BLENHEIM SCHOOLS

First Aid Policy

Policy Folder: Health & Safety

BLENHEIM SCHOOLS

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1.0 INTRODUCTION

Blenheim Schools, as part of Outcomes First Group Limited (OFGL), recognises that prompt first aid/emergency aid treatment is instrumental in reducing the effects of injury or illness suffered at work and will comply fully with the provisions of The Health and Safety (First-Aid) Regulations 1981, and associated HSE Guidance.

The organisation's Policy therefore is to provide adequate and appropriate equipment, facilities and trained personnel to enable first aid to be given to employees if they are injured or become ill at work. The organisation is therefore committed to:

- Providing, on all company premises (and non-company premises where the Company is legally "in control", where staff are employed), sufficient numbers of trained personnel, equipment and information available to ensure that someone competent in basic first aid or emergency aid techniques can rapidly attend to an incident.
- Ensuring that appropriate first aid arrangements are made for peripatetic employees.
- Ensuring that appropriate first aid arrangements are made for the people we support and other members of the public (e.g. visitors and contractors).
- To provide information to employees on first aid arrangements.

Compliance: This policy complies with all relevant regulations and other legislation as detailed in the *Compliance with Regulations & Legislation Statement*.

2.0 LEGISLATION

Under The Health and Safety (First-Aid) Regulations 1981 employers have a duty to provide adequate first aid equipment, facilities and suitable personnel to render first aid to employees.

The HSE Regulations do not require employers to provide first aid for anyone other than their own employees. However, it is strongly recommended that employers include non-employees in their assessment of first-aid needs and make provision for them. This may require first-aiders to receive additional training above the legal minimum requirement so that they are able to act competently, for example additional training in paediatric first aid within early years school settings.

3.0 DEFINITIONS

First aid is defined as:

The provision of treatment for the preservation of life and minimising the consequences of injury and illness until medical help is obtained, and the treatment of minor injuries which would otherwise receive no treatment, or which does not require professional medical treatment."

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A first-aider is

Someone who has undertaken suitable training and has an appropriate First Aid qualification and remains competent to perform their role. This means that they must hold a valid certificate of competence in either:

- First Aid at Work (FAW), issued by an accredited training organisation or recognised awarding body; or
- Emergency First Aid at Work (EFAW), issued by an accredited training organisation or a recognised awarding body, or
- Paediatric First Aid (early years provision), issued by an accredited training organisation or a recognised awarding body.

Appointed Person is

A person who's role is to oversee first aid equipment (e.g. checks and, as appropriate, replenishing the first aid boxes and defibrillator), calling the emergency services when required, reporting incidents in accordance with local arrangements, and whilst they do not provide first aid themselves they support trained first aiders and manage the situation until help arrives. Typically, an appointed person would be used in low-level hazards areas such as those that might be found in offices and shops.

An appointed person is not required to have any formal training.

4.0 ORGANISATION & MANAGEMENT

Board of Directors
The Board of Directors have ultimate responsibility for ensuring that the Company meets its statutory obligations and that effective arrangements for the management of health and safety are put in place and are therefore responsible for setting and approving policy direction

Chief Executive Officer
The Chief Executive has overall responsibility for ensuring that the Company meets its statutory obligations and that effective arrangements for the management of health and safety are put in place.

Managing Directors/Operational Director of specific services
The Managing Directors have executive responsibility to manage Health and Safety including compliance with Health and Safety at Work Act, etc. 1974 and other relevant legislation, best practice guidance and Company policies to meet legal and organisational requirements

Regional Directors/Heads of Service/Operational Managers
Regional Directors/Heads of Service/Operational Managers are responsible for the ensuring the provision of arrangements in relation to first aid are in place and for ensuring that the company's policy is implemented for their respective services.

Head of Health and Safety
The Head of Health and Safety is responsible for advising on appropriate measures to meet legal and organisational requirements as required.

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Managers (Registered Managers, Principals, Head Teachers)
Managers are responsible for

- Undertaking the first aid risk assessment to ensure that adequate first aid can be provided during all work hours including assessing the first aid requirements for off-site activities where there may be an increased risk of injury
- Ensuring provision of relevant and adequate first aid supplies stored in suitable containers
- Ensuring the provision of adequate number of staff trained in first aid (FAW/EFAW/Paediatric first aid/Appointed persons) throughout the times that the premises are in use.
- Sufficient notices are displayed at appropriate places indicating the location of first aid equipment and trained first aiders so that assistance can be quickly summoned. These should be reviewed and amended regularly.
- Adequate access to a telephone is always available to call emergency services when required.
- Ensuring that all employees are aware of first aid arrangements in the event of an accident or illness.
- A suitable first aid room is available when the need is identified.
- Visitors and contractors are provided with information regarding first aid procedures and how to access first aid provision prior to commencing work, if this will be available to them whilst working on-site.
- Records are maintained of:
    - checking of first aid boxes and defibrillators by nominated person;
    - all first aid administered must be recorded as part of the relevant electronic accident/incident reporting system.
- Maintaining details of Certified First Aiders, Appointed Persons, their training records, and training renewal dates.

First Aiders
First aiders are responsible for

- Administering first aid to employees in accordance with their training, when required to do so, and to refer staff for specialist help, when required.
- To record all treatment provided, including the nature of first aid given, together with the date and time it was given.
- To present themselves for training at the appropriate time.

Other Nominated Persons

- Nominated person(s) (e.g. Appointed Persons) are responsible for maintaining stocks of first aid kits and appropriate signage is in place as directed by the site Managers.

5.0 FIRST AID ARRANGEMENTS

First Aid Provision

At all Outcomes First Group workplaces, there must be adequate and appropriate provision of first aid equipment, facilities and appropriately trained staff to enable first aid to be administered to employees and non-employees if they become injured or ill.

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The actual level of first aid provision at each workplace will be decided based on an assessment of need.

Where the work activity at any service involves particular risks, for example work with hazardous substances or working with dangerous tools or machinery, first aid needs will be greater and managers may need to increase the number of first aiders and associated controls within the assessment of first aid needs.

It is important to ensure that first aid provision is adequate and appropriate during all working hours, so planned annual leave and/or maternity leave of first aiders must be covered.

6.0 ASSESSMENT OF FIRST AID PROVISION

The Health and Safety (First-Aid) Regulations 1981, require employers to assess the needs for first aid with regard to the workplace, the location, the numbers and needs of employees and the activities taking place.

When deciding the level of First Aid required it should be borne in mind that the facilities and equipment should enable immediate assistance to be given to employees suffering from potential injuries or illness associated with the specific undertaking rapid summoning of an ambulance or medical assistance.

Typically, first-aiders will hold a valid certificate of competence in either First Aid at Work (FAW), Emergency First Aid at Work (EFAW), or Paediatric First Aid. These qualifications enable a first-aider to give emergency first aid to someone who is injured or becomes ill whilst at work.

The Regulations do not prescribe the level of First Aid facilities an employer must provide, because every workplace has different hazards. The level of service provided must be appropriate to the risks identified in the workplace assessment, and separate assessments may be required for various parts of the premises, and off-site activities dependent on the operations undertaken.

In determining the nature and extent of first aid provision within our sites, the factors to be considered and which should therefore be recorded if a record is desired, include:

- the nature of the work and workplace hazards and risks;
- The amount of staff and their locations.
- the sites history of accidents;
- the size of the site;
- the needs of travelling, remote, and lone workers;
- work patterns/shifts;
- the distribution of the workforce;
- the remoteness of the site from emergency medical services;
- employees working on shared or multi-occupied sites;
- cover for annual leave and other absences of first-aiders and appointed persons;
- first-aid provision for non-employees.

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7.0 LEVELS OF FIRST AID PROVISION

The findings of the first-aid needs assessment will help to determine how many first-aiders/appointed persons are required. There are no standard rules on exact numbers as it should be determined by the needs assessments taking into account all the relevant circumstances of each individual workplace.

Following completion of the first aid needs assessment/checklist, the associated flowchart (*Appendix 1*: taken from L74 the guidance on the regulations) serves as a general guide on how many first-aiders or appointed persons might be needed. The numbers quoted are suggestions only as all relevant information should be taken into account to make a valid judgement.

A First Aider (FAW) is someone who has undergone an approved training course in First Aid at Work and who holds a current First Aid at Work Certificate. Their role involves:

- undertaking first aid treatment in accordance with their training,
- summoning an ambulance or other external medical services,
- maintain the first aid container to the required level as listed on the standard list of contents
- record all cases treated via the appropriate online reporting system (e.g. Info Exchange, Sleuth).

An Emergency First Aider (EFAW) is someone who has undergone an approved Emergency First Aid at Work training course (of minimum one-day duration) and who holds a current Emergency First Aid at Work Certificate. They are normally used in low hazard locations; their role involves:

- Undertaking basic emergency first aid in accordance with their training,
- Summoning the assistance of a First Aider where available,
- Summoning an ambulance or other medical services
- Maintain the first aid container to the required level as listed on the standard list of contents
- Record all cases via the appropriate online reporting system (e.g. Info Exchange, Sleuth).

A Paediatric First Aider is someone who has undergone an approved training course in Paediatric First Aid and who holds a current certificate. Their role involves:

- undertaking first aid treatment in accordance with their training,
- summoning an ambulance or other external medical services,
- maintain the first aid container to the required level as listed on the standard list of contents
- record all cases treated via the appropriate online reporting system (e.g. Info Exchange, Sleuth).

Insurance
All suitably trained staff providing first aid are covered by the insurance arrangements for the Company.

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8.0 FIRST AID MATERIALS, EQUIPMENT & FACILITIES

When the assessment of first-aid requirements has been completed, the materials, equipment and facilities needed should be provided to make sure that the level of cover identified as necessary will be available to employees and others at all relevant times. This will include ensuring that first-aid equipment is suitably marked, easily accessible, and is available in all places where working conditions require it.

There is no mandatory list of items to be included in a first-aid container. The decision on what to provide will be determined by the findings of the first-aid needs assessment.

As a guide, where work activities involve low hazards, a minimum stock of first-aid items might be:

- a leaflet giving general guidance on first aid (for example, HSE's leaflet Basic advice on first aid at work)
- 20 individually wrapped sterile plasters (assorted sizes), appropriate to the type of work (hypoallergenic plasters can be provided if necessary);
- two sterile eye pads;
- two individually wrapped sterile triangular bandages;
- six safety pins;
- two large, sterile, individually wrapped unmedicated wound dressings;
- six medium-sized sterile individually wrapped unmedicated wound dressings;
- at least three pairs of disposable gloves (latex free and non-powdered).

Travelling first-aid kit contents

There is no mandatory list of items to be included in first-aid kits for travelling workers. They might typically contain:

- a leaflet giving general guidance on first aid (for example HSE's leaflet Basic advice on first aid at work);
- six individually wrapped sterile plasters (hypoallergenic plasters can be provided, if necessary);
- two individually wrapped triangular bandages, preferably sterile;
- two safety pins;
- one large, sterile, unmedicated dressing;
- individually wrapped moist cleansing wipes;
- two pairs of disposable gloves (latex free, non-powdered).

First aid kits can be purchased which comply with British Standard BS 8599 however, whether using a first-aid kit complying with BS 8599 or an alternative kit, the contents should reflect the outcome of the first-aid needs assessment.

Each workplace should have at least one first aid box supplied with a sufficient quantity of first-aid materials suitable for the particular circumstances, and if necessary a body spills kit.

Large sites will require more than one first-aid box, and suitable quantities of body spills kits. All first aid boxes must be identified by a white cross on a green background.

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First-aid boxes should be easily accessible and located where possible near to hand washing facilities. First aid boxes must only be used to store first aid materials, and nothing else. They must not contain tablets, medications, creams etc.

First Aiders & Emergency First Aiders must inspect the contents of first-aid containers on a monthly basis (contents must be re-stocked as soon as possible after use).

Automated External Defibrillators (AEDs)

All OFG sites must have an Automated External Defibrillator (AED) available to use in the case of an emergency cardiac situation, and that this provision is formally documented within their Assessment of First Aid Needs.

An AED should also be accompanied by an emergency response kit, containing items such as a pair of tough cut shears, preparation razor, nitrile gloves (non-latex), wipes, a towel, and a face shield.

Although persons do not need to undertake any formal training to use an AED, it is an integral part of the syllabus within the FAW, EFAW, and Paediatric training courses.

9.0 ACCIDENT / INCIDENT REPORTING

Any events where attention is required by an appointed person, First Aider or qualified person to deliver first aid must be reported following the accident/incident reporting policy and report via the appropriate online reporting system (i.e. Info Exchange).

10.0 TRAINING

There are 3 levels of training courses to consider:

- Emergency First Aid at Work (EFAW) training enables a first-aider to give emergency first aid to someone who is injured or becomes ill while at work.
- First Aid at Work (FAW) training includes the same content as EFAW, and also equips the first-aider to apply first aid to a range of specific injuries and illnesses.
- Paediatric First Aid – specifically for child related incidents

On completion of the first aid at work (FAW) training, successful candidates should be able to:

- understand the role of the first-aider, including reference to:
  - the importance of preventing cross infection;
  - the need for recording incidents and actions;
  - use of available equipment;
- assess the situation and circumstances in order to act safely, promptly and effectively in an emergency;
- administer first aid to a casualty who is unconscious (including seizure);
- administer cardiopulmonary resuscitation and use an automated external defibrillator;
- administer first aid to a casualty who is choking;

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- administer first aid to a casualty who is wounded and bleeding;
- administer first aid to a casualty who is suffering from shock;
- provide appropriate first aid for minor injuries (including small cuts, grazes and bruises, minor burns and scalds, small splinters).
- administer first aid to a casualty with:
    - injuries to bones, muscles and joints, including suspected spinal injuries;
    - chest injuries;
    - burns and scalds;
    - eye injuries;
    - sudden poisoning;
    - anaphylactic shock;
- recognise the presence of major illness (including heart attack, stroke, epilepsy, asthma, diabetes) and provide appropriate first aid.

On completion of an emergency first aid at work (EFAW) course, successful candidates should be able to:

- understand the role of the first-aider, including reference to:
    - the importance of preventing cross infection;
    - the need for recording incidents and actions;
    - use of available equipment;
- assess the situation and circumstances in order to act safely, promptly and effectively in an emergency;
- administer first aid to a casualty who is unconscious (including seizure);
- administer cardiopulmonary resuscitation and use an automated external defibrillator;
- administer first aid to a casualty who is choking;
- administer first aid to a casualty who is wounded and bleeding;
- administer first aid to a casualty who is suffering from shock;
- provide appropriate first aid for minor injuries (including small cuts, grazes and bruises, minor burns and scalds, small splinters).

Note: an 'Appointed Person' is not required to have any formal training.

11.0 INFECTION CONTROL

Those most at risk of infection are, in theory, first aiders attempting to give resuscitation or trying to stop bleeding. As a precautionary measure a suitable resuscitation mask or shield should be provided where a risk of infection may occur.

To minimise risk of cross contamination/ infection whilst administering first aid, first-aid personnel must cover all exposed cuts/abrasions on their own bodies with a waterproof dressing before administering treatment.

They must also wash their hands before and after applying dressings.

Disposable nitrile/vinyl gloves and aprons must be worn whenever blood, or other body fluids are handled

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First aiders must comply with all infection prevention and control policies and procedures for the company, for example in cleaning up spilt blood or other bodily fluids.

If contact is made with any other person's body fluids the area should be washed immediately and medical advice sought.

Further advice on infection control is available in the Control of Infection Policy

Any injuries incurred whilst providing first aid (including sharps injuries) must be reported via the appropriate online reporting system (i.e. Info Exchange, Sleuth).

12.0 MONITORING & REVIEW

This policy will be reviewed every 2 years, unless changing circumstances require an earlier review.

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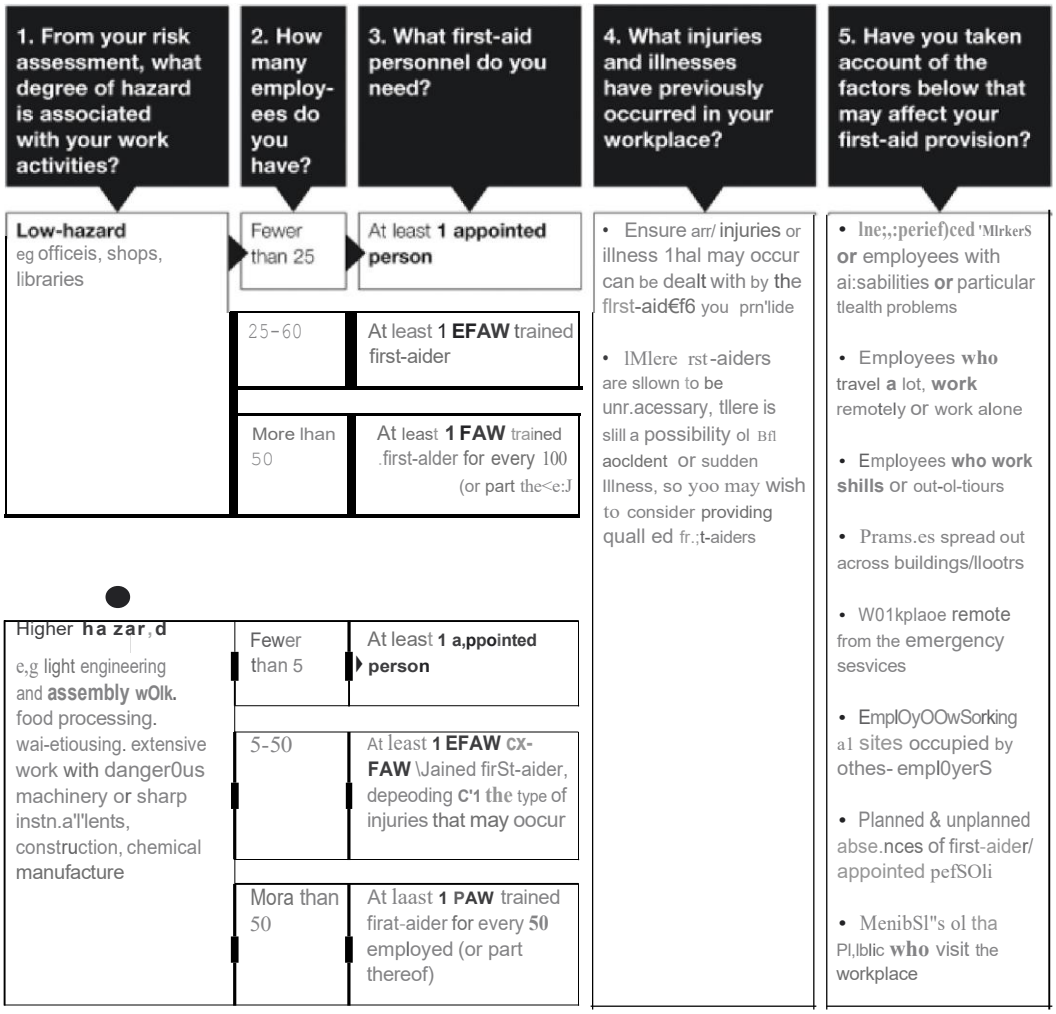
13.0 APPENDIX 1



Appendix 2

Contacting Emergency Services

A qualified first aider or another nominated person will dial 999, ask for an ambulance and then speaking clearly and slowly and be ready with the following information:

1. The school/nursery telephone numbers:
2. The location as follows:

   The postcode of the building where the ambulance needs to come to:

   - _____
   - _____
   - Give exact location in the school/nursery of the person needing help.
3. The name of the person needing help
4. The approximate age of the person needing help
5. A brief description of the person's symptoms (and any known medical condition)
6. Inform ambulance control of the best entrance to the school/nursery and state that the crew will be met at this entrance and taken to the pupil.

Do not hang up until the information has been repeated back.

Please note that the person calling should be with the child, as the emergency services may give first aid

instructions over the telephone.

Send a member of staff to wait at the entrance to guide the ambulance service to the person needing help.

Also, ensure that one or more of the following members of staff are informed that an ambulance has been called to the school/nursery: Headteacher and Head of Operations

Ensure that the child's parents/guardians have been contacted.

Never cancel an ambulance once it has been called.

Appendix 3

Bodily Fluid Spillage Policy

Blood and body fluids (e.g. faeces, vomit, saliva, urine, nasal and eye discharge) may contain viruses or bacteria capable of causing disease. It is, therefore, vital to protect both yourself and others from the risk of cross infection. In order to minimise the risk of transmission of infection, both staff and pupils should practise good personal hygiene and be aware of the procedure for dealing with body spillages. This document is to be used in conjunction with Public Health Agency: *Guidance on infection control in schools and other childcare settings* (April 2017).

There are Bodily Fluid Disposal Kits available at _____

Bodily Fluid Spillage Clean-Up Procedure

1. Cordon off the area until clean-up is completed.
2. Put on disposable gloves and a disposable plastic apron from the nearest First Aid kit.
3. Ensure that any cuts or abrasions are covered with a plaster.
4. Never use a mop or similar equipment to clean up bodily fluids – use only disposable items.
5. Place absorbent towels or sand/proprietary powders over the affected area and allow the spill to absorb.
6. Wipe up the spill immediately, using these and then place in a bin (which has a bin liner).
7. Put more absorbent towels over the affected area and then contact the Facilities Manager for further help.
8. If a Body Fluid Disposal Kit is available, then the instructions for use should be followed. All contaminated materials need to be placed in a yellow clinical waste bag, placed in the designated clinical waste bin in the medical room and later disposed of correctly.
9. Avoid getting any bodily fluids in your eyes, nose, mouth or on any open sores.
10. If a splash occurs onto the body, wash the area well with soap and water or irrigate with copious amounts of saline.
11. If the spillage has been quite extensive then the area may need to be closed off until the area can be cleaned correctly.
12. The area must be cleaned with disinfectant following the manufacturer's instructions.
13. An appropriate hazard sign needs to be put by the affected area.
14. The area should be ventilated and left to dry.
15. Anyone involved in cleaning up the spillage must wash their hands thoroughly afterwards with soap and water.

Please note that:

- The bin that has had the soiled paper towels put in needs to be tied up and ideally placed in the yellow bin or double bagged and put in an outside bin.
- Any article of clothing that has been contaminated with the spill should be wiped cleaned and then put in a plastic bag and tied up for the parents to take home.

- Any soiled wipes, tissues, plasters, dressings, etc. must ideally be disposed of in the clinical waste bin (yellow bag). If not available, then the gloves being used need to be taken off inside out, so that the soiled item is contained within them. This can be placed in a sanitary waste disposal bin, which is regularly emptied.

Further information and guidance can be found here.

Appendix 4

Asthma Emergency Procedures (Please also refer to the school/nursery Asthma Form)

Asthma management

The school/nursery recognises that asthma is a serious but controllable condition and the school/nursery welcomes any pupil with asthma. The school/nursery ensures that all pupils with asthma can and do fully participate in all aspects of school/nursery life, including any out of school/nursery activities. Taking part in PE is an important part of school/nursery life for all pupils and pupils with asthma are encouraged to participate fully in all PE lessons. Teaching staff will be aware of any child with asthma from a list of pupils with medical conditions kept in the staff room. The school/nursery has a smoke free policy. It is the parents' responsibility to ensure that the school/nursery is provided with a named, in-date reliever inhaler, which is kept in the classroom, not locked away and always accessible to the pupil. Teaching staff should be aware of a child's trigger factors and try to avoid any situation that may cause a pupil to have an asthma attack. It is the parents' responsibility to provide a new inhaler when out of date. Pupils must be made aware of where their inhaler is kept and this medication must be taken on any out of school/nursery activities.
As appropriate for their age and maturity, pupils are encouraged to be responsible for their reliever inhaler, which is to be brought to school/nursery and kept in a school/nursery bag to be used as required. A spare named inhaler should be brought to school/nursery and given to the class teacher for use if the pupil's inhaler is lost or forgotten.

Trigger factors

- Change in weather conditions
- Animal fur
- Having a cold or chest infection
- Exercise
- Pollen
- Chemicals
- Air pollutants
- Emotional situations
- Excitement

Common signs of an asthma attack:

- pupil unable to complete an activity
- increased anxiety
- coughing
- shortness of breath
- wheezing
- feeling tight in the chest
- being unusually quiet
- difficulty speaking in full sentences
- sometimes younger children express feeling tight in the chest and a tummy ache.

Do . . .

- keep calm
- encourage the pupil to sit up and slightly forward – do not hug them or lie them down
- make sure the pupil takes two puffs of their reliever inhaler (usually blue) immediately and preferably through a spacer
- ensure tight clothing is loosened
- reassure the pupil.

If there is no immediate improvement, continue to make sure that the pupil takes two puffs of reliever inhaler every two minutes up to 10 puffs or until their symptoms improve.

999

Call an ambulance urgently for any of the following:

- the pupil's symptoms do not improve in 5–10 minutes
- the pupil is too breathless or exhausted to talk
- the pupil's lips are blue
- you are in any doubt.

Ensure the pupil takes two puffs of their reliever inhaler every two minutes until the ambulance arrives.

After a minor asthma attack

- Minor attacks should not interrupt the involvement of a pupil with asthma in school/nursery. When the pupil feels better he/she can return to school/nursery activities.
- The parents/guardians must always be told if their child has had an asthma attack.

Important things to remember when an asthma attack occurs:

- Never leave a pupil having an asthma attack.
- Younger pupils may require assistance to administer their inhaler and/or spacer.
- If the pupil does not have their inhaler and/or spacer with them, send another teacher or pupil to School/nursery Reception to get their spare inhaler and/or spacer.
- In an emergency situation school/nursery staff are required under common law, duty of care, to act like any reasonably prudent parent.
- Reliever medicine is very safe. During an asthma attack, do not worry about a pupil overdosing.
- Send a pupil to get another teacher/adult if an ambulance needs to be called.
- Contact the pupil's parents/carers immediately after calling the ambulance.

A member of staff should always accompany a pupil taken to hospital by ambulance and stay with him/her until their parent arrives.

Do not cancel an ambulance once called, even if the pupil's condition appears to have improved

Appendix 5a

Anaphylaxis Emergency Procedures

Anaphylaxis has a whole range of symptoms. Any of the following may be present, although most pupils with anaphylaxis would not necessarily experience all of these:

- generalised flushing of the skin anywhere on the body
- nettle rash
- (hives) anywhere on the body
- difficulty in swallowing or speaking
- swelling of throat and mouth
- possible blue colouring around the mouth returning to normal as breathing returns to normal
- alterations in heart rate
- severe asthma symptoms (see Appendix 3 for more details); breathing may be slow and noisy
- abdominal pain
- rigid muscle spasms
- twitching of one or more limbs or the face
- nausea, vomiting and possible incontinence
- sense of impending doom
- sudden feeling of weakness (due to a drop in blood pressure)
- pupil may feel confused may fall to the ground, collapse or become unconscious.

Do . . .

If a pupil with allergies shows any possible symptoms of a reaction:

- assess the situation
- follow the pupil's emergency procedure closely, these instructions will have been given by the hospital consultant

- administer appropriate medication in line with perceived symptoms

Don't . . .

- try to stop the seizure
- put anything in the pupil's mouth.

999

If you consider that the pupil's symptoms are cause for concern, call for an ambulance (see Appendix 2). State:

- that you believe them to be suffering from anaphylaxis
- the cause or trigger (if known)

While awaiting medical assistance, the designated trained staff should:

- continue to assess the pupil's condition
- position the pupil in the most suitable position according to their symptoms

Symptoms and the position of pupil

- If the pupil is feeling faint or weak, looking pale, or beginning to go floppy, lay them down with their legs raised. They should NOT stand up
- If there are also signs of vomiting, lay them on their side to avoid choking
- If they are having difficulty breathing caused by asthma symptoms or by swelling of the airways they are likely to feel more comfortable sitting up

Do . . .

- If symptoms are potentially life-threatening, give the pupil their adrenaline injector into the outer aspect of their thigh
- Make a note of the time the adrenaline is given in case a second dose is required and also notify the ambulance crew
- On the arrival of the paramedics or ambulance crew the staff member in charge should inform them of the time and type of medicines given. All used adrenaline injectors must be handed to the ambulance crew.

After the emergency

- After the incident, carry out a debriefing session with all members of staff involved
- Complete an incident form
- Ensure that parents/guardians have replaced any medication used

Do not cancel an ambulance once called, even if the pupil's condition appears to have improved.

We also use the following allergy plans for students:

chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.bsaci.org/wp-content/uploads/2025/07/BSACI-AllergyActionPlan-EpiPen-OCTOBER-24.pdf

Appendix 5b

Sample Risk Assessment for the use of a School/nursery Emergency Epi-pen

SIGNIFICANT ISSUE	HOW TO MANAGE IT (risk reduction factors)	WHO TO BE INFORMED		
		Parents	Staff	Pupils
Lack of awareness - staff don't know how to administer emergency Epi-pen	● Administration of medicines policy is explained to staff at induction. Staff are also invited to practise following demonstration with the training Epi-pen on a regular basis with the school nurse ● Healthcare plans shared with relevant staff ● Health issues of pupils are identified on iSAMS under the red medical flag	*	*	*
Medication given in error	● Medical needs of children are identified in the medical questionnaire when they join the school/nursery. Children diagnosed with anaphylaxis are made known to staff, and their individual care plans are shared. ● Signs and symptoms of anaphylaxis clearly explained ● Procedure for checking medication is carried out - name of child, medication to be given and expiry date verified prior to administration	*	*	*
Emergency medication is not locked away	● Emergency medication is stored in a sealable 'emergency use only' allergy response kit at a height, in the medical room	*	*	
Medication given is out of date	● Medication expiry date is regularly checked by the school nurses, and replaced as necessary	*	*	
Lack of consent	● Written consent is required by parents of children who have anaphylaxis for use of an emergency Epi-pen	*	*	*
School/nursery unaware of medical condition	● A process is in place for identifying a child who has anaphylaxis, that requires monitoring in school/nursery with the with Health Conditions questionnaire	*	*	*
No healthcare plan in place	● A healthcare plan must be devised when anaphylaxis is diagnosed, in conjunction with appropriate medical practitioner, parents / guardian and School Nurse/Lead First Aider using standard forms provided by school/nursery/ hospital.	*	*	*
No record of emergency Epi-pen being administered	● 'Administration of Medicines' form to be used when medication is given, which includes information such as parent consent and record of prescribed medicine given. An ambulance is called for when the emergency Epi-pen is used.	*	*	*
Medication not disposed of responsibly	● The emergency Epi-pen used is stored safely out of the way whilst dealing with the child, and then passed on to the emergency services when they arrive.	*	*	

Appendix 6

Diabetes Emergency Procedures

Pupils with diabetes can attend school/nursery and carry out the same activities as their peers but some forward planning may be necessary. Staff must be made aware of any pupil with diabetes attending school/nursery.

Hyperglycaemia

This is when a person's blood glucose level is high (over 10mmol/l) and stays high. Hyperglycaemia develops much more slowly than hypoglycaemia but can be more serious if left untreated. It can be caused by too little insulin, eating more carbohydrate, infection, stress and less exercise than normal. Common symptoms:

- Thirst
- Frequent urination
- Tiredness and weakness
- Dry skin
- Nausea and vomiting
- Breath smelling of acetone (eg nail polish remover)
- Blurred vision
- Unconsciousness.

Do . . .

Call the pupil's parents who may request that extra insulin be given. The pupil may feel confident to give extra insulin. If a pump is used it should indicate how much insulin to give. The pupil may be equipped to self-test blood or urine.

Do Dial 999

If any of the following symptoms are present, then call the emergency services:

- deep and rapid breathing (over breathing)
- vomiting
- breath smelling of acetone (nail polish remover).

Hypoglycaemia

This is when a person's blood glucose levels are too low (below 4 mmol/l). This happens very quickly. The pupil should test his or her blood glucose levels if blood testing equipment is available. Hypoglycaemia may be caused by:

- too much insulin
- warm weather
- stress
- a delayed or missed meal or snack
- not enough food, especially carbohydrate
- unplanned or strenuous exercise
- drinking large quantities of alcohol or alcohol without food
- sometimes there is no obvious cause

Common symptoms:

- hunger
- trembling or shakiness
- sweating
- anxiety, agitation or irritability
- fast pulse or palpitations
- tingling, for example in the lips
- glazed eyes or blurred vision
- dizziness
- headache
- pallor
- mood change, especially angry or aggressive behaviour
- lack of concentration
- vagueness, incoherence or confusion
- drowsiness.

Do . . .

- Follow the guidance provided in the care plan agreed by parents
- Immediately give something sugary and fast-acting to eat or drink, to raise the blood sugar level quickly, such as one of the following:
    - Lucozade, apple juice or non-diet drink such as cola, three or more glucose tablets. (The pupil should always carry glucose supplies and extra supplies are kept in emergency boxes.)
    - five sweets, e.g. jelly babies

- GlucoGel

The exact amount needed will vary from person to person and will depend on individual needs and circumstances, be guided by the person. After 10 – 15 minutes check the blood sugar again. If it is below 4 give another sugary quick-acting carbohydrate. This will be sufficient for a pump user but for pupils who inject insulin a longer-acting carbohydrate will be needed to prevent the blood glucose dropping again, such as:

- roll/sandwich
- a glass of milk
- portion of fruit
- cereal bar
- two biscuits
- a meal if it is due.

If the pupil still feels hypo after 15 minutes, something sugary should be given again. When the child has recovered, give them some starchy food, as above. Allow the pupil to have access to regular snacks and inform parents.

Don't . . .

- send the child out of your care for treatment alone

Do Dial 999

If the pupil becomes unconscious:

- Call for an ambulance
- Do not give them anything to eat or drink
- Place pupil in the recovery position and seek the help of the Lead First Aider or a first aider.
- Do not attempt to give glucose via mouth as pupil may choke.
- Inform parents.
- Accompany pupil to hospital and await the arrival of a parent.

Do not cancel an ambulance once called, even if the pupil's condition appears to have improved.

Appendix 7

Epilepsy Emergency Procedures

First aid for seizures is quite simple and can help prevent a child from being harmed by a seizure. First aid will depend on the individual child's epilepsy and the type of seizure they are having. Some general guidance is given below, but most of all it is important to keep calm and know where to find help.

Tonic-clonic seizures Symptoms:

- The person loses consciousness; the body stiffens, and then falls to the ground. This is followed by jerking, twitching movements or muscle spasms. A blue tinge around the mouth is likely, due to irregular breathing. Loss of bladder and/or bowel control may occur. After a minute or two the jerking movements should stop, and consciousness slowly returns.

Do …

- Protect the person from injury – (remove harmful objects from nearby).
- Cushion their head
- Look for an epilepsy identity card or identity jewellery. These may give more information about a pupil's condition, what to do in an emergency, or a phone number for advice on how to help.
- Once the seizure has finished, gently place them in the recovery position to aid breathing.
- Keep calm, reassure the person and allow him/her to rest when the seizure subsides.
- Stay with the person until recovery is complete.
- Move other pupils away and maintain the person's dignity
- Inform parents

Don't …

- Restrain the pupil
- Put anything in the pupil's mouth
- Try to move the pupil unless they are in danger
- Give the pupil anything to eat or drink until they are fully recovered
- Attempt to bring them round.

Dial 999

Call for an ambulance if…

- You believe it to be the pupil's first seizure
- The seizure continues for more than five minutes
- One tonic-clonic seizure follows another without the person regaining consciousness between seizures
- The pupil is injured during the seizure
- You believe the pupil needs urgent medical attention.

Then . . .

- Describe the event and its duration to the paramedic team on arrival.
- Reassure other pupils and staff.
- Accompany the pupil to hospital and await the arrival of a parent.

Seizures involving altered consciousness or behaviour

Simple partial seizures - Symptoms:

- Twitching
- Numbness
- Sweating
- dizziness or nausea
- disturbances to hearing, vision, smell or taste a strong sense of déjà vu

Complex partial seizures - Symptoms:

- plucking at clothes
- smacking lips, swallowing repeatedly or wandering around
- the person is not aware of their surroundings or of what they are doing

Atonic seizures - Symptoms:

- sudden loss of muscle control causing the person to fall to the ground. Recovery is quick.

Myoclonic seizures - Symptoms:

- brief forceful jerks which can affect the whole body or just part of it. The jerking could be severe enough to make the person fall.

Absence seizures - Symptoms:

- the person may appear to be daydreaming or switching off. They are momentarily unconscious and totally unaware of what is happening around them.

Do . . .

- Guide the person away from danger
- Look for an epilepsy identity card or identity jewellery. These may give more information about a person's condition, what to do in an emergency, or a phone number for advice on how to help
- Stay with the person until recovery is complete
- Keep calm and reassure the person
- Explain anything that they may have missed.

Don't . . .

- 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.

Dial 999

Call for an ambulance if . . .

- One seizure follows another without the person regaining awareness between them
- The person is injured during the seizure
- You believe the person needs urgent medical attention.

Do not cancel an ambulance once called, even if the pupil's condition appears to have improved.

Appendix 8a

Head Injury Policy and a Graduated Return to Play

1. Introduction

The school/nursery's Head Injury Policy has been written in accordance with NICE clinical guidelines, World Rugby Concussion Guidance and England Rugby Club Concussion - Headcase Resources. Since the majority of head injuries in the EYFS are minor, the staff will manage these incidences themselves and seek advice from the school nurse/lead first aider, if necessary who will instigate the head injury policy if required.

2. Background

A head injury is defined as any trauma to the head excluding superficial injuries to the face. Fortunately, the majority of head injuries within school/nursery are minor and can be managed at school/nursery or at home. However, some can be more severe, and it is important that a child is assessed and treated accordingly. The risk of brain injury can depend on the force and speed of the impact and complications such as swelling, bruising or bleeding can occur within the brain itself or the skull.

Concussion is defined as a traumatic brain injury resulting in the disturbance of brain function. There are many symptoms, but the most common ones are dizziness, headache, memory disturbance or balance problems. Concussion is caused by either a direct blow to the head or blows to other parts of the body resulting in a rapid movement of the head, such as whiplash.

It is also important to note that a repeat injury to the head after a recent previous concussion can have serious implications.

3. Process for managing a suspected head injury

All head injuries that occur on the school/nursery site must be referred to the School Nurse/Lead First Aider, if on site, for immediate assessment. The exception for this is if the pupil needs urgent medical attention, at which point the Emergency Services should be called first prior to calling the nurse/lead first aider. If there is not a nurse on site, the pupil must be assessed and monitored for at least one hour by a qualified First Aider and referred for medical review as per the guidelines in this document. If in doubt, the First Aider should call NHS 111 for advice or 999.

If after one hour the pupil is symptom free, he/she can return to lessons but must be kept under observation for the remainder of that day. This applies even if the pupil feels it is unnecessary. As concussion typically presents in the first 24-48 hours following a head injury, it is important that the pupil is monitored and assessed as above.

4. Recognising Concussion

One or more of the following signs clearly indicate a concussion:

- Seizures
- Loss of consciousness – suspected or confirmed
- Unsteady on feet or balance problems or falling over or poor co-ordination
- Confused
- Disorientated – not aware of where they are or who they are or the time of day
- Dazed, blank or vacant look
- Behavioural changes; for example, more emotional or more irritable

One or more of the following may suggest a concussion:

- Lying motionless on the ground
- Slow to get up off the ground
- Grabbing or clutching their head
- Injury event that could possibly cause concussion

IF A PUPIL IS PLAYING SPORTS AND HAS SUFFERED A HEAD INJURY AND/OR IS SHOWING SIGNS OF CONCUSSION, HE/SHE SHOULD IMMEDIATELY BE REMOVED FROM TRAINING/PLAY FOR THE REST OF THE LESSON.

5. Emergency Management

The following signs may indicate a medical emergency and an ambulance should be called immediately:

- Rapid deterioration of neurological function
- Decreasing level of consciousness
- Decrease or irregularity of breathing
- Any signs or symptoms of neck, spine or skull fracture or bleeding for example bleeding from one or both ears, clear fluid running from ears or nose, black eye with no obvious cause, new deafness in one or more ear, bruising behind one or more ear, visible trauma to skull or scalp, penetrating injury signs
- Seizure activity
- Any pupil with a witnessed prolonged loss of consciousness and who is not stable (i.e. condition is worsening)

6. Referral to Hospital

The School Nurse/Lead First Aider, or in their absence, a qualified First Aider, should refer any pupil who has sustained a head injury to a hospital emergency department, using the Ambulance Service if deemed necessary, if any of the following are present:

- Glasgow Coma Scale (GCS) score of less than 15 on initial assessment.
- Any loss of consciousness as a result of the injury.
- Any focal neurological deficit - problems restricted to a particular part of the body or a particular activity, for example, difficulties with understanding, speaking, reading or writing; decreased sensation; loss of balance; general weakness; visual changes; abnormal reflexes; and problems walking since the injury.
- Amnesia for events before or after the injury (assessment of amnesia will not be possible in preverbal children and unlikely to be possible in children aged under 5).
- Persistent headache since the injury.
- Any vomiting episodes since the injury.
- Any seizure since the injury.
- Any previous brain surgery.
- A high-energy head injury. For example, pedestrian struck by motor vehicle, occupant ejected from motor vehicle, fall from a height of greater than 1 metre or more than 5 stairs, diving accident, high-speed motor vehicle collision, rollover motor accident, accident involving motorised recreational vehicles, bicycle collision, or any other potentially high-energy mechanism.
- Any history of bleeding or clotting disorders (such as haemophilia) or if the injured person takes medicine to thin the blood.
- Current anticoagulant therapy such as warfarin.
- Current drug or alcohol intoxication or consumption of alcohol or drugs just before the injury.
- A change in behaviour, like being more irritable or losing interest in things around you (especially in children under 5)
- The child has been crying more than usual (especially in babies and young children)
- There are any safeguarding concerns (for example, possible non-accidental injury or a vulnerable person is affected).
- Continuing concern by the professional about the diagnosis.

In the absence of any of the risk factors above, consider referral to an emergency department if any of the following factors are present, depending on judgement of severity:

- Irritability or altered behaviour, particularly in infants and children aged under 5 years.
- Visible trauma to the head not covered above but still of concern to the healthcare professional.
- No one is able to observe the injured person at home.
- Continuing concern by the injured person or their family/guardian about the diagnosis.

For day pupils, it is the responsibility of the parent/guardian to take the pupil to the nearest Emergency Department if it is recommended by the School Nurse/Lead First Aider. For Boarders it is the responsibility of the House Parents if available. The procedure for taking pupils to hospital should be referred to in the staff code of conduct, with reference also to the safeguarding policy.

7. Questions to ask the pupil to determine issues with memory.

If they fail to answer correctly any of these questions, there is a strong suspicion of concussion

“Where are we now?”

“Is it before or after lunch?”

“What was your last lesson?”

“What is your Tutor’s/Class Teacher’s name?”

“What Class are you in?”

8. DO’s and DON’Ts

- Subject to parental consent, the pupil’s age and any allergies, the pupil may be given Paracetamol but must not be given Ibuprofen or Aspirin as these can cause the injury to bleed.
- If he/she is vomiting or at risk of vomiting DO NOT give him/her anything to eat or drink until completely recovered
- Unless there are injuries elsewhere, monitor the pupil in a semi upright position so that the head is at least at a 30-degree angle if lying down.
- DO apply a covered instant cold pack to the injured area for 15-20 minutes UNLESS the area has an open wound.

9. Head Injury Notifications

The person supervising the pupil at the time is responsible for contacting:

- The School Nurse/Lead First aider
- The pupil’s parents/carers if a day pupil, unless this responsibility is taken by the School Nurse/Lead First aider
- The Pupil’s Tutor/Class teacher
- Main Reception and Facilities & Estates Manager if an ambulance is called
- Head of Year/Prep/Senior/Sixth Form and Headteacher if pupil is taken to hospital

- Boarding House Parents if a boarder who can then inform the parent/guardian

If the head injury is minor and the pupil stays at school/nursery, for day pupils the parent/carers should be informed by the School Nurse/Lead first aider or the responsible adult and a Head Injury Letter given to take home and the pupil monitored carefully for potential deterioration of symptoms.

10. Returning to school/nursery and sporting activities following a head injury and/or concussion

For minor head injuries, the pupil can return to school/nursery once he or she has recovered. If the pupil has a diagnosed concussion, the symptoms of concussion can persist for several days or weeks after the event. Therefore, returning to school/nursery should be agreed with the parents/carers, the School Nurse/Lead First Aider and the pupil's doctor.

For return to exercise and sporting activities within school/nursery for pupils with concussion, the school/nursery follows the Rugby Union's Graduated Return to Play Pathway (which can be accessed here: GRTP). This requires an initial minimum two weeks' rest (including 24 hours complete physical and cognitive rest) Pupils can then progress to Stage 2 only if they are symptom free for at least 48 hours, have returned to normal academic performance and have been cleared by the pupil's doctor or the School Nurse/Lead First Aider. This pathway must be adhered to regardless of the pupil's/parents'/carers' views. The reason for this is that a repeat head injury could have serious consequences to the pupil during this time.

The pupil can then progress through each stage as long as no symptoms or signs of concussion return. If any symptoms occur, they must be seen by a doctor before returning to the previous stage after a minimum 48-hour period of rest with no symptoms.

On completion of stage 4, in order for a pupil to return to full contact practice, he/she must be cleared by his/her doctor or approved healthcare professional. This can be the School Nurse.

A School Graduated Return to Play Pupil Progress Sheet (Appendix 8b) has been developed in order to monitor and communicate the pupil's progress and this outlines the 5 stages of the GRTP pathway to follow. It should be completed by the PE staff members or School Nurse/Lead First Aider in conjunction with the pupil's parents/guardian. For day pupils it is the parent/guardian's responsibility to inform the pupil's external sports clubs if the child has sustained a head injury and/or concussion. For boarding pupils, it is the responsibility of the House Parents.

For ease of reference, the following sporting activities will not be permitted until Stage 5 of the GRTP:

Rugby; Football; Cricket; Basketball; Netball; Rounders

Pupils may still attend Games lessons, but an alternative role will be found for them during the session.

11. Reporting

An accident form will be completed by the witness to the event, first aider or School Nurse. If the incident requires reporting to RIDDOR this will be actioned by the School Nurse/Lead First Aider/Bursar.

12. References

Concussion – Headcase Resources England Rugby, available online at:

https://www.englandrugby.com/participation/playing/headcase

Head injury: assessment and early management National Institute for Health and Care Excellence (NICE Guidelines CG176 January 2014; last updated September 2019), available online at: https://www.nice.org.uk/guidance/cg176

World Rugby Concussion Guidance World Rugby Player Welfare, available online at: https://playerwelfare.worldrugby.org/concussion

NHS Head Injury and Concussion, available online at: https://www.nhs.uk/conditions/minor-head-injury/

Appendix 8b: Graduated Return to Play Pupil Progress Sheet

Name of Pupil:_____ Supervising First Aider:_____

Pupil's Class _____ Date of Concussion _____

1. Overall Minimum Timescales

Age Group	Minimum Rest Period Post Concussion	GRTP Period	Minimum Time Out
All Pupils	14 rest days + 1 recovery day	8 Days	23 Days (where applicable, a minimum of 3 weekends of fixtures missed)

Pupils may not return to play in designated team and contact sports until:
1. all their symptoms have subsided.
2. they have followed the GRTP protocol.
3. they have been medically cleared to return.

2. GRTP Progress Sheet

This sheet is to be completed by the School Nurse/Lead First Aider, in consultation with parents and the pupil's medical practitioner. Pupils can move on to the next stage only once they have been symptom free

during the full period of each stage. If they are not symptom free, they must have a minimum 48 hour rest period and then go back to the previous stage.

Rehabilitation Stage	**Example exercise at each stage of rehabilitation**	**Objective of stage**	**Minimum timescale of Stage**	**Dated and signed by pupil/parent as comfortable to move to next stage**	**Dated and signed by school nurse/lead first aider as comfortable to move to next stage**
Rest	None	Rest	14 days		
1. No activity	Complete physical and mental rest without symptoms	Recovery	1 day		
2. Light aerobic exercise	Walking, swimming or stationary cycling keeping intensity below 70% maximum predicted heart rate. No resistance training	Increase heart rate	2 days		
3. Sport-specific exercise	Running drills. No impact activities	Add movement	2 days		
4.Non-contact training drills	Progression to more complex training drills e.g. passing drills. May start progressive resistance training	Exercise, coordination and mental load	2 day		
5. Following medical clearance, full contact practice	May participate in normal training activities	Restore confidence and assess functional skills by coaching staff	2 days		
6. After 24 hours, return to play	Player rehabilitated	Recovered	MINIMUM TOTAL: 23 days		

Appendix 8c: Sample Head Injury Letter

Date:

Dear Parent/Carer

We wish to inform you that _____banged his/her head at approximately _____am/pm today. He/she was checked and treated, and has been under supervision since. If any of the following symptoms appear within the next few days, it is advised that you seek immediate medical advice.

- unconsciousness, or lack of full consciousness (for example, problems keeping eyes open) drowsiness (feeling sleepy) that goes on for longer than 1 hour when he/she would normally be wide awake
- difficulty waking your child up
- problems understanding or speaking
- a change in behaviour, like being more irritable or losing interest in things around them (especially in children under 5)
- crying more than usual (especially in babies and young children)
- problems with memory
- loss of balance or problems walking
- weakness in one or more arms or legs
- problems with their eyesight e.g. blurred vision/dilated pupils
- painful headache that won't go away with painkillers
- vomiting
- seizures (also known as convulsions or fits)
- clear fluid coming out of their ear or nose
- bleeding from one or both ears.

He/she may experience a mild headache and some nausea which should go away within the next few days. If it doesn't then please take your child to see your doctor. If he/she is feeling unwell, we suggest that he/she doesn't return to school until fully recovered.

If you have any queries, please do not hesitate to contact us

Yours Faithfully

School Nurse/Lead First Aider Ms Teresia Capes

Appendix 9

Infectious Illnesses

UKHSA (formerly Public Health England) updated its guidelines in February 2023 for reducing the transmission of infectious diseases to other pupils and staff. These are set out below.

ILLNESS	PERIOD OF EXCLUSION	COMMENTS
In this table, * denotes a notifiable disease. Registered medical practitioners in England and Wales have a statutory duty to notify their local authority or UK Health Security Agency (UKHSA) HPT of suspected cases of certain infectious diseases.		
Athlete's Foot	None	Individuals should not be barefoot at their setting (for example in changing areas) and should not share towels, socks or shoes with others.
Chickenpox	At least 5 days from onset of rash and until all blisters have crusted over.	Pregnant staff contacts should consult with their GP or midwife and inform them that they have been in contact with chickenpox. Any children being treated for cancer or on high doses of steroids should also seek medical advice.

Cold sores	None	Avoid kissing and contact with the sores
Conjunctivitis	None	Children do not usually need to stay off school with conjunctivitis if they are feeling well. If, however, they are feeling unwell with conjunctivitis they should stay off school until they feel better. If an outbreak or cluster occurs, consult your local health protection team (HPT).
Respiratory infections including coronavirus (COVID-19)	Individuals should not attend if they have a high temperature and are unwell. Individuals who have a positive test result for COVID-19 should not attend the setting for 3 days after the day of the test.	Individuals with mild symptoms such as runny nose, and headache who are otherwise well can continue to attend their setting.
Diarrhoea and vomiting	48 hours from last episode of diarrhoea or vomiting	If a particular cause of the diarrhoea and vomiting is identified, there may be additional exclusion advice, for example E. coli STEC and hep A. For more information, see Managing outbreaks and incidents.
Diptheria*	Exclusion is essential. Always consult with your UKHSA HPT.	Preventable by vaccination. For toxigenic Diphtheria, only family contacts must be excluded until cleared to return by your local HPT.
Flu (influenza) or influenza like illness	Until recovered	Report outbreaks to your local HPT. For more information, see Managing outbreaks and incidents.
Glandular Fever	None	
Hand foot and mouth	None	Contact your local HPT if a large number of children are affected. Exclusion may be considered in some circumstances.
Head Lice	None once treated	Treatment is recommended for the pupil and close contacts if live lice are found
Hepatitis A	Exclude until 7 days after onset of jaundice (or 7 days after symptom onset if no jaundice).	In an outbreak of hepatitis A, your local HPT will advise on control measures.
Hepatitis B, C, HIV	None	Hepatitis B and C and HIV are blood borne viruses that are not infectious through casual contact. Contact your UKHSA HPT for more advice.
Impetigo	Until lesions are crusted or healed, or 48 hours after starting antibiotic treatment.	Antibiotic treatment speeds healing and reduces the infectious period.
Measles	4 days from onset of rash and well enough	Preventable by vaccination with 2 doses of MMR. Promote MMR for all individuals, including staff. Pregnant staff contacts should seek prompt advice from their GP or midwife.
Meningococcal Meningitis* or septicaemia*	Until recovered	Meningitis ACWY and B are preventable by vaccination. Your local HPT will advise on any action needed.
Meningitis* due to other bacteria	Until recovered	Hib and pneumococcal meningitis are preventable by vaccination. Your UKHSA HPT will advise on any action needed.
Meningitis viral	None	Milder illness than bacterial meningitis. Siblings and other close contacts of a case need not be excluded.
MRSA	None	Good hygiene, in particular handwashing and environmental cleaning, are important to minimise spread. Contact your UKHSA HPT for more information.
Mumps*	5 days after onset of swelling	Preventable by vaccination with 2 doses of MMR. Promote MMR for all individuals, including staff.
Ringworm	Not usually required	Treatment is needed
Rubella* (German Measles)	For 5 days from onset of rash	Preventable by vaccination with 2 doses of MMR. Promote MMR for all individuals, including staff. Pregnant staff contacts should seek prompt advice from their GP or midwife.
Scabies	Can return after first treatment.	Household and close contacts require treatment at the same time.
Scarlet Fever*	Exclude until 24 hours after starting antibiotic treatment.	Individuals who decline treatment with antibiotics should be excluded until resolution of symptoms. In the event of 2 or more suspected cases, please contact your UKHSA HPT.
Slapped cheek/	None (once rash has	Pregnant contacts of case should consult with their GP

Fifth disease/ Parvovirus B19	developed)	or midwife.
Threadworms	None	Treatment recommended for child and household.
Tonsilitis	None	There are many causes, but most cases are due to viruses and do not need or respond to an antibiotic treatment.
Tuberculosis* (TB)	Until at least 2 weeks after the start of effective antibiotic treatment (if pulmonary TB) Exclusion not required for non-pulmonary or latent TB infection. Always consult your local HPT before disseminating information to staff, parents and carers, and students.	Only pulmonary (lung) TB is infectious to others, needs close, prolonged contact to spread. Your local HPT will organise any contact tracing.
Warts and verrucae	None	Verrucae should be covered in swimming pools, gymnasiums and changing rooms
Whooping cough (pertussis)*	2 days from starting antibiotic treatment, or 21 days from onset of symptoms if no antibiotics	Preventable by vaccination. After treatment, non-infectious coughing may continue for many weeks. Your local HPT will organise any contact tracing.

The NHS website has a useful resource to share with parents.

Blenheim Schools
blenheimschools.com

Atria,
Spa Road,
Bolton, BL1 4AG

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