John Scottus Pre-School

Accidents and Incidents Policy

This policy will be available to view and examine by all members of the school community: Parents, Staff, Board of Management and Trustees. They will be available for inspection in the Pre-school classroom in Old Conna, Ferndale Rd, Rathmichael, Co Dublin and on our School website.

Child Care Act 1991 (Early Years Services) Regulations 2016 (Síolta Standard 2: Environments, Síolta Standard 9: Health and Welfare) (National Standard 4: Records, National Standard 12: Health Care, National Standard 20: Safety)

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.

NOTE: Ongoing risk assessment is in place to prevent accidents and incidents from occurring [see risk Assessment Sheets, Safety Statement]

Policy and Procedure:

Measures to be taken to Prevent Accidents and Incidents:

- A Safety Statement is prepared and reviewed on a regular basis and an annual risk assessment will be carried out.
- Daily risk assessments are carried of the children's room, outdoor area and, sanitary area and a written record kept and open to inspection.

- Children will be adequately supervised in accordance with the recommended child/adult ratios dictated by the Child Care Act 1991 (Early Years Services) Regulations 2016.
- Each room is designed for easy and unobtrusive supervision by the staff at all times.
- Our staff know which children are present at any one time.
- We ensure that no child can leave the premises undetected.
- The main door is locked at all times.
- Only suitable and age-appropriate materials and equipment are available to children.
- All electrical sockets are fitted with safety covers.
- Furniture and equipment is arranged to minimise safety risks.
- Sun block protection will be used during hot weather; parents/guardians will be advised to provide a hat that covers the head, neck, ears.

Incidents and accidents will occur. By endeavouring to keep them at a minimum we can reduce the amount that occurs. Have a watchful eye. Know what the children in your care are doing at all times. Watch out especially for new children in your group as they are the most vulnerable.

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

- The First Aid box is always fully equipped, easily identifiable and location is known to all staff, so that it can be accessed following an incident or accident with a preschool child. 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

Reporting Accidents and Incidents:

- All accidents/incidents even minor ones, are recorded in an accident record sheet, with details on how they are dealt with or treated.

Any of the following incidents must be notified to TUSLA:

(a) The death of a preschool child while attending the service. This includes the death of a child in hospital following transfer to hospital from the service.

(b) Diagnosis of a preschool child attending the service, an employee, unpaid worker, contractor or other person working in the service as suffering from an infectious disease within the meaning of the Infectious Disease Regulations 1981(SI No 390 of 1981) and amendments.
http://www.hpsc.ie/NotifiableDiseases/ListofNotifiableDiseases/

(c) Any incident which results in the service being closed for a length of time.

(d) A serious injury to a preschool child while attending the service that requires immediate medical treatment by a registered medical practitioner whether in a hospital or otherwise.

(e) An incident which results in a child going missing from the service.

A registered provider must notify the Early Years Registration Office First Floor, South East Wing, St Joseph's Campus, Mulgrave Street Limerick or ey.registration@TUSLA.ie of any of the incidents listed here in the Notification of Incidents Form. **http://www.tusla.ie/services/preschool-services/notification-of-incidents-form**

- A copy of the completed Accident and Incident Form must always be placed on the child's file.

- Parents/guardians will always be contacted and informed immediately of any injury.
- Parents/guardians will be asked to sign off on the accident /incident report and will receive a copy.
- Records are accessible to all relevant staff in case of an emergency.
- All serious accidents will be reported to the Insurance Company.
- Records are kept on file for a minimum period of two years or up to 21 years if necessary and will be available for inspection

Note: “a serious injury” is defined by TUSLA as an injury that requires immediate medical treatment by a registered medical practitioner whether in hospital or otherwise.

Accident and Incident Record:

The accident and incident form should be fully completed with as much detail as possible. It is important that full names are used when referring to staff members and that the form is signed both by the person in charge and the parent/guardian.

First Aid Box:

Materials:	**1-5 Children**	**6-25 Children**	**25-50 Children**
Hypoallergenic plasters	12	20	20
Sterile eye pads (bandage attached)	2	6	6
Individually wrapped triangular bandages	2	6	6
Small individually wrapped sterile un medicated wound dressings	1	2	4
Medium individually wrapped, non-stick, sterile, unmedicated wound dressings	1	2	4
Individually wrapped antiseptic wipes	8	8	10
Paramedic shears	1	1	1
Latex gloves – non-powdered latex or Nitril gloves (latex-free)	1 box	1 box	1 box
Additionally, where there is no running water, sterile eye wash	1	2	2

In addition to a First Aid Box you may have a 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.

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 you know are definitely not allergic to these substances may be kept. In addition, cotton wool for cleaning wounds and multi-purpose bowl 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 easy 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 band aids/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 wound.
- 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. Ice packs are available in the first aid box.

First aid should be performed where possible away from other children. Ensure that the children you are leaving are left supervised. If this is not possible then administer first aid 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 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 breast bone. Be sure to keep well off the breast bone. 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 preauthorization 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:

Child Level Emergency Procedure Plan:

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 Child 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.
- Information regarding the child, is parent's responsibility to advise the service about 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 parent's 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.

Sample Emergency Procedure Plan A:

The service will use the following emergency procedure:

1. **FIRST Call emergency medical care 999, 112 or 911**
2. Follow the instructions from the emergency services and **only** administer the child's auto-injector or inhaler under their instruction. Note time of administration.
3. Contact the child's parent/guardian.
4. Under the instruction of the emergency services **only** a second auto-injector or inhaler 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.

Sample Emergency Procedure Plan B:

We will use the following emergency procedure:

1. 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. **Call emergency medical care 999, 112 or 911**
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.

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, lunch room 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 they have a child at risk in their care. Children will learn about anaphylaxis as part of the curriculum.