17. Fist Aid policy/procedure/FAR

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Document Author:	**YMCA Childcare, CB**
Document Approved:	**Paul McDonald**
Person(s) responsible for developing, distributing and reviewing Policy	**Paul McDonald Michelle Cullen**
Person responsible for approving Policy	**Paul McDonald**
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This policy has been communicated to parents/guardians.

Relevant staff know the requirements and have a clear understanding of their roles and responsibilities in relation to this policy.

Relevant staff have received training on this policy.

Statement of Intent: It is our policy to promote the health, wellbeing and personal safety of all our children and staff. Through developing and regularly reviewing accident prevention procedures and fire safety. Although we adhere to all safety precautions and follow TUSLA guidelines, accidents can occur.

Children with additional healthcare needs that need first aid are managed in line with the child's individual care plan.

Roster Requirements for People Trained in First Aid: We aim to follow the roster requirements as outlined by Tusla in relation to the First Aid Responder (FAR) Education and Training Standard established by the Pre-Hospital Emergency Care Council (PHECC).

- The number of people trained in first aid for children (FAR) and available for first aid response is based on the Service's risk assessment including the size of the Service and the hazards identified.
- At least one person is trained in first aid (FAR) and is available to the children while the Service is in operation.
- At least one person trained in first aid (FAR) is available to the children when on outings.
- A list of people trained in first aid (FAR) is available.
- In-date certification for each trained FAR is available.

Emergency Contact Details: Emergency medical assistance contact details are publicly displayed within the Service (Example a local doctor's number or a nearby hospital)

Recording of First Aid Care and Responses Provided: Care given in a first aid situation is documented in line with this policy on accidents and incidents.

First Aid Equipment:

- First Aid boxes are restocked as required by the designated staff member after each use.
- A list of supplies that the first aid box must have is included in the first aid box.

- The first aid box contained appropriate first aid supplies for minor injuries to be treated within the service.
- Medicines, creams and ointments are kept out of reach of children and not stored in the first aid box.

The procedures to have in place in the event of an accident:

- The First Aid box is always fully equipped, easily identifiable and its location is known to all staff, so that it can be accessed following an incident or accident with a child attending the Service. Any substances, which may cause an allergy, will not be included.
- Medical supplies are checked regularly.
- A designated First Aider (certified) is on the premises at all times.
- Staff must wear protective clothing (disposable apron and gloves) to clean any bodily fluids or spillages.
- If a child is involved in an incident or accident, they will be taken into a quiet area, if possible.
- In the case of a serious accident, we have a local doctor on call, they will be called and the child's parents/guardians contacted immediately or we will call an ambulance. If parents cannot be reached, the emergency contact persons (as identified on the Child Registration Form) will be contacted.
- If the child has to go to the hospital immediately, staff will accompany the child, if the ambulance personnel permit. The child's record will be taken to the hospital. Parents/guardians are responsible for all doctors or hospital fees where applicable.
- The staff member will not sign for any treatment to be carried out on the child in the hospital. The staff will wait with the child until the parent/guardian arrives.
- A risk assessment will be completed following any accident or incident

Recommended Contents of First Aid Box and Kits:

Materials	First Aid Travel Kit Contents	First Aid Box Contents		
		1 - 10 people	11 - 25 people	26 - 50 people[1]
Adhesive plasters	20	20	20	40
Sterile eye pads (No.16 – bandage attached)	2	2	2	4
Individually wrapped triangular bandages	2	3	6	6
Safety pins	6	6	6	6
Individually wrapped sterile, unmedicated wound dressings Medium (No. 8) 10 x 8 cm)	1	2	2	4
Individually wrapped sterile unmedicated wound dressings Large (No. 9) 13 x 9 cm)	1	2	6	8
Individually wrapped sterile, unmedicated wound dressings Extra-large (No. 3) 28 x 17.5 cm)	1	2	3	4
Individually wrapped disinfectant wipes	10	10	20	40
Paramedic shears	1	1	1	1
Examination gloves (pairs)	3	5	10	10
Sterile water where there is no clear running water[2]	2 x 20mls	1 x 500mls	2 x 500mls	2 x 500mls
Pocket face mask	1	1	1	1
Water-based burns dressing[3] - small (10 x 10 cm)	1	1	1	1
Water-based burns dressing - large	1	1	1	1
Crepe bandage (7cm)	1	1	2	3

[1] If more than 50 people are involved, supplies should be increased accordingly.

[2] If mains tap water is not readily available for eye irrigation, sterile water or sterile normal saline (0.9%) in sealed disposable containers should be provided. Each container should hold at least 20mls and should be discarded once the seal is broken. Eye baths, eye cups and refillable containers should not be used for eye irrigation due to risk of cross infection.

[3] Where mains tap water is not readily available for cooling burnt area. The water-based burns dressing container should be CE marked.

First Aid Box:

FIRST AID BOX MONTHLY CHECK

Check if any items are missing or out of date and take appropriate action tore-stock

Date	Items Missing	Items out of date	Action Taken	Signature

Materials	1-10 children	11-25 children	26-50 children[1]
Adhesive plasters	20	20	40
Sterile eye pads (No.16 – bandage attached)	2	2	4
Individually wrapped triangular bandages	3	6	6
Safety pins	6	6	6
Individually wrapped sterile, unmedicated wound dressings (Medium (No. 8) 10 x 8 cm)	2	2	4
Individually wrapped sterile unmedicated wound dressings (Large (No. 9) 13 x 9 cm)	2	6	8
Individually wrapped sterile, unmedicated wound dressings (Extra-large (No. 3) 28 x 17.5 cm)	2	3	4
Individually wrapped disinfectant wipes	10	20	40
Paramedic shears	1	1	1
Examination gloves (pairs)	5	10	10
Sterile water where there is no clear running water[2]	1 x 500mls	2 x 500mls	2 x 500mls
Pocket face mask	1	1	1
Water-based burns dressing[3] - small (10 x 10 cm)	1	1	1
Water-based burns dressing- large	1	1	1
Crepe bandage (7cm)	1	2	3

[1] If more than 50 people are involved, supplies should be increased accordingly.
[2] If mains tap water is not readily available for eye irrigation, sterile water or sterile normal saline (0.9%) in sealed disposable containers should be provided. Each container should hold at least 20mls and should be discarded once the seal is broken. Eye baths, eye cups and refillable containers should not be used for eye irrigation due to risk of cross infection.
[3] Where mains tap water is not readily available for cooling burnt area. The water-based burns dressing container should be CE marked.

FIRST AID TRAVEL BOX MONTHLY CHECK

Check if any items are missing or out of date and take appropriate action to re-stock

Date	Items Missing	Items out of date	Action Taken	Signature

Materials	First Aid Travel Kit Contents	1-10 children	11-25 children	26-50 children[1]
Adhesive plasters	20	20	20	40
Sterile eye pads (No.16 – bandage attached)	2	2	2	4
Individually wrapped triangular bandages	2	3	6	6
Safety pins	6	6	6	6
Individually wrapped sterile, unmedicated wound dressings (Medium (No. 8) 10 x 8 cm)	1	2	2	4
Individually wrapped sterile unmedicated wound dressings (Large (No. 9) 13 x 9 cm)	1	2	6	8
Individually wrapped sterile, unmedicated wound dressings (Extra-large (No. 3) 28 x 17.5 cm)	1	2	3	4
Individually wrapped disinfectant wipes	10	10	20	40
Paramedic shears	1	1	1	1
Examination gloves (pairs)	3	5	10	10
Sterile water where there is no clear running water[2]	2 x 20mls	1 x 500mls	2 x 500mls	2 x 500mls
Pocket face mask	1	1	1	1
Water-based burns dressing[3] - small (10 x 10 cm)	1	1	1	1
Water-based burns dressing - large	1	1	1	1
Crepe bandage (7cm)	1	1	2	3

[1] If more than 50 people are involved, supplies should be increased accordingly.
[2] If mains tap water is not readily available for eye irrigation, sterile water or sterile normal saline (0.9%) in sealed disposable containers should be provided. Each container should hold at least 20mls and should be discarded once the seal is broken. Eye baths, eye cups and refillable containers should not be used for eye irrigation due to risk of cross infection.
[3] Where mains tap water is not readily available for cooling burnt area. The water-based burns dressing container should be CE marked.

In addition to a First Aid Box the Service may have a fever scan thermometer and a tough cut scissors.

Where mains tap water is not readily available for eye irrigation, sterile water or sterile normal saline (0.9%) in sealed disposable containers should be provided. Each container should hold at least 30ml and should not be re-used once the seal is broken. At least 90ml should be available.

Accessibility of First Aid Equipment:

- First Aid equipment is marked, easily recognisable and accessible to adults but inaccessible to children.
- A fully equipped first aid box is available within the Service in the following areas and situations:
- on each floor of each building used by children
- on outings.

First Aid: We will ensure that:

- At least one adult, qualified in giving First Aid, should always be present on site. This qualification should be current.
- All members of staff are familiar with simple First Aid procedures, such as mouth to mouth resuscitation, and for staff training to be given on this subject.
- First Aid boxes and a simple First Aid book should be provided and sited in designated areas.
- They should be stored in places which are easily available to all adults, but beyond the reach of children. Contents of the boxes should be checked regularly and replaced as necessary.
- The Service should have suitably equipped first aid boxes for adults and children.
- The First Aid box must not contain any substance which may cause allergies. However, an accessory box containing sticking plaster and antiseptic lotion for children who, the Service knows are definitely not allergic to these substances may be kept. In addition, cotton wool for cleaning wounds and multi-purpose bowls are recommended.
- Eye bath/eye cup/refillable containers should not be used for eye irrigation.
- A list of what should be in the box is printed on the inside of the lid. All items removed from the box must be replaced immediately after use.

First Aid Officer Duties:

- We have a designated First Aid Officer.
- An Accident and Incident report must be filled in and kept in the First Aid file. All reports to be signed by the Manager.
- The First Aid Officer will supervise children who are under observation, as a result of accidents/sickness while on the premises.
- The First Aid Officer will keep an up to date list of contact numbers for parents/guardians, doctors and hospitals in an easily accessible place.
- The First Aid Officer will be responsible for re-stocking the First Aid kit at regular intervals, at least once a month.
- Report faulty electrical equipment immediately.
- Daily attendance records are kept.
- All flammable materials are safely stored outside of children's areas.

Carrying out First Aid:

- Antiseptic creams or wipes are never applied except those contained in the first aid box. To prevent an infection occurring, a band aid may be applied. Where this is the case please ensure that the band aid is the correct size. Please note that some children are allergic to bandaids/plasters. This will be noted on their Registration Form.
- Disposable gloves must be worn when dealing with open wounds, vomit or blood. Always wash hands thoroughly after administering first aid.
- Tissue/cotton wool and water is used for all injuries. Never, ever, use soap on wounds.
- Cold compresses are used for minor bumps, kicks, pinches, falls, scratches, where slight swelling and/or bruising may occur.

- Cold compresses are used for major bumps, bites, pinches, falls where swelling and bruising will occur. An ice pack can be found in the freezer compartment of the fridge in the kitchen. Ice packs should be replaced as they are used and when necessary.

First aid should be performed where possible away from other children. Ensure that the children being left, are left supervised. If this is not possible then first aid should be administered on the spot.

All staff members, (students, substitutes and auxiliary staff members exempt), should have a valid first aid certificate and should update this when necessary.

Choking and Strangulation:
Food, hard sweets, peanuts and marbles are the most common cause of choking. Blind cords, curtain cords or clothing (e.g. ribbons and belts) are a serious strangulation risk to children.

Dealing with Infant Choking (under 1 year):

1. Turn the infant face down with their head lower than their body. Support their head, jaw and neck.
2. Give 5 back blows using the heel of your hand between the infant's shoulders
3. Turn the infant onto its back while still supporting their head and neck.
4. Give 5 chest thrusts by placing two fingers over the lower half of the infant's breastbone, below the imaginary line between the nipples.
   Keep doing 5 back blows and 5 chest thrusts until the object pops out and the infant begins to breathe again.
5. If the infant becomes unresponsive, call for help and send someone to dial 999 or 112. Stay on the phone and listen carefully to the advice.

- You must begin CPR (Cardio Pulmonary Resuscitation).
- If during CPR you can see the object, remove it with your fingers but do not place your fingers in the infant's mouth if you cannot see the object.

Dealing with a Child Choking (over 1 year):

1. Ask the child: Are you choking? Can you breathe?
2. If the child cannot, breathe, talk or cough, stand or kneel behind the child. Start the Heimlich Manoeuvre by placing the flat thumb side of your fist between the child's navel and the breastbone. Be sure to keep well off the breastbone. Wrap your other hand around your fist and press upwards towards their stomach.
3. Keep doing this until the object pops out and the child starts to breathe again.
4. If the child becomes unresponsive, gently lower them to the floor. Call for help and send someone to dial 999 or 112. Stay on the phone and listen carefully to the advice.

- You must begin CPR (Cardio Pulmonary Resuscitation).
- If during CPR you can see the object, remove it with your fingers but do not place your fingers in the child's mouth if you cannot see the object.

Anaphylaxis: is a sudden and severe allergic reaction which can be fatal, requiring immediate medical emergency measures be taken.

The Service recognises that it has a duty of care to children who are at risk from life-threatening allergic reactions while under our supervision. The responsibility is shared among parents/guardians and health care providers

This policy is designed to ensure that children at risk are identified, strategies are in place to minimize the potential for accidental exposure, and staff and key volunteers are trained to respond in an emergency situation

While the Service cannot guarantee an allergen-free environment, the management will take reasonable steps to provide an allergy-safe and allergy-aware environment for a child with life-threatening allergies.

The Service will implement the following steps:

- A process for identifying an anaphylactic child.
- Keeping a record with information relating to the specific allergies for each identified anaphylactic child to form part of the child's Registration Form.
- A process for establishing an emergency procedure plan, to be reviewed annually, for each identified anaphylactic child to form part of the child's Registration Form.
- Procedures for storage and administering medications, including procedures for obtaining pre authorization for employees to administer medication to an anaphylactic child.
- All incidents will be recorded and the process reviewed.

Anaphylaxis Procedures:

Description of Anaphylaxis: Signs and symptoms of a severe allergic reaction can occur within minutes of exposure to an offending substance. Reactions usually occur within two hours of exposure, but in rare cases can develop hours later. Specific warning signs as well as the severity and intensity of symptoms can vary from person to person and sometimes from reaction to reaction in the same persons.

An anaphylactic reaction can involve **any** of the following symptoms, which may appear alone or in any combination, regardless of the triggering allergen:

- **Skin:** hives, swelling, itching, warmth, redness, rash.
- **Respiratory (breathing):** wheezing, shortness of breath, throat tightness, cough, hoarse voice, chest pain/tightness, nasal congestion or hay fever-like symptoms (runny itchy nose and watery eyes, sneezing), trouble swallowing.
- **Gastrointestinal (stomach):** nausea, pain/cramps, vomiting, diarrhoea.
- **Cardiovascular (heart):** pale/blue colour, weak pulse, passing out, dizzy/light-headed, shock.
- **Other:** anxiety, feeling of "impending doom", headache, uterine cramps in females.

Because of the unpredictability of reactions, early symptoms should never be ignored, especially if the person has suffered an anaphylactic reaction in the past.

It is important to note that anaphylaxis can occur without hives.

If an allergic child expresses any concern that a reaction might be starting, the child should always be taken seriously. When a reaction begins, it is important to respond immediately, following instructions in the child's *Child Emergency Procedure Plan*. The cause of the reaction can be investigated later. The following symptoms may lead to death if untreated:

- Breathing difficulties caused by swelling of the airways.
- A drop in blood pressure indicated by dizziness, light-headedness or feeling faint/weak.

Identifying Individuals at Risk: At the time of registration, parents/guardians are asked to report on their child's medical conditions, including whether their child has a medical diagnosis of anaphylaxis. Information on a child's life threatening conditions will be recorded and updated on the child's Registration Form annually. It is the responsibility of the parent/guardian to:

- Inform the Manager when their child is diagnosed as being at risk for anaphylaxis.
- In a timely manner, complete medical forms and the Child Emergency Procedure Plan which includes a photograph, description of the child's allergy, emergency procedures, contact information and consent

to administer medication. The Child Emergency Procedure Plan should be posted in key areas such as in the child's playroom, the office, the feedback notebook etc., Parental permission is required to post or distribute the plan.

- Provide the Service with updated medical information at the beginning of each year and whenever there is a significant change related to their child.

Record Keeping – Monitoring and Reporting:
For each identified child, the Manager will keep a Child Emergency Procedure Plan on file. These plans will contain the following information:

- Child-Level Information
  - Name
  - Contact information
  - Diagnosis
  - Symptoms
  - Emergency Response Plan
- Service-Level Information
  - Emergency procedures/treatment
- GP section including the child's diagnosis, medication and GP signature.

Emergency Procedure Plans:

- The Manager must ensure that the parents/guardians and child (where appropriate), are provided with an opportunity to meet with designated staff, prior to the beginning of each year or as soon as possible to develop/update an individual Child Emergency Procedure Plan. The Child Emergency Procedure Plan must be signed by the child's parents/guardians and the child's GP. A copy of the plan will be placed in readily accessible, designated areas such as the playroom and office.

The Emergency Procedure Plan will include at minimum:

- The diagnosis.
- The current treatment regime.
- Who within the Service is to be informed about the plan – e.g. key workers, volunteers, playmates.;
- Current emergency contact information for the child's parents/guardians.;
- A requirement for those exposed to the plan to maintain the confidentiality of the child's personal health information.
- It is a parent's responsibility to information the Service regarding any change/s in the child's condition.
- It is the Service's responsibility for updating the child's records.

Emergency Plans: Management will consult with parents, staff and the insurance company to decide on an appropriate emergency plan on a case by case basis to ensure that an appropriate course of action is taken for the child. The following two plans A and B will be used in consultation with parents/guardians and then an individual plan will be written up.

Parents/guardians will be required to sign a declaration that they are happy for the staff to follow the decided emergency plan. In the event of an emergency designated staff will follow the plans as decided by parents/guardians and management.

Emergency Procedure Plan: We will use the following emergency procedure:

1. One staff member will administer the child's auto-injector (single dose) at the first sign of a reaction. The use of epinephrine for a potentially life-threatening allergic reaction will not harm a normally healthy child, if epinephrine was not required. Note time of administration.
2. **A second staff member will call emergency medical care 999, 112 or 911**

a. The service should identify who will do which task in each room.

3. Contact the child's parent/guardian.
4. A second auto-injector may be administered within 10 to 15 minutes or sooner, after the first dose is given IF symptoms have not improved (i.e. the reaction is continuing, getting worse, or has recurred).

5. If an auto-injector has been administered, the child must be transported to a hospital (the effects of the auto-injector may not last, and the child may have another anaphylactic reaction).
6. One person stays with the child at all times.
7. One person goes for help or calls for help.

The Manager or designated staff must ensure that emergency plan measures are in place for scenarios where the child is off-site (e.g. bringing additional single dose auto-injectors on outings).

Provision and Storage of Medication: The location(s) of child auto-injectors must be known to all staff members. Parents/guardians will be informed that it is the parents/guardians' responsibility:

- To provide the appropriate medication (e.g. single dose epinephrine auto-injectors) for their anaphylactic child.
- To inform the staff where the anaphylactic child's medication will be kept (i.e. with the child, in the child's playroom, and/or other locations).
- To inform the staff when they deem the child competent to carry their own medication/s) and it is their duty to ensure their child understands they must carry their medication on their person at all times.
- To provide a second auto-injector to be stored in a central, accessible, safe but unlocked location.
- To ensure anaphylaxis medications have not expired.
- To ensure that they replace expired medications.

Allergy Awareness, Prevention and Avoidance Strategies:

a) Awareness: The person in charge should ensure:

- That all the Service staff and persons reasonably expected to have supervisory responsibility of children receive training, in the recognition of a severe allergic reaction and the use of single dose auto-injectors and standard emergency procedure plans.
- That all members of staff including substitute employees, employees on call, and volunteers have appropriate information about severe allergies including background information on allergies, anaphylaxis and safety procedures.
- With the consent of the parent, the person in charge and the staff must ensure that the child's playmates are provided with information on severe allergies in a manner that is appropriate for the age and maturity level of the child, and that strategies to reduce teasing and bullying are incorporated into this information.

Posters which describe signs and symptoms of anaphylaxis and how to administer a single dose auto-injector should be placed in relevant areas. These areas may include playrooms, office, staff room, lunchroom etc.

b) Avoidance/Prevention: Individuals at risk of anaphylaxis must learn to avoid specific triggers. While the key responsibility lies with the child's family, the Service must participate in creating an "allergy-aware" environment. Special care is taken to avoid exposure to allergy-causing substances. Parents/guardians are asked to consult with the staff before sending in food to playrooms where there are food-allergic. The risk of accidental exposure to a food allergen can be significantly diminished by means of such measures.

Non-food allergens (e.g. medications, latex) will be identified and restricted from playrooms and common areas where a child with a related allergy may encounter that substance.

Training Strategy: A training session on anaphylaxis and anaphylactic shock will be held for all the staff. Efforts shall be made to include the parents/guardians, and children (where appropriate), in the training. Experts (e.g. public health nurses, trained occupational health and safety staff) will be consulted in the development of training policies and the implementation of training. Training will be provided by individuals trained to teach anaphylaxis management. The training sessions will include:

- Signs and symptoms of anaphylaxis.
- Common allergens.
- Avoidance strategies.
- Emergency protocols.
- Use of single dose epinephrine auto-injectors.

- Identification of at-risk children (as outlined in the individual Child Emergency Procedure Plan).
- Emergency plans.
- Method of communication with and strategies to educate and raise awareness of parents/guardians, children, employees and volunteers about anaphylaxis.

Additional Best Practice: Participants will have an opportunity to practice using an auto-injector trainer (i.e. device used for training purposes) and are encouraged to practice with the auto-injector trainers throughout the year, especially if there is a child at risk in the Service's care. Children will learn about anaphylaxis as part of the curriculum if there is a child present with a nut allergy.

Signed: _____ Date: _____

Name:

Person responsible for approving the Policy

Appendix F: Notification of Incidents Form

TUSLA An Ghníomhaireacht um Leanaí agus an Teaghlach Child and Family Agency

Child Care Act (Early Years Services) Regulations 2016

Part VIII, Article 31, Notification of Incident Form

Tusla ID No.:		Date of Notification	
Service Name and Address		Service Contact Number:	

Type of Service			
Full day care service	☐	Pre-school service in a drop-in centre	☐
Part-time day care service	☐	Childminding service	☐
Sessional pre-school service	☐	Overnight service	☐

Day of Event	Date of Event	Time of Event	Location of Event

Names of those present at time of incident:	

Type of Event Article 31			
Death of a Child in service	☐	Irregular Closure of a centre	☐
Death of a child in hospital /home following transfer from service	☐	Serious Injury to a child	☐
Diagnosed Infectious Disease Child	☐	Child missing from service	☐
Diagnosed Infectious Disease staff member	☐	Child removed without consent from service	☐

Sequence/chronology and description of the incident

Actions taken by the service to manage the incident

Actions taken by the service to manage the incident

Are there outstanding safety / risk matters to be addressed at the time of notification?

Notification Details				
Notified to	**Yes**	**No**	**Date**	**Details**
Parents/Guardians	☐	☐		
Ambulance	☐	☐		
Fire Services	☐	☐		
An Garda Síochána	☐	☐		
EHO	☐	☐		
HSE Public Health	☐	☐		
Registered provider (if offsite)	☐	☐		

Service Incident Report	
Has the service completed a separate incident report?	Name and contact details of person who wrote incident report?

Declaration (To be Completed by Person in Charge)	
I confirm that the information contained in this notification is accurate and correct	
Signature:	
Print Name:	
Date:	