
Illness and injury policy

Approved: 12 Mar 2019

Reviewed: 2 Sept 2019

Review due: 2 Sept 2020

Purpose

To promote the good health of the children in our care, and this policy describes the processes YMCA East Surrey and staff will take to prevent the spread of infection and to prevent injury, along with the appropriate action required when children become ill or are injured in our care.

Responsibilities and monitoring

Monitor: Head of Children's Services
Approve: Board of Management
Endorse: Children's Services Committee
Propose: CEO
Draft and review: Children's Services Development Manager

Policy and procedure

Infectious diseases or illnesses

We encourage and promote good health and hygiene within all of our childcare settings, with staff being vigilant for the signs and symptoms of infectious diseases such as chickenpox, measles, mumps, rubella, meningitis, hepatitis, diarrhoea, vomiting and fevers of over 101°F/38°C.

If a child becomes ill whilst in the care of YMCA East Surrey, their parent/carer will be contacted by phone immediately.

If we have reason to believe that any child is suffering from a notifiable disease, as identified under the Health Protection (notification) Regulation 2010, the Head of Children's Services will inform Ofsted and the local authority. We will act on any advice given by the Health Protection Agency and inform Ofsted of any action taken.

YMCA Children's Services staff will let other parents/carers and staff know about any infectious diseases or illnesses (including head lice) that a child at our settings may have through posters and team meetings, with consideration at all times regarding confidentiality.

We are aware of the effects of infectious diseases and illnesses and within YMCA settings, staff must wear protective clothing (disposable aprons and gloves) when undertaking any personal or intimate care (see Personal and intimate care policy), and follow good hygiene practice concerning the clearing of any spilled bodily fluids at all times.

Parents/carers must wait for the recommended period by the Health Protection Agency before returning their child to the setting following an illness (see Appendix 1).

First aid

Under duties set out in the Health and Safety (First Aid) Regulations 1981, YMCA Children's Services recognises its responsibilities in providing adequate and appropriate equipment, facilities and personnel to enable suitable first aid to be given.

At YMCA Children's Services settings, all members of senior staff are responsible for first aid. All senior staff must have an up-to-date Paediatric First Aid certificate, along with First Aid at Work certificate, both of which are renewed every three years and enable them to administer first aid when necessary.

The settings Managers are responsible for maintaining the correct contents of all first aid boxes, ensuring that its contents are up to date, in good condition and fulfil the criteria set out in the Health and Safety Regulations 1981.

The first aid box should contain:

- ▶ A card or leaflet giving general guidance
- ▶ Sterile triangular bandages
- ▶ Adhesive plasters
- ▶ A sterile eye pad with attachment
- ▶ Crepe bandages
- ▶ A sterile gauze
- ▶ Micropore tape
- ▶ Sterile cornering for serious wounds
- ▶ Individually wrapped assorted dressings
- ▶ Waterproof disposable gloves
- ▶ Disposable bags for soiled material

The location of the first aid box will be clearly displayed around the Children's Services setting.

A first aid bag will be taken on all offsite visits or outings (see Operational procedure for outings).

Major accident/illness

Staff must wear protective clothing (disposable aprons and gloves) at all times.

The Coordinator/leader of the setting will assess the situation and decide whether the child needs to go to hospital by ambulance or whether the child can wait for the parent/carer to come.

If the staff member in charge is uncertain whether an ambulance should be called, then they should immediately seek medical advice by phoning 111 and contacting the parent/carer to ascertain their wishes regarding medical treatment. If there is any further doubt or parent/carer cannot be immediately reached, 999 should be called and an ambulance requested.

If the child needs to go straight to hospital

- ▶ A member of the Children's Services team will call an ambulance
- ▶ The Coordinator/leader of the setting will call the parent/carer to make arrangements to meet at the hospital
- ▶ The Coordinator/leader in charge of the setting will allocate a senior member of the Children's Services team to accompany the child to the hospital. Copies of any

relevant paperwork: permission forms, care plans, known allergies, medication forms will be also taken

If the child can wait for the parent/carer to come

- ▶ The Coordinator/leader of the setting will contact the parent/carers
- ▶ The Coordinator/leader of the setting will allocate a member of the Children's Services team who will stay with the child to make them comfortable and monitor them.
- ▶ The Coordinator/leader of the setting will explain to the parent/carer when they arrive what has happened and/or the symptoms being shown. It will then be for the parent/carer to seek medical advice; the parent/carer will be required to sign the sign out register.

A report of any accident is recorded on an accident form, and parent/carers will be asked to sign the form as an acknowledgement that they have been informed of the accident and the actions taken (see Accident and incident reporting policy).

Minor accident/illness

The Coordinator/leader of the setting will assess the situation, and then contact the parent/carers if appropriate.

The setting first aider will carry out any first aid that is required. If appropriate the child will be resettled back into an activity the person in charge of the setting will observe them or allocate a member of the Children's Services team to do so.

Accident or incidents are recorded on a specific accident/incident form. This is completed by the member of staff who witnessed the accident or incident (see Accident and incident reporting policy)

In the event of a child being send home with an illness, a Sickness Information form will be filled in and given to the parent/carer. This form outlines the guidance for returning the child to the setting.

Appendix 1

Guidance on infection control in schools and other childcare settings 2017

Guidance on infection control in schools and other childcare settings



March 2017

Prevent the spread of infections by ensuring: routine immunisation, high standards of personal hygiene and practice, particularly handwashing, and maintaining a clean environment. Please contact the Public Health Agency **Health Protection Duty Room (Duty Room) on 0300 555 0119** or

visit www.publichealth.hscni.net or www.gov.uk/government/organisations/Public-health-england if you would like any further advice or information, including the latest guidance. Children with rashes should be considered infectious and assessed by their doctor.

Rashes and skin infections	Recommended period to be kept away from school, nursery or childminders	Comments
Athlete's foot	None	Athlete's foot is not a serious condition. Treatment is recommended
Chickentox*	Until all vesicles have crusted over	See:Vulnerable children and female staff – pregnancy
Cold sores, (Herpes simplex)	None	Avoid kissing and contact with the sores. Cold sores are generally mild and self-limiting
German measles (rubella)*	Four days from onset of rash (as per "Green Book")	Preventable by immunisation (MMR x 2 doses). See:Vulnerable children and female staff – pregnancy
Hand, foot and mouth	None	Contact the Duty Room if a large number of children are affected. Exclusion may be considered in some circumstances
Impetigo	Until lesions are crusted and healed, or 48 hours after commencing antibiotic treatment	Antibiotic treatment speeds healing and reduces the infectious period
Measles*	Four days from onset of rash	Preventable by vaccination (MMR x 2). See:Vulnerable children and female staff – pregnancy
Molluscum contagiosum	None	A self-limiting condition
Ringworm	Exclusion not usually required	Treatment is required
Roseola (infantum)	None	None
Scabies	Child can return after first treatment	Household and close contacts require treatment
Scarlet fever*	Child can return 24 hours after commencing appropriate antibiotic treatment	Antibiotic treatment recommended for the affected child. If more than one child has scarlet fever contact PHA Duty Room for further advice
Slapped cheek (fifth disease or parvovirus B19)	None once rash has developed	See:Vulnerable children and female staff – pregnancy
Shingles	Exclude only if rash is weeping and cannot be covered	Can cause chickenpox in those who are not immune i.e. have not had chickenpox. It is spread by very close contact and touch. If further information is required, contact the Duty Room. See:Vulnerable children and Female Staff – Pregnancy
Warts and verrucae	None	Verrucae should be covered in swimming pools, gymnasiums and changing rooms

Diarrhoea and vomiting illnesses	Recommended period to be kept away from school, nursery or childminders	Comments
Diarrhoea and/or vomiting	48 hours from last episode of diarrhoea or vomiting	
E. coli O157/VTCC	Should be excluded for 48 hours from the last episode of diarrhoea	Further exclusion is required for young children under five and those who have difficulty in adhering to hygiene practices
Typhoid* [and paratyphoid*] (enteric fever)	Further exclusion may be required for some children until they are no longer excreting	Children in these categories should be excluded until there is evidence of microbiological clearance. This guidance may also apply to some contacts of cases who may require microbiological clearance
Shigella* (dysentery)		Please consult the Duty Room for further advice
Cryptosporidiosis*	Exclude for 48 hours from the last episode of diarrhoea	Exclusion from swimming is advisable for two weeks after the diarrhoea has settled

Respiratory infections	Recommended period to be kept away from school, nursery or childminders	Comments
Flu (influenza)	Until recovered	See:Vulnerable children
Tuberculosis*	Always consult the Duty Room	Requires prolonged close contact for spread
Whooping cough* (pertussis)	48 hours from commencing antibiotic treatment, or 21 days from onset of illness if no antibiotic treatment	Preventable by vaccination. After treatment, non-infectious coughing may continue for many weeks. The Duty Room will organise any contact tracing necessary

Other Infections	Recommended period to be kept away from school, nursery or childminders	Comments
Conjunctivitis	None	If an outbreak/cluster occurs, consult the Duty Room
Diphtheria*	Exclusion is essential. Always consult with the Duty Room	Family contacts must be excluded until cleared to return by the Duty Room. Preventable by vaccination. The Duty Room will organise any contact tracing necessary
Glandular fever	None	
Head lice	None	Treatment is recommended only in cases where live lice have been seen
Hepatitis A*	Exclude until seven days after onset of jaundice (or seven days after symptom onset if no jaundice)	The duty room will advise on any vaccination or other control measure that are needed for close contacts of a single case of hepatitis A and for suspected outbreaks.
Hepatitis B*, C, HIV/AIDS	None	Hepatitis B and C and HIV are bloodborne viruses that are not infectious through casual contact. For cleaning of body fluid spills. See: Good Hygiene Practice
Meningococcal meningitis*/ septicaemia*	Until recovered	Some forms of meningococcal disease are preventable by vaccination (see immunisation schedule). There is no reason to exclude siblings or other close contacts of a case. In case of an outbreak, it may be necessary to provide antibiotics with or without meningococcal vaccination to close contacts. The Duty Room will advise on any action needed.
Meningitis* due to other bacteria	Until recovered	Hib and pneumococcal meningitis are preventable by vaccination. There is no reason to exclude siblings or other close contacts of a case. The Duty Room will give advice on any action needed
Meningitis viral*	None	Milder illness. There is no reason to exclude siblings and other close contacts of a case. Contact tracing is not required
MRSA	None	Good hygiene, in particular handwashing and environmental cleaning, are important to minimise any danger of spread. If further information is required, contact the Duty Room
Mumps*	Exclude child for five days after onset of swelling	Preventable by vaccination (MMR x 2 doses)
Threadworms	None	Treatment is recommended for the child and household contacts
Tonsillitis	None	There are many causes, but most cases are due to viruses and do not need an antibiotic

* denotes a notifiable disease. It is a statutory requirement that doctors report a notifiable disease to the Director of Public Health via the Duty Room.

Outbreaks: If a school, nursery or childminder suspects an outbreak of infectious disease, they should inform the Duty Room.

Good hygiene practice

Handwashing is one of the most important ways of controlling the spread of infections, especially those that cause diarrhoea and vomiting, and respiratory disease. The recommended method is the use of liquid soap, warm water and paper towels. Always wash hands after using the toilet, before eating or handling food, and after handling animals. Cover all cuts and abrasions with waterproof dressings.

Coughing and sneezing easily spread infections. Children and adults should be encouraged to cover their mouth and nose with a tissue. Wash hands after using or disposing of tissues. Spitting should be discouraged.

Personal protective equipment (PPE). Disposable non-powdered vinyl or latex-free CE-marked gloves and disposable plastic aprons must be worn where there is a risk of splashing or contamination with blood/body fluids (for example, nappy or pad changing). Goggles should also be available for use if there is a risk of splashing to the face. Correct PPE should be used when handling cleaning chemicals.

Cleaning of the environment, including toys and equipment, should be frequent, thorough and follow national guidance. For example, use colour-coded equipment, follow Control of Substances Hazardous to Health (COSHH) regulations and correct decontamination of cleaning equipment. Monitor cleaning contracts and ensure cleaners are appropriately trained with access to PPE.

Cleaning of blood and body fluid spillages. All spillages of blood, faeces, saliva, vomit, nasal and eye discharges should be cleaned up immediately (always wear PPE). When spillages occur, clean using a product that combines both a detergent and a disinfectant. Use as per manufacturer's instructions and ensure it is effective against bacteria and viruses and suitable for use on the affected surface. Never use mops for cleaning up blood and body fluid spillages – use disposable paper towels and discard clinical waste as described below. A spillage kit should be available for blood spills.

Laundry should be dealt with in a separate dedicated facility. Soiled linen should be washed separately at the hottest wash the fabric will tolerate. Wear PPE when handling soiled linen. Children's soiled clothing should be bagged to go home, never rinsed by hand.

Clinical waste. Always segregate domestic and clinical waste, in accordance with local policy. Used nappies/pads, gloves, aprons and soiled dressings should be stored in correct clinical waste bags in foot-operated bins. All clinical waste must be removed by a registered waste contractor. All clinical waste bags should be less than two-thirds full and stored in a dedicated, secure area while awaiting collection.

Sharps, eg needles, should be discarded straight into a sharps bin conforming to BS 7320 and UN 3291 standards. Sharps bins must be kept off the floor (preferably wall-mounted) and out of reach of children.

Sharps injuries and bites

If skin is broken as a result of a used needle injury or bite, encourage the wound to bleed/wash thoroughly using soap and water. Contact CP or occupational health or go to A&E immediately. Ensure local policy is in place for staff to follow. Contact the Duty Room for advice, if unsure.

Animals

Animals may carry infections, so wash hands after handling animals. Health and Safety Executive for Northern Ireland (HSENI) guidelines for protecting the health and safety of children should be followed.

Animals in school (permanent or visiting). Ensure animals' living quarters are kept clean and away from food areas. Waste should be disposed of regularly, and litter boxes not accessible to children. Children should not play with animals unsupervised. Hand-hygiene should be supervised after contact with animals and the area where visiting animals have been kept should be thoroughly cleaned after use. Veterinary advice should be sought on animal welfare and animal health issues and the suitability of the animal as a pet. Reptiles are not suitable as pets in schools and nurseries, as all species carry salmonella.

Visits to farms. For more information see <https://www.hseai.gov.uk/publications/preventing-or-controlling-ill-health-animal-contact-visitor-attractions>

Vulnerable children

Some medical conditions make children vulnerable to infections that would rarely be serious in most children, these include those being treated for leukaemia or other cancers, on high doses of steroids and with conditions that seriously reduce immunity. Schools and nurseries and childminders will normally have been made aware of such children. These children are particularly vulnerable to chickenpox, measles and parvovirus B19 and, if exposed to either of these, the parent/carer should be informed promptly and further medical advice sought. It may be advisable for these children to have additional immunisations, for example pneumococcal and influenza. This guidance is designed to give general advice to schools and childcare settings. Some vulnerable children may need further precautions to be taken, which should be discussed with the parent or carer in conjunction with their medical team and school health.

Female staff* – pregnancy

- If a pregnant woman develops a rash or is in direct contact with someone with a potentially infectious rash, this should be investigated by a doctor who can contact the duty room for further advice. The greatest risk to pregnant women from such infections comes from their own child/children, rather than the workplace
- Chickenpox can affect the pregnancy if a woman has not already had the infection. Report exposure to midwife and GP at any stage of pregnancy. The GP and antenatal care will arrange a blood test to check for immunity. Shingles is caused by the same virus as chickenpox, so anyone who has not had chickenpox is potentially vulnerable to the infection if they have close contact with a case of shingles.
- German measles (rubella). If a pregnant woman comes into contact with german measles she should inform her GP and antenatal care immediately to ensure investigation. The infection may affect the developing baby if the woman is not immune and is exposed in early pregnancy.
- Slapped cheek disease (fifth disease or parvovirus B19) can occasionally affect an unborn child. If exposed early in pregnancy (before 20 weeks), inform whoever is giving antenatal care as this must be investigated promptly.
- Measles during pregnancy can result in early delivery or even loss of the baby. If a pregnant woman is exposed she should immediately inform whoever is giving antenatal care to ensure investigation.
- All female staff born after 1910 working with young children are advised to ensure they have had two doses of MMR vaccine.

*The above advice also applies to pregnant students.

Immunisations

Immunisation status should always be checked at school entry and at the time of any vaccination. Parents should be encouraged to have their child immunised and any immunisation missed or further catch-up doses organised through the child's GP.

For the most up-to-date immunisation advice and current schedule visit www.publichealth.hscni.net or the school health service can advise on the latest national immunisation schedule.

When to immunise	Diseases vaccine protects against	How it is given
2 months old	Diphtheria, tetanus, pertussis (whooping cough), polio and Hib Pneumococcal Infection Rotavirus Meningococcal B Infection	One Injection One Injection Orally One Injection
3 months old	Diphtheria, tetanus, pertussis, polio and Hib Rotavirus	One Injection Orally
4 months old	Diphtheria, tetanus, pertussis, polio and Hib Pneumococcal Infection Meningococcal B Infection	One Injection One Injection One Injection
Just after the first birthday	Measles, mumps and rubella Pneumococcal Infection Hib and meningococcal C Infection Meningococcal B Infection	One Injection One Injection One Injection One Injection
Every year from 2 year old up to 17	Influenza	Nasal spray or Injection
3 years and 4 months old	Diphtheria, tetanus, pertussis and polio Measles, mumps and rubella	One Injection One Injection
Girls 12 to 13 years old	Cervical cancer caused by human papillomavirus types 16 and 18 and genital warts caused by types 6 and 11	Two Injections over six months
14 to 18 years old	Tetanus, diphtheria and polio Meningococcal Infection ACWY	One Injection One Injection

This is the immunisation Schedule as of July 2016. Children who present with certain risk factors may require additional immunisations. Always consult the most updated version of the "Green Book" for the latest immunisation schedule on www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book-the-green-book

From October 2017 children will receive hepatitis B vaccine at 2, 3, and 4 months of age in combination with the diphtheria, tetanus, pertussis, polio and Hib vaccine.

Staff immunisations. All staff should undergo a full occupational health check prior to employment; this includes ensuring they are up to date with immunisations, including two doses of MMR.

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