RIPPLEVALE

SCHOOL

First Aid Policy

Staff Responsible:	Deputy Head	
Approved by:	Senior Leadership Team	**Date:** Nov 2019
Last reviewed on:	December 2021	
Next review due by:	December 2022	

Ripplevale School
First Aid Policy

'Ripplevale School provides a caring, learning environment where our students make meaningful progress, relative to their individual starting points. Our aim is to encourage them to develop appropriate personal, social and employable skills enabling them to become

The Place for First Aid

First aid can preserve life and prevent minor injuries becoming major ones. Under the First Aid at Work Regulations 1981 employers have to ensure that there are adequate and appropriate equipment and facilities for providing first aid in the workplace. This policy has been produced based on the above document and the Department for Education's document, "First Aid in School, Early Years and further education document updated February 2022.

This guidance does not constitute an authoritative legal interpretation of the provisions of any enactments or regulations or the Common Law; that is exclusively a matter for the Courts.

First-Aid Provision at Ripplevale School comprises:

1. Suitably stocked first-aid containers situated around the school.
2. An appointed person to take charge of first-aid arrangements as nominated in the Health & Safety Policy.
3. Information for employees on first-aid arrangements (identified in the staff handbook).
4. This provision has been supplemented by a regular risk assessment to determine if any additional provision is required.
5. Risk assessments are made as required by careful consideration of each incident and discussion with the school's Health & Safety Consultants.
6. First-aid provision available at all times while people are on school premises, and also off the premises whilst on school visits.

Responsibilities

Health and safety legislation places duties on employers for the health and safety of their employees and anyone else on the premises. In schools this includes responsibility for the Headteacher and teachers, non-teaching staff, pupils and visitors (including contractors). Who the employer is depends on the type of school. For example:

At Ripplevale School the company as the employer, is primarily responsible for health and safety matters, with the Directors, managers and staff also having responsibilities.

The employer is responsible, under the Health and Safety at Work etc. Act 1974 (HSWA), for making sure that a school has a health and safety policy. This should include arrangements for first aid, based on a risk assessment of the school, and should cover:

- numbers of first-aiders/ appointed persons;
- numbers and locations of first-aid containers;
- arrangements for off-site activities/ trips;
- out of school hours arrangements e.g. lettings, parents evenings.

The employer should also make sure that their insurance arrangements provide full cover for claims arising from actions of staff acting within the scope of their employment. It is the employer's responsibility to make sure that the statutory requirements for provision of first aiders are met, that

appropriate training is provided and that correct procedures are followed. The employer should be satisfied that any training has given staff sufficient understanding, confidence and expertise. (More information is given in the section on Insurance)

The Directors are required to develop policies to cover their own school. This should be based on a suitable and sufficient risk assessment carried out by a competent person. The Directors have general responsibility for all the school's policies. In practice, most of the day to day functions of managing health and safety are delegated to the Headteacher.

The Headteacher is responsible for putting the Director's policy into practice and for developing detailed procedures. The Headteacher should also make sure that parents are aware of the school's health and safety policy, including arrangements for first aid.

Teachers' conditions of employment do not include giving first aid, although any member of staff may volunteer to undertake these tasks. Teachers and other staff in charge of pupils are expected to use their best endeavours at all times, particularly in emergencies, to secure the welfare of the pupils at the school in the same way that parents might be expected to act towards their children. In general, the consequences of taking no action are likely to be more serious than those of trying to assist in an emergency.

The employer must arrange adequate and appropriate training and guidance for staff who volunteer to be first alders/ appointed persons. The employer must ensure that there are enough trained staff to meet the statutory requirements and assessed needs, allowing for staff on annual/ sick leave or off-site.

What are a first-aiders main duties?

First aiders must complete a training course approved by the Health and Safety Executive (HSE).

In school, the main duties of a first-aider are to:

- give immediate help to casualties with common injuries or illnesses and those arising from specific hazards at school;
- when necessary, ensure that an ambulance or other professional medical help is called.
- enter details of injuries and treatment outcome in the appropriate record.
- administer first aid and keep appropriate records.

What is an appointed person

An appointed person is someone who:

- takes charge when someone is injured or becomes ill
- looks after the first-aid equipment e.g. restocking the first-aid container;
- ensures that an ambulance or other professional medical help is summoned when appropriate.

Appointed persons are not first aiders. They should not give first aid treatment for which they have not been trained. However, it is good practice to ensure that appointed persons have emergency first aid training/ refresher training, as appropriate. These courses do not require HSE approval. They normally last four hours and cover the following topics:

- what to do in an emergency;
- cardiopulmonary resuscitation;
- first aid for the unconscious casualty;

- first aid for the wounded or bleeding.

Emergency first-aid training should help an appointed person cope with an emergency and improve their competence and confidence.

First Aiders – What do schools need to do??

Employers must provide adequate and appropriate equipment, facilities and qualified first-aid personnel.

“In the light of their legal responsibilities for those in their care, schools should consider carefully the likely risks to pupils and visitors, and make allowance for them when drawing up policies and deciding on the numbers of first-aid personnel.”

Where first aid is provided for staff and pupils, schools should ensure that:

- provision for employees does not fall below the required standard;

The Directors and/ or Headteacher should regularly review the school’s first-aid needs (at least annually), and particularly after any changes, to ensure the provision is adequate. Where minimum numbers of trained first aiders are set, these should be monitored to ensure that these standards are being met.

The employer or the Headteacher with the delegated function must inform all staff (including those with reading and language difficulties) of the first-aid arrangements. This should include the location of equipment, facilities and first-aid personnel, and the procedures for monitoring and reviewing the school’s first-aid needs.

A simple method of keeping staff and pupils informed is by displaying first-aid notices in staff/ common rooms. The information should be clear and easily understood.

Notices must be displayed in a prominent place, preferably at least one in each building if the school is on several sites.

Including first-aid information in induction programmes will help ensure that new staff and pupils are told about the first-aid arrangements. It is good practice to include such information in a staff handbook.

Insurance

In the event of a claim alleging negligence by a member of the school staff, action is likely to be taken against the employer rather than the employee.

Employers should make sure that their insurance arrangements provide full cover for claims arising from actions of staff acting within the scope of their employment.

Risk Assessment of First Aid needs

Ripplevale School includes staff, pupils and visitors when carrying out risk assessments for first-aid needs.

The proximity of the emergency department of the Hospital also has a bearing on the risk assessments.

Specific Hazards or risks on site

For example; hazardous substances, dangerous tools and machinery. Temporary hazards, such as building or maintenance work, should also be considered and suitable short-term measures put in place.

Are there staff or pupils with special health needs or disabilities? What age range does the school cater for? Different first-aid procedures may apply to pupils in primary and secondary schools. For example, the age of pupils may affect the type of first-aid procedures required, such as resuscitation techniques. First-aid training organisations can provide advice on training for first-aid personnel in schools.

Accident statistics and monitoring

The Directors, Headteacher and school's Health and Safety Officer will monitor all accident and injury at work records.

Accident statistics can indicate the most common injuries, times, locations and activities at a particular site. These can be a useful tool in risk assessment, highlighting areas to concentrate on and tailor first-aid provision to.

The Directors/ Headteacher should consider the likely risks to pupils and visitors, as well as employees, when drawing up policies and deciding on the numbers of first-aid personnel.

The HSC provide guidance on numbers of first-aid personnel based on employee numbers. As a general guide, they recommend that: "Schools will generally fall into the lower risk category, but some schools or areas of activity may fall into the medium risk category. " Ripplevale School has based provision on the results of their risk assessment. When considering how many first-aid personnel are required, the Directors / Headteacher have considered:

- adequate provision for lunch-times and breaks;
- adequate provision for leave and in case of absences
- first-aid provision for off-site activities i.e. school trips. If a first-aider accompanies pupils off-site, will there be adequate first-aid provision in the school?
- adequate provision for practical departments, such as science, technology, home economics, physical education;
- adequate provision for out of hours activities e.g. sports activities, clubs;
- any agreements with contractors on joint provision for first aid for their employees;

Unless first-aid cover is part of a member of staff's contract of employment, people who agree to become first-aiders do so on a voluntary basis. When selecting first aiders the Directors/ Headteacher have considered the individual's:

- reliability and communication skills;
- aptitude and ability to absorb new knowledge and learn new skills;
- ability to cope with stressful and physically demanding emergency procedures;
- normal duties. A first aider must be able to go immediately to an emergency.

First-aid notices should be displayed which are clear and easily understood by all.

Qualifications and Training

A first-aider must hold a valid certificate of competence, issued by an organisation whose training and qualifications are approved by the HSE.

Training courses cover a range of first aid competencies. However, standard first aid at work training courses do not include resuscitation procedures for children.

First aid at work certificates are only valid for three years. Employers should arrange refresher training and re-testing of competence before certificates expire. If a certificate expires, the individual will have to undertake another full course of training to become a first aider. The school should keep a record of first aiders and certification dates.

First-Aid materials, equipments and facilities

Employers must provide the proper materials, equipment and facilities at all times. First-aid equipment must be clearly labelled and easily accessible.

First-aid containers are situated:

Medical Room
School Kitchen
Grab Bag (staff room) for PE/sports
Post 16 Kitchen
Reception
Secondary Classes 5 (science), 1 (art) 11 (food tech)
The Hub Kitchen
Trade Skills
All School Vehicles
Garage

All first-aid containers must be marked with a white cross on a green background.

Contents of a first-aid container

Where there is no special risk identified, a minimum provision of first-aid items would be:

- a leaflet giving general advice on first aid;
- 20 individually wrapped sterile adhesive dressings (assorted sizes);
- two sterile eye pads;
- four individually wrapped triangular bandages (preferably sterile);
- six safety pins;
- six medium sized (approximately 12cm x 12cm) individually wrapped sterile unmedicated wound dressings;
- two large (approximately 18cm x 18cm) sterile individually wrapped unmedicated wound dressings;
- one pair of disposable gloves.
- Equivalent or additional items are acceptable.

The First-aider is the person responsible for examining the contents of first-aid containers. These should be checked frequently and restocked as soon as possible after use. Items should be discarded safely after the expiry date has passed.

Travelling first-aid containers

Before undertaking any off-site activities, the Headteacher should assess what level of first-aid provision is needed. The HSE recommend that, where there is no special risk identified, the following is a minimum stock of first-aid items for travelling

- a leaflet giving general advice on first aid.
- six individually wrapped sterile adhesive dressings;
- one large sterile unmedicated wound dressing approximately 18cm x I 8cm~ two triangular bandages;
- two safety pins;
- individually wrapped moist cleansing wipes; one pair of disposable gloves.
- Equivalent or additional items are acceptable. Additional items may be necessary for specialised activities.

This first-aid container shall be maintained in a good condition; suitable for the purpose of keeping the items referred to above in good condition; readily available for use; prominently marked as a first-aid container.

Minibus first-aid containers

Transport Regulations require that the minibus has on board a first-aid container with the following items:

- ten antiseptic wipes, foil packaged;
- one conforming disposable bandage (not less than 7.5 cms wide); two triangular bandages;
- one packet of 24 assorted adhesive dressings;
- three large sterile unmedicated ambulance dressings (not less than 15 cm x 20 cm); two sterile eye pads, with attachments
- twelve assorted safety pins;

Staff using items **must replace them immediately** on return to school. All stock to replenish 1st Aid boxes is stored in the Medical Room in the Main House. Should replenished stocks run low, staff are to alert administration to re-order. Stocks should be also checked termly.

Employers must provide suitable and sufficient accommodation. The Education (School Premises) Regulations 1996 require every school to have a suitable room that can be used for medical or dental treatment when required, and for the care of pupils during school hours. The area, which must contain a washbasin and be reasonably near to a WC, need not be used solely for medical purposes, but it should be appropriate for that purpose and readily available for use when needed. Schools should consider using this room for first aid. However, first-aid facilities may need to be made available quickly. Organisations such as HSE provide detailed advice on first-aid rooms. The school has a first aid room with washing facilities for the care of pupils. Adjacent to this is a medical room which the school keeps its controlled and over the counter medications and records such as medication administration records sheets.

Individual care plans and risk assessments.

As part of the admissions process students known allergy and medical conditions are declared and the school parent support advisor (PSA) will work with parents and other relevant organisations to create care plans and risk assessments for use in school and on trips. Any additional training needed for staff is also sourced. Medical conditions included epilepsy, diabetes and asthma etc. All care plans and risk assessments are sent out to all staff to read once written and also available on the school teacher database and as hard copy in the staff room folders.

Hygiene / infection control

All staff should take precautions to avoid infection and must follow basic hygiene procedures. Staff should have access to single-use disposable gloves and hand washing facilities, and should take care when dealing with blood or other body fluids and disposing of dressings or equipment. Further guidance is available in the DfEE publication HIV and AIDS: A Guide for the Education Service.

Spillage of blood/body fluids

Instructions

1. Cover the spill with absorbent paper towels to avoid stepping in it.
2. Block off the area of the body fluids spill to prevent further spread.
3. Put on vinyl gloves and carefully wipe up the spill with the paper towels or use absorbent gel and carefully place the mess in a plastic bag.
4. Pour a mixture of 1-part disinfectant to 10 parts of water carefully on the area of the spill. Avoid splashing. The disinfectant and water solution should remain in contact with the spill area for at least 20 minutes.
5. Carefully wipe up the area with paper towels and avoiding dripping.
6. Double-bag all towels from the body fluids spill along with the gloves used to clean the mess and tie the bags closed.
7. Dispose of the double-bagged materials in the garbage and wash your hands thoroughly with soap and warm water.

Reporting Accidents and Record Keeping

Under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) some accidents must be reported to the HSE.

The employer must keep a record of any reportable injury, disease or dangerous occurrence. This must include: the date and method of reporting; the date, time and place of the event; personal details of those involved and a brief description of the nature of the event or disease. This record can be combined with other accident records.

The following accidents must be reported to HSE if they injure either the school's employees during an activity connected with work, or self-employed people while working on the premises:

- accidents resulting in death or major injury (including as a result of physical violence);
- accidents which prevent the injured person from doing their normal work for more than three days (including acts of physical violence).

For definitions of major injuries, dangerous occurrences and reportable diseases see HSC/E guidance on RIDDOR 1995, and information on Reporting School Accidents.

HSE must be notified of fatal and major injuries and dangerous occurrences without delay (e.g. by telephone). This must be followed up within ten days with a written report on Form 2508. Other reportable accidents do not need immediate notification, but they must be reported to HSE within ten days on Form 2508.

An accident that happens to pupils or visitors must be reported to the HSE on Form 2508 if:

- the person involved is killed or is taken from the site of the accident to hospital; **and**
- the accident arises out of or in connection with work.

Like fatal and major injuries to employees or dangerous occurrences, these accidents must be notified to HSE without delay and followed up in writing within ten days on Form 2508.

In HSE's view an accident must be reported if it relates to:

- any school activity, both on or off the premises;
- the way a school activity has been organised and managed (e.g. the supervision of a field trip);
- equipment, machinery or substances;
- the design or condition of the premises.

These records must be kept for **a minimum of 3 years.** They may:

- be used for reference in future first-aid needs assessments;
- be helpful for insurance and investigative purposes.

In an emergency, the Headteacher / teacher in charge should have procedures for contacting the child's parent/ guardian/ named contact as soon as possible. The school will report all serious or significant incidents to the parents e.g. by sending a letter home with the child, or telephoning the parents.

The school will keep a record, using the accident book, of any first aid treatment given by first aiders and appointed persons. This pre-set form includes:

- the date, time and place of incident;
- the name (and class) of the injured or ill person;
- details of the injury/ illness and what first aid was given;
- what happened to the person immediately afterwards (for example went home, resumed normal duties, went back to class, went to hospital);
- name and signature of the first aider or person dealing with the incident.

Ripplevale School currently as forty eight qualified first aiders to ensure continuity of cover. Senior management ensure that there are always sufficient first aiders on the premises and ensure first aid trained staff are present at all off site activities.

When to call an ambulance if any of the below occur:

It is dictated on a students individual care plan

Students with known medical conditions will have risk assessments and care plan for staff to follow. These will have been written with the school, parents and medical professionals involved with the student. Care plans and risk assessments are made accessible in a folder in the staff room and saved on the boys files on the school database and accessible by all staff. Conditions include epilepsy, diabetes and asthma. A care plan and risk assessment will dictate when to call and ambulance for that individual.

Epilepsy

Should a seizure last longer than 5 minutes, the individual has a second seizure, this is the individuals first seizure or they become injured and ambulance should be called. It is school policy that an ambulance should be called in the event of any seizure.

Severe chest pain

Chest pain indicating a heart attack is often described as a crushing pain accompanied by a general feeling of being unwell, says Mike Knapton. It usually spreads to the jaw or the left arm, but don't

wait for that to happen. Richard Diment, chief executive of the Ambulance Service Association, says: "We would rather attend a false alarm than arrive too late." In some ethnic minorities, heart attacks feel more like indigestion - so call 999 to be safe.

Deep wounds

Sometimes a stab wound is obvious - other times it can be difficult to see. If a victim has been stabbed with a long knife or knitting needle the wound may be small, but they may be bleeding internally. They may be cold, clammy and grey and become confused.

A sudden and severe headache

A headache that comes on "like a thunderclap", particularly at the back of the head, can indicate a stroke or similar condition. Often the victim is still able to call an ambulance for himself, but may soon become confused. A subarachnoid haemorrhage, similar to a stroke, feels like being hit on the back of the head with a baseball bat.

Severe allergic reaction

Reactions that follow eating or touching certain substances, such as peanuts or shellfish, can indicate a serious allergy. Symptoms can include difficulty breathing and swelling of the mouth. The victim often turns bright red.

Severe burns and scalds

Often the severity of a burn or scald is evident from the intensity of the pain. The victim can go into shock and will look cold, clammy and sweaty. Often they will feel sick and become confused. A severe burn is indicated by swelling, and does not have to cover a large area to be a danger.

Heavy blood loss

It is often difficult to know how much blood a person has lost, says Dr Reyes-Hughes. "A little goes a long way." But if an accident victim has blood coming through his clothes, or there is blood on the ground, call an ambulance.

Broken bones

Broken bones do not always puncture the skin, but often the pain is bad enough to know that an ambulance is necessary. Sometimes the break will cause a lump to form under the skin.

Meningitis

A high temperature, drowsiness and a purplish rash, particularly in a baby, are warning signs of meningitis and mean an ambulance is needed. If meningitis is suspected and there is no rash, use your common sense - is the person's level of consciousness decreasing? A rash does not always indicate meningitis. Try pressing it hard with a clear glass - if it is purplish and does not disappear it is likely to indicate meningitis.

Unconsciousness

If a person cannot be roused, he is probably unconscious. Even if you think he's drunk, says Dr Reyes-Hughes, you should call an ambulance - he might deteriorate further. Unconsciousness is also indicative of other conditions, such as diabetic coma, overdose, stroke and head injury.

Suspected stroke

The victim often experiences a sudden, severe headache and may become confused. Their emotional status could change and they may appear miserable or drunk. Speech becomes slurred and movement may be lost down one side, making the limbs floppy. There may be a sudden or gradual loss of consciousness.

A baby or adult turning blue

"If somebody has actually stopped breathing it is obviously a much more acute emergency," says Dr Fred Kavalier, "but turning blue is a good sign it's time to call an ambulance." Turning blue indicates that a person has stopped breathing or is having difficulty breathing, possibly because they are having a severe asthma attack.

Difficulty breathing

Asthma can be a killer. An asthmatic who is not responding to their inhaler, and whose breathing is getting worse, should call an ambulance. "Generally, if breathing difficulties are making it impossible to speak and are not getting any better after five or 10 minutes, call 999," says Dr Kavalier.

Head Injuries

Children frequently sustain minor head injuries. This advice sheet gives details of what symptoms and signs should be looked for in children who have hit their head whilst at school and when medical advice should be sought.

If after a head injury a child remains unconscious or fits an ambulance should be called immediately and the parents contacted. If a child suffers from any of the following symptoms medical advice must be sought and if advised the child should be taken to see either their GP or to A & E/minor injuries by the parents or by school staff.

- Loss of consciousness
- Vomiting
- Sleepiness
- Fits or abnormal limb movements
- Persisting dizziness or difficulty walking
- Strange behaviour or confused speech

Children may appear well immediately after sustaining a head injury but show signs of complications later in the day. School staff must remain vigilant and take the appropriate action if the child develops a problem. It would be advisable for the child to not take part in any contact games or PE following a head injury.

If a child sustains a head injury whilst at school, the following information should be recorded from any witness.

- Was the child behaving in an unusual way before the injury?
- What happened to cause the injury?
- If they fell, how far did they fall?
- What did they hit their head against?
- Did the child lose consciousness? If so, for how long?
- How did they appear afterwards?
- Did they vomit afterwards?
- Was the child observed to have any other problem after the injury?

Regardless of whether the school seek medical advice about the child, this information should be given to parents/carers afterwards. It may be that the child becomes unwell after school and the information will be helpful to parents if they need to see a doctor.

In addition parents will be notified by phone following any minor head injury to their child and invited in to inspect the injury. Each head injury will also be recorded in the accident book and a slip advising of the injury sent home with the child. Both will be completed by the person dealing initially with the accident.

If an accident occurs during break or lunchtime the duty staff must ensure that the class teacher and LSA are aware of the injury.

It is school policy that all accidents & injuries MUST be reported immediately to the Hreadteacher or the Health &Safety Officer

Cardiopulmonary Resuscitation (CPR)

If you are required to perform cardiopulmonary resuscitation (CPR), you should conduct a risk assessment (in the Police this would be a "dynamic risk assessment") and adopt appropriate precautions for infection control.

- In adults, it is recommended that If you are trained to do so, after 30 compressions, provide 2 rescue breaths. Alternate between providing 30 compressions and 2 rescue breaths. If you are unable or unwilling to provide ventilations, give continuous chest compressions. Compression-only CPR may be as effective as combined ventilation and compression in the first few minutes after non-asphyxial arrest (cardiac arrest not due to lack of oxygen). *Resuscitation council adult basic life support guidelines2021* file:///C:/Users/jlovett/Downloads/Adult%20basic%20life%20support%20Guidelines.pdf

Cardiac arrest in children is more likely to be caused by a respiratory problem (asphyxial arrest), therefore chest compressions alone are unlikely to be effective.

If a decision is made to perform mouth-to-mouth ventilation in asphyxial arrest, use a resuscitation face shield where available.

This statement is for anyone who is performing CPR/defibrillation in an out-of-hospital setting. Whenever CPR is carried out, particularly on an unknown victim, there is some risk of cross infection, associated particularly with giving rescue breaths. Normally, this risk is very small and is beset against the inevitability that a person in cardiac arrest will die if no assistance is given.

Paediatric advice

We are aware that paediatric cardiac arrest is unlikely to be caused by a cardiac problem and is more likely to be a respiratory one, making ventilations crucial to the child's chances of survival. However, for those not trained in paediatric resuscitation, the most important thing is to act quickly to ensure the child gets the treatment they need in the critical situation.

For out of hospital cardiac arrest, the importance of calling an ambulance and taking immediate action cannot be stressed highly enough. If a child is not breathing normally and no actions are taken, their heart will stop and full cardiac arrest will occur.

Relevant Documents

1. Health & Safety Policy
2. Staff Handbook
3. Staff Induction Programme
4. The Department for Education guidance (updated 5.4.22) Health and safety: responsibilities and duties for schools https://www.gov.uk/government/publications/health-and-safety-advice-for-schools/responsibilities-and-duties-for-schools
5. The Health and Safety Executive (sourced April 2022) https://www.hse.gov.uk/pubns/priced/l74.pdf#page=9
6. First aid at work: The Health and Safety (First-Aid) Regulations 1981. Guidance on Regulations L74 https://www.hse.gov.uk/pubns/priced/l74.pdf#page=9
7. Resuscitation Council Guideline 2021 https://www.resus.org.uk/library/2021-resuscitation-guidelines

UPDATE SCHEDULE

Version	Reviewed	Reason for update
V2	April 2019	Transfer to new format and update FA box locations
V3	Nov 2019	Annual Review
V4	May 2020	Covid 19
V4	January 2021	Reviewed by JL/KH
V5	December 2021	Reviewed by JL/KH
V6	April 2022	Reviewed by JL

APPENDIX A

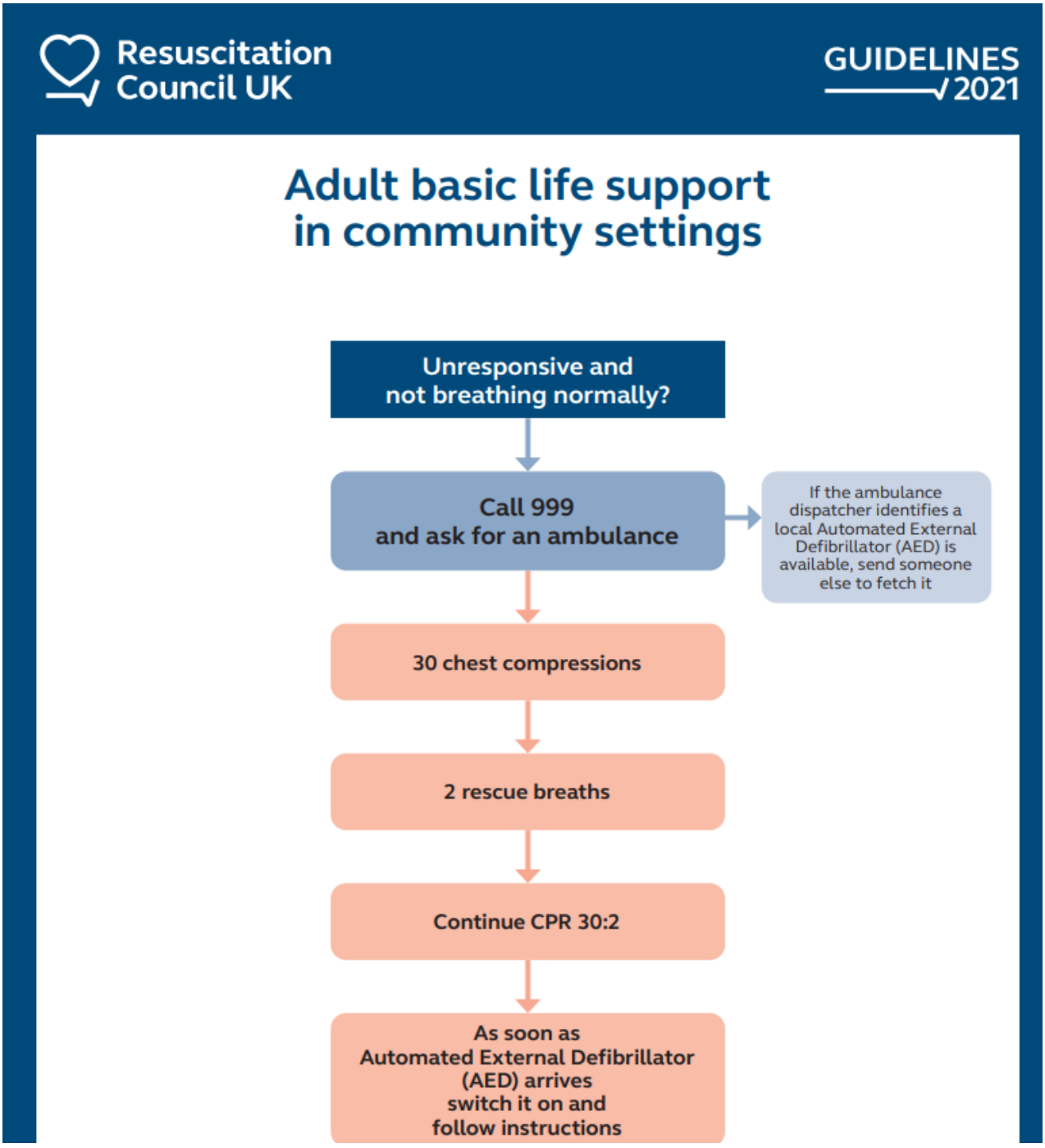
Please note; this is an appendix to FA policy so when updating remember to update FA policy also
Updated 22.04.2022

Name	Title	Expiry Date
Natalie Baker	First Aid at Work	July 2022
Rose Erricker	First Aid at Work	July 2022
Simon Jackson	First Aid at Work	July 2022
Jamie Lovett	First Aid at Work	July 2022
Anne Logan	Outdoor First Aid/Emergency Paediatric & Emergency First Aider	Nov 2024
Jay Abrahams	Emergency First Aider	April 2025
Jennifer Amos	Emergency First Aider	February 2025
Wendy Austin	Emergency First Aider	April 2025
Aaron Beech	Emergency First Aider	April 2025
Karly Belsey	Emergency First aider	April 2025
Kieran Blown	Emergency First Aider	September 2023
Sarah Boost	Emergency First Aider	February 2025
Leanne Britten	Emergency First Aider	February 2025
Mary Brown	Emergency First Aider	September 2023
Katie Buddle	Emergency First Aider	September 2023
Jo Bushell	Emergency First Aider	April 2025
Steve Devereux	Emergency First Aider	April 2025
Elaine Dix	Emergency First Aider	September 2023
Donna Dodd	Emergency First Aider	April 2025
Peter Drew	Emergency First Aider	February 2025
Diana Dunn	Emergency First Aider	April 2025
Darren Elgar	Emergency First Aider	September 2023
Robert Goodfellow	Emergency First Aider	September 2023
Dawn Grinstead	Emergency First Aider	September 2023
Jennie Halpin	Emergency First Aider	April 2025
Sue Heath	Emergency First Aider	September 2023
Harrison Hinkins	Emergency First Aider	April 2025
Amy King	Emergency First Aider	February 2025
Justin Lucock	Emergency First Aider	February 2025
Shona McCormack	Emergency First Aider	February 2025
Jemma McFadyen	Emergency First Aider	September 2023

Ione Marsden	Emergency First Aider	September 2023
Carly May	Emergency First Aider	September 2023
Hayley Morris	Emergency First Aider	April 2025
Andrea Murphy	Emergency First Aider	November 2022
Stephanie Parsons	Emergency First Aider	September 2023
John Phoenix	Emergency First Aider	September 2023
Vivienne Richardson	Emergency First Aider	September 2023
Mark Roberts	Emergency First Aider	April 2025
Steve Sayer	Emergency First Aider	February 2025
Ollie Schofield	Emergency First Aider	September2023
Max Shelton	Emergency First Aider	February 2025
Heather Spalding	Emergency First Aider	January 2025
Laina Spicer	Emergency First Aider	February 2025
Tina Taylor	Emergency First Aider	September 2023
Sinead Varlese	Emergency First Aider	September 2023
Hanna Wilson	Emergency First Aider	February 2025
Michele Wood	Emergency First Aider	September 2023
Vanessa Buckle	Safe Handling of Medication	N/A
Karen Castle	Safe Handling of Medication	N/A
Elaine Dix	Safe Handling of Medication	N/A
Robert Goodfellow	Safe Handling of Medication	N/A
Simon Jackson	Safe Handling of Medication	N/A
Carly May	Safe Handling of Medication	N/A
Jane Norris	Safe Handling of Medication	N/A
Michele Wood	Safe Handling of Medication	N/A
Jemma McFadyen	Safe Handling of Medication	N/A
Hayley Morris	Safe Handling of Medication	N/A
Jamie Lovett	Safe Handling of Medication	N/A
Anne Logan	Safe Handling of Medication	N/A
Peter Drew	Safe Handling of Medication	N/A

LIST IS DISPLAYED IN THE FOLLOWING AREAS:
Reception, building 15, Post 16, Primary School, Admin Office, House Hallway, Kitchen, The Hub, Trade Skills, Med room, Food Tech Rooms, Gym Hallway

FIRST AID LOCATED IN;
Reception, Secondary Class 1 (Art), Secondary Class 5 (Science), Secondary Class 11 (Food Tech), Grab Bag for events and PE (staff room), Trade Skills, The Hub (R1), House med room, polytunnel, primary building middle room on both floors


Resuscitation Council UK
GUIDELINES 2021
Adult basic life support in community settings
Unresponsive and not breathing normally?
Call 999 and ask for an ambulance
If the ambulance dispatcher identifies a local Automated External Defibrillator (AED) is available, send someone else to fetch it
30 chest compressions
2 rescue breaths
Continue CPR 30:2
As soon as Automated External Defibrillator (AED) arrives switch it on and follow instructions

Cardiopulmonary Resuscitation Guidelines – Resuscitation Council UK 2021 - Adult Basic Life Support

How to recognise cardiac arrest - Resuscitation Guidelines 2021

- Start CPR in any unresponsive person with absent or abnormal breathing.
- Slow, laboured breathing (agonal breathing) should be considered a sign of cardiac arrest.
- A short period of seizure-like movements can occur at the start of cardiac arrest. Assess the person after the seizure has stopped: if unresponsive and with absent or abnormal breathing, start CPR.

How to alert the emergency services

Alert the emergency medical services (EMS) immediately by dialling 999 on your phone, if a person is unconscious with absent or abnormal breathing.

- A lone bystander with a mobile phone should dial 999, activate the speaker or another hands-free option on the mobile phone and immediately start CPR assisted by the dispatcher.
- If you are a lone rescuer and you have to leave a victim to ring the ambulance service, alert the ambulance service first and then start CPR.
- Should you not have access to a mobile a staff member or student can be sent to notify reception or the nearest adult to make the call

High-quality chest compressions

- Start chest compressions as soon as possible.
- Deliver compressions on the lower half of the sternum (‘in the centre of the chest’).
- Compress to a depth of at least 5 cm but not more than 6 cm.
- Compress the chest at a rate of 100–120 min^{-1} with as few interruptions as possible.
- Allow the chest to recoil completely after each compression; do not lean on the chest.
- Perform chest compressions on a firm surface whenever feasible.

In adults, it is recommended that If you are trained to do so, after 30 compressions, provide 2 rescue breaths. Alternate between providing 30 compressions and 2 rescue breaths. If you are unable or unwilling to provide ventilations, give continuous chest compressions. Compression-only CPR may be as effective as combined ventilation and compression in the first few minutes after non-asphyxial arrest (cardiac arrest not due to lack of oxygen). Resuscitation council adult basic life support guidelines2021

file:///C:/Users/jlovett/Downloads/Adult%20basic%20life%20support%20Guidelines.pdf

Cardiopulmonary Resuscitation Guidelines – Resuscitation Council UK 2021 - Paediatric Basic Life Support

Those with a duty to respond to paediatric emergencies (usually healthcare professional teams) should use the following sequence:

- Ensure the safety of rescuer and child.
- Check the child's responsiveness:
- Gently stimulate the child and ask loudly, 'Are you alright?'

If the child responds by answering or moving:

- Leave the child in the position in which you find them (provided they are not in further danger).
- Check their condition and get help if needed.
- Reassess the child regularly.

If the child does not respond:

- Shout for help.
- In cases where there is more than one rescuer, a second rescuer should call 999 (outside hospital) to summon emergency medical services (EMS) or call 2222 if in an NHS hospital to summon the clinical emergency team immediately. If calling 999 preferably use the speaker function of a mobile phone.
- Turn the child onto their back and open the airway using head tilt and chin lift:
    - Place your hand on their forehead and gently tilt their head back.
    - With your fingertip(s) under the point of the child's chin, lift the chin. Do not push on the soft tissues under the chin as this may block the airway.
    - If you still have difficulty in opening the airway, try the jaw thrust method: place the first two fingers of each hand behind each side of the child's mandible (jawbone) and push the jaw forward (towards you).
    - Have a low threshold for suspecting injury to the neck. If you suspect this, try to open the airway using jaw thrust alone. If this is unsuccessful, add head tilt gradually until the airway is open. Establishing an open airway takes priority over concerns about the cervical spine.
- Keeping the airway open, look, listen, and feel for abnormal/absent breathing by putting your face close to the child's face and looking along the chest whilst simultaneously looking for signs of life.
- Look for chest movements:

- Listen at the child's nose and mouth for breath sounds.
- Feel for air movement on your cheek.
- In the first few minutes after cardiac arrest a child may be taking infrequent, noisy gasps. Do not confuse this with normal breathing.
- Look, listen, and feel for no more than 10 seconds before deciding – if you have any doubts whether breathing is normal, act as if it is not normal.
- Simultaneously look for signs of life (these include any movement, coughing, or normal breathing).

(Note: Studies have shown how unreliable feeling for a pulse is in determining presence or absence of a circulation even for trained paediatric healthcare workers, hence the importance of the need to look for signs of life. However, if a healthcare worker wishes to also check for a pulse this should be done simultaneously with the breathing assessment).

If the child IS breathing normally:

- Consider turning the child onto their side into the recovery position (see below) or maintain an open airway with head tilt – chin lift or jaw thrust.
- Send or go for help – call the relevant emergency number on your mobile phone where possible. Only leave the child if no other way of obtaining help is possible.
- Check for continued normal breathing.

If the child's breathing is abnormal or absent

- Give 5 initial rescue breaths.
    - Although rescue breaths are described here, it is common in healthcare environments to have access to bag-mask devices and providers trained in their use should use them as soon as they are available. In larger children when BMV is not available, competent providers can also use a pocket mask for rescue breaths.
    - While performing the rescue breaths, note any gag or cough response to your action. These responses, or their absence, will form part of your ongoing assessment of 'signs of life'
- Rescue breaths for an infant:
    - Ensure a neutral position of the head (as an infant's head is usually flexed when supine, this may require some gentle extension) and apply chin lift.
    - Take a breath and cover the mouth and nose of the infant with your mouth, making sure you have a good seal.
    - If the nose and mouth cannot both be covered in the older infant, the rescuer may attempt to seal only the infant's nose or mouth with their mouth (if the nose is used, close the lips to prevent air escape).

- Blow steadily into the infant's mouth and nose over 1 second sufficient to make the chest rise visibly. This is the same time period as in adult practice.
- Maintain head position and chin lift, take your mouth away, and watch for their chest to fall as air comes out.
- Take another breath and repeat this sequence four more times.

- Rescue breaths for a child over 1 year:
  - Ensure head tilt and chin lift; extending the head into 'sniffing' position.
  - Pinch the soft part of the nose closed with the index finger and thumb of your hand on their forehead.
  - Open the mouth a little but maintain the chin lift.
  - Take a breath and place your lips around the mouth, making sure that you have a good seal.
  - Blow steadily into their mouth over 1 second sufficient to make the chest rise visibly.
  - Maintaining head tilt and chin lift, take your mouth away and watch for the chest to fall as air comes out.
  - Take another breath and repeat this sequence four more times.
  - Identify effectiveness by seeing that the child's chest has risen and fallen in a similar fashion to the movement produced by a normal breath.

For both infants and children, if you have difficulty achieving an effective breath, the airway may be obstructed:

- Open the child's mouth and remove any visible obstruction. Do not perform a blind finger sweep.
- Ensure that there is adequate head tilt and chin lift but also that the neck is not over extended; try repositioning the head to open the airway.
- If head tilt and chin lift has not opened the airway, try the jaw thrust method.
- Make up to 5 attempts to achieve effective breaths. If still unsuccessful, move on to chest compressions.

Note:

1. If there is only one rescuer, with a mobile phone, they should call for help (and activate the speaker function) immediately after the initial rescue breaths. Proceed to the next step while waiting for an answer. If no phone is readily available perform one minute of CPR before leaving the child.

2. In cases where paediatric BLS providers are unable or unwilling to start with ventilations, they should proceed with compressions and add ventilations into the sequence when able (another provider, equipment available).

Following the rescue breaths, if you are confident that you can detect signs of life:

- Continue rescue breathing, if necessary, until the child starts breathing effectively on their own.

- Unconscious children and infants who are not in cardiac arrest and clearly have normal breathing, can have their airway kept open by either continued head tilt - chin lift or jaw thrust or, when there is a perceived risk of vomiting, by positioning the unconscious child in a recovery position.

- Re-assess the child frequently.

Following the rescue breaths, if there are no signs of life or if you are unsure:

- Start good quality chest compressions.

    - Rate: 100-120 min^{-1} for both infants and children.

    - Depth: depress the lower half of the sternum by at least one third of the anterior–posterior dimension of the chest (which is approximately 4 cm for an infant and 5 cm for a child).

    - Compressions should never be deeper than the adult 6 cm limit (approx. an adult thumb's length).

    - Release all pressure on the chest between compressions to allow for complete chest recoil and avoid leaning on the chest at the end of a compression.

    - Allow adequate time for chest recoil to occur (approximately 50% of the whole cycle should be the relaxation phase, i.e., from the start of one compression to the next).

    - Chest compression pauses should be minimised so that 80% or more of the CPR cycle is comprised of chest compressions.

- For all children, compress the lower half of the sternum:

    - To avoid compressing the upper abdomen, locate the xiphisternum by finding the angle where the lowest ribs join the sternum (breastbone).

    - Compress the sternum one finger's breadth above this.

    - After each compression, release the pressure completely then repeat at a rate of 100–120 min^{-1}.

    - Allow the chest to return to its resting position before starting the next compression.

    - After 15 compressions, tilt the head, lift the chin, and give rescue breaths.

- Continue compressions and breaths in a ratio of 15:2.
- Perform compressions on a firm surface.
- The best method for compression varies slightly between infants and children.