Oakwood School
First Aid Policy

This policy applies to the whole school, including the EYFS

CONTENTS:

Definitions:

"DfE"	Department for Education
“First Aid”	Basic medical treatment given to someone as soon as possible after they have been hurt in an accident or incident
“First Aider”	A person who has completed a 1-day course of emergency first aid from a competent trainer and holds a current certificate
“First Aid Kit”	An easily identifiable box, with a white cross on a green background, that contains a supply of in-date equipment
“HSE”	Health and Safety Executive
“PFA”	Paediatric First Aid qualification which is recognised by Ofsted for Early Years (EYFS) and meets Childcare Registration requirements
“RIDDOR”	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations

1 Introduction

1.1 The school complies with the Guidance on First Aid for Schools Best Practice Document published by the DfE (last updated February 2014).

1.2 All companies are required by The Health and Safety (First Aid) Regulations 1981 (amended 2013) to provide trained first aid human resources and treatment in the event of injury or ill health on the premises.

1.3 Any First Aid will be administered in a timely and competent manner, with procedures effectively implemented according to this policy.

2 First Aid

2.1 All staff, both teaching and non-teaching, are responsible for dealing with minor incidents requiring first aid. However no one should perform any first aid procedures that they have not been adequately trained to do. If there is any concern about the first aid which should be administered, one of the qualified First Aiders will be consulted.

During lesson time first aid is mostly administered by the class teacher or teaching assistant.

If an accident occurs in the playground and first aid is required, one of the staff members on duty in the playground should send the child to the First Aid Point where a qualified First Aider will be on duty. If necessary, staff may ask an older child to accompany the injured child. If required, the qualified First Aider may be called to assist in the playground.

2.2 The main First Aid Point at breaktime is the school office, and at lunchtime it is the Art Room (although the first aider is based outside). Fully equipped first aid kits are kept in these areas, as well as in both the Early Years classrooms. Additional supplies are stored in the staffroom. Some teachers have their own basic kits in the classroom. Ice packs are located in the fridge in Reception, staffroom, Art room and hall kitchen.

2.3 First Aid kits are looked after by Mrs Askew, and she also completes checklists annually to ensure sufficient and appropriate levels of stock. Mrs Daly regularly replenishes the outside first aid kits. All staff are responsible for notifying them if any replacement items are required or if something is past its expiry date.

The contents of our First Aid kids will vary slightly according to where they are situated, however in the main the kits will contain the following:

Bandages, Plasters, Dressings, Antiseptic wipes, Gauze swabs, Disposable gloves, Steri-strips, Eye washes, Slings, Scissors, Tweezers, Safety pins

2.4 Ten members of staff are currently trained in emergency first aid at work, and at least two are on the school premises when children are present. A list of all current First Aiders is on display in the hall and staffroom.

Eight members of staff currently have a PFA qualification. For Early Years children, at least one person who has a current PFA certificate is on the school premises at all times when those children are present and at least one Paediatric first-aider is available on any school trip.

Regular, HSE approved first aid training is provided for all staff (either the 'Emergency First Aid at Work' course or 'Paediatric First Aid' for those working within the Early Years). All First Aid Training is updated at least every 3 years. Appendix A lists the names of qualified first aiders.

2.5 For more significant injuries and if the need arises, office staff will telephone for emergency assistance. In those cases where a child needs to be taken to hospital, parents will be contacted immediately and at least one member of staff will be available, if necessary, to accompany the child.

2.6 Significant injuries require two members of staff to assess the situation, and any severe head injury will be referred to the Head or Deputy Head. When treating any injury, common sense should prevail. Staff are advised to follow the First Aid guidelines in Appendix B.

2.7 All head injuries and other injuries that require significant first aid are recorded in a school accident book. These are kept with the main first aid kits and a copy of the form is sent home to parents. All incidents involving children in the Early Years (ie. Reception and Nursery) are recorded. For Early Years children with bumped heads, the accident book is taken outside when the child is collected for the parent (or adult collecting them) to sign. For any children in the Nursery to Year 2 who bump their head, they will be given a 'Bumped Head' sticker.

2.8 Should a child be quite seriously hurt, parents are contacted through the emergency telephone number that is kept on file. These numbers are updated annually, but parents are encouraged to inform us when contact details change. Old books are kept on file in the school office for at least one year for review by the Health & Safety Committee.

2.9 Guidance on when to call an ambulance:

In a situation where an immediate ambulance may be deemed necessary, the discretion of the first aider on duty and other staff involved will be used. Where emergency specialist assistance is sought, there is no need to consult the Head or Deputy Head in advance, any member of staff can call for an ambulance. The following situations are ones where the need to call an immediate ambulance are particularly recognised:-

1) Suspected anaphylactic shock.
2) A seizure (fit) which lasts longer than 5 minutes.
3) Injury resulting in severe blood loss, that cannot be controlled by pressure and elevating the injured part.
4) Severe breathing difficulty and not responding to the usual measures (eg. severe asthma attack not responding to inhalers & the child cannot talk in short sentences due to breathlessness; OR prolonged choking episode not relieved by 5 sharp blows to the back and 5 front thrusts and the child cannot talk or take a clear breath).
5) Suspected meningitis such that a child has a temperature above 38c accompanied by a dark red or purple rash that does not disappear with pressure from a glass (the 'glass test').

In these situations a 999 ambulance will be called and then the parents contacted as soon as is practically possible. A copy of the Emergency Treatment Authorisation Form and accident record should be taken.

2.10 All accidents (near misses, potential hazards and damage) are reported to a member of the school's Health & Safety Committee, which is responsible for investigating such incidents and ensuring that corrective action is taken where appropriate to prevent a recurrence.

2.11 The school will report to the HSE (Telephone 0845-300 9923) any incident which falls under RIDDOR. Major injuries include the following:

- Fracture, other than a bone in the wrist, hand, ankle or foot;
- Amputation;
- Dislocation of the shoulder, hip, knee or spine;
- The loss of sight of an eye (whether temporary or permanent);
- Chemical or hot metal burn to the eye or any penetrating injury to the eye;
- Injury resulting from an electric shock or electrical burn leading to unconsciousness;
- Unconsciousness caused by asphyxia or exposure to harmful substance;
- Acute illness requiring medical treatment, or loss of consciousness arising from absorption of any substance by inhalation, ingestion or through the skin, or illness believed to have resulted from exposure to a biological agent or its toxins or infected

material;
- Any other injury: leading to hypothermia, heat-induced illness or unconsciousness, or requiring resuscitation, or which results in the person injured being admitted to hospital as an inpatient for more than 24 hours (unless that person is detained only for observation).

It might be that the extent of the injury may not be apparent at the time of the accident or immediately afterwards, or the injured person may not be immediately admitted to hospital. Once the injuries are confirmed, or the person has spent more than 24 hours in hospital, then the accident must be reported as a major injury.

2.12 Should a child sustain a particular injury which requires bed rest and somewhere to wait for collection, they will be taken to the Medical Room which is contained within the staffroom. A member of staff will provide appropriate supervision. Should this room be occupied at the time it is needed, the occupants will be asked to leave until the child has been collected.

3 Medication and allergies

3.1 Whilst we discourage a culture of parents sending pupils into school when they are not well, many pupils will at some time have a condition requiring medication. For many the condition will be short-term – perhaps the duration of a short absence from school. However, although a child may soon be well enough to be back at school, medication may perhaps still be required during the school day for a short period. The administration of medicine at Oakwood falls within our remit for the Duty of Care for the children, and arrangements are therefore in place should medication be required once during the school day.

Firstly, where possible, all anti-biotics should be administered by parents out of school hours. However, should this not be feasible, a request should be made in writing via the medicines book to one of the office or Nursery staff, who are responsible for administering any medicines.

We will not administer aspirin to any pupils unless it has been prescribed by a doctor.

3.2 Children are not allowed to bring in any type of medicine to self administer (eg. cough mixture or Capol), even if they are in Year 5 or 6 as other children risk having access to these medicines. However juniors are permitted to take their own throat lozenges if necessary, and these should be kept in their school bag. Children may, however, administer inhalers themselves, or with the help of the teacher if necessary.

Where regular medication is required (eg. Piriton), once-off verbal permission will be gained from parents prior to administering.

However, medicines must always be provided in the original container.

3.3 All medication should be clearly named. With regard to asthma pumps, parents of infant children should hand these to the class teacher whilst juniors can keep theirs in a tray at their desk or elsewhere in their classroom. All epipens will be kept in the school office. It is the responsibility of parents to ensure that asthma pumps or epipens (which are in date) are available in school if their child needs one.

3.4 Where on the other hand children have long-term medical needs, we will do everything we can to enable them to attend school regularly. If it is unavoidable that a child has to take medicine in school for treatment for a long-term illness to be effective, then each individual

case will be considered on its own merits. Parents must give us details of the child's condition and what treatment has been prescribed. Medication should be brought to school in a secure, labelled container with the child's name and dosage required. Medication will be kept in accordance with safety requirements, either stored in the Medicines cabinet upstairs or kept in the staffroom fridge if appropriate

3.5 Where long term needs for emergency medication exist, the school will require specific guidance on the nature of any likely emergency and how to cope with it while awaiting paramedical assistance. Detailed written instructions should be sent to the school and the parent should also liaise with their child's class teacher. If the emergency is likely to be of a serious nature, emergency contact numbers must be given where an adult is available at all times.

3.6 Medical information on each child is obtained when they first start at the school and updated information is requested annually. This list is circulated to all staff members at the beginning of each academic year so that they are aware of any children who suffer from certain medical conditions, and in particular those such as severe allergies, asthma, epilepsy, diabetes etc. A list of all children with particular food allergies is displayed in the hall and updated periodically.

3.7 Staff involved in administering the medication receive appropriate training and support from health professionals where necessary.

- A health and safety risk assessment is carried out to manage any identified risks.
- No member of staff is required to administer medication unless willing to do so.
- Where possible the medicine should be self-administered under the supervision of an adult.
- Written records are kept by office staff for all medicines administered.

4 Safety/HIV Protection/Spillage of body fluids

4.1 There may be rare occasions where it is necessary for staff to restrain a pupil physically, to prevent them from inflicting injury to others, causing self-injury, damaging property, or being disruptive. In such cases only the minimum force necessary may be used, and any action taken must be only to restrain the pupil. If restraint has been required, a written report will be made in the Incidents log book in the Head's office.

4.2 Hazardous substances will be safely stored in a secure area. Maintenance and when necessary examination and testing will take place of items such as electrical equipment and gas appliances.

4.3 Staff are advised to always wear disposable gloves when treating any accidents/incidents which involve body fluids. Make sure any waste (wipes, pads, used gloves etc) are placed in a plastic bag and fastened securely for disposal. If a child has significant blood spillage on their clothes, they can be changed into their PE kit if required. Their clothes should be placed in a plastic bag and fastened securely ready to take home.

4.4 Also see separate First Aid guidelines for more detail on the disposal of body fluids.

5 Monitoring and review

5.1 It is the responsibility of the Head to monitor and evaluate the effectiveness of this policy.

5.2 This policy will be formally reviewed every two years, however it will be amended earlier if legislation or school procedures change prior to that time.

Signed: C Candia

This policy will be reviewed every 2 years	
Title	First Aid
Version	6
Date of Review	18 July 2019
Author	Ciro Candia, Head
Approved by SMT	Yes
Approval/Review required by PACT or sub-committee	Yes
Latest Review (state whether changes were made)	Yes (by Exec Committee)
Next Review Date	Summer 2020

This policy should be read in conjunction with the following related policies:
Health, Safety & Welfare

Appendix A

Oakwood School
Qualified First Aiders

(as at Sept 2019)

Emergency First Aid at Work (10):

Carrie Askew

Geraldine Daly

Jane Oliver

Julia Rafat

Lolita Symes

Ellen Teague

Tori Truett

Christine Faulkner

Paediatric First Aid (8):

Alberto Kurti

Carey Watson

Val O'Neill

Siobain Barron

Liz Clarke

Shanida Lobo

Sandra Palmer

Candela Marquez

Appendix B

FIRST AID GUIDANCE NOTES (also refer to First Aid Policy and Staff Handbook)

Sick or Injured Persons
What to do if a child is ill or injured

The legal responsibility of all members of staff is considered to be "in loco parentis" which means, that we are expected to act as all prudent parents would do. Thus, we would more easily be found negligent if we did nothing than if we attempted to act in the child's best interests. The basic principle is that a teacher or member of the support staff cannot claim that a sick or injured child is not their responsibility. The Health and Safety at Work Act requires all employees to share responsibility for the workplace of themselves and of others using it so far as is reasonable and practical.

Children should only be in school if they can take part in all school activities, with the exception of recovery from broken limbs or similar injuries. Children who are on antibiotics should remain at home if they are unwell, however if they are well enough to attend school then medication can be given upon written request.

If a child should contract a contagious illness or condition, they should remain at home and the school informed immediately. Return to school is not permitted until the incubation period has passed and the child is fully recovered. Children should not return to school for at least 24 hours after the last bout of vomiting or diarrhoea (or 48 hours for children in Nursery & Reception). If a child becomes ill at school, at the teacher's discretion, parents will be notified and asked to take the child home. If children are not well enough to join in all school activities they should not be in school.

For a minor injury that cannot be dealt with by the class teacher or assistant, staff should arrange for the child to be taken to a First Aider or bring the First Aider to the child.

If a child appears to be badly injured or seriously ill (e.g. serious loss of blood, severe pain in abdomen, bone or joint, unconsciousness):
DO NOT MOVE THE CHILD. SEND FOR HELP AT ONCE.

Calling an Ambulance
The First Aider on site must make a decision to call an ambulance. Guidance notes are also given in the Staff Handbook. **It is always best to err on the side of caution,** bearing in mind that additional injuries may be caused if unqualified persons move a casualty. An ambulance should be called if there is **significant bleeding, shock, seizure, suspected anaphylactic shock, serious fractures which are disabling, cardiac arrest, suspected meningitis or breathing difficulties.**
• Dial 999
• State which service(s) you require: Ambulance (Call for Police or Fire Brigade as necessary)
• Give the age and sex of the casualty and state whether breathing/not breathing, conscious or unconscious and a brief description of the injury. Any additional factors known e.g. asthmatic, anaphylactic, diabetic etc
• Give the address of the school : 59 Godstone Road, Purley, Surrey, CR8 2AN

Stop bleeding by pressure and keep the child warm and quiet to minimise the shock. Find out all you can about what happened and whether the child is in pain. Always be encouraging: never discuss how bad it might be!

ONE person must take charge who will:
1) Send for an ambulance if necessary
2) Send for a First Aider.
3) Notify the Head.

4) Make arrangements for the care of the child's property.
5) Arrange to contact the child's parents and check that this has been done.
If the child is taken to hospital he or she must be accompanied by an adult, who must be prepared to remain there with the child.

If a child is ill or injured on a school trip the same principles apply as for 1 and 2.
Remember that when a child is ill or injured this changes the day's arrangements. Always ensure there is enough supervision for the other children on the trip, so that the sick or injured member of the group can be properly looked after. A suitably qualified First Aider with a portable first aid kit must be on all off-site activities.

Major Accidents to pupils or visitors
Major accidents which involve pupils or visitors who are killed or taken from the site of the accident to hospital need to be reported without delay to HSE, followed by Form F2508.

Reportable diseases need to be noted including:
- Date and diagnosis of the disease
- Who is affected
- The name of the disease

A full list of reportable diseases is held by Mrs Askew in the Health & Safety file.

Wounds and Bleeding
Remember: NEVER perform any First Aid Procedures that you have not been adequately trained to do.
The following is an aide-memoire only. The aims of First Aid for bleeding and wounds are to:
• Stop bleeding as quickly as possible, because severe loss of blood could be serious and lead to death.
• Prevent infection, by keeping germs out.

Treatment:
• Place the casualty in a lying position, preferably with legs raised.
• Elevate injured part, unless a fracture is suspected, and loosen tight clothing.
• Expose wound, removing as little clothing as possible.
• Control bleeding by pressing sides of wound firmly together or by applying direct pressure to the part that is bleeding, over a clean dressing preferably, a clean towel, handkerchief or any other item of clean linen.
• Apply sterile dressing into the depth of the wound until it projects above the wound, cover with padding and bandage firmly.
• If foreign bodies are present in the wound, or bone is projected, cover the wound with a sterile dressing and apply enough pads round the wound to enable bandage to be applied in a diagonal manner, avoiding pressure on projecting foreign body or bone.
• If bleeding continues through dressing, put another dressing over the previous dressing and bandage it firmly. Never remove dressings that are already in place – this disturbs the blood clot and can easily make bleeding worse.
• At all times reassure the patient and keep him/her relaxed and lying as still as possible; any unnecessary movement will tend to make bleeding more severe.
• Keep casualty warm with blankets.
• Except in cases of only slight injuries with small loss of blood, get the casualty as comfortably and quickly as possible.

WARNING
Stab wounds and puncture wounds can cause injury and infection deep inside the body, even though the skin wound is only small. Therefore such wounds should be regarded as serious and the casualty sent to hospital.

Burns and Scalds

• Cool immediately. If limb or extremity is affected, immerse in cold water or place under a gently running tap, until pain is reduced.
• Remove burnt clothing only if absolutely necessary and after cooling has begun. Stuck clothing should be left alone.
• Do not break blisters; keep immersed in cold water if still painful.
• Remove anything of a constricted nature – e.g. rings, bangles, belts, boots – before swelling starts.
• Cover the burn with a large sterile dressing. If no dressing is available, use the cleanest non-fluffy covering available. Dressing should cover an area bigger than the burn. If necessary use several dressings. A burn cool pack can be used prior to dressing a wound.
• If burn is larger than the palm of the hand, send casualty to a hospital as quickly as possible. Clingfilm can be used to cover the area and keep it free from infection.

WARNING
DO NOT apply lotion, antiseptics or anything greasy to burns.
DO NOT use hairy or fluffy materials to cover a burn.

In the case of electrical burns, do not touch the casualty until you are certain that the electricity is switched off. Any child receiving a burn resulting from an electric shock should be taken immediately to hospital.

Diabetes

You MUST know if you are teaching a diabetic child. The school office must be kept up to date with details of where parents can be contacted in an emergency, also telephone numbers of the Child's Doctor, Hospital etc.

The child should always be carry glucose or sugar in his or her pocket and may need to eat in class or before PE and games lessons. It is very important that diabetics eat meals at regular times and are allowed to eat small snacks at other times when they need extra food. The only major problem the diabetic child is likely to have in school will be an INSULIN REACTION (Hypoglycaemia). Some of the first signs may consist of confusion, poor work, poor handwriting. If any of these are noticed – sugar in any form is the correct treatment (sugar, sweets, sugary drinks). If reaction has not developed too far the child will return to normal, but SHOULD NEVER BE SENT OUT OF THE ROOM WITHOUT SUPERVISION.

Insulin reactions do not occur very frequently. They are usually brought on by more exercise than usual, delay in getting meals or inadequate meals or excessive Insulin dosage. If a reaction occurs at school, parents should be advised by telephone and in writing.

If the child has developed an Insulin reaction or is unwilling to swallow sugar, this should be considered an EMERGENCY - AND THE CHILD TAKEN TO HOSPITAL. Every effort should be made to contact the parents as soon as possible.

Symptoms of Hypoglycaemic Reaction:

Trembling, numbness
Late symptoms – sweating, tingling of the mouth and fingers, poor orientation, weakness, loss of memory, drowsiness, blurring of vision, unconsciousness, headache, abnormal gait, convulsions, abnormal behaviour.

NOTE: The child may be wearing a Medic-Alert or Necklet which would identify the condition, if the teacher has not already been made aware of the child's Diabetic condition.

Epilepsy: A Guide for Staff

Types of seizure:
Major fit ('grand mal' or 'convulsion'). This type of fit can be very frightening when seen for the first time. The child may make a strange cry, (a physical effect that does not indicate fear of pain), and fall suddenly. Muscles first stiffen and then relax, and jerking or convulsive movements begin which can be quite vigorous.

Saliva may appear round the mouth, occasionally blood-flecked, if tongue or cheeks have been bitten. The child may pass water.

This type of fit may last several minutes, after which the child will recover consciousness. He/she may be dazed or confused – a feeling that can last from a few minutes to several hours – and may want to sleep or rest quietly after the attack. Although alarming to the onlooker this type of fit is not harmful to the child and is not a medical emergency unless one fit follows another and consciousness is not regained. Should this happen, medical aid should be sought without delay. This condition is known as status epilepticus.

Minor fit ('absence' or 'petit mal'). This type of seizure may easily pass unnoticed by parents or teachers. The child may appear merely to daydream or stare blankly. There may be frequent blinking of the eyes, but otherwise none of the outward signs associated with a major seizure. Though brief, these periods of clouded consciousness can be frequent. They can lead to a serious learning problem if not recognised and treated, because the child is totally unaware of his surroundings and receives neither visual nor aural messages during a seizure.

Psychomotor fit ('complex partial' or 'temporal lobe'). This occurs when only part of the brain is affected by the excessive energy discharge. There may be involuntary movements such as twitching, plucking at clothes or lip smacking. The child appears to be conscious may be unable to speak or respond.

'Sub-clinical seizures'. These are often not recognised because, as the name suggests, they cannot be seen. They may be indicated if a child's attainment level drops significantly, or the standard of oral or written work is below expectations for no accountable reason. Where sub-clinical seizures are suspected, the matter should immediately be brought to the attention of the Head. Calm observation of any seizure may well provide vital information for the doctors, who rarely see the child having a seizure. Cooperation between teachers, parents and the family doctor/paediatrician can prevent a child with epilepsy from becoming a handicapped adult.

Classroom First Aid

The reaction and competence of the teacher is the most important factor in any classroom acceptance of a seizure. In a minor fit, understanding and a matter-of-fact approach are really all that are needed. A teacher should be aware of the possibility of mockery when the fit has passed and deal with it, if it arises, according to the age group concerned. If the child has a major seizure, classmates will respond to the calm behaviour of the teacher. Ensure that the child is out of harm's way, but move him/her only if there is danger from sharp or hot objects, or electrical appliances.
Observe these simple rules and LET THE FIT RUN ITS COURSE.

• Cushion the head with something soft (a folded jacket would do but DO NOT try to restrain convulsive movements).
• DO NOT try to put anything at all between the teeth.
• DO NOT give anything to drink.
• Loosen tight clothing around the neck, remembering that this might frighten a semi-conscious child and should be done with care.
• DO call an ambulance or doctor if you suspect status epilepticus.
• As soon as possible, turn the child to the side in the semi-prone position to aid breathing and general recovery. Wipe away saliva from around the mouth.
• If possible stay with the child to offer reassurance during the confused period which often follows this form of seizure.

Asthma

Almost three million people in the UK have asthma and at least one in 10 children are diagnosed as having asthma in the UK. Each year 2000 people die from asthma in the UK. It is thought that the majority of these deaths are preventable. Due to this fact it is essential that we as teachers understand the causes that lead to an attack and how to deal with an attack when it happens. Most children are able to lead a normal

life by managing their asthma and being aware of situations which could lead to an asthma attack. However, staff need to be fully informed and able to cope with this potentially fatal disease.

It is important that each teacher can respond positively to these questions:
a) Do you know which, if any, children have asthma in the classes which you teach?
b) Are you aware of the situations that can lead to an asthma attack?
c) Would you know what to do if this happened in one of your lessons?

Causes of Asthma:
Asthma causes narrowing of the airways, the bronchi, in the lungs, making it difficult to breath. An asthma attack is the sudden narrowing of the bronchi. Symptoms include attacks of breathlessness and coughing and tightness in the chest, which can exacerbate the difficulty in breathing. People with asthma have airways which are almost continuously inflamed (red and sore) and are therefore very sensitive to a variety of common stimuli. It is not an infectious, nervous or psychological condition, although stress may sometimes lead to symptoms.

A child's inflamed airways are quick to react to certain triggers (irritants) that do not affect other children without asthma. The things that trigger asthma vary from child to child. The known triggers include:
• Viral infections (common cold)
• Allergies, e.g. grass pollen, animals (hamsters, rabbits, cats, birds, etc.)
• Exercise
• Cold weather or strong winds
• Excitement or prolonged laughing
• Sudden changes in temperature
• Numerous fumes such as glue, paint and tobacco smoke.

Effects on Child:
• Breathlessness during exercise
• Coughing during which wheezing or whistling is heard coming from the child
• General difficulty in breathing
• Tightening of the chest
• Anxiety of the child.

When an Asthmatic joins the Class:
• Ask parents about child's asthma and current treatment
• All children should have easy access to medication
• If necessary, discreetly remind child to take medication.

Sport and the Asthmatic Child:
Exercise is a common trigger for an asthma attack but this should not be the reason for children not to participate in PE or Games. As far as possible, children should be encouraged to participate fully in all sporting events. Swimming is to be encouraged. Prolonged spells of exercise are more likely than short spells to induce asthma attacks. Teachers of PE should be particularly aware of children with asthma when working outside on cold, dry days or when there are strong winds.

Asthmatic children are commonly allergic to grass pollen so this should be considered, especially during the summer months. Teachers should beware of competitive situations when children with asthma may over exert themselves.

Exercise triggered asthma will be helped if the teacher ensures that the child uses his/her inhaler before exercise begins and keeps it with them during the lesson. No child should be forced to continue games if they say they are too wheezy to continue.

Technology

Teachers should be particularly aware of asthma sufferers during activities producing dust and fumes, e.g. paint, glue and varnish.

Medication
There are two types of treatments:
Preventers - these medicines are taken daily to make the airways less sensitive to the triggers.
Generally preventers come in brown and sometimes white containers.
Relievers - these medicines are bronchodilators which quickly open up the narrowed airways and help the child's breathing. Generally relievers come in blue containers.
Key:
A - Aerosol, puffer of dry-powder inhaler
B - Tablet and/or syrup

How you can help during an attack
Children with asthma learn from their past experience of attacks; they usually know just what to do and should carry the correct emergency treatment. Because asthma varies from child to child, it is impossible to give rules that suit everyone.

However, the following guidelines may be helpful:

1. Ensure that the reliever medicine (such as Attrovent, Bricanyl or Ventolyn) is taken promptly and properly. This will be in aerosol, puffer or dry powder inhaler form. A reliever inhaler (usually blue) should quickly open up narrowed air passages: try to make sure it is inhaled correctly. Preventer medicine (such as Intel, Becotide or Pulmicort) is of no use during an attack; it should be used only if the child is due to take it.
2. Stay calm and reassure the child.
Attacks can be frightening, so stay calm and do things quietly and efficiently. Listen carefully to what the child is saying and what he or she wants: the child has probably been through it before.
Try tactfully to take the child's mind off the attack. It is very comforting to have a hand to hold but don't put your arm around the child's shoulder as this is very restrictive.
3. Help the child to breathe.
In an attack people tend to take quick and shallow breaths, so encourage the child to breathe slowly and deeply. Most people with asthma find it easier to sit fairly upright or leaning forwards slightly.
They may want to rest their hands on their knees to support the chest. Leaning forwards on a cushion can be restful, but make sure that the child's stomach is not squashed up into the chest.
Lying flat on the back is not recommended.
In addition to these three steps loosen tight clothing around the neck and offer the child a drink of warm water because the mouth becomes very dry with rapid breathing.

Call a doctor urgently if:
• The child is either distressed or unable to talk
• The child is getting exhausted
• You have any doubts at all about the child's condition.

If a doctor is unobtainable call an ambulance.

After the attack:
Minor attacks should not interrupt a child's concentration and involvement in school activities. As soon as the attack is over, encourage the child to continue with normal school activities.

How teachers can help:
• Ensure all asthmatic children take any necessary treatment before sport or activities.
• Ensure relievers are readily available for use by asthmatic children when required.
• Check with child or parent that correct treatments and instructions are supplied for school outings.

• Be aware that materials brought into the classroom may trigger a child's asthma, and additional treatment may be necessary.
• Make a point of speaking to parents of children needing to use their inhaler for relief more often than usual.
• Act as an educator to children with asthma and their peers.
• Know what to do in an emergency.

Do's and Don'ts in Acute Asthma
• *Don't panic.*
• *Do be aware of procedure to follow if the child does not improve after medication.*
• *Don't lie the child down - keep her/him upright.*
• *Don't open a window - cold air might make the condition worse.*
• *Don't crowd the child - give space - not cuddles.*
• *Do give reliever medication - bronchodilators.*
• *Don't give inhaled steroids (e.g. Becotide, Pulmicort).*
• *Do reassure the child.*
• *Do reassure the other children and keep them away.*

What to do in an emergency
1. Keep calm.
2. Allow child space to breathe (no sudden change in temperature).
3. Use reliever inhaler.
4. If no improvement after 5 minutes repeat inhaler giving a high dose. Dial 999 or take to hospital (two adults required).
5. Ask someone to warn the hospital you are on the way.
6. Demand immediate attention on arrival at hospital.

SEEK MEDICAL HELP URGENTLY IF:
1. The reliever (medication) has no effect after five to ten minutes.
2. The child is either distressed or unable to talk.
3. The child is getting exhausted.
4. You have any doubts at all about the child's condition.

CALL THE PARENTS AND AN AMBULANCE
Minor attacks should not interrupt a child's concentration or involvement in School. When the attack is over encourage them to continue with their lessons/activities. This information has been taken from the National Asthma Campaign booklet "Asthma at School".

Grazes
If a graze requires attention, tap water or an antiseptic wipe should be used. As much of the dirt as possible will be removed. Wet wounds need to be dried with a swab. In order to avoid infection, some wounds will require covering (this is up to the discretion of the First Aider). This can either be a small plaster or gauzes for larger wounds.

Lacerations
For all lacerations, the blood flow should be stopped by compression. Swabs are preferable, but in extreme cases anything will do. If necessary, blood loss can be reduced by elevation of the limb. If the bleeding cannot be controlled, the child should be taken immediately to hospital. Please note that if there is any concern about permanent scarring, parents should be encouraged to take their children either to their GP or the hospital.

Head injuries
Any child who is knocked unconscious or has amnesia from a head injury should be taken immediately to hospital. If there has been blurred vision or vomiting, parents should be encouraged to take their child to

hospital. In very minor head injuries, an ice pack should be used and parents informed verbally at the end of the day and via a copy of the Accident Record. All children who have received a minor head injury should be monitored throughout the day.

Nose bleeds
The head should be tipped forward and the area just below the nose bridge should be pinched. If bleeding has not stopped after 10-15 minutes, the parents should be informed and the child taken to hospital.

Neck injuries, strains and sprains
Where there is concern that the neck has been injured or if the child is unable to move, they should be immobilised wherever they are. Children who incur strains and sprains should be allowed to rest. An ice pack should be applied and the limb should be elevated. If there is any concern about deformities, the child should be taken to hospital.

Eye injuries
Most eye injuries will require irrigation. Either an eye wash or tepid water from a tap may be used.

Insect bites
Stings are best treated with water or ice packs. Stings near the eyes, lips or nose should be handled with great care as these may lead to breathing difficulties. If a child displays any anaphylactic symptoms, the emergency services should be contacted immediately and a paramedic crew requested. A child's medical records should be checked to see if they are allergic to particular insect bites.

Sun protection
During the summer months, children are encouraged to wear a school sunhat whilst outdoors. Parents are encouraged to apply sunscreen to their children before coming into school. Due to child protection considerations, teachers and other members of staff are not allowed to apply sunscreen. Older children may apply sunscreen themselves.

Disposal of bodily fluids
The best way to prevent possible infection is to avoid contact with body fluids. However, as this is not always possible, these hygiene guidelines have been written to help staff deal with bodily fluids safely.

Your Skin
Your first line of defence is your skin - germs cannot get through it unless it is cut or broken.

- Cover cuts/scrapes with a waterproof plaster after washing with soapy water and drying the area thoroughly.
- If the plaster begins to come away at the edges, remove it, wash, dry, and replace it with a new plaster.
- If you develop a skin disease, such as eczema or dermatitis, especially on the hands, immediately consult with your own doctor or your local Medical Centre before accepting an instruction to clean up bodily fluids.
- Before dealing with any body-fluid spillage you must put on a pair of rubber or disposable gloves.
- If you are clearing a large spillage you must also wear a disposable plastic apron.
- If your gloves or apron become cut or torn, dispose of them safely and put on new ones at the earliest opportunity.
- If you are in the middle of clearing up a spillage, STOP, wash and dry your hands before putting on a new pair of gloves.

Spillages On A Flat Surface

- Cover the spillage completely with a layer of absorbent material (newspaper, kitchen roll, toilet paper, floor cloth, paper towels).
- Using a suitable disinfectant (if necessary, diluted with water) and clean the area of the spillage.

- Remember to add the disinfectant to the water, not the water to the disinfectant (to avoid splashes).
- If you get disinfectant on your skin, wash it off at once with plenty of fresh running water.
- If the disinfectant is likely to damage the surface, use hot water with plenty of soap or detergent lather and clean as above.
- Dispose of cloths/material used as infected waste. *Discuss this process with your local Medical Centre – see section on "Disposing of Infected Waste" below.*

Extensive Spillages

- If the spillage is very extensive, as for example in a toilet with a lot of urine on the floor, the entire area should be mopped with plenty of very hot water containing soap or detergent.
- Mop up as much of the liquid as possible then clean the area with a suitable disinfectant solution if available.

Surfaces That Are Not Flat

- Dip a handful of absorbent material in the disinfectant solution and wipe up the spillage.
- Dispose of materials used as infected waste. *Discuss this process with your local Medical Centre - see section on "Disposing of Infected Waste" below.*

Dealing With Dried Vomit

- Dried vomit should be soaked with hot water and soap/detergent, left to soften, and disposed of as for infected waste.
- Then the surface should be washed clean as above.

Dealing With Human Faeces

- Where possible faeces may be scraped up (e.g. using a dustpan or shovel) and put down a toilet.
- Diarrhoea should be dealt with as for dried vomit or as a normal spillage.

Splashes Of Bodily Fluids

- If you do get splashed with another person's body-fluid on an area of unbroken skin, wash it off immediately.
- If you can, use hot soapy running water for three to five minutes and rinse and dry well. If you are allergic to soap use plenty of plain water.
- REMEMBER - tears are not a problem but saliva and phlegm may be.

Disposing Of Infected Waste

NOTE: It is up to the school to discuss and make arrangements (should they be necessary) with their local Medical Centre. Follow any advice given. Should you be required to follow clinical waste disposal procedures, it is likely to include the following;

- Infected waste must be disposed of as 'clinical waste' in a proper clinical waste sack or container provided for the disposal of infected waste.
- When clinical waste sacks or containers are two thirds full they should be carefully sealed and kept in a safe and secure location until they can be collected.
- Clinical waste sacks are likely to be available through the Medical Centre.
- Remember: infected waste must never be put into an ordinary dustbin, or disposed of with other waste.

Disinfecting Equipment

- Thoroughly wash any equipment you have used to clear up body fluids, such as a dustpan or shovel, with hot soapy water.
- If you use a cloth or handful of absorbent material to wash and/or dry your equipment, dispose of them as for infected waste.

Disinfecting Floors, Furniture, Etc.

- After you have disinfected and removed the spillage, you must make safe the surfaces that were covered by the spillage.
- All surfaces should be washed with plenty of hot water and soap/detergent, or approved disinfectant in order to remove any traces of germs which might remain.
- Any floor areas that become wet during cleaning should be clearly marked to warn people of the slipping hazard.
- After cleaning floors and steps must be left dry.

Disinfecting Clothing

- If your clothing becomes soiled with body-fluids, washable items should be washed in a washing machine if available, on as hot a wash and rinse cycle as possible for the fabric.
- If the item is heavily soiled, as much as possible of the spillage should be removed first by sluicing with soapy water while wearing gloves and a disposable apron.

Disposal Of Protective Clothing

- If you have been wearing an apron, take it off whilst still wearing your gloves, and dispose of it, as infected waste.
- Then wash your hands in hot soapy water with your gloves still on, dry with absorbent material available and remove the gloves by peeling them off from inside to out. They should also be disposed of as infected waste.

Dealing With Cuts

- If you cut yourself with a sharp object, such as a used needle or a piece of broken glass, which has already cut someone else, encourage the wound to bleed by pinching and kneading the area - under cold running water, if possible.
- Then wash the wound with hot soapy water.
- Apply a pad of clean, absorbent material to the wound with firm pressure till bleeding stops.
- Wash off any blood round the wound without disturbing it, dab dry with clean material and apply a waterproof dressing.

Reporting Accidents

It is essential that you report any accident, which involves an injury or possibility of infection to the Administrator as soon as possible on the day it happens.

- An Accident Report Form must be completed as soon as possible for each person who has been injured or who may have been infected.

Counselling/Support Following Accidents

- If you are still worried about any risks following any accident which involves an injury or possibility of infection to yourself then you should contact your GP for further advice.