ST. CHRISTOPHER SCHOOL
LETCHWORTH GARDEN CITY

First Aid Policy

September 2022

CONTENTS

SECTION 1 General Policy Statement

1.1 The Governors and Headmaster of St Christopher School accept their responsibility under the Health and Safety (First Aid) Regulations 1981 and acknowledge the importance of providing First Aid for employees, children and visitors within the School.

1.2 The Governors are committed to the school's procedure for reporting accidents and recognise their statutory duty to comply with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013.

1.3 The provision of first aid in the School will be in accordance with the Department of Education's guidance on First Aid in School.

Signed: _____
(Head)

Date: _____

Signed: _____
(Chair of the Governing Body)

Date: _____

Section 2 Statement of First Aid Organisation

The School's arrangements for carrying out the policy includes nine key principles.

2.1 Places a duty on the Governing Body to approve the policy.

2.2 Place individual duties on all employees.

2.3 To report, record and where appropriate investigate all accidents.

2.4 Record all occasions when first aid is administered to employees, pupils and visitors and report incidents to parents.

2.5 Provide equipment and materials to carry out first aid treatment.

2.6 Make arrangements to provide training to employees, maintain a record of that training and review annually. This includes training for management of pupils/employees with particular medical conditions (e.g. asthma, diabetes, epilepsy). Please refer to Protocol for Administration and Control of Medicines within the School Environment.

2.7 Establish a procedure for managing accidents in school which require first aid treatment.

2.8 Provide information for employees on the arrangements for first aid.

2.9 Undertake a risk assessment of the first aid requirements of the School.

SECTION 3 Arrangements for First Aid

3.1 Materials, equipment and facilities

3.1.1 The School will provide materials, equipment and facilities as set out in Section 58 of the Department for Education and employment's Guidance on First Aid in Schools.

3.1.2 The location of first aid containers in the school are:

3.1.2.1.1 Art rooms
3.1.2.1.2 Arundale Boarding House
3.1.2.1.3 CDT Department
3.1.2.1.4 Finance Office
3.1.2.1.5 Head Gardener's Shed
3.1.2.1.6 Head's PA Office
3.1.2.1.7 Junior School
3.1.2.1.8 Kitchen
3.1.2.1.9 Learning Support Department
3.1.2.1.10 Maintenance (Building Officer's room)
3.1.2.1.11 Maintenance Workshop
3.1.2.1.12 Minibuses: YS70 ZJO
SF21 DTZ
HJ12 MJF
LB11 LTF
3.1.2.1.13 Nursery (Montessori)
3.1.2.1.14 Room 12
3.1.2.1.15 Science Department
3.1.2.1.16 Servery
3.1.2.1.17 Sports Department – Sports Hall, Pavilion, Office and Gym
3.1.2.1.18 Theatre (Head of Drama's Office)
3.1.2.1.19 Vege Centre

3.1.3 The contents of the first aid boxes will be checked on a regular basis by the Surgery staff.

3.1.4 Equipment and materials to carry out first aid treatment will be adjusted according to the requirements of the area. **Please refer to Annex 5 First Aid Kits in the Workplace (BS 8599-1) Published June 2011**

3.1.5 The Surgery will be responsible for all record keeping on first aid.

In compliance with The Education (School Premises) Regulations 1999 the Governing Body has ensured that a room for medical use has been set aside, ie. the Surgery. This facility contains the following.

3.1.5.1 sink with running hot and cold water; drinking water (if not available on mains tap) and disposable cups;
3.1.5.2 paper towels;
3.1.5.3 smooth-topped working surfaces;
3.1.5.4 range of First Aid equipment (at least to the standard required in First Aid boxes) and proper storage;

3.1.5.5 chair;
3.1.5.6 a couch or bed (with waterproof cover), pillow and blankets;
3.1.5.7 soap;
3.1.5.8 clean protective garments for First Aiders;
3.1.5.9 suitable refuse container (foot operated) lined with appropriate disposable yellow plastic bags, i.e. for clinical waste;
3.1.5.10 an appropriate record-keeping facility;
3.1.5.11 a means of communication, e.g. telephone.
3.1.5.12 a WC is nearby.

3.1.6 Suitable accommodation, including toilet and washing facilities, is provided in order to care for the needs of boarding pupils or pupils whose parents live far away from school and cannot immediately collect them. The Surgery area contains two, 2 bedded sick bays, one for females and one for male pupils. This accommodation is separate from the main boarding area. There is a room for the Nurse to stay overnight if she needs to care for sick boarders.

3.1.7 In addition to any First Aid provision on site, boarders have access to local medical, dental, optometric and other specialist services. Boarders have the choice to be registered with the School GP Dr Carole Brooks, Birchwood Surgery, Letchworth. Detailed records of all boarders are available from the Surgery.

3.1.8 In the case of care for pupils with chronic conditions or disabilities, dealing with medical emergencies and the use of household remedies. This information is documented in the 'Protocol for Administration and Control of Medicines within the School Environment'.

3.1.9 The 'Protocol for Administration and Control of Medicines within the School Environment', covers all aspects of medical provision beyond first aid and discusses the confidentiality and rights of pupils which are appropriately respected. This includes the right of a pupil deemed to be 'Gillick Competent' to give or withhold consent for his/her treatment.

3.2 Appointment of First Aiders

3.2.1 The appointment of First Aiders within the School complies with requirements set out in section 40 of the Department for education and Employment.

3.2.2 The completed Risk Assessment is provided at Annex 1 to this policy.

3.2.3 The Head has appointed the Bursar to be the Health and Safety Officer at the school. The School Nurse has the responsibility to:

3.2.3.1 take charge when someone is injured or becomes ill
3.2.3.2 look after the first aid equipment eg. restocking the first aid container
3.2.3.3 inform relevant staff/parents of incident
3.2.3.4 record incident/illness
3.2.3.5 make arrangements for the care of pupils with particular medical conditions, eg. asthma, epilepsy, diabetes or anaphylaxis including information sessions for staff of these medical conditions.
3.2.3.6 ensure that Boarding House Staff understand emergency procedures when the school nurse is off duty at weekends

3.2.4 The Governing Body will support all members of staff to undertake emergency first aid training and refresher training. Emergency First Aid Courses are provided by an external provider.

3.2.5 In addition to meeting the statutory requirement placed upon them to provide first aid for employees the Governing Body accept their responsibilities towards non-employees. In order to provide first aid for pupils and visitors, the Health and Safety Officer has undertaken a risk assessment to determine how many emergency First Aiders are required and how many employees with a First Aid at work certificate of competence are required in addition to the nursing cover.

3.2.6 The Governing Body acknowledge that unless first aid cover is part of a member staff's contract of employment, those who agree to become First aiders do so on a voluntary basis. First Aid training is offered to **all** staff.

3.2.7 Where pupils are travelling on a mini-bus the following items will be carried:

3.2.7.1 ten antiseptic wipes, foil packaged
3.2.7.2 one disposable bandage (not less than the 7.5 cm wide)
3.2.7.3 two triangular bandages
3.2.7.4 three large sterile un-medicated ambulance dressings (not less than 15 cm x 20 cm)
3.2.7.5 two sterile eye pads with attachments
3.2.7.6 12 assorted safety pins
3.2.7.7 one pair of rustless blunt-ended scissors.

3.2.8 In addition to the items set out for the first aid boxes in School the following items will be provided at the Surgery as suggested by the Department of Education's guidance for first aid at schools document:

3.2.8.1 Disposable drying materials
3.2.8.2 Plastic bowls – one for cleaning wounds and one for cleaning vomit, excreta, etc.
3.2.8.3 Household bleach or similarly effective solution – one part to ten parts water for cleaning sinks and bowls and soiled surfaces.
3.2.8.4 Yellow biohazard type plastic bags for disposing of bulky amounts of blooded waste (see the next page for procedures for handling blood)
3.2.8.5 Items in the above, and any other medical supplies the Surgery may use will be kept locked away from access by children.

3.3 Information on First Aid Arrangements

3.3.1 The Bursar will inform all employees at the School of the following:

3.3.1.1 the arrangements for recording and reporting accidents;
3.3.1.2 those employees with qualifications in first aid

3.3.2 The School Nurse will inform all employees at the School of the following:

3.3.2.1 The arrangements for first aid
3.3.2.2 the location of first aid boxes
3.3.2.3 Hygiene procedures for dealing with the spillage of body fluids.

3.3.2 In addition the Bursar will ensure that signs are displayed throughout the School providing the following information:

3.3.2.1 names of employees with first aid qualifications
3.3.2.2 location of first aid boxes

3.3.3 All members of staff will be made aware of a copy of the School's first aid Policy.

3.3.3.1 When children are present, there will always be at least one qualified first aider on site.
3.3.3.2 Accidents/incidents are initially recorded in the Surgery Department by the School Nurse. Depending on the seriousness of the incident, parents will be informed by phone, email, or a letter will be sent home with the pupil.

3.4 Provision away from the School

Provision for first aid on school visits and journeys will be determined by risk assessment carried out by those appointed persons responsible for the trip. First aid bags will be supplied by the surgery with the amount of stock being determined by the numbers attending the trip and the contents adjusted according to the nature of the trip. Staff information sessions will be provided by the nurse for arrangements for pupils with particular medical conditions and the administration of medicines to pupils.

3.5 Review of the First Aid policy

3.5.1 The First Aid Policy will be reviewed annually by the Surgery staff in conjunction with the Health and Safety Officer and agreed by the Headmaster and governing body.

SECTION 4 Accident Report

4.1 This section of the First Aid Policy is to comply with the School's Health and Safety Policy.

4.2 The Health and Safety Officer implements the School's procedure for reporting:

4.2.1 all accidents to employees; visitors and pupils
4.2.2 all incidents and near misses

4.3 The Governing Body is aware of its statutory duty under The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) in respect of reporting the following to the Health and Safety Executive as it applies to employees.

4.3.1 An accident that involves an employee being incapacitated from work for more than 3 consecutive days (excluding the day of the accident but including non-working days).
4.3.2 An accident which requires admittance to hospital for in excess of 24 hours.
4.3.3 Death of an employee.
4.3.4 Major injury such as fracture, amputation, dislocation of shoulder, hip, knee or spine.

4.4 For non-employees and pupils an accident will only be reported under RIDDOR:

4.4.1 where it is related to work being carried out by an employee or contractor and the accident results in death or major injury; or

4.4.2 it is an accident in school which requires immediate emergency medical treatment at hospital

4.5 The pupil accident reporting procedure is provided at Annex 2 to this policy.

SECTION 5 Pupil accidents involving their head

5.1 The Governing Body recognise that accidents involving the pupil's head can be problematic because the injury may not be evident (eg. internal) and the effects only become noticeable after a period of time.

5.1.1 If a pupil receives a blow to the head then they will be assessed by the Surgery staff.

5.1.2 The incident is recorded electronically via medical tracker and a letter sent to parents/carers electronically with NHS concussion guidelines. An attempt to call the parent/carer will also be made in the event of a head injury.

5.1.3 A copy of the parental letter is provided at Annex 4.

5.2 Please note that this procedure applies to all other injuries/incidents assessed by the School Nurse and treated accordingly.

SECTION 6 Transport to Hospital or Home

6.1 The Surgery staff will determine what is a reasonable and sensible action to take, in the circumstances of each case.

6.2 Where the injury is an emergency, an ambulance will be called following which the parent will be called. Clear instructions should be given to the ambulance crew as to the patient's location. A responsible person needs to be available to meet the ambulance and guide the crew to the patient.

6.3 Where hospital treatment is required but it is not an emergency, then the Surgery nurse will contact the parents for them to take over the responsibility of the child.

If the parents cannot be contacted then the Surgery nurse may decide to transport the pupil to hospital.

6.4 Where the Surgery nurse makes arrangements for transporting a child then the following points will be observed, where practicable:

6.4.1 only staff cars insured to cover such transportation will be used.

SECTION 7	Personnel

7.1 This section contains the names of employees at the school with a qualification in first aid or who have a first aid responsibility.

7.2 Surgery staff:

7.2.1 Bryony Nicholls
7.2.2 Claire Crandon

7.3 Emergency First Aiders

7.3.1 A list of qualified First Aiders and the training schedule is available from Byron Lewis, Director of Activities. Byron is responsible for identifying personnel for their training and updates. Training is carried out by St John's Ambulance or an external provider. There is at least one qualified person on each School site when children are present. Monte and Junior School staff have Paediatric First Aid training.

SECTION 8	Approval

8.1 This Policy was approved by the Governing Body of the School at their meeting on Thursday 7 October 2021 and recorded by resolution in the minutes of meeting.

Date of policy review _____

Bryony Nicholls
School Nurse

Amended by Bryony Nicholls October 2019
Approved by Governors 12 October 2019
Approved by Governors 7 October 2021
Amended by School Nurse February 2022
Amended by School Nurse September 2022

ANNEX 1

FORM RA8

SCHOOL FIRST AID RISK ASSESSMENT

School	**ST CHRISTOPHER SCHOOL**
Assessor's Name	**The Bursar**
Assessor's Signature	_____
Date of Assessment	_____

This form is to enable the Health and Safety Officer of the School to determine the number of appointed persons/First Aiders required by the Health and Safety (First Aid) Regulations 1981 and the Approved Code of Practice. The form allocates weightings to possible replies to the questions. These weightings are shown in brackets.

- Complete Parts 1-16 of the Assessment by placing a tick (✔) in the appropriate box. Unless otherwise stated, choose only <u>one</u> reply for each question.
- Calculate the overall total for Parts 1-16 using Table A. Once you have calculated your overall total, refer to Table B to determine your First Aid requirement.

<u>PART 1</u>

What types of injury to employees have been recorded in the past?

Injury

a)	Minor cuts and bruises; eye irritation		(1)
b)	Lacerations; burns; concussion; serious sprains; minor fractures	X	(2)
c)	Amputations; poisonings; major fractures; multiple injuries; fatalities		(3)

<u>PART 2</u>

What are the risks of injury arising from the work undertaken by employees as identified in your risk assessments?

Category of Risk

a)	Trivial/Tolerable Risk	X	(1)
b)	Moderate/Substantial Risk		(2)
c)	Intolerable Risk		(3)

PART 3

Does your workplace contain any of the specific hazards listed below?

		(Choose appropriate)	
a)	Hazardous substances	X	(3)
b)	**Dangerous tools**	**x**	**(3)**
c)	Dangerous machinery	X	(3)
d)	Dangerous loads/animals		(3)
	Total for Part 3	9	

PART 4

Are there parts of your establishment where different levels of risk can be identified?

a)	Yes	X	(2)
b)	No		(1)

PART 5

Type of work undertaken

a)	Offices, libraries, classrooms, etc		(1)
b)	Construction, work with dangerous machinery, sharp instruments etc (This includes school workshops and laboratories)	X	(2)

Are there hazards for which additional First Aid skills are necessary?

a)	Yes	X	(2)
b)	No		(1)
	Total for Part 5	4	

PART 6

Are there inexperienced workers on site or employees with disabilities?
(This includes NQTs and pupils in specialist subject areas)

a)	Yes	X	(2)
b)	No		(1)

PART 7

Are there several buildings on site or multi-floor buildings?

a)	Yes	X	(2)
b)	No		(1)

PART 8

Is there shift work or out-of-hours working?

a)	Yes	X	(2)
b)	No		(1)

PART 9

Is the workplace remote from emergency medical services?

a)	Yes		(2)
b)	No	X	(1)

PART 10

Do you have employees at work sites occupied by other employees? (eg. catering, cleaning)

a)	Yes	X	(2)
b)	No		(1)

PART 11

Do you have any work experienced trainees?

a)	Yes		(2)
b)	No	X	(1)

PART 12

Do members of the public visit your premises?

a)	Yes	X	(2)
b)	No		(1)

PART 13

Do you have employees with reading or language difficulties?

a)	Yes	X	(2)
b)	No		(1)

PART 14

Do you have pupils with disabilities or special health care needs?

a)	Yes	X	(2)
b)	No		(1)

PART 15

What is the age range of your pupils?

a)	11-18				X	(3)
b)	11-16					(2)
c)	3-11	5-11	3-7	7-11	X	(1)
				Total for Part 15	4	

PART 16

What is the Net Capacity of the school?

a)	Under 100 places		(1)
b)	101 – 210 places		(2)
c)	211 – 420 places		(3)
d)	421 – 500 places		(4)
e)	501 – 1000 places	X	(5)
f)	Above 1000 places		(6)

TABLE A

Now that you have completed the risk assessment, enter the totals for Each Part in the boxes below and calculate the Overall Total.

PART 1	2
PART 2	1
PART 3	9
PART 4	2
PART 5	4
PART 6	2
PART 7	2
PART 8	2
PART 9	1
PART 10	2
PART 11	1
PART 12	2
PART 13	2
PART 14	2
PART 15	4
PART 16	5
OVERALL TOTAL	43

Having obtained the overall total refer to **Table B** to determine the recommended level of first aid personnel.

TABLE B

Recommended First Aid Personnel

LOW RISK

Overall Total 16 to 33

A Fewer than 50 employees and up to 210 pupil places:

- one appointed person;
- one emergency first aider.

OR

B Fewer than 50 employees and more than 210 pupil places:

- one appointed person
- one qualified first aider at work.

Where no member of staff will volunteer for the first aid at work qualification, then the school should substitute with employees who have been trained in emergency first aid.

MEDIUM TO HIGH RISK

Overall Total 34 to 51

A

- one appointed person
- two qualified first aiders at work

Where the net capacity of the school is above 1000 places then an additional qualified first aider at work.

B

- consideration should be given to having additional emergency first aider at work

The above table is a recommended minimum level of provision.

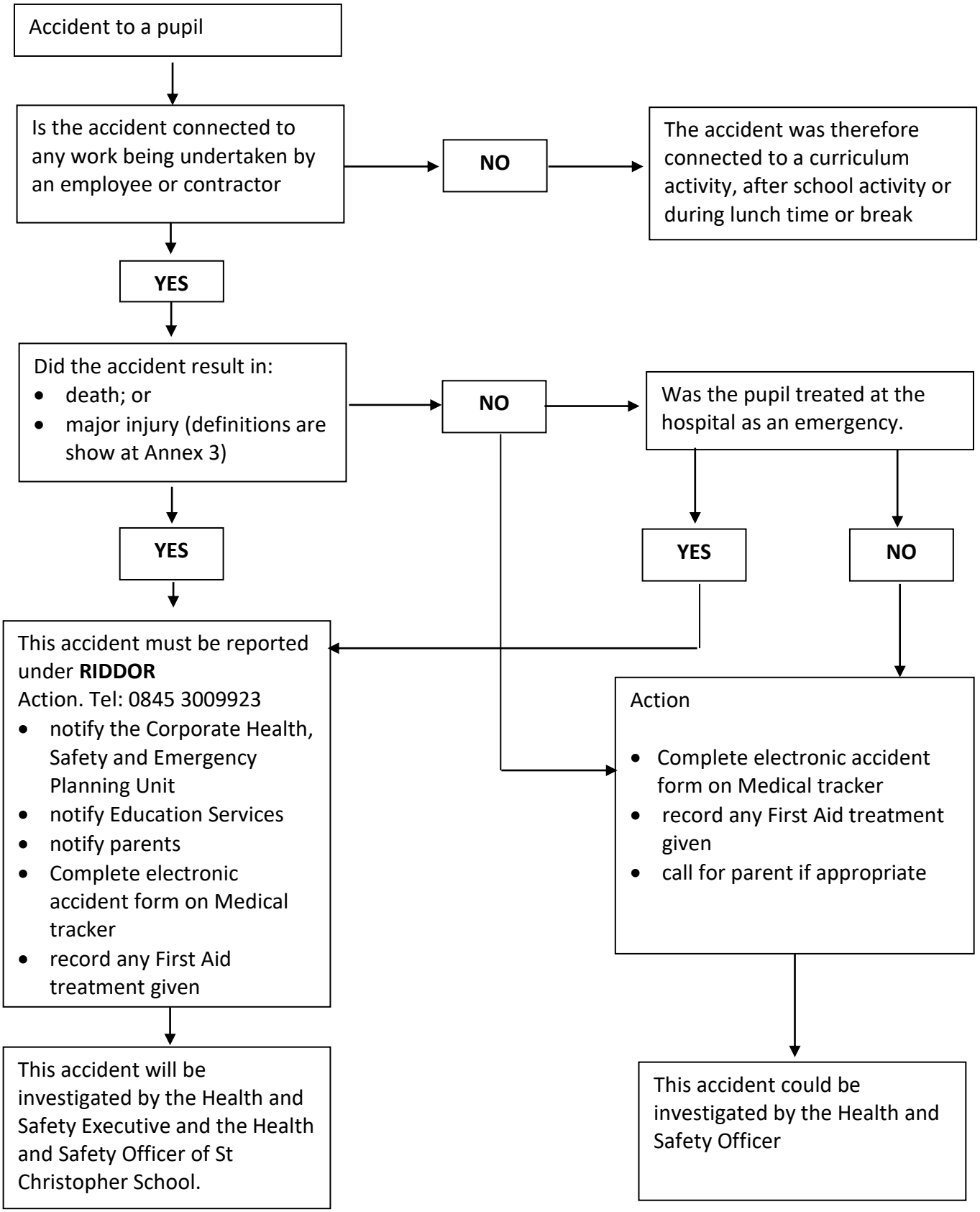
Schools must give additional consideration to the following factors when determining the level of provision:

a) the arrangements when a qualified first aider is not on site due to absence/training;

b) the design/layout of the site/premises is such that staff who are trained in emergency first aid should be available.

ANNEX 2

PUPIL ACCIDENT REPORTING PROCEDURE



ANNEX 3

DEFINITION OF MAJOR INJURIES WHICH MUST BE REPORTED TO THE HEALTH AND SAFETY EXECUTIVE

- fracture other than to fingers, thumbs or toes;
- amputation;
- dislocation of the shoulder; hip, knee or spine;
- loss of sight (temporary or permanent);
- chemical or hot metal burn to the eye or any penetrating injury to the eye;
- injury resulting from an electric shock or electrical burn leading to unconsciousness or requiring resuscitation or admittance to hospital for more than 24 hours;
- any other injury leading to hypothermia, heat-induced illness or unconsciousness; or requiring admittance to hospital for more than 24 hours;
- unconsciousness caused by asphyxia or exposure to a harmful substance or biological agent;
- acute illness requiring medical treatment, or loss of consciousness arising from absorption of any substance by inhalation, ingestion or through the skin;
- acute illness requiring medical treatment where there is reason to believe that this resulted from exposure to a biological agent or its toxins or infected material

ANNEX 4

Dear Parent

ACCIDENT INVOLVING THE HEAD

I have to inform you that today your child had an accident which involved a blow to the head.

The nature of the accident was such that it was not necessary to summon an ambulance or call for you to collect your child.

Following the accident your child was closely observed for any signs of any adverse effects but none were seen.

Details are provided on the reverse side of this letter.

As a precaution you are strongly advised to monitor your child and if you are concerned you should seek medical advice.

Yours sincerely

School Nurse

HEAD INJURY INSTRUCTIONS

Any injury or blow to the head will cause a certain degree of concussion. The seriousness of the concussion depends upon the severity of the injury. Nearly all patients with even a slight concussion will probably have a headache for 48 hours. They may well feel a little washed out and irritable during this period. Children often feel sick and may vomit and appear to be sleepy. This is to be expected in children who have had a blow to the head and lasts 12-24 hours.

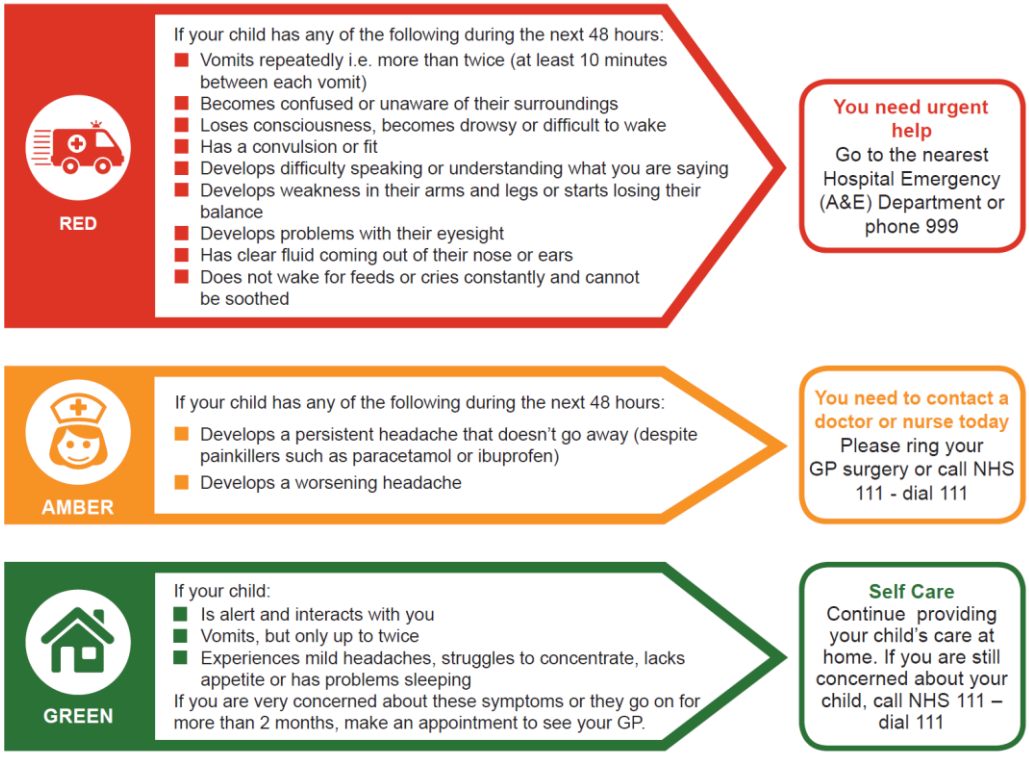
Should
· The headache become severe
· The vomiting increase
· The sleepiness increase so that it is difficult to get the child to talk
· The irritability increase
· The child finds that bright light causes distress
· The child have a fit

Then
The child should be taken immediately to hospital for further examination.

A child with a head injury should not be left unattended at home for any length of time.

Simple paracetamol is suitable for pain relief.

Advice after a head injury to a child
· Allow the child to rest by reducing noise and light levels
· Allow a few days off school
· Give paracetamol for headache
· Discourage noisy play or television programmes
· Encourage plenty of drinks until normal appetite returns
· Inform the teacher the child has had a head injury
· If your child has symptoms which worry you or persist after 2 weeks consult a doctor



ANNEX 5

First Aid Kits in the Workplace (BS 8599-1)

The *Health and Safety (First-Aid) Regulations 1981* require employers to provide adequate and appropriate equipment, facilities and personnel to ensure that employees receive immediate attention if they are injured or taken ill at work. These regulations apply to all workplaces including those with fewer than five employees and to the self-employed.

However, there has historically not been much in the way of guidance on what a first aid kit should contain. This means that in the event of an emergency, some organisations find that their first aid kits lack the essentials, or include out-dated or inadequate components that are of limited use to the first aider. The British Standards Institute (BSI) has created a new British standard for first aid kits in the workplace. The *BS 8599-1* standard (published in June 2011) recommends the correct number of particular components for small, medium, large or travel-size kits and also recommends how many kits are needed depending on the size of the organisation. It sets the minimum level that first aid kits should conform to and should be followed by manufacturers of first aid kits and anyone who assembles first aid kits in the workplace. The new *BS 8599-1* standard takes into account more modern and functional products encompassing a wider range of common workplace risks. Some changes include:

- increased number of disposable gloves, which are now required to be sterile, which are far more dextrous than vinyl gloves and eliminate possible latex allergies;
- fewer triangular bandages as they are no longer used for the immobilisation of limb injuries;
- introduction of smaller absorbent wound dressings for finger injuries, where a plaster will not be sufficient;
- introduction of tearable non-woven, hypoallergenic adhesive tape to secure bandages without using safety pins;
- introduction of water-based sterile gel burn dressings (which do not require any pre-cooling with water) and a conforming bandage to secure it;
- introduction of a resuscitation face shield to provide a protective barrier for first aiders administering mouth-to-mouth resuscitation.

The *BS 8599-1* standard gives recommendations on the amount and size of the first aid kits necessary for different workplace environments based on the category of risk (low risk: e.g. shops, offices; medium risk: e.g. warehousing, light engineering work; high risk: e.g. construction, work with chemicals) and the number of employees. Requirements are set concerning marking and information to be supplied by manufacturers.

Requirements are also given for the container holding the components. The container should be able to fit all of the relevant components inside and close securely, and should be clean, dustproof and provide protection for the contents in a workplace environment.

Workplace first aid kits can be complemented by other items that have been identified during a risk assessment, if necessary. Where there are unusual hazards that are specific to a particular workplace environment, workplace first aid kits should be supplemented with additional, appropriate components.

ANNEX 6

Use of an Automated External Defibrillator (AED)
St Christopher School holds 2 AED's.

1. Mediana A15 Hearton AED. The AED can be found in the cupboard below the main fire panel which is situated opposite the senior school main entrance doorway. This cupboard is kept unlocked and accessible for all emergencies.

2. Mindray, BeneHeart CIA, AFI-23032168. This is housed within a yellow cabinet, situated outside the Sports Hall main doors to the left hand side. This has been registered with the ambulance service and the access code is C159X.

Both AED'S are kept fully equipped and checked monthly by the School Nurses. This check is recorded in a folder kept in Surgery. Training will be provided as part of the Staff First Aid Training.

Signs to indicate the location of the AED are in:
- The swimming pool foyer
- Changing rooms, boys/office entrance
- Junior school foyer

Training practice for staff that have missed the official training will be available on request where the AED can be demonstrated by surgery staff.

In the UK approximately 30,000 people sustain cardiac arrest outside hospital and are treated by emergency medical services each year.

Electrical defibrillation is well established as the only effective therapy for cardiac arrest caused by ventricular fibrillation (VF) or pulseless ventricular tachycardia (VT). The scientific evidence to support early defibrillation is overwhelming: the delay from collapse to delivery of the first shock is the single most determinant of survival. If defibrillation is delivered promptly, survival rates as high as 75% have been reported.

The chances of successful defibrillation decline at a rate of about 10% with each minute of delay: basic life support will help to maintain a shockable rhythm but is not a definitive treatment.

The Resuscitation Council (UK) recommends strongly a policy of attempting defibrillation with the minimum of delay in victims of VF/VT cardiac arrest.

Sequence of actions when using an AED:

The following sequence applies to both semi-automatic and automatic AED's in a victim who is found to be unconscious and not breathing normally;

1. Follow the adult basic life support sequence. Do not delay starting CPR using a ratio of 30 compressions to 2 rescue breaths unless the AED is available immediately.
2. As soon as the AED arrives:
   - If more than one rescuer present, continue CPR while the AED is switched on. If you are alone, stop CPR and switch on the AED.

- Follow the voice/visual prompts.
- Attach the electrode pads to the patient's bare chest.
- Ensure that nobody touches the victim while the AED is analysing the rhythm.

3a If a shock is indicated:
- Ensure that nobody touches the victim.
- Push the shock button as directed (fully automatic AED's will deliver the shock automatically).
- Continue as directed by the voice/ visual prompts.
- Minimise as far as possible, interruptions in chest compressions.

3b. If no shock is indicated;
- Resume CPR immediately using a ratio of 30 compressions to 2 rescue breaths.
- Continue as directed by voice/visual prompts.

4. Continue to follow the AED prompts until:
- Qualified help arrives and takes over OR
- The victim starts to show signs of regaining consciousness, such as coughing, opening his eyes, speaking, or moving purposefully AND starts to breathe normally

OR
- You become exhausted.

Placement of AED pads

Make sure that the victim's chest is sufficiently exposed to enable correct pad placement. Chest hair will prevent pads adhering to the skin and will interfere with electrical contact. Shave the chest only if hair is excessive, and even then spend as little time as possible on this. Do not delay defibrillation if a razor is not available.

Ensure that any metal objects are removed from the victim: bras with metal under wiring, heavy medallions or anything metal around the chest area.

Place the AED pads according to the visual instructions on the AED. Please note that the same pads may be used for a child up to 8 years or less than 25kg, the only difference is the placing of the pads and pressing the switch on the AED to **paediatric mode**. For adults or those weighing over 25kg, switch to **adult mode**. This switch is located on top of the AED next to the shock button.

Although most pads are labelled left and right, or carry a picture of their correct placement, it does not matter if their positions are reversed. It is important that if this happens 'in error', the pads should not be removed and replaced because this wastes time and they may not adhere adequately when re-attached.

Defibrillation if the victim is wet

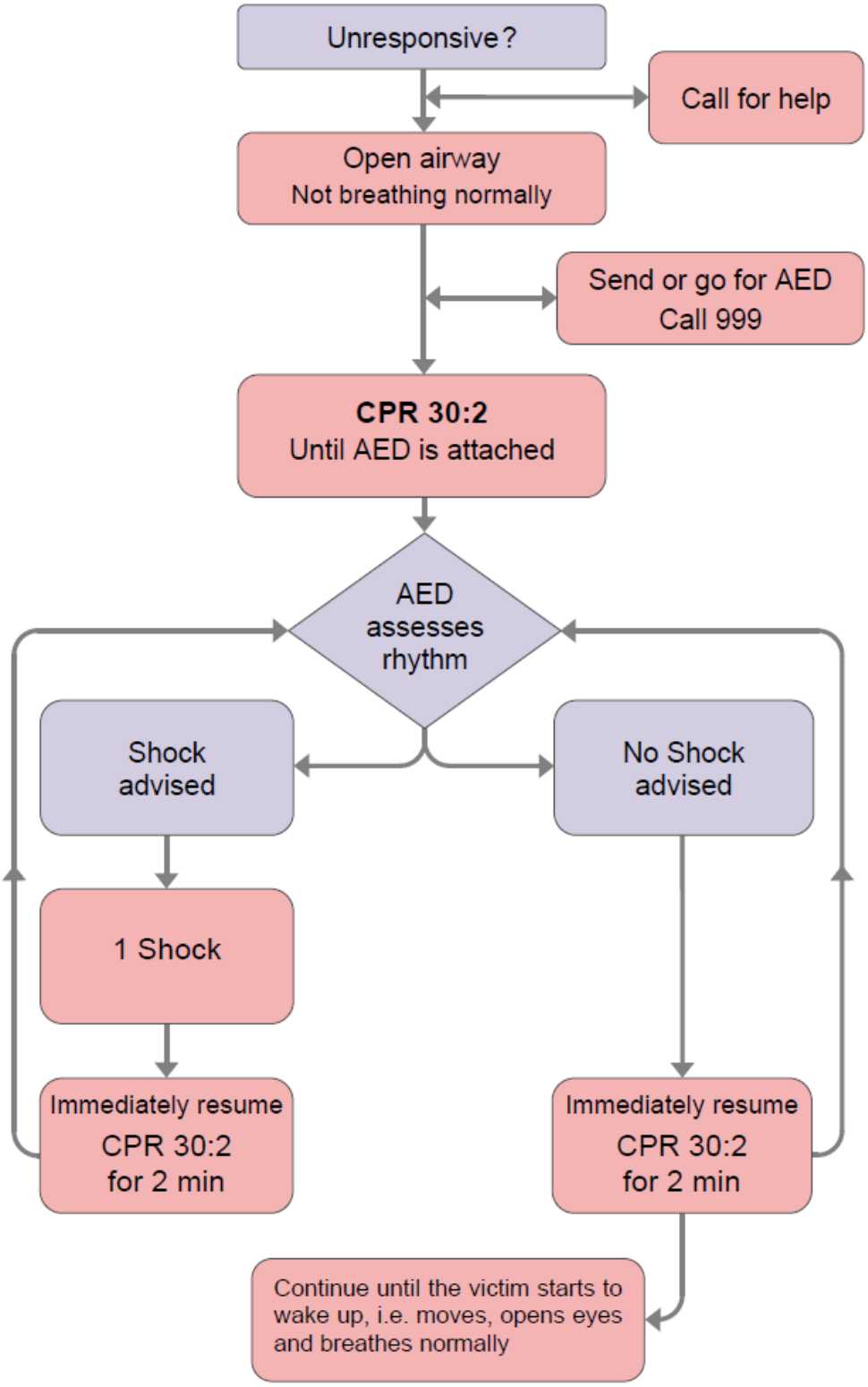
As long as there is no contact between the user and the victim when the shock is delivered, there is no direct pathway that the electricity can take that would cause the user to experience a shock. Dry the victim's chest so that the adhesive AED pads will stick and take particular care to ensure that no one is touching the victim when a shock is delivered.

Defibrillation in the presence of supplemental oxygen

There are no reports of fires caused by sparking where defibrillation was delivered using adhesive pads. If supplemental oxygen is being delivered by a face mask, remove the face mask and place the oxygen cylinder at least one metre away before delivering a shock. Do not allow this to delay shock delivery.

Resuscitation Council (UK)

AED algorithm



Minimise interruptions in CPR

The importance of early, uninterrupted chest compressions is emphasised throughout this guideline. Interrupt CPR only when it is necessary to analyse the rhythm and deliver a shock. When two rescuers are present, the rescuer operating the AED applies the electrodes while the other continues CPR. The AED operator delivers a shock as soon as the shock is advised, ensuring that no one is in contact with the victim.

CPR before defibrillation

Provide good quality CPR while the AED is brought to the scene. Continue CPR whilst the AED is turned on, and then follow the voice/visual prompts. Giving a specified period of CPR as a routine before rhythm analysis is not recommended.

ANNEX 7

CONCUSSION PROTOCOL FOR SENIOR SCHOOL

This protocol has been produced with the guidance from the International Rugby Board (IRB), Rugby Football Union (RFU), 'Headcase' Resources, Great Britain Hockey and England Hockey. All of which have developed policies and advice from the Zurich Guidelines published in the Consensus Statement on Concussion in Sport and adapted for rugby by the IRB.

The information contained in this protocol is intended for educational and guidance purposes only and is not meant to be a substitute for appropriate medical advice or care.

If you believe that you or someone under your care has sustained a concussion we strongly recommend that you contact a qualified healthcare professional for appropriate diagnosis and treatment.

What is Concussion?
CONCUSSION MUST BE TAKEN EXTREMELY SERIOUSLY

- Concussion is a brain injury caused by either direct or indirect forces to the head including the nose and face
- Concussion typically results in the rapid onset of short-lived impairment of brain function loss of consciousness occurs in less than 15% of concussion cases and whilst a feature of concussion, loss of consciousness is not a requirement for diagnosing concussion
- Concussion results in a disturbance of brain function (e.g. memory disturbance, balance problems or symptoms) rather than damage to structures such as blood vessels, brain tissue of fractured skull
- Concussion is only one diagnosis that may result from a head injury. Head injuries may result in one or more of the following:

    1. Superficial injuries to scalp or face such as lacerations and abrasions
    2. Sub-concussive event – a head impact event that does not cause a concussion
    3. Concussion – an injury resulting in a disturbance of brain function
    4. Structural brain injury – an injury resulting in damage to a brain structure for example fractured skull or a bleed into or around the brain

Concussion in Children or Adolescents
It is widely accepted that children and adolescent athletes (18 years and under) with concussion should be managed more conservatively. This is supported by evidence that confirms that children:

- Are more susceptible to concussion
- Take longer to recover
- Have more significant memory and mental processing issues
- Are more susceptible to rare and dangerous neurological complications, including death caused by a second impact syndrome

Prevention Procedure
In order to try and reduce the risk of concussion the following guidance is followed:

- Ensure the playing or training area is safe e.g. playing area condition, safety equipment utilized
- Ensure correct playing techniques are coached and performed consistently by all players
- Explain the dangers of inappropriate tackles or styles of play and penalise them immediately if they occur
- Encourage players and parents to report any concussions that occur during any game and training sessions and to report concussions that occur out of school. It is essential that all parties involved communicate if a play is concussed

Diagnosis and Assessment of Concussion.
All players with a suspected concussion where no appropriately trained personnel are present MUST be assumed to have a diagnosed concussion and MUST be removed from the field of play and not return to play or train on the same day. In this situation, players must be referred to a healthcare professional for further assessment.

The Sport Concussion Assessment Tool (5th edition) developed by the Concussion In Sport Group, supports this Recognise and Remove message. This tool highlights the signs and symptoms suggestive of a concussion and includes an "Immediate or On-field Assessment" which could be useful for pitch-side use.

Possible signs and symptoms of concussion
Visible clues of potential concussion – what you see
Any one or more of the following visual clues can indicate a possible concussion:

- Dazed, blank or vacant look
- Lying motionless on ground/slow to get up
- Unsteady on feet/balance problems or falling over/un-coordinated
- Loss of consciousness or responsiveness
- Confused/not aware of plays or events
- Grabbing/clutching of head
- Convulsion
- More emotional/irritable

Symptoms of potential concussion – what you are told
Presence of any one or more of the following signs and symptoms may suggest a concussion:

- Headache
- Dizziness
- Mental clouding, confusion, or feeling slowed down
- Visual problems
- Nausea or vomiting
- Fatigue
- Drowsiness/feeling like "in a fog"/difficulty concentrating
- "Pressure in head"
- Sensitivity to light or noise

Questions to ask
Failure to answer any of these questions correctly may suggest a concussion:

- What venue are we at today?
- Which half is it now?
- Who scored last in this game?
- What team did you play last week/game?
- Did your team win last game?

If a player has signs or symptoms of a possible concussion that player must be RECOGNISED AND REMOVED. IF IN DOUBT, SIT THEM OUT

On field or pitch side management
A player with signs or symptoms of concussion must be removed in a safe manner in accordance with emergency procedure and medically assessed.

If a cervical spine (neck) injury is suspected, the player should only be removed by emergency healthcare professionals with appropriate spinal care training.

Team-mates, coaches, match officials, team managers, administrators or parents who observe an injured player displaying any of the signs or symptoms after an injury event with the potential to cause a concussion MUST do their best to ensure that the player is removed from the field of play in a safe manner.

The school chooses to delay the concussion assessment until a 15 minute rest period has been undertaken. This allows athletes time to rest prior to an assessment. This rest period is recommended to allow athletes to recover from game induced fatigue and avoid false positive results occurring due to this fatigue.

All players with a suspected or known concussion MUST go through a graduated return to play (GRTP) protocol and should be seen by a Medical Practitioner either at hospital or their own GP surgery.

REMEMBER THE 6 R'S:

Recognise: Know the signs and symptoms of concussion

Remove: if a player is concussed or there is even a potential concussion they should be removed from play immediately

Recovery from Concussion
Recovery from concussion is spontaneous and typically follows a sequential course. The majority (80-90%) of concussions resolve in a short (7-10 day) period, although the recovery time frame may be longer in children and adolescents.

Players must be encouraged not to ignore symptoms at the time of injury and must not return to play prior to the full recovery following a diagnosed concussion. The risks associated with premature return to play include:

- A second concussion

- Increased risk of other injuries due to poor decision making or reduced reaction time associated with concussion
- Reduced performance
- Serious injury or death due to an unidentified structural brain injury
  A potential increased risk of developing long-term neurological deterioration

Protective Equipment
Rugby head guards DO NOT protect against concussion. They do protect against superficial injuries to the head such as cuts and grazes. This has been demonstrated in a number of research studies now. There is some evidence to suggest that they may increase risk taking behaviours in some players. Mouth/gum shields do not protect against concussion either.

Graduated Return to Play (GRTP)
All players with a diagnosed or potential concussion must go through a graduated return to play (GRTP) program as outlined in this document. A GRTP programme should only commence if the player:
- has completed the minimum rest period for their age
- is symptom free and off medication that modifies symptoms of concussion

Medical clearance is required prior to commencing a GRTP.

Refer: Once removed from play, the player should be referred the School Nurse who will assess them and refer them to Hospital or their own GP if necessary. If the School Nurse is not available and concussion is suspected then parents should be called and advised to take them to see a Medical Practitioner.

Rest: Players must rest from exercise until symptom free and then a GRTP must be followed:

- Under 19 year of age – two weeks rest followed by GRTP protocol
- Individuals should avoid the following initially and then gradually re-introduce them:
  - Reading
  - TV
  - Computer games
  - Driving
- Needing to miss a day or two of academic study is no unusual

Recover: Full recovery, being symptom free, from the concussion is required before return to play is authorised by a medical practitioner.

Return: They must go through a GRTP and receive medical clearance in writing before returning to play. It is the responsibility of parents to obtain this and confirmation that clearance has been obtained must be kept by the school

Recurrent Concussions
Following concussion a player is at increased risk of a second concussion with the next 12 months. Players with:

- A second concussion
- A history of multiple concussions
- Unusual presentations; or

- Prolonged recovery

Should be assessed by a medical practitioner (doctor) with experience in sports related concussions. If such a practitioner is not available then the player should be managed using the GRTP protocol from the lower age group as a minimum.

Onset of Symptoms
The signs and symptoms of concussion can present at any time but typically become evident in the first 24-48 hours following a head injury.

The management of a GRTP should be undertaken on a case by case basis and with the full cooperation of the player. The commencement of the GRTP will be dependent on the time in which the symptoms are resolved.

It is important that concussion is managed so that there is physical and cognitive rest (avoidance of activities requiring sustained concentration), until there are no remaining symptoms for a minimum of 24 consecutive hours without medication that may mask the symptoms.

The Graduated Return to Play Program
The GRTP Program contains six distinct stages:

- The first stage is the recommended rest period for the athlete's age
- The next four stages are training based restricted activity
- Stage 6 is a return to play

Under the GRTP Program, the player can proceed to the next stage if no symptoms of concussion are shown at the current stage (that is, both the periods of rest and exercise during that 24 hour period).

If any symptoms occur while progressing through the GRTP Protocol, the player must return to the previous stage and attempt to progress again after a minimum 24 hour period of rest has passed without the appearance of any symptoms.

Prior to entering Stage 5, a medical practitioner or approved healthcare professional and the play must first confirm that the player can take part in this stage. Full contact practice equates to return to play for the purposes of concussion. However, return to play itself shall not occur until Stage 6.

The GRTP applies to all sporting activities.

Conclusion
Concussion is a serious injury that if not treated correctly can have significant long term effects. However when playing contact sports and participating in other physical activities concussion is always a risk factor whatever precautions are taken. We aim to minimise the possible risks by ensuring that our students follow the advised concussion procedures as advised by all the sporting governing bodies.

We will always advise that further professional medical advice is sought if you have any concerns about whether or not your child is suffering from concussion and report any such

injury to the school as soon as possible so that we can provide the appropriate care during their recovery.

Links

NHS Services. There are a number of NHS services or resources that HCPS may find useful:

- NHS 111
- NHS Choices (www.nhs.uk)
- Specialist Minor Head Injury Clinics (www.nhs.uk/service-search)
- NICE Guidelines (http://publications.nice.org.uk/head-injury-cg56)
- United States CDC Concussion Education website (www.cdc.gov/concussion)

Other Services

Headway, the brain injury charity specialise in providing advice, support and rehabilitation services to individuals and their families following a head injury (www.headway.org.uk)

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POCKET CONCUSSION RECOGNITION TOOL TO HELP IDENTIFY CONCUSSION IN CHILDREN, YOUTH AND ADULTS.

Recognise and remove. Concussion should be suspected if one or more of the following visible clues, signs, symptoms or errors in memory questions are present.

1. Visible Clues of suspected concussion. Any one or more of the following visual clues can indicate a possible concussion:

- Loss of consciousness or responsiveness
- Lying motionless on ground/slow to get up
- Unsteady on feet/balance problems or falling over/incoordination
- Grabbing/clutching of head
- Dazed, blank or vacant look
- Confused/not aware of plays or events

2. Signs and symptoms of suspected concussion. Presence of any one or more of the following signs and symptoms may suggest a concussion:

- Loss of consciousness
- Seizure or convulsion
- Balance problems
- Nausea or vomiting
- Drowsiness
- More emotional
- Irritability
- Sadness
- Fatigue or low energy
- Nervous or anxious
- 'Don't feel right'
- Difficulty remembering
- Headache
- Dizziness
- Confusion
- Feeling slowed down
- 'Pressure in head'
- Blurred vision
- Sensitivity to light
- Amnesia
- Feeling like 'in a fog'
- Neck Pain
- Sensitivity to noise
- Difficulty concentrating

3. Memory Function. Failure to answer any of these questions correctly may suggest a concussion:

- 'what venue are we at today?'
- 'which half is it now'
- 'who scored last in this game?'
- 'what team did you play last week/game?'
- 'did your team win the last game?'

Any athlete with a suspected concussion should be IMMEDIATELY REMOVED FROM PLAY, and should not be returned to activity until they are assessed medically. Athletes with a suspected concussion should not be left alone and should not6 drive a motor vehicle.
It is recommended that, in all cases of suspected concussion, the player is referred to a medical professional for diagnosis and guidance as well as return to play decisions, even if the symptoms resolve.

RED FLAGS. If ANY of the following are reported then the player should be safely and immediately removed from the field. If no qualified medical professional is available, consider transporting by ambulance for urgent medical assessment:

- Athlete complains of neck pain
- Increasing confusion or irritability
- Repeated vomiting
- Seizure or convulsion
- Weakness or tingling/burning in arms or legs
- Deteriorating conscious state
- Severe or increasing headache
- Unusual behaviour change
- Double vision

Remember:
- In all cases, the basic principles of first aid (danger, response, airway, breathing, circulation) should be followed.
- Do not attempt to move the player (other than the required for airway support) unless trained to do so.
- Do not remove helmet (if present) unless trained to do so.

GRADUATED RETURN TO PLAY (GRTP) PROTOCOL

Stage	Rehabilitation Stage	Exercise Allowed	Objective
1	Rest	Complete physical and cognitive rest without symptoms.	Recovery
2	Light aerobic exercise	Walking, swimming or stationary cycling keeping intensity <70% maximum predicted heart rate. No resistance training.	Increase heart rate and assess recovery
3	Sport-specific exercise	Running drills. No head impact activities.	Add movement and assess recovery
4	Non-contact training drills	Progression to more complex training drills, eg. passing drills. May start progressive resistance training.	Add exercise and coordination, and cognitive load. Assess recovery.
5	Full Contact Practice	Normal training activities.	Restore confidence and assess functional skills by coaching staff. Assess recovery.
6	Return to Play	Player rehabilitated	Safe return to play once fully recovered.

ANNEX 8

ACCEPTING A STUDENT BACK TO SCHOOL ON CRUTCHES

St Christopher School requires a letter from a medical professional (GP, hospital, etc) detailing exactly what injury has been sustained before accepting responsibility for a student on crutches. The letter should include detgails of whether the student is required to use crutches in school and approximately how long for. Further information to be detailed, if possible, includes: when weight bearing should begin and any follow-up appointments (fracture clinics, physiotherapy, etc).

We would appreciate the student being dropped off by a parent/carer on their initial return to school to enable the following to be discussed/explained: leaving lessons early, medication (particularly analgesia), collecting from school arrangements can be discussed, follow-up appointments noted.

In terms of the health and safety issues within food/textiles, science and technology each of these teams will make an individual decision as to whether a student on crutches can join in with the practical activities. Provisions should be made during the lesson for students to 'sit-out' within the classroom environment if it is felt too dangerous for them to join in, and they could complete other work.

With regard to the issue of protective footwear ('beckham boot' or similar, as issued by A&E department/GP surgery) it is recommended that the PHM give guidance as to the circumstances this may be removed for personal hygiene reasons and how best to manage safely in the shower/bath.

Accepting to care for students on crutches without clear medical information, potentially puts the school at risk. Therefore, it is unacceptable for students to return to school on crutches if they have obtained them from means other than a professional/medical establishment, ie. friends, football coaches, etc. these students have not been officially checked out either at GP or Emergency Department/school physio and are a potential danger to both themselves and other students.

Use of Crutches
Never sit down or stand up with the crutches on your arms.

On Sitting
Make sure you are close to the chair
Take the crutches off your arms
Hold both crutches in one hand
Feel for the chair with the other hand
Lower yourself into the chair

On Rising
Hold the crutches in one hand
Push on the arm of the chair with the other hand
Stand up; then put the crutches under arms/slip through arm clasps

Walking
Keep elbows into your sides
Crutches forward then injured foot
Lean on crutches, so that you use them with the injured leg
Step through the good leg

Stairs
If you feel unsafe, go up and down stairs on your bottom
Ascending – the good leg leads and the bad leg and crutches follow
Descending – crutches and bad leg lead followed by good leg

Maintenance
Check regularly that the rubber ends (ferrules) are not worn or clogged with dirt or stones. If you have a problem with the crutches, contact the department which issued them to you.

When you no long need your crutches, please return them to the department of issue promptly with the return slip or your name and address.

Exercises

- To prevent swelling when you are not up and about, sit with your leg elevated on a stool, so that your foot is higher than your hip.
- Support your knee to prevent strain.
- To improve circulation, curl and stretch your toes for five minutes every hour.
- If your leg is not in plaster of Paris you may be given more active exercises to promote the healing of your injury.
- Do these exercises as instructed.
- If you are unable to weight bear at one week, please seek further medical attention.