

# **Roxeth Mead School**

Buckholt House  
25 Middle Road  
Harrow on the Hill  
Middlesex  
HA2 OHW

## **FIRST AID POLICY**

**EYFS and main school**

**2014**

### **First Aid Policy Statement** **For EYFS and main school**

***Designated staff member: Mrs Linda O'Neil (Rookery)***

***Other qualified Paediatric First Aiders: Mrs Kalsi (Class 1) Mrs Amin (Class2) Mrs Power (Class 3), Mrs Isaacs (Class 4) Mrs Ghatora.***

***All staff have done a First Aid in the workplace course***

#### **Aim:**

- That all children and adults in our care should receive a high standard of timely and competently administered first aid care.
- That all staff are aware of the agreed procedures so that treatment can be provided as efficiently and calmly as possible.
- That in an emergency situation all staff are aware of the administration of emergency medication procedures *e.g. epipen usage, asthmatic inhalers.*
- That all staff should be aware of any child in the school who may be at a higher risk of needing emergency first aid due to known medical problems *e.g diabetes, epilepsy* and any specific immediate action that may need to be taken.

#### **Purpose:**

- Gives clear guidelines to all staff on the first aid procedure and the administration of any medication.
- Clearly defines staff and their roles/responsibilities
- Ensures safe administration and storage of medications in school
- Ensures good first aid cover on outings.
- Ensures adequate detailed reporting of accidents

### **Summary:**

Roxeth Mead School takes its responsibilities of first aid care very seriously and ensures that all staff are aware of the correct procedures for dealing with both accidents and also any known medical conditions which may result in the need of emergency treatment. Any person who may be 'at risk' is discussed at our daily meetings as soon as we are aware of any potential problems.

Where necessary a request is made for the persons practice nurse to attend the school and address all staff members.

An annual review is held of all Health and Safety matters. Particularly in view of our small staff numbers, all staff are encouraged to put forward any ideas for improving any aspect of all our policies at any time.

Roxeth Mead is like an extended family with all staff involved in all aspects of the daily school life and the safe and efficient administration of our policies.

*Prepared by Deanna Hinton*

*January 2007  
Last updated July 2014*

## **First Aid Policy Guidelines**

### **Training:**

- This is available for all staff members and will usually be arranged with St. John's or Margaret Smith who is a qualified First Aid Trainer
- It is proposed that a trained first aid instructor will do an INSET day with all staff later in the year.
- Retraining is given to all first aiders when necessary.
- Outside bodies are involved in teaching all staff if there are specific problems relating to any child
- There are currently 3 qualified first aiders on the staff as well as Deanna Hinton S.R.N.
- There is always someone on the premises available to deal with first aid emergencies.
- Members of staff report to the Head teacher if parents pass on any relevant medical information.

### **First Aid kits:**

- There is a first aid kit located on every floor. Locations are marked and all staff are made aware of these areas.
- Kit contents are checked on a regular basis and replaced as necessary.
- The designated first aider ensures that a kit is taken on any school outings and is responsible for requesting replacement items that may have been used.

### **Accident reporting:**

- The accident book is located in the kitchen
- RIDDOR ( Reporting of Injuries, Diseases and Dangerous Occurrences Regulations, 1995) is the responsibility of the senior member of staff on duty at the time.

### **Treatment:**

- **Minor injuries** can be treated by any member of staff although it is usual policy at Roxeth Mead for a child to be seen by a first aider.
- **Plasters** are only used if it is assumed that the child does not have any sensitivity problems.  
(i) by asking the child (ii) being made aware of any problems on the child's medical form.
- **Bumped heads** should be treated with an ice pack and the child observed for any adverse reaction. Parents must be informed.

- **Major accidents/injuries:** Must always be dealt with by a qualified first aider and the child's parents informed immediately.

### **Epipens:**

- 1 in classroom and 1 in staff room. Parents to ensure these are replaced when date expired.  
**Additional check by form teacher at the beginning of each term.**

### **Emergency service calls:**

- Details relating to the making of these calls is situated in the office and the kitchen/staff room

#### **Staff making the call to give the following information**

1. Details of incident/injuries
  2. Child's name
  3. Age
  4. Conscious/unconscious
  5. Location of the school
- If an emergency call is made for any incident a member of staff should go into Middle Road to guide emergency services to the location of the incident.
  - If casualty is a child then a member of staff should accompany the child to hospital and the child's parents informed immediately of details and hospital location. If an adult then next of kin should be informed.

### **This document which embraces the EYFS legislation is to be to be read in conjunction with:**

Administration of medicines, policy and procedures.

Good hygiene practice

RIDDOR

Accident reporting

Spillage of blood and other body fluids

Treatment of Asthmatic attacks and other common emergencies

Head injury reporting forms

Individual Health Care plans

Management of First Aid equipment and cabinets

Communicable diseases

COSHH guidance

Calling an ambulance

School outings and risk assessments



## **FIRST AIDERS**

<b>Name</b>		<b>Location</b>
Mrs. O'Neill Mrs Ghatora Mrs Kalsi	Rookery Rookery Class 1	Ground Floor
Mrs Amin Mrs. Isaacs	Class 2 Class 4	
Mrs. Power	Class 3	

**FIRST AID KITS are located:**  
**GROUND FLOOR: Kitchen in marked cupboard**  
**FIRST FLOOR: First Aid cabinet in toilet area**  
**TOP FLOOR: First Aid cabinet outside computer room**

### **ADMINISTRATION OF MEDICINES. POLICY AND PROCEDURES**

This policy is written with reference to the D of E Guidance on Managing Medicines 2014, Supporting pupils at school with medical conditions (2014) Children and Families Act 2014 and having regard to issues that may also be raised to comply with the school's duties under the Equality Act 2010.

Roxeth Mead School also acknowledges that some children may also be disabled, have special educational needs (SEN) and a statement, or Education, Health and Care (EHC) plan which brings together health and social care needs, as well as their special educational provision.

For children with SEN, this policy and guidance should be read in conjunction with the SEN code of practice.

Roxeth Mead School believes in :

- ensuring that pupils at school with medical conditions should be properly supported so that they have full access to education, including school trips and physical education.
- supporting pupils at school with medical conditions.
- consulting health and social care professionals, pupils and parents to ensure that the needs of children with medical conditions are effectively supported.

- the importance that parents feel confident that their child's medical condition will be supported effectively in school and that they will be safe.
- making decisions about the support they provide, with advice from healthcare professionals and with full consultation and the views of parents and pupils.
- careful and considerate planning into reintegrating a pupil back into school after periods of absence.

However, in line with their safeguarding duties, the governing body will ensure that pupils' health is not put at unnecessary risk from, for example infectious diseases. They therefore do not have to accept a child in school at times where it would be detrimental to the health of that child or others to do so

The Governors via the Headteacher will ensure that:

- sufficient staff are suitably trained for the appropriate pupil needs. Specific  
individual training needs to be discussed with professionals
- all relevant staff will be made aware of the child's condition
- cover arrangements are available in case of staff absence
- any supply teachers are suitably and fully briefed
- additional risk assessments for school visits and other school activities outside of the normal timetable will be carried out.

all individual healthcare plans will be developed, monitored and regularly reviewed (at least annually) with teaching staff, healthcare professional, parents and the pupil in line with the school's agreed policy and any statement or EHC plan already in place.

**Children who have long term medical conditions and who may require ongoing medication must have a Healthcare Plan Form completed.**

**Individual Healthcare Plans will include the following information:**

- Who in the school needs to be aware of the child's condition and the support required
- The arrangements for written permission from parents and the headteacher for medication to be administered by a member of staff. Form to be completed.
- Details of any separate arrangements or procedures required for school trips or other school activities outside of the normal school timetable that will ensure the child can participate eg risk assessments
- Where confidentiality issues are raised by the parent/child, the designated individuals to be entrusted with information about the child's condition
- what to do in an emergency including whom to contact, and contingency arrangements

Some children may have an emergency healthcare plan prepared by their lead clinician that could be used to inform development of their individual healthcare plan.

- Names and contact details of all healthcare professionals and their roles. e.g
  - the head teacher
  - the parent or carer
  - the child (if appropriate)
  - class teacher
  - care assistant or support staff (if applicable)
  - staff who are trained to administer medicines
  - staff who are trained in emergency procedures
  - G.P
  - other health care professionals
- Parents are to be provided with a copy of the signed plan. All contributors including the parents are to sign the agreed plan.
- It is the parents or guardians responsibility to inform the school of any changes that may require the agreed plan to be revised at anytime.

## **Medicine administration**

**All given medication must be recorded in the Medicine Administration Book and signed as given by the staff member.**

These procedures are written in line with current guidance in 'Managing Medicines in Schools and Early Years Nursery (Early Years Foundation Stage - EYFS).

While it is not our policy to care for sick children, who should be at home until they are well enough to return to the school, we will agree to administer medication as part of maintaining their health and well-being or when they are recovering from an illness.

As far as possible, administering medicines will only be done where it would be detrimental to the child's health if not given while at school.

Children taking prescribed medication must be well enough to attend school.

Wherever possible GP's should be asked of the possibility in prescribing medication that can be taken at home in the morning and evening outside of school hours.

**If a child has not had a medication before, it is advised that the parent keeps the child at home for the first 48 hours to ensure that there are no adverse effects, as well as to give time for the medication to take effect.**

A medicine administration consent form **must** be completed in full and signed before **any** medication is given.

**Only** prescribed medication will be given.

**The school will only accept prescribed medicines that are in date, labelled, provided in the original container as dispensed by a pharmacist and include instructions for administration, dosage and storage. The exception to this is insulin which must still be in date, but will generally be available to schools inside an insulin pen or a pump, rather than in its original container Please check that medication is in date.**

Medicine spoons and oral syringes must be supplied by the parent if required.

Medications may only be used for the child whose name appears on the medicine. This includes emergency adrenaline injections (Epipen) and inhalers.

### **Medicine storage**

All medicines are to be stored in the designated secure places in the marked plastic boxes in the fridge or top cupboard in the kitchen. Medicines must not be left in the reach of any pupil.

It is the form teacher's responsibility to hand medicine back to the parent at the end of the day

### **Refusal of Medication**

If a child refuses to take medicine or carry out a necessary procedure, staff should not force them to do so, but follow the procedure agreed in the individual healthcare plan if one exists.

Parents should be informed so that alternative options can be considered

### **Medicines on trips and outings**

Medication for a child is taken in a sealed plastic box clearly labelled with the child's name and name of the medication. Inside the box, with the medication, is a copy of the consent form/medication form with the details as given above, which the parent signs on our return.

**On no account may medicine be decanted into other containers or packets or envelopes. The original pharmacy labelled medication should be within the box.**

### **Disposal of medicines**

When no longer required, medicines should be returned to the parent to arrange for safe disposal. Sharps boxes should always be used for the disposal of needles and other sharps. These are to be provided by the parent if required.

### **Emergency hospital treatment**

A member of staff should always accompany a child taken to hospital by ambulance, and should stay until the parent arrives. Health professionals are responsible for any decisions on medical treatment when parents are

not available.

### **Staff 'duty of care'**

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

Teachers are not contractually obliged to give medication or supervise a pupil taking it. It is, therefore, a voluntary activity.

Prime responsibility for a pupil's health rests with the parents/guardians, who should write to the headteacher giving sufficient information on their child's medical needs, requesting that medication be administered to him or her.

Agreement should be reached between the parents and the school as to the latter's role in supporting the child's medical needs, in accordance with the school's policy. Staff should then be consulted by the headteacher and asked to volunteer. Individual decisions on involvement must be respected.

Pupils should not be taken to hospital in staff cars. An ambulance should be called.

### **Medicines Act 1968**

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

### **PRACTICAL ADVICE ON ASTHMA, EPILEPSY, DIABETES AND ANAPHYLAXIS (Managing Medicines)**

The medical conditions in children that most commonly cause concern in schools and settings are asthma, diabetes, epilepsy and severe allergic reaction (anaphylaxis). Advice and it is important that the needs of children are assessed on an individual basis.

From April 2004 training for first-aiders in early years settings must include recognising and responding appropriately to the emergency needs of babies and children with chronic medical conditions.

### **ASTHMA**

*What is Asthma?*

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

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

### *Medicine and Control*

There are two main types of medicines used to treat asthma,

- **Relievers** (blue inhalers) are medicines taken immediately to relieve asthma symptoms and are taken during an asthma attack. They are sometimes taken before exercise. Usually a child will only



need a reliever during the school day.

- **Preventers** (brown, red, orange inhalers, sometimes tablets) are usually used out of school hours.

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

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

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

*The signs of an asthma attack include:*

6. coughing
7. being short of breath
8. wheezy breathing
9. feeling of tight chest
10. being unusually quiet

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

*An ambulance should be called if:*

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

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

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

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

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

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

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

All staff, particularly PE teachers, should have training or be provided with information about

asthma once a year. This should support them to feel confident about recognising worsening symptoms of asthma, knowing about asthma medicines and their delivery and what to do if a child has an asthma attack.

New legislation planned for 2015 will enable schools to hold inhalers for emergency purposes.

## **EPILEPSY**

*What is Epilepsy?*

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

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

any factors which might possibly have acted as a trigger to the seizure – e.g.

- visual/auditory stimulation, emotion (anxiety, upset) any unusual “feelings” reported by the child prior to the seizure
- parts of the body demonstrating seizure activity e.g. limbs or facial muscles
- the timing of the seizure – when it happened and how long it lasted
- whether the child lost consciousness
- whether the child was incontinent

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

What the child experiences depends whether all or which part of the brain is affected. Not all seizures involve loss of consciousness. When only a part of the brain is affected, a child will remain conscious with symptoms ranging from the twitching or jerking of a limb to experiencing strange tastes or sensations such as pins and needles

Where consciousness is affected; a child may appear confused, wander around and be unaware of their surroundings. They could also behave in unusual ways such as plucking at clothes, fiddling with objects or making mumbling sounds and chewing movements. They may not respond if spoken to. Afterwards, they may have little or no memory of the seizure.

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

After a seizure a child may feel tired, be confused, have a headache and need time to rest or sleep. Recovery times vary. Some children feel better after a few minutes while others may need to sleep for several hours. Another type of seizure affecting all of the brain involves a loss of consciousness for a few seconds.

A child may appear ‘blank’ or ‘staring’, sometimes with fluttering of the eyelids. Such absence seizures can be so subtle that they may go unnoticed. They might be mistaken for daydreaming or not paying attention in class. If such seizures happen frequently they could be a cause of deteriorating academic performance.

### ***Medicine and Control***

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

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

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

parents as part of the health care plan.

*During a seizure* it is important to make sure

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

*An ambulance should be called during a convulsive seizure if:*

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

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

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

*Training in the administration of rectal diazepam is needed* and will be available from local health services if a child should need this treatment during school hours.

**Staying with the child afterwards is important as diazepam may cause drowsiness. Where it is considered clinically appropriate, a liquid solution midazolam, given into the mouth or intra-nasally, may be prescribed as an alternative to rectal Diazepam.**

Instructions for use must come from the prescribing doctor.

For more information on administration of rectal diazepam, see Form 9

Children and young people requiring rectal diazepam will vary in age, background and ethnicity, and will have differing levels of need, ability and communication skills. If arrangements can be made for two adults, at least one of the same gender as the child, to be present for such treatment, this minimises the potential for accusations of abuse.

Two adults can also often ease practical administration of treatment. Staff should protect the dignity of the child as far as possible, even in emergencies.

The criteria under the national standards for under 8s day care requires the registered person to ensure the privacy of children when intimate care is being provided.

## **DIABETES**

*What is Diabetes?*

- Diabetes is a condition where the level of glucose in the blood rises. This is either due to
  - the lack of insulin (Type 1 diabetes)
- or
- because there is insufficient insulin for the child's needs or the insulin is not working properly (Type 2 diabetes).
  - About one in 550 school-age children have diabetes.
  - The majority of children have Type 1 diabetes. They normally need to have daily insulin injections, to monitor their blood glucose level and to eat regularly according to their personal dietary plan.

- Children with Type 2 diabetes are usually treated by diet and exercise alone.

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

### ***Medicine and Control***

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

Increasingly, older children are taught to count their carbohydrate intake and adjust their insulin accordingly. This means that they have a daily dose of long-acting insulin at home, usually at bedtime; and then insulin with breakfast, lunch and the evening meal, and before substantial snacks. The child is taught how much insulin to give with each meal, depending on the amount of carbohydrate eaten.

**They may or may not need to test blood sugar prior to the meal and to decide how much insulin to give. Diabetic specialists would only implement this type of regime when they were confident that**

the child was competent. The child is then responsible for the injections and the regime would be set out in the individual health care plan.

Children with diabetes need to ensure that their blood glucose levels remain stable and may check their levels by taking a small sample of blood and using a small monitor at regular intervals. They may need to do this during the school lunch break, before PE or more regularly if their insulin needs adjusting. Most older children will be able to do this themselves and will simply need a suitable place to do so. However younger children may need adult supervision to carry out the test and/or interpret test results.

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

Children with diabetes need to be allowed to eat regularly during the day. This may include eating snacks during class-time or prior to exercise.

Schools may need to make special arrangements for pupils with diabetes if the school has staggered lunchtimes. If a meal or snack is missed, or after strenuous activity, the child may experience a hypoglycaemic episode (ahypo) during which blood glucose level fall too low. Staff in charge of physical education or other physical activity sessions should be aware of the need for children with diabetes to have glucose tablets or a sugary drink to hand.

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

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

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

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

### **An ambulance should be called if:**

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

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

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

### **ANAPHYLAXIS**

*What is anaphylaxis?*

**Anaphylaxis is an acute, severe allergic reaction requiring immediate medical attention.**

It usually occurs within seconds or minutes of exposure to a certain food or substance, but on rare occasions may happen after a few hours.

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

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

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

### ***Medicine and Control***

The treatment for a severe allergic reaction is an injection of adrenaline (also known as epinephrine). Pre-loaded injection devices containing one measured dose of adrenaline are available on prescription. The devices are available in two strengths – adult and junior.

Should a **severe allergic reaction** occur, the adrenaline injection should be administered into the muscle of the upper outer thigh.

**An ambulance should always be called.**

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

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

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

Studies have shown that the risks for allergic children are reduced where an individual health care plan is in place. Reactions become rarer and when they occur they are mostly mild. The plan will need to be agreed by the child's parents, the school and the treating doctor.

### **Important issues specific to anaphylaxis to be covered include:**

- anaphylaxis – what may trigger it
- what to do in an emergency
- prescribed medicine

- food management
- precautionary measures

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

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

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

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

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