First Aid Policy

This document applies to all members of staff and pupils of The Pilgrims' School (including EYFS) and includes Governors, Music and Drama Teachers, Volunteers, Parents and Visitors.

Responsibility of: The Head Nurse
Reviewed: October 2025
Next Review Date: October 2026
Approved by Governors: TBC

FIRST AID POLICY
Consent

Parental consent is sought for all pupils for:

a. Delivery of first aid as needed

b. Administering of over-the-counter medications (if required)

c. An anaesthetic in the event of an emergency which requires it.

First aid will be delivered to anyone for whom parental consent has not been obtained (eg visiting sports teams) if judged to be a medical necessity (the Good Samaritan principle). First aid will not be delivered to anyone explicitly refusing to take it.

Staffing

During Term Time the main administrators of first aid in the school will be the nurses, and during Choir time, the administrators of first aid will be the boarding team on duty, with the Head nurse on call for support and advice if needed. There will always be a nurse or boarding team member available on each school site (ie Main School or Q School) when pupils are present. We have a whole school First Aid training every three years, where staff are trained to varying degrees of First Aid from Paediatric First Aid to First Aid at Work and School First Aid. Staff are given a refresher training in Anaphylaxis, Asthma and choking annually at Inset.

Medication

Conditions such as asthma, anaphylaxis and epilepsy may require the delivery of prescribed medications. This is described in more detail in the Healthcare Handbook. A list of pupil medical conditions is maintained and made available to all staff who need to know including catering staff in the case of food allergies.

First Aid Kits

These are stored in locations around the school:

- Each minibus (x5)
- Swimming pool changing room
- Science Prep Room
- Workshop
- Main pavilion on Wolvesey
- Kitchen
- In Pre-prep (dining room and disabled toilet)
- Catering

- Fire station area near Front office
- Eye wash First aid kit in the maintenance area
- Cathedral Song room

There are several fully stocked First aid bags available from the nurses/matrons to be taken on school trips/outings as requested.

All first aid kits are checked and re-stocked every half-term by the school nurse or more frequently if used.

Body spillage kits with written instructions are available from the Medical Hub and the domestic department. Travel body spillage kits are kept in glove box of each minibus. These will be re-stocked by nurses as required.

Defibrillators

The school has 2 defibrillators, one in the Main School reception and one in the main sports pavilion on Wolvesey.

ACTIONS TO BE TAKEN

If a person is obviously extremely unwell or injured:

- Only move the casualty if in imminent danger otherwise avoid moving until a nurse arrives.
- Stay with the person, deliver first aid as competent (or send another responsible person to get a competent provider)
- Provide reassurance.
- Ring Emergency Services (999) for an Ambulance.
- Ensure child has an appropriate escort and a copy of his health records if possible (accessed in the Hub in the brown Cupboard)
- Inform Duty Staff, a member of SLT, and parents as soon as possible.
- Record the incident on Medical Tracker and on an accident form (see appendix 2) which must be given to the Health and Safety officer at the earliest opportunity. To be included must be the location of the accident, the details of the injury (including specifying left or right side), what first aid has been delivered and any action taken to prevent any further accidents in that location. Serious injuries or accidents caused by the fabric of the school are reportable under RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995). See Appendix 3 for guidelines. Such incidents must be reported at the soonest opportunity to the Health and Safety Officer and Senior Management to inform the Health and Safety Executive through a RIDDOR report. For further information go to www.hse.gov.uk

Calling an Ambulance

Whilst guidance can be provided on when to call an ambulance, each incident will require an element of common sense. As a general guide, if in doubt, call 999. There are some injuries/illnesses which are always best dealt with by the emergency services. These include;

- Serious head injury (involving loss of consciousness or blood or clear liquid coming from ears or signs of concussion ie confusion/reduced consciousness level /visual disturbance/vomiting),
- Obviously fractured bones where moving the casualty will cause pain or further injury
- Heart attack
- Severe bleeding
- A severe allergic reaction
- If child is unwell and poisoning is suspected
- An asthma attack which continues despite delivery of reliever inhaler
- Any person with reduced consciousness level of any cause
- Epileptic fit
- Any fall from height
- Any trauma to the head/neck which results in neck pain
- Any rash in an unwell child that does not blanche with the 'tumbler test' – possible meningitis
- Penetrating eye injuries

Wolvesey Sports Ground (Post code: SO21 9NB) Notice of this postcode is posted in the window of the first Pavillion.

When calling an ambulance to the sports fields be aware that the barrier across College Street will restrict access. A key to open the barrier is available from the Nurses (radio channel 4), Director of Operations and Maintenance staff (via radio channel 9) or Winchester College porters (located in Porters' Lodge, College Street). A person should be posted by the barrier to direct the ambulance crew to the casualty.

If the child is unwell or injured and possibly requires further treatment, but does not need emergency treatment:

- Contact the duty nurse (duty phone 07787807099 radio channel 4 or Hub 01962-857604)
- Outside working hours contact School Nurse, Nicki Beaumont (07709562790) for advice, if required.

OR

- Contact the boy's GP if possible (08.00 - 18.30 hrs). If not, ring the "Out of Hours" GP service on 111 or online 111
- OR
- Ring NHS Direct Tel 111 or go to NHS111 online. The doctor will then advise any further course of action. If the child requires an appointment, they will ring back again with an

appointment venue and time (this has been known to take several hours, therefore it may be worth explaining to the doctor that we are a school with a complex timetable and that it would be greatly appreciated if they could contact us promptly

- Contact parents.

If the child requires Accident & Emergency Treatment or a Doctor's appointment:

- Ensure child has an appropriate escort and a copy of his health records if possible, which can be accessed on Medical Tracker, or paper copies in the health records within the Hub storage cupboards.
- Contact child's parents if local. They may prefer to take the child to A+E or G.P. themselves or may be able to meet and relieve the accompanying staff member.
- Boys must be accompanied by a member of staff and transported to GP/ A&E via taxi if an ambulance is not required. This ensures the staff member can tend to the sick/injured child on the journey. Receipts must be obtained and delivered to the Finance Manager at earliest opportunity. In the unlikely event of no taxis being available, staff will be covered by the school insurance to transport boys in their own vehicle on an emergency/irregular basis only.
- Keep parents informed of their son's condition and treatment.

Accident Reporting

In the event of an accident requiring medical treatment, it is to be recorded in accordance with the Accident Reporting Guidelines at Annex A.

ANNEX A

Accident Reporting Policy and Guidance

The Pilgrims' School Accident Report Form should ideally be filled by two people, although there will be circumstances when this is not achievable. All completed reports are to be sent to the Health and Safety (H&S) Officer AClark@pilgrims-school.co.uk

The accident report should be filled by the Line Manager of the employee who had the accident, or the teacher of the pupil who either witnessed the accident, or had it explained to them in the first instance.

All employee, contractor and visitor accidents must be recorded. The recording of a pupil accident should be a judgement. If the accident is caused by the fabric of the building or the grounds, then it must be recorded. It the accident is part of a curricular activity then it must also be reported. If the accident is whilst the pupil is 'at play' then it will not necessarily need to be reported. Advice can be sort from the Health and Safety Officer on this point. However, non-curricular sporting accidents which are outside the bounds of good play should be reported.

All accident reports must be kept in a confidential manner under the Data Protection Act. Any person filling an accident report should not be privy to other accident reports unless there is a very good reason for them to be seen.

Accident reports must be kept safely for a minimum of three years after the date the form was filled in.

Should the accident constitute a RIDDOR[1] report then please refer the report immediately to the H&S Officer.

For examples of the above please go to http://www.hse.gov.uk/riddor/guidance.htm or contact the school's H&S Officer.

[1] The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 state that certain injuries, diseases or dangerous occurrences must be reported through the Incident Contact Centre. The main requirements for reports to be made are:

- Deaths
- Major Injuries
- Reportable Over 3 day Injuries
- Reportable Diseases
- Reportable Dangerous Occurrences

Accident Report Form

TO BE COMPLETED BY: a) Member of staff in charge of the activity or b) Line Manager and / or the Individual injured (if adult) or c) Other responsible person.

1. Injured Person: **2. Person Filling the Form:**

Name: ……..... Name: …….....

Home Address: Address:
……..... .....
……..... .....
……..... .....

Postcode: ……..... Postcode: ……..

Date of Birth: .....

3. Signature: ……..... Signature: ……

4. Today's date: ……

5. Was the injured person (please circle):

Employee / Pupil / Contractor / Visitor / Other .....(please specify)

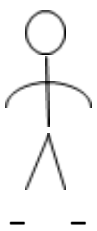
ACCIDENT DETAILS

6. Date of Accident: …… Time of Accident: ……

7. Exact Location of Accident: …….

8. Details of How the Accident/Incident happened and what caused it (if possible):
…….....
…….....
…….....

9. Details of Injury: ……
…….
…….
…….



10. Detail of First Aid Administered: ……
……
……

11. Did the injured person (please circle relevant answer)?

Return to work/class / Go home / Go directly to a doctor's surgery / Go to hospital

Details: ……

12. Was the accident witnessed? Yes / No

Name of Witness: ……

Address of Witness: ……
……
……

Telephone Number .....

13. Is this accident RIDDOR reportable? Yes/No (If in doubt, consult HSO)

Over 3-day injury Yes/No

Attended Hospital Yes/N

14. Please sign and date this form:

Name: ……

Position / Appointment in school: ……
.
Date: ……

This form must now be passed on to the school H&S Officer, in a sealed envelope for reasons of confidentiality, or email to: AClark@Pilgrims-school.co.uk
Data Protection: This information will be used for school statistical purposes though may be passed to the HSE or other statutory body in the event of a serious occurrence.

Annex B: Anaphylaxis and Allergy Policy
(Approved by school doctor)

1.
The Pilgrims' School recognizes that anaphylaxis is **a severe and potentially life-threatening allergic reaction** affecting more than one body system, such as the airways, heart, circulation, gut, and skin. Symptoms can start within seconds or minutes of exposure to the food or allergen and usually will progress rapidly. On rare occasions, there may be a delay in the onset of an allergic reaction by a few hours. There may or may not be skin symptoms. If ONE or more of these signs are present, use the adrenaline auto injector without delay **AND CALL AMBULANCE:**
Signs of anaphylaxis:

A. AIRWAY: persistent cough, hoarse voice, difficulty swallowing, swollen tongue/throat

B. BREATHING: difficulty or noisy breathing, wheeze, or persistent cough

C. CONSCIOUSNESS: persistent dizziness, pale, or floppy, suddenly sleepy, collapse or unconscious.

IF IN DOUBT GIVE AUTO INJECTOR OF ADRENALINE INTO SIDE OF MID-THIGH. If no improvement, use second injector into the opposite thigh

2.
The **common causes of anaphylaxis** include 14 allergens according to the food standard agency. These are: celery, cereals containing gluten (such as wheat, barley and oats) crustaceans (such a prawns, crabs and lobsters) eggs, fish, lupin, milk, molluscs (such a mussels and oysters) mustard, peanuts, sesame, soybeans, super dioxide and sulphites, and tree nuts (such as almonds, hazelnuts, walnuts, brazil nuts, cashews pecans pistachios and macadamia nuts). Non-food causes include wasp or bee stings, natural latex (rubber), and certain drugs such as penicillin. In some people, exercise can trigger a severe reaction – either on its own or in combination with other factors such as food or drugs (e.g. aspirin).
Our aim at The Pilgrims' School is to prevent allergic reactions from happening and treat them successfully if they do occur. We endeavour to provide nut and sesame free food here, and to ensure that all food provided is clearly labelled to prevent allergic reaction. We also do not allow lotions, potions, or medication which may contain nuts or sesame *of any kind* to be stored or given at Pilgrims.'

3.
The Pilgrims' School ensures children at risk of anaphylaxis are included in all aspects of school life by having a clear policy which is understood by school staff and pupils. New staff are also made aware of the policy. Staff are not encouraged to bring food into school, but if they do, the contents must be checked by the Catering managers or the nurses and must be consumed away from the boys. Staff are made aware of this annually at September inset and reminded by email once a term.

4.
All staff who encounter children at risk of anaphylaxis will be provided with training on anaphylaxis and correct use of an Automatic Adrenalin injector from the school nurse, on an annual basis or more often if requested.

5.

Management of children at risk of anaphylaxis

Parents are to notify the school Nurse if their child has an allergy. Any child prescribed with an Adrenaline Automatic Injector (Epipen/Emerade/Jextpen) – an **AAI** – will have an individual management plan agreed and signed by parents, the school Nurse, and GP. There is a list of each boy at risk of **anaphylaxis,** which has his photo ID, Year Group, and allergens. Copies of this list are in the **Hub, Front Office, Staff Room, Dining Room, and Science Lab.** It is the responsibility of the school Nurse to ensure the allergy list is amended, as necessary. **It is the responsibility of the staff to check that a boy at risk of anaphylaxis is carrying his orange bum bag with his adrenaline in it, prior to taking him off the school premises. In Pre-Prep the boys with Anaphylaxis have their bags kept in their classroom and teachers are responsible for accompanying those children wherever they go.**

6.

Tutors of children prescribed with an AAI are individually notified by the School Nurse. Teaching staff are to notify the School Nurse or Matron if a child prescribed with an AAI is leaving the school premises for a school-supervised activity. Kitchen staff have a list of children with food allergies and pictures of children at risk and liaise with the Head Nurse.

7.

The school catering staff will carefully check all food product ingredient lists for nuts, sesame or other known allergens. **No products containing nuts or sesame are permitted in the school**. Parents may not bring in cakes from outside, and if birthday cakes are required these can be ordered from the Catering department in advance and supplied at a cost. Parents are made aware of this each term by school post reminder from the Senior nurse.

8.

Boys with allergies need to collect all their food from the catering staff at the hot plate, where the correct food is checked off the allergy list. This includes pudding/cheese and biscuits. Should a boy wish to have salad he must ask for it so it can be prepared separately from the salad counter. The salad bar is not to be used due to potential cross contamination of allergens eg mustard in some salads.

Allergens in the food for that day will be displayed for the staff and boys at each meal.

Boys at risk of anaphylaxis must take their used plates individually to the trolley; they are not required to stack crockery. Dining-room tables must be thoroughly disinfected after use, and cutlery and crockery cleaned by industrial dishwasher. In the event of dishwasher failure individual disposable plates and cutlery are used

9.

A child with a history of allergy is to notify an adult immediately if he eats or is in contact with something he believes he is allergic to. The adult must stay with the child and send others to inform the School Nurse or Matron, to collect the nearest appropriate emergency adrenaline auto injector, and to inform the Headmaster/SLT via Front Office or to dial the emergency services.

The person administrating care for a boy who is having an allergic reaction would administer antihistamine from his emergency bag in the first instance unless demonstrating any one of the ABC symptoms above which would require immediate Adrenaline injector to be given. Observe the boy

for recovery or deterioration following his anaphylaxis emergency plan. In the event of two adrenaline injectors being required, the opposite leg would be used for the second administration. Nurses need to ensure that boys with anaphylaxis know the procedure above if they feel they are reacting to food given. Nurses need to educate the friends/class of boys with anaphylaxis if age appropriate.

10.
Each boy who needs emergency medication has his own orange bum bag with his individual management plan kept in a clearly named orange bum bag in a named pigeonhole outside washup by the dining room. Pre-Prep bum bags are in the boy's classrooms hanging up by the entrance door of that class. Photo identification of all boys with anaphylaxis are kept in the Hub, Kitchen, Front Office, Staff Room, Dining Room, and Science Lab.

11.
Parents of day boys are responsible for replacing expired or used medication (nurses will alert parents of expiry). The school nurse is responsible for replacing boarders' medication. The Head Nurse sends a letter out to all parents of boys with Anaphylaxis before they start at school, or after anaphylaxis has been diagnosed if the boy is already a pupil. The letter outlines our processes to manage severe allergies at school and on trips/matches. A record of all expiry dates of emergency medicines are kept on Medical Tracker, and on in a folder.

12.
Two generic AAI's (2 x 0.15mg and 1x 0.3mg) will be kept in a pigeonhole in the Boys Hall, and generic EpiPens' are also kept in the Dining Room**.** This is in the event of a child *not* prescribed with an AAI, having an anaphylactic reaction. This may only be given by the school nurse under the direct instruction of Paramedic/Doctor. These generic AAIs may also be taken by the nurses to the fields for matches.

13.
Any boy with anaphylaxis needs to take his orange bum bag to the fields when playing matches, hang it up on the coat hook by the door of the first pavilion, and return it to their pigeonhole near the dining room afterwards. During the holidays when Multisport courses are held, parents are required to provide packed lunches for their boys. The Sports coach and the Head nurse write to parents to remind them not to bring in food which contain specific allergens to that cohort of boys. Any lunches containing allergens are thrown away, and fresh sandwiches provided. Parents are contacted afterwards.

14.
For trips and away matches, please see 22 and 23.

15.
Boys going to Forest School who have allergies are given latex-free gloves to avoid risk of touching hazelnut trees.

16.
Policies and procedures are to be reviewed after a reaction has occurred.

<u>Children with food intolerances and non-anaphylactic allergy</u>

17.
A list of **all boys** with food sensitivities and food allergies of all kinds is collated and updated by the Head Nurse and kept on ISAMS for all to access. The Head nurse ensures that all lists in catering are up to date.

18.
All pupils with food allergies will collect their specially prepared food from the hot trolley where allocated members of the catering staff are available to sign boys off the *daily catering list of boys with allergies*. This includes puddings.

19.
When boys receive treats at events such as Book Club, Set Competitions, Chamber Choir, or concerts, **special consideration needs to be given to all boys with allergies/intolerances**, and an alternative treat should be provided. All ingredients checked by Catering manager. This includes VMT's and external Coaches/ Chorister and Quirister staff.

20.
Staff should educate children with allergies so that they are increasingly able to take responsibility for their allergy and make safe dietary choices. For example, children with allergies are not allowed to exchange food with others. They may not be offered food from the table by staff or boys in case of cross contamination. They must take snacks from the boxes labelled specially for them at snack time, and not from any other snack box or source.

21.
Nurses will also ensure that Games staff know who has food allergies.

22.
When boys leave the site. All boys who are chosen to play in away matches, or who go on trips, are highlighted on a list (or team sheet) by nurses, with allergies noted, and this information is given to the staff member responsible. The teacher in charge is responsible for ensuring the correct equipment, such as AAI's, are taken with the boy, and placed on the hook outside the door of the first pavilion, visible to all. The teacher in charge will instruct relevant boys to collect their diets from the caterers at the away school or site. Teachers/Gaps need to know exactly where each Emergency bum-bag is situated for their team.

23.
Nurses will inform away schools of boys with food allergies when playing away matches and inform our catering department of boys from other schools coming to The Pilgrims' School for match teas who have allergies.

Revised OCTOBER 2025

Nicki Beaumont
Head Nurse

Annex C: Asthma policy

The Pilgrims' School recognises that asthma is an important condition affecting many school children.
The Pilgrims' School encourages children with asthma to achieve their potential in all aspects of school life by having a clear policy which is understood by school staff and pupils. Lists with photos of the boys with Asthma are kept in the Hub, Front Office, and the Staff room kitchen. A boy with Asthma will have this recorded on iSAMS and his asthma plan uploaded onto Medical Tracker.

Management of Asthma
Immediate access to reliever inhalers is vital. Children are encouraged to always carry a blue bum bag in which there is a reliever inhaler and a spacer. Instructions regarding how to manage an asthma attack are kept within the bag.

In accordance with the Asthma UK guidelines issued in September 2014, emergency inhalers with a spacer are available in the Hub, in the Pavilion and in the First Aid kits.

Boys are allowed to see the school Nurse at any time should they feel it is necessary.

Dayboys:
Parents are asked to ensure that the school Nurse is provided with a labelled spare reliever inhaler for dayboys. These will be kept in a locked medicine cabinet in the Hub in case the child's inhaler runs out or is lost or forgotten. All boys are given a blue Bum Bag which contains their inhaler and a spacer. These are kept in the named pigeonhole in the dining room corridor next to the wash-up area and need to be accompany boys taken to sporting events, and trips. Pre-prep Asthma bags are kept in their classroom and accompany them on school trips, Forest schools etc. School staff are not required to administer medication to children except in an emergency, however most of our staff are trained to do this. School staff who do this are insured by the school when acting in accordance with this policy. All school staff will allow children take their own medication when they need to and encouraged to communicate when this occurs to the nurses.

Boarders:
Boarders with asthma are registered with the school Doctor and will each have a personal asthma action plan uploaded to Medical Tracker. The school Nurse can administer medication in accordance with this action plan. New and spare inhalers will be ordered by the school Nurse as necessary and kept in a locked medicine cabinet. Inhaler and peak flow technique will be assessed on a termly basis and further education given where required. Spacers are encouraged when steroid inhalers are given. Main school boarders keep their bum bags in the Hub; Q school boarders keep their bum bags in named pigeonholes near washup in the dining room corridor.

Individual Asthma plans are written for each boarder, and Asthma reviews are done by the school Doctor twice a year. Each boarder with asthma has a weekly peak flow recorded and monitored. Any child who is wheezy, or needs to use their preventative inhaler, is closely monitored. Nurses will listen to their chest for wheeziness, using a stethoscope and either an emergency appointment is made with the GP or School Doctor will see them in his clinic if the delay is minimal. Daily peak flows will be recorded on children who are wheezy, and medication is reviewed and altered in liaison with

the school doctor. Parents will be kept informed if their child is having and difficult time controlling their asthma and outdoor sport needs to be carefully reviewed if the weather is wet and cold.
In an emergency asthma attack a child will be given up to 10 puffs of Ventolin via a spacer. If this does not relieve the child, an ambulance needs to be called and a farther 10 puffs are given.

Record keeping

When a child joins the school, parents are asked if their child has asthma. All parents of dayboys with asthma are sent a letter about the management of Asthma in this school and given a form to complete regarding the medication their child is prescribed. Parents are asked to inform the school Nurse of any alterations in prescriptions. Boarders also have a record kept of their prescribed asthma medications and any changes made to them. This information is kept in the 'Asthma folder' and is available to all staff.

Physical Education

Taking part in sport is an essential part of school life. PE teachers are aware of which children have asthma from a list given to them by the school Nurse. The school Nurse amends the list as necessary. Children with asthma are encouraged to fully participate in PE. Teachers will remind children whose asthma is triggered by exercise to take their reliever inhaler before the lesson and, if a child needs to use their inhaler during a lesson, will be encouraged to do so. Children will be responsible for keeping their reliever inhaler with them.

The School Environment

The school does all that it can to ensure the school environment is favourable to children with asthma. The school has a non-smoking policy.

As far as possible, the school does not use chemicals in science and art lesson that are potential triggers for children with asthma.

Asthma Attacks

All staff who encounter children with asthma know what to do in the event of an asthma attack.

The school adheres to the following procedure, which is clearly displayed in all classrooms, the staff room, the workroom, Q-school, the pavilions and all first aid kits:

Signs of an attack –
Coughing
Shortness of breath
Wheezy breathing
Feeling of tight chest
Being unusually quiet

What to do –
Keep child calm – do not panic
Ensure child has two puffs of reliever (blue) inhaler
Loosen tight clothing
Reassure child

If no immediate improvement –
Continue to give child 2-10 puffs of Salbutamol via a spacer until his symptoms improve. This can be repeated.

Call 999 or a doctor urgently if –
Symptoms do not improve in 5 minutes
Child is too breathless or exhausted to talk
Child's lips are blue
Or if you are in doubt

Reviewed October 2025

Annex D: Pilgrims Policy for Epilepsy

Epilepsy is a condition that affects the brain which causes seizures or fits. Treatment can be given to manage it. Seizures can be varied, from short vacant episodes to full tonic/clonic seizures where consciousness is lost and it much more severe in nature.

Symptoms of epilepsy

Symptoms of epilepsy can include:

- The body becomes floppy or stiff
- Suddenly falling to the floor
- Jerking or twitching movements of the body
- Incontinence
- Losing awareness of surroundings- the patient may stare vacantly into space, not able to respond normally
- Unusual feelings or sensations, such a strange smells, numbness or tingling, changes in vision, or suddenly feeling frightened. This is also known as an Aura.
- Unusual behaviour, such as fidgeting or walking around and not being aware of behaviour.

Seizures may last a few seconds or minutes and stops by itself.
The patient may remember the seizure afterwards or not.
Symptoms of epilepsy often start in young children and people over 50 but can happen at any age.

EPILEPSY – FIRST AID IN THE EVENT OF A SEIZURE

- Stay calm.
- **Note the time seizure starts and stops.**
- If appropriate, put something soft under the head or cradle head in hands and move anything that could injure the patient.
- Loosen tight clothing around neck.
- Only move the person if in a dangerous place – better to move things away if risk of injury.
- Prevent crowding.
- Speak gently and calmly to person.
- Do NOT attempt to restrict or restrain movement. If wandering, guide away from danger
- Do NOT attempt to put anything in their mouth.
- Remain with the patient and send someone else (if available) to inform the school nurse and return to you to tell you they have done so.

Call ambulance if:

- badly injured
- the seizure is a first one
- having trouble breathing

- one seizure immediately follows another.
- **seizure lasts more than 5 minutes.**

Once out of seizure:

- Roll into Recovery position.
- Wipe away excess saliva and, if breathing laboured, check in mouth
- Maintain dignity as much as possible.
- Reassure until fully recovered.
- Do NOT give food or drink until fully alert.
- Record information – time, aura, level of consciousness, colour, actions, length of recovery – **report to nurse Duty phone** 07787807099 or channel 4 on radio
- Allow to rest / sleep after event.
- Inform parents (if no school nurse or matron)

N. Beaumont Head Nurse

Reviewed October 2025

Annex E: Protocol following a Head Injury

Concussion is taken extremely seriously to ensure the safety and the long-term health of pupils at The Pilgrims' School. Although head injuries are most likely to occur during contact sports activities, they can happen at any time; whilst the advice given in this policy is largely associated with sports injuries it is applicable to any head injury.

To summarise this policy:

1. Pupils suspected of having concussion must be removed from playing contact sport **immediately** and must not resume play in the same match until cleared to do so by the school's nursing staff.
2. All pupils suspected of having concussion must be medically assessed.
3. All players suspected of having concussion or diagnosed with concussion must go through a Graduated Return to Activity and protocol (GRAS).
4. Players must receive medical clearance before returning to play.

The following expands on these points above and comes from the recommendations from the Rugby Football Union, which suggest we remember the 4 R's:

1.Recognise the signs and symptoms of concussion:
Concussion should be suspected if one or more of the following visible clues signs symptoms or errors in memory are present.

- Loss of consciousness or unresponsiveness
- Lying motionless on ground/slow to get up.
- Unsteady on feet/Balance problems or falling over.
- Grabbing/clutching of head
- Dazed, blank or vacant look.
- Confused/not aware of plays or events.
- An impact seizure/convulsion
- Tonic posturing-lying rigid/motionless due to muscle spasm (may appear to be unconscious)
- More emotional/irritable than normal for that person
- vomiting

The presence of one or more signs and symptoms of suspected concussion may suggest a concussion:

-loss of consciousness
-seizure or convulsion
-balance problems
-nausea or vomiting
-drowsiness
-more emotional
-sadness
-fatigue or low energy
-nervous or anxious
- "doesn't feel right".
-difficulty remembering
-headache
-dizziness
- confusion
-feeling slowed down
-Blurred vision
- Sensitivity to light
-amnesia
-feeling like "in a fog"
- Neck pain
-Sensitivity to noise
- Difficulty concentrating
-pressure in the head
-concerns expressed by parent, official, spectators about a player

Memory function:
Failure to answer any of these questions correctly may suggest a concussion.
"What venue are we at today?"
"Which half is it now?"
"What team did you play last week/game?"
"Who scored last in this game?"
"Did your team win the last game?"

2.Remove the player from play

Any child suspected of having concussion must be removed from play and not returned to activity until assessed medically for diagnoses and guidance as well as return to play decisions, even if the symptoms resolve.
Continuing to play increases their risk of more severe, longer lasting concussion symptoms, as well as increases their risk of other injury:

- *You should not let them return to play that day.*
- *You should not let them be left alone*
- *You should make sure they are seen by a doctor as soon as possible that day, either at the GP surgery or A&E.*

How is a concussion treated?

- ***In the first 24 hours avoid Ibuprofen or aspirin as these medications may increase the chance of bleeding. Paracetamol/Calpol may be given instead for headaches.***

*Concussion symptoms are made worse by exertion, both physical and mental. The most important treatment for a concussion is **REST:***

- *The child should not exercise or do any activities that may make them worse, like reading, working on the computer or playing video games.*
- *If mental activities (eg: reading, concentrating, using the computer) worsen their symptoms, they may have to stay home from school.*
- *If they go back to activities before they are completely better, they are more likely to get worse, and to have symptoms last longer.*

3. Recover fully before returning to sport

1. Once they are recovered and cleared to do so by a Healthcare professional, they can start a stepwise increase in activities having followed the Graduated Return to Activity and Sport protocol

Red Flags

Red flags In the event of a child displaying any of these symptoms either on the pitch, or within the school, an ambulance needs to be called immediately:

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

4.RETURN to play- When can a concussed child return to contact sport?

It is very important that the child does not go back to rugby or any other contact sport, if they have any concussion symptoms or signs. Return to sport and activity must follow a stepwise Graduated Return to activity and Sport (GRAS)

At The Pilgrims school we follow the GRAS RFU guidelines for this:

-24-48 hours initial relative rest with no screen time

- Light aerobic exercise until day 15 if no symptoms

-Full contact practice earliest from day 15

-Return to play earliest from day 21 if symptom free for 14 days.

At the Pilgrims' School it is Policy for the Parents to take responsibility to obtain medical clearance before returning to play unless the child is boarding, in which case the responsibility for medical clearance is with the school nurses, who will be in communication with the boarder's parents.

Return to sport and activity must follow a step-wise Graduated Return to Activity and Sport Play (GRAS)

At The Pilgrims school we follow the RFU guidelines for this:

Graduated Return to Activity and Sport (GRAS)

Name: ……. Form: ……

Date of Concussion/Head Injury: …… Symptoms: …….

Parent signature: …… Parent name: ……

This protocol applies to all club/school sides that a player belongs to.
Any player must be medically cleared to play if concussion has been noted.
Nurses in the Medical Centre will assess the pupil, and where necessary recommend a further GP/A&E evaluation.

Rehabilitation stage		Exercise allowed	Requirement	Signed by Health Care Professional
1 24-48hrs after concussion	Initial relative rest.	Easy daily activities – light walking only, consider time off or adaptation of study. Continue to rest if activities mildly increase symptoms	Minimum 24 – 48 hours	Signed Date
2 Minimum 24hrs after concussion event	Return to daily activities and light physical exercise.	Increase daily mental activities. Gradually introduce very light physical exercise eg 10 -15 mins walking. Mild symptoms are okay but if worsen during this stage then rest until they subside.	Move on to stage 3 when mild symptoms are not worsened by daily activities/light physical exercise	Signed Date
3	Light aerobic exercise	Increase time that daily activities can be tolerated. Introduce low impact, light physical exercise such as jogging, swimming, 10 – 15 mins max. Increase duration and intensity according to tolerance	Minimum Day 8 before moving onto stage 4 and able to tolerate exercise and daily living activities without more than mild symptoms increasing.	Signed Date
4 (earliest day 8)	Non-contact training drills.	Continue to increase schoolwork and daily activities as tolerated. Return to non-contact training activities. No head impact activities.	If symptoms more than mildly increase stop and rest until they subside.	Signed Date
5 (Earliest Day 15)	Full contact practice	Daily activities and school work should have returned to normal.	Should be symptom Free. If symptoms return, then player needs to go back to stage 4.	Signed

		Return to normal rugby training, including contact. Exposure to activities involving head impacts or risk of should by gradual.		Date
6 Earliest day 21	Return to play.	Return to normal level of activity and return to game/match play	Symptom free for preceding 14 days and continue to be symptom free..	Signed as fit by Date

At the Pilgrims' School it is Policy for the Parents to take responsibility to obtain medical clearance before returning to play unless the child is boarding, in which case the responsibility for medical clearance is with the school nurses, who will be in communication with the boarder's parents.

Nicki Beaumont
Senior Nurse
Reviewed October 2025

Annex F: Protocol for managing Diabetes at The Pilgrims' School

Insulin is a hormone that is made by the pancreas, which is an organ that helps with digestion. But in children with Type 1 diabetes the body has stopped producing it. That is why children with type 1 diabetes need to take insulin whether through injections or an insulin pump. This is a condition which can cause immense stress in a family, as it is a serious life-long condition. It is vital that the school nurses, and the school develop a strong connection of communication with the family of the child, to reassure both parents, and child. Often readings of blood sugars can be monitored directly to a parent's phone, and warnings can be communicated immediately should there be extreme readings, requiring immediate intervention.

Managing a diabetic boy in school would involve looking after the pump, or injections of insulin according to the blood sugar of the child. The nurses need to help the child check their blood sugar. Children with diabetes must be allowed to eat regularly during the day. This may include eating snacks during class-time or prior to exercise. It may be necessary to make special lunchtime arrangements for students with diabetes. If a meal or snack is missed, or after strenuous activity, a hypoglycaemic episode (a hypo) may occur. The symptoms include: - hunger - sweating - drowsiness - pallor - glazed eyes - shaking or trembling - lack of concentration - irritability - headache - mood changes, especially angry or aggressive behaviour. If these symptoms are ignored the student will rapidly progress to loss of consciousness and a hypoglycaemic coma. If a student has a 'hypo,' it is particularly important that they are not left alone and that a fast-acting sugar, such as glucose tablets, a glucose rich gel, or a sugary drink is given immediately. An ambulance must be called if: recovery takes longer than 10 -15minutes or the student becomes unconscious.

Hyperglycaemia (high glucose level) may also be experienced by some students. It is usually slow to develop. Treatment is the administration of insulin. Symptoms include: - a dry skin - a sweet or fruity smell on the breath rather like pear drops or acetone - excessive thirst, hunger, or the passing of urine - deep breathing - fatigue. The diabetes of most children is controlled by an intramuscular pump. Older students may be on multiple injections and others may be controlled on an insulin pump. A child may or may not manage their own injections, so nurses need to help with this, and may need a suitable, private place to administer them. More information may be found, for example from: http://www.diabetes.org.uk/

NBeaumont
Head Nurse
October 2025

Annex G: Protocol: Use of an automated external defibrillator

The school protocol aims to provide clear and simple instructions for the use of the AED provided at the Pilgrims' school for all first aiders in the case of an emergency.

The AED can be found in the front hall by the main entrance, and in the first Pavilion on Wolvesey. It is kept unlocked and accessible for all emergencies. It is kept fully equipped and is checked every 8 weeks by the school nurses. This check is recorded in the medical room in the green folder with First Aid kit log. This can be found in the locked cabinet in the Hub. The staff will be provided 3 yearly training on the AED by a qualified instructor and regular updates/training practice will be available on request.

The school nurse is responsible for the upkeep and maintenance and checking of the school defibrillator.

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

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

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

The Resuscitation Council (UK) recommends strongly a policy of attempting defibrillation with the minimum of delay in victims of VF/VT cardiac arrest. Sequence of actions when using an automated external defibrillator

The following sequence applies to the use of both semi-automatic and automatic AEDs in a victim who is found to be unconscious and not breathing normally:

1. Follow the adult BLS sequence. Do not delay starting CPR unless the AED is available immediately.

2. as soon as the AED arrives:

- If more than one rescuer is present, continue CPR while the AED is switched on. If you are alone, stop CPR and switch on the AED.
- Follow the voice / visual prompts.
- Attach the electrode pads to the patient's bare chest.
- Ensure that nobody touches the victim while the AED is analysing the rhythm.

3A. if a shock is indicated:

- Ensure that nobody touches the victim.
- Push the shock button as directed (fully-automatic AEDs will deliver the shock automatically).
- Continue as directed by the voice / visual prompts.
- Minimise, as far as possible, interruptions in chest compression.

3B. if no shock is indicated:

- Resume CPR immediately using a ratio of 30 compressions to 2 rescue breaths.
- Continue as directed by the voice / visual prompts.

4. Continue to follow the AED prompts until:

- qualified help arrives and takes over OR
- the victim starts to show signs of regaining consciousness, such as coughing, opening his eyes, speaking, or moving purposefully AND starts to breathe normally OR
- You become exhausted.

Placement of AED pads

Place one AED pad to the right of the sternum (breast bone), below the clavicle (collar bone). Place the other pad in the left mid-axillary line, approximately over the position of the V6 ECG electrode. It is important that this pad is placed sufficiently laterally and that it is clear of any breast tissue.

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

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

Defibrillation if the victim is wet

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

Defibrillation in the presence of supplemental oxygen

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

Minimise interruptions in CPR

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

CPR before defibrillation

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

Voice prompts

The sequence of actions and voice prompts provided by an AED are usually programmable and it is recommended that they be set as follows:

- deliver a single shock when a suitable rhythm is detected;
- no rhythm analysis immediately after the shock;
- a voice prompt for resumption of CPR immediately after the shock;
- a period of 2 min of CPR before further rhythm analysis.

Storage and use of AEDs

AEDs should be stored in locations that are immediately accessible to rescuers; they should not be stored in locked cabinets as this may delay deployment. Use of the UK standardised AED sign is encouraged, to highlight the location of an AED. People with no previous training have used AEDs safely and effectively. While it is highly desirable that those who may be called upon to use an AED should be trained in their use, and keep their skills up to date, circumstances can dictate that no trained operator (or a trained operator whose certificate of training has expired) is present at the site of an emergency. Under these circumstances no inhibitions should be placed on any person willing to use an AED.

The AED should be checked by the school nurses on a weekly basis to ensure the AED is in working order. This should include checking the expiry dates for the pads. This should be documented to fit health and safety requirements.

Children

Standard AED pads are suitable for use in children older than 8 years. Special paediatric pads, that attenuate the current delivered during defibrillation, should be used in children aged between 1 and 8 years if they are available; if not, standard adult-sized pads should be used. The use of an AED is not recommended in children aged less than 1 year. However, if an AED is the only defibrillator available its use should be considered (preferably with the paediatric pads described above).

N. Beaumont

Head Nurse

October 2025