1. PURPOSE

1.1 To maintain the health and well- being of all students and school personnel by providing access to primary, preventive health care service in a school setting.

1.1.1 To organize and manage the school clinic according to Department of Health standard and evidence base practice guidelines.

1.1.2 To run the clinic as a first aid center for accidents and injuries that occur in school.

1.1.3 To report more serious/major incidents involving students to the parents, directly by telephone, as soon as possible or as per the school protocol.

1.1.4 To provide a temporary resting place for ill or sick students or staff.

1.1.5 To arrange immediate transfer to hospital for any student or member of staff who requires emergency medical attention.

1.1.6 To clearly label and store student's individual medication, in an appropriate and safe manner.

1.1.7 To administer medications as prescribed by the school doctor or by written instruction from the parent.

1.1.8 To ensure clinic medicines are placed in a cupboard, which is locked all the times.

1.1.9 To maintain and encourage good practices in hygiene and hand washing throughout the school, by education and example.

1.1.10 To follow any health advice given by the Department of Health and the Abu Dhabi Public Health for infectious diseases/ epidemics that might affect the students and staff of the school.

1.1.11 To follow all Department of Health requirements for student medical exams and record keeping.

1.1.12 To help and advise parents and staff regarding current health issues as the need arises.

1.1.13 To impart knowledge and information on health matters to students through health Education/awareness programs and teachings.

2. SCOPE

2.1 This applies to all school clinic staff of Via Medica International Healthcare (VMIH). It must be read and understood for the specification, implementation and delivery of health services as per the DOH- Department of Health Standard and Clinical Best Practice Guidelines.

3. POLICY STATEMENT

3.1 Via Medica International Healthcare is committed to provide clinical best practices, quality care and safety of students and school personnel through health awareness, health promotion, health education and acute care/first aid management in the school campus/setting.

4. DEFINITION

4.1 VMIH – Via Medica International Healthcare LLC

4.2 Health Record – Is a single record of all data on an individual health status.

4.3 Medication – Is a prescription substance regarded as effective for the use for which it is designed in bringing about the recovery, maintenance or restoration of health, or the normal functioning of the body.

4.4 Record – Is any information recorded in any way, including, but not limited to, handwriting, print, tape, electronic storage, computer diskette, film, microfilm, and microfiche.

4.5 School Nurse – is a licensed Registered Nurse (RN) practicing in a school or college who is responsible for the health of enrolled children, adolescents or adults

5. PROCEDURES AND RESPONSIBILITIES

5.1 STUDENT HEALTH RECORD

5.1.1 Health records shall be maintained in the custody of the school clinic and shall be available to a patient or his/her designated representative through the attending healthcare professional at reasonable times and upon reasonable notice.

5.1.2 Each student has a medical file in school.

5.1.3 A complete, comprehensive, and accurate student medical record is maintained for each student.

5.1.4 A record includes a recent history, physical examination, any pertinent progress notes, medications, laboratory reports, imaging reports as well as communication with other student/ patient personnel.

5.1.5 Records and highlight allergies, management of allergies and untoward drug reactions.

5.1.6 The Clinic maintains an immunization record of all students.

5.1.7 Records organized in a consistent manner that facilitates continuity of care.

5.1.8 Records include information regarding but not limited to:

5.1.8.1 Health history, including chronic conditions and treatment plan

5.1.8.2 Screening results and necessary follow-up

5.1.8.3 Immunization status and certification

5.1.8.4 Health examination reports

5.1.9 Ensure that the medical record storage system is equipped with environmental control, applicable safety & security measures.

5.1.10 Only school clinic, healthcare providers will have access to the student's health records and related information.

5.1.11 The Individual Health Care Plan for a student with chronic health condition, will include:

5.1.11.1 The parental authorization of a student's treatment

5.1.11.2 The physician's order to administer a medication, related to the condition

5.1.11.3 Documentation of any nursing assessments completed

5.1.11.4 Documentation of any consultations with school personnel, students, parents, or health care providers related to a student's health problem(s), recommendations made, and any known results.

5.1.11.5 Documentation of the health care provider's orders, if any and parental permission to administer medication or medical treatment to be given in school by the school nurse.

5.2 DAILY FIRST AID ADMINISTRATION

5.2.1 VMIH School nurse/physician evaluate and completes clinical assessment for the students who visits clinic for consultation with or without teacher referral.

5.2.2 Every student that attends the clinic will be listed in the daily census using registry school clinic logbook. It includes:

5.2.2.1 Student ID

5.2.2.2 Name of Student

5.2.2.3 Class they are assigned to

5.2.2.4 Date & Time In

5.2.2.5 Chief Complaint

5.2.2.6 Intervention

5.2.2.7 Remarks

5.2.2.8 Time Out

5.2.3 If there is a need for the student to stay in the clinic for observation, the nurse will inform the teacher in charge through telephone and e-mail stating the type of injury and the treatment given.

5.2.4 All clinical assessment details logged into VMIH registry school clinic logbook.

5.2.5 If the student is stabilized and qualifies to go back to class, nurse will inform the teacher in charge stating the current condition and the student released back to class with signed slip.

5.3 TRANSFERRING AND SENDING STUDENTS TO HOME/ CLINIC/ HOSPITAL/ DISCHARGED TO HOME (NON-EMERGENCY)

5.3.1 After assessment by the school nurse/physician, if the student is not fit enough to remain in school, need to go back home and take rest. Below steps to be followed.

5.3.1.1 Notifies the Teacher In-Charge /School administrator /counsellor/student affairs regarding the details of the patient condition.

5.3.1.2 An official e-mail will be sent to teacher in charge informing that the student will be going home.

5.3.1.3 Parents will be informed by school administrator regarding the status or condition of the patient and confirms the collector to collect the student from clinic.

5.3.1.4 VMIH school nurse /physician fills **Parent notification /Early Leave form.**

5.3.1.5 Students get discharged with confirmed collector and hand over Parent notification /Early Leave form to collector.

5.3.1.6 A copy of filled form filed inside Student Medical Record.

5.4 REFERRAL FOR FURTHER CLINIC EVALUATION AND MANAGEMENT

5.4.1 After assessment by the school nurse/physician if the student needs further hospital/clinic evaluation and management. Below steps to be followed.

5.4.1.1 Notifies the Teacher In-Charge /School administrator /counsellor/student affairs regarding the details of the patient condition.

5.4.1.2 Parents will be informed by school administrator and nurse regarding the status /condition of the patient and informs the child need to be collected from school to other specialized healthcare facilities for further clinical management.

5.4.1.3 A **referral form** will be handed over to the parents/guardians which need to be presented for the referring facility.

5.4.1.4 VMIH school nurse /physician fills **Parent notification /Early Leave form.**

5.4.1.5 Students get discharged with confirmed collector and hand over Parent notification /Early Leave form to collector.

5.4.1.6 A copy of filled form (i.e., referral form, Parent notification /Early Leave form) filed inside Student Medical Record.

5.5 EMERGENCY REFERRAL (LIFE THREATENING)

5.5.1 The school nurse/physician examines the patient and confirms the need for referral to the other facility.

5.5.2 Evaluates if it's a life-threatening case such as:

5.5.2.1 Shock

5.5.2.2 Brain Injury/ Concussion (Severe)

5.5.2.3 Respiratory Distress/ Failure with low SPO2 of below 95%

5.5.2.4 Major Burns

5.5.2.5 Fracture of Long Bone

5.5.2.6 Seizure for more than 5 minutes or new case of seizure episode

5.5.2.7 Excessive Bleeding

5.5.2.8 Unresponsive

5.5.3 **General Guidelines:**

5.5.3.1 Ensure patient safety

5.5.3.2 Initiate first aid as per protocols.

5.5.3.3 Monitor vital signs continuously.

5.5.3.4 Prepare for transfer to the Emergency Room (ER) via ambulance as needed.

5.5.3.5 Document all actions and communications thoroughly.

5.5.4 **Documentation:**

5.5.4.1 Record time of incident, symptoms, interventions performed, and time of referral.

5.5.4.2 Hand over all information to emergency responders and notify the school administration.

Life Threatening Case	Assessment	Immediate Action	Referral
a. Shock	*Symptoms: Pale, clammy skin, rapid pulse, shallow breathing, confusion, or unconsciousness* • Check vitals (blood pressure, heart rate, respiratory rate) • Confirm potential causes (e.g., severe injury, bleeding, allergic reaction)	• Lay the patient flat with legs elevated if there is no suspected spinal injury • Administer oxygen if available • Control any visible bleeding • Keep the patient warm with a blanket	• Call for ambulance immediately • Monitor vital signs and responsiveness while waiting for transport • Notify parents/ guardians
b. Brain Injury/ Concussion (Severe)	*Symptoms: Loss of consciousness, confusion, repeated vomiting, severe headache, dizziness, or slurred speech* • Perform Glasgow Coma Scale (GCS) to assess consciousness level *(refer to **VMIH-AH-PR-043 Pathway for Management & Assessment of Brain Injury/ Concussion**)*	• Stabilize the head and neck, assume a potential spinal injury • Avoid giving anything by mouth • If vomiting occurs, turn the patient to their side (recovery position)	• Call for an ambulance immediately • Monitor for changes in consciousness, seizures, or respiratory distress • Inform parents/guardians of the situation
c. Respiratory Distress/ Failure with Low SPO2 (below 95%)	*Symptoms: Difficulty breathing, wheezing, cyanosis (bluish lips/skin), confusion, or fatigue* • Measure SpO2 (oxygen saturation) and observe respiratory effort	• Administer oxygen via mask or nasal cannula • Position the patient upright to ease breathing • Provide any prescribed bronchodilator (if applicable)	• Call for an ambulance if the SpO2 remains below 95% despite interventions • Continuously monitor breathing and oxygen saturation • Notify parents/guardians
d. Major Burns	• Assess the type and severity of the burn (extent, depth, location) • Check for signs of shock (cool, clammy skin, rapid pulse)	• Remove the source of the burn (clothes, jewelry, etc.) • Cool the burn with running water for at least 10 minutes (avoid ice) • Cover the burn with a sterile non-stick dressing or clean cloth • Do not break blisters or apply ointments	• Call for an ambulance immediately if the burn is large, deep, or located on the face, hands, or genitals • Monitor for signs of shock • Inform parents/guardians

Life Threatening Case	Assessment	Immediate Action	Referral
e. Fracture of Long Bone	*Symptoms: Visible deformity, swelling, bruising, inability to move the limb, intense pain* • Check circulation, sensation, and movement distal to the injury site	• Immobilize the affected limb using a splint and padding • Avoid moving the limb unnecessarily • Keep the patient still and comfortable	• Call for an ambulance for transport to the ER • Monitor for signs of shock, especially with open fractures • Notify parents/guardians
f. Seizure for more than 5 minutes OR New Seizure Episode	• Note the time the seizure started and any history of epilepsy • Observe for signs of prolonged seizure or abnormal behavior post-seizure	• Ensure the patient's safety (move objects away, place padding under their head) • Do not restrain or put anything in the patient's mouth • If seizure lasts more than 5 minutes, initiate emergency response	• Call for an ambulance if the seizure persists longer than 5 minutes or if it is a first-time seizure • Monitor airway and breathing post-seizure • Inform parents/guardians
g. Excessive Bleeding	*Symptoms: Continuous bleeding despite direct pressure, pale skin, and signs of shock* • Check for underlying cause (laceration, injury)	• Apply direct pressure to the wound with a clean cloth • Elevate the affected area if possible • Apply a tourniquet if bleeding does not stop with direct pressure	• Call for an ambulance if bleeding is uncontrollable • Monitor for signs of shock (cold, clammy skin, weak pulse) • Notify parents/guardians
h. Unresponsive Patient	• Check for response by calling out the patient's name and gently shaking • Assess airway, breathing, and circulation (ABC)	• If no response, initiate Basic Life Support (BLS), including CPR if necessary • Ensure airway is open, and begin rescue breathing and chest compressions if there's no pulse • Use an Automated External Defibrillator (AED) if available and indicated	• Call for an ambulance immediately • Continue CPR until emergency medical services (EMS) arrive • Notify parents/guardians

5.5.5 Refer to **VMIH-AH-CL-PP-005: Emergency Referral to Hospital/ Emergency Room** for the detailed process of referring a patient with life-threatening conditions.

5.5.6 The school nurse will immediately notify the school administrator, counselor, or student affairs office, providing all relevant details of the injury, the actions taken, and the hospital/clinic where the student will be transported.

5.5.7 The school administrator and nurse will promptly inform the parents/guardians about the incident, including the nature of the injury and the interventions carried out.

5.5.8 Simultaneously, the school reception will call an ambulance by dialing **999** or **998**.

5.5.9 The school nurse/physician will conduct a comprehensive assessment, documenting the findings in the **Referral Form** and **Nurses/Physician Notes**. This

documentation will include, but is not limited to, history-taking, vital signs, physical assessment, and any medical interventions provided.

5.5.10 The **Referral Form** must include the following detailed information:

5.5.10.1 Student's full name, age, address, and contact number

5.5.10.2 Parent's/guardian's full name, address, and contact number

5.5.10.3 Any known allergies and relevant medical history

5.5.10.4 Immunization details, if available

5.5.10.5 A precise account of the incident/accident, including the patient's condition at the time of the encounter. It must accurately reflect the services rendered, with the date and time of care provided

5.5.10.6 Details of any medications or first aid administered at school

5.5.11 The School Administrator will arrange for a staff member to accompany the student in the ambulance to the hospital, as the school nurse must remain in the clinic.

5.5.12 The student will be transported to the hospital immediately with the completed referral form.

5.5.13 A copy of all assessment documents will be filed in the student's medical record.

5.5.14 A detailed incident report will be submitted to the facility's HSE (Health, Safety, and Environment) department, with a copy retained for Via Medica International Healthcare's records.

5.6 NOTIFICATION OF PARENT/ GUARDIAN

5.6.1 Parents will be informed either verbally by phone or email dependent on the condition of their child, they will be advised of any occurrence that requires follow up or monitoring and of any medication administered.

5.6.2 Parents are updated by the School Nursing Team of any changes or variations to their child's health and wellbeing.

5.7 MEDICATION MANAGEMENT

5.7.1 **Medication Administration**

5.7.1.1 Any Medications shall only be administered by the school nurse as prescribed by a DOH-licensed physician for acute or chronic conditions or as required in an emergency situation.

5.7.1.2 All health care professionals undergo appropriate training and competencies towards handling emergency situation and medication administration.

5.7.1.3 Before administering any medication, the school nurse must secure the consent of Parents/Guardians (whether prescribed or in emergency situations).

5.7.1.4 Consent must be renewed annually (for any prescribed medication) or every time there is a change in the medication administration requirements.

5.7.1.5 According to DOH standards, medications that can be administered by the school nurse in emergency cases are limited to the following:
- 5.7.1.5.1 Epinephrine for acute allergic reactions
- 5.7.1.5.2 Metered-dose Inhalers
- 5.7.1.5.3 Paracetamol
- 5.7.1.5.4 Antihistamine Cream

5.7.1.6 All medication administered information and related activities and reactions shall be recorded in the student's medical record.

5.7.1.7 After administering the medication, the license nurse/physician must document in the patients file all the necessary information about medication administration with date, time, his/her signature and stamp.

5.7.1.8 For administration of prescribed medication, all medications must be in a original container with clear instruction of administration and dosage.

5.7.1.9 School clinic will always maintain confidentiality of medical records.

5.7.1.10 All cases of suspected adverse reactions to medical products and medication errors shall be reported by the school nurse to DOH, as required by the relevant DOH policies and regulations.

5.7.2 **Medication Storage and Access – Handling**

5.7.2.1 All medications stored in a designated medication storage area.

5.7.2.2 Storage area will be kept locked at all times and access given only to the school nurse.

5.7.2.3 The medication in all areas of the facility is stored under the conditions specified by the manufacturer to maintain stability of the products. These include correct environmental conditions.

5.7.2.4 Expiration date of all medication inspected and monitored on a monthly basis.

5.7.2.5 Open containers of medicines (should contain a label of opening date and expiry date) in the clinical area will be checked by nurse prior to medication administration.

5.8 EMERGENCY KIT – HANDLING

5.8.1 Emergency medical kit with required emergency medications available in the clinic to ensure the availability of adequate medicines to provide basic life support measures.

5.8.2 The emergency medical kit is equipped with AED, suction apparatus, oxygen, BP apparatus.

5.8.3 Clinic staff trained and competent on Basic Life Support as well as safety and administration of the emergency drugs.

5.9 INFECTION PREVENTION AND CONTROL

5.9.1 Standard Precaution includes a group of infection prevention practices that apply to all health care providers and patients, regardless of suspected or confirmed infection status wherein healthcare is delivered. The use of appropriate precautions will reduce transmission of infection from one person/patient to another. It will be utilized for all contact with patients' blood, body fluids, secretion and excretion (except sweat) and or mucous membranes.

5.9.2 Hand hygiene is the most important practice in the prevention and the spread of infectious disease, it is done;

- 5.9.2.1 Before and after each patient contact;
- 5.9.2.2 After removing examination gloves;
- 5.9.2.3 Immediately after contact with blood, body fluids or mucous membranes; and
- 5.9.2.4 After contact with patient surroundings

5.9.3 Gloves will be worn for:

- 5.9.3.1 Touching blood;
- 5.9.3.2 All body fluids, secretions and excretions regardless of whether they contain visible blood or not and mucous membranes;
- 5.9.3.3 Contact with non-intact skin; and
- 5.9.3.4 Handling objects or surfaces soiled with blood or bloody fluids

5.9.4 Masks will be worn for:

- 5.9.4.1 Any time due to splashes on the face with blood and/or body fluids and secretions especially when suctioning; and
- 5.9.4.2 Any time in close contact with a patient who is coughing.
- 5.9.4.3 Masks should be changed between patients or during patient treatment if it becomes wet or moist.

5.9.5 Protective devices ((including gloves, masks, and eye and face protection) are to be removed after patient personal care activities.

5.9.6 Needles and sharp instrument. Sharps are defined as needles, sharp edged instruments, broken glassware that maybe contaminated with blood or body fluid.

- 5.9.6.1 Used needles should never be recapped, bend, break or hand manipulated.
- 5.9.6.2 Used needles, disposable syringes, scalpel blades, and other sharp items are to be disposed of in a designated puncture-resistant biohazard container; and
- 5.9.6.3 The sharp end of needles and sharp instruments is always to be pointed away from oneself and others.

5.9.7 Environmental Control

- 5.9.7.1 Develop procedures for routine care, cleaning and disinfection of environmental surfaces, especially frequently touched surfaces in the clinics.

5.9.8 Linen

5.9.8.1 Handle in manner that prevents transfer of microorganism to others and to environment.

5.9.8.2 Used linen is considered to be contaminated and linen must be bagged at the point of origin, before placing in the soiled linen cart.

5.9.9 Respiratory Hygiene / Cough Etiquette

5.9.9.1 Instruct symptomatic person to cover mouth / nose when sneezing and coughing;

5.9.9.2 Respiratory secretions, use tissue, dispose properly; and wear mask or keep if possible 3 feet distance.

5.9.10 Spillages

5.9.10.1 5.14.10.1 When dealing with spillages of blood and body fluids, ensure adequate ventilation when using hypochlorite (10,000 ppm).

5.9.10.2 Pour sodium hypochlorite (10,000 ppm) onto paper towel placed over the spill, leave for 5 Minutes.

5.9.10.3 Wash area with hot water and detergent.

5.10 COMMUNICABLE DISEASE NOTIFICATION

5.10.1 Early notification is essential in order to promote early control measures to limit spread of the disease.

5.10.2 Delegated staff working in VMIH are required to report any communicable disease to the Infection Control Team by completion of the Notification of Communicable Disease form.

5.10.3 For notification purposes communicable disease are classed into 3 groups.

5.10.3.1 Immediate notification by telephone and email

5.10.3.2 Notification within 1 day by email

5.10.3.3 Notification within 7 days by email

5.10.4 Notification of communicable diseases is mandatory by the law per the DOH.

5.10.5 Communicable disease will be notified to the Abu Dhabi Health Authority by a member of the Infection Control using the line on “e-services notification system”.

5.11 COVID-19 Procedure

5.11.1 If a student becomes sick at school with any of the following COVID-19 related symptoms:

5.11.1.1 Fever (37.5℃ and above), Cough, Body ache, Fatigue, Shortness of breath, Sore throat, Runny nose, Diarrhea, Nausea, Headache, Loss of smell or taste.

5.11.1.1.1 Student will be referred to the school clinic for further assessment.

5.11.1.1.2 Student will stay in the isolation or quarantine room while waiting for parents.

5.11.1.1.3 Parents will be contacted immediately by the COVID-19 Response Team Focal Person to retrieve the student from school and to consult a doctor.

5.11.1.1.4 The school nurse will not administer any medicines to the sick student. Only if a student is having a difficulty and shortness of breath shall the school nurse administer basic low flow of oxygen until transported to the hospital.

5.11.1.1.5 The student will only return to school with a COVID-19 negative result, or a medical report stating that the symptoms are due to other diseases, a sick leave and improvement of health status.

5.11.1.1.6 Information about the student will be kept confidential other than the relevant government authorities; ADEK and Abu Dhabi Public Health Center (ADPHC) using the infectious diseases notification (IDN) system.

5.11.1.1.7 Cleaning and disinfection of the room and surfaces are thoroughly done after the patient is discharged from the isolation/quarantine room.

5.12 DIABETES MELLITUS CARE MANAGEMENT AND INSULIN – Glucagon Administration

5.12.1 **The school medical team will ensure that:**

5.12.1.1 All students with Diabetes Mellitus have complete, accurate and updated documents.

5.12.1.2 All those involved in the care of student while in school is made aware of the child condition.

5.12.1.3 All medications received for the student should be clearly labelled with the child's name, class year and section, should be in original container as dispensed by the pharmacist with expiry date and instructions.

5.12.1.4 The following supplies will be in the premises at all times:

5.12.1.4.1 For blood glucose level checking: Glucometer, test strips and lancets

5.12.1.4.2 Medicine of the student (with signed Medicine Authorization Consent)

5.12.1.4.3 Juice-containing sugar

5.12.1.4.4 Insulin

5.12.1.4.5 Glucagon Kit

5.12.1.5 In the event of Hyperglycemic/Hypoglycemic Emergency:

5.12.1.5.1 Blood glucose level will be checked

5.12.1.5.2 Appropriate first aid treatment will be provided by the school medical team as deemed necessary

5.12.1.5.3 Parents/ Guardians will be notified

5.12.1.5.4 Parents/ Guardians may opt to collect the child or the school may arrange for transport to hospital of choice as deemed necessary by the school medical team.

5.12.2 **The Diabetes Care Plan will contain the following:**

5.12.2.1 Date of Plan
5.12.2.2 Student Name, Class, Year and Section
5.12.2.3 Type of Diabetes and Date of Diagnosis
5.12.2.4 Name and Contact Numbers of Parents/ Guardians and Attending Physician
5.12.2.5 Level of independency of the student to check and manage his/her blood glucose level
5.12.2.6 Guidelines for need to check blood glucose in the school
5.12.2.7 Guidelines for Insulin Therapy
5.12.2.8 Guidelines for Glucagon Therapy
5.12.2.9 Signed consent for information sharing and emergency treatment
5.12.2.10 This information is documented as part of the child school medical record.

5.13 ALLERGY MANAGEMENT

5.13.1 Students with a documented history of anaphylaxis will require parental authorization for emergency treatment.
5.13.2 All students with life threatening allergies will be highlighted and identified by the Medical Team.
5.13.3 The Allergy Action Plan includes the following:

5.13.3.1 Telephone number for parents and alternate emergency contacts
5.13.3.2 Student's photo
5.13.3.3 Specific information about the student's allergy and treatment and history of previous allergic episodes.
5.13.3.4 Consent for administering emergency medications and emergency transfer to the nearest emergency healthcare facility.

5.14 HEAD LICE

5.14.1 Routine Headlice Checks are generally not needed but can be done upon request from the School Senior Management Team.
5.14.2 In case of suspected head lice is reported, a head inspection check is carried out by the school nurse.
5.14.3 In the case of live head lice:

5.14.3.1 School nurses educate parents on treatment options and preventive measures.
5.14.3.2 Re-check student upon return to school.

5.14.4 In the case of Nits only:

5.14.4.1 School nurse shall notify parents and provide advice on treatment.

5.14.4.2 Re-check student after 1 week

5.14.5 Students will be allowed to continue the classes.

5.14.6 Screening of the rest of the students in the class of the affected child will be performed such that early detection and intervention will be done to prevent a Pediculosis outbreak.

5.15 NEEDLE STICK INJURIES

5.15.1 Injuries from needles used in medical procedures are called needle-stick or sharp injuries. Sharps include syringes, scalpels, lancets and glass from broken equipment. This type of injuries caused a potential risk of acquiring blood-borne diseases, particularly but not limited to Hepatitis B, Hepatitis C and Human Immunodeficiency Virus (HIV).

5.15.1.1 **In the event of needle-stick injury, the following must be done immediately:**

5.15.1.1.1 Wound should be washed with soap and water but without scrubbing. Antiseptic and skin washes must not be used.

5.15.1.1.2 Encourage bleeding of punctured wound gently under running water. Wound must not be sucked.

5.15.1.1.3 An incident report will be submitted by the school nurse to the HSE Manager and a copy for VMIH record.

5.15.1.1.4 Refer to a Primary Health Clinic for the following procedure or follow recommendation by the PHC physician.

5.15.1.1.5 A baseline blood work-up of the injured student/staff will be done. This will include Hepatitis B surface antibody titer, Hepatitis C antibody titer and HIV antibody level.

5.15.1.1.6 Post-exposure prophylaxis will be followed:

- For Hepatitis B – If the injured person has been vaccinated then no treatment will be given. But if he/she is unvaccinated then give Hepatitis B Immunoglobulin and administer Hepatitis B vaccine series.
- For Hepatitis C – No treatment is currently recommended.
- For HIV – If the source is positive or unknown, the injured person will be referred to an infectious specialist doctor for a mandatory 4-week regimen of 2 types of HIV drugs that must be started within 48 hours post-exposure.

5.16 MEDICAL AND HAZARDOUS WASTE MANAGEMENT

5.16.1 Medical wastes are materials or waste produced as a result of health care activities capable of causing harm through disease or injury to human or the environment if improperly disposed.

5.16.1.1 *Medical waste* is to be disposed of according to the color-coded bags available in the clinics.

5.16.1.2 *Stone-filled waste bags,* in an upright position, in a designated safe area which is locked and well ventilated.

5.16.2 Sharps shall be disposed in leak-proof, rigid and puncture resistant sharp containers.

5.16.3 Bio-hazardous waste shall be collected at the end of the day by the housekeeping staff on duty to be place in the yellow / green large bin provided by the contracted local medical waste management company. Sharp containers/boxes are collected and changed when they are ¾ filled or filled up to the mark or fill line.

5.16.4 School nurses are the key persons in charge of overseeing the clinical and non-clinical waste and biohazard materials disposal program.

5.17 HEALTH SCREENING

5.17.1 School nurse will conduct mandatory health screening on students in accordance with DOH standards for School health screening.

5.17.2 All screening results shall be maintained in the students' health records.

5.18 HEALTH EDUCATION

5.18.1 The aim of health education is to:

5.18.1.1 Make students health conscious

5.18.1.2 Set up a health standard in the school

5.18.1.3 Provide health information to students

5.18.1.4 Take preventive and precautionary measures against communicable diseases

5.18.1.5 Identify students with a physical defects and health hazards and adopt remedial measures

5.18.2 School health professionals will conduct health education sessions with students that will help in improving and bring awareness towards their health. The school nurse will coordinate with the facility coordinator for the health education schedules.

5.18.3 Physical Fitness Awareness which includes but not limited to:

5.18.3.1 Physical Fitness (HRPF)

5.18.3.2 Skill-related Physical Fitness (SRPF)

5.18.3.3 Physiological Fitness

5.18.4 Educate and awareness to students related to Sleep and Sleep Disorders

5.18.4.1 Awareness about what is sleep and why it is important

5.18.4.2 Signs and symptoms of sleep disorders

5.18.4.3 The role of sleep for students

5.18.4.4 Steps can be taken for healthy sleep habits and get a good night's sleep

5.19 HEALTHY DIET

5.19.1 Children need a healthy, balanced diet which is rich in fruits, vegetables and starchy foods such as bread, pasta and cereals. Children encouraged to eat a variety of foods to help ensure that they obtain a wide range of nutrients in order to stay healthy. Parental support is required in promoting a healthy diet by avoiding sweets, chocolates and sugary or fizzy drinks at school, as these foods have little or no nutritional value. Students are encouraged to drink water regularly throughout the school day.

5.20 IMMUNIZATION

5.20.1 The school nurse shall facilitate the vaccination process and coordinates with the school personnel pertaining to the vaccination requirements and timeline.

5.20.2 The parents/guardians are required to submit the student's vaccination records for record purposes and must be kept in the student's school medical record/file.

6. ATTACHMENTS

6.1 Attachment 1 – Emergency Cases Protocol
6.2 Attachment 2 – Pathway for Assessment and Management of Brain Injury/ Concussion
6.3 Attachment 3 – Routine Referral Protocol
6.4 Attachment 4 – Chain of Communication

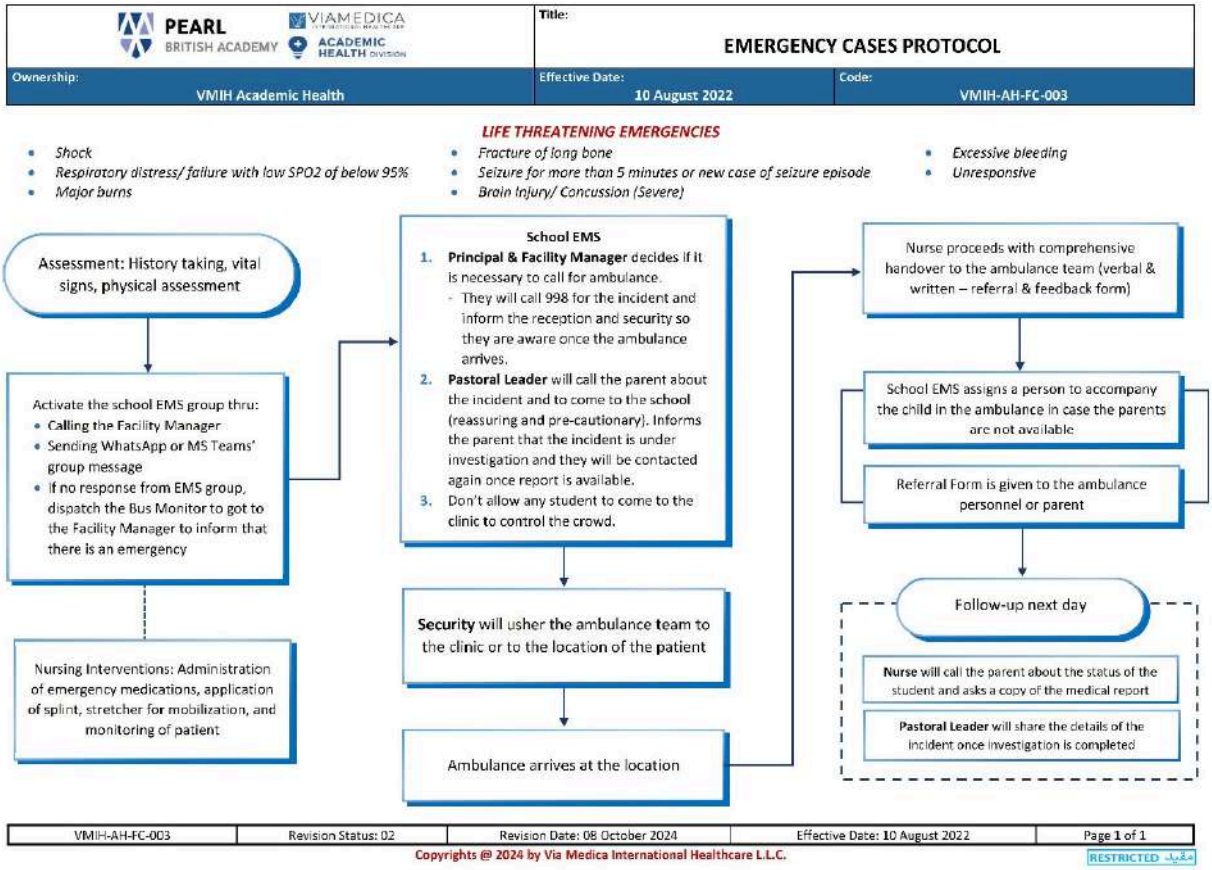
7. REFERENCES

7.1 Law No. (8) of 2008 Concerning the Reorganization of Abu Dhabi Education Council
7.2 ADEC Public Schools (P-12) Policy Manual, 2013-2014
7.3 DOH Standards for Administration of Medication in Schools, 2012
7.4 DOH Standard for Healthcare Facility Licensure, 2012

8. APPROVAL:

UPDATED BY:	**QA/QC**	Date:	04 October 2024
APPROVED BY:			
Name:	**Ms. Wilma L. Schuck**	Signature:	
Designation:	**Head of the Academic & Quality Dept./ Chief Nursing Officer**	Date:	04 October 2024

Attachment 1 – Emergency Cases Protocol



PEARL BRITISH ACADEMY | VIAMEDICA INTERNATIONAL HEALTHCARE | ACADEMIC HEALTH DIVISION

Title: EMERGENCY CASES PROTOCOL

Ownership: VMIH Academic Health | Effective Date: 10 August 2022 | Code: VMIH-AH-FC-003

LIFE THREATENING EMERGENCIES

- *Shock*
- *Respiratory distress/ failure with low SPO2 of below 95%*
- *Major burns*
- *Fracture of long bone*
- *Seizure for more than 5 minutes or new case of seizure episode*
- *Brain Injury/ Concussion (Severe)*
- *Excessive bleeding*
- *Unresponsive*

Assessment: History taking, vital signs, physical assessment

Activate the school EMS group thru:
- Calling the Facility Manager
- Sending WhatsApp or MS Teams' group message
- If no response from EMS group, dispatch the Bus Monitor to got to the Facility Manager to inform that there is an emergency

Nursing Interventions: Administration of emergency medications, application of splint, stretcher for mobilization, and monitoring of patient

School EMS

1. **Principal & Facility Manager** decides if it is necessary to call for ambulance.
   - They will call 998 for the incident and inform the reception and security so they are aware once the ambulance arrives.
2. **Pastoral Leader** will call the parent about the incident and to come to the school (reassuring and pre-cautionary). Informs the parent that the incident is under investigation and they will be contacted again once report is available.
3. Don't allow any student to come to the clinic to control the crowd.

Security will usher the ambulance team to the clinic or to the location of the patient

Ambulance arrives at the location

Nurse proceeds with comprehensive handover to the ambulance team (verbal & written – referral & feedback form)

School EMS assigns a person to accompany the child in the ambulance in case the parents are not available

Referral Form is given to the ambulance personnel or parent

Follow-up next day

Nurse will call the parent about the status of the student and asks a copy of the medical report

Pastoral Leader will share the details of the incident once investigation is completed

VMIH-AH-FC-003 | Revision Status: 02 | Revision Date: 08 October 2024 | Effective Date: 10 August 2022 | Page 1 of 1

Attachment 2 – Pathway for Assessment and Management of Brain Injury / Concussion

PEARL BRITISH ACADEMY / VIAMEDICA ACADEMIC HEALTH DIVISION	Title: PATHWAY FOR ASSESSMENT & MANAGEMENT OF BRAIN INJURY / CONCUSSION	
Ownership: VMIH Academic Health	Effective Date: 04 October 2024	Code: VMIH-AH-PR-043

1 INITIAL ASSESSMENT (ON-THE-SPOT TRIAGE)

- **Secure the Area**
  - Ensure the child is in a safe location, and the environment is controlled.
  - Keep the child calm; avoid unnecessary movements.
- **Immediate Assessment of ABCs (Airway, Breathing, Circulation)**
  - Check if the child is responsive; ensure that breathing is normal and has an open airway.
  - Monitor vital signs.
- **Check for Loss of Consciousness (LOC)**
  - Determine if the child lost consciousness at any point, even briefly.

2 SYMPTOM EVALUATION (MILD VS. SEVERE INJURY)

- **Assess for Signs of Severe Brain Injury**
  - Call the ambulance immediately if there is: severe headache, loss of consciousness, vomiting, seizures, neck pain, unequal pupils, weakness, slurred speech, confusion or drowsiness.
- **Assess for Mild Brain Injury / Concussion**
  - Child is alert and able to respond to questions.
  - Symptoms: dizziness, headache, blurred vision, sensitivity to light/noise, emotional changes.
- **Neuro Assessment**
  - Assessment using Glasgow Coma Scale, pupil reaction, and motor strength.

3 IMMEDIATE MANAGEMENT BASED ON SEVERITY

Severe Injury

- Activate EMS (999/998) immediately
- Stabilize head and neck
- Administer oxygen if necessary
- Monitor vital signs
- Keep the child calm and reassured

Mild Concussion

- Monitor closely in the clinic
- Rest: Keep the child in a quiet area
- Reassess frequently for worsening signs (red flags like vomiting and drowsiness)
- Notify the parents of the incident

4 COMMUNICATION & DOCUMENTATION

- **Document** the incident thoroughly:
  - Time of the injury, assessment findings, symptoms observed, and actions taken.
- **Communicate** effectively with the child's parents or guardians, explaining:
  - The nature of the injury, your assessment, recommendations.
- **Prepare for Transfer**
  - Ensure the child's emergency contact details, medical history, incident report are ready.

5 POST-INJURY MANAGEMENT

- **If Sent to Emergency Room (Severe Injury)**
  - Follow-up with parents to track the child's recovery, provide any additional documentation needed for further care.
- **Mild Concussion**
  - Advise parents on home care: rest (physical and cognitive), avoid screens and loud environments, monitor for worsening symptoms for 24-48 hours.
  - Recommend a follow-up with the child's primary care provider before returning to school.

IF UNCONCIOUS, ASSUME POTENTIAL SEVERE BRAIN INJURY AND CALL EMERGENCY SERVICES 999 / 998

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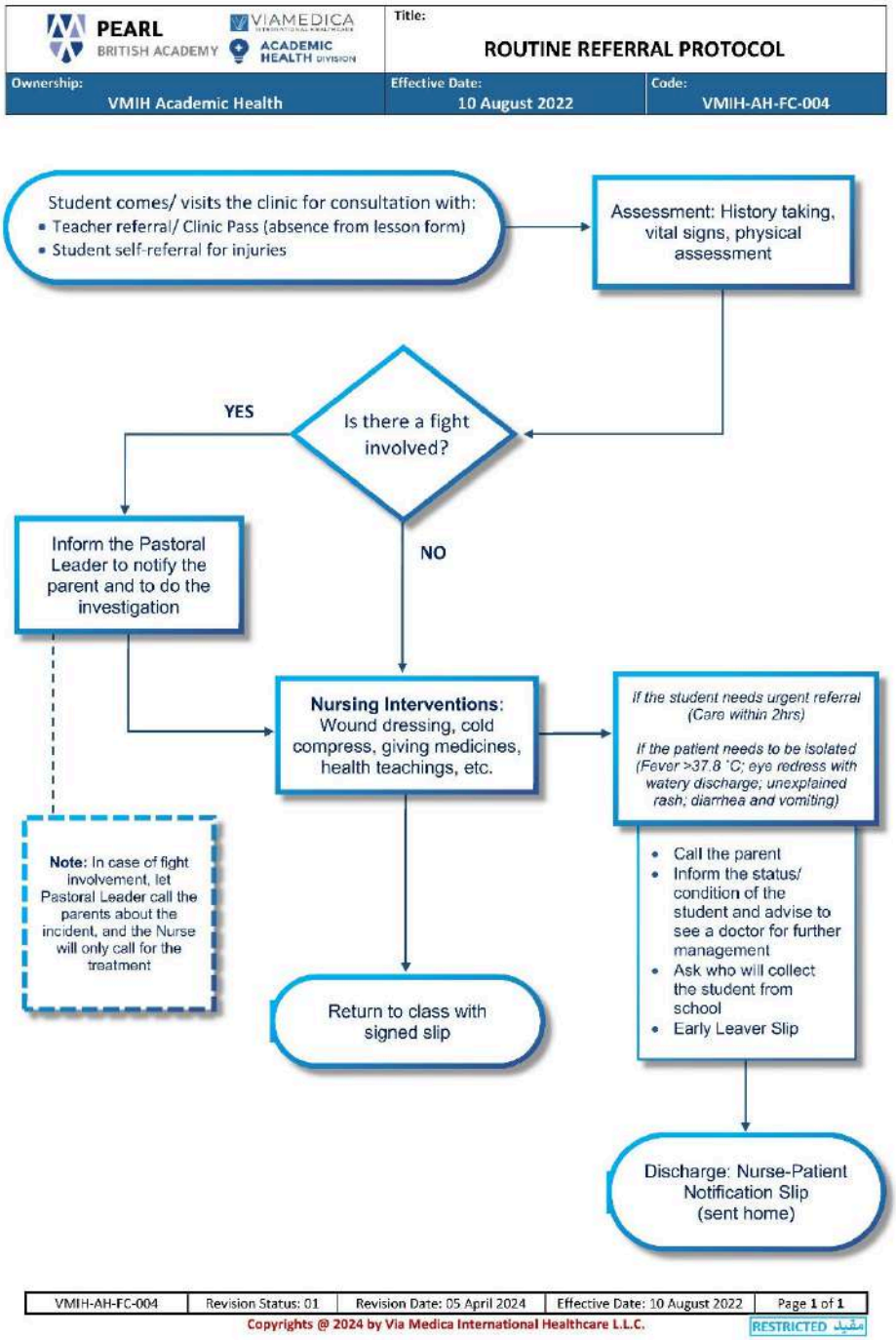
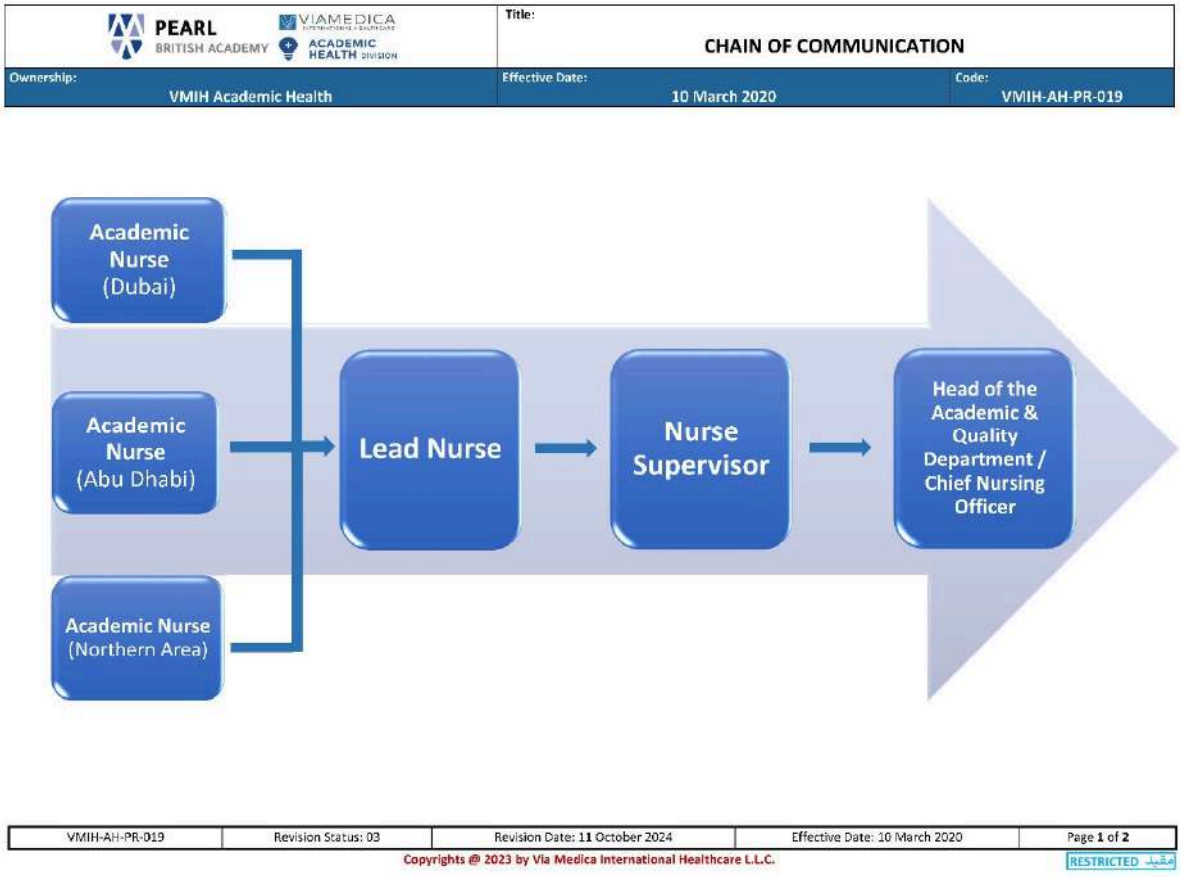
Attachment 3 – Routine Referral



Attachment 4a – Chain of Communication



Attachment 4b – Chain of Communication

PEARL BRITISH ACADEMY / VIAMEDICA ACADEMIC HEALTH DIVISION	Title: CHAIN OF COMMUNICATION	
Ownership: VMIH Academic Health	Effective Date: 10 March 2020	Code: VMIH-AH-PR-019

POSITION	NAME	MOBILE NO.	EMAIL ADDRESS	REMARKS
Head of the Academic & Quality Department / CNO	Ms. Wilma L. Schuck		wschuck@viamedica-international.com	1. Email for all your concerns/ issues 2. All emails please copy
Nursing Supervisor	Ms. Jesusa Espineda	054 990 3788	jespineda@viamedica-international.com	1. Email for all your concerns/ issues 2. All emails please copy
Nursing Supervisor	Ms. Judith Galve	054 990 3782	jgalve@viamedica-international.com	
Lead Nurse	Ms. Jinky Gutang	02 444 6500 ext. 410	schoolassistant@viamedica-international.com	Staff Support & Staff Related Issues
HR Manager	Ms. Roxane Baltar		baltar@viamedica-international.com	HR related Queries
Accountant	Ms. Rowena Besorio		rbesorio@viamedica-international.com	Finance related queries
Quality & Safety Internal Auditor	Mr. Allen Yamson		quality_safety@viamedica-international.com	Email for all clinic related concerns/ issues

VMIH-AH-PR-019	Revision Status: 03	Revision Date: 11 October 2024	Effective Date: 10 March 2020	Page 2 of 2