • Aid breathing by gently placing them in the recovery position once the seizure has finished (see pictures) • Stay with the person until recovery is complete • Be calmly reassuring • **GET MATRON – use a runner**	• Restrain the person's movements • Put anything in the person's mouth • Try to move them unless they are in danger • Give them anything to eat or drink until they are fully recovered • Attempt to bring them round

b. **Call for an ambulance if:**

(1) You know it is the person's first seizure, or

(2) The seizure continues for more than three minutes, or

(3) One tonic-clonic seizure follows another without the person regaining consciousness between seizures, or

(4) The person is injured during the seizure; or

(5) You believe the person needs urgent medical attention.

If in doubt, call an ambulance.

c. **Focal (partial) seizures.** Sometimes the person may not be aware of their surroundings or what they are doing. They may pluck at their clothes, smack their lips, swallow repeatedly, and wander around.

Do	Don't
• Guide the person from danger • Stay with the person until recovery is complete • Be calmly reassuring • Explain anything that they may have missed • **GET MATRON – use a runner**	• Restrain the person • Act in a way that could frighten them, such as making abrupt movements or shouting at them • Assume the person is aware of what is happening, or what has happened • Give the person anything to eat or drink until they are fully recovered • Attempt to bring them round

d. **Call for an ambulance if.**

(1) You know it is the person's first seizure.
(2) The seizure continues for more than five minutes.
(3) The person is injured during the seizure
(4) You believe the person needs urgent medical attention

If in doubt, call an ambulance.

4. **First aid for people who use a wheelchair.** If you use a wheelchair, or you have other mobility problems, speak to your GP or epilepsy specialist. They should give you a care plan, which includes advice on how people should help you if you have a seizure. Here are some general first aid guidelines for people who have a seizure in a wheelchair.

Do	Don't
• Put the brakes on, to stop the chair from moving • Allow the person to remain seated in the chair during the seizure (unless they have a care plan which says to move them). Moving the person could possibly lead to injuries for the person having the seizure and the carer • If the person has a seatbelt or harness on, leave it fastened • If the person doesn't have a seatbelt or harness, support them gently, so they don't fall out of the chair. The person's care plan should give advice on what to do after the seizure has finished. For example, whether it is safe to move the person from the chair to put them in the recovery position. • Cushion the person's head and support it gently. A head rest, cushion or rolled up coat can be helpful.	• Restrain the person's movements • Put anything in the person's mouth • Give them anything to eat or drink until they are fully recovered • Attempt to bring them round

5. **Post incident action.** Once the incident is complete, ensure that matron is aware. Ensure an Accident Report has been filled in and that the parents and/or guardians are made aware.

Appendix 6

MEDICAL FORM

SURNAME……..

FIRST NAMES……

NHS NUMBER……

DATE OF ADMISSION TO SCHOOL……

DATE OF BIRTH……

PLACE OF BIRTH……..

Past Serious Illnesses (with dates)…….
……..

Has your child had any of the following? Please give dates.

Mumps ……

Chicken Pox ……

Whooping Cough ……

Measles ……

German Measles (Rubella) ……

Rheumatic Fever ……

Jaundice ……

X-Rays ……

Any abnormality ……

Has your child had inoculations against the following? Dates are important

Diphtheria	1st	2nd	3rd
Whooping Cough			
Tetanus (Toxoid)			
Polio			

Mumps Measles Rubella (MMR)……..
Tuberculosis (BCG)……..
Cholera ……
Yellow Fever ……
Typhoid ……
Others ……

Appendix 7

MEDICATION CHART

ALL DRUGS BROUGHT IN TO SCHOOL MUST BE RECORDED ON THIS SHEET

DATE	NAME OF PUPIL	MEDICATION	ACTION

Appendix 8

REGULAR MEDICINE CHART

WEEK BEGINNING: _____

NAME	DRUG	DOSE	SUN	MON	TUES	WED	THUR	FRI	SAT

Appendix 9

INTIMATE CARE PRINCIPLES

1. **Introduction.** This intimate care policy should be read in conjunction with the following

a. Sherborne Prep School's child protection policy

b. Sherborne Prep School's health and safety policy and procedures

c. Sherborne Prep School's policy for the administration of medicines

d. Sherborne Prep School staff's code of conduct or guidance on safe working practice.

2. **Guiding principles.** Sherborne Prep 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. It is acknowledged that these adults are in a position of great trust. Sherborne Prep School recognises that there is a need to treat all children, whatever their age, gender, disability, religion or ethnicity, with respect when intimate care is given. The child's welfare and dignity is of paramount importance. No child should be attended to in a way that causes distress or pain.

3. **Definition**. Intimate care can be defined as any care which involves washing, touching or carrying out a procedure to intimate personal areas which most people usually carry out themselves but some children are unable to do because of their young age, physical difficulties or other special needs. Examples include care associated with continence (for example nappy changing) and menstrual management as well as more ordinary tasks such as help with washing, toileting or dressing. It also includes supervision of children involved in intimate self-care.

4. **Best Practice.**

a. Staff who provide intimate care at Sherborne Prep School should be trained to do so including in child protection and health and safety training in moving and handling (which can be provided by the appropriate LA officers/advisers) and are fully aware of best practice regarding infection control, including the need to wear disposable gloves and aprons where appropriate.

b. Staff will be supported to adapt their practice in relation to the needs of individual children taking into account developmental changes such as the onset of puberty and menstruation.

c. As an additional safeguard, staff involved in meeting intimate care needs will not usually be involved with the delivery of sex education to the same children, wherever possible.

d. There is careful communication with each child who needs help with intimate care in line with their preferred means of communication (verbal, symbolic, etc.) to discuss their needs and preferences. Where the child is of an appropriate age and level of understanding permission should be sought before starting an intimate procedure.

e. All children will be supported to achieve the highest level of autonomy that is possible given their age and abilities. Staff will encourage each child to do as much for his/herself as possible.

f. Children who require regular assistance with intimate care have written Individual Education Plans (IEP) or care plans agreed by staff, parents/carers and any other professionals actively involved, such as school nurses or physiotherapists. These plans include a full risk assessment to address issues such

as moving and handling, personal safety of the child and the carer. Any historical concerns (such as past abuse) should be noted and taken into account.

g. Where a care plan or IEP is not in place, parents/carers will be informed the same day if their child has needed help with meeting intimate care needs (eg: has had an 'accident' and soiled him/herself). It is recommended practice that information on intimate care should be treated as confidential and communicated in person, by telephone or by sealed letter, not through the home/school diary.

h. Every child's right to privacy will be respected. Careful consideration will be given to each child's situation to determine how many carers might need to be present when a child needs help with intimate care. Adults who assist children one-to-one should be employees of the school and be DBS checked at the appropriate level.

i. It is not always practical for two members of staff to assist with an intimate procedure and also this does not take account of the child's privacy. It is advisable, however, for a member of staff to inform another adult when they are going to assist a child with intimate care.

j. Wherever possible the same child will not be cared for by the same adult on a regular basis; there will be a rota of carers known to the child who will take turns in providing care. This will ensure, as far as possible, that over-familiar relationships are discouraged from developing, while at the same time guarding against the care being carried out by a succession of completely different carers.

k. Wherever possible staff should care for a child of the same gender. However, in some circumstances this principle may need to be waived; for example, female staff supporting boys in a where no male staff are available. Male members of staff should not normally provide routine intimate care (such as toileting, changing or bathing) for adolescent girls. This is safe working practice to protect children and to protect staff from allegations of abuse.

l. The religious views and cultural values of families should be taken into account, particularly as they might affect certain practices or determine the gender of the carer.

m. All staff should be aware of the school's confidentiality policy. Sensitive information will be shared only with those who need to know.

5. **Child Protection**. The Governors and staff at Sherborne Prep School recognise that children with special needs and disabilities are particularly vulnerable to all types of abuse.

n. The school's child protection policy and inter-agency child protection procedures will be accessible to staff and adhered to.

o. From a child protection perspective it is acknowledged that intimate care involves risks for children and adults as it may involve staff touching private parts of a child's body. It may be unrealistic to expect to eliminate these risks completely but in this school best practice will be promoted and all adults will be encouraged to be vigilant at all times.

p. Where appropriate, all children will be taught personal safety skills carefully matched to their level of development and understanding.

q. If a member of staff has any concerns about physical changes in a child's presentation, e.g. unexplained marks, bruises, soreness etc s/he will immediately report concerns to the Head Master or DSL. A clear written record of the concern will be completed and a referral made to the LADO if necessary, in accordance with inter-agency procedures.

r. If a child becomes distressed or very unhappy about being cared for by a particular member of staff, this should be reported to the form teacher or Head Master. The matter will be investigated at an appropriate level and outcomes recorded. Parents/carers will be contacted at the earliest opportunity as part of this process in order to reach a resolution. Staffing schedules will be altered until the issue(s) are resolved so that the child's needs remain paramount. Further advice will be taken from outside agencies if necessary.

s. If a child makes an allegation against an adult working at the school, this will be investigated in accordance with the School's policies.

6. **Physiotherapy.** Children who require physiotherapy whilst at school should have this carried out by a trained physiotherapist. If it is agreed in the IEP or care plan that a member of the school staff should undertake part of the physiotherapy regime (such as assisting children with exercises), then the required technique must be demonstrated by the physiotherapist personally, written guidance given and updated regularly. Under no circumstances should school staff devise and carry out their own exercises or physiotherapy programmes. Adults (other than the physiotherapist) carrying out physiotherapy exercises with pupils should be employees of the school. Any concerns about the regime or any failure in equipment should be reported to the physiotherapist.

7. **Medical Procedures.** Children with disabilities might require assistance with invasive or non-invasive medical procedures such as the administration of rectal medication, managing catheters or colostomy bags. These procedures will be discussed with parents/carers, documented in the IEP or care plan and will only be carried out by staff who have been trained to do so. Any members of staff who administer first aid should be appropriately trained. If an examination of a child is required in an emergency aid situation it is advisable to have another adult present, with due regard to the child's privacy and dignity.

8. **Massage.** Massage is now commonly used with children who have complex needs in order to develop sensory awareness, tolerance to touch and as a means of relaxation. Staff at Sherborne Prep School might be involved in delivering aspects of programmes devised by therapists. It is recommended that massage undertaken by school staff should be confined to parts of the body such as the hands, feet and face in order to safeguard the interest of both adults and children.

9. **Record Keeping.** It is good practice for a written record to be kept in an agreed format every time a child has physiotherapy or requires assistance with intimate care, including date, times and any comments such as changes in the child's behaviour. It should be clear who was present. The record to be recorded on ISAMs in the Pastoral Care section.

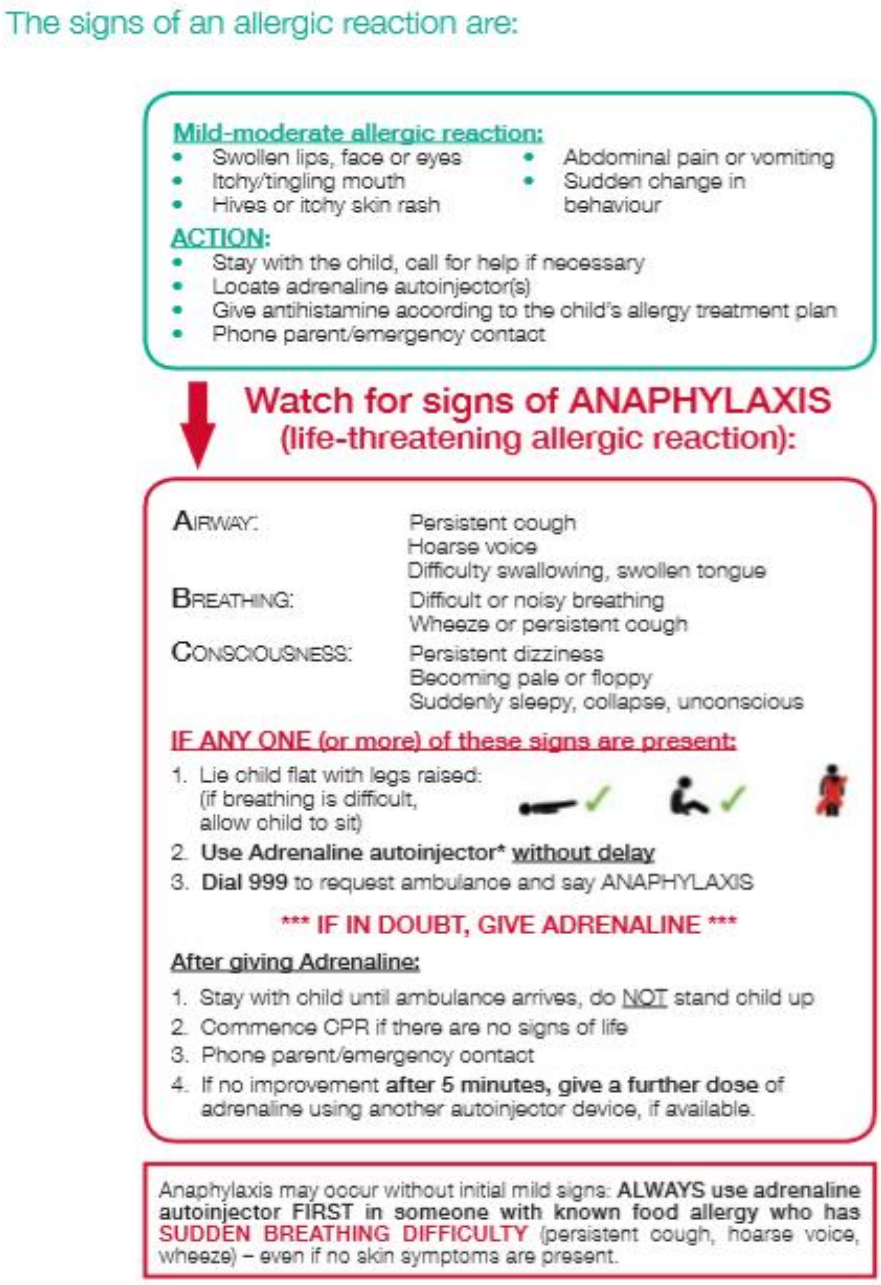
Appendix 10

EPIPEN

1. **Introduction.** Protocol Anaphylaxis is a severe systemic allergic reaction. At the extreme end of the allergic spectrum, the whole body is affected usually within minutes of exposure to the allergen. It can take seconds or several hours. This policy has been drafted in accordance with the recommendations and advice from the Department for Education's guidance.

2. **Anaphylaxis.** Anaphylaxis involves one or both of two features:
   a. Respiratory difficulty (swelling of the airway or asthma).
   b. Hypotension (fainting, collapse or unconsciousness).

3. **Symptoms and immediate actions.** The symptoms and immediate actions are:



4. **Individual care plans.** Each child who may potentially need to use an Epipen has an individual care plan. An example is at end of this Appendix. The details of the individual care plan and responsibilities are:

a. Admissions to inform Matron of the requirement.
b. Matron to draft – a review to be completed annually.
c. Matron will have the parent sign a copy.
d. Matron to brief of the staff at INSET.

As part of the process, the Matron will ask the child's GP for written permission to hold, and if necessary, to administer the Epipen.

5. **Storage.** Storage and care of the Epipens is the responsibility of Matron. They are to:

a. On a monthly basis the Epipens are present and in date. Where an Epipen is due to expire, to inform the parents of the requirement to replace.

b. Ensure that the Epipens are stored at room temperature or in line with manufacturer's guidelines, protected from direct sunlight and extremes of temperature.

c. Schools may wish to require parents to take their pupil's own prescribed AAIs home before school holidays (including half-term breaks) to ensure that their own AAIs remain in date and have not expired.

d. Dispose of an Epipen once it has been used.

e. All Epipens will be stored in a PIN coded safe in the staff workroom. Each child's Epipens to be stored in a pencil case clearly labelled with a copy of the individual care plan inside the pencil case. Trained staff to be given the PIN code and a copy to be held in the School Office.

6. **Information.** Staff will receive the following information:

Information	**When and how**	**Who**
Which children require an Epipen	Termly at INSET	Matron
Training register	Annually and when updated	Bursar
Training register	Copy in the staff workroom	Bursar
Training register	Copy in the office	School Admin Officer

7. **Offsite activities**[2]**.** The event organiser is responsible for conducting a risk assessment for an offsite event. As part of this assessment, both iSAMs and Matron should be consulted for children with known ailments, including any child who requires an Epipen. As a minimum the following must be annotated and carried on the trip:

a. Name and the detail on the risk assessment.
b. A copy of the individual's care plan.
c. 2 Epipens.
d. All staff briefed.
e. An Epipen qualified member of staff to be on the trip.

[2] Sporting event and/or a school trip of any kind. If the child is taken off the School premises

8. **Training.** The School will provide regular and accredited training for the use of Epipens. The Bursar to organise the training and to maintain a qualification register and a copy of the certificate. Guidance on those who should be trained is:

a. As many sports staff as practical.
b. As many form teacher(s) as practical.
c. Office staff.
d. Boarding staff.
e. A member of staff in Pre-prep, DT/Science and Nursery.

9. **Informing parents.** Parents must be informed if an allergic reaction is expected. The Matron to call the parents and to inform the Headmaster, Deputy Head, Bursar and School Doctor.

INDIVIDUAL HEALTH CARE PLAN
XXXX Smith

PHOTO

ALLERGENS: **Peanuts and cashew nuts**
MILD ALLERGIC REACTION: Itchy ears, itchy throat, vomiting and crying. Take XXXX to sick bay where Matron will give XXXXXXX

SEVERE ALLERGIC REACTION: Possible anaphylaxis but has never suffered this before.

- Shout for help and lie XXXXX down
- Call 999, state anaphylactic shock and state location. Send a runner who will direct paramedics to exact location in the school.
- Send a runner to collect epipen from sick bay and second epipen from XXXX location
- Talk slowly and calmly to XXXXX and ensure her that she will soon feel better.
- Administer epipen into thigh, avoiding any clothing hems. Note the time of administration.
- Hold the epipen at a distance of 10cms away from her thigh, at a right angle, avoiding clothing hems, remove the blue safety cap, orange end down and jab firmly into thigh and listen for a click. Hold in place for 3 seconds and remove.
- The dose can be repeated after 5 minutes if no improvement.
- Give the used epipen to the ambulance crew.
- Contact mother on 11111111 or 22222222
- Do not stand XXXXXX up.
- If she is vomiting, lay her in the recovery position.

If XXXXXX is taken off site for a trip or a match, both epipens, plus medication must go with her. The member of staff responsible must know where they are and how to administer the adrenaline. If going to another school Matron will contact the school to inform the nurses that XXXXXX is allergic to cashew nuts and peanuts.

Signed by Matron

Agreed and signed by parent

Appendix 11

HEAD INJURIES

Introduction. This paper provides guidance for staff treating head injuries within Sherborne Prep School. It should be used in conjunction with the newest available evidence and the Matron's clinical judgement of the casualty.

For the purpose of this guideline, 'head injury' is defined as any trauma to the head, other than superficial injuries to the face.

It is advised that all students who sustain a head injury should be taken to sick bay for assessment. They should not go alone and should be accompanied by a responsible adult. Accident forms should be completed by the necessary department. If the injury occurs at an away match the student must be assessed before getting on the coach back to school.

Head Injury as a result of sport

Staff involved in high risk areas should all be first aid trained and should carry a copy of the RFU pocket head injury advice leaflet. Remember "if in doubt, sit it out" it is much better to err on the side of caution.

Sporting head injuries are most likely to occur during rugby hence the RFU guidance is the main reference.

Criteria for referral to Accident and Emergency

1. Unconsciousness, or lack of full consciousness as a result of the injury
2. Amnesia for events immediately before or after the injury
3. Persistent headache since the injury
4. More than one vomiting episode since the injury
5. Any focal neurological deficit since the injury (including problems understanding, visual changes, weakness, reduced sensation, loss of balance)
6. Any suspicion of skull fracture or penetrating head injury (including otorrhoea or rhinorrhoea, black/racoon eyes without damage to the eyes, bleeding from the ear, deafness, bruising behind the ear, visible trauma suspicious of a depressed or open fracture)
7. A high energy head injury
8. Any seizure
9. Irritability or altered behaviour
10. Continuing concern

Assessment method and documentation

The pocket concussion recognition tool should be used for assessment if there is no qualified medical practitioner. Concussion should be suspected in the presence of any of the signs and symptoms in the recognition tool and medical advice should be sought.

The incident must be recorded in the medical book, on iSAMS and parents or guardians must be informed. In the case of a boarder, the Head of Boarding must be notified. An accident form should be completed and a copy given to the bursar. A head injury advice sheet must be given to the parents.

Off Games and follow up care

Following a concussion or suspected concussion the day-to-day management and return to sporting activities for day children will be the responsibility of the parents. They must liaise with Matron and the Director of Sport so the school is aware of the individual plan for the child. In the case of a boarder with concussion, the GRTP guidelines will be implemented with the support of the school doctor. Before a child can commence the exercise elements of the GRTP there is a statutory rest period of 2 weeks and they must be symptom free before they can move to the next level, this decision will be made by the school doctor. All information must be recorded on iSAMS so all staff have access to the information.