

SCHOOL DISTRICT NO. 50
(HAIDA GWAII/QUEEN CHARLOTTE)

FIRST AID ATTENDANT'S
MANUAL



ACKNOWLEDGEMENTS

This first aid manual would not be available for reference without the past efforts of the Health and Safety Group of the Vancouver School Board who original designed and compiled this information.

With special thanks to the following individuals:

| | |
|-------------------|--|
| John Bonnet | Provincial Coordinator, Occupational Health & Safety, BC Public School Employer's Association |
| Collette O'Reilly | Manager of Health, Safety and Employee Support, Vancouver School Board |
| Ken Lear | Health & Safety Officer, Vancouver School Board |
| Fernando De Melo | Health, Safety and Employee Support Clerk, Vancouver School Board |
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* Adapted from School District No. 60's First Aid Attendant's Manual by School District No. 50's District Health & Safety Committee

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SCOPE AND PURPOSE

This manual is a reference for School District No. 50 First Aid Attendants. It is intended to promote a consistent standard of first aid and provide direction on administrative procedures associated with first aid.

The manual should be readily available in the first aid room and placed in ready view of staff.

The manual is divided into broad subject areas so that information can be quickly located.

Suggestions for improvements or additional information on first aid treatment should be sent to:

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FIRST AID COVERAGE & WCB REGULATIONS

The Worker's Compensation Board of BC Regulation requires that first aid services must be available to employees during "working hours." This does not mean that employees cannot enter the building until the first aid attendant arrives, nor does it mean that all employees must leave the building before the first aid attendant leaves. Rather, first aid services should be reasonably available at any time to employees who are expected to be at work.

The Worker's Compensation Board of BC requires that the school district provide the following:

Schedule 1

Table 5: Hazard Classification

Less than 20 Minutes Surface Travel Time to Hospital

| | | |
|------------|-----------|--|
| * 0 – 10 | Employees | No First Aid Attendant required |
| * 11 – 50 | Employees | Level One First Aid Attendant required |
| * 51 – 100 | Employees | Level Two First Aid Attendant required |

Schedule 1

Table 5: Hazard Classification

More than 20 Minutes Surface Travel Time to Hospital

| | | |
|-----------|-----------|---|
| * 0 – 5 | Employees | No First Aid Attendant required |
| * 6 – 30 | Employees | Level One First Aid Attendant required |
| * 31 – 50 | Employees | Level One First Aid Attendant with Travel Endorsement required |
| * 51 – 75 | Employees | Level Three First Aid required |

NOTE: School site are responsible for and required to make arrangements for appropriate first aid coverage.

For school dances or other special events, the schools are responsible for and required to make arrangements for appropriate first aid coverage.

~ SECTION A: FIRST AID PROCEDURES FOR EMPLOYEES ~

EMPLOYEES UNDER THE INFLUENCE OF ALCOHOL OR DRUGS

First aid attendants are not responsible for determining whether an employee is under the influence of alcohol or drugs nor whether the individual should not be allowed to remain on the premises. However, all first aid attendants have a general responsibility to protect the well being of others and so can not ignore a person, who because of their condition, may be at greater risk of personal harm.

Being at work under the influence of alcohol or drugs, in and of itself, is an administrative and potential disciplinary matter and should be dealt with accordingly by the administrator/supervisor. When involved with an employee who appears to be under the influence of drugs or alcohol:

1. Treat the first aid issue(s) for which they have been reported to you.
2. As with any first aid case, determine if medical assistance is required.
3. Have the employee remain in the first aid room, if applicable.
4. Request the presence of an administrator/supervisor.

Under ideal circumstances the administrator/supervisor will handle the following matters. However, if the administrator/supervisor is delayed and the employee indicates their intent to leave the premises:

1. The employee should be offered a safe alternate form of transportation such as a taxi.
2. Inform any employee who appears to be impaired from alcohol or drugs and who indicated their intent to leave the premises and operate a vehicle that, if they, choose to leave with this intent, the police will be called.
3. If the employee leaves the premises with the intent to operate a vehicle, call the police.

When it appears that the employee's well being in immediate danger (e.g., extreme lethargy, severe lack of coordination, delirium, unconsciousness, etc.)

1. Perform appropriate first aid.
2. Call for ambulance service and emergency medical assistance.

~ REQUESTING AMBULANCE SERVICE ~

1-800-461-9911

When requesting the services of an ambulance to attend to a seriously injured or ill employee the attendant must be ready to provide the following information:

1. Type of emergency
2. Nature of the injury or condition
3. School/site name and address
4. School/site phone number
5. Exact location where the ambulance should enter the grounds

As a general rule, if there is ever any doubt whether or not an ambulance is required, then an ambulance should be called.

The first aid attendant is responsible for determining which is the best exit to summon the ambulance to and directing staff in this regard.

1. The school/site administrator/supervisor (or any available employee) should be asked to keep the exit route clear.
2. Another employee should be asked to direct the ambulance to the chosen exit.
3. After the injured or ill employee is evacuated the administrator/supervisor should be informed of the patient's identity.

~ COMMUNICATION IN THE EVENT OF A SERIOUS INJURY OR DEATH ~

In the event of a serious injury or death of an employee:

1. Inform the school/site administrator/supervisor or designate
2. Inform School District 50 administration
3. Inquiries by the media regarding any such incident should be referred to either the Office of the Superintendent or the Secretary Treasurer of School District 50

~ REFUSAL OF TREATMENT BY AN EMPLOYEE ~

If an employee refuses treatment for a significant debilitating injury the following action should be taken:

1. Document the incident in the employee Accident Record Book.
2. Read the entry to the employee
3. Ask the employee to sign the entry and witness the signature
4. If the employee refuses to sign, do not force the issue
5. Contact the administrator/supervisor and inform him/her that the employee has refused treatment

NOTE: The First Aid Attendant should advise the administrator/supervisor on the above process. If the situation warrants the administrator/supervisor should direct the employee to leave the work site and obtain medical certification of fitness to return to work with respect to the injury/illness at hand.

~ RECORDING AND REPORTING EMPLOYEE INJURIES ~

The Worker's Compensation Board of BC requires employers to report accidents/incidents that result in injuries which require medical treatment. Minor injuries not requiring medical treatment need not be reported to the Worker's Compensation Board of BC, however, School District 50 is required to keep record of these injuries. First aid records are required to be kept on file with the employer for a period of ten years.

The value of any first aid record is largely dependent on the detail and accuracy of the observation noted by the first aid attendant. Where a report of injury is received by telephone, email or by means other than in person, the mode of reporting should be noted on the record.

Injury – Employee Returns to Work

When first aid is given to an employee or the employee reports an injury and no medical aid is required:

1. An entry in the First Aid Accident Record Book is required.
2. Employees must be reminded of the need to inform the first aid attendant if the injury results in a subsequent medical visit.

Injury – Employee Subsequently Obtain Medical Attention

Where the injury results in a referral to a doctor or medical practitioner or the employee indicates an intent to seek medical attention:

1. The employee will complete WCB Forms 6 – Worker's Application for Compensation and 6A – Worker's Report to the Employer (*available on School District 50's website*)

2. The first aid attendant will complete WCB Form 7A – First Aid Report (*available on School District 50's website*)
3. The originals should be faxed immediately to the Board Office at 559-8849 and faxed to WCB at 1-888-922-8807
4. The Board Office will complete WCB Form 7 – Employer's Report of Injury or Occupational Disease and will fax this information to WCB within 72 hours of the injury
5. The injury should be reported to the School Safety Committee, who will complete an Investigation Report of Employee Accident/Injury/Near Miss
6. Once the Investigation Report has been completed by the School Safety Committee it should be faxed to the Board Office for review by the District Health and Safety Committee

Injury – Employee is Immediately Transferred to Medical Attention

Where the employee requires immediate medical attention and the employee's administrator/supervisor is on site, it will be the first aid attendant's responsibility to notify the administrator/supervisor and deliver the WCB forms to him/her.

If the employee does not routinely work at the location (e.g. maintenance) or their administrator/supervisor is not at that site the first aid attendant shall contact the relevant department administrator/supervisor and forward the WCB forms to him/her.

~ SECTION B: FIRST AID PROCEDURES FOR STUDENTS ~

STUDENTS UNDER THE INFLUENCE OF ALCOHOL OR DRUGS

First aid attendants are not responsible for determining whether a student is under the influence of alcohol or drugs nor whether the individual should not be allowed to remain on the premises. However, all first aid attendants have a general responsibility to protect the well being of others and so can not ignore a person, who because of their condition, may be at greater risk of personal harm.

Being at school under the influence of alcohol or drugs, in and of itself, is an administrative and potential disciplinary matter and should be dealt with accordingly by the administrator. When involved with a student who appears to be under the influence of drugs or alcohol:

1. Treat the first aid issue(s) for which they have been reported to you.
2. As with any first aid case, determine if medical assistance is required.
3. Have the student remain in the first aid room, if applicable.
4. Request the presence of an administrator.

Under ideal circumstances the administrator will handle the following matters. However, if the administrator is delayed and the student indicates their intent to leave the premises:

1. The student should be offered a safe alternate form of transportation such as a taxi.
2. Inform any student who appears to be impaired from alcohol or drugs and who indicated their intent to leave the premises and operate a vehicle that, if they, choose to leave with this intent, the police will be called.
3. The parent/guardian should be notified by the administrator.
4. If the student leaves the premises with the intent to operate a vehicle, call the police.

When it appears that the student's well being is in immediate danger (e.g., extreme lethargy, severe lack of coordination, delirium, unconsciousness, etc.)

1. Perform appropriate first aid.
2. Call for ambulance service and emergency medical assistance.
3. The parent/guardian must be notified by the administrator.

Any student who appears to be under the influence of alcohol or drugs should be:

1. Referred for counselling and/or medical treatment.

Students are not to be left unattended in the medical room unless, the first aid attendant is relieved by an administrator or teacher.

~ REQUESTING AMBULANCE SERVICE ~

1-800-461-9911

When requesting the services of an ambulance to attend to a seriously injured or ill student the attendant must be ready to provide the following information:

1. Type of emergency
2. Nature of the injury or condition
3. School/site name and address
4. School/site phone number
5. Exact location where the ambulance should enter the grounds

As a general rule, if there is ever any doubt whether or not an ambulance is required, then an ambulance should be called.

The first aid attendant is responsible for determining which is the best exit to summon the ambulance to and directing staff in this regard.

1. The school/site administrator/supervisor (or any available employee) should be asked to keep the exit route clear.
2. Another employee should be asked to direct the ambulance to the chosen exit.
3. After the injured or ill student is evacuated the administrator should be informed of the patient's identity.
4. The parent/guardian(s) will be notified by the administrator.

~ COMMUNICATION IN THE EVENT OF A SERIOUS INJURY OR DEATH ~

In the event of a serious injury or death of a student on school property, during a school function, or during a school related activity:

1. Inform the school administrator or designate
2. The administrator or designate will inform School District 50 administration
3. Inquiries by the media regarding any such incident should be referred to either the Office of the Superintendent or the Secretary Treasurer of School District 50

HANDLING STUDENTS WITH NON-MEDICAL PROBLEMS

CHILD ABUSE

Disclosures of child abuse or evidence of child abuse must be reported to the local office of the Ministry of Children and Family Development:

1. As soon as possible document the disclosed abuse, the circumstances of the disclosure and the student's statement in his/her own word if possible.
2. Reporting is the responsibility of the person who receives the information.
How to Report:
 - Monday to Friday 8:30 am – 4:30 pm call the local district office at 559-4403 in Queen Charlotte or 626-5481 in Masset
 - Monday to Friday after 4:30 pm, Saturdays, Sundays and Statutory Holidays call the Helpline for Children toll free at 310-1234
3. Follow the guidelines outlined under School District 50's "Educational Handbook: Reporting Abuse"
4. Do not contact the student's parents or guardians: this is the responsibility of the investigating social worker.
5. The school administrator should be informed that you have contacted the Ministry of Children and Family Development (details should not be provided).

HEALTH COUNSELLING

When a student may require health or personal hygiene counselling the case is to be referred to the school administrator or counsellor.

MENTAL OR EMOTIONAL DISTRESS

Students who appear to be mentally or emotionally disturbed must be referred to the school administrator or counsellor. Referrals may then be made to outside agencies if deemed necessary.

~ TREATMENT OF INJURED STUDENTS ~

When a student is injured at school or when under school supervision:

1. The teacher of the student(s), having the duty of care, should if necessary, administer basic first aid treatment (i.e. start the breathing, stop the bleeding, treat for shock by keeping the patient warm and comfortable). (NOTE: Each school shall have a staff member or administrator with a current First Aid Certification.)
2. The staff member or administrator should then make a decision based on an assessment of the seriousness of the injury either to:
 - a. contact the parents, or
 - b. call the ambulance (and then phone the parents), or
 - c. call the doctor (and inform a parent), or
 - d. take a student to a hospital (and inform the parents), or
 - e. return the student to normal activity, or
 - f. place a student in a suitable area that is regularly supervised by a teacher. The frequency of observation should not be less than once every five minutes for the first twenty minutes. If the student is unable to resume normal activity (a) to (d) should be taken.
3. Students with the following injuries shall be delivered to an appropriate medical facility as soon as possible:
 - a. any head trauma
 - b. suspected fractures
 - c. cuts or gashes causing considerable bleeding
4. The person taking action to deliver the student to an appropriate medical facility must inform the school administrator.
5. The staff member or administrator should complete a School's Protection Program "Student Incident Report" as soon as it is possible to do so. This form is to be forwarded to the District Office for review.
6. The staff member or administrator shall, if the injury is serious, inform the Superintendent of Schools or the Secretary Treasurer immediately.
7. No injured student shall be sent home unaccompanied. The school shall ensure that the student is delivered to the care of an appropriate person.

All Injuries and Illnesses

For each visit make an entry in the Student First Aid Book and note the:

- a. Date and time
- b. Name of student
- c. Nature of problem
- d. Treatment rendered
- e. Disposition
- f. Time of departure

Complete the School Protection Program (SPP) School Incident Form for all medical referrals including dentists. The completed form will be turned into the administrator for further action and distribution.

~ REFUSAL OF TREATMENT BY A STUDENT ~

If a student:

1. Reports to first aid with an injury, then
2. Refuses first aid treatment, and
3. The first aid attendant determines that first aid is required and the injury could lead to consequential problems, take the following action:
 - a. Request the presence of the administrator or designate and explain the problem in front of the student and administrator
 - b. If the problem still cannot be resolved, document the incident
 - c. If possible keep the student in the medical room while arrangements are made to remove the student from the school to their home or to medical attention.
 - d. The administrator will contact the student's parents/guardians.

Note: The student should not be permitted to return to school until medical clearance is produced.

It is the responsibility of the administrator or designate to contact the student's parents/guardians by telephone if possible. If contact is not possible the parents/guardians should be notified of the incident by the administrator in writing.

~ SECTION C: FIRST AID ROOM ADMINISTRATION ~

HYGIENE IN FIRST AID ROOMS

PERSONAL HYGIENE

Hand Washing

Hand washing is essential to prevent infection and the spread of bacteria. Hand washing must be routinely practiced by all first aid attendants. First aid attendants should wash their hands:

- When coming on duty
- When hands are visibly dirty
- Before and after contact with patients, before eating or going for breaks, after using the toilet
- After blowing or wiping the nose routinely throughout the day
- After removing gloves before going home
- After handling soiled articles, instruments, dressings, etc.
- Before and after wound dressing procedures
- When a glove is torn or punctured or is suspected of leaking (remove the glove first)

The proper hand washing procedure/method is:

1. Wet hands thoroughly in warm, running water.
2. Add soap and make a lather using a brisk scrubbing motion. Wash the fingers, palms, back of hands, wrists and under the nails. Scrub the hands for approximately one minute. Unlike a disinfectant which kills bacteria, soap cleans by removing them and allowing them to be rinsed off. This is why it is necessary to scrub when ordinary soap is used.
3. Rinse hand thoroughly. The water should flow from the fingers back towards the wrists and arms.
4. Dry hands off with a paper towel and use the towel to turn off the faucet. Discard the used towel in the waste-basket.

How to Remove Disposable Gloves

Remove disposable gloves as soon as possible if they become damaged or contaminated. Remove them after you have completed the task that required gloves. Gloves should also be removed before leaving the work/treatment area. **Do not wash and reuse your gloves** and use new gloves for each new task.

Follow these steps to make sure your hands do not contact any blood or body fluids left on used gloves during removal:

1. With both hands gloved:
 - Grasp the outside of one glove at the top of the wrist
 - Peel off this glove from wrist to fingertips while turning it inside out as you pull the glove off your hand and away from you

- Hold the glove you just removed in your gloved hand
2. With the ungloved hand:
 - Peel off the second glove by inserting your finger on the inside of the glove at the top of your wrist
 - Turn the glove inside out while pulling it away from you, leaving the first glove inside the second
 3. Dispose of the entire bundle promptly in a plastic garbage bag.
 4. Wash your hands thoroughly with soap and water as soon as possible after removing gloves and before touching non-contaminated objects and surfaces.

SANITARY TECHNIQUES FOR FIRST AID TREATMENT AREA

First Aid Treatment Area Counter Surfaces

The counter surface of each treatment area should receive a thorough cleaning at the start and end of each work day. Counter surfaces can be cleaned with a solution of 10-12% bleach or a hospital grade germicidal cleaner. Cleaning agents can be obtained through the school custodian.

- Remember:
1. Clean counter surfaces immediately after any known contamination occurs.
 2. Some individuals may suffer from bleach allergies.

Handling Soiled Dressing/Towels

After removing a soiled dressing, immediately place it directly in the disposal bin lined with a plastic bag.

- Remember: Do not place soiled dressings on the counter top; this practice contaminates the surface of the treatment area.

Telfa Dressings

Before cutting a sterile Telfa pad to accommodate the wound size remove the outer wrapping and cut the Telfa with sterile scissors.

- Remember: Do not cut through the outer package; this practice contaminates the Telfa dressing inside.

Utensils (Instruments)

The utensils (e.g. scissors, forceps, etc.) should be washed in a cold sterilizing instrument tray after each use. The tray contents should be re-sterilized once weekly using a cold sterilizing solution.

Warning: Do not place contaminated utensil back on the instrument tray; this practice contaminates all the utensils on the tray.

Dispensing Creams and Lotions

Use a new, clean tongue for each application of lotion or cream.

Remember: Reusing dispensing applications may result in the spread of infection and/or bacteria.

How to Pick Up a Sharp and Place it in a Sharps Container

Follow these steps to pick up improperly discarded sharps and other items that could carry HIV and/or Hepatitis B & C viruses:

1. Have disposable waterproof gloves (such as natural rubber, latex, neoprene, nitrile or vinyl) and a proper sharps container ready.
2. Put the gloves on. Place the sharps container next to the needle or other item. Do not hold the container in your hand, or you might accidentally cut or stick yourself.
3. If you are comfortable using tongues or pliers, use them to pick up the needle or other sharp and place it into the sharps container. This is the preferred method. If you are not comfortable using the tongues or pliers, pick up the needle by the shaft. In either case, place the needle or other sharp into the sharps container, sharp end/needle first. Do not insert your fingers into the opening of the container and keep you free hand out of the way.
4. Remove and discard the gloves.
5. Wash your hands with soap and water.
6. Do not overfill the sharps container. When it is about three-quarters full, replace it with a new one and properly dispose of the container and its contents. Do not attempt to open or empty sharps containers.
7. Clean tongues or pliers with one part bleach to ten parts water and let soak for ten minutes. Rinse the tongues thoroughly.

Ordering Supplies

1. First aid attendants are responsible for ensuring that required first aid supplies and appropriate quantities are available on site and in the first aid room. The various department heads (science, PE, industrial ed, etc.) are responsible for ensuring that appropriate first aid supplies are on hand in their departments.
2. Medications are not to be ordered as first aid items by the first aid attendant.

FIRST AID KITS

Personal First Aid Kits

These items must be kept in a container. The container must be weatherproof is necessary to keep the items clean and dry.

- 1 pressure dressing
- 6 sterile adhesive dressings, assorted sizes, individually packaged
- 6 individually packages towelettes
- 1 wallet-sized instruction card advising the worker to report any injury to the employer for entry in the first aid records, and instructions on how to call for assistance

The following outlines the required first aid supplies as set by the Board of School Trustees.

POLICY 6430-1 **FIRST AID** **November 1999**

MEDICAL ROOM SUPPLIES

SAFETY SUPPLY CANADA

| | | |
|-----------------------------|------------|-------------------|
| Bandaid (regular) | #032D109- | 1 box |
| | #032O111- | 1 box |
| Bandaid (butterfly) | #032D178- | 1 box |
| | #032D179- | 1 box |
| Bandage - Compress | #032D405- | 5 |
| Cotton Balls | #032D351- | 4 box |
| Elasto Strip 1-1/2" | #032D147- | 1 box |
| Gauze Pads 2 X 2 | #034L105 - | 8 box |
| Gauze Pads 3 X 3 | #034L110 - | 12 box |
| Gauze Roll 1" | #032D301- | 5 rolls |
| Ice Pack | #032Y335 - | 5 |
| Needles | - | 1 pkg. |
| Oil of Cloves (Tooth Drops) | #032Y514 - | small btle. 4 ml. |
| Penlight | | |
| Q-tips | #032D567 - | 4 box |
| Safety Pins | #032Y439 - | variety 1 of |
| Slings (triangular bandage) | #032D469- | 2 of |
| Adhesive tape - 1" | #032D128- | 2 rolls |
| - 1/2" | #032D021- | 2 rolls |
| Non-allergic tape - 1" | #032D607- | 1 pack (12) |
| - 1/2" | #032D605- | 1 pack (24) |
| Temp-away | | |
| Tensor bandage - 2" | #032D485- | 2 roll |
| - 3" | #032D487- | 1 roll |
| Tongue depressors | #032Y249 - | 1 box |
| Tweezers | #032T290 - | 1 |
| Paper Bags | - | 20 small |
| Liquid Antiseptic Soap | #032V120 - | 50 ml. |
| Scissors | #032T758 - | 1 of |
| | #032L125 - | 3 of |
| | #032D237- | 2 of |
| | #032D301- | 1 of |
| | #032D015- | 1 of |

SCHEDULE 2

INDUSTRIAL EDUCATION/SCIENCE ROOM

| B.C. WCB #2 Kit | | Order Kit #1 |
|--|-------------------------------|----------------|
| Packet A | - 4 hand cleansers | #030A100 |
| | - 12 alcohol wipes | |
| Packet B | - merthiolate - 60 ml | - 2 of |
| Packet C | - 1" x 3" adhes. bandages | - 25 of |
| Packet D | - 2" Sterile Bandage compress | - 4 of |
| Packet E | - 4" Sterile Bandage compress | - 1 of |
| Packet F- | - 2 Gauze Pads | |
| | - 2 Eye shields | |
| Packet G | - Soluble burn ointment | - 2-1oz. tubes |
| Packet H | - 36" x 36" Gauze compress | - 1 of |
| Packet I | - 2" x 5 yd. gauze bandage | - 2 of |
| | - 1" x 5 yd. gauze bandage | - 1 of |
| Packet J- | triangular bandage | - 1 of |
| Hand Cleansers - Antiseptic Towlettes | | - 12 of |
| Gauze pads (sponges) 3" x 3" | #034L110 | - 12 of |
| Band-aids | #032D067 | - 2 of |
| Compress Dressing - 2" | #032D952 | - 4 of |
| - 4" | #032D006 | - 6 of |
| Eye Shield | #032Y304 | - 2 of |
| Eye Pad Ointment | #034L175 | - 2 of |
| Gauze Dressing - 36" x 36" | #034L125 | - 3 of |
| Gauze bandage - 2" | #032D237 | - 2 of |
| - 1" | #032D301 | - 1 of |
| Adhesive tape - 1" | #032D015 | - 1 of |
| Triangular bandage | #032D469 | - 6 of |
| Scissors | #032T758 | - 1 of |
| Tweezers | #032T290 | - 1 of |
| Finger Tip bandage | #032D455 | - 1 of |
| Knuckle bandaid | #032D065 | - 1 of |
| Needles | | |
| Eye cup and wash | Solution #032Y310 | - 1 of |
| | Cup #032Y277 | - 1 of |
| Sterile Pads | #0320409 | - 1 of |
| First Aid Manual | | |
| Log Book to record use and replenishment of kit. | | |

TRAVEL AND PHYSICAL EDUCATION

| | | | |
|------------------------------------|----------|---|-------------|
| Adhesive Tape - 1" | #032D022 | - | 1 of |
| - 2" | #032D017 | - | 1 of |
| Adhesive Tape - non-allergic 1" | #032D055 | - | 1 roll |
| - 2" | #032D057 | - | 1 roll |
| Compress Dressings (ABD) 2 x 4 #13 | #032D421 | - | 12 of |
| Gauze Bandage - 2" | #032D237 | - | 6 of |
| Gauze Dressing - 3" x 3" | #032D307 | - | 6 envelopes |
| Liquid Soap - Antiseptic | #034L018 | - | 1 of |
| Safety Pins | #032Y439 | - | 1 of |
| Scissors | #032T758 | - | 1 of |
| Sling (triangular bandage) | #032D469 | - | 2 of |
| Telfa pads - 2" x 2" | #032D407 | - | 1 of |
| Tweezers | #032T290 | - | 1 of |

| | |
|---------------------------|-----------|
| First Aid Kits - Vehicles | BC#01 Kit |
| First Aid Kit - Shops | BC#1 Kit |

~ SECTION D: STANDARD TREATMENT PRACTICES ~

GENERAL PRACTICES

Some injuries/illness that occur commonly among students and employees are not fully covered in first aid training courses.

In recognition of this short coming, Standard Treatment Practices are developed to guide the first aid attendant handling these types of injuries/illnesses.

SYMPTOMS OF COMMON CHILDREN’S DISEASES

Note: First aid attendants should not attempt to diagnose medical conditions. The following is provided for information only.

If any of the following conditions are suspected, refer to a family doctor for advice or treatment.

| DISEASE | SYMPTOMS | NOTES |
|---------------------------|--|--|
| Chickenpox | <ul style="list-style-type: none"> • Fever • Runny nose • Tiredness • Itchy, blister-like rash | <ul style="list-style-type: none"> • Stay away from school until all blisters are crusted or until 6 days after rash appears, whichever is longer |
| Conjunctivitis (Pink-Eye) | <ul style="list-style-type: none"> • The white of the eye looks pink • The edges of the eyelid look red and swollen • The discharge from the eye may be thick, clear, white or yellow-green in colour | <ul style="list-style-type: none"> • Stay away from school until eye discharge has stopped or after treatment for 24 hours |
| Impetigo | <ul style="list-style-type: none"> • Patches of honey coloured crusts on a moist red base • One or many patches may appear on the face, arms and legs | <ul style="list-style-type: none"> • Refer to medical treatment for advice |
| Measles | <ul style="list-style-type: none"> • Fever of 38.3°C (101°F) or greater • Eyes inflamed or sensitive to light • Runny nose • Dry cough • Dusky red, blotching rash on the 3rd or 4th day starting on the face spreading to the trunk and limbs more than 3 days • White spots inside the mouth | <ul style="list-style-type: none"> • Stay away from school until 5th day following appearance of rash |
| Mumps | <ul style="list-style-type: none"> • Swelling in the cheek at the angle of the jaw • Swelling may on one or both cheeks, with tenderness of the swollen glands • Cold-like symptoms such as fever, muscle aches, headaches | <ul style="list-style-type: none"> • Stay away from school for 3 days following the beginning of swelling |
| Scabies | <ul style="list-style-type: none"> • Itching which may worsen at night • Many tiny blisters, scratch-like marks and crusts • Occurs mostly in skin folds, between fingers, on wrists, trunk, male genitals, female breasts | <ul style="list-style-type: none"> • Stay away from school until treated |

| | | |
|-----------|---|---|
| Rubella | <ul style="list-style-type: none"> Swollen glands behind the ears and near the base of the skull A fine, pale, red rash on the face and spreading to the trunk and limbs Mild cold-like symptoms | <ul style="list-style-type: none"> Must stay away from school for 4 days after the appearance Keep away from pregnant women |
| Ringworm | <ul style="list-style-type: none"> Scaly, red, raised, small patches often with a clear centre on the skin Itching Patches of hair loss with red scaly scalp Short broken hairs visible | <ul style="list-style-type: none"> Stay home until treatment starts, refer for medical advice and treatment |
| Head Lice | <ul style="list-style-type: none"> Itching, irritation of the scalp or neck area Grey/brown insects about 1-2mm long can be seen at the nape of the neck, behind the ears | <ul style="list-style-type: none"> Stay away from school until treated |

DENTAL ACCIDENT PROCEDURES

The following is a guide to the treatment of common dental injuries. Be cautious not to overlook other injuries or conditions that may accompany the dental injury (example: head injury, trauma, etc.). When in doubt, call for emergency medical treatment or have the patient attend hospital emergency.

| INJURY | GENERAL PROCEDURE |
|-------------------------------|--|
| Injury to gums, cheek, tongue | <ol style="list-style-type: none"> To stop bleeding, apply direct pressure with clean towel or bandage. Have patient keep mouth still and sit upright. To prevent swelling, apply cold compress. Ascertain source of injury. Do not attempt to remove embedded objects. Have patient attend dentist or hospital emergency immediately. |
| Tooth knocked out | <ol style="list-style-type: none"> Find the tooth quickly; always hold it by the crown, not the root. Rinse tooth gently under running water. Do not scrub or use cleaning agent. Place tooth in milk, if not available, wrap in soaked gauze. Have patient attend dentist immediately. Teeth replaced quickly will often reattach, so time is of the essence. |
| Suspected jaw fracture | <ol style="list-style-type: none"> Have patient attend hospital emergency |
| Tooth knocked out of position | <ol style="list-style-type: none"> Clean area gently with warm water and gauze. To prevent swelling, apply cold compresses. Have patient attend dentist immediately, even if displacement looks minor. The tooth should be moved back into position and splinted as soon as possible. |
| Broken Tooth | <ol style="list-style-type: none"> Clean tooth and area with arm water and gauze. To prevent swelling, apply cold compress. Have patient attend dentist immediately. Handle tooth fragment as described in "Tooth Knocked Out" |

ANIMAL/DOG BITES

When treating a person who has been bitten by a dog or other animal:

1. Examine for open wound and/or puncture marks.
2. Note any wound(s) that initially appears to be puncture marks. (Note: A puncture wound may appear to be very small cut)
3. Clean and disinfect all wounds.
4. If significant wounds/injuries are present, send the patient for immediate medical attention.
5. If possible determine the student/employee's record of tetanus immunization. If this information is reliable, send it with the student/employee to the medical centre.
6. Inform the supervisor/administrator or designate of the incident. Provide them with details regarding the location and time of the incident, a description of the animal and whether the animal is at large or continuing to be a nuisance around the school/site. It is the responsibility of the supervisor/administrator/designate to secure the school site and its property from continuing threat of animal attack.
7. If the animal is a dog and the dog's owner is unknown and the dog continues to be a nuisance around the school sit or the initial attach has been vicious one, the SPCA should be called to have someone pick up the animal.
8. Try hard to find the home address of the dog owner. Phone this information to the Health Inspector and give a description of the animal. The Health Inspector will contact the dog's owner and request that the dog be contained.

NOTE: Tetanus booster doses following a wound, are not necessary in fully immunized individuals unless the interval since the last dose exceeds five years. Booster doses given more frequently than recommended above may lead to adverse local and systemic reactions. Appropriate cleansing and disinfection of the wound is imperative.

INSECT STINGS/BITES

Local stinging or biting insects include but are not limited to: bees, yellow jackets, wasps and hornets. The toxicity varies with the amount of venom injected, patient sensitivity and the site of the sting. Multiple stings, and stings around the nose, eyes or throat are particularly dangerous and may lead to an airway obstruction or permanent damage. In previously sensitized individuals, life-threatening reactions can occur from a single sting at any site.

Honey bees stings are sterile, whereas the venom of the yellow jacket, wasp and hornet is contaminated and more likely to cause infection.

Remember: Some individuals have allergic reaction to these stings that can be life threatening.

When treating person with insect stings/bites:

1. Patients exhibiting an allergic reaction, or with multiple stings, or with stings around the eyes, nose or throat should be referred promptly to a hospital or medical clinic.

2. A stinger remaining in the tissue indicates a honeybee sting. Immediately remove the stinger by flicking with finger tip or removing with needle, pin or straight blade. Do not squeeze venom sac as this will release more venom. Do not cut or pick the sting site.

Signs, Symptoms and Treatment

1. Local Reactions: pinprick sensation followed by swelling, itching and warmth over site. Symptoms disappear within a few hours.
 - Treatment for Local Reactions: non-allergic person
 - Wash area with soap and water
 - Apply ice near the sting site
 - May apply an antiperspirant or sting stop containing an aluminium salt, or calamine lotion.
2. Generalized Allergic Reactions (onset of symptoms within seconds to minutes of sting)
 - Sneezing, generalized itching, hives, edema which proceed to:
 - Constriction in throat
 - Difficulty in breathing
 - Broncho-constriction
 - Elevated blood pressure
 - Weakness, sweating, fainting, coma
 - Nausea, vomiting, diarrhea
 - Involuntary muscle spasms and convulsions may be seen following multiple stings

Note: Delayed serum sickness reaction may occur over 10-14 days following the sting. Symptoms are: fever, malaise, headache, hives, lymphadenopathy, polyarthritis

FIRST AID TREATMENT FOR ANIMAL REPELLENT SPRAYS IN THE EYES OR ON THE SKIN

There have been a number of incidents in which individuals have been sprayed with animal repellents during school or work. These materials contain about 5-10% red pepper extract, 15% methylene chloride and 75% white mineral oil.

These materials are highly irritating to the eyes and skin and should be removed as soon as possible.

When treating individuals exposed to animal repellent and sprays the Poison Control Centre advises that the following steps are followed:

EYES

1. Remove contact lenses (if possible)
2. Flush eyes with lukewarm water for a minimum 10-15 minutes.
3. Refer all patients to the emergency department of the nearest hospital as soon as possible for further flushing with saline solution

SKIN

1. Remove any clothing contaminated with the spray
2. Flush skin with lukewarm tap water for a minimum of 10-15 minutes. A mild soap will also help to remove the material.
3. If the skin is still irritated after flushing with tap water, refer the patient to the emergency department of the nearest hospital for further flushing with saline solution.

EXPOSURE VIA HUMAN BITES

Infection following human bites is caused by organisms (bacteria) commonly found in the mouth. A human bite is well known to carry a high risk of infection. These infections can be treated with antibiotics. However, the following blood-borne pathogens are unlikely to be transmitted by bites.

Hepatitis B Virus (HBV) Transmission

Transmission of Hepatitis B is unlikely as very few school children are carriers and saliva contain far fewer viral particles than blood. However, documented cases of hepatitis B transmission have occurred following a human bite.

HIV (Human Immunodeficiency Virus) Transmission

There has only been one confirmed case of HIV transmission following a human bite; in this case, there was exposure to blood as well as saliva.

Hepatitis C Virus Transmission

There are no known confirmed cases of Hepatitis C being transmitted through a human bite.

When treating injuries from human bites:

Minor Bite

(Superficial Scratch or Skin Unbroken)

1. Cleanse the area thoroughly with warm water and soap or suitable antiseptic.
2. Advise all patients to see a doctor if signs of infection develop.
3. Notify immediately the parent/guardian if a student is bitten.
4. Clean up all contaminated materials and surfaces by following the guidelines outlined earlier in this section.

Major Bite

(Ragged, Deep, Persistent Bleeding)

1. Cleanse the area thoroughly with warm water and soap or suitable antiseptic.
2. Irrigate the wound well with water.
3. Cover with a sterile bandage. Apply ice for immediate swelling or pain.
4. Refer all patients to a doctor or hospital emergency as soon as possible.
5. Notify immediately the parent/guardian if a student is bitten.
6. If available, document and forward the patient's vaccination records for tetanus and Hepatitis B with the patient to the doctor.
7. Clean up all contaminated materials and surfaces by following the guidelines outlined earlier in this section.

section.

Exposure via Mucous Membranes (Mouth or Eyes)

Mucous membranes are fluids in the mouth, nasal passage and eyes. If these body parts are exposed to blood borne pathogens:

1. Flush the eye or mouth thoroughly with water for 10 to 15 minutes.
2. Refer all patients to the emergency room of the nearest hospital. The patient should be assessed for risk of exposure to blood-borne pathogens at the emergency department as soon as possible, preferably within 2 hours of the incident.
3. Notify immediately the parent/guardian if a student is exposed to blood or body fluids.
4. Clean up all contaminated materials and surfaces by following guidelines above.

GUIDELINES FOR PREVENTION OF INFECTION FROM BLOOD BORNE PATHOGENS (HIV & HEPATITIS B & C)

The following information is provided to assist persons providing first aid in schools. While the chances of caring for a person with either of these infections are very low it is recommended that these guidelines regarding handling blood are followed for all persons.

The guidelines are:

1. Avoid blood where possible; if it is reasonable, have the injured person care for themselves under supervision. For example, if the injured person has a bleeding nose, hand them some tissue and have them apply pressure to their own nose.
2. When necessary to handle blood, wear gloves (vinyl or latex non-sterile).
3. If the patient's blood does get on the care giver's hands or body, wash it off with soap and water as quickly as possible.
4. Dressings and materials used to cleanse or cover wounds be disposed of in a plastic bag lined, covered receptacle. For disposal, the entire plastic bag is to be removed and the receptacle relined.
5. Put a 10% household bleach solution on any blood spills on floors or furniture prior to cleaning up (hot water and soap can be used on areas where bleach would cause damage).

Exposure via Needle Stick Injuries

When treating a needle stick injury:

1. Handle the needle with tongs, if practical. Place the needle in a puncture proof container. Sharps containers should be located in the First Aid Room.
2. Cleanse the puncture area thoroughly with warm water and soap or a suitable antiseptic. Pinch around the injection site to draw out any fluid from the puncture.
3. Refer all patients to hospital emergency. The patient exposed to the risk of blood-borne pathogens should be assessed at the emergency department as soon as possible, preferably within 2 hours of the incident.

4. Notify immediately the parent/guardian of any student with a needle stick injury.
5. Document and forward the following information (if known) and the needle container with the patient to the doctor in the emergency department.
 - Needle history – was the needle previously used or was it packaged? Was the needle from a known or unknown source?
 - The patient’s vaccination record for tetanus and Hepatitis B.
6. Clean up all contaminated materials and surfaces by following guideline above.

Risk of Infection by Blood-Borne Pathogens Following a Needle Stick Injury

The probability of infection from a needle stick injury depends on several factors:

- A person’s immune status (if they have been vaccinated for Hepatitis B)
- The presence of viable virus in the blood within the syringe.
- The amount of virus in the blood which the person was exposed.
- The depth of the wound and whether spontaneous bleeding occurred.
- Whether appropriate and timely post-exposure prophylaxis is provided.

The average risk of infection following a needle stick injury from a known infectious source is:

| | |
|-------------|--------------|
| Hepatitis B | - up to 30% |
| Hepatitis C | - up to 10% |
| HIV | - about 0.3% |

Information on Post-Exposure Prophylaxis

For patients who have been classified as having received a significant exposure to body fluids identified as Hepatitis B, C or HIV positive, treatment may include blood samples and the following:

Hepatitis B: Post-exposure prophylaxis depends upon the patient’s vaccination history.

- Non-vaccinated patients will most likely receive the HBV vaccine plus HBIG (Hepatitis B Immune Globulin)
- Vaccinated patients with adequate antibodies will probably not receive any further treatment. Vaccinated patients whose antibody levels have not been checked within the last 2 years or whose antibody levels are low or undetectable will be re-vaccinated and may also be administered HBIG.

Hepatitis C: There is not post-exposure prophylaxis to prevent Hepatitis C virus infection.

HIV: Post-exposure prophylactic medication recommendations are rapidly evolving. The current recommendation is to initiate prophylactic-therapy if there is exposure or risk of exposure to HIV. Therapy should be initiated as soon as possible after exposure, preferably within 2 hours to offer the best chance of preventing HIV infection.

COMMON IMMUNIZATION REACTIONS AND TREATMENT

Reactions to vaccination are generally mild and resolve without treatment. During an immunization clinic at school, the team of nurses who give the vaccination are on site to attend to any immediate minor or severe reactions. Minor reaction may be experienced for a few days after immunization.

Minor Reactions

Minor reactions are common and often subside in 12-48 hours. These include:

1. **Tenderness** at the injection site with swelling and redness (1-3 cm across), a student may not want to move the affected limb.

Treatment - a cold compress to the area for about 10 minutes can reduce swelling and tenderness.

2. **Fever** can occur within the first 24-48 hours (or 7-15 days following the measles vaccine). Other symptoms may include swelling of the lymph nodes closest to the injection site, muscle and joint pain and drowsiness.

Treatment – for a fever, increase fluids and recommend a tepid sponge bath at home. Parent/guardian(s) should be notified to contact their family doctor.

Note: ASA products (Asprin & Bayer) should never be given to a child with a fever because they can increase the risk of Rheyes Syndrome.

Severe Reactions

Severe delayed reactions are extremely rare. Symptoms may include:

1. **Swelling** beyond the site of the injection, along with pain and restriction of movement involving the entire limb.

Treatment - a cold compress to the area for about 10 minutes can provide some relief. The student should be referred to their family doctor.

2. **Persistent fever over 39°C** can result in seizures.

Treatment – cold compresses and tepid sponge baths. The student should be referred for medical treatment as soon as possible.

Treatment for Generalized Allergic Reactions

Student/employee with no previous history of allergic reactions:

1. Immediately contact hospital emergency services
2. Keep the person calm and still
3. Apply ice over the sting or infected site

Student/employee with a history of severe allergic reactions;

1. Immediately contact hospital emergency services
2. Follow the Emergency Treatment Plan which may include the use of Epipens or Anakits

HYPOTHERMIA/FROST BITE

Hypothermia

Signs and Symptoms:

Shivering, slurred speech, irritable, stumbling, denial, slow pulse, slow breathing. Hypothermia affects the brain's ability to function properly and should always be considered serious.

Prevention:

Stay dry and wear layers of warm, dry clothing. Eat proper food and snacks for energy.

Treatment:

- Do not give the victim alcohol
- Do not massage the victim
- Do not walk the victim around
- Do not use warm or hot water to warm a hypothermia victim

Note: The above measures will dilate the blood vessels and make the victim feel warm, however, it brings cold blood to the body core from the arms and legs and lowers the body's core temperature.

- Keep the victim warm and dry
- Move the victim very gently
- Get medical assistance immediately

Frost Bite:

1. **Do not thaw** the frozen part, unless you can keep the part thawed (refreezing causes more tissue damage)
2. Do not rub snow on the frozen part of the victim's body
3. If you wish to thaw the frozen part, immerse the frozen part into water heated to exactly 39-40°C
4. General medical assistance immediately

~ SECTION E: MEDICAL CONDITIONS ~

DIABETES

The only problem a diabetic student is likely to have in school will be an insulin reaction (too little sugar in the blood). These should not occur frequently. They are usually brought on by more exercise than usual, delay in having a meal or smaller meal than usual.

Signs and Symptoms of Insulin Reaction:

- Hunger
- Trembling
- Perspiring
- Pale clammy skin
- Weakness
- Nausea
- Drowsiness
- Tingling of mouth and fingers
- Irrational behaviour

Treatment:

1. Provide a form of glucose immediately (i.e., sugar, honey, syrup, sweetened fruit juice, etc.)
2. Contact emergency medical services if the individual is unable to swallow or loses consciousness
3. Monitor the individual for improvement
4. Have the individual rest
5. The administrator or designate should be informed of the incident
6. If the student is to be sent home, the administrator or designate is responsible for contacting the parent of guardian.

Remember: no matter what the diabetic emergency, giving sugar will not harm the patient.

EPILEPSY

Most seizures, although frightening and dramatic, are self-limiting.

Seizures may be caused by a variety of conditions, including:

- Not taking prescribed anti-convulsive medication
- Hypoglycaemia in diabetic patients
- High fevers
- Over exertion
- Malnutrition
- Light stimulation

When a seizure occurs:

- DO NOT restrain the movement of the patient
- DO NOT put anything between their teeth or in their mouth
- Protect the individual from striking surrounding objects that may cause an injury

- If the seizure lasts more than 2 minutes contact emergency medical services
- Stand by until the seizure stops and the individual has fully recovered consciousness from the confusion which sometimes follows a seizure
- Allow the individual to rest if they feel tired, they may return to class once they feel better
- Inform the administrator or designate and have then notify the parent or guardian

ASTHMA

Asthma affects approximately ten percent of children in Canada. Acute asthmatic attacks are precipitated by different factors for different individuals, but may include:

1. Allergic reaction to pollens, animals, dust, smoke, sawdust, etc.
2. Respiratory infection
3. Cold air
4. Emotional distress
5. Exercise
6. Other irritants
7. Medication

During an Asthma attack:

1. Determine the individual's ability to breath and reassure the individual
2. Assist the individual in taking their medication if available (e.g., inhaler, bronchodilator)
3. If the individual's symptoms persist:
4. Medication has not helped, or
5. The patient has difficult breathing, is blue or sweating
6. Contact Emergency Medical Services and initiate Artificial Respiration or Cardio Pulmonary Resuscitation as necessary.
7. Notify the administrator, who will contact the parent/guardian(s) if the patient is a student

~ SECTION F: RECOMMENDATIONS ~

UNIVERSAL PRECAUTIONS

Body Fluids

The term body fluids includes: blood, urine, drainage from scrapes and cuts, feces, vomit, respirator and nasal secretions, and saliva. The body fluids of all persons are considered as containing potentially infectious agents. In most instances, the risk is low and depends on the type of fluid involved, the kind of contact made with it and the stage of infection of the carrier. When possible, avoid direct contact with body fluids.

Hand Washing

The proper hand washing procedure/method is:

1. Wet hands thoroughly in warm, running water.
2. Add soap and make a lather using a brisk scrubbing motion. Wash the fingers, palms, back of hands, wrists and under the nails. Scrub the hands for approximately one minute. Unlike a disinfectant which kills bacteria, soap cleans by removing them and allowing them to be rinsed off. This is why it is necessary to scrub when ordinary soap is used.
3. Rinse hand thoroughly. The water should flow from the fingers back towards the wrists and arms.
4. Dry hands off with a paper towel and use the towel to turn off the faucet. Discard the used towel in the waste-basket.

Jewellery

Jewellery should not be worn when working with students who require repeated physical contact and care. Micro-organisms can become lodged in settings or stones.

Gloves

- Wear disposable, nitrile gloves when direct hand contact with body fluids is anticipated; i.e., treating a cut or bloody nose, changing a soiled diaper, etc.
- Wear gloves to handle any soiled items.
- Wash hands after removing gloves. Gloves do not eliminate the need for good hand washing.

Soiled Laundry

1. Clothing soiled with body fluids should be washed separately from other items.
2. Pre-soaking may be required for heavily soiled clothing. If material is bleachable, add ½ cup of household bleach to wash cycle. If material is not colour fast, add ½ cup non-chlorine bleach (i.e. Clorox) to the wash cycle.

Disposals

1. Contaminated disposable items (gloves, paper towels, tissues, bandages, diapers, etc.) should be placed into a white-coloured plastic garbage bag so that it is identifiable to all staff, then immediately placed into the garbage cart in the custodian's room.
2. Non-disposable items, such as clothing, should be rinsed and placed in plastic bags. Pre-soaking in cold water may be required to remove blood or stains.

Safe Handling of Spilled Body Fluids

1. When a body fluid spill is discovered, students should be kept away until clean-up is complete.
2. The staff member should put on nitrile gloves before starting the clean-up. Chemical-splash goggles are also recommended.
3. The staff member should prepare a solution of disinfectant/sanitizer.
4. The custodian should be made aware of the spill in case further clean-up is required.
5. Wipe up as much of the body fluid as possible with paper towels. Soiled paper towels should be disposed of directly into a white garbage bag.
6. Spray disinfectant solution onto the body spill and allow the solution to decontaminate the site for two minutes – resilient flooring (i.e. carpet) should be cleaned as soon as possible.
7. The area should then be wiped clean with paper towel.

Contact with Body Fluids

1. If you accidentally come into contact with body fluids and you have open sores or wounds on the skin that come into contact with body fluids:
 - a. Wash your hands immediately and thoroughly with soap and water
 - b. Apply antiseptic to wound
 - c. Notify doctor of the incident
 - d. Disinfect or remove contaminated clothing
2. If you accidentally come into contact with body fluids and you do not have open sores or wounds on the skin that come into contact with the body fluids:
 - a. Wash hands immediately and thoroughly with soap and water
 - b. Disinfect or remove contaminated clothing
3. If you are going to provide assistance to someone who is bleeding:
 - a. Put on disposable nitrile gloves before providing assistance
 - b. Dispose of gloves and wash hands thoroughly with soap and water after giving assistance

Safe Handling of Hypodermic Needles and Syringes

1. Needles and syringes must NOT be picked up by students
2. When needles or syringes are discovered, students must be kept away from the site until disposal is complete
3. Arrange to have the garbage collection tongs and the “sharps container” brought to the site (e.g. and empty bleach bottle)
4. Using the garbage collection tongs and extreme caution to prevent needle sticks, a staff member should transfer the needle or syringe into the sharps container. DO NOT pick up needles or syringes with bare hands.
5. Return the sharps container to a secure location in the School District No. 50
6. Staff members who dealt with the needles or syringes should then follow the procedures for “How to Wash Hands Properly”
7. Advise the Health and Safety Officer of unusual and repeated incidents.

If a student or staff member suffers a needle stick injury, the wound should immediately be washed with soap and warm, running water and the person should be referred to immediate medical attention.

HEAD LICE

See Appendix 1

~ SECTION G: BOARD POLICIES~

POLICY 4700

ALLERGIC REACTION / ANAPHYLAXIS

November 2001

PROCEDURE

"Anaphylaxis – sometimes called "allergic shock" or "generalized allergic reaction" – is a severe allergic reaction that can lead to rapid death, if untreated." Common causes are food, latex, insect stings, medication and exercise.

Ensuring the safety of the anaphylactic children in a school setting depends on the cooperation of the entire school community.

This policy summarizes the responsibilities of all members of the school community in minimizing the risk of exposure and ensuring immediate response to an emergency.

POLICY 4700-1

ALLERGIC REACTION / ANAPHYLAXIS

November 2001

1. Allergic Reaction/Anaphylaxis

It is suggested that the following principles serve as a foundation for individual school plans for dealing with life threatening allergies:

- Parental involvement in all phases of planning.
- Cooperation rather than enforcement.
- Open communication.
- Flexibility in implementation.
- Proactive planning.
- Doing what is reasonable and prudent.
- Age appropriate student awareness and self-monitoring.

2. Information and Awareness

Parents/guardians have the primary responsibility for informing school personnel regarding their child's severe allergy. The physician must diagnose the child with anaphylaxis and prescribe the specific treatment protocol.

Safety measures a school can reasonably expect to implement are:

- 2.1 "Medical Alert Card" (including photograph of child, allergen to avoid, and management plan) and "Request for Administration of Medication at School" completed and signed by the physician and parents should be obtained.
- 2.2 A meeting with the child's parents to establish individual care plans should be held at the beginning of the school year.
- 2.3 In consultation with the parents, medical alert posters should be posted in the office, classroom, medical room and any other room that is used on a regular basis by the child.

- 2.4 All staff (teaching and non-teaching) must be made aware of and be able to visually identify students who have potentially life-threatening allergies. This may include: custodians, supervisors, bus drivers, substitute teachers, first aid attendants, parent volunteers, coaches, and food services personnel.
- 2.5 An annual training session for all staff regarding the administration of medication and EpiPen (in consultation with the public health nurse and parent) must be held and reviewed mid-year.
- 2.6 There needs to be recognition by all concerned of the increased danger when changes to the routine occur, especially field trips, Sports Days, extracurricular outings, and on treat days and festive occasions
- 2.7 There needs to be recognition by all concerned of the increased danger in cafeterias, home economics classes and in other food services areas.
- 2.8 The child's teacher(s) should receive additional information about the child from the parent. The teacher(s), parent(s), and family doctor must maintain open lines of communication.
- 2.9 The Administrator early in the school year should, through the school newsletter, inform the school community's cooperation in reducing the presence of the allergen in the school. An explanation of what an anaphylactic reaction is should be given.

3. Avoidance of the Allergen

The parent and the child have primary responsibility for avoiding the allergen. For a primary child there is a need for the school to assume a greater responsibility than it would be an older child. It is not possible to achieve a completely allergen-free school, as there can be hidden or accidentally introduced sources. Appropriate to the age of the child, the school should attempt to reduce the child's exposure to allergic foods within the school setting by arranging or ensuring as much of the following as possible:

- 3.1 There should be no trading and sharing of foods, food utensils and food containers in the allergic child's classroom.
- 3.2 All food allergic children should only eat lunches and snacks that have been prepared at home.
- 3.3 A hand washing routine, both before and after eating, for all children in the classroom of an anaphylactic child should be implemented.
- 3.4 Surfaces such as tables in the areas where students eat and that the child frequents should be washed clean using a disinfectant.
- 3.5 The use of foods in crafts, cooking classes and special celebrations may need to be restricted depending on the allergies of the students.
- 3.6 The allergic child's classroom should be checked for other sources of the allergen, e.g. play dough, beanbags, stuffed toys – peanut shells are sometimes used.
- 3.7 An allergen restricted eating area should be provided using a cooperative approach with fellow students and their parents.
- 3.8 Peanut allergies require more stringent management plans. They are one of the most common food allergies and the leading cause of food induced anaphylaxis.

- (a) Where there is a peanut allergic child in a school an allergy free classroom needs to be instituted.
 - (i) In an elementary school where children eat in their classroom the allergic child's classroom needs to be peanut-free.
 - (ii) In a school where children eat in a common area, either that common area needs to be peanut-free or a second eating area needs to be established which is peanut-free.
 - (b) Foods served by the school should omit peanuts and other nuts if peanut allergic individuals are present.
 - (c) If there is to be cooking or food preparation in the child's class, the parent of the allergic child should be notified ahead of time so that issues, such as cross contamination of bulk food, can be discussed.
 - (d) It should be recognized that this would reduce but not eliminate the risk of accidental exposure.
- 3.9 If the allergic child is to take part in a field trip by school bus, the bus should receive a visual inspection by the driver prior to the trip in order that any obvious allergen can be removed. The allergic child should sit in the front seat.
- 3.10 The school should treat the use of an allergy causing substance to bully or threaten an allergic child as if the child had been threatened with a weapon.

4. Emergency Response Procedures

- 4.1 Since it is impossible to reduce the risk of accidental exposure to zero, an anaphylactic child may require emergency lifesaving measures while at school.
- 4.2 Each school must develop and practice an emergency response plan (including such topics as: how to access the EpiPen, who will administer it, what to say when calling an ambulance, contacting parents, and safeguards for field trips and other special events).
- 4.3 An up-to-date supply of EpiPens provided by the parent(s) must be stored in a covered, secure, unlocked area for quick access. Students should be encouraged to carry an auto-injector on their person wherever possible.
- 4.4 Regardless of 4.3 above every school should have its own EpiPens.
- 4.5 When in doubt use the EpiPen or AnaKit and obtain professional medical assistance.

PROCEDURE

1. When it is necessary for a student to receive medication during school hours, the parent/guardian shall complete the REQUEST AND RELEASE FOR ADMINISTRATION OF PRESCRIBED MEDICATION BY SCHOOL DISTRICT EMPLOYEES form (attached).
2. A copy of REQUEST AND RELEASE FOR ADMINISTRATION OF PRESCRIBED MEDICATION BY SCHOOL DISTRICT EMPLOYEES will be forwarded to the appropriate Health Unit.
3. A medical alert card shall be completed and placed in student cumulative folder when the medical condition is pertinent and/or chronic.
4. Medication is stored in a secure location.
5. The medication shall be in a container dispensed by a pharmacy properly labelled and dated.
6. Records shall be kept detailing the administration of the medication. The record shall contain the date, time, name and signature of administering employee.
7. Parents/guardians are required to deliver the medication to the school.
8. The medication is administered in an appropriate location.
9. When necessary medical direction shall be requested from the appropriate Health Unit.
10. The Administrative Officer shall advise staff that only the administrative officer(s) or designated staff shall administer prescribed medication.
11. A copy of the Request and Release for Administration of Prescribed Medication shall be stored with the medication.
12. Employees have the right of refusal.

**ADMINISTRATION OF PRESCRIBED
MEDICATION TO STUDENTS
BY SCHOOL DISTRICT EMPLOYEE**

REQUEST AND RELEASE FOR ADMINISTRATION OF MEDICATION

I/We _____ the parents(s)/legal guardian(s) of

| STUDENT'S NAME | I.D. NO. |
|----------------|----------|
| | |

Confirm that on the instructions of a qualified doctor, _____ (name of doctor) that it is necessary for _____ to receive the following medication at school for his/her medical condition.

TO BE COMPLETED BY ATTENDING PHYSICIAN:

(Below specify manner of administration, e.g. orally, external application, injection and specify the daily administration times, if any).

| MEDICATION | DOSAGE | ADMINISTRATION | FREQUENCY/TIME |
|------------|--------|----------------|----------------|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

I/WE HEREBY REQUEST that the above medication be administered by non-medical school staff to _____ in the above manner.

| POSSIBLE SIDE EFFECTS |
|-----------------------|
| 1. |
| 1. |
| 3. |
| 4. |

ATTENDING PHYSICIAN

(Signature)

(Date)

IN CONSIDERATION of the School Board authorizing certain of its employees to administer the above medication as required in this request and release form. I/WE HEREBY RELEASE AND FOREVER DISCHARGE the Board of School Trustees, School District No. 50 (HAIDA GWAI/QUEEN CHARLOTTE), its members, officers, administrators and employees of and from all claims whatsoever and actions or causes of action which I/We have against the Board, its members, officers, administrators and employees arising out of the administration of the medication referred to in this request and release form.

DATED AT _____, B.C. _____, 20_____.

Witness

Parent(s)/Legal Guardian(s)

**ADMINISTRATION OF PRESCRIBED
MEDICATION TO STUDENTS**

STUDENT NAME:

| DATE | TIME | NAME OF EMPLOYEE ADMINISTERING MEDICATION | SIGNATURE |
|------|------|--|-----------|
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Is There a Louse in the Classroom?



A Head Lice Information Package For School Staff

NORTHERN HEALTH
authority

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INTRODUCTION

Head lice can affect anyone. Head lice are annoying and may cause itching, but they do not transmit or cause disease. Children and adult's reactions to head lice can subject children to teasing, bullying and isolation. Reactions to head lice can significantly interfere with a child's emotional well-being, social status in the classroom and ability to learn. For these reasons, head lice infestations should be treated.

Current research shows that school exclusion, early dismissal and no-nit policies do not prevent or control head lice infestations. In fact, these practices further stigmatize children, erode their self-esteem and interfere with learning. These practices are also at odds with other health concerns. For example, children with colds or flu viruses have a greater potential for spreading illness but are seldom excluded from school because of these.

It is important to keep children from missing school. Children should not be excluded from school or sent home early because of head lice. Parents of children should be advised to treat children to prevent the negative emotional and social impact of head lice infestations.

NORTHERN HEALTH AUTHORITY POSITION STATEMENT

The Northern Health Authority does not support school exclusion, early dismissal and no-nit policies as these disrupt the education process and adversely affect children's self-esteem and social status in the classroom.

RATIONALE

- 1) Lice may be present on the scalp for weeks before they are discovered. Only 30 percent of individuals scratch their scalp when they have head lice. As children are often in the classroom for days or weeks before head lice are detected, there is no benefit in sending them home early.
- 2) Head lice infestations are often misdiagnosed. The presence of fluff or dandruff in the hair are often mistaken for nits. Also, the presence of nits does not mean a child has an active infestation. It is difficult to differentiate between nits and empty egg casings. Even under ideal conditions, 10-30% of nits do not hatch.
- 3) Head lice are frequently over diagnosed, which leads to overuse of pediculocides (chemical head lice products). Overuse of pediculocides can be hazardous to a child's health.
- 4) Negative reactions to head lice adversely affect children by subjecting them to teasing and bullying.

WHAT THE SCHOOL CAN DO ...

- Consider Parent Advisory Committee and Public Health Nurse input in developing a school plan for the identification and control of head lice.
- Develop an understanding of the symptoms of head lice infestation.
- Distribute letters and treatment information to parents of the identified cases of head lice.
- Distribute letters and treatment information to parents of the classroom contacts of a case of head lice.

WHAT PARENTS CAN DO...

- Be aware of the symptoms of head lice and the treatment procedures.
- Check the heads of all family members on a weekly basis. Increase this to daily head checks when a case of head lice has occurred in your child's classroom or one of the family members has been in contact with head lice.
- Treat the infested heads.
- Contact PHN for resources and further information when treatment has failed to rid your child's head of head lice.
- Teach your children not to share hair accessories, hats, coats, combs, brushes, etc. with others.

WHAT THE PUBLIC HEALTH NURSE CAN DO ...

In the school:

- Participate in the development of a school plan for the identification and control of infestations in cooperation with the school principal, staff and the Parent Advisory Committee.
- Determine if the school staff have an adequate knowledge of head lice and the control of infestations.
- Provide information as needed, including information on environmental control i.e. dress-up centers, cloak rooms, hanging jackets on the back of desk chairs.
- Receive referrals from school staff to follow-up treatment failures or other concerns pertaining to controlling/managing head lice.
- Provide training if the school chooses to use parent volunteers.

With families:

- Group presentations about head lice and head lice control. This would be particularly effective with kindergarten parents early in the school year.
- Follow-up for treatment failures or other concerns pertaining to controlling/managing head lice i.e., provision of information through written handouts, videos, or individual counseling.

BIOLOGY

Head lice are very small –about 2 – 3 mm long. The colour of adults ranges from white to gray to brown and may vary with the skin or hair color of the person infested. Head lice are wingless so they can't fly or jump.

Nits (head lice eggs) are tiny oval specs about one third the size of a sesame seed. They are found glued to the strands of the hair, very close to the scalp. Nits hatch in about 7 days, mature in about 8 or 9 days and can then lay eggs. Lice are not able to move off the head until they are fully grown, which takes about 7 days.

They may live for 2 to 4 weeks on the human head, and during this time, females may lay up to 6 eggs a day. Off the human head, they survive for about 48 hours.

Active versus Inactive Head Lice Infestation

A person has an active infestation if head lice are found crawling on their head or there are many nits within 6mm of the scalp. Nits found further down the shaft of the hair (more than 6 mms from the scalp) have already hatched. Treatment is not recommended for people who have nits further than 6mm from the scalp.

MYTHS AND FACTS ABOUT HEAD LICE



“Sometimes I’m Misunderstood”

Myth 1: The presence of head lice is a sign of poor personal hygiene.

Fact: We head lice prefer a clean scalp. It doesn’t matter to us your sex, age, race or how much money you have.

Myth 2: Only children get head lice.

Fact: We like adults as much as children, but it’s easier to move from one child to another because of their close contact in daycare, preschools or schools.

Myth 3: If your head isn’t itchy, you don’t have lice.

Fact: Contrary to common thinking, we may be in your hair for weeks or months without making you itch. In fact, even though we are in your hair, only 1/3 of you will be scratching.

Myth 4: Long hair encourages infestation.

Fact: We are more interested in your scalp than your hair so cutting hair will not get rid of us.

Myth 5: Head lice can be “caught” from plants, pets and other animals.

Fact: I can live on YOU, but I can’t live on your plants, pets or other animals.

Myth 6: Head lice can jump and fly from one person to another.

Fact: We don't have wings. We can't jump, but we can run quickly from one head to another "*wherever and whenever heads meet*".

We may hide in hats and other headgear, scarves, hair accessories, helmets, head phones, etc. We can only survive for up to 48 hours away from your head.

Myth 7: An itchy scalp following treatment is a sign of treatment failure.

Fact: Your scalp may be itchy for up to 10 days after successful treatment. If your head is itchy past 10 days, it may be a sign that I am still there or my friends have moved in!

Myth 8: Head lice cause disease. An outbreak of head lice is a public health emergency.

Fact: I am a nuisance but I do not carry germs or spread disease.

Myth 9: No nit policies are effective in eliminating head lice.

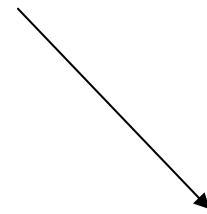
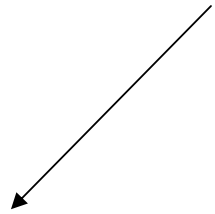
Fact: There is no evidence that shows no-nit policies reduce head lice infestations. Nits are removed to enhance the effectiveness of treatment, but should not be a reason to keep a child out of school.

Myth 10: The presence of nits means an active infestation.

Fact: 10-30% of children with nits never develop an active infestation.

TREATMENTS

Treatment Options



OPTION A

Chemical Shampoos

Kill the Lice
&

Remove the
Nits

Special lice shampoos are used because they have been tested and determined to be an effective and acceptable treatment

OPTION B

Wet-combing

Remove the
Lice

&
Forget the Nits

Non-chemical ways to find and eliminate head lice

Wet combing with hair conditioner immobilizes lice

Note: the research to support this method is unclear, but many people say it works

OPTION A CHEMICAL SHAMPOOS

Kill the Lice and Remove the Nits

This option involves using chemical head lice shampoos to kill the lice on the head and is followed up with removal of nits from the hair with a nit comb or with your fingers. Head lice shampoos should only be used on active infestations and should be applied when hair is dry. Research shows these shampoos work when used properly. **Overuse of these shampoos can be dangerous.**

Ask your pharmacist about head lice shampoos

STEPS TO FOLLOW

DO

1. Check the heads of all family members. Check hair behind ears and back of neck for lice eggs (nits) – look for silvery oval specks “glued” to the strands of hair, very close to the scalp.
2. **READ HEAD LICE SHAMPOO DIRECTIONS CAREFULLY** and apply according to directions.
3. Remove nits.
Use a metal “nit” comb or use your fingers to pull nits from the strands of hair.
4. Only wash articles of clothing that come in direct contact with the head. Wash clothing, bed sheets and pillow cases in hot water, then dry in the hot cycle of the dryer. If articles can’t be put in hot water or dried on a hot cycle, put the items in a sealed plastic bag for 48 hours, or place the bag in the deep freeze for 24 hours.
5. Apply head lice shampoo a second time 7 – 10 days later.
6. Check heads of family members throughout the year and if lice or ‘nits’ are found – start again at Step 1.

REMEMBER

If one person in the family has head lice, there is an increased chance that other family members have head lice too.

Dandruff can be flicked off the hair; nits are stuck to the hair strand.

Products differ in terms of whether to apply to dry or wet hair and the length of time the treatment remains on the head.

Experts differ in their opinions on the need to remove nits. Nit removal is included here as nit removal may help to ensure there will be less eggs on the head to hatch, thereby improving the effectiveness of the treatment.

There is no evidence that a major clean up of the house is necessary to get rid of head lice.

A second shampoo will make sure that any nits that have hatched after the first shampoo and are now lice, will be killed before they have a chance to lay any more eggs.

OPTION B WET-COMBING

Remove the Lice and Forget the Nits

This method is inexpensive, safe, and easily accessible, but takes more time. While there is no conclusive scientific evidence to support this treatment, many people report its success. This method is based on understanding the life-cycle of the louse. Wet-combing immobilizes lice so you can comb them out of the hair, but it does not remove the nits from the hair. It takes 7 days for a nit to hatch. Combing treatments are done every 3 – 4 days for two weeks to remove lice before they are fully grown and able to reproduce. Although not required, many people still choose to remove the nits with this method. You can use your fingers to pull the nits from the strands of hair.

STEPS TO FOLLOW

DO

1. Wash hair with ordinary shampoo and rinse.
2. Apply *lots* (about ½ cup – or more for long hair) of conditioner (any brand) to hair– **do not rinse out the conditioner.**
3. Comb sections of hair using a fine tooth metal comb. (You can use a metal nit comb).

Place the teeth of the comb into small sections of the hair at the roots. Firmly draw the comb toward you, through to the end of the hair. Check for lice after each stroke and clean the comb by wiping or rinsing. Continue section by section until the entire head is done. Make sure hair stays wet with conditioner during the combing.

4. Rinse hair. Leave hair dripping wet. Repeat combing without

REMEMBER

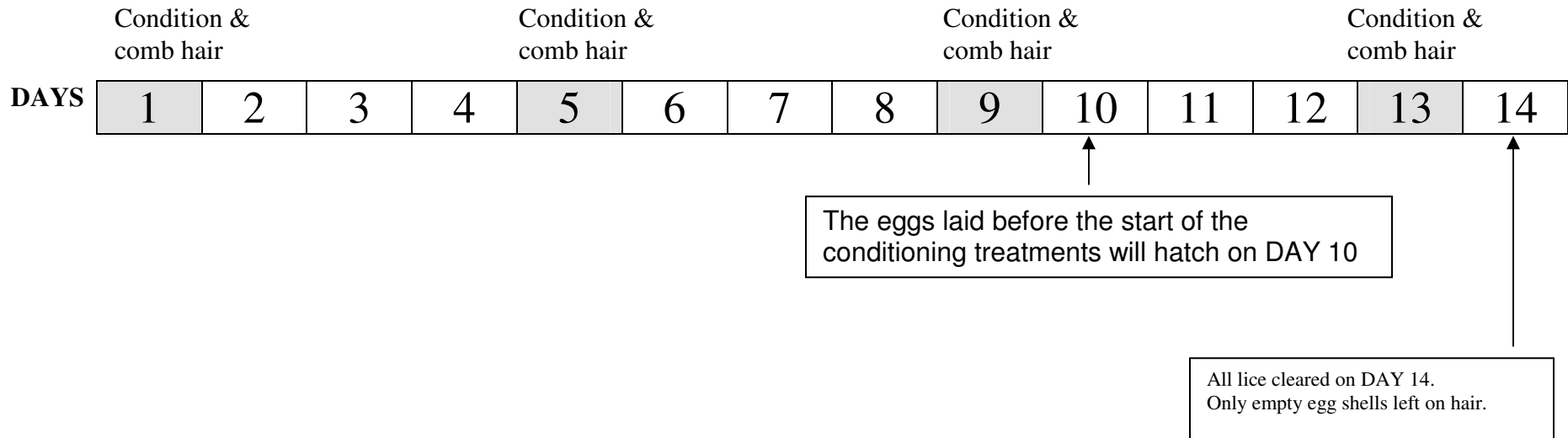
Untangle the hair with a regular wide tooth comb.

Note: On average, a Bug Busting session takes about ½ -1 hour per person.

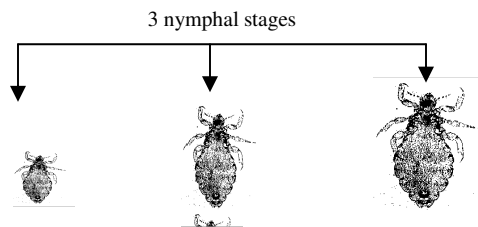
Metal nit combs are available at the Pharmacy for approximately \$8.00.

Regularly removing the lice before they are fully grown and able to lay eggs will get rid

THIS IS THE WAY TO LOSE THE LOUSE



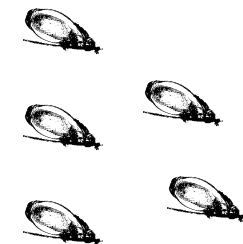
7 – 10



Full grown louse



MATING



Female lays eggs

Lice are not inclined to move off the head where they hatch until nearly full grown. It takes 7 days minimum to become fully grown.

WHERE YOU CAN GET CHEMICAL TREATMENTS FOR OPTION A

Chemical head lice treatments are available “over the counter” at pharmacies. (Ask your pharmacist for them). Costs range from about \$7.00 to \$11.00 per treatment depending on the pharmacy and brand of treatment purchased. A metal nit comb is purchased separately (see section on ‘Combs’ below).

Some school Parent Advisory Committees sponsor parents who can’t afford the treatment. Enquire at your school to see if this is available.

Families on income assistance can obtain head lice treatment products through the Ministry of Human Resources. The family must obtain a prescription from a family physician which can then be presented to the financial aid worker for reimbursement. If you can’t afford treatments, try option B.

Families with a treaty card can obtain head lice treatment products by obtaining a prescription from a family physician. Present the prescription to the pharmacist and the treatment will be covered for you.

A WORD ON COMBS

Some general things to keep in mind with combs are:

- regular combs will not remove head lice and nits (lice eggs)
- there are two types of special head lice combs: a head **lice** comb has more space between the teeth and will remove lice but not nits, which are much smaller than lice. A **nit** comb’s teeth have less space between the teeth and will remove both lice and nits
- plastic combs are not useful because they are so flexible that the teeth separate, break off and head lice and nits are bypassed as the comb is dragged through the hair

A metal NIT comb is recommended – The best nit combs have closely spaced metal teeth (about .15mm between teeth) that are about 1” to 1 ½” long. With a short-toothed comb, it is difficult to completely comb through most types of hair. The metal toothed comb is more durable; the teeth won’t spread, bend or break. The best metal combs have one side of the teeth beveled (on an angle). This allows you to place the teeth of the comb closer to the scalp each time you start to comb through the hair.

OTHER

While there is no research to support the effectiveness of these approaches, some parents say they work.

Suffocating Remedies

These remedies involve applying mayonnaise, Vaseline or olive oil to the hair, covering the hair with a shower cap, leaving it on overnight (or 8 hours) and combing the lice out the next morning. Once the mayonnaise, Vaseline or olive oil are washed out with shampoo, the nits must be removed. Parents should be aware that it can take up to 10 days to remove all the Vaseline from the hair.

Combination Remedies

A combination approach involves treating hair with a chemical lice shampoo, then following this by applying one of the suffocating remedies listed above.

Naturopathic Remedies

For families wanting information on naturopathic remedies, the family can check with health food outlets, naturopathic practitioners or pharmacists for more information.

NOTE: Tea tree oil may be toxic and is not recommended by BC Poison Control.

DANGEROUS AND UNDESIRABLE REMEDIES

The following treatments are not safe or effective.

- insect sprays (Raid)
- flea soap
- Chinese chalk
- oil (WD40)
- alcohol
- kerosene
- Gasoline
- shaving the head

PREVENTING/CONTROLLING TRANSMISSION IN THE CLASSROOM

Environment

Head lice do not fly or jump. They move from one head to another by crawling. Head lice are only spread by touching heads (which allows lice to move on to the new head) or by touching clothing (which allows head lice from a comb or hat to move to a new comb or hat). They can only survive for 48 hours off of the human head so a classroom that is closed for the weekend is considered clean when it reopens on Monday.

Best practice in the prevention of the spread of head lice in the schools is to offer cubicles for each student to place their clothing in when they are not wearing it. Cubicles should be large enough to accommodate the winter clothing necessary in our northern climate. The cubicles should have sides to prevent the clothing from touching each other. This way each individual student's clothing is isolated to one area and not touching the next students. An alternative would be to have students place their jacket on the back of their desk chair.

Education

Education is the key to preventing the spread of head lice in the classroom. Students need to be taught how it is spread and what they can do to prevent the spread of head lice. Also, have children avoid direct head to head contact during classroom activities ie., reading time.

Videos and printed resources materials are available through the Health Units.

WHEN TREATMENT DOESN'T WORK...

The most common causes of treatment failure include:

Reason #1: Inadequate information or understanding about head lice or the treatment method used.

The treatment methods can be confusing for many people, especially Option B and C which are based on understanding the life-cycle of the head lice. If unsure about the treatment or prevention of head lice, please talk to your Public Health Nurse.

Reason #2: The head lice shampoo was not applied properly.

The most common errors with using the shampoo include:

- Applying the shampoo to wet hair: Applying the shampoo to wet hair dilutes the chemicals in the shampoo. When exposed to water head lice close their breathing holes which also makes it harder for the chemicals to penetrate and kill the lice.
- Not using enough shampoo to thoroughly cover all the hair: Thick and long hair will require more head lice shampoo. Make sure you use enough head lice shampoo to thoroughly wet all hair – especially behind the neck and ears. One way to make sure that you have covered all the hair is to comb the product through the hair with a regular comb.
- Not leaving the shampoo on long enough: Chemicals in the shampoo take time to work. Make sure you follow the product instructions.
- Not applying the second treatment 7-10 days later: With option A (using lice shampoos), you need to use the shampoo again 7-10 days after the first treatment. This is because no product kills 100% of eggs and eggs take 7 days to hatch. Therefore, re-treatment in 7-10 days is a mandatory part of treatment.

Reason #3: The lice are resistant to the chemical in the shampoo.

Head lice may be resistant to the chemicals in the lice shampoo. If this happens, the chemicals are no longer able to kill all the lice. You can tell if the head lice are resistant by treating the head as directed, then checking for live lice. Use a fine tooth comb and look for movement. If the lice are all dead the shampoo is working. If the lice are still moving they are resistant to the chemicals in the shampoo. If the lice are resistant switch to another brand with a different "active ingredient" or try one of the other options. Ask your pharmacist for help.

Reason #4: The hair was previously washed using shampoo with built-in conditioner.

Conditioners in regular shampoos can coat the hair and make it more difficult for chemicals in the head lice shampoos to cover the hair and scalp.

Reason #5: The nits weren't removed.

No shampoo is 100% effective. Nit removal will help ensure effectiveness of head lice shampoos and that there will be less eggs on the head to hatch.

Reason #6: The head lice shampoo is too old.

The active chemicals in many shampoos weaken over time. Check the expiry date of the head lice shampoo before you use it.

Reason #7: Another infestation has occurred.

If the above reasons don't explain why the treatment hasn't worked, re-infestation has likely occurred. Reinfestation almost always results from head to head contact with a person who has lice (re-infestation from the environment is very rare). If hair is clear one week after treatment, then head lice are found later, re-infestation has probably occurred. If you suspect re-infestation, ask your child with whom she/he has had head to head contact, and see if they can be checked. Look beyond your child's classroom; look at direct head to head contact opportunities your child has had during play and within the family.

What you should do

Immediate retreatment with a different pediculocide followed by a second treatment 7-10 days later is recommended. If infestation recurs or persists, alternative remedies like option B, are recommended to avoid excessive exposure to chemical head lice treatments.

CHRONIC INFESTATION - SCHOOL RESOURCE

Chronic infestation with head lice may occur for a variety of reasons. School staff should assess the cause for suspected chronic infestation. Common causes and suggested responses to these are as follows:

1. The child / family has limited knowledge or understanding of head lice control
What schools can do:
 - Encourage family to identify close contacts; if infested, close contacts are then encouraged to get treated
 - Prepare and distribute a standard resource for parents
 - In collaboration with school PAC Committees and the Public Health Nurse, develop a plan for responding to chronic infestation
 - Consult the Public Health Nurse for more information.
2. Treatment failures/ improper application of recommended treatments or non-compliance with follow- up treatments (see page 12 ‘When Treatment Doesn’t Work’)
What schools can do:
 - Acknowledge parent’s frustration
 - Assess family’s knowledge and understanding of lice and treatment options
 - Assess whether treatment was carried out
 - Review the life cycle of the louse and treatment options as necessary
 - Consult the Public Health Nurse for more in-depth family education as needed.
3. Limited financial resources for recommended treatment options.
What schools can do:
 - Encourage family to use low cost alternatives (wet combing)
 - Explore alternatives for financial support (see page 9, ‘Where You Can Get Chemical Treatments for options A and C)
4. Misdiagnosis
What schools can do:
 - Educate parents, teachers, and PAC members on accurate diagnosis, the life cycle of the louse, and treatment options.
5. Parents do not view head lice treatment as a priority
What schools can do:
 - Acknowledge parents feelings, frustration and concerns
 - Recognize family’s right to determine who becomes involved in their care
 - Identify family strengths, (i.e., concern for their child), and use these to encourage involvement with treatment
 - Identify other people who can act as resources for the family (i.e.: relatives, neighbours, etc.)
 - Consult the Public Health Nurse with more in-depth family education as needed.

EDUCATIONAL AND SUPPORT RESOURCES

NOTE: Most of the following resources were produced several years ago, so some information may differ from this handbook. The most recent research and practices for head lice management and control are included in this handbook.

Pamphlets:

1. **Getting Rid of Head Lice by Wet Combing: A Non-Chemical Method of Treating Head Lice**, Vancouver Coastal Health Authority, June, 2000.
2. **Head Lice Health File**, Ministry of Health, December, 1993.
3. **Is There a Louse Handbook**, Northern Health Authority, August, 2003

Videos: (availability of specific videos may vary between Health Unit offices):

1. **Head to Head With Lice**, Department of Health Care and Epidemiology, UBC, 1992.
2. **The Facts of Lice**, Kelsey Productions, 1999.
3. **Head Lice to Dead Lice**, (1997), Sawyer Mac Productions.
4. **Advice on Lice**, (1990), Magic Lantern.

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Burgess, I. (1998). Head Lice: Developing a practical approach. The Practitioner, 242, pp.126-129.

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APPENDIX A: SAMPLE LETTER TO PARENTS (Head Lice in Classroom)

Dear Parent:

Re: Head Lice

A case of head lice has occurred in your child's classroom. Head lice do not carry disease and do not have anything to do with cleanliness. The only harmful effect from head lice is the way children and adults react. Negative reactions to head lice can harm children's self-esteem and result in their isolation from others.

Please check your child's hair carefully for head lice or nits. Please let the school know if you find lice or nits. If you do, check all other members of the family and treat those infested by using one of the treatment options.

For further information about head lice and treatment approaches, please contact the health unit at _____.

Sincerely

Principal

APPENDIX A: SAMPLE LETTER TO PARENTS (Your Child has Head Lice)

Dear Parent:

Re: Head Lice

During a recent head check at school, your child was found to have head lice. Head lice do not carry disease and do not have anything to do with cleanliness. The only harmful effect from head lice is the way children and adults react. Negative reactions to head lice can harm children's self-esteem and result in their isolation from others.

To ensure your child is not the focus of negative attention and to prevent transmission in the classroom, please treat your child's hair using one of the treatment options. Also, check all other members of your family and treat their hair if you find lice or nits.

For further information about head lice and treatment approaches, please contact the health unit at _____.

Sincerely

Principal

NORTHERN HEALTH *authority*

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