First Aid Policy

Lancing College

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1 Policy Statement

1.1 This policy is written as an extension to the Lancing College Health and Safety Policy and is linked to the Health Centre Policy endorsed by the Senior Management Team of the College.

1.2 Lancing College will ensure, so far as is reasonably practicable, that first aid arrangements will be managed in compliance with the Health and Safety (First Aid) at Work Regulations 1981.

1.3 Management of first aid arrangements will be undertaken in such a way as to provide adequate arrangements for training and re-training of first aiders, provision of first aid equipment and facilities and for the recording of first aid treatment and near misses. Arrangements will be such that first aid may be offered to employees, students, visitors, contractors and others who may be affected by the activities of the organisation.

2 Aims / Objectives

2.1 To endeavour to comply with all relevant legislation
2.2 To undertake suitable and sufficient assessments of first aid needs
2.3 To identify and implement reasonably practicable arrangements for dealing with first aid incidents
2.4 To provide competent persons for carrying out first aid treatment
2.5 To conduct regular checks on first aid equipment and the availability of consumables

3 Responsibilites

3.1 The Head Master, working through the College's Health and Safety Committee will ensure that the appropriate policies, procedures and audit protocols are in place and reviewed from time to time.

3.2 The Senior Management Team will ensure that these policies and procedures are communicated, implemented and adhered to on a sustainable basis throughout all College timetable, sports, activities and events.

3.3 The Heads of Department will ensure that these policies and procedures are communicated, implemented and adhered to on a sustainable basis in their respective areas of responsibility.

3.4 The College Health and Safety Committee will ensure that suitable and sufficient assessments are carried out to ascertain first aid needs. Additionally the committee will ensure that suitable first aid notices are displayed, detailing locations of first aid equipment, names of first aiders and contact information.

3.5 The Health Centre Manager will ensure that suitable equipment, facilities and consumables are provided for first aid treatment.

3.6 First aiders will ensure that all first aid treatments are recorded in the College's accident reporting system on the VLE whenever first aid treatment is applied. If

required, the relevant Health and Safety Executive (HSE) reportable paperwork will also be completed.

4 Process

4.1 The process is that the injured person or witnessing staff member in charge, (or their representative), fills in the Accident Report Form. This is sent immediately to the Health and Safety Manager who then investigates and logs the incidences. All accidents/incidents are reported to the Health and Safety Committee for review. Actual names are withheld from this report stating only whether it was a visitor, pupil or employee.

4.2 The completed forms are kept securely online by the Health and Safety Manager. If there is an injury or incident that should be reported to the HSE, this will be done by the Bursar's Personal Assistant or the Health and Safety Manager.

4.3 The College Health and Safety Manager will ensure that when required, the relevant HSE reportable paperwork is completed and arrangements are in place for a suitable budget for training and updating of first aiders and maintenance of first aid supplies.

4.4 The College's Health and Safety Committee will ensure that audits are carried out periodically to ensure the effectiveness of first aid arrangements.

5 Training Arrangements

5.1 Who is trained as a first aider will be on the recommendation of the College Health and Safety Committee and Health Centre Manager to the Headmaster.

5.2 Training for first aiders will be undertaken by a qualified First Aid Instructor or Qualsafe approved First Aid training provider.

5.3 Initial Training, re-qualification and updating of the Emergency First Aid at Work (EFAW) courses are organised each term as required. More in-depth or specialised first aid courses are sourced as required, if it is not possible for the Health Centre Manager to complete the training.

5.4 Training of staff for specific emergency assistance e.g. Allergies, Adrenaline Auto Injector training is conducted by the Health Centre Manager who maintains the relevant records.

5.5 A database is maintained showing Names, Qualification held, expiration dates and spread of first aid within the College. This will also assist in assessing need and identify shortfalls of cover.

6 Information

6.1 All information regarding first aid should be treated as confidential. However, certain information is needed for the safety of those concerned and is provided on a strictly need to know basis from the Health Centre Manager.

6.2 When an incident occurs the next of kin (N.O.K.) is informed depending on the severity of the injuries. In the case of a pupil, the Housemaster or Housemistress as well as the Duty Nursing Sister will be aware. Details of N.O.K for staff members/volunteers are held by the Bursary and are available when necessary. The N.O.K, are informed by the Bursary or the Health Centre Manager if appropriate.

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First Aid Procedures

Introduction
The Health and Safety (First Aid) Regulations 1981 set out the essential aspects of first aid that employers have to address. Employers are required to:

- Carry out an assessment of first aid needs appropriate to the circumstances of each workplace
- Provide adequate numbers of qualified first aiders throughout the organisation
- Maintain levels of competence of first aiders
- Provide adequate equipment for first aid treatment
- Provide adequate first aid rooms or other suitable areas for first aid treatment
- Record first aid treatment

First Aid Assessment
A first aid assessment has been carried out, on behalf of the Health and Safety Committee which has identified minimum numbers and type of first aiders required by the College. The assessment has been based upon the numbers of employees and students within the College and the activities undertaken.

First Aid Personnel
The current first aid risk assessment has identified the following minimum numbers of qualified first aiders that are required within the College.

First Aid at Work: 4 EFAW: 12

Although the above numbers of first aiders and emergency first aiders are the minimum requirements, the Health and Safety Committee have increased the provision to take into consideration holidays and other absences, sports, trips and activities requiring specialist requirements and high risk areas. The actual numbers are below, broken into two time periods:

Type of cover	**Term Time**	**Out of Term time**	**Total**
Duty nursing sister	1 (24hrs per day)	0	1
FAW	4	3	7
AFA/Specialist	3	0	3
EFAW/AP	107	30	107
Grand Total	**115**	**33**	**115**

During school holidays (out of Term Time) sufficient first aid trained personnel are still available to provide cover for the employees still on site. Members of staff taking students

on activities outside College when third party first aid facilities cannot be relied upon should have among their group, a suitably first aid trained person, (as a minimum to EFAW [appointed person] status). First aid equipment and consumables taken on such activities will be determined by the Health Centre Manager after consultation with the activity leader.

Training of first aid personnel
All first aiders and emergency first aiders must hold a valid certificate of competence, approved by the Health and Safety Executive with details stored by the Health and Safety Manager. A first aider or appointed person only has authority when appointed by the Head Master after endorsement by the Health and Safety Manager and Health Centre Manager. The Health Centre Manager will maintain a register of all qualified and authorised staff and arrange retraining as and when necessary.

Courses for first aiders and emergency first aiders
Members of staff wishing to train in first aid should in the first instance contact the Health Centre Manager who will determine the need and if necessary, arrange for a suitable and convenient course. Update and requalification training will be arranged as required.

First aid updates are also available on EduCare as online courses.

Application of first aid
First aiders should only provide first aid treatment for which they have been trained and are competent to administer. If in any doubt the duty nursing sister should be contacted as soon as is reasonably practicable for advice or to take over the incident if necessary. Professional emergency assistance should be called at the earliest opportunity if necessary.

Arrangements for particular medical conditions
Any member of the College with particular medical conditions e.g. Asthma, Allergies, epileptic seizures etc. are required to carry any necessary personal medication at all times and, when off site should provide additional medication to be held by a responsible person on the trip.

Those staff with particular conditions or requiring particular medication are responsible for their own medication and the safe and secure storage of the same and for ensuring that pupils are not able to access this.

Those with particularly sensitive conditions also have medication pre-positioned in what is assessed to be high risk areas e.g. Dining room, Boarding house and the Health Centre. Staff are trained to assist and administer certain types of medication if necessary i.e. Adrenaline Auto injector. Specific risk assessments are to be conducted for vulnerable individuals.

Guidance on first aid incidents is at appendix 2 to this leaflet.

Spillage of bodily fluids.
Spillage kits are provided in areas where there is a risk of bodily fluid contact and written procedures are provided. Minibuses also carry small spillage kits but additional kits may be needed for extended journeys. The Health Centre runs a "Yellow bag" system where contaminated first aid materials and waste can be disposed of correctly and safely. Spillage kit replacements can be sourced from The Domestic Services Manager.

First aid boxes/kits and equipment
First aid boxes are provided by the College and are distributed and restocked by the Health Centre Manager as necessary. The location of the boxes and any suitable signage is the responsibility of the College's Health and Safety Committee and the Health Centre Manager.

Staff members using items from first aid boxes/kits should seek replacement stock from the Health Centre Manager at the earliest opportunity. All staff will be reminded by email termly to check all first aid boxes/kits in their area in the College and request necessary items to update and maintain kits in a usable condition. Discrepancies in contents must be communicated to the Health Centre Manager in order for supplies to be updated.

Staff members in certain areas are nominated to check first aid boxes/kits monthly, sign and date the label on each box to confirm check have been completed. Any restocking is arranged through the Health Centre Manager. Boxes need to be taken to the Health Centre and the nursing staff will restock.

The minimum contents of a first aid kit will be:-

1 x First aid guidance card
Ix foil blanket
2 x Triangular bandage
2 x medium sterile un-medicated dressings
2 x large sterile un-medicated dressing
2 x sterile eye pad, with attachment
Individually wrapped sterile adhesive dressings various sizes
4-6 0.9% saline pods
Gauze swabs
1 x resuscitation aid
1 x pair of disposable gloves
1x scissors
1x yellow disposal bag
Disposable ice pack if appropriate

First aid box locations:
Health Centre
Maintenance Managers' Office
Carpenters' Workshops
Plumbers' Workshop
Electricians' Workshop
D & T Centre x 2
Chemistry Labs
Art School x 2
Dance Studio
Swimming Pool
Sports Hall
Squash Courts
Pavilion Changing Rooms
Grounds men's Tea room
Theatre x 2
Head Master's Office
Bursar's Office
Main Kitchen x 2
Common Room
The Library
Chapel (Verger's Office)
Domestic Services Rest Room
Reception
CCF Office
College Minibuses
College work Vehicles
Numerous Sports First Aid Bags

Additional items will be added to specific first aid kits where requirement is deemed necessary by the Health Centre Manager and College's Health and Safety Committee.

Additional first aid kits, for specific activities and trips are available for short term loan form the Health Centre.

The swimming pool has a floating spinal board (on the wall, pool side)
(This equipment must only be used by fully trained personnel).
They all must be replaced after use.

Vehicles used to transport students
First aid boxes will be provided in all the vehicles used for transporting students. It is the responsibility of the driver to ensure that the contents of the first aid box have not been used (boxes are sealed with a paper seal). Drivers using any items from the first aid box should inform the transport manager who will provide a replacement immediately the vehicle has returned to College. The actual contents of the first aid boxes within vehicles will be determined by legislation (The Road Vehicles [C & U] Regulations 1986, schedule 7).

Ambulance access
Should an ambulance be required to attend an incident, contact is to be made by the fastest means via the 999 system. Please ensure the ambulance service is given exact details of where they should go (Lancing College is not sufficient) and a guide is to be sent to meet the ambulance at the agreed point to direct it to the casualty by the shortest route. Access to the Dyke Field sports pitches can be obtained from the Coombes Road. An emergency key, to the Coombes Road gate, is held in the both the hockey and rugby store rooms.

First Aid Room
The Health Centre is the nominated First Aid Room.

First aid notices
Suitable notices are displayed in prominent positions about the College which indicate the names and contact information of first aiders and the locations of first aid equipment. A list of first aid trained personnel is also available on the intranet.

Reporting, Record Keeping and Reviewing
All first aid incidents, however minor, must be reported by the person giving first aid treatment and / or the person who received treatment, at the earliest opportunity. This person must enter all relevant information regarding the incident on the College Accident Form remembering that this information is "Need to Know" and, when completed, are treated as Confidential. Forms are completed on the VLE and returned to the Health & Safety Manager. However, the Health Centre may complete forms where necessary and passes them directly to the Health and Safety Manager for any further action to be addressed.

All first aid incidents and near misses are reported to the College Health and Safety manager for investigation and action where appropriate.

All incidents falling within the RIDDOR reporting process are dealt with by the Bursar's Personal Assistant as required.

All incidents logged through the College Accident Forms are reviewed on a regular basis by the College Health and Safety Committee. The Health and Safety Committee's main concern is the incident, the result of the incident, any patterns that occur, could a future similar event be avoided

and what procedures if any can be put in place to reduce the likelihood of a reoccurrence. For confidentiality all names are removed from this detail.

The Health and Safety Committee will review periodically the provision and requirement for first aid within the College to maintain levels of cover and ensure ongoing requirement match, College needs.

Guidelines for Administering First Aid

If in doubt about any injury, refer to the Duty Nursing Sister for advice

Ext : 5916 Mobile : 07990500707

All incidents must be reported on the College Accident Form on the VLE and forwarded to the Health and Safety Manager ASAP.

MINOR INJURIES

Sprains, grass burns, pulled muscles, "dead leg", strained ligaments, tendon damage etc.	Treated on site and referred to the Health Centre if further treatment is required.

POTENTIALLY SERIOUS INJURIES

Fractures	Rest - keep warm - support the injured part. Call the duty nurse and 999 if appropriate depending on extent of injury
Dislocations	Keep comfortable and call for duty nurse and 999 if appropriate.
Eye Injury	Minor /Major trauma - cover with clean cloth, refer to Health Centre.
Head Injury	Stop - do not resume game/activity. Follow Head injury protocol
Suspect concussion?	Refer to duty nursing Sister. Any pupil concussed may not play contact sports again for three weeks. Follow concussion protocol Unconscious casualties MUST be taken by ambulance to hospital.
Unconscious patient	The vital action is to ensure that patient is breathing easily. Best position - lying prone with head to one side with fingers holding jaw forward to keep airway clear.

	Call ambulance and send for Duty nursing sister. If breathing stops commence resuscitation.
Serious injury. Spinal Injury to neck or back should be considered if the casualty complains of severe pain at site of injury with loss of sensation below this and inability to move limbs below injury level.	**DO NOT MOVE**. Call for the emergency services (9.999) and send for duty nursing Sister and send guide for the ambulance. Keep warm by covering with available clothes and 'space blanket'. **DO NOT GIVE DRINK OR FOOD**
SPECIFIC MEDICAL CONDITIONS	
Asthma	Calm and reassure the casualty and help them to adopt a comfortable breathing position, not lying. Follow Asthma Protocol – see Appendix 3 Assist with administration of the casualties own medication. If no improvement contact the Duty Nursing Sister ASAP and/or ambulance.
Epilepsy	Protect the casualty from injury or harm. Follow Epilepsy Protocol – See Appendix 3 After seizure check airway/breathing. Place in recovery position/treat any injuries if necessary send for duty nursing sister. Monitor duration of seizure.
Allergy	Assess the casualty and ask whether they know if they suffer from an allergy. Follow Anaphylaxis Protocol – See Appendix 3 **If yes**, assist them to take their medication. Help them to adopt a comfortable breathing position and send for the duty Nursing Sister ASAP. If worried they are not responding to call for the emergency services (9.999).

	If no, Treat any symptoms and call the emergency services (9.999) and the duty Nursing Sister.
Diabetes	Assess the casualty and ask whether they know if they suffer from any medical condition or carry any medical information. Follow Diabetes Protocol – See Appendix 3
	Assist with administration of the casualties own medication if they have it. If no improvement or no medication contact the duty Nursing Sister and the emergency services (9.999) as appropriate.
Head Injury	**All pupils following a head injury must be escorted to the Health Centre by a member of staff** (or at the very least by a competent pupil). The Health Centre will assess and treat or refer on as appropriate and also put head injury post-concussion protocol in place.

<u>Transportation of Injured Pupils</u>

Minor Injury	Pupil to return to House either on his/her own or accompanied by another pupil if warranted.
Potentially Serious Injury	If a car is available move the casualty to the Health Centre if safe to do so. If no car is available, send a messenger to the nearest telephone for transport request.
	The casualty should not be left alone. An adult should accompany the casualty at all times and if the teacher running the game/activity is the only one available, priority must be given to the injury and the game/activity stopped ensuring the remaining students are safe.
Serious Injury	The game/activity should be stopped ensuring the remaining students are safe. The pupil must not be left without adult supervision. Contact should be made with the Duty Nursing Sister and the

emergency services (9.999) if appropriate. The nearest location with a telephone should be asked to make the emergency calls and guide sent to direct the emergency services directly to the scene if required.

Asthma Protocol

What to do in the event of asthma attack

*__keep calm__

*encourage pupil/staff/visitor to sit up slightly rather than lying down

*do not hug them or lie them down

*initially give two puffs of their **reliever** inhaler (usually the blue one) **preferably through a spacer**

*loosen tight clothing

*reassure the person

***call duty Sister to scene**

IF THERE IS NO IMMEDIATE IMPROVEMENT:*continue to give one puff of reliever inhaler (via spacer if possible) every 5 minutes or until their symptoms improve.(there must be at least 30 seconds between each puff as it takes 30 seconds for the inhaler to 'recharge')

CALL 999 IF:

*there is no improvement in symptoms in 5-10 minutes

*the person is too breathless or exhausted to talk

*the person's lips are turning blue

***if you are in doubt**

Don't take a chance; asthma can be fatal

***Continue to give one puff of reliever inhaler every minute until the ambulance arrives**

Never leave a pupil having an asthma attack on their own always send someone to call for help

Call the duty Sister on ext 5916 or med centre mobile: 07990 500707 .....and state the emergency is an asthma attack and also whether inhaler/spacer is required.

In an emergency situation school staff are required under common law, duty of care, to act like any reasonably prudent parent.

Reliever medication is very safe. During an asthma attack do not worry about a pupil overdosing

Contact the pupil's parents/guardian as soon as possible after calling ambulance. A member of staff should always accompany child in ambulance.

MINOR ASTHMA attacks should not interrupt FULL involvement of a pupil in school life.

SEVERE ALLERGY (ANAPHYLAXIS PROTOCOL)

ADRENALINE AUTO INJECTOR (AAI) protocol

In the event of any person being exposed to an allergen and suffering a severe reaction action must be taken immediately.

Keep calm ..... THE MOST IMPORTANT!

Give an antihistamine tablet **immediately** even if there appears to be little or no initial reaction:

i.e. ONE CETIRIZINE 10MG **or** ONE PIRITON TABLET 4mg

Observe for any development of signs or symptoms

If there are any developments of signs or symptoms for example:

BECOMES PALE AND FLOPPY

BLUISH AROUND LIPS

HAS ANY DIFFICULTY BREATHING AND OR TALKING NORMALLY

DESCRIBES TONGUE AS BEING TOO BIG FOR MOUTH

BEGINS TO LOOSE CONSCIOUSNESS

GIVE AAI IMMEDIATELY i.e. EPIPEN OR EMERADE OR JEXT

CALL 999

Tell the ambulance handler it is an anaphylactic reaction and what action has been taken.

Remember it will take 10 full seconds for the adrenaline to be discharged from the syringe. Ensure that the AAI it is injected in the mid-section of the outer thigh and held for a count of 10 seconds (10 elephants counted allowed) until the whole dose is given. Early removal of the syringe from the leg will result in the adrenaline going on the floor!

IF ADRENALINE IS GIVEN AN AMBULANCE MUST BE CALLED.

Record the time the epipen is given and give the empty syringe to the ambulance crew.

EPILEPSY PROTOCOL

If you see someone having a seizure or fit, there are some simple things you can do to help.

It might be scary to witness, but do not panic.

If you're with someone having a seizure:

- only move them if they're in danger, such as near a busy road or hot cooker
- cushion their head if they're on the ground
- loosen any tight clothing around their neck, such as a collar or tie, to aid breathing
- turn them on to their side after their convulsions stop – read more about the recovery position
- stay with them and talk to them calmly until they recover
- note the time the seizure starts and finishes

Support them gently and cushion their head, but do not try to move them.

*Do not put anything in their mouth, including your fingers. They should not have any food or drink until they have fully recovered.

when to call an ambulance

Call 999 and ask for an ambulance if:

- it's the first time someone has had a seizure
- the seizure lasts longer than is usual for them
- the seizure lasts more than 5 minutes, if you do not know how long their seizures usually last
- the person does not regain full consciousness, or has several seizures without regaining consciousness
- the person is seriously injured during the seizure

PLEASE NOTE...People with epilepsy do not always need an ambulance or to go to hospital every time they have a seizure.

DIABETES PROTOCOL

What is type 1 diabetes?

Type 1 diabetes is a serious condition where your **blood glucose (sugar) level** is too high because your body can't make a hormone called **insulin**.

This happens because your body attacks the cells in your pancreas that make the insulin, meaning you can't produce any at all.

We all need insulin to live. It does an essential job. It allows the glucose in our blood to enter our cells and fuel our bodies.

When you have type 1 diabetes, your body still breaks down the carbohydrate from food and drink and turns it into glucose. But when the glucose enters your bloodstream, there's no insulin to allow it into your body's cells. More and more glucose then builds up in your bloodstream, leading to high blood sugar levels. Therefore insulin needs to be injected as prescribed by your specialist doctor.

The aim of treatment is to maintain blood sugar levels between 4 and 10 mmols/l.

If blood sugar (blood glucose) levels BGL falls below 4 then he is in danger of becoming' hypoglycaemic' i.e. having a 'hypo'. To combat this take some fast acting sugar: 50ml of lucozade is ideal or (fruit juice or a glucose sweet or similar fast release glucose) and follow this by giving a carbohydrate e.g. a digestive biscuit, piece of toast etc. If it is just before a meal then just the 50mls of Lucozade followed by meal and insulin as usual.

Symptoms of hypoglycaemia (hypo) are:.

Early signs of a low blood sugar level include:

sweating

feeling tired

dizziness

feeling hungry

tingling lips

feeling shaky or trembling

a fast or pounding heartbeat (palpitations)

becoming easily irritated, tearful, anxious or moody

turning pale

If a low blood sugar level is not treated, you may get other symptoms, such as:

weakness

blurred vision

confusion or difficulty concentrating

unusual behaviour, slurred speech or clumsiness (like being drunk)

feeling sleepy

seizures or fits

collapsing or passing out

A low blood sugar level, or hypo, can also happen while you're sleeping. This may cause you to wake up during the night or cause headaches, tiredness or damp sheets (from sweat) in the morning.

There may be occasions when BGL is high. e.g. over 20mmols/l. At this point he needs to check ketone le Symptoms of hyperglycaemia include:

- increased thirst and a dry mouth
- needing to pee frequently
- tiredness
- blurred vision
- unintentional weight loss
- recurrent infections, such as thrush, bladder infections (cystitis) and skin infections

If pupils feels unwell ALWAYS send to Health Centre with a member of staff or a sensible pupil. NEVER send pupil on their own.

Concussion Management in Independent Schools

Aims

1. To acknowledge the significance of concussion, however it occurs.

2. To encourage an understanding in both the pupil and the school that a return to sport too soon after a concussion injury carries significant risk to immediate and long-term health.

3. To acknowledge that concussion can affect cognitive functioning for weeks after an injury, and to encourage schools to provide individualised support for affected pupils.

4. To provide a protocol to follow if a pupil suffers a suspected concussion within the school environment to facilitate a timely medical review.

5. To provide a protocol to follow during the recovery phase to ensure that a pupil is appropriately managed to allow them to make a full and safe recovery.

Introduction

Concussion is a complex process affecting the brain which is induced by biomechanical force. Concussion typically results in the rapid onset of short-lived impairment of brain function that resolves spontaneously. It does not require a loss of consciousness to be diagnosed and, in fact, many people with concussion do not present this way.

The 6th International Consensus Statement on Concussion in Sport defines concussion as follows:

Sport-related concussion is a traumatic brain injury caused by a direct blow to the head, neck or body resulting in an impulsive force being transmitted to the brain that occurs in sports and exercise-related activities. This initiates a neurotransmitter and metabolic cascade, with possible axonal injury, blood flow change and inflammation affecting the brain. Symptoms and signs may present immediately, or evolve over minutes or hours, and commonly resolve within days, but may be prolonged.

No abnormality is seen on standard structural neuroimaging studies (computed tomography or magnetic resonance imaging T1- and T2-weighted images), but in the research setting, abnormalities may be present on functional, blood flow or metabolic imaging studies. Sport-related concussion results in a range of clinical symptoms and signs that may or may not involve loss of consciousness. The clinical symptoms and signs of concussion cannot be explained solely by (but may occur concomitantly with) drug, alcohol, or medication use, other injuries (such as cervical injuries, peripheral vestibular

dysfunction) or other comorbidities (such as psychological factors or coexisting medical conditions).

One of the key themes of concussion management is prevention. We are aware that too many young people are being exposed to what can be a significant injury through their involvement in sport. Sport has many positives within the Independent School setting and beyond. The aim of concussion prevention is not to restrict access to sport, but rather to make the sport safer with the use of sport specific warm ups and changes to the rules that have been proven to reduce the risks involved.

Common early signs and symptoms of concussion

Indicator	Evidence
Symptoms	Headache, dizziness, "feeling in a fog"
Physical signs	Loss of consciousness, vacant expression, vomiting, inappropriate playing behaviour, unsteady on legs, slowed reactions
Behavioural changes	Inappropriate emotions, irritability, feeling nervous or anxious
Cognitive impairment	Slowed reaction times, confusion/disorientation, poor attention and concentration, loss of memory for events up to and/or after the concussion
Sleep disturbance	Drowsiness

(Ref IRB 2013)

Concussion can occur in any situation where there is the potential for a head injury. Particular attention should be paid to high impact sports, those involving the potential for falls from a height, or involving activity on a hard surface e.g. cycling.

It should be noted that the symptoms of concussion can first present at any time (but typically in the first 24-48 hours) after the incident which caused the suspected concussion.

Why worry about Concussion in Schools?

Second Head Injury Syndrome (SIS)

SIS describes the situation in which a pupil sustains a second head injury before the symptoms from the first head injury have resolved. This can cause the brain to lose its ability to auto regulate intracranial and cerebral perfusion pressure. In rare cases this can lead to cerebral oedema and herniation, causing collapse and death within minutes. In addition, if the injured person has had a small intra-cerebral bleed/haematoma which has not been apparent after the first injury, a second blow to the head may trigger significantly greater, and more damaging, bleeding with potential lifelong consequences.

The Effects of Multiple Concussions

One of the challenges of making recommendations in this area is that there are not good longitudinal studies in the school age population about the impact of concussion following pupils through adolescence and into older age. Numerous studies of professional boxers have shown that repeated brain injury can lead to chronic encephalopathy, termed *dementia pugilistica* in 1937. Likewise, the autopsies of 2 former professional football players with a history multiple concussions demonstrated changes that were consistent with chronic encephalopathy. It is not known how applicable those findings are to the school age population where the severity of impacts is likely to be less, but the development of their brains is not complete at the time of the injuries. The effect of multiple concussions in our pupil population over time may be significant. Experience suggests that some pupils are more prone to concussion than others, whether that be because of poor technique, physical size, or their individual neuroanatomy. Careful thought should be given to managing these situations, and it is likely that a conversation with the pupil and their parents would be sensible to agree a way forward.

Cognitive Functioning

There is robust evidence that concussion affects cognitive functioning for days after the injury, even if the initial presentation is mild. A return to any exercise or academic study too soon or in an uncontrolled way can prolong loss of function and delay recovery.

Whilst the guideline applies to all age groups, particular care needs to be taken with children and adolescents due to the potential dangers associated with concussion in the developing brain. The school doctor is often uniquely placed to raise awareness of these dangers within the school environment and to advise the school on an appropriate process to follow for pupils who have sustained a concussion.

Diagnosis and Management of Concussion

How do I know there is a Concussion?

It is vital to empower the pitch side staff and referees in any sport to be aware of the signs of concussion, and to remove any player suspected of being concussed from the field of play immediately.

Visible clues of concussion - what you see

Any one or more of the following visual clues can indicate a concussion:

- Dazed, blank or vacant look
- Lying motionless on the ground / slow to get up
- Unsteady on feet / balance problems or falling over / incoordination
- Loss of consciousness or responsiveness
- Confused / not aware of plays or events
- Grabbing / clutching of head
- Seizures
- More emotional /irritable than normal for that person

Symptoms of concussion - what you are told

Presence of any one or more of the following 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 the head
- Sensitivity to light or noise

Questions to ask to further assess

Failure to answer any of these questions 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?

It is intended For those involved with pitch side management of concussion, there is a very detailed assessment tool called the Sport Concussion Assessment Tool SCAT6 that helps to standardise the assessment, and provides a useful guide to the process. for

Healthcare Professionals and is accurate within 72 hours of injury and up to 5–7 days post injury.

Management of a Suspected Concussion

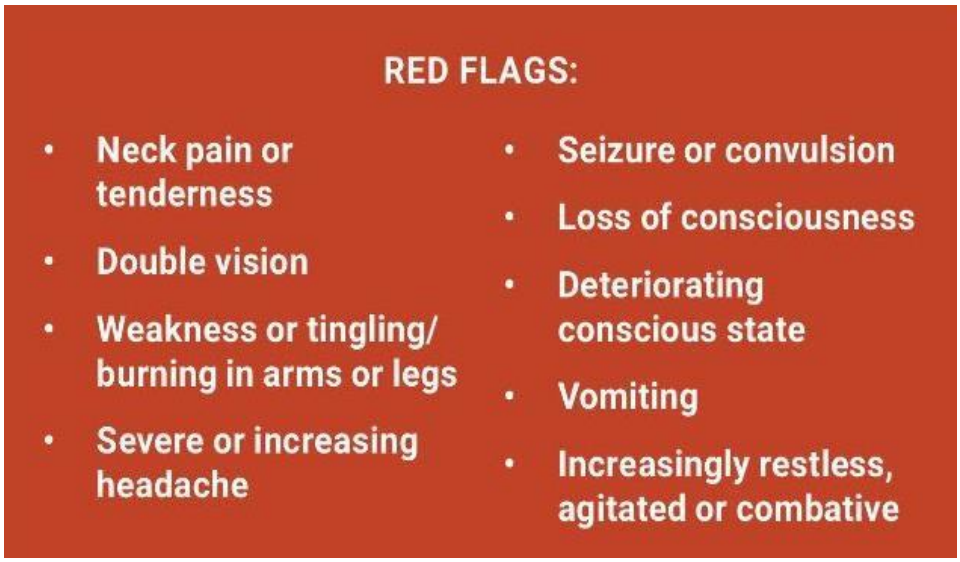
Immediate Management

A pupil falls to the ground after a blow to the head.

- If they immediately get to their feet unaided and they appear fully conscious and orientated
  They may continue as before the injury

- If they are unable to get up for a short period of time or they appear confused or disorientated
  They must be removed from play and be checked by an appropriately trained Healthcare Professional

- If they demonstrate any Red Flag Symptoms:



They must be transferred to hospital. Dial 999 for ambulance and DO NOT DELAY for example by calling for doctor or nurse

If they are unconscious on the field, the game must stop, and they should not be moved except by appropriately trained medical personnel using a spinal stretcher. The pupil must be removed in a safe manner in accordance with emergency management procedures. If a cervical spine injury is suspected the player should only be removed by emergency healthcare professionals with appropriate spinal care training.

IF IN DOUBT SIT THEM OUT

Concussion Assessment

The structure of medical services in schools is such that the school doctor may see a pupil 24-72 hours after the injury and is thus dependent on the whole team collecting data to ensure an accurate diagnosis. There may be limited time to make the assessment and, in that situation, carrying out a full SCAT6 is not feasible; it is not how that assessment is designed to be used. Instead there is a tool called the Sport Concussion Office Assessment Tool (SCOAT6/Child SCOAT6) which has been designed especially for that situation to improve consistency of diagnosis. The Child SCOAT6 should be used in patients aged 8–12 years, while the SCOAT6 should be used in patients 13 years and older.

It is recommended that the following are included in the SCOAT6:

- A 10-word recall and digit backwards test.
- Measurement of systolic and diastolic blood pressure as well as heart rate taken supine after 2 min rest and after standing for 1 min.
- Evaluation of the cervical spine range of motion, muscle spasm, palpation for segmental tenderness and midline tenderness.
- A neurological examination including assessment of cranial and spinal nerves, motor function, sensation and deep tendon reflexes.
- Timed tandem gait as a single task and a more complex dual task with the addition of 3 cognitive tasks (such as serial 7's, months backwards or word recall backwards).
- The modified vestibular ocular motor screening.
- Delayed word recall, a minimum of 5 min after completion of the immediate word recall test.
- A mental health and sleep screen.

It would be ideal if this could be implemented for each concussion assessment in schools, but to do so would have a significant workload implication and may not be possible in every setting. Consideration could be given in individual settings as to which elements might be plausible to include.

Additionally it is suggested that a careful history is taken in order to establish the mechanism of the injury. Coaches and pitch side nurses / paramedics are well placed to detail the mechanism of injury. A clinical assessment aimed at diagnosing concussion can be done after the acute assessment, which allows the pupil to have rested and rehydrated for a brief period to remove fatigue as a contributing factor.

The pupil should be asked to explain what happened in their own words and should move through the incident in a logical order, for example:

- When did the injury happen?
- Whom were you playing?
- In which team were you playing?
- How far into the match did the injury happen?

It is suggested further that the pupil explains exactly what they remember, for example:

- Were you tackling or being tackled?
- Did the incident happen off the ball?
- What hit your head?
- Do you remember the impact or hitting the ground?
- How did you feel immediately afterwards?
- Did you have any blurred vision or changes to your colour vision?
- Did you feel nauseous, did you vomit?
- Did you have any problems with your balance or noises in your ears?
- Were you confused at any time?
- Did you have a headache or any loss of consciousness?
- Can you remember everything that happened or are there any parts you can't remember?
- Did you leave the pitch?
- What happened next, were you seen by a Healthcare Professional?
- How were you 10, 30 and 60 minutes later?
- What about later that evening?
- Did you go to a hospital A&E department?
- Did you feel more irritable or emotional than usual?
- How well did you sleep that night and how did you feel the following morning?
- Did you notice any problems with your concentration or mood in the days afterwards?
- When did you feel completely back to normal from your point of view?

In terms of examining the pupil, the key points to consider should be:

- Fundoscopy, including checking the pupillary reflexes
- Assessment of the eye movements including observing the presence / absence of nystagmus
- Performing Romberg's Test and a finger-to-nose test
- Asking and testing for unilateral deafness / ear drum damage

The diagnosis of concussion is a clinical one and there is no one test that can definitively confirm or refute it. It can be difficult to diagnose and can present with an evolving

collection of symptoms and signs over a number of days. Caution is advised therefore and if the school doctor is in any doubt, it is better to err on the side of making the diagnosis of concussion.

Obviously, a loss of consciousness associated with a head injury should be treated as concussion irrespective of any symptoms the pupil had after the event. These cases will involve less than ten percent of those pupils with concussion.

Utilising the SCAT6 and SCOAT6 forms

As mentioned, completing the documents for each pupil affected is very time consuming. Despite this, the structured format has clinical and medicolegal value leading to a debate about how best to find a balance. A suggestion would be for the first contact clinicians to complete the first 3 pages of the SCAT6, up to and including Step 2 (the symptom evaluation) with the option of continuing if a complex concussion is suspected.

The clinician responsible for diagnosing and managing the pupil would then complete the first 4½ pages of the SCOAT6 document up to and including the symptom evaluation with the option of continuing if complex concussion is suspected. In both instances this is moving away from the model suggested in the consensus statement, but this is a pragmatic approach, given the constraints within the UK healthcare system. Trained support staff (nurses, paramedics, or physiotherapists) can be involved with parts of this work to support the concussion management.

Concussion Recognition and Management within the School

Whilst the guidelines apply to all age groups, particular care needs to be taken with children and adolescents due to the potential dangers associated with concussion in the developing brain. The school doctor is often uniquely placed to raise awareness of these dangers within the school environment, and to advise their school on an appropriate process for pupils who have sustained a concussion to follow.

Education of staff and pupils about the signs and symptoms of concussion is the priority if the aim is to try and ensure that people feel able to report concussion. If everyone is aware of the symptoms, pupils are more likely to feel able to say to their friends that they have concerns about them in this regard.

There are many online education modules run by different agencies that are useful for staff training (don't forget to include the House Staff) and the RFU has produced some excellent videos for both junior and senior players, as well as for parents to help educate about concussion.

Once the diagnosis is made, it is important to have a robust chain of communication to take the information back to the school. Don't rely on a pupil with concussion to deliver the right message. An electronic database for sports injuries that is accessible to all staff would be useful and failing that an email from the health centre to the house staff, coaches and rehab team could be used.

It is recommended that there is a single member of staff who is responsible for co-ordinating the gradual return to play (GRTP) process, and it is helpful to have a form that can be signed off (either electronically or in person) at each stage of the process. This will ensure that when the school doctor sees the pupil when he or she has finished the GRTP, it can be easily checked that they have done what was expected of them.

The gold standard would be an assessment by a well-trained clinical team (nurse, physiotherapist, paramedic, or doctor) throughout the process starting on the pitch, at the point of diagnosis, after two weeks to clear the pupil to start the GRTP and finally to clear them as being fit for contact.

A pupil with significant and / or prolonged symptoms should be flagged up for close monitoring by the school doctor, and ongoing symptoms at 4 weeks should prompt a specialist referral.

Good communication throughout this process is vital with the pupil given consistent and positive advice, with the school staff all working from the same protocol and parents informed from the onset.

Return to Learn and Return to Play

The current evidence shows that recommending strict rest until the complete resolution of concussion-related symptoms is not beneficial. Relative rest, which includes activities of daily living and reduced screen time, is indicated immediately and for up to the first 2 days after injury. Restricting screen time beyond 48 hours is not usually required although it should be recognised that this is an individual situation that may need re-evaluation if symptoms are worsening with resumption of normal activities.

These tables from the UK Concussion Guidelines for Grassroots Sport provide very useful reference points for the process.

GRADUATED RETURN TO EDUCATION/WORK& SPORTSUMMARY	
Stage 1	**Relative Rest for 24–48 hours** • Minimise screen time • Gentle exercise*
Stage 2	**Gradually introduce daily activities** • Activities away from school/work (introduce TV, increase reading, games etc)* • Exercise –light physical activity (e.g. short walks) *
Stage 3	**Increase tolerance for mental & exercise activities** • Increase study/work-related activities with rest periods* • Increase intensity of exercise*
Stage 4	**Return to study/work and sport training** • Part-time return to education/work* • Start training activities without risk of head impact*
Stage 5	**Return to normal work/education and full training** • Full work/education • If symptom-free at rest for 14 days consider full training
Stage 6	**Return to sports competition (NOT before day 21) as long as symptom free at rest for 14 days and during the pre-competition training of Stage 5**

In addition, these guidelines contain a blended Graduated Return to Learn and Play (GRTL & GRTP) template set out below. It is unlikely that schools will be able to provide an individualised approach for pupils. The example below is intended to provide a framework for schools to follow if they wish.

Stage	Focus	Description of activity	Comments
Stage 1 **Days 0-2**	**Relative rest period (48 hours)**	Take it easy for the first 48 hours after a suspected concussion. It is best to minimise any activity to 10 to 15-minute slots. Pupil may walk, read and do some easy daily activities provided that their concussion symptoms are no more than mildly increased. Phone or computer screen time should be avoided to help recovery.	
Stage 2 **Day 2-4**	**Start to return to normal school activities** **GRTL**	• Increase mental activities through easy reading, limited television, and limited phone and computer use. • Late start, breakfast in house, join lessons at break time (c11am) and complete periods 3,4 & 5 • Advancing the volume of mental activities can occur as long as they do not increase symptoms more than mildly.	There may be some mild symptoms with activity, which is OK. If they become more than mildly exacerbated by the mental or physical activity in Stage 2, rest briefly until they subside.
	Physical Activity **GRTP**	• After the initial 48 hours of relative rest, gradually increase light physical activity. • Increase daily activities like moving around the school and short walks. Briefly rest if these activities more than mildly increase symptoms.	
Stage 3 **Day 4-7**	**Increasing tolerance for thinking activities** **GRTL**	• Late start, breakfast in house, start lessons at break time (c11am) and complete periods 3,4 & 5, lunch and periods 6 and 7 • Once normal level of daily activities can be tolerated then explore adding in some additional school work such as prep, longer periods of reading or work in 20 to 30-minute blocks with a brief rest after each block. • Discuss with school about rest breaks and intensity of activities	Progressing too quickly through stages 3 - 5 whilst symptoms are significantly worsened by exercise may slow recovery. Although headaches are the most common symptom following concussion and may persist for several months, exercise should be limited to that which does not more than mildly exacerbate them. Symptom exacerbation with physical activity and exercise is generally safe, brief and is self-limiting typically lasting from several minutes to a few hours.
	Light aerobic exercise for remainder of week 1 **GRTP**	• Walking or stationary cycling for 10–15 minutes. Start at an intensity where able to easily speak in short sentences. The duration and the intensity of the exercise can gradually be increased according to tolerance. • If symptoms more than mildly increase, or new symptoms appear, stop and briefly rest. Resume at a reduced level of exercise intensity until able to tolerate it without more than mild symptom exacerbation. • Brisk walks and low intensity, body weight resistance training are fine but no high intensity exercise or added weight resistance training.	

Stage	Focus	Description of activity	Comments
Stage 4 **Day 8-14**	**Return to study** **GRTL**	• Expectation is that the pupil is back to normal academic activities unless their symptoms prevent this	Progressing too quickly through stages 3 - 5 whilst symptoms are significantly worsened by exercise may slow recovery. Although headaches are the most common symptom following concussion and may persist for several months, exercise should be limited to that which does not more than mildly exacerbate them. Symptom exacerbation with physical activity and exercise is generally safe, brief and is self-limiting typically lasting from several minutes to a few hours.
	Non-contact structured training **GRTP**	• Start training activities in chosen sport once not experiencing symptoms at rest from the recent concussion. It is important to avoid any training activities involving head impacts or where there may be a risk of head injury. Now increase the intensity of exercise and resistance training.	
Stage 5 **Day 15-21**	**Return to full academic activity GRTL**	• Ongoing return to full activity and catch up on any missed work.	Individuals should only return to training activities involving head impacts or where there may be a risk of head injury when they have not experienced symptoms at rest from their recent concussion for 14 days. Recurrence of concussion symptoms following head impact in training should trigger removal of the player from the activity.
	Unrestricted training activities **GRTP**	• Start with non-contact and gradually build up complexity and intensity of sports-specific exercise • If applicable introduce contact and non-structured training in final stages of week 2.	
Stage 6	**Return to competition**	This stage should not be reached before day 21* (at the earliest) and only if no symptoms at rest have been experienced from the recent concussion in the preceding 14 days and now symptom free during pre-competition training. * The day of the concussion is Day 0	Resolution of symptoms is only one factor influencing the time before a safe return to competition with a predictable risk of head injury. Approximately two-thirds of individuals will be able to return to full sport by 28 days but children, adolescents and young adults may take longer.

If any post-concussion symptoms occur during this process, then the pupil should drop back to the previous step and try to progress again after 48 hours.

Academic Considerations

Most pupils will need some allowances, especially at the start of their recovery, and the Houseparent or Tutor may be well placed to negotiate with teaching staff on their behalf. Staff should be aware that concentration, reading speed, memory and emotional stability may all be affected, and expectations of the pupil should be adjusted to take this into account. Consideration should be given to a managed return to full school days as in the table above, and the gradual re-introduction of homework if appropriate. Appropriate adjustments to consider include:

- Environmental adjustments such as modified school attendance times, frequent rest breaks and limited screen time on electronic devices
- Curriculum adjustments such as extra time to complete prep and support with taking notes in class
- Assessment adjustments such as delaying assessments and/or permitting additional time to complete them

Complex and prolonged Concussion

Concussion may be deemed prolonged if symptoms persist beyond 4 weeks in children and adolescents. Symptoms may be physical, cognitive, sleep related and/or mood-behavioural. Support and reassurance are important, ongoing clinical supervision and care may benefit from collaborative care with external agencies may be of benefit.

Early referral back to the School MO or local GP as well as the educational support service is advised. Special consideration may need to be applied for if this period overlaps with exams. In addition, cervico-vestibular rehabilitation may be of benefit**.**

Further Sources of Information

UK Grassroots Concussion Guidance for Non-Elite sport 2023

World Rugby Concussion Management

RubgySafe Toolkit from the England RFU

Pocket Concussion Recognition Tool

Understanding Concussion video for pupils and parents

6th International Concensus Statement on Concussion

September 2023

FIRST AID ARRANGEMENTS FOR OFF-SITE VISITS AND ACTIVITIES

Leaders or another adult member/s of the party should have adequate knowledge of first aid for the visit or activity being undertaken. The level of first aid cover deemed necessary for the activity or visit should be determined by risk assessment, it should be at an 'EFAW (Appointed Person)' status level as minimum.

Categories of visit and first aid requirements

The level of knowledge, which may be required, will depend on many factors including:

- The result of the risk assessment conducted for the activity or visit to be undertaken.
- The nature of the visit, and whether it is residential – see below
- Those involved, including experience, ability and training
- The extent to which "outside" first aid assistance is available
- The environment, and particularly the remoteness or otherwise of the location

Hence after Risk Assessment the activity should be categorised into one of the following levels of risk:-

-
- **Category A: Day trips, visits and sports in the local area**

These are activities and visits within the local area which present no special risks and can be safely supervised by a leader judged competent to lead educational visits and sporting fixtures generally and where medical assistance is readily available or can be accessed reasonably quickly. Examples will include:

- Walking in parks
- Field studies in non-hazardous environments
- Sporting fixtures
-
- **Category B: Outside local area or overnight but within UK**

These are activities and visits outside the local area, but within the UK mainland, which present no special risks and can be safely supervised by leaders who have had more experience of leading these types of activities and are judged competent to lead educational visits and sporting activities generally. There may be need for more formal first aid experience/qualifications if assessed necessary in the risk assessment connected for that activity. Examples will include:

- Visits to museums and galleries in London
- Participation in a non-hazardous sporting event in another town or location away from Lancing
- Visits to theme parks
- Field studies in other towns or cities

Category C: Hazardous visits or activities and overnight abroad

These could include some of the following but the risk assessment will determine the level of first aid cover required:

- Residential trips; and/or
- Any visit or activity deemed hazardous; and/or
- Visits abroad
- Activities or visits involving persons deemed to be vulnerable

On a Category C visit or activity, it is desirable that a fully certificated first aider be included in the party, unless provision is available at the location, and will be accessible to the party throughout their activities. In this case the journey **must** be covered by someone who is trained to EFAW (appointed person) level as a minimum.

In the 'wilderness', on Category C activities, when the normal emergency services will be more than 30 minutes travelling time by foot or 2.5 kilometres in distance at any time, in that terrain, the party **must** include a fully certificated first-aider trained for the relevant activity/terrain. The travelling time must take into account uphill sections and precipitous ground conditions, which would need to be traversed by the emergency services.

First Aid Equipment

For all visits and associated journeys, an appropriate first aid kit must be readily available and its contents checked and replenished regularly.

The Health and Safety Executive recommend the following is included in a first aid kit, where no special risk of injury is anticipated:

- a leaflet giving general advice on first aid
- six individually wrapped and sterile adhesive dressings
- one large un-medicated wound dressing, approximately 18cm x18cm
- two triangular bandages
- two safety pins
- individually wrapped and sterile cleansing wipes
- one pair of disposable gloves
- a resuscitate (for hygienic mouth to mouth resuscitation) may also be helpful

Emergencies

If emergency treatment is required College procedures must be followed, the student should be accompanied at all times and the College kept informed of the situation. Should the need arise to take pupils to a hospital or doctor, the following should be observed.

"Generally, staff should not take pupils (young people) to hospital in their own car. However, in an emergency it may be the best course of action. The member of staff should be accompanied by another adult and have public liability vehicle insurance". The College has 'Occasional Business Use' insurance to cover this eventuality but staff members must register the vehicle with the College to ensure insurance cover first.

To ensure that first aid kits are suitable for use when needed, below is a list of those responsible for arranging the following checks:-

1. Check the kits monthly (get replacements from the Health Centre).
2. Take the kit to the Health Centre annually for full inspection.
3. Ensure all first aid incidents are reported in the Accident Book held in the Bursary so that records are maintained and any reportable incidents can be followed up.

Art School x 2	Art Technician
Bursary	Bursar's Personal Assistant
Catering Dept x 2	Catering Manager
Catering Van x 1	Catering Manager
CCF	SSI
Chemistry Labs x 3	Science Technician
D&T x 2	DT Technician
Dance studio	Head of PE
Domestic Services	Domestic Services Manager
Domestic Services van	Domestic Services Manager
Electricians Workshop	Health and Safety Manager
Exams/ Academic Admin	Exams Officer
Farm project	Farm Manager
Grounds Van	Head Grounds man
Grounds office	Head Grounds man
Head Master's Office	Head Master's Assistant
Library	Head Librarian
Post Room	Post Room Staff
Maintenance office	Maintenance Manager
Maintenance Vehicles x 5	Maintenance Manager
Maintenance workshops	Maintenance Manager
Minibuses	Transport Manager
Pavilion	Head Grounds man
All Boarding Houses.	House Matron
Sports Hall	Domestic Services Manager
Sports Staff x 40 bags.	Director of Sports - **To be returned to Health Centre at the end of each term for restocking as necessary.**
Squash court	Director of Sports
Swimming pool	Swimming Pool Supervisor
The Common Room	Common Room Steward
Theatre	Theatre Technical Manager