OLD BUCKENHAM HALL

Medical Care Policy

(Including OBH's Positive Mental Health Policy)

OBHP22

Date of Issue: October 2018
Reviewed: September 2020
Review Date: September 2021

Medical Care in School

Personnel responsible for Medical Provision: Emma Easdale – RGN

Introduction

This Medical Care Policy addresses the responsibilities of Old Buckenham Hall (OBH / The School) to provide adequate and appropriate medical care to pupils and staff and outlines the procedures and facilities in place to meet that. OBH recognises and values the importance of children's physical and mental health and emotional wellbeing as the foundation to everything else that happens in school. Pupils with disabilities are provided with appropriate care and assistance that promotes dignity and choice.

This is a whole school policy and informs practice in the Early Years Foundation Stage, Pre Prep, After School care in the Pre Prep and the Prep School.

The Policy includes care of those with chronic conditions and disabilities, dealing with medical emergencies and the use of household remedies. It should be read in conjunction with the First Aid Policy (OBHP11) and the Medical Policy Addendum - COVID 19.

The School Nurse is registered with the NMC and is responsible for the medical needs of boarders and day pupils. She holds a daily surgery, dispenses regular medication, administers first aid, presides over sick bay and is available to provide health advice to pupils, staff and parents. She works closely with parents when their child has specific medical needs requiring long term medication and will ensure individual healthcare plans are in place. She is contactable by phone if off site. (07776 691665)

All boarding staff have completed recognised first aid and administering medicines courses. There is medical cover 24 hours a day. A matron or nurse can normally be found around the matron's sitting room or surgery, however, if they have been called away they are required to leave a message on the noticeboard clearly stating their whereabouts. Walkie talkies are available as necessary.

Doctor - The school has a nominated doctor; Dr Mark Hainsworth, a local GP. He visits the school weekly (Monday) and can easily be accessed at other times. When a child becomes a boarder (weekly and full) we recommend that they sign up with the school doctor. Female doctors are available if requested and pupils may also speak to a doctor in private should they wish. During holidays, pupils can be seen as a Temporary Resident with their home GP if necessary.

Dentist - Taking children for routine dental appointments is not the responsibility of OBH School staff, and parents are encouraged to arrange these during the school holidays or at home weekends where possible. If a child needs to see a dentist in an emergency the school will arrange care and the parents will be informed. The school dentist is Bank Buildings, Sudbury. 01787 881100

Optician - As with dental appointments, parents are encouraged to arrange these in the holidays, but in emergency, we use Drage and Tozer in Sudbury. 01787 310090

The school aims to be Nut Free.

Illness During School Time

There are separate sickbays with ensuite facilities, available for both boys and girls. A child who develops a high temperature or has a contagious condition will be isolated in sickbay. Parents will be contacted by phone, and informed of their child's illness, on the same day or as soon as is reasonably practicable. All visits are recorded on iSams. In sickbay

- Cross infection is to be avoided; hence no pupils may visit those in sickbay, should an infectious disease be suspected.
- A nurse, matron or first aider will always be available in the building when sickbay is occupied.
- Pupils in sickbay are provided with a bell to call for help in case they need urgent attention.
- Fresh water is always provided. (unless fluids are restricted.)
- Disposable vomit bowls and tissues are to be provided.
- Frequent hand washing must be undertaken by patients and staff in sickbay.

- Pupils may watch TV for short periods of time only. Reading, playing games and listening to story tapes are encouraged to avoid prolonged TV viewing.
- Food should be regularly offered, considering the pupil's medical condition.
- Parents must be informed where possible if their child is kept in sickbay overnight. Telephone contact between pupils and parents is possible using the surgery telephone, as long as precautions are taken to avoid cross infection.
- Accurate records are kept on iSams.

Pupils with a temperature over 38.0* are to be admitted to sickbay and given an age appropriate dose of Paracetamol or Ibuprofen which will reduce the body temperature as well as relieving aches and symptoms of fever. During the day time the temperature should then be checked 4 - 6 hourly. Fluids must be offered frequently.

In the case of an infectious outbreak (e.g.noravirus) and more beds are required, a dormitory will be converted into a second sickbay.

Parents / guardians are encouraged to take their child home if the illness becomes protracted.

If the number of patients is increasing and the disease is becoming a school epidemic, pupils are to be sent home where possible, to limit the spread of infection. All bedding from sickbay is to be washed on a high heat i.e.: 60 degrees.

Accidents and minor injuries

In the event of an accident requiring first aid, the nurse, matron or a designated first aider is to be found. If the injury warrants an ambulance e.g. a major bleed, a substantial head injury, a person is struggling to breath; this will be called immediately. (See Appendixes for chronic illness and emergency guidelines for sporting injuries and for specific guidance as to when to call an ambulance) A member of staff will always accompany a child to hospital. Parents will be contacted immediately or as soon as is reasonably practicable. All is recorded on iSams.

In EYFS and Pre-Prep - A child who has an accident or minor injury will be seen initially by a member of Pre-Prep staff, trained in Pediatric First Aid. If further advice or treatment is required, they will be seen by the school nurse or matron. They are always accompanied by a Pre-Prep member of staff. After treatment a decision is made as to whom will inform the parents. (i.e. the Pre-Prep member of staff or nurse/matron.) Parents/ guardians will be phoned on the same day or as soon as is reasonably practicable. All is recorded on iSams.

Any serious accident must be recorded in the accident book, located in the surgery. These forms should then be handed to the Bursary. The forms are recorded and the requirements of RIDDOR completed. They are also investigated where necessary and monitored to identify trends. The School Nurse attends termly H&S meetings.

All visits to the surgery are recorded on iSams; including minor accidents (usually those which do not involve external medical intervention) i.e. a cut finger with a plaster applied, a blister, etc

Although the School Nurse should always be the first port of call; first aid kits are available in the staff room, kitchen, bursary and school offices, estates hut, science, DT, art, minibuses and school car, swimming pool, pitchside. First Aid kits are always taken on offsite activities and trips. If personal medication is required, the nurse will train the trip/activity leader and provide written information and instructions. (See Appendix 13 Protocol for Medical Coverage on School Trips)

An automatic external defibrillator located in the inner hall (in the cupboard opposite the reception desk). Approximately 15 members of staff have received AED training.

Confidentiality

All medical information about pupils is confidential, whatever their age. On occasions, it may be necessary for the school doctor and nurse to pass on information to parents, academic and boarding staff where the safety of a pupil or of other pupils might be compromised, or where there is a statutory duty to report. Wherever possible, information is passed on with the pupil's consent.

Both the school doctor and the nurse have professional obligations regarding confidentiality and in accordance with these, medical details about pupils, regardless of age, will, in general, remain confidential. However, we recognise that in providing care we do have to liaise with parents/guardians and staff and pass on information as necessary. Ideally this will be with the pupil's prior consent but there may be rare occasions when the school doctor or nurse considers that it is in the pupil's better interests, or necessary for the protection of the wider School community, to divulge relevant information. There is a statutory duty on professional staff to divulge information where there are child protection issues.

Parental Consent for Medical Care

On entry to the school parents are required to complete a Health Questionnaire outlining significant past medical problems, current ones and present treatment, as well as known allergies and the dates and details of all immunisations. Parents are asked to inform the School Nurse at the start of term or the end of an exeat if their child has received any significant medical treatment or any immunisations whilst at home.

The parent/guardian is also asked to sign a consent form that allows school staff to administer medication, and authorises the school to act in "loco parentis" and give emergency first aid, medical treatment, and obtain dental emergency treatment when required.

Pupils with a specific medical/ health need will have an individual health care plan, prepared by the nurse in conjunction with the parents. These are available on iSams and in the Surgery; copies are also kept in the individual child's medical records. These health care plans will always accompany the child on trips. Any special arrangements or additional staff training for the care of that child will be arranged. (e.g.treating a diabetic hypo, the use of an EpiPen).

Obtaining consent prior to providing treatment is good practice and a legal requirement. While written parental consent is the ideal standard, it should be noted that the law states any child under the age of 16, if thought to be "competent" and "of sufficient understanding and maturity to enable him or her to understand fully what is proposed" may give or withhold consent. (Fraser Competency Guidelines 1986, Gillick Competency)

Pupil Health Records and Record Keeping

Adequate and contemporaneous medical and nursing records are kept in both written and computer form.

Any visit to the school surgery, appointment with a health professional or to hospital is recorded on iSAms.

All dispensed medication is recorded on iSams. A drug stock take is also maintained on iSams.

Any medication given to a day pupil (including Pre-Prep and EYFS children) will be firstly recorded on iSams and then copied onto a medicine slip for the pupil to take home. This prevents parents administering repeat medicine too early.

Individual healthcare plans are written for any pupil with a medical condition or taking regular medication. These are reviewed at least annually, or sooner if care or medication change.

Records are regularly checked and audits run by the nurse and any patterns or concerns highlighted. All records are kept in the school archives until a child is 25, when they will be securely destroyed. Because the requirement to monitor records may occasionally conflict with the nurse's obligation to maintain confidentially; arrangements are available to keep separate records.

Health questionnaires are kept in a locked cupboard in Surgery along with the signed consent forms, and any letters from parents or other health professionals.

Prescribed treatments are dispensed, as per instruction, and recorded on the daily drug chart. The pupil's name, the date and time, the dose, and signature of staff, are recorded.

Medical Alerts
If a child is treated for asthma, epilepsy, anaphylaxis, diabetes or cancer or has a history of significant allergy, it is important that teaching and sports staff are alerted to this. With the parents' consent the diagnosis will appear on a pupil's school electronic record.

With parental permission a list of Pre Prep and Prep School pupils with specific medical conditions are kept in the surgery and every first aid bag. The school kitchen has a copy of children with food allergies. This is updated every term, or more often if necessary.

Mental Health and Emotional Wellbeing (See Positive Mental Health Policy)
The school recognises that emotional wellbeing and good mental health is fundamental to a pupil fulfilling their potential. The school promotes positive emotional wellbeing and resilience through its teaching and learning, assemblies, the PSHE programme, form time, school policies and a general school ethos of staff really knowing each individual pupil. Pastoral care is at the centre of how the school operates; Staff meetings, boarding meetings, observations, informal chats with children, colleagues and parents may all highlight a child struggling or whose behaviour is changing. Early intervention and support, welfare plans, sessions with the school counsellor, referral to the school doctor or to outside agencies are all available as necessary. The School Nurse and Matrons have completed the Mental Health First Aid Course.

Provision for Special Dietary Requirements - The school makes provision for special requirements, whether for medical reasons, e.g. Coeliac disease, or religious reasons. See our Catering Policy for allergen information.

Provision for Disabilities - The school will endeavour to implement plans to meet the needs of a child with disabilities.

Immunisations - Immunisations are given in line with the schedule laid down by the Dept. of Health. Written consent will be sought before each injection.

Off Games Policy

The School Nurse, or a Senior Matron, will decide if a pupil should be "off games". The School Nurse displays a note of "off games" in the staff room. Alternatively, at shorter notice, if she deems a pupil is unfit for a specific activity she will tell the relevant member of staff. The School Nurse will decide when a pupil is fit to resume some or any activities. In Pre Prep and EYFS a parent or a member of staff will decide if a child is fit to play games. All of the above is recorded on iSAms.

First Aid Cover for Matches and Children visiting from other schools

Cover is provided at all home matches by the School Nurse or trained first aiders. When a player is injured the First Aider will decide whether they are fit to continue and must inform the referee of the reason to keep the injured child out of play.

School has a duty of care to all visiting children. First Aid cover is provided at every home fixture or social function for all children on the premises. All details of treatment given to visiting pupils are recorded in the medical book / iSams and communicated to the staff from the schools concerned. Medication is only administered to visiting pupils after authorisation from the member of staff from the visiting school. If an accident form is necessary it will be completed, and a copy will be given to the accompanying member of staff.

Visits, Trips and Residential Outings

OBH School staff in charge of outings are accountable for all children taken out of school and must ensure that risk assessments are complete, and that they liaise with the School Nurse to ensure that all medical needs are considered, and an appropriate first aid kit is taken.

The School Nurse will inform relevant staff and other schools of any significant medical information. Health issues are recorded in iSams and can be used when completing the risk assessment.

The School Nurse or Matron will provide first aid kits for all school trips. (Pre Prep and EYFS will take their own from their staff room.) The nurse will make sure staff supervising the trip are aware of any medical needs, relevant emergency procedures and will provide a copy of any relevant healthcare plans. Arrangements for taking and storing medicines will be made. Adequate medical supplies will be provided, with clear written instructions for administration. Medical contact details will be provided for overnight trips.

It is the responsibility of the member of staff taking the trip to ensure they take any First Aid kit with them. This includes EpiPens, inhalers, etc.

Administration of Medicines

All medication must be licensed for Paediatric use.

Written consent for the administration of all medicines, creams, and first aid treatment is detailed above If parents bring in medicine from home they are also required to sign a consent form.

In cases where parents are unable to give written permission (for example in the middle of the day) and the First Aider and parent agree that to delay medication would be to the detriment of the health or comfort of the child, consent by email will be accepted. A record is made of the conversation and an email must be sent by the parent stating the time of last dose and giving permission to medicate the child.

Receiving, Control and Administration of Medicines

- All medicines must be delivered to the School Nurse or Matron in person by the parent/guardian. No child may bring medication into school. A parent/guardian of a day pupil must fill in a consent form for medicine required during the day. If a child requiring medication comes in by bus, their medicine should be handed to the bus driver, who will then bring it up to surgery on arrival. Consent forms can be found in the surgery, pre prep, school office, and they can also be downloaded from the school website.

- All medicines are kept in a locked cupboard or fridge and administered through the dispensary, except for asthma inhalers, vitamins and epipens. The fridge temperature is recorded daily

- All prescribed medication is to be handed into the matrons/nurse in its original packaging, clearly labelled with the child's name and dosage of the medicine and the frequency of administration. (i.e. in the original container dispensed by a pharmacist.)

- Parents of boarders in the Prep school are not usually informed of homely remedies administered to their child. For day children no analgesia will be given within four hours of the child arriving in school, unless a phone call to the parent has ascertained they have not had any medication earlier in the day.

- A list of pupils' allergies is kept on the door of the dressings cupboard and is checked prior to administration of medication to check for allergies or any parental concerns

- No pupil is allowed to keep medication in their dormitories. The exception to this being Ventolin inhalers and only then, when a pupil has been assessed by the nurse as being capable and fit to self-administer.

- Only designated persons (see list in dispensary) may administer medication, this includes prescribed and non-prescribed medicines. They will have completed a first aid course and received training to dispense.

- When administering prescribed medication, the dispenser will check for the child's name, the prescribed dose, the expiry date and any written instructions provided by the prescriber on the label or container. (A dispensing checklist is displayed on the drug cupboard)

- Prescribed medication is dispensed to children at the times indicated by the doctor, and signed for on the drug chart.

- Medication prescribed for one child is never to be used for another.

- Over the counter (OTC) medicines are stored in a locked cupboard in the dispensary, and administered according to protocol, and recorded on iSams.

- A list of the stock OTC medicines is available.

- Any refusal to take medicines or reactions to medicines will be recorded.

- Medicines will be handed back to parents at the end of term.

- Sharp boxes will always be used to dispose of needles.

- Unfinished and out of date medicines are disposed of through the local pharmacy.

- Any medicine brought in by an overseas pupil must be reviewed by Dr Hainsworth before it can be given. Information must be gained from the parent/guardian as to its use, and if necessary an alternative UK medication can be prescribed.

- Controlled drugs are stored and administered in accordance with the 1973 Misuse of Drugs (Safe Custody) Regulation. (In a separate double locked

cupboard, that only named staff have access to. Separate records of dispensing are kept.)

SELF ADMINISTRATION

Whilst we recognise that children should begin to take responsibility for their own health, it is school policy that all medication is dispensed and supervised through the surgery. Exceptions are only made when it is necessary for a pupil to have access to their medication immediately. (e.g. a Ventolin inhaler)

An asthmatic may carry their inhaler and keep one in their bedside locker after their ability to self-medicate has been assessed by the school nurse. (see self-assessment form) This assessment will ensure the pupil has

1. An adequate understanding of when to take the treatment.
2. Displayed competent inhaler technique.
3. An awareness of when to call for help if symptoms are not improving.
4. An awareness of the importance of keeping medicine safe from other pupils.

PROTOCOL FOR ADMINISTERING HOMELY REMEDIES

Homely remedies may be given providing prior written permission from the parents/guardians exists.

Examples of these medicines include: (see appendix 1 and 2)

- Paracetamol for pain and fever
- Ibuprofen for pain and fever

- Simple linctus for coughs
- Lactulose for constipation
- Sudafed for nasal congestion
- Cinnarizine for travel sickness
- Piriton (chlorphenamine) for allergy
- Citirizine for allergy

When issuing medication, dispensers are to

1. Be aware of the reason for giving the medicine.
2. Check whether the pupil is allergic to any medication.
3. Check whether the pupil has taken any medication recently and, if so, what.
4. Check whether the pupil has taken that medication before and, if so, where they're any problems.
5. Check the expiry date on the container.
6. Record the details – the name of the pupil, the reason for the medication, the name and dose of the medication and the date and time. These must be recorded immediately and signed.
7. If a pupil experiences an adverse reaction to a drug or it is given in error, the drug error procedure will be followed. (Appendix 3)

Monitoring and Review

This Policy will be reviewed annually or when there are changes in legislation.

Bibliography

Supporting pupils at school with medical conditions. Dept. of Ed. Dec 2015
Counselling for Schools: a blueprint for the future Dept. of Ed Feb 2016
Mental Health and Behaviour in Schools Dept. of Ed March 2016
Reasonable Adjustments for Disabled Pupils - guidance from Dept. of Ed April 2015
Guidance on the use of emergency salbutamol inhalers in schools – Dept of Ed 2015
Automated external defibrillators (AEDs) A guide for schools - Dept of Ed Sept 2018

Guidance on the use of adrenaline auto-injectors in schools – Dept of Health 2017

Attachments:

Appendix 1 Homely Remedies
Appendix 2 Analgesia Pain Relief
Appendix 3 Drug Error Procedure
Appendix 4 Dental Policy (MOSA Guidelines)
Appendix 5 Management of Needlestick and Sharps Injuries
Appendix 6 Guidelines for dealing with the Care of an Ill Child and Chronic Illness
Appendix 7 Asthma Policy
Appendix 8 Head Injury
Appendix 9 Diabetes
Appendix 10 Auto Adrenaline Injectors (Epipens, Emerode, Jext)
Appendix 11 Epilepsy
Appendix 12 First Aid: Sports injuries
Appendix 13 Protocol for Medical Coverage on School Trips
Appendix 14 Sickness and Diarrhoea Protocol
Appendix 15 Procedure for cleaning up bodily fluids
Appendix 16 Guidelines on the management of viral outbreaks of Diarrhoea and Vomiting
Appendix 17 Head lice advice
Appendix 18 OBH's Positive Mental Health Policy

HOMELY REMEDIES

NAME OF DRUG	INDICATIONS	CONTRA INDICATIONS	SIDE EFFECTS	DOSAGE
PARACETAMOL	Fever Pain	Allergy Liver Impairment Alcohol Dependence	Rash Liver Damage	<u>Suspension 120mg/5mls</u> 2-4 years 180mg (7.5mls) 4-6 years 240mg (10mls) <u>Suspension 250mg/5mls</u> 6-8 years 250mg (5mls) 8-10 years 375mg (7.5mls) 10-12 years 500mg (10mls) 12-16 years 750mg (15mls) <u>Tablets 500mg</u> 6-12 years 250-500mg 12 -16 years 500mg (1g for acute pain) Adult 500mg-1g Can be given 4-6hrly. Max of 4 doses in 24 hours.
IBUPROFEN	Fever Pain (particularly period pains, and pain associated with inflammation and musculoskeletal disorders.)	Allergy Hx of gastric ulcer Use with care in asthmatics and people taking anti coagulation medication	Gastric upset Haemorrhage	<u>Suspension 100mg/5mls</u> 3-7 years 5mls 8-12 years 10mls <u>Tablets 200mg</u> 12 yrs-adult 200mg-400mg Leave 4hours between doses up to 3 doses in 24 hrs
GLYCERINE, LEMON&HONEY	Dry, Irritating Cough	Diabetes		Under 12years 5mls Over 12 years 10mls

Author: School Nurse
Date of Issue: October 2018
Reviewed: September 2020
Review Date: September 2021

				Up to 4 doses in 24 hours
SUDAFED	Nasal Decongestant	Allergy	Rash Hallucinations (rarely)	2-5 years 2.5mls 6-12 years 5mls 12+ 10mls Can be given 4-6hrly, up to 4 times a day.
PIRITON (chlorphenamine)	Antihistamine (relief of allergy symptoms) Urticaria (allergic rash) 1st line emergency treatment of anaphylaxis	Allergy Epilepsy If on MAOI anti-depressants Porphyria	Drowsiness Gastric disturbances Dry Mouth Tinnitus Headache	Syrup 2mg/5mls 2-6 years 2.5mls 7-12 years 5mls 12+ 10mls 4-6 hourly up to a max of 3 doses. Tablets 4mg 6-12 years ½ tab 4-6 hrly No more than 6 half tabs in 24 hrs. 12- adult 1 tab 4-6hrly No more than 6 tabs in 24 hrs.
STUGERON 15 (cinnarizine 15mg)	Motion Sickness	Allergy Epilepsy Porphyria Parkinson's Disease	Drowsiness Rash	5-12 years 1 tablet 12+ 2 tablets (ideally 2 hours prior to travelling)
CETIRIZINE (zirtek)	Hayfever Allergic Reactions Urticaria	Allergy Renal Impairment Pregnancy Breast Feeding	Headache Dry Mouth Dizziness	Syrup 1mg/ml 2-6 years 5mls once a day 6-adult 10mls once a day Tablets 10mg 6 years-adult 10mg once a day.
VASELINE	Dry skin/Lips			Topical
CETRABAN	Dry skin /Moisturiser	Broken skin		Topical

EURAX	Insect bites, stings	Broken skin		Topical
Hedrin 4% lotion	Head lice	Avoid eyes	For external use only	Follow instructions on bottle

For women of childbearing age remember to consider pregnancy and breast feeding

APPENDIX 2

Analgesia (pain relief)

No aspirin for any children

Paracetamol (Check homely remedy chart for contra indications and dosages.)

- Dulls pain receptors in the brain.
- Should be first choice for fever or pain.
- Best for headaches.
- Has no effect on inflammation.
- Don't give half doses.
- Be aware that other drugs may contain paracetamol. e.g. feminax, nightnurse. CHECK if they have already had paracetamol.

Ibuprofen (Check homely remedy chart for contra indications and dosages.)

- Reduces inflammation and pain.
- Should not be used for asthmatics.
- Do not give for chicken pox
- Can be inter spaced with paracetamol to reduce temperature. (e.g. if fever or pain persist after 1st dose of paracetamol, 2 hours later give ibuprofen, 2 hours later give paracetamol. DO NOT EXCEED MAXIMUM DAILY DOSE.)
- Best for back pain, period pains, sprains, earache, toothache and sunburn.

APPENDIX 3

DRUG ERROR PROCEDURE

If a drug error is made it is your responsibility to ensure the child is safe. Keep him/her under close observation.

- Phone/report it to the School Nurse (currently Emma Easdale 07776 691665
- If you are unable to contact her ring Bildeston Surgery 01449 740254 and speak to the on-call Doctor.
- Clearly and calmly explain the problem and follow his/her advice.
- **If at all worried that the child is in severe danger or there is any loss of consciousness, or severe anaphylaxis ring 999.**
- Inform the Headmaster/Deputy Head
- Record the error in the Accident Book and your subsequent action on iSams.

School Nurse's Responsibilities

- Ensure the child is safe and receiving the correct medical care.
- Consult the Doctor/A&E as necessary.
- Inform the parents.
- Liaise with the Headmaster.
- Keep accurate records.

APPENDIX 4

DENTAL POLICY in line with MOSA Guidelines

It is recommended that both day and boarding pupils should, so far as is possible, continue to receive dental care of a routine nature from their regular dentist during school holidays. This most particularly includes non-urgent orthodontic work.

OBH has a close working relationship with an appropriately qualified Dental Practitioner who is prepared to take on provision of care following dental trauma. Mr Tom Norfolk, Bank Buildings, Sudbury, 01787 881100

OBH promotes a policy of good dental health, including advice concerning the reduction in sugary foods and drinks.

It is recommended that mouthguards should be worn in situations where dental trauma is a possibility. They are a requirement for Rugby, Hockey, and Lacrosse. Mouthguards should be professionally measured and fitted by an appropriately qualified dental practitioner. OPRO visit the school annually.

Standard treatment for broken teeth is to place the fragment piece between the lip and the gum, or if not suitable, in milk and consult a dentist immediately. Where this is not possible contact NHS Direct 111 to find the nearest Accident and Emergency department that has a dentist on call. On no account allow the broken tooth to dry out and do *not* use disinfectant.

If the tooth gets knocked out of mouth completely, the best chance for the tooth is early re-implantation.

- If the tooth is clean, hold it by the white part (the bit that is usually visible) and, making sure it's the right way around, gently push it back into its socket.
- If the tooth is dirty, rinse it in milk or cold water before gently pushing it back into place.
- Hold the tooth in place by biting on a handkerchief and go to the dentist immediately for advice.
- If you cannot re-implant the tooth, follow the instructions as above for broken tooth. Re-implantation is most successful if carried out within 30mins; the chances of success start to fall dramatically after 60mins.

Appendix 5

Management of Sharps and Needlestick Injuries

- Sharps must go in an approved container (BS7320, UN3291)
- Sharps bins are obtained from Command Domestic Services. (Contract cleaning sevices)
- They must be assembled correctly in accordance with the instructions on the bin.
- When the sharps bin is 2/3rds full it must be fully locked and disposed of through Command Domestic Services.

Procedure for Needlestick Injuries

- The injured area should be encouraged to bleed under a running tap and washed with soap and water.
- Seek immediate medical advice from Dr Hainsworth at Bildeston surgery. (01449 740254) or in his absence go to A&E.
- Fill in an accident form.
- Record details on iSams.
- Immunisation against Hepatitis B encouraged

APPENDIX 6

GUIDELINES FOR THE CARE OF AN ILL CHILD AND DEALING WITH CHRONIC ILLNESS

The following guidance is specific to each condition. When followed they represent high standards of care. They are written in line with RCN and NICE guidelines.

The School holds paramount the health of all pupils and has procedures in place designed to ensure we carry out this responsibility pro-actively, promptly, efficiently and sympathetically. The surgery and medical team form an integral part of the School's pastoral care, and the nurse and matronal staff are available at all times to deal with any first aid incidents or sick children.

If a child is ill or has been involved in an accident the Parents/Guardians are informed as soon as practically possible. Contacting the parents of a sick child is the responsibility of the school nurse or senior matron and must not be done by the pupil.

There are policies and guidelines on dispensing medications, looking after chronic illnesses and dealing with medical emergencies. These are all available in the surgery and on the school intranet. The nurse writes individual health care plans for children with health needs.

All matronal staff and first aiders are expected to follow guidelines in The First Aid Manual (10th Edition) endorsed by St John's Ambulance, The Red Cross and St Andrews First Aid. Copies are available in the surgery and Pre Prep.

Minor grazes and cuts are cleaned with water / wipes and where deemed appropriate covered with a plaster.

Where a child presents themselves as unwell, an initial assessment of their condition is made, and they may then be monitored in the surgery for a period of time. If a child is kept upstairs the nurse/matron will inform the school office and write it up on the staff room board.

Where a child is complaining of a headache - encourage fluids, rest, sun hats/screen and fresh air. If the headache persists it may be treated with paracetamol. (if the parents have signed a consent form) Refer to the homely remedies protocol.

Where a pupil is physically sick, the parents are contacted as a matter of course and asked to collect their child. The parents are then asked to keep their child at home for at least 48 hours from the last vomit. If parents are unable to be contacted, or abroad, the pupil will be isolated in sick bay and cared for by the nurse and matronal staff. No child should return to School if they are infectious,

contagious, suffering from any vomiting and/or diarrhoea, their temperature is not normal, or they remain generally medically unfit for School.

Sore throats rarely require antibiotics. (See SIGN/NICE guidelines) Encourage fluids and treat fever (37.5*) and pain with paracetamol. (Refer to the homely remedies protocol) If it persists inform the nurse/doctor.

Burns can be very serious. If the size of the burn is larger than a 50pence coin, the pupil must be seen by a medical professional for advice. Certain chemical burns may seriously irritate or damage the skin. Cool the affected area with cold water until the pain is relieved, may take up to 10 minutes. Cover with a non-adhesive dressing or cling film if skin broken.

Procedure in The Event of An Accident

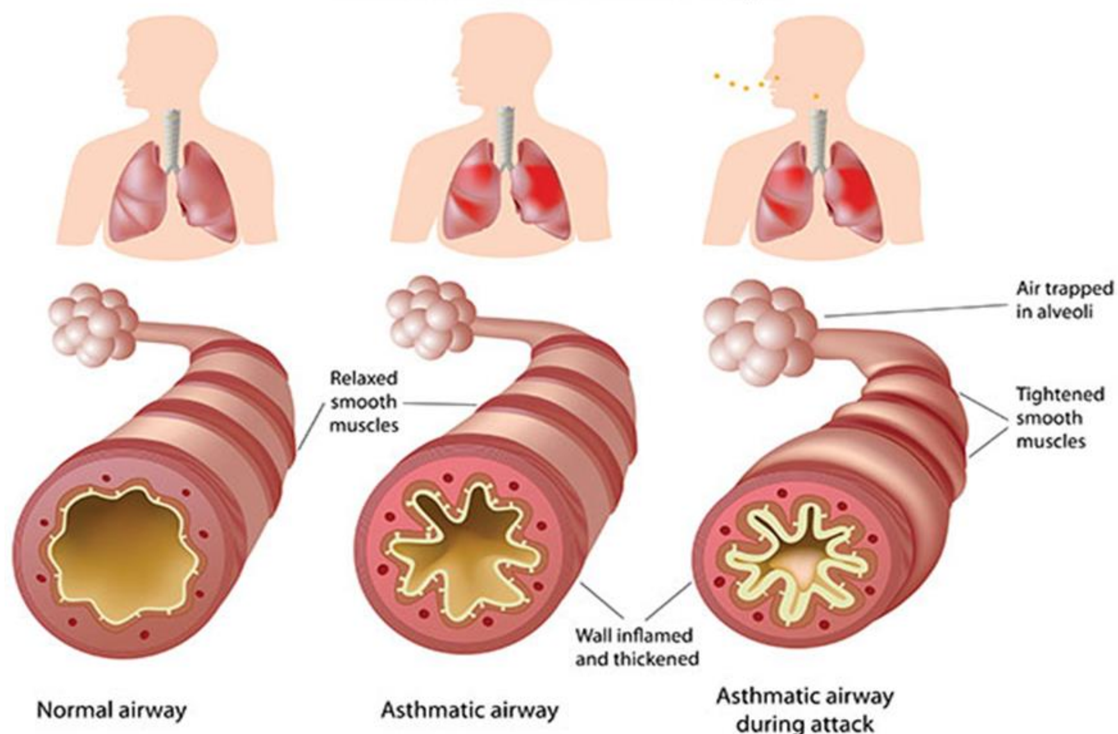
IN ANY LIFE-THREATENING SITUATION AN AMBULANCE SHOULD BE CALLED AT THE EARLIEST OPPORTUNITY WITHOUT WAITING FOR THE FIRST AIDER TO ARRIVE

- A child must find an adult quickly to inform him/her what has happened and where.
- The adult must assess the extent of the injury.
- If the casualty cannot be moved, send a child or another adult to summon the school nurse or matron. Stay with the casualty.
- If the casualty can be moved, he/she should be sent to the nurse accompanied: if serious, by a member of staff, if slight, by a pupil.
- The Nurse or matron will either treat according to protocols and first aid principles or call for an ambulance if more serious.
- An accident report form must be completed.

APPENDIX 7

OBH -Asthma Policy

Asthma is a condition that affects small tubes (airways) that carry air in and out of the lungs. When a person with asthma is exposed to something, that irritates their airways (an asthma trigger), the muscles around the walls of the airways tighten so that the airways become narrower and the lining of the airways becomes inflamed and starts to swell. Sometimes, sticky mucus or phlegm builds up, which can further narrow the airways. These reactions make it difficult to breathe, leading to symptoms of asthma (Source: Asthma UK).



OBH recognise that asthma is a widespread, serious, but controllable condition. We welcome all pupils with asthma and aim to support these children in participating fully in school life. We endeavour to do this by ensuring we have:

- ✓ an asthma register
- ✓ an up-to-date asthma policy,
- ✓ an asthma lead, (currently Emma Easdale)
- ✓ all pupils always have immediate access to their reliever inhaler
- ✓ all pupils have an up-to-date asthma action plan,
- ✓ an emergency salbutamol inhaler
- ✓ ensure all staff have regular asthma training,

- ✓ promote asthma awareness pupils, parents and staff.

Asthma Register
We have an asthma register of children within the school, which we update at least annually, by asking parents/carers if their child is diagnosed as asthmatic or has been prescribed a reliever inhaler a reliever inhaler. We then ensure that the pupil has:

- a personal asthma healthcare plan,
- their reliever (salbutamol/terbutaline) inhaler in school,
- permission from the parents/carers to use the emergency salbutamol inhaler if they require it and their own inhaler is broken, out of date, empty or has been lost. (see back of policy)

Asthma Lead
This school has an asthma lead who is named above. It is the responsibility of the asthma lead to manage the asthma register, update the asthma policy, manage the emergency salbutamol inhalers and ensure measures are in place so that children have immediate access to their inhalers.

Medication and Inhalers
All children with asthma have immediate access to their reliever (usually blue) inhaler at all times. The reliever inhaler is a fast acting medication that opens up the airways and makes it easier for the child to breathe.

Some children will also have a preventer inhaler, which is usually taken morning and night, as prescribed by the doctor/nurse. This medication needs to be taken regularly for maximum benefit.
Children are encouraged to carry their reliever inhaler as soon as they are responsible enough to do so. We would expect this to be by Year 3. We will discuss this with each child's parent/carer and teacher. We recognise that all children may still need supervision in taking their inhaler. A spare reliever inhaler for each child is kept in the pigeonholes in the surgery.
Pre Prep children's reliever inhalers are kept in the staff, with copies of their individual healthcare plans.

Staff training
Staff will have regular asthma updates. This training can be provided by the school nurse or doctor. They are taught how to recognise an asthma attack and how to manage an asthma attack. In addition, guidance will be displayed in the staff room, the surgery, posters around school and the boarding houses.

School Environment
OBH does all that it can to ensure the school environment is favourable to pupils with asthma. OBH has a definitive no-smoking policy. Pupil's asthma triggers will be recorded as part of their asthma action plans and the school will ensure that pupil's will not encounter their triggers, where possible.
Common triggers can include:

- ➢ *Colds and infection*

- *Dust and house dust mite*
- *Pollen, spores and moulds*
- *Feathers*
- *Furry animals*
- *Exercise, laughing*
- *Stress*
- *Cold air, change in the weather*
- *Chemicals, glue, paint, aerosols*
- *Food allergies*
- *Fumes and cigarette smoke (Source: Asthma UK)*

Exercise and activity
Taking part in sports, games and activities is an essential part of school life for all pupils. All staff will know which children in their class have asthma and all PE teachers at the school will be aware of which pupils have asthma from the school's asthma register.
Pupils with asthma are encouraged to participate fully in all activities. PE teachers will remind pupils whose asthma is triggered by exercise to take their reliever inhaler before the lesson, and to thoroughly warm up and down before and after the lesson. It is agreed with PE staff that pupils who are mature enough will carry their inhaler with them and those that are too young will have their inhaler labelled and kept in a box at the site of the lesson (Pre-Prep). If a pupil needs to use their inhaler during a lesson, they will be encouraged to use it.

When asthma is affecting a pupil's education
The school are aware that the aim of asthma medication is to allow people with asthma to live a normal life. Therefore, if we recognise that if asthma is impacting on their life a pupil, and they are unable to take part in activities, tired during the day, or falling behind in lessons the school nurse will discuss this with parents/carers, and suggest they make an appointment with their asthma nurse/doctor. It may simply be that the pupil needs an asthma review, to review inhaler technique, medication review or an updated Personal Asthma Action Plan, to improve their symptoms. OBH recognises that pupils with asthma could be classed as having disability due to their asthma as defined by the Equality Act 2010, and therefore may have additional needs.

Emergency Salbutamol Inhaler in school
OBH is aware of the guidance 'The use of emergency salbutamol inhalers in schools from the Department of Health' (March 2015) which gives guidance on the use of emergency salbutamol inhalers in schools.
The emergency salbutamol inhaler will only be used by children who have been diagnosed with asthma and prescribed a reliever inhaler OR who have been prescribed a reliever inhaler **AND** for whom written parental consent for use of the emergency inhaler has been given.

Common 'day to day' symptoms of asthma
OBH recognises that some of the most common day-to-day symptoms of asthma are:

- Dry cough

- wheeze (a ‘whistle’ heard on breathing out) often when exercising
- Shortness of breath when exposed to a trigger or exercising
- Tight chest

These symptoms are usually responsive to the use of the child’s inhaler and rest (e.g. stopping exercise).

Asthma Attacks

OBH recognises that if all the above is in place, we should be able to support pupils with their asthma and hopefully prevent them from having an asthma attack. However, we are prepared to deal with asthma attacks should they occur.

Signs of an asthma attack are:

- Persistent cough (when at rest)
- A wheezing sound coming from the chest (when at rest)
- Difficulty breathing (the child could be breathing fast and with effort, using all accessory muscles in the upper body)
- Nasal flaring
- Unable to talk or complete sentences. Some children will go very quiet
- May try to tell you that their chest ‘feels tight’ (younger children may express this as tummy ache)

If the child is showing these symptoms we will follow the guidance for responding to an asthma attack recorded below. However, we also recognise that we need to call an ambulance immediately and commence the asthma attack procedure without delay if the child:

- Appears exhausted
- is going blue
- Has a blue/white tinge around lips
- has collapsed

In the event of an asthma attack:

- Keep calm and reassure the child
- Encourage the child to sit up and slightly forward
- Use the child’s own inhaler – if not available, use the emergency inhaler
- Remain with the child while the inhaler and spacer are brought to them
- *Shake the inhaler and remove the cap
- *Place the mouthpiece between the lips with a good deal, or place the mask securely over the nose and mouth
- *Immediately help the child to take two puffs of salbutamol via the spacer, one at a time. (1 puff to 5 breaths)
- If there is no improvement, repeat these steps* up to a maximum of 10 puffs

- Stay calm and reassure the child. Stay with the child until they feel better. The child can return to school activities when they feel better.
- If you have had to treat a child for an asthma attack in school, we will inform the parents/carers.
- If a child has had to use 6 puffs or more in 4 hours the parents should be made aware.
- If the child does not feel better or you are worried at ANYTIME before you have reached 10 puffs, call 999 FOR AN AMBULANCE and call for parents/carers.
- If an ambulance does not arrive in 10 minutes give another 10 puffs in the same way
- A member of staff will always accompany a child taken to hospital by an ambulance and stay with them until a parent or carer arrives

ASTHMA CLINIC PROTOCOL (for Boarders)

Children will be seen at least annually. All asthma care will be in line with the SIGN/BTS, September 2016 guidelines.
Aims of asthma care

- To recognise asthma
- To maintain an asthma register
- To abolish /reduce symptoms and therefore the risks of severe attacks
- To maximise lung function
- To provide ongoing education and support self-management plans

An appointment will include

- A full history of symptoms, trigger factors, previous control.
- Height and weight >optimum PEFR
- PEFR and review of PEFR diary
- Checking appropriate inhaler and inhaler technique
- Treatment plan
- Education (particularly ensuring the pupils recognise a worsening of symptoms and know when to get help)

References

- Asthma UK www.asthma.org.uk
- BTS/SIGN asthma Guidelines 2019
- Department of Health (2014) Guidance on the use of emergency salbutamol inhalers in schools

APPENDIX 8

Head injury

Minor head injury and knocks to the head are common, particularly in children. Following the injury, if the person is conscious (awake), and there is no deep cut or severe head damage, it is unusual for there to be any damage to the brain and one should observe natural recovery.

However, sometimes a knock to the head can cause damage to the brain or to a blood vessel next to the brain. A damaged blood vessel may bleed into the brain, or more commonly, into the area between the brain and the skull (a 'subdural haemorrhage'). This is uncommon but can be serious. Symptoms of damage or bleeding may not develop for some hours, or even days, after a knock to the head. In rare cases, symptoms from a slow bleed can develop even weeks after a head injury.

Concussion is a temporary impairment of brain function usually caused by a blow that has shaken the brain within the skull. If the pupil has been concussed he/she may make a graduated return to sport 14 days after the injury, if they are symptom free. They may not train or play contact sports for a minimum of three weeks in accordance with RFU guidelines.

All head injuries are reported and assessed by the nurse or matron. The pupil is observed for a minimum of 30 minutes to ensure there are no changes in their level of consciousness or behaviour that may indicate concussion or any head injury requiring further investigation by a doctor. The pupil will remain the responsibility of the staff in charge at the time of injury until handed over to the School Nurse or Matron with an explanation of the incident. The parents must be informed as soon as possible.

Details of the accident are recorded on iSams and an accident form completed by the member of staff who reported the incident.

For day pupils a sick bay note is completed and sent home with the pupil at the end of the school day. Head Injury guidelines are also sent home.

Ideally the nurse will speak to the parents; in her absence the form teacher or house parent will give the information. At the end of her shift the nurse/matron will hand over details to the next matron on, concerning any boarders' head injuries. Head Injury guidelines are available in the surgery.

Pupils are assessed by the nurse using the Glasgow Coma Scale, SCAT 5 (sports concussion assessment tool-3) and following NICE guidelines (2016).

Any pupil who has sustained a significant head injury, been concussed or lost consciousness must be seen by a Doctor.

Any Pupils whose has an open wound on the skull must be seen by a Doctor.

Always keep detailed and accurate records.
Fill in the accident book as required.
<u>If in any doubt refer to the school doctor or A&E.</u>

Recognising a serious head injury

Always assume a casualty with a head injury may have a neck injury.
A pupil does not have to be knocked out (lose consciousness) to have had concussion. A pupil who has had a head injury should be closely observed in the surgery for 30minutes.

<u>Observe for the following symptoms</u>

- Increasing drowsiness
- Worsening headache
- Confusion / Slurred speech
- Dizziness / Balance problems
- Nausea / Vomiting
- Visual disturbances
- Blood or clear fluid leaking from the ears or nose.

Any pupil with any of the symptoms above must be assessed by a doctor.

Following a head injury further serious problems can arise over the first 48 hours. If a pupil feels unwell or unusual in the days following a head injury, concussion or a bleed should be considered and medical advice sort.

Observe for

- A drop in academic performance, difficulty with problem solving
- Poor attention and concentration in class
- Unusual irritability /Inappropriate emotions

Unusual drowsiness or sleeping during the day.

Appendix 9

Diabetes Care

OBH supports the main points outlined in the RCN policy document Supporting Diabetes in schools. (2013)

*The needs of the children with diabetes are paramount. *Treatment regimens are led by clinical need. *Children with diabetes have equitable access to all curricular and extra-curricular activities. *Where support is required, training is provided by trained healthcare professionals.

OBH ensures children with diabetes have sufficient support to ensure optimal glycaemic control within the school environment enabling them to meet their full academic capacity.

Management and treatment involves

a) Monitoring of blood glucose levels.
b) Giving medications and supporting changing treatment regimes.
c) Treating emergency situations, such as hypoglycaemia, or illness that affects diabetic control.
d) Access to a healthy, balanced diet.
e) All diabetic children have an individualized healthcare plan formulated with the child, school nurse, diabetes specialist nurse, parents, school doctor. These plans of care should be updated regularly or whenever there is a change in care.

A Healthcare Plan includes

- Blood glucose monitoring.
- Guidance on interpretation of blood glucose results.
- Guidance on the adjustment of insulin.
- Emergency guidelines, Hypoglycaemic and Hyperglycaemia, illness management and treatment plan
- the provision of supplies.
- Sport and exercise management - including off site activities and sport.
- Support with administration of insulin to prevent exclusion.
- Food and dietary management.

Other Matters to consider

- The School Nurse with arrange the storage of insulin and supplies
- Needle stick injury and safe storage of sharps bins. (see appendix 5).
- Staff teaching – the Nurse is responsible for updating as necessary

ALL STAFF should be aware of the symptoms of hypoglycaemia.
• Hunger • Sweating • Drowsiness • Pallor • Glazed eyes • Shaking or trembling • Lack of concentration • Irritability • Headache • Mood changes, especially angry or aggressive

See Pupil's Individual Healthcare plans for treatment regimes.

Appendix 10

USE OF AUTO ADRENALINE INJECTORS (AAIs)

ANAPHYLAXIS IS A SEVERE RECTION TO AN ALLERGEN
AAIs are kept in named pigeon holes in the Surgery. Whenever the pupils leave the school they MUST have their AAI with them. A pupil may carry his own AAI. If a child in the Pre Prep or EYFS has an AAI it is kept in the Pre-Prep staff room.

Pupils with known allergies

- All pupils with a known severe allergy, for which adrenaline has been prescribed, are required to have a named AAI (e.g. Epipen, Jext, Emerode) in school at all times.
- Parents should supply the information to the school on the medical history forms.
- AAIs will be prescribed for the boarders by the school G.P. Day children should ideally provide two AAIs to the school – these are kept in the surgery.
- They must be clearly named and be replaced on expiry.
- A list of all pupils who have been prescribed an AAI is displayed in the surgery, staff room and kitchens.
- Any Staff taking a trip/sports fixture must always collect individual pupils AAIs from the surgery and then return them on arrival back at school.
- Staff are updated regularly on the use of AAIs.

Symptoms of anaphylaxis are:

- Tightening of the throat/difficulty in breathing
- Collapse /loss of consciousness
- Skin redness
- Itchy hives
- Tingling and swelling of hands/feet/eyelids/mouth/lips
- Sense of impending doom

Action (see individual care plan)

- Keep calm and assess the situation
- If able administer anti histamine
- Administer AAI
- Dial 999 and say 'Anaphylaxis'
- Administer second EpiPen dose after 5 – 15 minutes if the patient does not respond.
- Maintain Airway, breathing and circulation. Do not leave unattended

OBH keeps an emergency AAIs in the surgery. It may be used on any pupil who has been prescribed an AAI whose device is unattainable, expired or misfired.

Appendix 11

Epilepsy Care

FIRST AID FOR SEIZURES IS QUITE SIMPLE AND CAN PREVENT A CHILD FROM BEING HARMED DURING A SEIZURE

- A known epileptic, a child will have an individualised care plan.
- There are different types of seizures which need different management.

Tonic – clonic seizure - The person loses consciousness; the body stiffens, then falls to the ground. This is followed by jerking movements. A blue tinge may appear around the mouth. Loss of bladder/bowel movement may occur. After a few minutes the jerking should stop, and consciousness slowly returns.

- Do
    - Call the Nurse for help
    - Protect the person from injury
    - Cushion their head
    - Aid breathing by placing in recovery position once the seizure has finished
    - Be calmly reassuring
    - Stay with the person
- Do not
    - Restrain
    - Put anything in the persons mouth
    - Attempt to move unless in danger
    - Give anything to eat or drink until fully recovered
    - Attempt to bring them round.

Medical Assistance
Call for an ambulance if one seizure follows another, the person is injured, or you feel urgent medical attention is required or if the seizure continues for more than 5 minutes.
Some children have medicine prescribed for this emergency and it can be administered by the nurse according to protocols and the individual healthcare plan.

Absence seizure – presents as daydreaming or switching off in the event of a simple partial seizure which can be twitching, numbness, sweating, dizziness or nausea with visual disturbance, hearing loss, a strong smell or taste or a strong déjà vu.

- Reassure
- Guide from danger
- Be calmly reassuring
- Stay with them until recovered
- Call the Nurse

Appendix 12

Sports Injuries

Follow first aid principles (First Aid Manual: The revised 10th Edition)

General Rules of Treatment for soft tissue injuries (think RICE)

- Rest and Reassurance. (keep pupil warm)
- Use Ice packs and consider analgesia.
- Support (Compression) injuries and Elevate
- Move casualty to the surgery to assess.

Where a suspected broken bone or dislocation has occurred the school nurse should be called to assesses the pupil. If the nurse is absent, she can be contacted on her mobile or a doctor at Bildeston Practice can be called. If in any doubt take the child to A&E. In extreme cases it may be necessary to call for the assistance of ambulance. The parents must be contacted, and the child accompanied to hospital.

Do Not Move

- A fracture or possible fracture of Neck, spine or pelvis.
- A compound or open fracture of the leg (one where the skin is broken, and the bone may be visible.)
- A fracture of any part of the leg with severe deformity.

Call 999 and follow First Aid guidelines.

Procedure for an unconscious casualty

- Clear the airway, check the breathing.
- If not breathing attempt mouth to mouth resuscitation.
- Turn the casualty on to their side (the coma position).
- Follow First Aid guidelines
- Call the Emergency Services.

Procedure for suspected neck and spinal injuries

If injury is suspected: -

- Do not move unless the casualty is in immediate danger
- Call for assistance - help from other members of staff and 999
- Kneel behind the casualty's head and support it in a neutral position. (see first aid manual – 10th edition - for technique)
- Use rolled up clothing/ blankets either side of the head to support it. Hold this steady, neutral position until an ambulance arrives.
- Keep the casualty warm to prevent shock. Reassure constantly.
- Hand over all relevant details to the ambulance staff.

Appendix 13

Medical Coverage Protocol for Pupils on School Trips.

Responsibilities of Teaching Staff

- Staff will familiarise themselves with the First Aid and Medical Care Policy (available on the staff room medical board and electronically on the school website)
- The lead teacher will ensure that there will be qualified first aiders on the trip.
- At least one week in advance of the outing staff:
  - Will familiarise themselves with the pupils' significant medical issues (SMI) and any individual health care plan(s). Information is available on iSams and from the School Nurse. The Healthcare Plans folder can be found in the surgery.
  - Will discuss needs of pupils with the School Nurse including pupils on medication, non-prescription medications & medical supplies that may be needed.
- Will collect the medications/supplies/First Aid kit/trip folder from the School Nurse.
- Will check medications brought in from home on the day of the trip, such as inhalers, are present.
- Will ensure medications are safely stored, administered and are appropriately documented in the trip folder/drug chart.
- Will ensure any accidents are reported to the nurse and recorded on the trip accident form.
- Will ensure they have access to a mobile phone and have the numbers for the direct surgery line 01449 744782 and Emma Easdale (School Nurse/Safeguarding) 07776 691655
- Will return the unused medication and medical supplies to Surgery

Responsibilities of the School Nurse

- Will ensure that Trip Folders, Healthcare Plans and the SMI list are kept up to date
- Will ensure medication and supplies are in date and are ready for collection by teaching staff prior to the trip
- Will ensure First Aid Kits are kept supplied
- Provide drug charts and written policies for all residential trips

AWAY MATCHES RESPONSIBILITIES

Games Coaches

- Staff will familiarise themselves with the First Aid and Medical Care Policy (available on the staff room medical board and electronically on the school website)

- Will familiarise themselves with the pupils' significant medical issues (SMI) and any individual health care plan(s). Information available on iSams and from the School Nurse. Health Care Plans folder can be found in the surgery.
- Will contact the School Nurse if additional information is needed
- Will have a current qualification in First Aid and will be confident in the administration of emergency anaphylaxis and asthma medication
- Will collect a First Aid kit from the staff room
- Will ensure that pupils who have asthma or severe allergies have their medication with them before leaving the school.
- Will document any accidents in the Accident Book (kept in the surgery)
- Will ensure they have access to a mobile phone and the numbers for the direct surgery line 01449 744782 and Emma Easdale (School Nurse/Safeguarding) 07776 691655

The School Nurse

- Will ensure that Health Care Plans and the SMI list are kept up to date
- Will ensure that SMI lists are published as hard copies in the staff room, first aid bags and the surgery for reference.
- Will be available to check and discuss team lists and any relevant SMIs
- Will ensure First Aid Kits are kept supplied
- Will ensure that staff have access to First Aid Training

Appendix 14

SICKNESS AND DIARRHOEA

To minimise the spread of a gastro-intestinal infection in the nursery and school environment we ask you to adhere to the following guidelines issued by PHE (Public Health England)

- If your child has been unwell at home with sickness and/or diarrhoea please keep your child off school for minimum of 48 hours following the last episode of illness.

- If your child is sick and/or has diarrhoea at school we will contact you to collect your child as soon as possible. Your child should then remain off school for a minimum 48 hour period following the last episode of illness.

- When your child returns to school we do ask that they are well enough to be eating their normal diet and do not have a temperature.

Please do not hesitate to contact the School Nurse if you have any queries

Appendix 15

Procedure for cleaning up bodily fluids

To help prevent cross infection the procedure below must be followed when dealing with bodily fluids:

The ‘gelling powder,’ disposable gloves, disposable yellow cloths and anti-bacterial cleaner are stored:

- Surgery - In the first cupboard on the right
- Pre Prep

After putting on gloves:

a) Sprinkle on enough gelling powder to cover liquid only

b) Use dustpan and brush to remove gelled liquid and place into yellow plastic bag

c) Mop up with disposal head mop /clean up using anti-bacterial spray

d) Place mop head, cloth, waste gel, gloves etc. in the yellow plastic bag

e) Put tied yellow plastic bag in clinical waste bin

f) Wash hands with antibacterial hand wash

Appendix 16

GUIDELINES ON THE MANAGEMENT OF VIRAL OUTBREAKS OF DIARRHOEA AND VOMITING.

Defining the start of an outbreak
"An outbreak is defined as having more linked cases, by time and place, with similar symptoms than would normally be expected." If many children/staff are becoming ill within 15-48 hours of being exposed, and in consultation with the school doctor; an outbreak will be declared and PHE (Public Health England) will be informed. The headmaster will be made aware of this decision before PHE is informed.

The end of an outbreak
An outbreak is considered over when there have been no new cases for 72 hours.

The four most important actions during an outbreak of diarrhoea and vomiting are

- Effective hand washing with soap and water. (alcohol sprays are not recommended above hand washing, and should only be used in addition to soap and water on visibly clean hands.)
- Prompt isolation and/ or exclusion of affected children and staff, until 48 hours after the last episode of diarrhoea and/ or vomit.
- Enhanced cleaning of the environment and equipment.
- Control of the source. (if it is food/ water borne)

If a child vomits or has diarrhoea in school, they must be isolated in the surgery and their parents informed. They must remain at home until 48 hours after the last episode. If a child is unable to go home, they will remain isolated and cared for in sick bay. If a member of staff is taken ill, they too must leave the school and remain at home until they have been clear of the symptoms for 48 hours.

Clinical treatment of diarrhoea and vomiting

- The main danger to observe for is dehydration. Ensure fluids are readily available, monitor for signs of dehydration and treat as needed.
- There is no evidence to support the use of antiemetics or antdiarrhoeal drugs.
- Keep the child comfortable and reassure.

School Nurse responsibilities

- To effectively manage an outbreak, ensure prompt use of infection control procedures, and to try to minimize the spread of infection.
- To liaise closely with the school doctor, the Headmaster, the SMTand the HPA.
- To comply with guidance and advice from PHE and provide them with details and numbers as per their action checklist.
- To ensure all staff, children and parents are aware of the outbreak, and how the virus is transmitted.
- To ensure all children in isolation are well cared for.

- To provide verbal and written information for all members of the OBH community.
- To communicate effectively with the kitchen and housekeeping teams.
- To continuously monitor the outbreak and maintain contemporous records.
- To consider the implications of an outbreak on any immuno-compromised staff or children in the OBH community and seek medical advice.

Enhanced cleaning during an outbreak

- Cleaning is the single most important weapon in removing contamination and containing outbreaks.
- Key control measures should include increased frequency of cleaning, environmental disinfection and prompt clearance of soiling caused by vomit or faeces.
- Attention should be paid to shared care areas (dorms, toilets, bathrooms/showers, sickbays), shared equipment (toys, cutlery, water bottles) and frequently touched hard surfaces (door handles, light switches, taps, flush handles, stair rails).
- No linen should be placed on the floor.
- Warm water and disinfectant should be used to clean all surfaces. Disinfectant should be a 0.1% chlorine releasing agent/ hypochlorite solution able to kill viruses and bacteria. (e.g. bleach or Milton). All disinfectants must be used in accordance with the manufacturers' instructions.
- Staff should wear appropriate protective clothing.
- All staff must adhere to the policy for disposal of bodily fluids and wear aprons and gloves for dealing with any vomit or faeces.
- Clean from unaffected areas to affected areas, or if possible, keep separate staff for unaffected and affected areas.
- During an outbreak use disposable cleaning materials including mop heads and cloths. Thoroughly disinfect reusable equipment between uses e.g. mop handles and buckets.
- During an outbreak, enhanced cleaning cover at the weekend needs to be organised.
- Vacuum cleaning carpets and floor buffing have the potential to recirculate viruses during an outbreak and are not recommended.
- Carpets and soft furnishings should be steam cleaned.
- Deep cleaning after an outbreak should include all the above as well as steam cleaning carpets, soft furnishings, curtains and mattresses in all contaminated rooms and areas.
- Beds sides, mattress covers (if applicable) and bedside tables should be wiped down with 0.1% bleach/hypochlorite solution. All linen must be cleaned - including cotton mattress covers.

Matrons responsibilities

- To care for children in sickbay in the absence of the nurse.
- To adhere to all guidelines and procedures re infection control, diarrhoea and vomiting guidelines and disposal of bodily fluids.

- To only use sick bay linen in the sickbay - do not move the child's own into sickbay.
- When a child has recovered - wipe down the bed, mattress cover and bedside table with 0.1% bleach/hypochlorite solution. All linen must be cleaned - including cotton mattress covers and pyjamas.
- No linen on the floor.
- Wear aprons and gloves for dealing with all bodily fluids.

Kitchen Responsibilities

- The kitchen will maintain scrupulously high hygiene standards.
- Follow any specific guidelines from PHE.
- Be aware that staff must stay off work at the first sign of any symptoms.
- No food served on communal sharing plates.

Laundry Responsibilities

- Soiled linen should never be placed on the floor.
- Manual soaking/sluicing/handwashing of contaminated items must **not** happen.
- All contaminated linen/clothing should be placed in red, soluble alginate bags and washed separately using the highest temperature possible. (preferably in a cycle that reaches 65*C for a least 10 mins or 71*C for at least 3 minutes.)
- Laundry staff should wear gloves and aprons when handling contaminated clothes and linen.

Pre Prep Responsibilities

- During an outbreak, limit the number of toys/equipment, and if possible stick to hard/plastic toys.
- Ensure regular cleaning of these toys with Milton or bleach.
- Cookery, sand play, playdough and water play should be suspended during an outbreak.

School Office Responsibilities

- During an outbreak the school office will provide the school nurse with the number of absences each morning.

Miscellaneous

- Children will be regularly reminded to wash their hands with soap and water. (assemblies, form time, etc.)
- Planned events should be discussed with the school medical team, SMT and PHE as to whether it is safe for them to go ahead, or if precautions are needed. (e.g. matches, trips, trial days)

Sources: Guidelines on Prevention and Management of Probable/ Confirmed Viral Outbreaks of Diarrhoea and Vomiting in Care Homes, Schools, Nurseries and other Childcare Settings -HPA, August 2012
Guidelines for the Management of Norovirus Outbreaks in Acute, Community Health and Social Care Settings - Norovirus Working Party (an equal partnership of professional organisations) March 2012

Appendix 17

Head Lice Policy

- Weekly and Full boarders are checked regularly (alternate Monday evenings) for headlice by wet combing.

- We ask parents of day pupils and any child not in on a Monday night, to check their children weekly at home.
- The best way to prevent headlice is to regularly check and comb through with a fine toothed comb. (e.g. nitty gritty comb).
- If an infestation of live lice or nits (the eggs of lice) is found it is treated with “hedrin” shampoo
- The application is repeated 7 days later.
- Parents and guardians will be informed.

OBH’s Positive Mental Health Policy

Policy Statement

Mental health is a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to her or his community. (World Health Organization)

OBH believes that with good mental health, children and young people do better in every way. They are happier in their families, are able to learn better, do better at school, and enjoy friendships and new experiences. The culture of the school is one that encourages and reinforces acceptance, understanding, and celebrates difference. As such, the emotional health and well-being of pupils and staff is of great importance to the school.

Childhood and teenage years are when mental health is developed, and patterns are set for the future, so a child with good mental health is much more likely to have good mental health as an adult, able to take on adult responsibilities and fulfil their potential. It is important to be able to recognise signs of poor emotional health, to be able to offer support but to know when to refer a child for professional help

This policy details the procedure that will be followed to assist pupils and/or staff who are suffering with poor emotional health. The terms “emotional health” and “mental health” are used interchangeably.

This policy should be read in conjunction with our medical care policy, anti - bullying policy, safeguarding policy, the PSHE policy and the SEND policy.

The Policy Aims to:

- Promote positive mental health in all staff and pupils
- Increase understanding and awareness of common mental health issues
- Alert staff to early warning signs of mental ill health
- Provide support to staff working with young people with mental health issues
- Provide support to pupils suffering mental ill health and their peers and parents or carers

Lead Member of Staff

Whilst all staff have a responsibility to promote the positive mental and emotional health of pupils, Emma Easdale, our school nurse and DSL is the primary contact.

Any member of staff who is concerned about the mental health or wellbeing of a pupil should speak to Emma Easdale in the first instance. If there is a fear that the student is in danger of immediate harm then the normal child protection procedures should be followed with an immediate referral to the DSL, the Headmaster or the designated governor. If the student presents as a medical emergency, the normal procedures for medical emergencies should be followed and emergency services should be called if necessary.

Where a referral to CAMHS is appropriate, this will be led and managed by Emma Easdale and the School Doctor.

Pastoral support and provision

Assessing, recording and reporting of children and young people's achievement - The assessment, reporting and recording systems within the school are rigorous, realistic and relevant to children and young people. The achievement of all children and young people is celebrated. Each child's positive contribution to the school community is praised and encouraged. More details can be found in the School's policies on rewards and sanctions. Pupils have access to a very wide range of activities across sporting, academic, musical and other creative subjects. Allowing each child to find their "thing".

Form teachers/tutors – Form teachers / tutors have daily contact with the children and are available to talk with pupils about any personal or social problems they may have. Daily staff briefings, at break time, allow any member of staff to raise any concerns.

The Boarding Team – which includes Houseparents, Matrons, and the School Nurse meets weekly and discusses any children of concern.

Giving children and young people a voice - Children and young people share responsibility in decision making within the school and are able to identify their contribution to school improvement via the School Council, Boarding House meetings and the annual pupil questionnaire.

Communication with home - Children have access to a telephone to call home, with permission, at any time. Overseas Boarders can Skype their parents. Parents are welcomed into the school for matches, Sunday services, concerts, plays, etc.

Peer Guides – All children new to the school or the boarding environment are given a named guide to help them settle in. The induction programme and buddying scheme is in place to help new boarders adjust to their new environment.

The School Nurse – has an open door policy and is available for advice and confidential consultations (Any concerns about specific pupils should be promptly reported to the nurse who, along with other key members of the pastoral team will draw up an Individual Welfare Plan.)

School Counsellor – The school counsellor visits weekly. Pupils can self-refer, or are referred by the school medical team after consultation with parents.

The Independent Listener is available to all Boarders. He visits the school regularly and their phone number is clearly displayed in the boarding houses.

Risk factors and Warning Signs –see appendix 1 & 2

Individual Care Plans

Individual care plan for pupils causing concern or who receive a diagnosis pertaining to their mental health will be compiled. This should be drawn up involving the pupil, the parents and relevant health professionals. This can include:

- Details of a pupil's condition
- Any safeguarding concerns
- Special requirements and precautions
- Medication and any side effects
- What to do and who to contact in an emergency
- The role the school can play
- A time schedule for re-evaluation of the Welfare Plan and assessment of progress

A pupil's dedicated pastoral team may include: their form tutor, the school nurse and/or doctor, houseparent, any member of staff chosen by the pupil as mentor/ key worker.

Teaching about Mental Health

The skills, knowledge and understanding needed by our pupils to keep themselves and others physically and mentally healthy and safe are included as part of our PSHE curriculum.

Managing disclosures

A pupil may choose to disclose concerns about themselves or a friend to any member of staff, so all staff need to know how to respond appropriately to a disclosure.

If a pupil chooses to disclose concerns about their own mental health or that of a friend to a member of staff, the member of staff's response should always be calm, supportive and non-judgmental.
Staff should listen rather than advise and our first thoughts should be of the child's emotional and physical safety rather than of exploring 'Why?'

All disclosures should be recorded in writing and held in the pupil's confidential medical file. This written record should include:

- Date
- The name of the member of staff to whom the disclosure was made
- Main points from the conversation
- Agreed next steps

This information should be shared with the Emma Easdale who will store the record appropriately and offer support and advice about next steps.

Confidentiality and sharing information

Information about the emotional and mental health of children, parents and staff within the School community must always be shared with sensitivity and discretion. We should be honest with regard to the issue of confidentiality and not circulate personal information without the express permission of the individual involved or their parent. If it is necessary for us to pass our concerns about a pupil on, then we should discuss with the pupil:

- Who we are going to talk to
- What we are going to tell them
- Why we need to tell them

Ideally, we would receive their consent, though there are certain situations when information must always be shared with another member of staff and / or a parent. If a child gives us reason to believe that there may be underlying child protection issues the DSL must be informed immediately.

Policy Review

OBH recognises that, even with excellent policies and procedures in place for early identification and appropriate intervention, cases of mental illness may still occur. We are committed to supporting any pupil with such problems This policy will be reviewed every 3 years as a minimum. Additionally, this policy will be reviewed and updated considering personnel changes, legislative changes and as a result of any reflective learning.

Appendix 1: Risk Factors.

There is no easy way of telling whether children will develop mental health problems or not. Some children maintain good mental health despite

traumatic experiences whilst others develop mental health problems even though they live in a safe, secure and caring environment.
There are however some common risk factors that increase the probability that children may develop mental health problems.

- Family breakdown.
- Pressure to have money, the perfect body, the perfect lifestyle. (Consumerism and 24-hour social networking.)
- Educational pressures
- Family history of mental health problems
- Substance abuse, involving themselves or their parents.
- Severe psychological trauma as a child e.g. Physical, emotional or sexual abuse. Witnessing violent or threatening behaviour / domestic violence.
- Neglect.
- Significant early loss of a close family member such as a parent or sibling.
- Significant illness of a close family member
- Inappropriate interest in or display of sexual behaviour for age of the child.
- Dysfunctional family life.
- Separation from parents/family for long periods of time.
- Poor ability to relate to others.
- Brain injury due to trauma or infection.
- Poor self esteem
- Changing school.
- Frequent changes in social circumstances such as moving house and losing contact with friends.
- Unrealistic cultural and educational expectations in academic, sporting and musical achievements.

Appendix 2: Warning signs of deteriorating mental health.

Recognizing symptoms is key. It can be difficult to distinguish between 'normal' problems that all children and adolescents experience from time to time, and behaviour that may be indicative of a mental health disorder.

The following characteristics and behaviours may be signs of an underlying mental health disorder:

- Getting significantly lower marks in school than usual
- Changes in activity and mood
- Avoiding friends and family / isolation
- Having frequent outbursts of anger and rage
- Losing his or her appetite
- Having difficulty sleeping
- Rebelling against authority
- Drinking a lot and/or using drugs
- Worrying constantly
- Experiencing frequent mood swings, feelings of failure
- Not concerned with his or her appearance
- Obsessed with his or her weight
- Lacking energy or motivation
- Hitting or bullying other children
- Attempting to injure him or herself

Children and young people with the most serious mental health disorders (e.g.severe psychosis or schizophrenia) may exhibit:

- Distorted thinking
- Excessive anxiety
- Odd body movements / ticks
- Abnormal mood swings
- Acting overly suspicious of others
- Seeing or hearing things that others don't see or hear

Appendix 3: Further information and sources of support about common mental health issues

Prevalence of Mental Health and Emotional Wellbeing Issues[1]

- 1 in 10 children and young people aged 5 - 16 suffer from a diagnosable mental health disorder - that is around three children in every class.
- Between 1 in every 12 and 1 in 15 children and young people deliberately self-harm.
- There has been a big increase in the number of young people being admitted to hospital because of self-harm. Over the last ten years this figure has increased by 68%.
- More than half of all adults with mental health problems were diagnosed in childhood. Less than half were treated appropriately at the time.
- Nearly 80,000 children and young people suffer from severe depression.
- The number of young people aged 15-16 with depression nearly doubled between the 1980s and the 2000s.
- Over 8,000 children aged under 10 years old suffer from severe depression.
- 3.3% or about 290,000 children and young people have an anxiety disorder.
- 72% of children in care have behavioural or emotional problems - these are some of the most vulnerable people in our society.

Below, we have sign-posted information and guidance about the issues most commonly seen in school-aged children. The links will take you through to the most relevant page of the listed website. Some pages are aimed primarily at parents but they are listed here because we think they are useful for school staff too.

Support on all these issues can be accessed via Young Minds (www.youngminds.org.uk), Mind (www.mind.org.uk) and (for e-learning opportunities) Minded (www.minded.org.uk).

Self-harm

Self-harm describes any behaviour where a young person causes harm to themselves in order to cope with thoughts, feelings or experiences they are not able to manage in any other way. It most frequently takes the form of cutting, burning or non-lethal overdoses in adolescents, while younger children and young people with special needs are more likely to pick or scratch at wounds, pull out their hair or bang or bruise themselves.

Online support

SelfHarm.co.uk: www.selfharm.co.uk
National Self-Harm Network: www.nshn.co.uk

Books

Pooky Knightsmith (2015) *Self-Harm and Eating Disorders in Schools: A Guide to Whole School Support and Practical Strategies*. London: Jessica Kingsley Publishers

[1] Source: Young Minds

Keith Hawton and Karen Rodham (2006) *By Their Own Young Hand: Deliberate Self-harm and Suicidal Ideas in Adolescents*. London: Jessica Kingsley Publishers

Carol Fitzpatrick (2012) *A Short Introduction to Understanding and Supporting Children and Young People Who Self-Harm*. London: Jessica Kingsley Publishers

Depression

Ups and downs are a normal part of life for all of us, but for someone who is suffering from depression these ups and downs may be more extreme. Feelings of failure, hopelessness, numbness or sadness may invade their day-to-day life over an extended period of weeks or months, and have a significant impact on their behaviour and ability and motivation to engage in day-to-day activities.

Online support

Depression Alliance: www.depressionalliance.org/information/what-depression

Books

Christopher Dowrick and Susan Martin (2015) *Can I Tell you about Depression?: A guide for friends, family and professionals*. London: Jessica Kingsley Publishers

Anxiety, panic attacks and phobias

Anxiety can take many forms in children and young people, and it is something that each of us experiences at low levels as part of normal life. When thoughts of anxiety, fear or panic are repeatedly present over several weeks or months and/or they are beginning to impact on a young person's ability to access or enjoy day-to-day life, intervention is needed.

Online support

Anxiety UK: www.anxietyuk.org.uk

Books

Lucy Willetts and Polly Waite (2014) *Can I Tell you about Anxiety?: A guide for friends, family and professionals*. London: Jessica Kingsley Publishers

Carol Fitzpatrick (2015) *A Short Introduction to Helping Young People Manage Anxiety*. London: Jessica Kingsley Publishers

Obsessions and compulsions

Obsessions describe intrusive thoughts or feelings that enter our minds which are disturbing or upsetting; compulsions are the behaviours we carry out in order to manage those thoughts or feelings. For example, a young person may be constantly worried that their house will burn down if they don't turn off all switches before leaving the house. They may respond to these thoughts by repeatedly checking switches, perhaps returning home several times to do so.

Obsessive compulsive disorder (OCD) can take many forms – it is not just about cleaning and checking.

Online support
OCD UK: www.ocduk.org/ocd

Books
Amita Jassi and Sarah Hull (2013) *Can I Tell you about OCD?: A guide for friends, family and professionals*. London: Jessica Kingsley Publishers

Susan Conners (2011) *The Tourette Syndrome & OCD Checklist: A practical reference for parents and teachers*. San Francisco: Jossey-Bass

Suicidal feelings

Young people may experience complicated thoughts and feelings about wanting to end their own lives. Some young people never act on these feelings though they may openly discuss and explore them, while other young people die suddenly from suicide apparently out of the blue.

Online support
Prevention of young suicide UK – PAPYRUS: www.papyrus-uk.org

On the edge: ChildLine spotlight report on suicide: www.nspcc.org.uk/preventing-abuse/research-and-resources/on-the-edge-childline-spotlight/

Books
Keith Hawton and Karen Rodham (2006) *By Their Own Young Hand: Deliberate Self-harm and Suicidal Ideas in Adolescents*. London: Jessica Kingsley Publishers

Terri A. Erbacher, Jonathan B. Singer and Scott Poland (2015) *Suicide in Schools: A Practitioner's Guide to Multi-level Prevention, Assessment, Intervention, and Postvention*. New York: Routledge

Eating problems

Food, weight and shape may be used as a way of coping with, or communicating about, difficult thoughts, feelings and behaviours that a young person experiences day to day. Some young people develop eating disorders such as anorexia (where food intake is restricted), binge eating disorder and bulimia nervosa (a cycle of bingeing and purging). Other young people, particularly those of primary or preschool age, may develop problematic behaviours around food including refusing to eat in certain situations or with certain people. This can be a way of communicating messages the child does not have the words to convey.

Online support
Beat – the eating disorders charity: www.b-eat.co.uk/about-eating-disorders

Eating Difficulties in Younger Children and when to worry: www.inourhands.com/eating-difficulties-in-younger-children

Books

Bryan Lask and Lucy Watson (2014) *Can I tell you about Eating Disorders?: A Guide for Friends, Family and Professionals*. London: Jessica Kingsley Publishers

Pooky Knightsmith (2015) *Self-Harm and Eating Disorders in Schools: A Guide to Whole School Support and Practical Strategies*. London: Jessica Kingsley Publishers

Pooky Knightsmith (2012) *Eating Disorders Pocketbook*. Teachers' Pocketbooks

Appendix 4: Guidance and advice documents

Mental health and behaviour in schools - departmental advice for school staff. Department for Education (2015)

Counselling in schools: a blueprint for the future - departmental advice for school staff and counsellors. Department for Education (2015)

Teacher Guidance: Preparing to teach about mental health and emotional wellbeing (2015). PSHE Association. Funded by the Department for Education (2015)

Keeping children safe in education - statutory guidance for schools and colleges. Department for Education (2016)

Supporting pupils at school with medical conditions - statutory guidance for governing bodies of maintained schools and proprietors of academies in England. Department for Education (2014)

Healthy child programme from 5 to 19 years old is a recommended framework of universal and progressive services for children and young people to promote optimal health and wellbeing. Department of Health (2009)

Future in mind – promoting, protecting and improving our children and young people's mental health and wellbeing - a report produced by the Children and Young People's Mental Health and Wellbeing Taskforce to examine how to improve mental health services for children and young people. Department of Health (2015)

What works in promoting social and emotional wellbeing and responding to mental health problems in schools? Advice for schools and framework document written by Professor Katherine Weare. National Children's Bureau (2015)

Appendix 5: Talking to students when they make mental health disclosures - **from Charlie Waller Memorial Trust (www.cwmt.org.uk)**

The advice below is from students themselves, in their own words, together with some additional ideas to help you in initial conversations

with students when they disclose mental health concerns. This advice should be considered alongside relevant school policies on pastoral care and child protection and discussed with relevant colleagues as appropriate.

Focus on listening

> *"She listened, and I mean REALLY listened. She didn't interrupt me or ask me to explain myself or anything, she just let me talk and talk and talk. I had been unsure about talking to anyone, but I knew quite quickly that I'd chosen the right person to talk to and that it would be a turning point."*

If a student has come to you, it's because they trust you and feel a need to share their difficulties with someone. Let them talk. Ask occasional open questions if you need to in order to encourage them to keep exploring their feelings and opening up to you. Just letting them pour out what they're thinking will make a huge difference and marks a huge first step in recovery. Up until now they may not have admitted even to themselves that there is a problem.

Don't talk too much

> *"Sometimes it's hard to explain what's going on in my head – it doesn't make a lot of sense and I've kind of gotten used to keeping myself to myself. But just 'cos I'm struggling to find the right words doesn't mean you should help me. Just keep quiet, I'll get there in the end."*

The student should be talking at least three quarters of the time. If that's not the case, then you need to redress the balance. You are here to listen, not to talk. Sometimes the conversation may lapse into silence. Try not to give in to the urge to fill the gap, but rather wait until the student does so. This can often lead to them exploring their feelings more deeply. Of course, you should interject occasionally, perhaps with questions to the student to explore certain topics they've touched on more deeply, or to show that you understand and are supportive. Don't feel an urge to over-analyse the situation or try to offer answers. This all comes later. For now, your role is simply one of supportive listener. So, make sure you're listening!

Don't pretend to understand

> *"I think that all teachers got taught on some course somewhere to say, 'I understand how that must feel' the moment you open up. YOU DON'T – don't even pretend to, it's not helpful, it's insulting."*

The concept of a mental health difficulty such as an eating disorder or obsessive compulsive disorder (OCD) can seem completely alien if you've never experienced these difficulties first hand. You may find yourself wondering why on earth someone would do these things to themselves, but don't explore those feelings with the sufferer. Instead listen hard to what they're saying and encourage them to talk and you'll slowly start to understand what steps they might be ready to take in order to start making some changes.

Don't be afraid to make eye contact

> *"She was so disgusted by what I told her that she couldn't bear to look at me."*

It's important to try to maintain a natural level of eye contact (even if you have to think very hard about doing so and it doesn't feel natural to you at all). If you make too much eye contact, the student may interpret this as you staring at them. They may think that you are horrified about what they are saying or think they are a 'freak'. On the other hand, if you don't make eye contact at all then a student may interpret this as you being disgusted by them – to the extent that you can't bring yourself to look at them. Trying to maintain natural eye contact will convey a very positive message to the student.

Offer support

> *"I was worried how she'd react, but my Mum just listened then said, 'How can I support you?' – no one had asked me that before and it made me realise that she cared. Between us we thought of some really practical things she could do to help me stop self-harming."*

Never leave this kind of conversation without agreeing next steps. These will be informed by your conversations with appropriate colleagues and the schools' policies on such issues. Whatever happens, you should have some form of next steps to carry out after the conversation because this will help the student to realise that you're working with them to move things forward.

Acknowledge how hard it is to discuss these issues

> *"Talking about my bingeing for the first time was the hardest thing I ever did. When I was done talking, my teacher looked me in the eye and said, 'That must have been really tough' – he was right, it was, but it meant so much that he realised what a big deal it was for me."*

It can take a young person weeks or even months to admit to themselves they have a problem, themselves, let alone share that with anyone else. If a student chooses to confide in you, you should feel proud and privileged that they have such a high level of trust in you. Acknowledging both how brave they have been, and how glad you are they chose to speak to you, conveys positive messages of support to the student.

Don't assume that an apparently negative response is actually a negative response

> *"The anorexic voice in my head was telling me to push help away so I was saying no. But there was a tiny part of me that wanted to get better. I just couldn't say it out loud or else I'd have to punish myself."*

Even though a student has confided in you, and may even have expressed a desire to get on top of their illness, that doesn't mean they'll readily accept help. The illness may ensure they resist any form of help for as long as they possibly can. Don't be offended or upset if your offers of help are met with anger, indifference or insolence; it's the illness talking, not the student.

Never break your promises

> *"Whatever you say you'll do you have to do or else the trust we've built in you will be smashed to smithereens. And never lie. Just be honest. If you're going to tell someone just be upfront about it, we can handle that, what we can't handle is having our trust broken."*

Above all else, a student wants to know they can trust you. That means if they want you to keep their issues confidential and you can't then you must be honest. Explain that, whilst you can't keep it a secret, you can ensure that it is handled within the school's policy of confidentiality and that only those who need to know about it to help will know about the situation. You can also be honest about the fact you don't have all the answers or aren't exactly sure what will happen next. Consider yourself the student's ally rather than their saviour and think about which next steps you can take together, always ensuring you follow relevant policies.