MET - Primary Settings First Aid, Supporting Children with Medical Needs, and Intimate Care Policy

June 2024

Document Type	Statutory Policy -Published online and available to all staff
Last Revision Date	June 2023
Next Revision Date	June 2025
Owner	Trust Data Lead
Author	Leicestershire County Council policy template revised
Version	1.1
Status	Approved by Trust Board

This policy applies to the following schools

All Trust primary settings and any school converting into the trust since the last review and approval of this policy.
Where this policy states 'school' this means any of our educational establishments and the wider Trust.
Where this policy states 'Headteacher' this also includes 'Head of School' and 'Centre Manager'.

Contents

This document is produced in conjunction with the Leicestershire Partnership Trust. We would like to acknowledge input from professional bodies and services with Leicestershire County, City and Rutland.
This policy document has been made specific for Mowbray Education Trust Primary settings. Please note additional information is available in the appendices listed on the schools website www.leicestershiretradedservices.org.uk relating to Individual Care Plans and specific medical needs/conditions.

This document refers to Governemnt templates (C to E) from Supporting Pupils with Medical Conditions Guidance where this is mentioned below please refer to the following link: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/349 437/Supporting_pupils_with_medical_conditions_-_templates.docx

MEDICAL NEEDS POLICY

1.0 Introduction

1.1. This document is revised in line with the current Department for Education 'Supporting pupils at school with medication conditions' - Statutory guidance for governing bodies of maintained schools and proprietors of academies in England'. (Amended December 2015) which replaces the previous 'Managing medicines in schools and early years settings' (2005).

1.2. The Children and Families Act (Section 100) places a duty on governing bodies ofmaintained schools, proprietors of academies and management committees of Pupil Referral Units to make arrangements for supporting pupils with medical conditions.

1.3. This policy covers the general administration of prescribed and non-prescribed medication. Such medications could be on a temporary, short term or one-off basis or for a longer term or continual period for pupils with ongoing support needs. Pupils who have longer term support needs should have an individual health care plan developed, recorded and reviewed at leastannually.

1.4. Each school is responsible for developing and regularly reviewing its own medication guidance, copies of which should be available to school staff and parents/carers.

1.5. Guidelines and information on administration of specific medicines for specific conditions are detailed in this guidance document. All information is available on the Leicestershire Traded Services website www.leicestershiretradedservices.org.uk.

Definition of Health Needs

1.6. For the purpose of this policy, pupils with health needs may be: - pupils with chronic or short-term health conditions or a disability involving specific access requirements, treatments, support or forms of supervision during the course of the school day or - sick children, including those who are physically ill or injured or are recovering from medical interventions, or - children with mental or emotional health problems. - Some children with medical conditions may have a disability. A person has a disability if he or she has a physical or mental impairment that has a substantial and long- term adverse effect on his or her ability to carry out normal day-to-day activities. Where this is the case, governing bodies must comply with their duties under the Equality Act 2010.

2.0 General Principles and Responsibilities

2.0 The Board of Trustees and staff of the Primary School settings wish to ensure that pupils with medication needs receive appropriate care and support while at school so that they have full access to education.

2.1 The head teacher accepts responsibility for members of the school staff administering or supervising pupils taking prescribed or non-prescribed medication during the school day.

2.2 Where possible, pupils will be encouraged to self-administer their own medication.

2.3 When medication is administered by staff, it shall be by those members of staff that have volunteered and been trained to do so, unless medically qualified staff are employed on site. It will not automatically be assumed that a qualified first aider will fulfil this role.

2.4 2.2Parents/carers have the prime responsibility for their child's health and should provide schools and settings with detailed information about their child's medical condition. This responsibility should be communicated via school/setting parent/carer meetings and/or via school communication systems such as WEDUC or alternative school communication system in use.

2.5 On the child's admission to the school the parent/carer should be asked to complete an admission form and a long or short term healthcare plan giving full details of medical conditions, any regular/emergency medication required, name of GP, emergency contact numbers, details of hospital consultants, allergies, special dietary requirements and any other relevant information. This information should be renewed annually. School will, where appropriate, complete a risk assessment and make any reasonable adjustments to enable the child to attend school.

2.6 Staff will not give prescription or non-prescription medication unless there is specific written

consent from a parent or carer.

2.7 No child under 16 should be given prescription or non-prescription medicines without a parent or guardian's written consent, except in exceptional circumstances where the medicine has been prescribed without the knowledge of the parents. In such cases, every effort should be made to encourage the child or young person to involve their parents, while respecting his or her right to confidentiality.

2.8 There must be adequate arrangements, including clear procedures, for safe receipt,storage, administration and disposal of medication and adequate access, to and privacy for, the use of medication

2.9 Medication must be in its original packaging. Non-prescription medicines such as hay fever treatment will be treated in the same way as prescription medicines in that they should be in a

clearly labelled original container with a signed consent form detailing the pupil's name, dose and frequency of administration. Staff may take a note of the quantity provided to them, liquids may be marked with a line.

2.10 Prescribed medicines should be in original containers labelled with the pupil's name, dose, and frequency of administration, storage requirements and expiry date.

2.11 Generally, it is not necessary for an over the counter medicine to be prescribed by a medical practitioner in order to be administered in the school setting. The exception is where the child may already be taking prescribed medication and there may be an interaction between prescribed and non- prescribed medicines. In this instance all medications should beprescribed.

2.12 The school should not hold stock of over the counter medications

2.13 Aspirin MUST not be given to children under 16 years of age unlessprescribed.

2.14 Pupils that have ongoing, long term or potentially emergency medication requirements should have an individual care plan completed and reviewed regularly. Pupils who require temporary, short term medication only requires a consent form to be completed.

2.15 If staff have any concerns related to the administration of a medication, staff should not administer the medication but check with the parents/carers and/ or a healthcareprofessional.

2.16 A child who has been prescribed a controlled drug may legally have it in their possession if they are competent to do so but passing it to another child for use is an offence. Monitoring arrangements may be necessary. A misuse of drugs' policy and procedure should be in place at the school to deal with situations for example, where pupils pass their medication to other pupils.

2.17 Schools should otherwise keep controlled drugs (The term 'controlled drug' is defined by the Misuse of Drugs Act 1971 ("the Act") as 'any substance or product for the time being specified in Part I, II or III of Schedule 2 of the Misuse of Drugs Act 1971'. Controlled drugs are subject to strict legal controls and legislation determines how they are prescribed, supplied, stored and destroyed), that have been prescribed for a pupil securely stored in a double locked nonportable container and only named staff should have access. Two people must witness the administration of the Controlled Drug. The controlled drug should be easily accessible in an emergency. A record should be kept of any doses used and the amount of the controlled drug held (Misuse of Drugs Act 1971 and COSHH 2002)

3.0 Setting Responsibilities

3.1 Educational settings should ensure that members of staff who volunteer to administer medicines will be offered professional training, a clear protocol and support as appropriate and required.

3.2 All staff should be familiar with normal precautions for avoiding infection and follow basic hygiene procedures. Staff should have access to protective disposable gloves and take care when dealing with spillages of blood or other body fluids and disposing of dressings or equipment. Ofsted guidance (https://www.gov.uk/government/organisations/ofsted) provides an extensive list of issues that early years providers should consider in making sure settings are hygienic

3.3 Close co-operation, and use of a standard process between schools, settings, parents/carers, health professionals and other agencies will provide a suitably supportive environment for children/young people with medical needs.

3.4 The school/setting will always take full account of authorised volunteers, temporary, supply and peripatetic staff when informing staff of arrangements in place for the administration of medicines and care.

3.5 The school/setting will always designate a minimum of two people it considers suitable and competent to be responsible for the administering of medicine to a child; this will ensure back up arrangements are in place if the principal member of staff with responsibility is absent or unavailable.

3.6 If a child/young person refuses to take medicine, staff will not force them to do so. Other examples include spat out or mishandling of medication. Staff will record the incident on the administration sheet. If refusal results in an emergency, the school/setting's normal emergency procedures will be followed. (Please see Government Templates: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/349437/Supporting_pupils_with_medical_conditions_-_templates.docx

Storage

3.7 Medication should be kept in a known, safe and secure location. This may need to be a refrigerator. This will be strictly in accordance with product instructions - paying particular note to temperature and in the original container in which dispensed. Temperature checks carried out daily and recorded.

3.71 Prescribed emergency medication, such as Adrenaline Auto-Injector devices (AAI) e.g. epi-pens, or asthma inhalers, should remain with the pupil, or close by at all times; including P.E and off-site educational visits.

3.72 Parents/carer are responsible for ensuring that the education setting has an adequate amount of medication for their child. As a general rule, no more than four weeks of medication should be stored at any one time.

3.73 Staff will check that the supplied container is clearly labelled with the name of the child, the name and dose of the medicine, the method and frequency of administration, the time of administration, and the expiry date. Staff in the school must not alter or add to the label.

3.74 Children/young people will be informed where their own medicines are stored and how to access them.

Disposal Return and Medication Errors

3.8 Sharp items must be disposed of safely using a sharps bin. These are available on prescription for pupils who require regular medication of this type, e.g. Insulin. These should be returned to the pupil / parent as per 'sharps guidelines (https://www.hse.gov.uk/pubns/hsis7.pdf. Schools can purchase a sharps bin for generic use, e.g., for the disposal of sharps that have been used in an emergency. it is then the school's responsibility to arrange for its safe disposal (Hazardous Waste Regulations 2005).

3.81 Parents/carers are responsible for collecting remaining medication at the end of each day or term (as appropriate) and for re-stocking medication at the start of each term. Parents will be sent a letter requesting collection. After two attempts the medication should be taken to a local pharmacist, for safe disposal. It is advised to keep a record of medication that is taken, and a signature is obtained from the receiving pharmacist.

3.82 Controlled drugs must only be taken to the dispensing pharmacist. Records of transferring medications must be witnessed and recorded.

3.83 Receipt of Controlled Drugs (CDs) Some young people have medication that is classified as a controlled drug (Misuse of Drugs Act 1971 schedule 2, storage labelled as CD). These drugs must be received in the appropriate manner and stored in the locked controlled drugs cabinet. Medication must be counted in, counted down as administered and counted out if they leave the building – this to be witnessed and recorded in the CD book. For controlled drugs that are returned via transport, staff should seal the CDs in an envelope and write the quantity contained within on the outside of the envelope to ensure parents know what quantity they will be receiving.

Record keeping

3.9 Consent forms must be signed before any medication is given. The educational setting is responsible for storing copies of signed consent forms. Consent forms should include:

- The pupil's name, age and class
- Contact details of the parent/carer and GP
- Details of any allergies the pupil may have.
- Clear instructions on the medication required, dose to be administered, frequency of dose and period of time medication will be required.

• Acknowledgement that the pupil has previously taken the required medication with no adverse reactions.
The parents should supply the school with the original medication information sheet whilst the medication is on site.
• A dated signature of the parent/carer.

All medication consent and healthcare plans will be tracked and stored electronically using https://www.medicaltracker.co.uk/ .

3.91 Changes to prescriptions or medication requirements must be communicated to theeducational setting by the pupil's parent/carers and a new consent form signed.

3.92 Individual care plans must be developed and reviewed for all pupils with needs that mayrequire ongoing medication or support. Such care plans should be developed with parents/carers, the educational setting and other professional input as appropriate.

3.93 Records must be kept for each child detailing each medication administered. There must also be a daily summary sheet detailing all pupils that have received medication that day under the supervision of the school.

4.0 Medical Emergencies

4.1 In the event of a medical emergency, all relevant procedures should be activated and 999 dialed as appropriate.

4.2 If a pupil needs to be taken to hospital, a member of staff should stay with the child until the parent/carer arrives, or accompany the child taken to hospital by ambulance. Schools need to ensure that they understand the local emergency services cover arrangements.

- Emergency number to call (including additional number to reach an outside line-ifapplicable) 999 or 112
- Navigational instruction, if different from the school or postcode

4.3 If a pupil does become ill at school, they must be accompanied to the school office or medical room by a member of staff. Wherever possible a qualified first aider should attend the location in which the pupil has become ill, this should be without delay.

4.4 In the event of a pupil experiencing a potentially life-threatening emergency, for example an asthma attack or a suspected allergic reaction, information on spare generic emergency medication held in school will need to be communicated to the emergency services. Guidance to then be taken from the emergency services during the 999 call.

4.5 A record of emergency medicines and their expiry dates should be kept and recorded each term for those educational settings which store such medications (for example Adrenaline Auto-Injector devices or asthma inhalers).

4.6 Emergency medicines should only be given to pupils with a signed consent form and following clear, agreed procedures detailed in the consent form or individual care plan. unless advised otherwise by the emergency services.

ANAPHALXYSIS

Emergency Adrenaline Auto Injectors

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/645476/Adrenaline_auto_injectors_in_schools.pdf In 2017, the law was changed: the Human Medicines (Amendment) Regulations 2017 now allows schools to obtain, without a prescription, "spare" AAI devices for use in emergencies, if they so wish. "Spare" AAIs are in addition to any AAI devices a pupil might be prescribed and bring to school. The "spare" AAI(s) can be used if the pupil's own prescribed AAI(s) are not immediately available (for example, because they are broken, out-of- date, have misfired or been wrongly administered). "Spare" AAI devices can be used in any pupil known to be at risk of anaphylaxis, so long as the school have medical approval for the "spare" AAI to be used in a specific pupil, and the child's parent/guardian has provided written authorisation. Not all children with food allergies and at risk of anaphylaxis are prescribed AAIs. These children can be given a spare AAI in an emergency, so long as:

- the school has a care plan confirming that the child is at risk ofanaphylaxis
- a healthcare professional has authorised use of a spare AAI in an emergency in that child.
- the child's parent/guardian has provided consent for a spare AAI to beadministered.

Schools are not required to hold spare AAI(s) – this is a discretionary change enabling schools to do this, if they wish. This applies to all primary and secondary schools (including independent schools) in the UK. Only those institutions described in regulation 22 of the Human Medicines (No.2) Regulations 2014 may legally hold "spare" AAIs. Holding a spare Auto Injector in school is not compulsory, however schools are strongly recommended to purchase generic / spare Adrenaline Auto Injectors.

Importantly holding a spare injector could be used (under the direction of the emergency services) to support a child suffering an allergic reaction, previously unidentified Asthma and Emergency Inhaler/ Inhaler use

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/416468/emergency_inhalers_in_schools.pdf

ASTHMA

From 1st October 2014 the Human Medicines (Amendment) (No. 2) Regulations 2014 will allow schools to obtain, without a prescription, salbutamol inhalers, if they wish, for use in emergencies. The emergency salbutamol inhaler should only be used by children, for whom written parental consent for use of the emergency inhaler has been given, who have either been diagnosed with asthma and prescribed an inhaler, or who have been prescribed an inhaler as reliever medication. The inhaler can be used if the pupil's prescribed inhaler is not available (for example, because it is broken, or empty). This change applies to all primary and secondary schools in the UK. Schools are not required to hold an inhaler – this is a discretionary power enabling schools to do this if they wish.

This guidance is non-statutory and has been developed by the Department of Health with key stakeholders, to capture the good practice which schools in England should observe in using emergency inhalers and which should form the basis of any school protocol or policy.

The Department of Health's 'Guidance on the use of emergency salbutamol inhalers in schools. March 2015' can be found in the link above. It is important that for all pupils with asthma that reliever inhalers are immediately accessible for use when the pupil experiences breathing difficulties. Should the pupil need to visit the medical room, they should be accompanied by a member of staff and not be left alone, in case of worsening symptoms. Schools may hold stocks of asthma inhalers containing salbutamol for use in an emergency by persons trained to administer them to pupils who are known to require such medication.

More detailed information can be obtained from the government website below: -
https://www.gov.uk/government/publications/emergency-asthma-inhalers-for-use-in-schools
Schools can buy inhalers and spacers from a pharmaceutical supplier in small quantities provided it is done on an occasional basis and is not for profit. A supplier will need a request signed by the principal or head teacher (ideally on appropriately headed paper) stating:

- the name of the school for which the product is required;
- the purpose for which that product is required, and
- the total quantity required. Wherever possible pupils should carry their own reliever inhaler or emergency medication treatment, but it is important that this is documented centrally.

EPILEPSY
http://www.youngepilepsy.org.uk/for-professionals/education-professionals
Children with epilepsy have repeated seizures that start in the brain. An epileptic seizure, sometimes called a fit, turn or blackout can happen to anyone at any time. Seizures can happen for many reasons. Epilepsy is a very individual condition, and every pupil with the condition will display different patterns and types of symptoms. In fact, the majority of children with epilepsy never have a seizure during the school day. It is because of this that it is particularly vital that a detailed individual health care plan is drawn up for every pupil with the condition. This plan should be written by the child's consultant or lead specialist and must have been written within the last year for it to be valid. Consulting with Parents: and medical staff, and should set out the particular pattern of the child's epilepsy

- what type of seizures the child has
- how long they last and what they look like
- what first aid is appropriate and how long a rest the child may need
- common triggers for the child's seizures
- how often is medication taken, and what the likely side effects are
- whether there is any warning prior to the seizure, and if so, what form it takes
- what activities might the parents or doctor place limits on
- whether the child has any other medical conditions
- to what extent the child understands their condition and its treatment.

If a child does experience a seizure in a school or setting, details should be recorded and

communicated to parents including: - any factors which might possibly have acted as a trigger to the seizure – e.g. visual/auditory stimulation, emotion (anxiety, upset) - any unusual "feelings" reported by the child prior to the seizure - parts of the body demonstrating seizure activity e.g. limbs or facial muscles - the timing of the seizure – when it happened and how long it lasted - whether the child lost consciousness - whether the child was incontinent This will help parents togive more accurate information on seizures and seizure frequency to the child's specialist.

Most children with epilepsy take anti-epileptic medicines to stop or reduce their seizures. Regular medicine should not need to be given during school hours. Any emergency medications may require appropriate training, parental and GP consent and specific written guidance. Please seek advice from health professionals and the individuals GP. Children with epilepsy should be included in all activities. Extra care may be needed in some areas such as swimming or working in science laboratories.
Concerns about safety should be discussed with the child and parents as part of the health care plan. During a seizure it is important to make sure, the child is in a safe position, not to restrict a child's movements and to allow the seizure to take its course.

5.0 Complaints Procedure

5.1 Should parents or pupils be dissatisfied with the support provided they should discuss their concerns directly with the school. If for whatever reason this does not resolve the issue, they may make a formal complaint via the school's complaints procedure.

5.2 Making a formal complaint to the Department for Education should only occur if it comes within scope of section 496/497 of the Education Act 1996 and after other attempts at resolution have been exhausted. In the case of academies, it will be relevant to consider whether the academy has breached the terms of its Funding Agreement (the contractual relationship between the academyand the Department for Education) or failed to comply with any other legal obligation placed on it. Ultimately, parents (and pupils) will be able to take independent legal advice and bring formal proceedings if they consider they have legitimate grounds to do so.

6.0 School Trips, Visits and Sporting Events

6.1 Medication required during a trip should be carried by the child, if this is normal practice. If not, then a trained member of staff or the parent/carer should be present, either of whom can carry and administer the medication as necessary.

6.2 Medication provided by the parent must be accompanied with written directions for its use. All responsible persons should have access to this information prior to the visit to enable sound judgements should a medical emergency arise. Team leaders should be comfortable with the administration of parental instructions when agreeing to accept young people as participants on a visit.

7.0 Home to school transport

7.1 For home to school transport, precautions will be considered to ensure the safety of the pupil during the journey. Children who require medication to travel between school and use SEND transport will have individual care plans in place and transport arrangements will be discussed with parents. Medication will be transferred with the transport escorts.

7.2 Appropriate trained escorts, if they consider them necessary, to be available for thejourney

7.3 Drivers and escorts should know what to do in the case of a medical emergency. They shouldnot generally administer medicines but where it is agreed that a driver or escort will administer medicines (i.e. in an emergency) they must receive training and support and fully understand what procedures and protocols to follow.

7.4 All drivers and escorts should have basic first aid training as part of their role to support with emergency first aid if required. Additionally, trained escorts may be required to support some pupils with complex medical needs. These can be healthcare professionals or escorts trained by them.

7.5 Where pupils have life threatening conditions, specific health care plans should be carried on vehicles. Individual transport health care plans will need input from parents and the responsible medical practitioner for the pupil concerned. The care plans should specify the steps to be takento support the normal care of the pupil as well as the appropriate responses to emergency situations.

FIRST AID POLICY

The aims of this policy are to ensure the health and safety of all staff, pupils and visitors to the Primary Schools within the Trust. In producing this policy staff and trustees are aware of their responsibilities with regards to First Aid within the Trust and in individual schools. This policy will provide information on responding to an incident and recording and reporting the outcomes.

1.0 Introduction

1.1 The Health and Safety at Work etc. Act 1974 imposes a general duty on employers to ensure that their establishments are safe and healthy places.

1.2 The Health and Safety (First Aid) Regulations 1981 (First Aid Regulations) (amended 1st October 2013) and the associated Health and Safety Executive (HSE) Approved Code of Practice (ACOP)

L74: First Aid at Work applies to all employers and employees who work in establishments.

1.3 The First Aid Regulations do not apply directly to non-employees, although ACOP L74 places emphasis on the need, when assessing the overall risk, to take account of all persons who have access to the premises. Therefore, it is sensible to combine first aid provisions and facilities for employees and non-employees (including visitors to the premises and contractors) ensuring that the level of provision for employees is not diluted.

1.4 This document sets out arrangements to ensure compliance with the First Aid Regulations and ACOP L74. It also provides guidance to management about what first aid facilities should be provided, the training of first aiders, administering treatment and the employer's responsibilities.

2.0 Employers Responsibilities

2.1 It is an employer's responsibility to ensure that there is adequate and appropriate equipment and facilities in place to enable the application of First Aid to employees who become ill or are injured at work, extending these responsibilities to visitors and contractors.

2.2 There is no ratio for the number of first aiders to employees although ACOP L74 offers some guidance which MET school staff should adhere to:

- Low risk workplaces (such as offices) - one trained First Aider to every 50 employees with an additional first aider for every 100 employees
- High risk workplaces - one trained first aider for five or more employees, with an additional first aider for every 100 employees

3.0 First-Aid Facilities

3.1 The number of first aiders, first aid kits and whether a dedicated first aid room is required will be dependent upon the assessment of risk and the criteria stated in 2.2 above.

3.2 First aid boxes or kits should be identifiable, signed with a white cross on a green background, easily accessible and placed in areas of greatest risk.

3.3 All staff members, as part of their initial induction, should be given information relating to:

(i) Who the first aid trained staff are;
(ii) Where the nearest first aid box/kit is located
(iii) Site procedure for dealing with first aid emergencies

3.4 First Aiders must make themselves known to all employees.

3.5 HSE guidance on suggested first aid box contents:

ITEM	MINIMUM

	QUANTITIES
First Aid Guidance	1
Sterile Adhesive Dressing (individually wrapped plasters)	20
Sterile eye pads	2
Sterile Triangular Bandage (individually wrapped)	4
Safety Pins	6
Medium Sterile Dressing	6
Large Sterile Dressing	2
Disposable Gloves	3 Pairs
Sterile Cleansing Wipes	4
Sterile Water or Saline (if mains water not available)	1 Litre

3.6 Other suggestions based on the activities being undertaken and risk assessment:

- Instant ice packs
- Disposable yellow plastic bags for clinical waste/sharps bin
- Silver foil survival blanket
- Protective Resuscitation Aid (Vent Aid)
- AED – Automatic External Defibrillator

3.7 An appointed person is given responsibility for checking and, where necessary, replenishing the contents of first aid boxes/kits to the above minimum quantities on a regular basis.

3.8 Sterile items are marked with a 'use-by' date. When replacing these items within the first aid boxes/kits the dates marked on such items should be checked to ensure that expired items are disposed of and replaced. For non-sterile items without dates, personal judgement should be used to determine whether they are fit for purpose.

3.9 Following administration of first aid, the first aider is responsible for ensuring any stock is replenished by informing their manager. Checks should be recorded.

3.10 Anti-bacterial pump soap, water and disposable drying materials or suitable equivalents must be available.

3.11 If utilising a designated room or area as a 'First Aid Room' to allow patients to sit/lay down quietly in private, it is important that casualties are not left alone, or are checked regularly, dependent on the severity of their illness/injury.

4.0 First Aid Training

4.1 First aid training providers will need to be able to demonstrate how they satisfy the HSE's First Aid Training Criteria

4.2 The main types of first aid personnel often referred to as "First Aiders" are:

i. For casualties aged 18 and over
   - Certified First Aider – First Aid at Work (FAW) - 3-day course.
   - Emergency First Aid at Work (EFAW) – 1 day course

ii. For casualties aged under 18:
   - Pediatric first aiders - 2-day course
   - Emergency pediatric first aider 1 day course

4.3 All first aiders are encouraged to conduct an annual refresher to ensure their skills remain up to date.

4.4 Staff will complete a formal refresher prior to the expiry of their certificate which is valid for 3 years. This training will be arranged in plenty of time before it expires. Should a certificate expire the employee will be required to complete the course in its entirety.

4.5 A qualified first aider will be readily available on the premises and easily contactable at all times when employees are at work.

4.6 In an Early Year's Foundation Stage setting, is at least one person who has a current Paediatric First Aid (PFA) certificate. This person must be on the premises, and available at all times when children are present and accompany children on outings. The PFA certificate must be a full course consistent with the criteria set out in Appendix 2 and Annex A of the Statutory framework for the early years foundation stage government guidance.

4.7 The cost of an individual's first aid training will be paid for by their school's budget.

5.0 Administration of First Aid

5.1 Any persons can administer first aid in line with the training they have received. However, it is not the responsibility of a first aider to administer medication.

5.2 Where accidents involve external bleeding, first aiders must wear protective gloves and ensure that their own personal wounds are covered with a waterproof dressing.

5.3 If a first aider receive bites, scratches or needle stick injuries, wash the wound with water, make it bleed, if you can, and then cover with a waterproof dressing. Report the incident to your line manager and record the incident through medical tracker. This should then be addressed within your sites workplace risk assessment to ensure sufficient and suitable control measures are in place (see the Leicestershire Traded Services Blood Borne Viruses and Needle Stick Injuries Guidance for more details).

5.4 Mouth to Mouth Resuscitation

5.4.1 If contaminated blood is present through facial injuries, and mouthto mouth contact is

required, a Vent Aid should be kept in first aid boxes/kits to facilitate this.

5.4.2 Where first aiders feel unable to deliver rescue breaths due to the presence of blood, vomit or other reason, they should endeavor to continue to provide compression only CPR in line with their training.

5.5 Requesting the Attendance of an Ambulance

5.5.1 All first aiders must be fully aware of their work location procedures for calling, and meeting, the emergency services.

5.5.2 First aiders should follow NHS guidance on when to visit an urgent care centre when deciding whether to call an ambulance, in line with their training. However, if there is any doubt, an ambulance should be called without delay and follow any instructions provided by the emergency services call handler.

6.0 Mental Health First Aid (MHFA)

6.1 It is important for employers to recognise the effects of metal health issues in the same way as physical first aid needs.

6.2 Mental Health First Aid (MHFA) is an educational course which teaches people how to identify, understand and help a person who may be developing a mental health issue. In the same way as we learn physical first aid, Mental Health First Aid teaches you how to recognise the crucial warning signs of mental ill health.

6.3 MHFA courses teach people how to:

- Recognise the signs and symptoms of common mental health issues
- Provide help on a First Aid basis
- Effectively guide someone towards the right support

Several members of staff across the Primary settings have completed the MHFA course.

7.0 Reviewing and Reporting

7.1 All incidents of first aid will be recorded on the Medical Tracker system. Ways of reporting and recording will be regularly reviewed. https://www.medicaltracker.co.uk/

8.0 Post Incident Support

8.1 It is acknowledged that dealing with an emergency situation can have a significant psychological impact on all involved. It is important for Managers/Head Teachers to be aware of the signs and

symptoms of post incident stress and provide support, where necessary. It must be noted that the effects can often take months to manifest.

8.2 Employees are encouraged to discuss incidents and seek professional support, if necessary, from their GP. The Leicestershire Traded Services Wellbeing Service can also be contacted where necessary via email - counsellingandwellbeing@leics.gov.uk

Further relevant information for information and completion such as healthcare plans and the full Leicestershire guidance can be sought from individual schools websites.

INTIMATE CARE POLICY

1. Introduction

Mowbray Education Trust is committed to ensuring that all staff responsible for the intimate care of children will undertake their duties in a professional manner at all times. We recognise that there is a need to treat all children with respect and dignity when intimate care is given. No child should be attended to in a way that causes distress, embarrassment or pain. Children's dignity will be preserved and a high level of privacy, choice and control will be provided to them. Staff that provide intimate care to children have a high awareness of safeguarding issues. Staff will work in partnership with parents/carers to provide continuity of care.
Pupils may require assistance with intimate care as a result of their age or due to having SEND. In all instances, effective safeguarding procedures are of paramount importance.
This policy has been developed to ensure that all staff responsible for providing intimate care undertake their duties in a professional manner at all times and treat children with sensitivity and respect.

The school is committed to providing intimate care for children in ways that:

- Maintain their dignity.
- Are sensitive to their needs and preferences.
- Maximise their safety and comfort.
- Protect them against intrusion and abuse.
- Respect the child's right to give or withdraw their consent.

- Encourage the child to care for themselves as much as they can.
  Protect the rights of all others involved.

2. Definition

Intimate care is any care which involves washing, touching or carrying out an invasive procedure to intimate personal areas. In most cases such care will involve procedures to do with personal hygiene and the cleaning of associated equipment as part of the staff member's duty of care. In the case of specific procedures only the staff suitably trained and assessed as competent should undertake the procedure (e.g. the administration of rectal diazepam).

The management of all children with intimate care needs will be carefully planned. The child who requires care will be treated with respect at all times; the child's welfare and dignity is of paramount importance. Staff who provide intimate care are fully aware of best practice. Suitable equipment and facilities will be provided to assist children who need special arrangements following assessment from the appropriate agencies. It is essential that the adult who is going to change the child informs the teacher and/or another member of staff that they are going to do this. There is no written legal requirement that two adults must be present. However, in order to completely secure against any risk of allegation, a second member of staff may be present where resources allow. Staff will be supported to adapt their practice in relation to the needs of individual children taking into account developmental changes such as the onset of puberty or menstruation. Wherever possible staff involved in intimate care will not be involved in the delivery of sex education to the children in their care as an extra safeguard to both staff and children involved. The child will be supported to achieve the highest level of autonomy that is possible given their age and abilities. Staff will encourage each child to do as much for him/herself as they are able. Individual intimate care plans will be drawn up for children as appropriate to suit the circumstances of the child. Each child's right to privacy will be respected.

Careful consideration will be given to each child's situation to determine how many carers will need to be present when the child is toileted. Wherever possible the child should be cared for by an adult of the same sex. However, due to staffing situations in this school this isn't always possible.
Therefore, in certain circumstances this principle may need to be waived where the failure to provide would result in negligence for example, female staff supporting boys in our school, as no male staff are available. Intimate care arrangements will be discussed with parents/carers on a regular basis and recorded on the child's personal care plan. The needs and wishes of children and parents will be taken into account wherever possible within the constraints of staffing and equal opportunities legislation.

3. Procedures for intimate care

- Staff who provide intimate care will have a list of personalised changing times for the children in their care, which will be adhered to at all times and will be shared with parents.
- Staff who provide intimate care will conduct intimate care procedures in addition to the designated changing times if it is necessary; no child will be left in wet/soiled clothing or nappies.

- If the designated member of staff for a child's intimate care is absent, a secondary designated member of staff will change the child adhering to the arranged times.
- Each child using nappies will have a clearly labelled box allocated to them in which there will be clean nappies, wipes and any other individual changing equipment necessary.
- Before changing a child's nappy, members of staff will put on disposable gloves and aprons, and the changing area will be cleaned appropriately using disposable blue roll paper and soap and hot water.
- The changing areas are warm and comfortable for the children and are private from others.
- Hot water and liquid soap are available for staff to wash their hands before and after changing a nappy; the changing area will also be cleaned appropriately after use using disposable blue roll paper and soap and hot water.
- The changing area has paper towels available for members of staff to dry their hands.
- Any soiled clothing will be placed in a tied plastic bag in the child's personal box and will be returned to parents at the end of the school day.
- Any used nappies will be placed in a tied plastic bag and disposed of in the appropriate bins.
- Any bodily fluids that transfer onto the changing area will be cleaned appropriately.
- If a pupil requires cream or other medicine, such as for a nappy rash, this will be provided in accordance with the medication policy and full parental consent will be gained prior to this.
-Older children and those who are more able will be encouraged to use the toilet facilities and will be reminded at regular intervals to go to the toilet.
- Members of staff will use the toilet introduction procedures to get children used to using the toilet and encourage them to be as independent as possible.
- Children will be reminded and encouraged to wash their hands after using the toilet, following the correct procedures for using soap and drying their hands.

4. Partnership Working

In some circumstances it may be appropriate for us to set up a home-setting/school agreement that defines the responsibilities that each partner has, and the expectations each has for the other. This could include

- Agreeing to ensure that the child is changed at the latest possible time, convenient to the parent/child before being brought to the setting/school.
- Providing the setting/school with spare nappies and a change of clothing. However the school/setting should also endeavour to keep spare clothes, of varying sizes that also reflect the gender and mix of clothing worn by the children, for emergencies
- Understanding and agreeing the procedures that will be followed when their child is changed at school –including the use of any cleanser or the application of any cream
- Take into account the child's own wishes and needs in how care is provided, and how they communicate this
- Agreeing to inform the setting/school should the child have any marks/rash
- Agreeing to a 'minimum change' policy i.e. the setting/school would not undertake to change the child more frequently than if s/he were at home
- Agreeing to review arrangements should this be necessary.

Equality Impact Assessment

The Trust carries out Equality Impact Assessments to ensure that policies, procedures, and practices cater for individuals who share protected characteristics in relation to the Equality Act 2010. The purpose of these assessments is to ensure that policies, procedures, and practices within the organisation are fair to all. If unfairness is highlighted, the assessment will also seek to show how this can be changed and, where it can't be changed, how it can be improved.

Monitoring arrangements

This policy will be reviewed every year by the Trust Data Lead. At every review, the policy will be shared with the Trust board for approval.

Log of Changes to Policy				
Version	Page	Change	Approver	Date
1.0	Whole document	General tidying up of formatting	TB	7.6.23
	3	Renaming of parental communication systems in schools		
	Whole document	Renaming of AAIs Adrenaline Auto-Injector devices for anaphylaxis		
	13	Clarify training requirements for first aiders		
1.1		No changes required	TDL	May 2024