

Clinical Procedure Guidelines

FOR CONNECTICUT SCHOOL NURSES



Connecticut State Department of Education

Connecticut State Department of Education

Stefan Pryor
Commissioner of Education

Division of Family and Student Support Services

Charlene Russell-Tucker, Chief Operating Officer

Bureau of Health/Nutrition, Family Services and Adult Education

Stephanie G. Knutson, R.N., M.S.N., School Health Consultant

Office of Communications and Community Partnerships

Matthew J. Falconer, Editor and Publisher
Andrea N. Wadowski, Graphic Designer



Contents

Acknowledgments

How to Use this Guide

Introduction

1. Overview

- Background 5
- Statistics 6
- Meeting the Challenge..... 6
- References..... 8

2. Fundamental Principles

- Delegation 10
- Documentation.....13
- Infection Control / Standard Precautions 14
- References..... 16

3. Part A: Legal Issues — Educational

- Special Education 18
- Individuals with Disabilities Education Act of 2004..... 19
- Section 504 of the Rehabilitation Act of 197321
- Individualized Health Care Plans 23
- The Role of the School Nurse (Registered Nurse) in Special Education and Section 504.....24
- Confidentiality: Family Educational Rights to Privacy Act..... 25
- Confidentiality: Health Insurance Portability and Accountability Act26
- Where FERPA and HIPAA May Intersect..... 27
- References.....28



Part B: Legal Issues — Clinical

Regulations.....	29
Licensure	30
Standards of Practice	32
Practice by Unlicensed Persons.....	34
Training of School Personnel by Parents.....	35
References.....	36

4. Organizational Structure: The Decision-making Process

Example of Collaborative Decision Making	39
--	----

5. Personnel

General.....	41
Qualifications for Regular, Contract, and Substitute Personnel	42
Planning for the Absence of Staff Providing Health Services.....	44
Consultation, Supervision, Continuing Education and In-Service Training	44
Delegation of Health Activities, Interdisciplinary and Transdisciplinary Team Functioning.....	45
References	47

6. Entry/Re-entry Process

References	51
------------------	----

7. Specialized Health Care Procedures

A. Asthma Management.....	53
B. Allergies	56
C. Blood Glucose Monitoring.....	57
D. Catheterization: Clean Intermittent	59
E. Catheter: External	62
F. Catheter: Indwelling.....	64
G. Catheterization: Reinsertion of Indwelling Urinary Catheter.....	66
H. Central Line Care	68
I. Diabetes	70
J. Enteral Tube Feedings	71
K. Health Assessment.....	76



L. Incontinence Care..... 78

M. Injectables: Intramuscular, Subcutaneous Medication or Vaccination Administration.....80

N. Insulin Pump Management..... 83

O. Intravenous Therapy 85

P. Mechanical Ventilation.....86

Q. Oral Feeding88

R. Oral or Inhaled Medication Administration90

S. Ostomy Management and Care 93

T. Oxygen Therapy 95

U. Pulse Oximetry.....99

V. Suctioning (non-tracheostomy).....101

W. Tracheostomy Care and Suctioning.....104

X. Vagus Nerve Stimulator 111

Appendices

Appendix A: Connecticut Board of Examiners for Nursing. Declaratory Ruling on Delegation by Licensed Nurses to Unlicensed Assistive Personnel 113

Appendix B: Connecticut Board of Examiners for Nursing. Declaratory Ruling on LPN Scope of Practice..... 113

Appendix C: Section 504 Parental Rights114

Appendix D: Suggested Qualifications and Role of the School Medical Advisor in the Implementation of the School Health Services Program 115

Appendix E: Nurse Practice Act..... 117

Appendix F: Qualifications of a school nurse.....118

Glossary



Acknowledgments

Numerous professionals contributed to the review and development of these guidelines.

A special thank-you to Michael Corjulo APRN, CPNP, AE-C, health services coordinator, ACES, and Patricia Krin, MSN, FNP-BC, NCSN, senior nurse administrator, Newington Public Schools, for the initial development of these guidelines.

Appreciation is extended to the following individuals:

Stephanie Knutson, MSN, RN, project manager

Deidre Anspach, RN, school nurse, Stamford Health Department

Janene Batten, MLS, AHIP, reference librarian, Yale School of Nursing

Verna Bernard-Jones, MSN, RN, president, Association of School Nurse of Connecticut

Eileen Boulay, BSN, RN, nurse consultant, DPH

Olga Brown, school nurse supervisor, Stamford Public Schools

Valerie Bryan, nurse consultant, DPH

Moira Bryson RN, special education nurse, Stamford Public Schools

Marie Burlette, RN, BSN, school nurse supervisor, Connecticut Technical High School System

Joan Cagginello, MS, BSN, RN, school nurse supervisor, Milford Health Department and Association of School Nurses of Connecticut

Cindy Colston, BSN, RN, Connecticut Children's Medical Center (CCMC)

Michael Corjulo APRN, CPNP, AE-C, health services coordinator, ACES

Andrea Dillon RN, BC, MEd, assistant director of health services, Capitol Region Education Council

Bonnie Edmondson, Ed.D., health education & coordinated school health consultant, CSDE

Edward Gleich, MD, medical adviser, Madison Public Schools

Donna Heins, MPH, RN, coordinated school health consultant, CSDE

Mary Joyce, school nurse supervisor, Clinton Public Schools

Raeanne Kelly, BSN, RN, pediatric otolaryngology nurse, Connecticut Children's Medical Center

Ann Kiwanuka, APRN, MSN, Department of Children and Families

Donna Kosiorowski, MSN, RN, school nurse supervisor, West Haven Public Schools

Cindy Kozak, RD, MPH, CDE, Diabetes Prevention and Control Program AIDS and Chronic Diseases Section, Connecticut Department of Public Health (DPH)

Patricia Krin, MSN, FNP-BC, NCSN, senior nurse administrator, Newington Public Schools

Suzanne Levasseur, MSN, APRN, supervisor of school health services, Westport Public Schools

Vincent A. Mustaro, senior staff associate for policy services, Connecticut Association of Boards of Education

Kathy Neelon, MS, BSB, RN, nurse coordinator, Wallingford Public Schools

Karen Owen, MSN, RN, school nurse, Madison Public Schools

Carole Passarelli, PNP, MS, RN, nurse consultant, Middletown Public Schools

Elizabeth Petrocelli, RN, nursing supervisor, Bridgeport Public Schools

Ellen Ryan, MPH, BSN, director of school health services, Darien Public Schools

Joanne Ryan, BSN, RN, nursing supervisor, Fairfield Public Schools

Kimberly Sandor, FNP, MSN, RN, nurse consultant, Connecticut Nurses Association

Terry Schramm, RNC-OB, AD,CCM, CICP, MSCC, Center School, East Hampton Public Schools



Nadine C. Schwab, BSN, MPH, NCSN, FASN, independent school health consultant
Miriam Selig, MD, school medical consultant, Stamford Health District
Martin Sklaire, MD, Connecticut Chapter of the American Academy of Pediatrics
Michael Smith, education consultant, CSDE
Lynn Sosa, MD, deputy state epidemiologist, DPH
Kari Sullivan, Physical Activity, Nutrition and Tobacco coordinator, Coordinated School Health, CSDE
Kimberly Traverso, education consultant, CSDE
Nancy Turner RNC, MSN, school nurse, Canterbury Public Schools
Steve Updegrave, MD, Connecticut Chapter of the American Academy of Pediatrics and medical adviser
– New Haven Public Schools
Trisha Vayda RN, BSN, NCSN, nursing supervisor, Enfield Public Schools
Grace Vetter, RN, school nurse supervisor, Public Schools

Recognition is also extended to the contributors of the CSDE's *Specialized Health Care Procedure Manual for School Nurses* (1997) and *Serving Students with Special Health Care Needs* (1992). These two documents have been merged and updated in developing the 2012 *Clinical Procedures Guidelines for Connecticut School Nurses*.

For more information on the CSDE's *Clinical Procedure Guidelines for Connecticut School Nurses*, please contact:

Stephanie G. Knutson, MSN, RN
School Health Consultant
Connecticut State Department of Education
Bureau of Health/Nutrition, Family Services and Adult Education
25 Industrial Park Road
Middletown, CT 06457
860-807-2108
stephanie.knutson@ct.gov

How to Use this Guide

THE CLINICAL PROCEDURE GUIDELINES FOR CONNECTICUT SCHOOL NURSES (CLINICAL GUIDELINES) IS PRIMARILY INTENDED to assist school nurses in developing the procedural aspects of individual health care plans for students with special health care needs and in providing task-specific training for other school personnel, when indicated. This practical guide provides the essential fundamental clinical principles that must be considered when establishing policies and procedures and for the implementation and delegation of health care in a school environment. The Clinical Guidelines is organized into the following sections:

- Introduction
- Chapter 1: Overview
- Chapter 2: Fundamental Principles
- Chapter 3: Legal Issues, Part A: Educational; Part B: Clinical
- Chapter 4: Organizational Structure: The Decision-making Process
- Chapter 5: Personnel
- Chapter 6: Entry/Re-entry Process
- Chapter 7: Specialized Health Care Procedures

[Chapter 1](#) through [chapter 6](#) provides a framework for the development of appropriate policies and procedures to meet the diverse health care needs of students in the school setting. Chapter 1 provides information on the background, diversity, and statistics related to students with special health care needs.

[Chapter 2](#) provides the fundamental clinical principles of delegation, documentation and infection control/standard precautions that must be incorporated into all aspects of health care service delivery and procedure development in schools.

[Chapter 3](#) provides a general overview about the applicable federal and state statutes and regulations



for the provision of educational and related services, as well as the provision of safe and appropriate health care services for students with disabilities, students with chronic medical conditions or are dependent on medical technology.

[Chapter 4](#) addresses the essential collaborative decision making of the internal organization structure of local and regional boards of education.

[Chapter 5](#) provides principles and guidelines that serve as a basis for policy and procedure development for school staff.

[Chapter 6](#) provides guidance on the entry or re-entry of students with health care needs into school.

[Chapter 7](#) provides practical guidance to assist school personnel in establishing safe practices for select procedures. Procedures are presented as a general guide, rather than an inclusive presentation of all aspects of the individual procedure and include:

- A brief definition and overview of common indications for the procedure.
- The purpose and rationale for performing the procedure in school.
- A general equipment list.
- General procedure steps.
- Select nursing considerations to highlight important aspects of each procedure. They are not intended to be an exhaustive list of potential nursing considerations, rather they are intended to be specific keys to safely performing the procedure.
- Delegation considerations when appropriate, are identified as a quick-reference option. The reader must refer to the more comprehensive delegation discussion in [chapter 2](#) to fully appreciate the implications of delegation decisions and responsibilities.

References and resources are provided at the end of each chapter.

Introduction

THE CLINICAL PROCEDURE GUIDELINES FOR CONNECTICUT SCHOOL NURSES (CLINICAL GUIDELINES) IS THE MERGER OF THE Connecticut State Department of Education's Specialized Health Care Procedure Manual for School Nurses (1997) and Serving Students with Special Health Care Needs (1992). This updated document integrates valuable concepts identified in the previous manuals and offers a contemporary and practical format intended to assist school nurses in developing the procedural aspects of individualized health care plans for students with special health care needs and in providing task-specific training for other school personnel, when indicated. The Clinical Guidelines may also serve as a resource for other health professionals in schools, as well as school administrators, nurses, and other health professionals in early intervention programs. Information that addresses the procedures identified in this manual is intended to be used as a guideline in conjunction with:

- sound theoretical knowledge;
- medical research and evidence-based clinical references;
- collaboration with professional peers and expert consultants; and
- collaboration with students, educators, families and caregivers.

The procedural guidelines delineate the general steps of physical health care activities and must always be used in conjunction with fundamental principles, standards, and safe practices recognized as vital to working with children with special or complex health care needs. Those principles, standards, and practices are reviewed in chapters 1 and 2, and should form the basis for planning, implementing and evaluating all specialized health care services for students, along with the following considerations



that are critical for quality health services in schools:

- collaboration between family; student; members of the school team, including the school medical adviser; and the student's health care providers is essential to the development of an appropriate plan of care to successfully and safely meeting the health care needs of students;
- a primary focus of health services planning is the promotion of student competence and independence in self-care, consistent with their transition plans;
- recognition that each student and family has unique cultural, spiritual, economic, social, and educational factors and values that influence their approach to health care;
- school nurses (registered nurses) are specifically identified as the medical professionals for facilitating appropriate delegation of select components of health care procedures;
- implementation of health care in schools;
- school nurses or other health care professionals must make delegation decisions based on the health care status and needs of students, legal requirements within the State of Connecticut, and state and national standards for professional practice;
- school nurses and other health care professionals must be licensed, clinically knowledgeable and competent to provide the necessary care and, if supervising the licensed practical nurses (LPN) or delegating care and supervising unlicensed assistive personnel (UAP), ensure the competency of these individuals to perform the delegated or supervised health care activities;
- school nurses are responsible for maintaining the level of competency required to create plans and perform medical or other procedures. This may often require acquisition of new or updated skills and knowledge;
- school nurses should consult with the school medical adviser, as indicated, in the assessment, planning, implementation and evaluation process; and
- local and regional boards of education need to support the ongoing clinical competency development of school nurses.

Additional considerations include the often rapid advancement of medical technology and revisions of procedures based on newly integrated evidence-based research. These considerations must be taken into account when planning, implementing, and delegating health care procedures.

Overview

THE PURPOSE OF THIS DOCUMENT IS TO ASSIST CONNECTICUT SCHOOLS, REGIONAL EDUCATIONAL SERVICE CENTERS, OR OTHER settings where educational services are being provided to students with special health care needs, in identifying appropriate services and staff in the school setting, and to plan the support services necessary to ensure the safety and well-being of all students during participation in school activities. *Clinical Procedure Guidelines for Connecticut School Nurses* (Clinical Guidelines) is intended to provide a framework for the development of appropriate policies and procedures to meet the diverse health care needs of students in school settings. It is based on the laws and regulations that apply to education and on the laws, regulations, licensures, and professional standards of practice that currently apply to the practice of medicine, nursing and other health disciplines in Connecticut.

Definition

Within this document, the term “student” refers to all children and young people, ages 3–21 years old, who are entering or who are in educational programs. The term “special health care needs” refers to

those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally (McPherson, 1998).

The definition is broad in order to incorporate the entire range of students with special health care needs, whether physiological or psychological in nature, on a continuum from mild to severe and with actual or potential health service needs that must be addressed within school environments. While there



is considerable emphasis in this document on those students with more severe physical health impairments, the philosophy and general guidelines are intended to apply to the entire spectrum of students with health service needs in the educational setting. Students with special health care needs that are psychological in nature include those who have mental, emotional, and behavioral problems, and require medication and/or special services, supports or programs to address those problems.

Whether a specific student's health impairment and health service needs affect his or her eligibility for special education cannot be determined in general guidelines. Therefore, this document's intent is *not* to identify who may or may not be disabled under either Section 504 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA), formerly the Education of the Handicapped. Related legal issues will be generally addressed in [chapter 3, part a](#).

The population of children and youths with special health care needs is a diverse one, since their conditions vary widely according to numerous factors. These factors include, but are not limited to:

- specific diagnosis;
- age of onset;
- the natural course, duration, and severity of disease processes or extent of disability;
- chronological age compared to the child's developmental stage;
- treatment regimens;
- family circumstances;
- impact on the child and family (functional, psychosocial, cultural, and financial)
- visibility of the condition;
- environment; and
- long-term outcomes (cure, stability, or deterioration).

While the specific diagnoses of students with special health care needs vary widely, they can be categorized by general type of disease or condition. These general categories, with examples of each type, are listed below. The list is not inclusive.

TABLE 1. Students with special health care needs

Category of Disease or Condition	Examples
1. Chronic disease	Asthma, cancer, cystic fibrosis, diabetes, seasonal respiratory allergies, sickle cell anemia, inflammatory bowel disease
2. Chronic infectious disease	Hepatitis infections, human immunodeficiency virus (HIV) infection
3. Congenital or acquired physical conditions	Congenital heart defect, spina bifida, cardiomyopathy
4. Psychological conditions	Childhood psychosis, major depressive disorder, bipolar disorder, oppositional defiant disorder, conduct disorder, attention deficit hyperactivity disorder
5. Acquired disability	Traumatic brain injury, lead poisoning, drug addiction
6. Severe acute illness, which may require complex medical care over several weeks or months	Nephritis, osteomyelitis, pneumonia



All students with special health care needs should be assessed for issues related to psychosocial concerns. Students with special health care needs have a greater risk of problems with depression, anxiety, psychosomatic complaints, and low self-esteem. While some students with special health care needs will function well academically, some may have more difficulties meeting with academic success (Selekman, 2006, Chatterton, et.al, 2006, Henderson, 2006). Absenteeism, underachievement, and social adjustment problems are disproportionately higher in students with special health care needs. Some students fall into a pattern of school avoidance or school refusal, and the risks of teasing and bullying are high (Eiser, 1997).

For students with special health care needs to access their education and have a successful school experience, school district requirements may include:

- assessment and periodic reassessment of their health status and level of functioning on a periodic basis to determine what special services or program modifications they may need;
- policies that support close collaboration with families;
- safe professional practice;
- appropriate instructional programs;
- related services necessary to ensure successful functioning in educational settings;
- enhanced communication and collaboration with health and social service providers in the community;
- education of school personnel; and
- smooth interdisciplinary teamwork.

Connecticut's public education system has the duty to provide opportunities for all students to achieve the statewide student goals (motivation to learn, mastery of the basic skills, acquisition of knowledge, competence in life skills and understanding society's values) (CSDE, 2001). As such, children with health impairments share the following common needs to:

- interact with healthy children;
- identify and capitalize on their strengths; and
- mature to become independent, positive, productive, and socially responsible adults with the minimum disability possible.

Background

In the early 1990s, the Connecticut State Department of Education formed a committee to develop guidelines for students with special health care needs in response to the increasing numbers of children with acute, long-term, and chronic health problems who attended schools in Connecticut. The original publication, *Serving Students with Special Health Care Needs*, was released in 1992. Its companion publication, *Specialized Health Care Procedure Manual for School Nurses*, was published in 1997. This publication, *Clinical Procedure Guidelines for Connecticut School Nurses* (Clinical Guidelines), is an update and merger of those two documents.

Across the nation, children with special health care needs are living longer, are able to live at home, attend school, and participate in their communities. Scientific and technological advances in the health care field have greatly enhanced the life opportunities of children with physical health impairments. It is no longer uncommon for children requiring special health care services and high technology procedures to be discharged home from the hospital, or not to be treated in the hospital at all, and to attend



school. Some of these children are dependent on external equipment and support for survival. Similarly, changes in the treatment of children with emotional and mental illness have also resulted in fewer and shorter hospitalizations, increased outpatient treatment while the child is at home, and attending school. Frequently today, students with emotional and mental illness are hospitalized for only a short time and attend a partial hospital program during afternoon school hours. This may require an adjustment of a student's schedule to provide supplemental tutoring for classes missed due to the hospital program. Children with special health care needs at the milder end of the spectrum may also require services or adaptations in school to minimize the negative aspects of their conditions or the treatments prescribed to control them.

Statistics

Children and youths with special health care needs include those who are at risk for a chronic physical, developmental, behavioral, or emotional condition that requires services. The *2009–10 National Survey of Children with Special Health Care Needs* found that 15.1 percent of the nation's children met the definition of children with special health care needs (CCAMHI, 2012).

According to Selekman and McCormick (2006), nationally 7 percent of students with chronic conditions are receiving special education, 5.5 percent of students are identified under the label of Other Health Impaired (OHI), and Zirkle (2009) notes that in 2008, 1.2 percent of public school students had 504 plans with the majority of students having a diagnosis of attention deficit hyperactivity disorder (ADHD).

According to the Connecticut State Department of Education's *Special Education Fast Facts, in 2006-07*, 11.2 percent of Connecticut students were in special education, which included 17.2 percent of students listed as OHI, with no breakout for ADHD.

According to the *2008 Special Education Parent Survey*, in 2007-08, more than 90 percent of special education students in Connecticut attended public (89.8 percent) and private or parochial (1.4 percent) schools. Twenty-two percent of the students with special education needs are listed as OHI-Attention Deficit Disorder/ADHD and 4.1 percent are listed as OHI.

According to the State of Connecticut *2011 Health Services Survey Report*, 88 percent of Connecticut school districts reported that over 167,000 students have one or more specific health care needs.

Meeting the Challenge

Advances in science and health care technology, in conjunction with society's increased commitment to promoting optimal learning and development for all children, have increased the opportunities for students with special health care needs to achieve their individual goals. However, these advances also bring with them substantial challenges for families, schools, health care providers, communities, and society as a whole. To meet these challenges in an effective, efficient, safe and appropriate manner, it is crucial that experts in education, health, social services, law, financing, and municipal services collaborate with families and communities in identifying and promoting practices and programs that will enhance the quality of these students' educational experiences and lives. A crucial step in meeting the special health care needs of students is the collaborative development, implementation, and evalua-



tion of standards and guidelines to ensure the provision of safe and appropriate education and support services in school settings.



References

- American Academy of Pediatric Dentistry. (2008). *Definition of Special Health Care Needs*. Retrieved on November 25, 2011, from http://www.aapd.org/media/policies_guidelines/d_shcn.pdf.
- Chatterton, J, Kaup, T, and Swanson, M. A. (2006). *Diabetes Management in the School Setting*.
- Connecticut Special Education Facts, 2006-07. (2008). http://www.csde.state.ct.us/public/cedar/edfacts/coe/CTEdFactso6_07.pdf.
- Connecticut State Department of Education, Bureau of Special Education. (2007-08). *Connecticut Special Education Parent Survey Summary Report*. http://www.sde.ct.gov/sde/lib/sde/PDF/DEPS/Special/ParentSurvey_Summary08.pdf.
- Connecticut State Department of Education. (2001). *The State Board of Education's Position Statement on the Education of Students with Disabilities* <http://www.sde.ct.gov/sde/LIB/sde/pdf/board/disabilities.pdf>.
- Connecticut State Department of Education. (2009). *Health Services Program Information Survey Report* http://www.educationconnection.org/new/pdfs/sde_hssurvey09.pdf.
- Eiser, C. (1997). Effects of chronic illness on children and their families. *Advances in Psychiatric Treatment*, vol. 3, pp. 204-210.
- Henderson, J. 2006, Seizure disorder, in Selekmán, J (ed.). *School Nursing A Comprehensive Text*. F.A. Davis, Philadelphia pp. 865-888.
- McPherson M, Arango P, Fox H, Lauver C, McManus M, Newacheck PW, Perrin JM, Shonkoff JP, Strickland B. *A new definition of children with special health care needs*. *Pediatrics*. 1998;102(1 Pt 1):137-40.
- Medical Home Portal. *About Children and Youth with Special Health Care Needs (CYSHCN)*. Retrieved on February 2, 2012 from <http://www.medicalhomeportal.org/clinical-practice/building-a-medical-home/children-and-youth-with-special-health-care-needs#citation318>.
- Selekmán, J (ed.) (2006). *School Nursing A Comprehensive Text*. F.A. Davis, Philadelphia pp.757-780.
- Selekmán, J and Gamel-McCormick, M. (2006). *School Nursing A Comprehensive Text: Children with chronic conditions*. F.A. Davis, Philadelphia pp. 615-645.
- Selekmán, J. (2006). *School Nursing A Comprehensive Text: Attention deficit hyperactivity disorder and learning disabilities*. F.A. Davis, Philadelphia pp. 705-727.
- The Child and Adolescent Health Measurement Initiative (CAMHI). Data Resource Center for Child and Adolescent Health. *2009/10 National Survey of Children with Special Health Care Needs*. Retrieved on February 2, 2012 from <http://childhealthdata.org/browse/snapshots/cshcn-profiles?rpt=9&geo=1>.
- Zirkle, P.A. (2009). History and Expansion of Section 504 Student Eligibility: Implications for School Nurses. *Journal of School Nursing*, Vol 25 pp. 256-260.

Fundamental Principles

CLINICAL GUIDELINES FOR CONNECTICUT SCHOOL NURSES (CLINICAL GUIDELINES) ADDRESSES STUDENTS' SPECIALIZED HEALTH care needs, potential settings, school environments and staffing patterns. The school nurse, administrator, teacher, and other school staff must collaborate with the student and family to find the best solution to meeting the health service needs of the student. In many situations, the required care may, be best provided by the school nurse or, under the supervision of a school nurse, another member of the school health team (such as, RN, LPN, or trained and certified health aide), or by another health professional when the care is within that professional's scope of practice. However, when safe care does not require direct nursing intervention, allowing other members of the school team to participate in the provision of care, when appropriate, can promote student independence; enhance opportunities for students with special health care needs to attend school in the least restrictive environment; and maximize efficient use of resources.

Student's health impairment can significantly influence the student's ability to perform and derive benefit from his or her educational program. Due to the dynamic nature of a student's health status, special health care needs may be present:

- daily;
- only once or twice a week;
- periodically;
- seasonally;
- on an emergency basis; or
- for a single protracted episode.

Additionally, such special needs may change in type or severity at any time, either abruptly, as in a



crisis, or more gradually, as with maturation or chronic disease progression.

For a student with special health care needs of any age to access and derive benefit from an appropriate program, whether in special or regular education, preschool or adult transition, it is essential for school personnel to collaborate and coordinate services with families, health care professionals and other community service providers.

Children with special health care needs must attend school in an environment that is safe, that promotes maintenance of an optimal health status, and that fosters the achievement of normal developmental tasks, personal satisfaction, optimism, and independence. School personnel must not only understand and address the special health care needs of individual students, but must also understand the *priorities of their families* and support the individual student and family to achieve their goals. Therefore, if school programs and support services are to meet the varied needs of students with special health care needs, they must be:

- child focused;
- family centered;
- developmentally appropriate;
- continuous and flexible;
- coordinated with health services, other community services and family;
- provided in a safe and least restrictive environment;
- high quality;
- evidenced-based; and
- documented.

The following guidance further expands upon the definition of these fundamental clinical principles in meeting the needs of students with special health care considerations.



The following fundamental clinical principles must be universally applied to all procedures in the Clinical Guidelines: delegation, documentation, and infection control.

Delegation

“Delegation of nursing tasks to unlicensed assistive personnel (UAPs) in school settings continues to be a necessary, yet challenging practice. Although the practice of delegation to UAPs in schools, as in other healthcare settings, is necessary due to limited resources and increasing healthcare needs, it remains essential to provide students with healthcare that is safe and high in quality. Therefore, school nurses must understand delegation decisions and processes and develop the skills necessary to train and supervise UAPs” (Resha, 2010).

Delegation is defined as the transfer of responsibility of performing a nursing task to unlicensed assistive personnel while retaining the accountability of doing the task. “The need for delegation of nursing tasks in the school setting is greater today than ever before due to the following factors identified by NASN (2006a), NASSNC (2000), and Spriggle (2009):

- unfunded mandates, such as health screenings and immunization reporting, that pull the school nurse away from direct care;



- shortage of qualified nursing staff in schools, i.e., lack of nurses who meet the state requirement to work as a school nurse;
- budgetary constraints that limit the schools' ability to hire and retain qualified staff;
- staffing patterns that assign one nurse to multiple school buildings thereby leaving buildings without nurses at various times; and
- federal and state requirements, such as the Individuals with Disabilities Education Act (IDEA) of 1975, Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act of 1990, requiring that school health services for complex student health needs, such as providing care to ventilator-dependent children, be provided so that students can access their education" (Resha, 2010).

"This growing need to provide skilled nursing care increases the need to properly utilize trained UAPs, while continuing to provide safe and high quality healthcare in the school environment... In order to provide safe healthcare in the school setting, school nurses need to understand the legal parameters, e.g. their state Nurse Practice Acts, rules, and regulations; along with clinical parameters, such as the standards of practice and professional health-related position statements developed by professional organizations, including, among others, the American Nurses Association, the National Association of School Nurses, and the American Academy of Pediatrics, for delegating nursing tasks and responsibilities to UAPs. In addition, the individual nurse's critical thinking skills are of utmost importance in providing safe care" (Resha, 2010).

The National Council of State Boards of Nursing (NCSBN) has identified "Five Rights of Delegation" that provide a resource for the licensed registered nurse to facilitate decisions about delegation. These include the *right task, right circumstances, right person, right direction/communication* and the *right supervision*.

The Connecticut Board of Examiners for Nursing (CBEN) issued a declaratory ruling on April 5, 1995, on "*Delegation by Licensed Nurses to Unlicensed Assistive Personnel*"

(see [appendix A](#)). The declaratory ruling defines in detail the responsibilities of registered professional nurses regarding the delegation of nursing functions to unlicensed assistive personnel (UAP) in Connecticut, including tasks which "meet [a] client's basic human needs and activities of daily living." The declaratory ruling provides guidelines and sets standards for school nurses (and the agencies that employ them) in making decisions regarding delegation and supervision of nursing services, and appropriate training of unlicensed assistive personnel in Connecticut. In addition, the CBEN considers these delegation standards when adjudicating a specific case.



Five Rights of Delegation

Right Task: One that is delegable for a specific patient.

Right Circumstances: Appropriate patient setting, available resources and other relevant factors considered.

Right Person: Right person is delegating the right task to the right person to be performed on the right person.

Right Direction/Communication: Clear, concise description of the task, including its objective, limits and expectations.

Right Supervision/Evaluation: Appropriate monitoring, evaluation, intervention, as needed, and feedback.

(NCSBN 1995)



The following premises on which Clinical Guidelines are based are reaffirmed in the declaratory ruling, as excerpted from sections III.A.2. and III.A.3 of the CBEN 1995 declaratory ruling on “*Delegation by Licensed Nurses to Unlicensed Assistive Personnel*”:

1. The registered nurse shall be responsible for determining what aspects of the medical and nursing regimen the registered nurse may delegate to the licensed practical nurse and unlicensed personnel, consistent with this ruling, regardless of the setting in which this occurs.
2. The performance of non-nurse delegated and non-nurse supervised nursing activities by unlicensed persons constitutes practicing nursing without a license and is not in the interest of the health, safety, and welfare of the public.
3. The registered nurse retains responsibility for the total nursing process and for its outcomes in all situations where delegation has occurred (CBEN 1995).



In Connecticut, assessment, planning, evaluation, and nursing judgment cannot be delegated.

According to the CBEN, any task (except the insertion of a Foley catheter and tube feeding) may be delegated as long as it does not require nursing judgment. “The nurse, when making decisions about delegation, shall consider:

- client safety and the potential for client harm;
- the stability and acuity of the client’s condition;
- the nature and complexity of the task and the type of technology employed in providing nursing care with consideration given to the knowledge and skill required to effectively use the technology;
- relevant infection control and safety issues;
- the requisite competency of the person to whom the task is being delegated;
- the ability of the nurse to provide supervision and evaluation of the specific task being delegated;
- the adequacy of resources available to the nurse to support, direct, supervise and evaluate the delegated activity; and
- the proximity and availability of the nurse responsible for delegation or assistance” (CBEN, 1995, 7).

In each individual situation, the decision to delegate a specific activity for a specific student must be made by the health professional whose scope of practice includes relevant assessment of the student and performance of the procedure. In nursing, the delegating school nurse determines on an individual basis:

- the level (intensity and acuity) of care required by the student;
- whether certain aspects of care or health care activities can be delegated;
- the type of personnel to whom the care can be delegated (licensed, unlicensed, certified, noncertified); and
- what training and supervision are required (see [appendix A](#) regarding nursing delegation and [appendix B](#) regarding LPN scope of practice).



It is counterproductive and potentially unsafe to require an unwilling or reluctant staff member to provide the specialized care.

The building administrator, in collaboration or consultation with the nursing supervisor, determines which personnel in the identified category are available to perform the procedure. This may require the administrator to review job descriptions (see [chapter 5](#)), school policy and procedures, relevant bargaining agreements, personnel schedules, other responsibilities of the staff members in question,



and personnel data regarding prior standardized training and certification, such as home health aide or nursing assistant preparation.

After ensuring that sufficient and appropriate training has been completed, the school nurse must document the training (including date or the training and training content), assesses the competence of the assigned unlicensed assistive personnel, and determine whether to proceed with delegation of the task to the specific staff members designated by the building administrator.

The school nurse remains responsible and legally accountable for any delegated tasks and must provide regular, ongoing supervision to individuals carrying out the activities. Additionally, the school nurse may determine at any time that the health care activity can no longer be delegated based on a change either in the health status of the student or in the staff member's performance of the care.



Delegation consists of: assessing and planning; communication; surveillance and supervision; and evaluation and feedback.

Documentation

Documentation for health care procedures must be done in accordance with the district's documentation policy or procedures and professional standards. The recommended procedures presented in this manual require written authorization by a prescribing health care provider and approval by a parent or guardian. In some cases, the procedure may be ordered using a procedure or treatment authorization form, such as for tube feeding or suctioning. For procedures such as blood glucose monitoring, the prescriber may have a signed plan of care from a pediatric endocrinology clinic for a student with diabetes. Other procedures may be part of a medication authorization that does not require an additional authorization, such as using a spacer with a metered dose inhaler (MDI).

Districts may choose a variety of methods, including narrative charting of procedures, to document clinical or medical procedures. Some examples include using a procedure or treatment record for daily tube feedings; a diabetes flow sheet for blood glucose monitoring; or the Individual Student Medication Record for a spacer used with an MDI. Documentation methods must be consistently used and may be done manually or electronically, depending on the documentation system a school district uses.

Regardless of the documentation system and options that a school district utilizes, the fundamental principles of nursing documentation must always apply. Documentation of health care in the school setting is required to meet legal mandates in creating a record that:

- accurately reflects professional nursing practice;
- provides a means to communicate with other health care professionals and families;
- provides a vehicle for quality assurance; and
- provides support in case of legal allegations.



Infection Control / Standard Precautions

Infection Control

Infection control, including hand washing and the use of nonsterile gloves, and other personal protective equipment as necessary, must be used when providing nursing care identified in these Clinical Guidelines. When the school nurse delegates a procedure, the nurse is responsible for ensuring that the training provided includes infection control, and the staff members receiving the delegation of each procedure demonstrate competency. All school personnel must follow standard precautions guidelines, including those specific to bloodborne pathogens.

School districts are required to:

- establish a written exposure control plan, as required by Occupational Safety and Health Administration (OSHA);
- establish adequate hand-washing facilities or alternatives;
- require staff to routinely observe standard precautions to prevent exposure to disease-causing organisms; and
- provide necessary equipment/supplies to implement the exposure control plan and budget for the replacement of supplies.

Exposure Control Plans

In December 1991, the OSHA published the Occupational Exposure to Bloodborne Pathogens Standard (29 CFR 1910.1030). This standard requires public school employers who have employees with occupational exposure to establish an exposure control plan that describes what work practices will be used to protect employees. It is important to note that all written programs must be site specific. The schools exposure control plan:

- should be developed by the chief administrative officer, with the advice of the school nurse or school health services program manager and the school medical adviser;
- use the guidelines from the Centers for Disease Control and Prevention (CDC), state and local health departments;
- must be a written policy; and
- should be reviewed annually.

School Exposure Control Plan Requirements

1. Delineate safe work practices that protect employees from exposure to bloodborne pathogens, including standard precautions (see [Standard Precautions](#) that follows), and the use of protective equipment such as gloves, face shields, and OSHA-approved sharps.
2. Outline how staff should handle blood-contaminated materials, including determining what engineering modifications and changes in practices are necessary (such as facilities and procedures for hand washing, use of needle-less devices, and disposal of hazardous waste within school buildings and facilities).



3. Determine which employees could reasonably be expected to have exposure to bloodborne pathogens or other materials potentially contaminated with blood as a result of performing job duties. This may include the school nurse, custodians, special education teachers, and bus drivers.
4. Provide training and education for all school staff, including custodians, transportation, and food services staff, on the prevention of exposure to bloodborne pathogens, standard precautions, availability of hepatitis B vaccine for staff in predetermined job positions and post-exposure procedures. This training needs to take place for new employees within 10 days of their employment and annually for all school staff.
5. Provide hepatitis B vaccine for occupationally exposed employees at no cost to the employee. Note: Some schools provide and administer this vaccine; others pay for the vaccine and have the local health department or other agency administer it.
6. Determine a post-exposure procedure to follow. The procedure should include a reporting procedure and must include immediate post-exposure medical evaluation and follow-up.
7. Determine how maintenance of records, including medical records, staff training records, sharps injury logs, and vaccine administration, will occur in accordance with guidelines for confidentiality of health records. (U.S. Department of Labor. OSHA. http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=standards&p_id=10051.)

Standard Precautions

Standard precautions are recommended practice for protection against transmission of bloodborne pathogens and other infectious diseases in the workplace. This is the practice of treating all human body substances (such as blood, urine, and feces) in any form (except sweat, which is not considered to be potentially infectious) as if it is infected with a bloodborne or other pathogen and avoiding all direct contact with this material. The guidelines pertain to all body fluids (regardless of visible blood), non-intact skin, and mucous membranes (CDC, 2005).

According to the Centers for Disease Control and Prevention, “schools inherently foster the transmission of infections from person to person because they are a group setting in which people are in close contact and share supplies and equipment. However, schools also can be instrumental in keeping their communities healthy by:

- encouraging sick students and staff to stay home and seek medical attention for severe illness;
- facilitating hand hygiene by supplying soap and paper towels and teaching good hand-hygiene practices;
- being vigilant about cleaning and disinfecting classroom materials and surfaces;
- providing messages in daily announcements about preventing infectious disease;
- adopting healthy practices such as safe handling of food and use of standard precautions when handling body fluids and excretions; and
- encouraging students and staff to get annual influenza vaccinations” (CDC, 2011).



References

- American Nurses Association (ANA) and the National Council of State Boards of Nursing (NCSBN). Joint Statement on Delegation. Retrieved on November 23, 2011, from https://www.ncsbn.org/Joint_statement.pdf.
- Caldart-Olson, L., McComb, M., Mazyck, D., Wolfe, L., Byrd, S. Field Trip Precautions. *NASN. School Nurse*, Mar 2005; vol. 20: pp. 7.
- Centers for Disease Control and Prevention (CDC), Division of Healthcare Quality Promotion. (2007). Guideline for Isolation Precautions: *Preventing Transmission of Infectious Agents in Healthcare Settings*.
- Centers for Disease Control and Prevention (CDC), Division of Healthcare Quality Promotion. (1998). Guidelines for Infection Control in Healthcare Personnel.
- Centers for Disease Control and Prevention (CDC). (November 2011). *Infectious Diseases at School*. Retrieved on March 15, 2012 from <http://www.cdc.gov/healthyyouth/infectious/>.
- Centers for Disease Control and Prevention (CDC). (April 2005). Standard Precautions.
- Clinical Guidelines for School Nurses Sixth Edition. (Revised 2007). School Health Alert.
- Collins, N., Murphy, P., Winters, L., Van Cleve, C., Minchella, L. National Association of School Nurses. *Newsletter*, Mar 2008; vol. 23: pp. 24-25.
- Connecticut Board of Examiners for Nursing. Declaratory Ruling on Delegation by Licensed Nurses to Unlicensed Assistive Personnel. Retrieved on November 23, 2011 from http://www.ct.gov/dph/lib/dph/phho/nursing_board/guidelines/unlicensed_ap_dec_rul.pdf.
- Connecticut Board of Examiners for Nursing. Declaratory Ruling on LPN Scope of Practice. Retrieved on November 23, 2011 from http://www.ct.gov/dph/lib/dph/phho/nursing_board/guidelines/lpndeclaratoryruling.pdf.
- Costante, C. School Health Nursing: Framework for the Future Part II. *The Journal of School Nursing*, Apr 2001; vol. 17: pp. 64-72.
- Davis-Alldritt, L. If I Delegate, Am I at Risk? *School Nurse*, Sep 2009; vol. 24: pp. 180-183.
- Erickson, C., Splett, P., Mullett, S., Stoltzfus, H., and Bielski, M. The Healthy Learner Model for Student Chronic Condition Management--Part I. *The Journal of School Nursing*, Dec 2006; vol. 22: pp. 310-318.
- Gordon, S., Barry, C., and Charlotte D. Delegation Guided by School Nursing Values: Comprehensive Knowledge, Trust, and Empowerment. *The Journal of School Nursing*, Oct 2009; vol. 25: pp. 352-360.
- Gursky, Beverly S., Ryser, Barbara J. A Training Program for Unlicensed Assistive Personnel. *The Journal of School Nursing*, Apr 2007; vol. 23: pp. 92-97.
- Harrigan, Judith F. What would you do? *School Nurse*, May 2002; vol. 17: pp. 20.
- National Association of School Nurses. Delegation and the School Nurse. *School Nurse*, Jan 2008; vol. 23: pp. 15.



- National Association of School Nurses. What Would You DO? *School Nurse*, May 2001; vol. 16: pp. 22.
- National Council of State Boards of Nursing. (2005). *Working with Others: A Position Paper*. Retrieved on November 23, 2011 from https://www.ncsbn.org/Working_with_Others.pdf.
- O'Dell, C., O'Hara, K., Kiel, S., McCullough, K. Emergency Management of Seizures in the School Setting. *The Journal of School Nursing*, June 2007; vol. 23: pp. 158-165.
- Resha, C. "Delegation in the School Setting: Is it a Safe Practice?" *OJIN: The Online Journal of Issues in Nursing*, May 2010; vol. 5, No. 2, Manuscript 5.
- Shelton, T.L. and Stepanek, J.S. (1994). Family-Centered Care for Children Needing Specialized Health and Developmental Services.
- Solum, Linda L., Schaffer, Marjorie A. Ethical Problems Experienced by School Nurses. *The Journal of School Nursing*, Dec 2003; vol. 19: pp. 330-337.
- Spriggle, M. Developing a Policy for Delegation of Nursing Care in the School Setting. *The Journal of School Nursing*, Apr 2009; vol. 25: pp. 98-107.
- United States Department of Health and Human Services (DHHS), National Institute for Occupational Safety and Health (NIOSH). Bloodborne Infectious Diseases HIV/AIDS, Hepatitis B Virus, and Hepatitis C Virus.
- United States Department of Labor. OSHA. *Occupational Safety and Health Standards*. Retrieved January 23, 2012, from http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=standards&p_id=10051.
- United States Department of Labor. OSHA. *Universal Precautions*. Retrieved on April 19, 2011, from <http://www.osha.gov/SLTC/etools/hospital/hazards/univprec/univ.html>.

3

Part A:

Legal Issues — Educational

Special Education

Special education laws and regulations are meant to protect students with disabilities. These laws and regulations ensure that students receive the services and assistance that may be necessary to make meaningful progress in their education program. In Connecticut, the special education system is based on the federal special education law, Individuals with Disabilities Education Improvement Act (IDEA 2004) and its implementing regulations, in combination with the state's special education law, Connecticut General Statutes Section 10-76a to 10-76h, inclusive, and the implementing regulations.

Special education is provided to students with an identified disability who need specially designed instruction to meet their unique needs and to enable students to access the general curriculum of the school district. Students who are eligible for special education services are entitled by federal law to receive a free appropriate public education (FAPE). FAPE ensures that all students with disabilities receive an appropriate public education at no cost to the family. FAPE differs from student to student because each has unique needs. Students who receive special education services receive services that are required in order for them to benefit from special education. These services are called "related services." Related services means "transportation and such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education, and includes speech-language pathology and audiology services, interpreting services, psychological services, physical and occupational therapy, recreation, including therapeutic recreation, early identification and assessment of disabilities in children, counseling services, including rehabilitation counseling, orientation and mobility services, and medical services for diagnostic or evaluation purposes. Related services also include



school health services and school nurse services, social work services in schools, and parent counseling and training” (34 CFR § 300.34[a]).

Individuals with Disabilities Education Act of 2004

Under the the Individuals with Disabilities Education Act of 2004 (IDEA), a child with a “disability” means: 1) a child evaluated in accordance with the IDEA as having one or more of the recognized disability categories; 2) the disability adversely affects educational performance; and 3) because of the disability and the adverse impact, the child needs special education and related services. The IDEA 2004 disability categories are as follows:

- autism
- deaf-blindness
- deafness
- emotional disturbance
- hearing impairment
- intellectual disability (mental retardation)
- multiple disabilities
- orthopedic impairment
- other health impairment (limited strength, vitality or alertness due to chronic or acute health problems such as lead poisoning, asthma, attention deficit disorder, diabetes, a heart condition, hemophilia, leukemia, nephritis, rheumatic fever, sickle cell anemia and Tourette syndrome)
- specific learning disability
- speech or language impairment
- traumatic brain injury
- visual impairment including blindness
- developmental delay (3- through 5-year-old children only).

In Connecticut, a school district is also required to provide identification, referral and evaluation services for students who may be gifted and/or talented. A district is not required but has the option of providing services to students who have been identified as being gifted and/or talented (CSDE, A Parent’s Guide to Special Education in Connecticut, 2007, 2).

Connecticut’s State Board of Education (SBE) believes that a unified and coordinated continuum of educational opportunities and supports, designed to address individual needs, serves and benefits all students. The SBE also supports the principle that Connecticut’s Common Core of Learning defines common goals for all students, including those with disabilities (CSDE, Position Statement on the Education of Students with Disabilities, 2001). The special education laws and regulations that support this principle are well intended, however, complex and detailed. The Connecticut State Department of Education (CSDE) Bureau of Special Education provides valuable resources and guidance documents with detailed information and explanation regarding special education laws, regulations, the special education eligibility process, services for students and other information on its Web site at <http://www.sde.ct.gov/sde/cwp/view.asp?a=2678&Q=320730#Legal>.

The CSDE’s *Special Education Resources Table* below lists publications specifically related to the processes and procedures for attaining special education services for students with disabilities.



TABLE 2. CSDE's Special Education Resources Table

Title	Description	URL
Special Education Publications	Best Practice Resources; Eligibility Documents; Guidance Documents/ Topic Briefs; Parent/Family Resources; and Secondary Transition Resources.	http://www.sde.ct.gov/sde/cwp/view.asp?a=2626&q=322672
<i>The State Board of Education's Position Statement On the Education of Students with Disabilities (2001)</i>	Position Statement On the Education of Students with Disabilities	http://www.sde.ct.gov/sde/LIB/sde/pdf/board/disabilities.pdf
CSDE's Division of Legal and Governmental Affairs Law: <i>Individuals with Disabilities Education Act (IDEA)</i>	Individuals with Disabilities Education Act (IDEA)	http://www.sde.ct.gov/sde/cwp/view.asp?a=2683&q=320334
<i>A Parent's Guide to Special Education in Connecticut (2007)</i>	Provides information for parents, guardians and other family members about laws, regulations, and policies affecting special education programs and services.	http://www.sde.ct.gov/sde/lib/sde/PDF/DEPS/Special/Parents_Guide_SE.pdf
<i>Before, During & After the PPT Meeting: Preparing for the PPT Meeting & Development of The Individualized Education Program (2008)</i>	Planning and Placement Team (PPT) Checklist	http://www.sde.ct.gov/sde/lib/sde/PDF/DEPS/Special/Before_PPT.pdf
<i>PPT 101: Understanding the Basics of the Planning and Placement Team Meeting</i>	Provides information on the process and procedure for referral and eligibility for special education; Individualized Education Programs; PPT; and parent's role in the PPT process.	http://www.sde.ct.gov/sde/lib/sde/PDF/DEPS/Special/PPT101.pdf
<i>Making the PPT Process More Effective for You and Your Child</i>	Provides information on the PPT process.	http://www.sde.ct.gov/sde/lib/sde/PDF/DEPS/Special/PPT_Process.pdf
<i>IEP Manuals and Forms (2010)</i>	CSDE's guidance to school districts in Connecticut to assist in using the IEP forms.	http://www.sde.ct.gov/sde/lib/sde/PDF/DEPS/Special/IEP-Manual.pdf
<i>Writing Standards-based IEP Goals and Objectives</i>	This multimedia presentation is designed to provide a tool and a process for helping Connecticut educators develop standards-based IEPs.	http://ctserc.org/s/index.php?option=com_content&view=article&id=516:using-a-word-bank-process-to-develop-standards-based-iep-goals-a-objectives-&catid=51:8-professional-development&Itemid=144
<i>Guidelines for Identifying Children with Learning Disabilities (2010)</i>	This document provides a comprehensive description of the changes in IDEA 2004 regarding the identification and eligibility determination of children with a specific learning disability.	http://www.sde.ct.gov/sde/lib/sde/PDF/DEPS/Special/2010_Learning_Disability_Guidelines_Acc.pdf



Section 504 of the Rehabilitation Act of 1973

Section 504 is a federal law designed to protect the rights of individuals with disabilities in programs and activities that receive federal financial assistance from the United States Department of Education (USDE). Section 504 provides in part that “No otherwise qualified individual with a disability in the United States . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance . . .” Recipients of this federal financial assistance include public school districts, institutions of higher education, and other state and local education agencies. The regulations implementing Section 504 in the context of educational institutions appear at 34 CFR Part 104.

The Section 504 regulations require a school district to provide a “free appropriate public education” (FAPE) to each qualified student with a disability who is in the school district’s jurisdiction, regardless of the nature or severity of the disability. Under Section 504, FAPE consists of the provision of regular or special education and related aids and services designed to meet the student’s individual educational needs as adequately as the needs of nondisabled students are met (OCR, 2011).

Who Is Protected under Section 504?

Section 504 covers qualified students with disabilities who attend schools receiving federal financial assistance. To be protected under Section 504, a student must be determined to: (1) have a physical or mental impairment that substantially limits one or more major life activities; or (2) have a record of such an impairment; or (3) be regarded as having such an impairment. Section 504 requires that school districts provide a free appropriate public education (FAPE) to qualified students in their jurisdictions who have a physical or mental impairment that substantially limits one or more major life activities.

Major life activities, as defined in the Section 504 regulations at 34 CFR 104.3(j)(2)(ii), include functions such as caring for one’s self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working. This list is not exhaustive. Other functions can be major life activities for purposes of Section 504. In the Amendments Act, Congress provided additional examples of general activities that are major life activities, including eating, sleeping, standing, lifting, bending, reading, concentrating, thinking, and communicating. Congress also provided a nonexhaustive list of examples of “major bodily functions” that are major life activities, such as the functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions. The Section 504 regulatory provision, though not as comprehensive as the Amendments Act, is still valid—the Section 504 regulatory provision’s list of examples of major life activities is not exclusive, and an activity or function not specifically listed in the Section 504 regulatory provision can nonetheless be a major life activity.

Physical or Mental Impairment that Substantially Limits a Major Life Activity

The determination of whether a student has a physical or mental impairment that substantially limits a major life activity must be made based on an individual inquiry. The Section 504 regulatory provision



at 34 CFR 104.3(j)(2)(i) defines a physical or mental impairment as any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genitourinary; hemic and lymphatic; skin; and endocrine; or any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. The regulatory provision does not set forth an exhaustive list of specific diseases and conditions that may constitute physical or mental impairments because of the difficulty of ensuring the comprehensiveness of such a list.

The CSDE's *Section 504 Resources Table* below lists publications specifically related to the processes and procedures for attaining services for students with disabilities and special health care needs.

TABLE 3. CSDE's Section 504 Resources Table

Title	Description	URL
<i>CSDE's Circular Letter C-13, Series 2008-09 Section 504 of the Rehabilitation Act of 1973: Procedural Safeguards Reissue of CIRCULAR LETTER C-9, Series 2000-2001</i>	Section 504 of the Rehabilitation Act of 1973: Procedural Safeguards	http://www.sde.ct.gov/sde/lib/sde/pdf/circ/circ08-09/c13.pdf
<i>Protecting Students With Disabilities: Frequently Asked Questions About Section 504 and the Education of Children with Disabilities</i>	This document is a revised version of a document originally developed by the Chicago Office of the Office for Civil Rights (OCR) in the U.S. Department of Education (ED) to clarify the requirements of Section 504 of the Rehabilitation Act of 1973, as amended (Section 504) in the area of public elementary and secondary education. The primary purpose of these revisions is to incorporate information about the Americans with Disabilities Act Amendments Act of 2008 (Amendments Act), effective January 1, 2009, which amended the Americans with Disabilities Act of 1990 (ADA) and included a conforming amendment to the Rehabilitation Act of 1973 that affects the meaning of disability in Section 504.	http://www2.ed.gov/about/offices/list/ocr/504faq.html
<i>CSDE's Division of Legal and Governmental Affairs Law: Section 504</i>	Section 504 Law	http://www.sde.ct.gov/sde/cwp/view.asp?a=2683&q=320334
<i>CSDE's Accommodating Special Dietary Needs in School Nutrition Programs (2011)</i>	Contains information on providing meals for children with special dietary needs, based on federal laws, U.S. Department of Agriculture regulations and Connecticut laws and regulations.	http://www.sde.ct.gov/sde/lib/sde/PDF/DEPS/Student/NutritionEd/AccommodatingSpecialDiets.pdf



Title	Description	URL
School Readiness Technical Assistance Alert (1999) Number TA/SR # 99-02: <i>Serving 3-, 4-, and 5-year-old Children with Disabilities</i>	Section 504 and School Readiness Programs	http://www.sde.ct.gov/sde/LIB/sde/pdf/deps/readiness/SR/TA_SR_99_02.pdf
<i>CSDE's Guidelines for Managing Life-Threatening Food Allergies in Connecticut Schools</i>	Allergy management in schools	http://www.sde.ct.gov/sde/lib/sde/PDF/deps/student/health/Food_Allergies.pdf
<i>CSDE's Guidelines for Blood Glucose Self-Monitoring in School</i>	Diabetes management	http://www.sde.ct.gov/sde/lib/sde/PDF/deps/student/health/GlucoseGuidelines.pdf

Individualized Health Care Plans

Oftentimes, students with special health care needs that are eligible for Section 504 or special education may have their individualized health care plan (IHCP) incorporated into the Section 504 plan or the individualized educational plan (IEP). However, some students have special health care needs on the milder end of the spectrum and do not meet the eligibility requirements for Section 504 or special education. As appropriate, these students may be provided with an IHCP, indicating accommodations or services based in regular education.

An individualized health care plan is a detailed and orderly program of action designed to monitor, prevent, reduce or eliminate identified health problems in order to maintain or improve a student's health status and level of wellness and to promote his or her learning and positive coping. The process of planning requires a team approach and includes the establishment of care priorities, a clear understanding of student specific goals, prescription of appropriate interventions, and delineation of measurements for goal achievement (National Association of School Nurses, 2008).

Health care plans identify solutions for diagnosed health problems (actual or potential); communicate the student's specific health needs, and the prescribed nursing and collaborative interventions for directing and evaluating the care given; and provide a mechanism for demonstrating accountability.

The IHCP is developed following the nursing process:

- assessment (includes subjective and objective data);
- nursing diagnoses;
- planning (includes student goals and expected outcomes);
- implementation (interventions employed); and
- evaluation.

Demographic data should include:



Important note: Students with special health care needs on the milder end of the spectrum and who do not meet the eligibility requirements for Section 504 or special education, may be provided with an IHCP indicating accommodations or services based in regular education.



- name;
- address;
- date of birth;
- grade;
- parents;
- contact information;
- primary care provider;
- preferred hospital;
- medical diagnoses;
- allergies;
- medications; and
- treatments.

While all registered nurses are taught how to write health care plans in their basic education, health care plans written for schools must take both health and educational needs into consideration during development. Registered school nurses who have had no pediatric experience and those who are new to the educational arena, may need assistance from an experienced school nurse or school nurse supervisor to appropriately perform this activity.

Only the registered school nurse can draft and finalize an individualized health care plan for a student. Other members of the education team, the family, licensed practical nurses (LPNs), and the student's health care providers may contribute to the development of the plan, but the registered school nurse retains overall responsibility for its production and implementation.



The nursing process is a goal-oriented method of caring that provides a framework to nursing care. It involves five major steps:

- Assessment (what data is collected?)
- Nursing Diagnosis (what is the problem?)
- Planning (how to manage the problem)
- Implementation (putting plan into action)
- Evaluation (did the plan work?)

The Role of the School Nurse (Registered Nurse) in Special Education and Section 504

The registered professional school nurse leads oversight of school health policies and programs in the school community. As such, school nurses actively collaborate with others to build student and family capacity for adaptation, self-management, self-advocacy and learning. Coordinating the linkage between the medical home, family and school is an important aspect of

the role of the school nurse. The school nurse has health expertise that is essential to school educational teams, such as the special education team, the individualized educational plan (IEP) team and the Section 504 team so that health-related barriers to learning can be reduced for each student (Wolfe, 2012).

In determining the level of health services necessary for students to adequately access their education, it is imperative that the school nurse is included as a member of the problem solving team. School nurses provide valuable input about the needs of students with health issues who have difficulties learning. They have the expertise to identify and recommend appropriate health accommodations or interventions to



Administrators must ensure that professional registered school nurses are included in the IEP and Section 504 team processes in order to appropriately address the health-related barriers to learning for identified students.



allow students full access to their education. Important information that may affect learning is often identified from the health history obtained by the registered school nurse. Best practice says that the nurse should be involved in the Response to Intervention (RTI)/Scientific Research-Based Intervention (SRBI) process to identify and support health needs and if significant health concerns are identified leading to an initial special education evaluation, the nurse must be part of the multidisciplinary team (CDE, 2008).

School nurses who engage in these multidisciplinary teams must also acquire the essential knowledge regarding the processes and protocol of special education team meetings, IEP meetings and Section 504 meetings. As the team's medical expert, the school nurse must be cognizant of the legal implications of their medical advice and suggested service for students. While priority is given to what is in the best interest of the student, school nurses must also consider the limitations of their local or regional boards of education.

Healthy children are successful learners. The registered school nurse has a multifaceted role within the school setting, one that supports the physical, mental, emotional, and social health of students and their success in the learning process. It is the breadth of nursing activities contained within the role of the school nurse and the unique non-medical setting that differentiates school nursing from other nursing specialties (NASN, 2010).

Confidentiality: Family Educational Rights to Privacy Act

The Family Educational Rights to Privacy Act (FERPA) is a federal law that protects the privacy of students' "education records" (20 U.S.C. § 1232g; 34 CFR Part 99). FERPA applies to educational agencies and institutions that receive funds under any program administered by the U.S. Department of Education (USDOE). This includes virtually all public schools and school districts and most private and public postsecondary institutions, including medical and other professional schools. If an educational agency or institution receives funds under one or more of these programs, FERPA applies to the recipient as a whole, including each of its components, such as a department within a university (34 CFR § 99.1(d)) (FERPA, 2008).

Private and religious schools at the elementary and secondary level generally do not receive funds from the USDOE and are, therefore, not subject to FERPA. Note that a private school is not made subject to FERPA just because its students and teachers receive services from a local school district or state educational agency that receives funds from the USDOE. The school itself must receive funds from a program administered by the USDOE to be subject to FERPA. For example, if a school district places a student with a disability in a private school that is acting on behalf of the school district with regard to providing services to that student, the records of that student are subject to FERPA, but not the records of the other students in the private school. In such cases, the school district remains responsible for complying with FERPA with respect to the education records of the student placed at the private school (FERPA, 2008).

An educational agency or institution subject to FERPA may not have a policy or practice of disclosing the education records of students, or personally identifiable information from education records, without a parent or eligible student's written consent (34 CFR § 99.30). FERPA contains several exceptions to this general consent rule (34 CFR § 99.31). An "eligible student" is a student who is at least 18 years of age or who attends a postsecondary institution at any age (34 CFR §§ 99.3 and 99.5[a]). Under FERPA, parents and eligible students have the right to inspect and review the student's education records and to seek to have them amended in certain circumstances (34 CFR §§ 99.10–99.12 and §§ 99.20–99.22). The term



“education records” is broadly defined to mean those records that are: (1) directly related to a student, and (2) maintained by an educational agency or institution or by a party acting for the agency or institution (34 CFR § 99.3) (FERPA, 2008).

At the elementary or secondary level, a student’s health records, including immunization records, maintained by an educational agency or institution subject to FERPA, as well as records maintained by a school nurse, are “education records” subject to FERPA. In addition, records that schools maintain on special education students, including records on services provided to students under the Individuals with Disabilities Education Act (IDEA), are “education records” under FERPA. This is because these records are (1) directly related to a student, (2) maintained by the school or a party acting for the school, and (3) not excluded from the definition of “education records” (FERPA, 2008).

At postsecondary institutions, medical and psychological treatment records of eligible students are excluded from the definition of “education records” if they are made, maintained, and used only in connection with treatment of the student and disclosed only to individuals providing the treatment (see 34 CFR § 99.3 “Education records”). These records are commonly called “treatment records.” An eligible student’s treatment records may be disclosed for purposes other than the student’s treatment, provided the records are disclosed under one of the exceptions to written consent under 34 CFR § 99.31(a) or with the student’s written consent under 34 CFR § 99.30. If a school discloses an eligible student’s treatment records for purposes other than treatment, the records are no longer excluded from the definition of “education records” and are subject to all other FERPA requirements (FERPA, 2008).

The FERPA regulations and other helpful information can be found at <http://www.ed.gov/policy/gen/guid/fpco/index.html>. For quick, informal responses to routine questions about FERPA, school officials may e-mail the U.S. Department of Education at FERPA@ed.gov. For more formal technical assistance on the information provided in this guidance in particular or FERPA in general, please contact the Family Policy Compliance Office at the following address: Family Policy Compliance Office U.S. USDOE of Education, 400 Maryland Ave. S.W., Washington, D.C. 20202-8520 (FERPA, 2008).

Confidentiality: Health Insurance Portability and Accountability Act

Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) in 1996 to, among other things, improve the efficiency and effectiveness of the health care system through the establishment of national standards and requirements for electronic health care transactions and to protect the privacy and security of individually identifiable health information. These are known as HIPAA’s Administrative Simplification provisions, and the United States Department of Health and Human Services (USDHHS) has issued a suite of rules, including a privacy rule, to implement these provisions. Entities subject to the HIPAA Administrative Simplification Rules (45 CFR Parts 160, 162, and 164), known as “covered entities,” are health plans, health care clearinghouses, and health care providers that transmit health information in electronic form in connection with covered transactions (45 CFR § 160.103) (HIPAA, 2008).

“Health care providers” include institutional providers of health or medical services, such as hospitals, as well as noninstitutional providers, such as physicians, dentists, and other practitioners, along with any other person or organization that furnishes, bills, or is paid for health care in the normal course of busi-



ness. Covered transactions are those for which the USDHHS has adopted a standard, such as health care claims submitted to a health plan (45 CFR § 160.103 definitions of “health care provider” and “transaction” and 45 CFR Part 162, Subparts K–R) (HIPAA, 2008).

The HIPAA Privacy Rule requires covered entities to protect individuals’ health records and other identifiable health information by requiring appropriate safeguards to protect privacy, and setting limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The rule also gives patients rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections (HIPAA, 2008).

Where FERPA and HIPAA May Intersect

When a school provides health care to students in the normal course of business, such as through its health clinic, it is also a “health care provider” as defined by HIPAA. If a school also conducts any covered transactions electronically in connection with that health care, it is then a covered entity under HIPAA. As a covered entity, the school must comply with the HIPAA Administrative Simplification Rules for Transactions and Code Sets and Identifiers with respect to its transactions.

However, many schools, even those that are HIPAA covered entities, are not required to comply with the HIPAA Privacy Rule because the only health records maintained by the school are “education records” or “treatment records” of eligible students under FERPA, both of which are excluded from coverage under the HIPAA Privacy Rule. See the exception at paragraph (2)(i) and (2)(ii) to what is considered “protected health information” (PHI) at 45 CFR § 160.103) (HIPAA, 2008).

In addition, the exception for records covered by FERPA applies both to the HIPAA Privacy Rule, as well as to the HIPAA Security Rule, because the Security Rule applies to a subset of information covered by the Privacy Rule (i.e., electronic PHI). Information on the HIPAA Privacy Rule is available at <http://www.hhs.gov/ocr/hipaa/>. Information on the other HIPAA Administrative Simplification Rules is available at <http://www.cms.hhs.gov/HIPAAGenInfo/> (HIPAA, 2008).

The HIPAA Privacy Rule specifically excludes from its coverage those records that FERPA protects. When determining whether personally identifiable information from student health records maintained by the educational agency or institution may be disclosed, school officials at institutions subject to FERPA should refer to FERPA and its requirements. While the educational agency or institution has the responsibility to make the initial, case-by-case determination of whether a disclosure meets the requirements of FERPA, the U.S. Department of Education’s Family Policy Compliance Office is available to offer technical assistance to school officials in making such determinations (HIPAA, 2008).



When determining whether personally identifiable information from student health records maintained by the educational agency or institution may be disclosed, school officials at institutions subject to FERPA should refer to FERPA and its requirements.



References

- CDE. (2008). *School Nurse's Role in Response to Intervention (Rtl) and Special Education*. Retrieved on February 7, 2012 from <http://www.cde.state.co.us/HealthAndWellness/download/nurRoleInRtl.pdf> <http://www.nasn.org/Default.aspx?tabid=226> http://www.nmschoolhealthmanual.org/shm_05.pdf
- Joint Guidance on the Application of the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) To Student Health Records. (2008). Retrieved on February 7, 2012, from <http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/hipaaferpajointguide.pdf>
- National Association of School Nurses (NASN) (2010). *Definition of school nursing*. Retrieved on February 7, 2012 from <http://www.nasn.org/Default.aspx?tabid=57>
- National Association of School Nurses. (2008). Individualized healthcare plans (IHP). Retrieved January 19, 2012 from <http://www.nasn.org/PolicyAdvocacy/PositionPapersandReports/NASNPositionStatementsFullView/tabid/462/ArticleId/32/Individualized-Healthcare-Plans-IHP-Revised-2008>
- New Mexico School Health Manual Section V. *Individualized Health Care Plans*.
- Office of Civil Rights (OCR). (2011). *Protecting Students with Disabilities: Frequently Asked Questions About Section 504 and the Education of Children with Disabilities*. Retrieved on February 7, 2012 from <http://www2.ed.gov/about/offices/list/ocr/504faq.html>
- Selekman, J. (ed). (2006). *School Nursing: A Comprehensive Text: Student Health and Education Plans*. F.A. Davis, Philadelphia, pp. 177-203.
- Wolfe, L.C. (2012). The profession of school nursing. In J. Selekman, *School Nursing: A Comprehensive Text*. Philadelphia: F.A. Davis.

Part B:

Legal Issues — Clinical

JUST AS THERE ARE COMPLEX EDUCATIONAL - LEGAL ISSUES RELATED TO THE EDUCATION OF STUDENTS WITH SPECIAL HEALTH CARE needs, there are equally complex clinical - legal issues regarding the provision of safe and appropriate health care services for students with special health care needs when they participate in school programs. To understand the complexity of these issues, it is necessary to review the laws, regulations, and professional standards of practice that govern the practice of health care professionals in Connecticut. While the emphasis in this section will be on the laws, regulations, and standards that apply to the practice of medicine and nursing in Connecticut, it is important to recognize that other health care professionals require licensure for entry into practice in this state. These include occupational and physical therapists, speech-language pathologists, and clinical psychologists.

Regulations

The Connecticut Department of Public Health (DPH) has regulatory responsibility for licensure of all health care professionals. To fulfill its obligation to protect the health, safety, and welfare of its citizens, the state legislature delegates the function of regulating the practice of certain health professions to respective Boards of Examiners and the DPH. School health professionals whose practices are regulated by a respective Board of Examiners include physicians, nurses, physical therapists, and clinical psychologists. (The practice of other school health professionals, including occupational therapists, speech language pathologists, and independent social workers are regulated through licensure by the DPH.) For example, the Board of Medical Examiners regulates medical practice in Connecticut and the Board of Examiners for Nursing regulates nursing practice in the state. Statutes enacted by the legislature grant specific power



and authority to these boards to regulate professional practice (regardless of the setting) and to monitor professional activities. The Connecticut Board of Examiners for Nursing (CBEN) has the power and authority to determine, based on the Nurse Practice Act, the scope of practice of the advanced practice registered nurse (APRN), the professional registered nurse (RN), and the licensed practical nurse (LPN). The CBEN is responsible for determining which professional nursing functions can be delegated to the LPN and what other nursing functions can be delegated to unlicensed assistive personnel (UAP). The CBEN has no regulatory authority but can issue administrative decisions or declaratory rulings. The DPH can promulgate such decision or rulings through the regulatory process.

The practice acts that apply to licensure of health professionals include language that prohibits unlicensed persons from practicing these professions for remuneration. Violation of the prohibitions can result in a fine and/or jail term. For example, the Nurse Practice Act (Connecticut General Statutes, Sections 20-87 through Sec. 20-102a), states that “No person shall, for remuneration, practice nursing as defined in subsection (a) of section 20-87a, unless properly licensed” (Connecticut General Statutes, Sections 20-102). Those found guilty of practicing nursing without a license can be fined up to \$500.00 and/or imprisoned for up to five years. Furthermore, each instance of patient contact or consultation, which is in violation of the Nurse Practice Act, constitutes a separate offense. It is the Board of Examiners for Nursing and the courts that decide whether someone is practicing nursing without a license.

The State of Connecticut has specific regulations regarding qualifications of school nurses and school nurse practitioners. According to state regulations Sections 10-212-1 through 10-212-7, school nurses and nurse practitioners must be qualified to practice in these positions. The regulations require that the school nurse/nurse practitioner must be a registered professional nurse, designated as RN, as defined in Section 20-87a of the Connecticut General Statutes, and currently licensed in the State of Connecticut. The regulations also define what professional experience and education a registered nurse must have to qualify as a school nurse. These are considered *minimal* requirements. Other licensed personnel, RNs, or LPNs may function in an assistive role to the school nurse but may not be designated as a school nurse.



Board of Examiners for Nursing

The licensed nurse is accountable to the Board of Examiners for Nursing for his/her practice as a nurse, regardless of the nurse's responsibilities to his/her employer for employment activities. School nurses may be disciplined by the Board of Examiners for Nursing for failing to practice nursing according to nursing standards even when such failure occurs because of his or her employer's directive. Such discipline can result in loss of the nurse's license (Connecticut General Statutes Section 20-90, Duties of the Board, <http://www.cga.ct.gov/2011/pub/Chap378.htm#Sec20-90.htm>).

Licensure

Physicians and nurses in Connecticut, as in all states throughout the nation, must be licensed to practice medicine or nursing in the state, that is, to provide services, and perform certain functions covered within



the professions' licensure acts. Licensure for medicine and nursing is based on successful completion of required academic and clinical programs, as well as successful completion of state and/or national qualifying examinations. The intent of licensure is to ensure that those who practice as physicians and nurses, or perform the functions described within the practice acts, have met certain *minimal* professional academic and clinical qualifications designed to protect the public from unsafe care. Unsafe care in medicine and nursing results in higher death rates, greater incidence of illness, injury or complication, unnecessary suffering and greater long-term expense both for the consumer and society (Chapter 378 *Nursing* and Chapter 370 *Physician*).

The practice of nursing by a registered nurse is defined in statute as

the process of diagnosing human responses to actual or potential health problems, providing supportive and restorative care, health counseling and teaching, case finding and referral, collaborating in the implementation of the total health care regimen and executing the medical regimen under the direction of a licensed physician, dentist or advanced practice registered nurse (Connecticut General Statutes, Section 20-87(a)).

Nursing diagnosis, providing supportive and restorative care, health counseling, teaching, case finding, and referral are *independent* functions of the RN; that is, functions that the nurse can perform without specific orders from a physician or dentist. Collaboration in the implementation of the total health care regimen and executing the medical regimen are functions that are *interdependent* with the physician, advanced practice registered nurse, or dentist; that is, functions that require specific orders for specific clients. As noted in [chapter 2](#), registered nurses may delegate specific functions to licensed practical nurses and to unlicensed persons under their supervision.

The registered nurse who has specialized training, education and experience beyond those required for RN licensure may also obtain licensure as an APRN. APRNs (nurse practitioners and clinical nurse specialists) who are so licensed:

performs acts of diagnosis and treatment of alterations in health status, as described in subsection (a) of this section, and shall collaborate with a physician licensed to practice medicine in this state. In all settings, the advanced practice registered nurse may, in collaboration with a physician licensed to practice medicine in this state, prescribe, dispense and administer medical therapeutics and corrective measures and may request, sign for, receive and dispense drugs in the form of professional samples in accordance with sections 20-14c to 20-14e, inclusive, ... (Connecticut General Statutes, Section 20-87[b])

The LPN is licensed to perform selected tasks and *share* responsibility under the direction of a registered nurse or an advanced practice registered nurse; and within the framework of supportive and restorative care, health counseling and teaching, case finding and referral, collaborate in the implementation of the total health care regimen and execute the medical regimen under the direction of a licensed physician or dentist (Connecticut General Statutes, Section 20-87[c]). In February 1989, the CBEN, in response to a request from the Connecticut general assembly, issued a declaratory ruling to clarify the role of the licensed practical nurse. That ruling states that the LPN:



Physicians can delegate certain licensed functions to other licensed health care providers under their supervision, but not to unlicensed persons (Gelfman and Schwab, 2005, p. 112).



1. Must perform his/her nursing functions and shared nursing responsibility under the direction of a registered nurse.
2. Can participate in all phases of the nursing process under the direction of the registered nurse to the following extent:
 - a. Contribute to the nursing assessment by collecting, reporting, and recording objective and subjective data in an accurate and timely manner. Data collection includes observation about the condition or change in condition of the client, and signs and symptoms of deviation from normal health status.
 - b. Participate in the development of the strategy of care in consultation with other nursing personnel by providing data; contributing to the identification of priorities; and contributing to setting realistic and measurable goals.
 - c. Participate in the assisting, delegating and giving of directed care by:
 - i. Providing care for clients whose conditions are stabilized or predictable.
 - ii. Providing care for clients whose conditions are critical and/or unpredictable under the direct supervision of the registered nurse and, when executing the medical regimen, under the direction of a licensed physician or dentist.
 - iii. Implement nursing care according to the priority of needs and established goals.
 - iv. Providing an environment conducive to safety and health.
 - v. Documenting nursing interventions and responses to care.
 - vi. Communicating nursing interventions and responses to care to appropriate members of the health team.
3. Must carry out all selected nursing tasks and shared nursing responsibilities under the direction of the registered nurse. The direction of the registered nurse should be immediately available, on site, in health care agencies providing in-patient and out-patient nursing services. In community health settings (which includes schools), the registered nurse must be responsible for the total plan of nursing care and should be proximately available for on-site visits and available by telephone.

Because of the complex health care needs of students in schools today, the Connecticut Advisory School Health Council, in its 1989 *Guidelines*

on the Roles and Qualifications of School Health Personnel, recommended that LPNs should be used in schools only where on-site supervision of the registered nurse is available. This is not a legal requirement; however, the RN must still consider the recommendation and the complexity of care potentially required by the students before determining that it is safe for a LPN to function in a setting where the RN is not onsite. The RN must determine the amount of on-site supervision that must be provided to ensure safe care and the RN remains responsible for the care provided.



LPNs in the School Setting

The LPN may contribute to, but may not be responsible for, nursing assessment, diagnosis, planning implementation or evaluation of client care. Nor can the LPN be responsible for implementation of the plan of care independent of the RN. In school settings, the registered nurse must be responsible for the total plan of nursing care, provide supervision, and should be proximately available for on-site visits and available by telephone.



Standards of Practice

In addition to state licensure and regulations for health professionals and the rulings or decisions of the respective Boards of Examiners for medicine and nursing, there are numerous and complex standards within medical and nursing practice that define other criteria for an “expert” in a specialty or subspecialty area of practice. In medicine, for example, specialties include psychiatry, pediatrics, and orthopedics, while subspecialties in the area of pediatrics and psychiatry include neonatology, adolescent medicine, developmental pediatrics, and child and adolescent psychiatry. Physicians must obtain further education and clinical experience, plus pass an additional board certification examination, in order to specialize in an area of medicine beyond “general” practice.

Education for registered nurses can take three different paths. The original “modern” route to RN education was the three-year hospital program, of which only one currently exists in the state. This program results in a *RN diploma* and is an *entry point for technical nursing practice*. This RN diploma has been moved into the two-year *associate of science in nursing*, and is also considered an *entry point for technical nursing practice*. The four-year *Bachelor of Science in nursing* is the *entry point for professional nursing practice*.

Most nurses educated in the last 20 years will have attended either a two or a four-year college. Nurses also must obtain further clinical experience and, generally further education, plus pass a national certification examination in order to become certified as an expert nurse in a specialty area. In nursing, specialty areas may include pediatric nursing, community/public health nursing, or psychiatric nursing. Further nursing subspecialties in these areas include, for example, neonatal nursing and school nursing. As of 1991, the National Board for Certification of School Nurses Inc. certifies school nurses and requires RNs to have a baccalaureate degree to sit for the exam. This certification is not required to practice, but it is a standard set forth by the National

Association of School Nurses (NASN) and that school districts may consider when hiring new personnel, and/or encouraging present personnel to pursue continuing education or developing salary incentives. Families should also know the preparation and expertise of the health care professionals providing services to their children.

There are additional standards of practice in nursing and in medicine that can be used in a court of law to demonstrate whether the nurse or physician met the required standard of care in a specific instance. These standards are generally developed and published by the profession’s national organization or related organizations such as the American Academy of Pediatrics for pediatricians or the American Nurses



Competency in School Nurse Practice

This document is designed to support the practice of school nursing within Connecticut schools. The areas of school nurse competency, supervision and evaluation are presented in an effort to promote high-quality school health services. The school nurse competencies delineate the knowledge and skills needed to practice nursing in the school setting. The competencies may be used in a variety of ways: a framework of nursing school instructors; an orientation plan for new school nurses; an evaluation tool for school nurses; a goal-setting tool for school nurses; and a program planning tool.

Connecticut State Department of Education, Health Promotion Services/School Nurse Web site at http://www.sde.ct.gov/sde/lib/sde/PDF/deps/student/health/Nursing_Competencies.pdf.



Association (ANA) for nurses. The most recent school nursing standards, *School Nursing Scope and Standards of Practice*, were published jointly by the ANA and NASN in 2011. Standards are valuable to health professionals in planning, administering, and evaluating appropriate services; identifying competency of practitioners; and to clinical supervisors in evaluating the health professional's performance. These standards have been used to develop the CSDE's *Competency in School Nurse Practice and Evaluation Tool*. In addition, there are numerous other standards for nursing practice including the NASN Code of Ethics (2002) and ANA Code of Ethics (2001).

Practice by Unlicensed Persons

As previously mentioned, practice acts include language that prohibit unlicensed persons from practicing licensed professions. In Connecticut, individuals may be imprisoned for up to five years and fined up to \$500, or both, for practicing without a license the following health professions: medicine, nursing, occupational therapy, physical therapy, psychology (not applicable to certified school psychologists) or school psychological examiners not licensed by the DPH as a psychologist under Connecticut General Statutes, Section 20-187(a), speech pathology and audiology. This means that there can be criminal, in addition to civil, consequences if a school employee performs the licensed function of one of those health professionals when the function or task has not been (or cannot be) delegated by the licensed professional. Such licensed functions of health professionals include, for example, assessment of the student's health status, development of a plan to meet the student's health care needs in school, or the performance of a health care procedure that has not been (or cannot be) delegated by the appropriately licensed professional.

In a court case in Oregon (see *Carol Mitts v. Hillsboro Union High Scholl District No. 3 et al.*, Washington County Circuit Court, Case No. 87-11420), a school district was sued by a school health assistant because the school principal assigned the health assistant (an unlicensed school employee) to perform clean intermittent catheterization (CIC) on a new middle grade student with spina bifida, following training by the mother and with intermittent supervision by the part-time school nurse. The court asked the Oregon State Board of Nursing for a declaratory ruling in the matter. The board's ruling was as follows:

... the central conclusion is that the unlicensed persons in the school setting may be required to perform tasks of nursing care when those tasks are properly delegated to them by a registered nurse. Unlicensed persons may not perform those tasks on their own volition nor be required to perform those tasks when directed to do so by school authorities or parents.

The issue here is not merely the performance of CIC in a school setting, and who may perform it. Rather the issue is the identification of health care needs of student and how best to meet those needs. The purpose of hiring individuals with various expertise and credentials in the school setting is to utilize their knowledge and skills to provide student with an environment for learning and the provision of related services. A nurse employed by, or under contract to, a school system must be allowed to use her skills and expertise in the nursing process to meet identified health care needs of students. The law requires no less.

The Oregon State Board of Nursing concluded that the principal was unlawfully practicing nursing without a license, not so much because he assigned the task of CIC, but rather because he presumed to understand the health care needs of the student (i.e., assumed the functions of health assessment,



diagnosis and planning) for which he was neither qualified nor licensed. The board also determined that the school nurse had not acted according to professional nursing standards. A footnote to the declaratory ruling states:

The Board expects that licensed nurses take an active role in applying the nursing process. (The school nurse's) role was passive in that she accepted the assignment by school authorities regarding (the student's) health care needs and acted upon that assessment by supervising (the health assistant).

In an additional footnote to the declaratory ruling, the Oregon State Board of Nursing noted that health assistants in school districts in Oregon were apparently being required “to engage in systematic problem solving which includes the steps of assessing, making nursing diagnoses, planning, intervening, and evaluating.” This constitutes the practice of nursing that health assistants may not lawfully do unless they are properly licensed.

Training of School Personnel by Parents

While the licensure acts do not prohibit parents from learning and providing specialized care to their own children, parents cannot take on the responsibility for teaching others to provide such care, nor can they unilaterally determine the best plan of care for their child in the school setting. Based on the practice acts for health professionals, it is illegal for school personnel to provide health care to a student based solely on instruction or guidance by a parent. This does not mean, however, that parents should not collaborate with the school nurse, for example, in developing a plan of care and in preparing other school personnel for their child's entry into school. Since the parents have expertise about the individual strengths and needs of their child, it is critical that they collaborate with the school nurse in preparing other school personnel to provide a safe environment for their child. Even if a parent is a licensed nurse, the parent cannot take on the sole responsibility of training school personnel to provide specialized care since the parent is not part of the school's organized structure and will not be responsible for the ongoing care of the student in school or for the supervision of other personnel providing care. The school system must ensure that the school nurse completes a health assessment of the student, determines that delegation of care is appropriate in the school, and is well prepared to train and supervise other school personnel who are providing the care.



References

- American Nurses Association. Principles for Delegation <http://nursingworld.org/MainMenuCategories/ThePracticeofProfessionalNursing/NursingStandards/ANAPrinciples/Principles-for-Delegation/PrinciplesofDelegation.aspx>
- American Nurses Association and National Council of State Boards of Nursing. *Joint Statement on Delegation* <http://www.nursingworld.org/MainMenuCategories/ThePracticeofProfessionalNursing/workplace/Work-Environment/Infofor-Nurses/ANANCSBNStatementonDelegationpdf.aspx>
- Caldara-Olson, L., McComb, M., Mazyck, D., Wolfe, L. and Byrd, S. Field Trip Precautions. *NASN School Nurse*, Mar 2005; vol. 20: pp. 7.
- Collins, N., Murphy, P., Winters, L., Van Cleve, C. and Minchella, L. Why Is Your State Nurse Practice Act Important to School Nursing Practice? *NASN Newsletter*, Mar 2008; vol. 23: pp. 24-25.
- Connecticut Board of Examiners for Nursing. *Declaratory Ruling on Delegation by Licensed Nurses to Unlicensed Assistive Personnel* http://www.ct.gov/dph/lib/dph/phho/nursing_board/guidelines/unlicensed_ap_dec_rul.pdf
- Connecticut Board of Examiners for Nursing. *Declaratory Ruling on LPN Scope of Practice* http://www.ct.gov/dph/lib/dph/phho/nursing_board/guidelines/lpndeclaratoryruling.pdf
- Connecticut State Department of Education. (1989). Connecticut Advisory School Health Council. *Roles and qualifications of school health personnel*.
- Connecticut State Department of Education. (2009). *Competency in School Nurse Practice* http://www.sde.ct.gov/sde/lib/sde/PDF/deps/student/health/Nursing_Competencies.pdf
- Connecticut State Department of Education. (2009). *School Nurse Competencies Checklist and Evaluation Tool* http://www.sde.ct.gov/sde/lib/sde/PDF/deps/student/health/Nursing_Competencies_Checklist.pdf
- Costante, C. School Health Nursing: Framework for the Future Part II. *The Journal of School Nursing*, Apr 2001; vol. 17: pp. 64-72.
- Davis-Alldritt, L. If I Delegate, Am I at Risk?. *NASN School Nurse*, Sep 2009; vol. 24: pp. 180-183.
- Delegation and the School Nurse. *NASN School Nurse*, Jan 2008; vol. 23: pp. 15.
- DuPlessis Erickson, C., Splett, P., Stoltzfus Mullett, S., Bielski Heiman, M.
- Gelfman, M.H.B. Discrimination in school:§504, ADA, Title IX, in Schwab, N.C. and Gelfman, M.H.B. (eds.) *Legal issues in School Health Services A Resource for School Administrators, School Attorneys, School Nurses, Sunrise River Press, North Branch, MN, pp. 335-371 (2005)*.
- Gordon, S. and Barry, C. Delegation Guided by School Nursing Values: Comprehensive Knowledge, Trust, and Empowerment. *The Journal of School Nursing*, Oct 2009; vol. 25: pp. 352-360.
- Gursky, B. and Ryser, B. A Training Program for Unlicensed Assistive Personnel. *The Journal of School Nursing*, Apr 2007; vol. 23: pp. 92-97.
- Harrigan, J. F. What would you do?. *NASN School Nurse*, May 2002; vol. 17: pp. 20.



- Healthy Learner Model for Student Chronic Condition Management--Part I, The. *The Journal of School Nursing*, Dec 2006; vol. 22: pp. 310-318.
- LPN Declaratory Ruling <http://www.ct.gov/dcf/lib/dcf/nurses/pdf/lpndeclaratoryruling.pdf>
- National Association of School Nurses. What Would You DO? *NASN School Nurse*, May 2001; vol. 16: pp. 22.
- National Council of State Boards of Nursing. Working with Others. https://www.ncsbn.org/Working_with_Others.pdf
- O'Dell, C., O'Hara, K., Kiel, S. and McCullough, K. Emergency Management of Seizures in the School Setting. *The Journal of School Nursing*, Jun 2007; vol. 23: pp. 158-165.
- Resha, C., (May 31, 2010) "Delegation in the School Setting: Is it a Safe Practice?" *OJIN: The Online Journal of Issues in Nursing* Vol. 15, No. 2, Manuscript 5.
- Solum, L., Schaffer, M. Ethical Problems Experienced by School Nurses. *The Journal of School Nursing*, Dec 2003; vol. 19: pp. 330-337.
- Spriggle, M. Developing a Policy for Delegation of Nursing Care in the School Setting. *The Journal of School Nursing*, Apr 2009; vol. 25: pp. 98-107.
- State of Connecticut Board of Education. (1991). Requirements and guidelines for special education and related services for children (ages 3-5) with disabilities. Hartford, Author.

4

Organizational Structure: The Decision-making Process

THE INTERNAL ORGANIZATIONAL STRUCTURE OF THE LOCAL SCHOOL DISTRICT SHOULD REFLECT AND SUPPORT THE COLLABORATIVE decision making of educators and health professionals at all levels of the organization. With the increasing complexity of health services required by students in school, both administrative and clinical judgments are critical in planning, implementing, and evaluating services for children with health impairments. Local school districts may need to review and revise organizational structures, policies and procedures to promote decision making that is truly collaborative in nature and to ensure that both administrative and clinical judgment are made by those who have the expertise and legal authority to make them.

It is important at the classroom level that team members (for example, the teacher, mental health professional, school nurse, physical therapist, occupational therapist and speech language pathologist) provide coordinated services with common, *child-focused, and family centered goals*. To do this, team members, including the family, must share information necessary to optimize the student's educational program and to ensure the student's health and safety. Similarly, it is essential that school administrators, school nurse supervisors, school medical advisers, pupil personnel coordinators and other appropriate supervisory and administrative personnel collaborate in planning programs, developing procedures, and resolving many of the difficult issues inherent in providing services for students with special needs. Finally, the local board of education should ensure that health-related issues are identified and considered in the process of developing and revising policy by consulting with the medical adviser, nursing supervisor, and community health experts. Consultation with attorneys who have expertise in education may also be beneficial in resolving legal issues regarding district policy or procedure.

Local school districts have the overall responsibility for providing a free and appropriate education in a safe environment for all of their students. In order to discharge administrative responsibilities as they



relate to the health care of students in schools, local school districts should:

- hire qualified health professionals who are competent and appropriately licensed to provide consultation, training, supervision, and/or direct health care services for the specific population served;
- ensure interdisciplinary collaboration in the development of policies and procedures;
- establish clear lines of authority, responsibility, and accountability for clinical decision making;
- develop policies and procedures which ensure that clinical decisions related to the health status and health care of students are made by health professionals who are qualified and legally authorized to make such decisions;
- delegate the responsibility for developing clinical policies, procedures and protocols specific to the delivery of health care services in the district to appropriately qualified health and mental health clinicians;
- delegate the authority and responsibility for making clinical decisions to the health and mental health professionals who are qualified to make them;
- consult with community health experts or use health advisory committees that include such experts;
- develop policies that ensure appropriate privacy and maintenance of confidentiality around student health information, third-party medical/psychiatric records, and school health records, including a process for ongoing professional development on this topic;
- establish mechanisms for interdisciplinary planning, joint problem solving, and collaborative evaluation of student services; and
- provide time and funding for necessary continuing education, professional development and in-service training for health and mental health professionals.

Within a school district, school health professionals have primary responsibility for:

- safe clinical services;
- the development of sound clinical policies, procedures and protocols; and
- final decision-making authority in the clinical aspects of health care delivery.

School administrators, educators, medical advisers, school social workers, school nurses, speech language pathologists, school psychologists, school counselors, physical therapists, occupational therapists, food service supervisors, transportation supervisors, and other professionals within the school community need to collaborate in the development, review, and revision of related policies, procedures, and student services on a regular basis.

Most school decisions related to serving students with special health care needs require some combination of both administrative judgment and clinical judgment. It is sometimes difficult to identify the specific components of the decision-making process, but it is important to make a collaborative effort to do so. When the various components of a decision-making process can be identified, they can then be developed into a procedure, protocol, or decision rubric for the future management of similar issues.

Example of Collaborative Decision Making

It is essential for all personnel to recognize that there will be conflicts and problems that arise in the process of planning for, providing, and evaluating the special services that students with special health care needs may require in school. It is important, therefore, for school districts to:

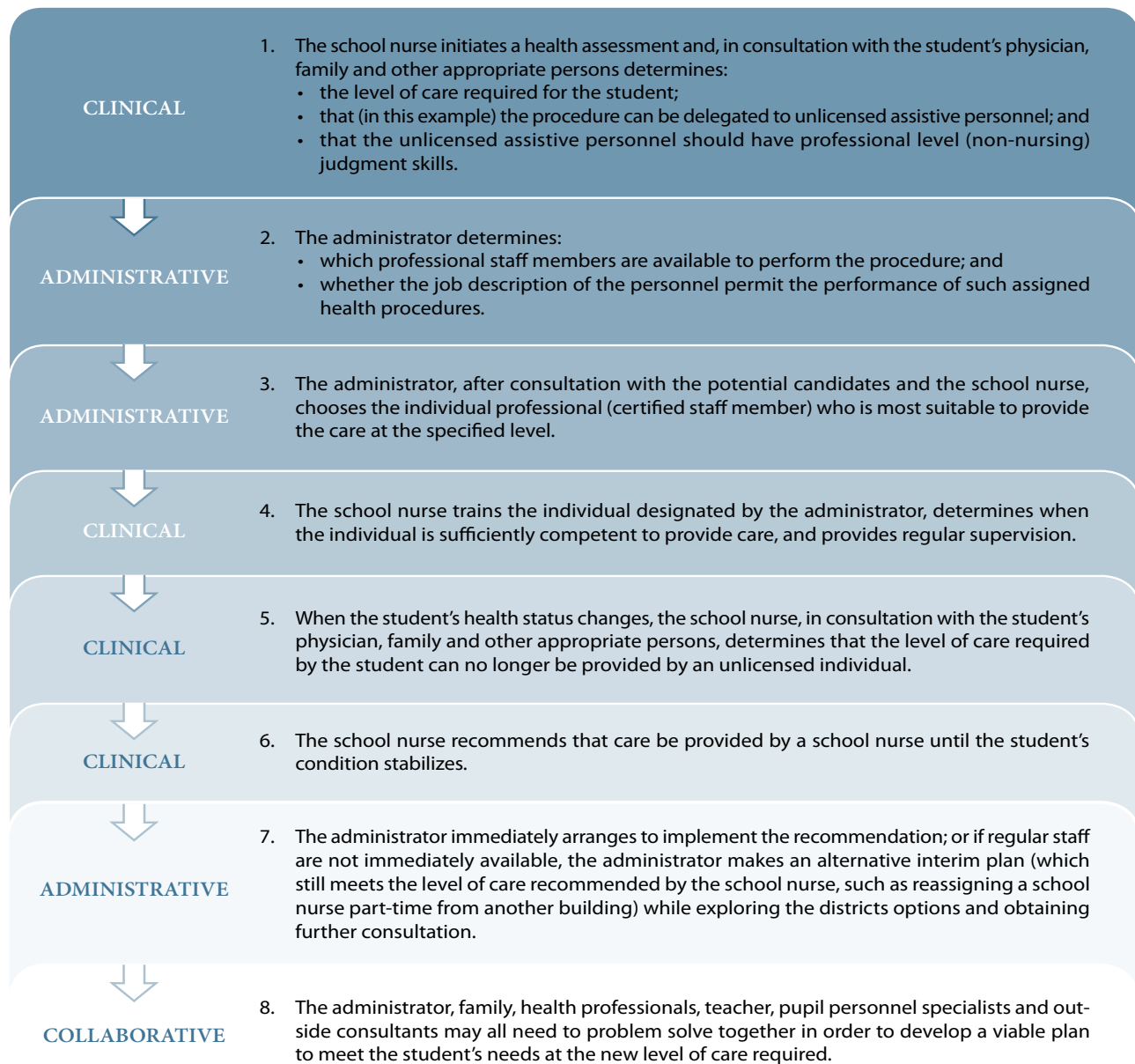
- provide adequate orientation of personnel to interdisciplinary team functioning;



- promote regular team meetings for communication about issues and problem solving; and
- define for all personnel an administrative structure that establishes clear lines of responsibility and authority for administrative and clinical decisions, for joint decision-making and for recourse when the first line of problem resolution is ineffective.

The health, safety, and, in some cases, life of a student may depend on clear lines of decision-making among personnel. The following is an example of Collaborative Decision Making:

A new student is eligible to enter the preschool program located in a district's elementary school. Because of the student's health impairment, she will require a health care procedure daily while in school. In the process of planning for the student to enter school, the decision about who should perform the required procedure must be made. The steps of a collaborative process for making this decision, including both administrative and clinical components, as well as the primary responsibility for specific aspects of the decision, are outlined below. Although the primary responsibility for each decision is indicated by "CLINICAL" or "ADMINISTRATIVE," in most instances the decision maker will make better judgments when others have been consulted during the decision-making process.



Personnel

POLICIES AND PROCEDURES RELATED TO PERSONNEL SHOULD BE REVIEWED AND REVISED AS NEEDED TO REFLECT THE HEALTH needs of the school community. The type and number of regular and consultant staff members that a school district may require will depend on the student population served, and that may vary over time.

The following principles and guidelines should serve as a basis for policy and procedure development in the area of personnel planning, hiring, role delineation, and related personnel issues regarding the provision of services for students with special health care needs.

General

1. The school medical adviser and school nurse supervisor/director/coordinator should be integrally involved in the development of personnel policies and procedures as they relate to school personnel working with students with special health care needs.
2. In school districts where there is not a nursing supervisor/director/coordinator (i.e., a professional nurse with supervisory or administrative responsibilities), the most qualified school nurse (for example, the school nurse with experience regarding various student health needs and district involvement), should participate in the development of such policies and procedures.
3. Consultation with other disciplines and with outside community experts in nursing, medicine, and related health fields is beneficial and may be essential.



4. School districts should examine the health services needs of the total student population to determine safe and appropriate staffing patterns. “The National Association of School Nurses (NASN) recommends a formula-based approach with minimum ratios of nurses-to-students depending on the needs of the student populations as follows: 1:750 for students in the general population, 1:225 in the student populations requiring daily professional school nursing services or interventions, 1:125 in student populations with complex health care needs, and 1:1 may be necessary for individual students who require daily and continuous professional nursing services. Other factors that should be considered in the formula-based approach are number of students on free or reduced lunch, number of students with a medical home, and average number of emergency services per year” (NASN 2010.)
5. Job descriptions should clearly delineate roles, responsibilities and lines of authority for professional personnel and should be based on standards of practice for the profession.
6. Personnel policies and procedures should require personnel to use:
 - a. appropriate infection control techniques to prevent the unwanted spread of communicable diseases (see Infection Control/Standard Precautions in [chapter 2](#)); and
 - b. standard precautions, when indicated to prevent exposure to blood borne viruses, including human immunodeficiency virus (HIV) and hepatitis viruses (United States Department of Labor, OSHA Instruction CPL 2-2.44A).
7. Hepatitis B immunizations must be offered free of charge to school nurses and other at risk school personnel who in the course of their regular responsibilities, are or may be exposed to blood and or other body fluids that are considered high risk for the transmission of hepatitis B (United States Department of Labor, OSHA Instruction CPL 2-2.44A). See also Infection Control/Standard Precautions in [chapter 2](#).
8. Before a licensed health professional assigns a task to unlicensed personnel, it is necessary to determine that the employee’s job description does not prohibit the performance of such a task.

Qualifications for Regular, Contract, and Substitute Personnel

1. School districts should hire qualified personnel based on the standards for the specific profession and specialty practice, when applicable, and the needs and ages of the students to be served.
2. School districts should ascertain that licensed health professionals whom they employ are in good standing in their professions and are currently licensed to practice in Connecticut.
3. School districts should ascertain that licensed and certified health professionals whom they employ have clinical experience relevant to providing services for children and families.
4. School nurses must have no less than the minimum (entry level) qualifications mandated for both educational preparation and relevant professional experience under Section 10-212 of the Connecticut General Statutes and Regulations. In many instances, the school district may prefer to seek professional nurses, nurse practitioners, or clinical nurse specialists who, in keeping current standards within the profession, have additional educational preparation, clinical experience, or both relevant to the profession of specialized health services to children in school settings. At the master’s degree level, nurses are prepared in subspecialty areas such as pediatrics, psychiatry, and public health.



Additionally, some of these nurses have expertise with infants, toddlers, and preschoolers, while others have expertise with school-age children or adolescents.

5. While Section 10-212 of the Connecticut General Statutes requires only one qualified school nurse per district, nurses who work independently (alone) in a school health office should, at a minimum, meet the basic requirements of that statute order to function as a school nurse as defined by this statute.

6. Section 10-205 of the Connecticut General Statutes requires local or regional school boards in towns having a population of 10,000 or more to appoint at least one legally qualified practitioner of medicine as school medical adviser.



School nurses are registered nurses (RNs) (see [appendix F](#)).

Section 10-207 of the Connecticut General Statutes further lists duties of medical advisers. It is strongly advised by the Connecticut School Health Advisory Council that every town, including those with populations of less than 10,000, appoint a school medical adviser or join with other towns to fill this position (see [appendix D](#)).

7. All professional and paraprofessional staff members, as well as appropriate contract and substitute personnel who may be the first responders to a medical emergency should obtain CPR/AED certification prior to employment and maintain current CPR/AED certification throughout employment.
8. All personnel should be knowledgeable about proper procedures for infection control and standard precautions and should routinely use them, as appropriate.
9. Contract personnel, such as physical and occupational therapists, should have the same qualifications for employment as required of employees. Contract personnel should be required to demonstrate participation in continuing professional education in an area of practice relevant to services for children in the school setting.

10. Substitute personnel, such as substitute nurses (registered nurses) must have the necessary credentials, knowledge, skills, and supports available to carry out the health service responsibilities of regular personnel. While LPNs can assist a school nurse, or provide one-to-one nursing for individual students and are supervised by a school nurse, using LPNs as substitute school nurses is not appropriate. By licensure and practice standards, LPNs cannot independently conduct nursing assessments that are the basis for nursing judgment and critical to safe student care. Therefore, an LPN would not be able to meet the daily acute care needs of the students.



Health aides cannot function as a substitute nurse. They are intended to assist the school nurse and should work under the direct (on-site) supervision of the nurse.

11. Orientation of substitute personnel to school buildings, and to individual students with specialized needs, as well as supervision of their performance, is essential for maintaining a safe environment during the absence of regular personnel.
12. Any decision to hire a health aide should be made collaboratively with the school nursing supervisor/director/coordinator or school nurse and the school medical adviser. Health aides are intended to assist the school nurse and should work under the direct (on-site) supervision of the nurse.
13. When a health aide is going to be hired, the school administrator should collaborate with the nursing supervisor or school nurse in the development of the job description and selection process.



14. If a health aide is hired to assist the school nurse in the health office, the health aide should minimally have CPR/AED certification and first aid training. The health aide is further trained by the school nurse in confidentiality and privacy requirements and other responsibilities of the position and remains under the supervision of the school nurse.

Planning for the Absence of Staff Providing Health Services

1. There should be a back-up or alternate plan that can be implemented when staff members providing health services are absent or are not available to provide care so that students can continue to attend school and receive safe care. The alternate plan may include designating another staff member, who has already been trained and is competent to care for the student, to be the substitute on a short-term basis, or it may include reassigning a nurse from another building for the day.
2. Whenever an alternate plan fails and a student must stay home due to inadequate staffing, the causes should be evaluated and steps should be taken to avoid similar circumstances in the future, including revision of the alternate plan.

Consultation, Supervision, Continuing Education and In-Service Training

1. Health professionals employed in school districts are practicing in nontraditional health care settings and need regular opportunities to update their clinical knowledge and skills. School districts should require that health professionals regularly access continuing education opportunities that are appropriate to their professional practice.
2. High-quality care for students may depend on the professional's ability to keep current with rapidly changing scientific and technological advances in the health care field and with changes in the application of these advances to the provision of individualized health care services. As is the case with educational advances, all provision of health care should be based on evidence-based practice.
3. Participation by school health professionals in continuing education designed for classroom teachers, while advantageous in some ways, will not suffice to keep the health professional current in his or her area of professional expertise.
4. All staff members (including school nurses) providing health care services should have clinical supervision by a health professional qualified to provide such supervision; they should also have access to consultation with expert health professionals.
5. In-service education and appropriate training of personnel may be necessary prior to the entry or re-entry of a student with complex physical or mental health needs to ensure the safety of the student or other students in the school. Such advance preparation must be provided as rapidly as possible so as not to become a barrier to the student's earliest entry or re-entry into school.
6. Non-health professional staff members, including teachers, transportation aides, school paraprofessionals and security personnel, require ongoing, professional development, and student-specific training related to health care activities and emergency assistance for which they may be responsible.



7. Non-health professional staff members, including transportation aides, paraprofessionals and security personnel, require appropriate supervision on the job.
8. Personnel who have regular or potential contact with body fluids (urine, feces, saliva, tears, nasal discharge, and vomitus without visible blood, blood, vaginal secretions, semen, cerebrospinal fluid, or other body fluids containing visible blood) should have ongoing general and specific instruction in the principles, and appropriate use and implementation of standard precautions.
9. Depending on the student population served, teachers, pupil personnel specialists, administrators, nonprofessionals, and/or transportation aides may require ongoing professional development and supervision in one of more of the following areas:
 - a. CPR;
 - b. first aid, including recognition of potential medical emergencies/anaphylaxis;
 - c. body mechanics/lifting procedures;
 - d. maintenance of confidentiality;
 - e. documentation;
 - f. child abuse recognition and reporting; and
 - g. youth suicide prevention.
10. Medication administration is another area that may need to be incorporated into ongoing professional development and training opportunities for principals and other certified and noncertified personnel, depending on their responsibilities for administering medications and according to Connecticut General Statutes and Regulations, include:
 - a. principles of medication administration;
 - b. EpiPen administration; and
 - c. student-specific medication training.

Delegation of Health Activities, Interdisciplinary and Transdisciplinary Team Functioning

1. The health care professional, such as the school nurse or the physical therapist, cannot be required to delegate a task to another staff member (who is either less prepared or not licensed) when the health professional determines that such delegation may put the student at risk for receiving unsafe or poor-quality care or, if in the case of nursing, the Board of Examiners for Nursing has determined that such licensed function cannot be delegated (see [chapter 3, part b](#)).
2. When a health professional delegates a task to other personnel, that health professional is responsible for the training, assessment of competencies, ongoing supervision and related evaluation of personnel to whom the tasks are delegated (see Delegation in [chapter 2](#).)
3. Licensed health care personnel are obligated to function at a level commensurate with their license but should not be required to perform new or unfamiliar procedures until they have received adequate preparation.
4. Health care professionals may require outside consultation and education to learn a new technique or application of new technology before providing specific services to a student. In addition, special equipment, equipment training, resources, materials, and reference information may be required.



5. Other school personnel, including certified and paraprofessional staff members, must not be required to take on delegated tasks and responsibilities until:
 - a. they have been adequately prepared and assessed for competency by the responsible health professional; and
 - b. a plan for regular and ongoing supervision is in place (see Delegation in [chapter 2](#)).
6. In general, the classroom teacher should not be designated to provide specialized health care services to individual students when doing so would represent an unwarranted commitment of time to the potential detriment of other students in the classroom. Exceptions may be necessary in an emergency.
7. Interdisciplinary collaboration among personnel and families is essential in all phases of planning, implementation, and evaluation of services for students with special health care needs in school.
8. Effective collaboration requires regular communication and time for joint planning and problem solving by supervisors and staff members involved in the provision of health services to students in school. The staff may vary according to the needs of the student and may include teachers, administrators, school medical advisers, school nurses, primary care providers, specialists, school social workers, school psychologists, school counselors, speech-language pathologists, occupational therapists, physical therapists, paraprofessionals, transportation personnel, food services personnel, and outside consultants.
9. All members of the team, including family members, must recognize the expertise of others, learn to use one another effectively, and collaborate accordingly.
10. Transdisciplinary functioning is potentially efficient and effective when staff members are crossing professional boundaries within shared areas of knowledge and expertise. Transdisciplinary functioning does not preclude the necessity for professional assessment, delegation, and supervision in areas of responsibility covered by licensure or specific to the expertise of a particular discipline.
11. Health assessment is the unique responsibility of physicians and registered nurses and cannot be delegated to other personnel, including LPNs.
12. Teachers, other certified personnel, and noncertified staff members cannot take on the licensed responsibilities of any health professional unless the responsibility is delegated, the teacher or other staff member is supervised, and the delegating health professional continues to monitor the child's health status.
13. Each member of the team must understand his or her unique responsibilities and expertise, as well as his/her own limitations and those of other members of the team.



It is unsafe and potentially illegal for individuals to assume that they have adequate theoretical and clinical knowledge or skill to provide services outside their own area of expertise without individual child assessment, delegation and personnel training, supervision, and evaluation by the appropriate licensed or certified professional. The clinical assessment responsibilities of one discipline cannot be assumed by a member of another discipline. It is unsafe, unethical and, in most instances, illegal for health and education professionals to practice in areas for which they have not received formal education, supervision, experience, or appropriate licensure or certification required by law or by professional standards. (See Delegation in [chapter 2](#).)



References

Connecticut General Statutes. Chapter 169 School Sanitation. Retrieved on November 30, 2011, from <http://www.cga.ct.gov/2011/pub/chap169.htm>.

Connecticut General Statutes. Section 10-212. School nurses and nurse practitioners. Administration of medications by parents or guardians on school grounds. Criminal history records checks. Retrieved on November 30, 2011, from <http://www.cga.ct.gov/2011/pub/chap169.htm>.

Connecticut State Department of Education. (1989). Connecticut Advisory School Health Council: Roles and qualifications of school health personnel.

National Association of School Nurses. (2010). Case-load Assignment: Position Statement. Retrieved on October 18, 2011 from <http://www.nasn.org/PolicyAdvocacy/PositionPapersandReports/NASNPositionStatementsFullView/tabid/462/smId/824/ArticleID/7/Default.aspx>.

United States Department of Labor. (2001). OSHA Instruction CPL 2-2.44A: Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens. Retrieved on November 30, 2011, from http://www.osha.gov/pls/oshaweb/owa-disp.show_document?p_table=directives&p_id=2570.

Entry/Re-entry Process

IT IS THE RESPONSIBILITY OF LOCAL SCHOOL DISTRICTS TO PROMOTE AND ENSURE THE EARLIEST POSSIBLE ENTRY INTO SCHOOL OF any eligible child. Unnecessary barriers to immediate school entry have uniformly been deemed illegal by the courts. There are, however, a few “necessary” restrictions to entry, which exist in Connecticut law to protect the health of an individual student, others in the school building or the community in general. Connecticut General Statutes Sections 10-204 and 10-206 require that prior to entry into school students must show proof of:

- a completed program of immunizations or initiation of an ongoing schedule of immunizations to meet the requirements; and
- a health assessment.

The intent of these mandated restrictions on school entry is fourfold:

1. To prevent students from entering school with communicable diseases that may put others at risk (such as active tuberculosis).
2. To ensure that adequate levels of immunization are maintained in the community to prevent outbreaks of those diseases controlled through immunization.
3. To identify children with previously unknown health conditions that may be cured or ameliorated with proper treatment, or of students with inadequate immunization protection.
4. To ensure that students with chronic or significant health conditions are assessed for special needs in school and that health care providers communicate those needs to school health personnel who can then plan for appropriate school adaptations, services or monitoring.



A current health assessment and up-to-date immunizations are essential for student enrollment in Connecticut schools.



In the large majority of cases, these health requirements are sufficient to protect the safety of the student and others, and school entry can proceed rapidly as long as these basic requirements are met. Assessment and planning for special services, program adaptations and/or the development of a health care plan, if indicated, can proceed at the time of or after the student's entry into school.

For some students, entry or re-entry into school requires a more complex process. These students have known health conditions, which may require:

- advanced planning to ensure appropriate management of a potential physiological or psychological emergency in school;
- advanced preparation of personnel, the environment, and other protections necessary to prevent deterioration in the student's health condition while in school; or
- specialized health services requiring planning and preparation in advance of the student's attendance.

In order to accommodate these students safely, it is critical that school districts, regional educational service centers, and other educational settings develop a process to ensure assessment of the student's individual health and safety needs in school and allow for sufficient preparation of both personnel and the environment *before entry*. This assessment and planning process, which may require some delay in school entry, should serve to minimize risks to the student once in school, and to maximize his or her potential to benefit from the educational program. When possible, advanced notification to schools by the parent or guardian and primary health care provider may allow the school adequate preparation time and eliminate the need for a delay at the desired time of entry.

When advanced notification is not feasible or has not occurred, delay in entry must be restricted to the absolute minimum time necessary to prepare for safe entry into school. If, for any reason, this delay may be longer than three weeks, an alternative education program, such as interim homebound, should be immediately developed and implemented until entry can proceed.

The development of appropriate entry procedures for new students and re-entry procedures for students who have been absent due to illness, injury, hospitalization, or outside placement in an educational program, should promote:

- family and professional collaboration;
- a safe environment; and
- the provision of appropriate health and other related services.

While procedures should be both straightforward and consistent, they should also be flexible and



Exception: Subtitle VII-B of the McKinney-Vento Homeless Assistance Act

Homeless students have the right to enroll in school immediately, even if lacking documentation normally required for enrollment, such as:

- previous school records;
- medical or immunization records;
- proof of residency;
- birth certificate;
- proof of guardianship; or
- other documents.

If a student does not have immunizations, or immunization or medical records, the local homeless education liaison must assist in obtaining them immediately; the student must be enrolled in school in the interim. Federal law supersedes state and local laws where there is a conflict (U.S. Constitution, Article VI).



based on the collaborative judgments of families and professionals. Additionally, the process may vary depending on the point of entry/re-entry, the child's age and presenting health needs, established family-professional relationships, and other factors. Regardless of these variations, the health assessment component of the entry/re-entry process is essential for all students with known or potential health impairments, whether physiological or psychological in nature. For example, when a student's presenting health need is behavioral or psychiatric in nature, the school psychologist or school social worker often takes the leadership role in the process of educational assessment and planning. The process is further enhanced when the mental health professional closely collaborates with the school nurse in the health assessment and development of the individualized health care plan.



References

Connecticut Department of Public Health: *Immunization Program*. <http://www.ct.gov/dph/cwp/view.asp?a=3136&q=388450>.

Connecticut General Statutes. *Chapter 169 School Health and Sanitation: Section 10-204a, Required immunizations. Section 10-204b, Rubella immunization. Section 10-204c, Immunity from liability. Section 10-206, Health assessments*. <http://www.cga.ct.gov/2005/pub/Chap169.htm>.

Immunization Requirements for Newly Enrolled Students at Connecticut Schools. <http://www.sde.ct.gov/sde/lib/sde/PDF/deps/student/health/SchoolImmunizations.pdf>.

McKinney-Vento Homeless Assistance Act. Reauthorized in January 2002 as Title X, Part C, of the No Child Left Behind Act. Retrieved on November 30, 2011 from http://www.naehcy.org/m_v.html.

Specialized Health Care Procedures

INFORMATION THAT ADDRESSES THE PROCEDURES IDENTIFIED IN THIS CHAPTER IS INTENDED TO BE USED AS A GUIDELINE IN CONJUNCTION with sound theoretical knowledge; medical research and evidence-based clinical references; collaboration with professional peers and expert consultants; and collaboration with students, educators, families, and caregivers.

The procedural guidelines delineate the general steps of physical health care activities and must always be used in conjunction with fundamental principles, standards, and safe practices recognized as vital to working with children with special or complex health care needs. Those principles, standards, and practices are reviewed in [chapters 1](#) and [2](#), and should form the basis for planning, implementing, and evaluating all specialized health care services for students.

This section addresses the following specialized health care procedures:

- | | | |
|--|--|--|
| A. Asthma | I. Diabetes | R. Oral or Inhaled Medication Administration |
| B. Allergies | J. Enteral Tube Feeding | S. Ostomy Management and Care |
| C. Blood Glucose Monitoring | K. Health Assessment | T. Oxygen Therapy |
| D. Catheterization:
Clean Intermittent | L. Incontinent Care | U. Pulse Oximetry |
| E. Catheter: External | M. Injectables: Intramuscular,
Subcutaneous Medication or
Vaccination Administration | V. Suctioning
(non-tracheostomy) |
| F. Catheter: Indwelling | N. Insulin Pump Management | W. Tracheostomy Care
and Suctioning |
| G. Catheterization:
Reinsertion of Indwelling
Urinary Catheter | O. Intravenous Therapy | X. Vagus Nerve Stimulator |
| H. Central Line Care | P. Mechanical Ventilation | |
| | Q. Oral Feeding | |



A. Asthma Management

Definition

A chronic inflammatory disease that results in bronchial hyper-reactivity (bronchospasm), mucous production, and reversible airway obstruction. Successful asthma management is based on the four components of the National Asthma Education and Prevention Program (NAEPP):

- measures of assessment and monitoring;
- education for a partnership in asthma care;
- control of environmental factors and comorbid conditions that affect asthma; and
- medications.

Purpose

Asthma management and control significantly contributes to school attendance and the general health and wellbeing of students.

Procedure

Metered Dose Inhaler with Spacer

Equipment: metered dose inhaler and holding chamber/spacer. Instructions for the use of a common brand of holding chamber/spacer may be found on the Forest Laboratories Inc. (2011) Web site at http://frx.com/pi/AeroChamberPlusFlow-VuLarge-Mouthpiece_PI.pdf. Instructions for the use of other brands of holding chamber/spacer may be found on the manufacturer's Web site.

Nebulizer Administration

Equipment: medication, nebulizer machine (air compressor), facemask, or a mouthpiece held in the mouth.

1. Set up and plug in the nebulizer machine in a location where the power source is close to a comfortable location for the medication to be administered.
2. Follow the directions for the specific brand of nebulizer machine and cup.
3. Most nebulizer cups unscrew from the top.
4. Most nebulized medication comes packaged in a unit-dose format, requiring the entire contents to be squirted into the bottom half of the nebulizer cup.
5. Screw the top of the cup back on and attach the tubing from the cup to the nebulizer machine and the cup onto the facemask or mouthpiece.
6. Place either the facemask on the student or the mouthpiece in his or her mouth and turn on the machine. A mist of medication should rapidly appear.



7. Instruct the student to take relatively normal slow deep breaths.
8. The cup may require some tapping on the sides toward the end of the treatment to optimize the completion of the dose.
9. The treatment is complete when there is no more mist from the cup (usually 10–15 minutes).

Peak Flow Meter (PFM) Administration

The proper use of a PFM can assist in providing an objective measure of one aspect of lung function. The PFM can measure the forced expiratory volume (FEV₁) at the first second of a forced exhalation. Accurate use of the PFM is primarily dependent on having a three-zone system that is based on the student's individual personal best measurement:

- Green Zone is 80–100 percent of the personal best.
 - Yellow Zone is 50–80 percent of the personal best.
 - Red Zone is less than 50 percent of the personal best.
1. Stand up (if possible).
 2. Shake down (like a thermometer) to reset.
 3. Take a deep breath.
 4. Seal your lips around the mouthpiece.
 5. *Do not stick your tongue in the mouthpiece or cover the end with your fingers.*
 6. Blow out as hard and fast as possible.
 7. If you cough or make a mistake, try again.
 8. Do three measurements with good technique. *Record* the best one.

Delegation Considerations

These procedures may be performed by the school nurse, RN (registered nurse), or LPN (licensed practical nurse). Asthma monitoring may also be delegated to appropriately trained, unlicensed assistive personnel with supervision, evaluation, and feedback and an individualized care plan (IHCP) in place.

Select Nursing Considerations

The school nurse can effectively partner with families and community health providers in assessing asthma control and having a positive impact on a student's asthma management. Key components of asthma management that are ideal for school nursing include:

- assessing history of cough (day and night), and exercise or activity intolerance;
- physical exam findings for complaints of acute symptoms, including response to medications;
- teaching and reevaluating proper inhaled medication technique;



- monitoring the frequency of quick-relief medication use and reporting to prescriber as indicated;
- reviewing the asthma action plan with student and family and making recommendations for follow-up asthma care as indicated; and
- active participation in the school's indoor air quality program.

School nurses must ensure that adequate inhaled medication is being administered, all medication administered for as needed (PRN) or acute symptoms is accompanied by the appropriate respiratory assessment before and after medication, and encourage the use of a holding chamber/spacer with all medication administration using a metered-dose inhaler (MDI).

References

- American Lung Association, www.lungusa.org.
- Center for Disease Control and Prevention. Asthma. <http://www.cdc.gov/asthma/nhis/default.htm>.
- Connecticut Department of Public Health Asthma Program: <http://www.ct.gov/dph/cwp/view.asp?a=3137&q=387872>.
- Connecticut State Department of Education Coordinated School Health Services Cadre of Trainers can provide a professional development session on asthma in schools: <http://www.sde.ct.gov/sde/cwp/view.asp?a=2678&q=320768>.
- Corjulo, M. (2011). Mastering the metered-dose inhaler: an essential step toward improving asthma control in school. *NASN School Nurse* 2011 26: 285.
- Forest Laboratories, Inc. (2011). Instructions for use: AeroChamber Plus Flow-Vu (aVHC), Retrieved January 20, 2012, from http://frx.com/pi/AeroChamberPlusFlow-VuLarge-Mouthpiece_PI.pdf.
- National Heart, Lung, and Blood Institute, National Asthma Education and Prevention Program Expert Panel Report 3: <http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.htm>.

Resources

- Guidelines for the Diagnosis and Management of Asthma <http://www.nhlbi.nih.gov/guidelines/asthma/index.htm>.
- National Asthma Education and Prevention Program <http://www.nhlbi.nih.gov/about/naepp/index.htm>.
- Asthma public education materials <http://www.nhlbi.nih.gov/health/public/lung/index.htm>.



B. Allergies

Definition

An allergic reaction occurs when the body releases chemicals in response to a specific protein found in some foods or the venom of an insect. These chemicals can cause a variety of symptoms ranging from relatively mild ones such as hives to severe life-threatening ones such as an inability to breathe, shock, and death (anaphylaxis).

Please refer to the CSDE's *Guidelines for Managing Life-Threatening Food Allergies in Connecticut Schools* for information on a comprehensive approach to allergy management in schools. This guideline is available on the Health Promotion Services/School Nurse Web site at http://www.sde.ct.gov/sde/lib/sde/PDF/deps/student/health/Food_Allergies.pdf.

Select nursing considerations

- Active participation in the development and monitoring of the district's allergy plan.
- Develop the individual student health care plan and emergency care plan through collaboration with student, families, school staff and health care providers.
- Work with students and staff to minimize the risk of allergy exposure.

Resources

Connecticut State Department of Education: http://www.sde.ct.gov/sde/lib/sde/PDF/deps/student/health/Food_Allergies.pdf.

The Food Allergy and Anaphylaxis Network <http://www.foodallergy.org>.



C. Blood Glucose Monitoring

Definition

Blood glucose monitoring is the procedure used to determine a student's blood glucose (sugar) level by the use of a blood glucose monitor (MedlinePlus Encyclopedia, 2010).

Purpose

To evaluate diabetes control; to adjust insulin dosage and nutritional intake.

Equipment

Blood glucose monitor, testing strips, sterile disposable lancet, automatic lancet or lancet pen (many diabetics use the same lancet for a period of time and keep that lancet in their pen), alcohol swab, cotton ball, or Band-Aid, disposal container.

Procedure

1. Wash hands or clean the child's fingertip with alcohol swab, by rubbing the area for 5–10 seconds and letting it dry.
2. Insert the monitor specific test strip into meter.
3. Using lancing device on the side of student's fingertip to get a drop of blood (It is best to draw blood from the side of the fingertip).
4. Gently squeeze or massage finger until a drop of blood forms. (Required sample sizes vary by meter.)
5. Touch and hold the edge of the test strip to the drop of blood, and wait for the result.
6. Blood glucose level will appear on the meter's display.
7. Wash hands.
8. Follow health care provider's orders for snacks, hyper or hypoglycemia, or insulin coverage.

Delegation Considerations

This procedure may be performed by a school nurse, RN, or LPN. Blood glucose monitoring may also be delegated to appropriately trained, unlicensed assistive personnel with supervision, evaluation and feedback, and an individualized health care plan (IHCP) in place.



Select Nursing Considerations

There are many different manufacturers of blood glucose meters. The school nurse needs to be familiar with each particular type he or she handles. Every blood glucose machine works differently, therefore it is important to read and understand the specific instructions that accompany the equipment, as well as having a plan for maintaining the device with quality control checks, cleaning, etc., to ensure the machine stays in proper working condition.

Most monitor companies provide manuals and instructional videos and will provide training, if requested. Hospitals are another resource that will provide training to school nurses for the consistent care and management of their patient's diabetes.

Students who are capable should be taught to perform this task independently or semi-independently with assistance.

References

- Connecticut State Department of Education, *Guidelines for Blood Glucose Self-Monitoring in Schools*, <http://www.sde.ct.gov/sde/lib/sde/PDF/deps/student/health/GlucoseGuidelines.pdf>.
- Connecticut State Department of Education, *Learning and Diabetes: A Resource Guide for Connecticut Schools and Families*. http://www.sde.ct.gov/sde/lib/sde/PDF/deps/student/health/Learning_and_Diabetes.pdf.
- The American Diabetes Association. <http://www.diabetes.org/living-with-diabetes/treatment-and-care/blood-glucose-control/blood-glucose-meters.html>.
- MedlinePlus Encyclopedia. (2010). Blood *glucose monitoring*. Retrieved January 3, 2012, from <http://www.nlm.nih.gov/medlineplus/ency/article/003438.htm>.



D. Catheterization: Clean Intermittent

Definition

Clean intermittent catheterization is done with or for students who are either unable to completely empty their bladders or unable to void independently (AUA Foundation, 2011).

Purpose

1. To allow students to completely empty their bladders on a periodic basis to prevent urinary tract infection or bladder leakage.
2. To assist students who do not have bladder control to empty their bladders on a periodic basis to prevent leakage.
3. The ultimate goal is for the student (if able physically and cognitively) to become independent in this procedure.

Equipment

Gloves, clean or sterile straight catheter, disposable wipes or soap and water, urinal or receptacle for urine if procedure is not performed on the toilet, water based lubricant, disposable towel or Chux to place under student if procedure is done on a cot.

Procedure

Male Catheterization

1. Wash hands.
2. Grasp sides of penis below the glans.
3. Clean the tip of the penis and urethra.
4. Retract foreskin if uncircumcised.
5. Gently stretch the penis upward.
6. Generously lubricate the catheter.
7. Have student take a deep breath.
8. Slowly insert the catheter until urine begins to flow and then about an inch more.
9. If you meet resistance before urine flows, have the student take another deep breath and continue with insertion (resistance in male catheterization is normal at about the level of the prostate).
10. If resistance continues or the student experiences pain, stop insertion, never force the catheter.



11. When urine flow has stopped, pinch the catheter and remove it slowly when urine flow has stopped.
12. Measure urine per student's order.
13. Discard bodily fluids and catheter per infection control procedures and school district policy.
14. Wash hands.
(American Academy of Pediatrics, Healthychildren, 2012).

Female Catheterization

1. Wash hands.
2. Prepare equipment: Using clean techniques open the urine catheterization package and lubricating jelly.
3. Place within easy reach.
4. Prepare the student.
5. Expose the urethral opening.
6. Clean the vulva and urethral opening from front to back, starting over the urethral meatus, then each side.
7. Continue to keep one hand in place exposing the urethral opening.
8. Generously lubricate catheter.
9. Separate the labia minora to clearly see the urinary meatus.
10. Have the student take a deep breath.
11. Slowly insert the catheter until urine begins to flow, then advance about an inch more.
12. Pinch the catheter and remove it slowly when urine flow has stopped.
13. Maintain clean environment.
14. Wash hands.
(American Academy of Pediatrics, Healthychildren, 2012).

Delegation Considerations

This procedure may be performed by a school nurse, RN, or LPN.

Select Nursing Considerations

- Assess area for redness, breakdown, swelling, or discharge.
- Note change in urine color, clarity, or odor, report signs and symptoms of urinary tract infection.
- Never use non-water-soluble lubricant.
- Some students will use a new catheter each time, others will need to wash and reuse catheters.
- Follow health care provider's orders (such as as frequency; strict measuring of output).



References

- AUA Foundation. (2011). *Bladder augmentation*. Retrieved January 3, 2012, from <http://www.urologyhealth.org/urology/index.cfm?article=56>.
- Centers for Disease Control. (2009). *Guideline for Prevention of Catheter-associated Urinary Tract Infections*. Retrieved January 14, 2012, from http://www.cdc.gov/hicpac/cauti/oo8_evidenceReview.html.
- American Academy of Pediatrics. Healthychildren. 2012. *Clean Intermittent Catheterization*. <http://www.healthychildren.org/English/health-issues/conditions/chronic/pages/Clean-Intermittent-Catheterization.aspx>.

Resources

- Centers for Disease Control. (2009). *Guideline for Prevention of Catheter-associated Urinary Tract Infections, 2009*. Retrieved January 14, 2012, from http://www.cdc.gov/hicpac/cauti/oo8_evidenceReview.html.
- Bray, L., and Sanders, C. (2007). Teaching children and young people intermittent self-catheterization. *Urologic Nursing*, 27, 203-9, 242.
- Infectious Disease Association of America, American Hospital Association, Centers for Disease Control, (n.d.). FAQs about catheter associated urinary tract infection. Retrieved January 14, 2012, from http://www.cdc.gov/hai/pdfs/uti/CA-UTI_tagged.pdf.



E. Catheter: External

Definition

An external catheter is a condom-type urinary collection device, vinyl rolled or with a jock-type supporter (AUA Foundation, 2011).

Purpose

To maintain social continence (clothing dry and/or free from odor).

Equipment

Gloves, washcloth, protective pad; self-adhesive external catheter or double-sided tape and external catheter; drainage bag (or leg bag) and tubing.

Optional depending on individual student: skin-prep adhesive; foam tape (Microfoam); stretch tape (Elastoplast); and clean clothing.

Procedure

1. Carefully roll off the external catheter and remove tape, if necessary.
2. Wash and dry penis and scrotum.
3. Using scissors, cut off any pubic hair that is matted, stuck together, or will be caught in the new condom.
4. Check the skin around penis and scrotum for skin problems, i.e., sores, redness, a rash, or swelling.
5. Leave about ½-inch space between the end of the external catheter and the tip of penis. This will help to avoid irritation.
6. If using tape around the penis, make sure the tape does not overlap on itself. The penis can be damaged if the tape reduces the blood circulation. Read the directions on the catheter package.
7. If using spray adhesive:
 - a. Cut a small hole in the center of a paper towel.
 - b. Put the penis through the hole. (This keeps pubic hair from being sprayed with adhesive.)
8. If using a self-adhesive catheter, move to step “b” below.
 - a. Read directions on external catheter package. Unroll the external catheter onto the penis about ½-inch.
 - b. Unroll the rest of the external catheter to cover the penis.



9. Hold the hand around the penis for 30 seconds. This will set the adhesive and help the external catheter stick to the penis.
10. If you need to use extra tape:
 - a. Clip and remove the ring from the external catheter. (If the ring is not removed, the pressure may damage the penis.)
 - b. Put tape around the penis. Half should be on the external catheter and half should be on the skin. Make sure the tape does not overlap on itself. (The penis can be damaged if the tape reduces the blood circulation.)
11. If you used spray adhesive, remove paper towel and throw it away.
12. Hook up the external catheter to the drainage tube or leg bag.
13. Change into dry clothes, if necessary
(*MedlinePlus Health Topic, 2010; National Association for Continence, 2012; Wound Ostomy and Continence Nurses Society, 2008*).

Delegation Considerations

- May be performed by a school nurse, RN, or LPN.
- May also be delegated to appropriately trained, unlicensed assistive personnel with supervision, evaluation and feedback, and an IHCP in place.

Select Nursing Considerations

This task may be performed on a cot, on the toilet, or in a wheelchair. Skin problems should be reported to the parent or health care provider. Students who are capable should be taught to perform this task independently.

References

- AUA Foundation. (2011). *Managing bladder dysfunction with products and devices*. Retrieved January 3, 2012, from <http://www.urologyhealth.org/urology/index.cfm?article=104>.
- Centers for Disease Control and Prevention. (2010). *Catheter-associated urinary tract infections*. Retrieved January 14, 2012, from http://www.cdc.gov/HAI/ca_uti/cauti_faqs.html.
- MedlinePlus Health Topic. (2010). *External incontinence devices*. Retrieved January 3, 2012, from <http://www.nlm.nih.gov/medlineplus/ency/article/003974.htm>.
- National Association for Continence. (2012). *Male external catheters*. Retrieved January 3, 2012, from <http://www.nafc.org/bladder-bowel-health/men-s-health/men-external-catheters/>.
- Wound Ostomy and Continence Nurses Society. (2008). *External Catheter: Fact Sheet 2008*. Retrieved January 3, 2012, from http://www.wocn.org/resource/resmgr/c_extcat.pdf.



F. Catheter: Indwelling

Definition

An indwelling catheter is inserted into the bladder to provide urinary drainage over a period of time from hours to weeks. It is attached to a closed drainage system that must be emptied periodically (AUA Foundation, 2011).

Purpose

To empty the bladder of urine as it accumulates; to minimize residual urine; to decrease incidence of bladder infection; to control incontinence.

Equipment

Gloves, disposable washcloth and towel, soap and water, graduated drainage container

Procedure

In general, other than emptying the drainage bag into a container and measuring the output, the only care required for an indwelling catheter in school would be if the student were toilet-ed for a bowel movement, the area around the urinary meatus would have to be cleansed if contaminated with feces.

Delegation Considerations

This procedure may be performed by a school nurse, RN, or LPN. With the appropriate training and supervision, monitoring may be performed by unlicensed assistive personnel or certified staff.

Select Nursing Considerations

Most students with an indwelling catheter will not require care of it during the school day, however *the school nurse must be notified* if there is any evidence of infection; pain; skin breakdown; displacement or obstruction of the catheter; bleeding; or a change in urine consistency, color, or odor.



References

- AUA Foundation. (2011). Managing bladder dysfunction with products and devices. Retrieved January 3, 2012, from <http://www.urologyhealth.org/urology/index.cfm?article=104>.
- Centers for Disease Control and Prevention. (2010). *Catheter-associated urinary tract infections*. Retrieved January 14, 2012, from http://www.cdc.gov/HAI/ca_uti/cauti_faqs.html.



G. Catherization: Reinsertion of Indwelling Urinary Catheter

Definition

Replacement of a dislodged indwelling urinary catheter. An indwelling urinary catheter is inserted into the bladder to provide urinary drainage over a period from hours to weeks. It is attached to a closed drainage system that must be emptied periodically (AUA Foundation, 2011).

Purpose

To maintain patency of the indwelling urinary catheter and to ensure emptying of the bladder of urine as it accumulates in order to: minimize residual urine; decrease incidence of bladder infection; and to control incontinence.

Equipment

Sterile gloves; sterile Foley catheter; sterile water (10 cc); 10 cc syringe; disposable wipes or soap and water; urinal or receptacle for urine, if procedure is not performed on the toilet; water-based lubricant; towel or disposable blue pads to place under student, if procedure is done on a cot; leg bag or other urinary drainage system.

Procedure

Male Catheterization

1. Grasp sides of penis below the glans.
2. Clean the tip of the penis and urethra.
3. Retract foreskin if uncircumcised.
4. Gently stretch the penis upward.
5. Lubricate the catheter.
6. Have student take a deep breath.
7. Slowly insert the catheter until urine begins to flow and then about an inch more.
8. If you meet resistance, have the student take another deep breath and continue with insertion (resistance in male catheterization is normal at about the level of the prostate).
9. If resistance continues or the student experiences pain, stop insertion. Never force the catheter.
10. Inflate balloon with appropriate amount of sterile water.
11. Pull gently on catheter until balloon is snugly against bladder neck.
12. Attach catheter to leg bag or other drainage system.
13. Attach catheter to thigh without tension on tubing.



Female Catheterization

1. Expose the urethral opening.
2. Clean the vulva and urethral opening.
3. Lubricate catheter.
4. Separate the labia minora to clearly see the urinary meatus.
5. Have the student take a deep breath.
6. Slowly insert the catheter until urine begins to flow, then advance about an inch more.
7. Inflate balloon with appropriate amount of sterile water.
8. Pull gently on catheter until balloon is snugly against bladder neck.
9. Attach catheter to leg bag or other drainage system.
10. Attach catheter to thigh without tension on tubing.

Delegation Decisions

According to the Connecticut Board of Examiners for Nursing, this task can only be performed by a school nurse, RN, or LPN (Board of Examiners for Nursing, 2002).

Select Nursing Considerations

In particular circumstances, nursing assessment may indicate that reinsertion of the catheter requires physician evaluation, such as when displacement is traumatic, (i.e., frank bleeding or swelling is present) or when reinsertion is difficult. It is recommended that the same size catheter be reinserted or as close a size as possible. If reinsertion is difficult or the decision is made not to replace the catheter, make sure the student is diapered or protected from soiling himself or herself or his or her clothing. A dry dressing may be used to cover a urinary stoma.

References

- AUA Foundation. (2011). Managing bladder dysfunction with products and devices. Retrieved January 3, 2012, from <http://www.urologyhealth.org/urology/index.cfm?article=104>.
- Board of Examiners for Nursing. (2002) Meeting Minutes: January 16, 2002. Retrieved January 17, 2012, from http://www.ct.gov/dph/lib/dph/phho/nursing_board/minutes/minutes_2002.pdf.



H. Central Line Care

Definition

A central line is a catheter most frequently placed through the chest wall into the right atrial chamber of the heart or a large central blood vessel. Central lines are placed internally (implanted), such as portacaths, or externally such as Hickman catheters. In school, central line care should be limited to ensuring that the dressing is occlusive and intact when applicable, intervening in an emergency; or care required to access the line for medication administration or nutrient administration. This procedure may include dressing reinforcement and/or heparin or saline flush.

Purpose

Long-term access to the circulatory system for medications, fluids, and nutrients.

Equipment

Gloves, antiseptic wipes/swabs, heparin or saline if ordered, appropriate size needle and syringe, sterile gauze, tape.

An emergency kit containing wipes, injection cap, heparin flushing supplies, dressing change supplies, and an extra clamp should be available at all times.

Procedure

Flushing or administering medications through a central line

1. Clean the injection cap for 30 seconds using an appropriate (chlorhexidine, povidone-iodine, alcohol) wipe; allow to air dry.
2. Using the appropriate flush solution or medication, draw up the solution as ordered.
3. Inject the flush or medication.
4. Flush line if ordered following administration of medication (Mannheim, J.K., 2010).

Changing cap on central line

1. Set up a clean work surface.
2. Gather all the supplies.
3. Wash your hands for 15 seconds with liquid antibacterial soap. Dry your hands thoroughly using paper towels.
4. Make sure that the central venous catheter (CVC) lumens are clamped.



5. Remove the new cap from its package.
6. Loosen, but do not remove, the cover on the end of the new cap.
7. While holding onto the lumen of the CVC with one hand, use the other hand to:
 - a. Remove the old cap and set it aside.
 - b. Remove the cover from the new cap.
 - c. Screw the new cap onto the open end of the lumen. This requires doing a lot with only one hand, but it is important to hold onto the lumen of the CVC to keep it from hanging free and touching anything.
 - d. Repeat these steps for each of the lumens.
 - e. Follow your routine to change caps in the same order as flushing.

Delegation Considerations

Must be performed by a trained registered nurse.

Select Nursing Considerations

Flushing or administering medications via a central line requires specialized nursing education. Contact an area hospital or other health care groups for training, as necessary. School nurses may need to provide central line care if a student is experiencing symptoms of infection, the catheter is dislodged, or if a student is experiencing shortness of breath or chest pain. Monitoring and ongoing assessments of the central line dressing and site are essential nursing care in a school environment.

Reference

Mannheim, J.K. (2010). Central venous catheter - flushing. Retrieved January 14, 2012, from <http://www.nlm.nih.gov/medlineplus/ency/patientinstructions/000157.htm>.



I. Diabetes

Definition

A chronic disease in which there are high levels of sugar in the blood. There are three major types of diabetes. The causes and risk factors are different for each type:

1. Type 1 diabetes can occur at any age, but it is most often diagnosed in children, teens, or young adults. In this disease, the body makes little or no insulin. Daily injections of insulin are needed. The exact cause is unknown.
2. Type 2 diabetes makes up most of diabetes cases. It most often occurs in adulthood, but teens and young adults are now being diagnosed with it because of high obesity rates. Many people with type 2 diabetes do not know they have it.
3. Gestational diabetes is high blood sugar that develops at any time during pregnancy in a woman who does not have diabetes (PubMed Health: Diabetes, 2012).

The school health team, which includes the school nurse, teachers, the school administrator and other school staff members and parents, plays an important role in helping students manage their diabetes. Effective diabetes management is crucial:

- for the immediate safety of students with diabetes;
- for the long-term health of students with diabetes;
- to ensure that students with diabetes are ready to learn;
- to participate fully in school activities; and
- and to minimize the possibility that diabetes-related emergencies will disrupt classroom activities (CSDE, 2005).

Please refer to the CSDE's *Learning and Diabetes a Resource Guide for Connecticut Schools and Families and Guidelines for Blood Glucose Self-Monitoring at School* for a comprehensive approach to diabetes management in schools. These guidelines are available on the Health Promotion Services/School Nurse Web site at <http://www.sde.ct.gov/sde/cwp/view.asp?a=2678&q=320768>.

References

- Connecticut Department of Education. (2005). *Learning and Diabetes a Resource Guide for Connecticut Schools and Families*. http://www.sde.ct.gov/sde/lib/sde/PDF/deps/student/health/Learning_and_Diabetes.pdf.
- Connecticut State Department of Education. *Guidelines for Blood Glucose Self-Monitoring at School*. <http://www.sde.ct.gov/sde/lib/sde/PDF/deps/student/health/GlucoseGuidelines.pdf>.
- PubMed Health. *Diabetes*. Retrieved on March 30, 2012, from <http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0002194/>.



J. Enteral Tube Feedings

Definitions

Delivering a liquid nutrient formula directly to the stomach, duodenum, or jejunum.

- *Enteral Nutrition:* Nutrition administered in the gastrointestinal tract.
- *Tube Feedings:* Enteral nutrition delivered via a tube, catheter, or stoma.
- *Stoma:* A stoma is a surgical bypass of a natural conduit.
- *Gastrostomy:* A stoma that bypasses the upper digestive tract and directly enters the stomach.
- *Jejunostomy:* Surgical creation of an opening to the middle portion of the small intestine (jejunum), through the abdominal wall.
(*American Society for Parenteral and Enteral Nutrition, 2011*).

Methods

Bolus feeding is the administration of liquid into a feeding tube using gravity to determine the rate the liquid passes through the tube. The liquid is either poured into a 60 cc syringe or a tube-feeding bag and held (or hung) at a height above the stomach that allows for the most desirable and tolerated rate of administration, typically over 15–30 minutes. Pushing the liquid in with the syringe is sometimes used to augment a bolus feeding (Altman GB, ed., 2003).

Tube feeding pump is a mechanical device that uses a matching tube-feeding bag and tubing. A set rate to administer a set volume over a specific period of time is programmed into the pump. Pumps vary in size and battery power potential. Tube feedings using pumps can be continuous (i.e., 30 cc/hr.) or intermittent (i.e., 240 cc over one hour). The school nurse needs to be competent using the specific type of pump for an individual student.

Types of Feeding Tubes

Feeding tubes use an abbreviation system that indicates the point where it enters the body and the point where it ends (and the liquid is infused).

1. *NGT* (Naso Gastric Tube): These can either be inserted for each feeding or remain in place for a set period of time.
2. *GT* (Gastrostomy Tube): These are surgically inserted through the stomach wall, leaving one end accessible on the abdomen and the other in the stomach. The most common type used in children is the low-profile brand “Mic-Key” (also referred to as a “button”). An extension tube is connected and locks in place when used for feedings,



hydration, or medications. When not in use this device caps off to remain relatively flush with the abdominal wall.

3. *G-JT* (Gastro-Jejunostomy Tube): Also surgically inserted through the stomach wall, entering the stomach, passing through the pylorus, and ending in the jejunal segment of the small intestine. These tubes are generally indicated for children who cannot tolerate food in their stomach. They may have a lumen that ends in the stomach and another lumen that ends in the jejunum, so the nurse needs to be clear if one lumen is for medication and the other is for feeding (it is helpful to label the two lumens).
4. *JT* (Jejunostomy Tube): Similar to the GT, except it is surgically inserted through the abdominal wall directly into the jejunal section of the small intestine (Rosewell Park Cancer Institute, n.d.).

Purpose

To provide a safe method of feeding a student who cannot tolerate oral feeding or requires supplementation to oral feeding in order to ensure adequate nutritional intake. Also, to provide continuity with the health care plans that students follow at home.

Equipment

Per provider's order and individual health care plan.

Procedure

Tube Feeding

- Prepare formula or liquid to be administered (normally room temperature).
- Ensure feeding tube is intact and in the correct anatomical position.
- Prime the feeding tube to minimize the amount of excess enteral air.
- Clamp or pinch-off feeding tube prior to opening to air (to avoid reflux of gastric contents out of tube).
- Attach syringe and administer fluids.
- Unclamp feeding tube.
- Administer feeding as directed.
- When feeding is complete, flush tube with prescribed amount of water.
- Cap or disconnect tube as indicated.

Medication Administration

- Prepare medication as prescribed.
- If administering a pill or capsule, ensure that solid particles are adequately dissolved or mixed in water.



- Clamp or pinch-off feeding tube prior to opening to air (to avoid reflux of gastric contents out of tube).
- Attach syringe and administer medication.
- Clamp or pinch-off feeding tube prior to disconnecting syringe in order to avoid reflux (and loss) of medication back out of tube.
- Flush with sufficient water to ensure that no medication is left in tube.
- If administering medication immediately before tube feeding, tube feeding may be used to flush through the medication.

Delegation Considerations

Initiating tube feeding or tube medication administration: RN, LPN

Monitoring of feeding: RN, LPN, physical therapist, occupational therapist, speech pathologist, teacher, school health aide, other certified personnel.

Select Nursing Considerations

1. Administration of any tube feeding in school requires a nurse to be present in the building.
2. Tube feedings in school require a *procedure authorization order and plan* signed by a prescribing health care provider and parent/guardian, including: the type of formula; amount; infusion type and rate; frequency of administration; and amount of water used to flush the tube.
3. The most significant risk with tube feedings is aspiration of liquid nutrition into the lungs.
4. Keys to preventing aspiration include:
 - a. Ensuring tube placement is appropriate.
 - b. Proper positioning.
 - c. Monitoring during feedings:
 - i. Stop feeding immediately for gagging, vomiting, coughing, change in skin color, or difficulty breathing. An immediate nursing assessment would then be indicated.
5. Additional considerations include:
 - a. Any specific method for securing a feeding tube.
 - b. Storage and preparation of the formula.
 - c. Caring for the insertion site:
 - i. Rashes tend to occur as a result of leaking around a GT stoma site.
 - ii. Management may include using a barrier ointment and frequent dry dressing application.
 - iii. Granulation tissue usually forms as a result of excess friction between the tube and the stoma site.
 - iv. Daily monitoring of the insertion site to ensure healthy skin integrity at the insertion site is essential.



6. Mic-Key tube considerations:
 - a. Mic-Key tubes should be level with the skin, able to rotate 360 degrees, and use a water-filled balloon in the stomach side of the stoma to maintain it in place.
 - b. The balloon is usually filled with 5 cc of sterile or distilled water and should routinely be checked once a week (at home), and more often if it appears loose or leaking (Kimberley Clarke, 2010) .
 - c. A balloon that is leaking and unable to hold water is an indication for Mic-Key tube replacement.
 - d. A spare Mic-Key should be maintained at school and the nurse needs to be trained in inserting a new one if it falls out:
 - i. Prompt reinsertion of a Mic-Key tube is vital to maintain the opening of the stoma site.
 - ii. If the nurse is unable to reinsert the Mic-Key, prompt medical attention is indicated.
7. NGT insertion in school is a relatively unique procedure that goes beyond the scope of this manual. Specific procedures and training needs for the school nurse should be obtained on a case-by-case basis. Once an NGT is properly inserted, the procedural steps listed above for feeding and medications can be applied.
8. Medication and nutrition administered into the jejunum require careful consideration since bypassing the stomach can affect absorption rates and tolerance.

References

- Altman GB, ed. Feeding and medicating via a gastrostomy tube. *Delmar's Fundamental and Advanced Nursing Skills*. 2nd Ed. Albany, NY: Delmar Thomson Learning; 2003: 742-749. Per Medlineplus <http://www.nlm.nih.gov/medlineplus/ency/patientinstructions/000333.htm>.
- Altman GB, ed. Feeding and medicating via a gastrostomy tube. *Delmar's Fundamental and Advanced Nursing Skills*. 2nd Ed. Albany, NY: Delmar Thomson Learning; 2003: 742-749. Per Medlineplus
- American Society for Parenteral and Enteral Nutrition. (2011). What is enteral nutrition? Retrieved January 17, 2012, from <http://www.nutritioncare.org/wcontent.aspx?id=266>.
- Bowden, V.R., and Greenberg, C.S. (2008). *Pediatric Nursing Procedures, 2nd edition*. Philadelphia, PA: Lippincott Williams and Wilkins.
- Guenter, P. and Silkroski, M. (2001). *Tube feeding: practical guidelines and nursing protocols*. Gaithersburg, MD: Aspen Publications, Inc.
- <http://www.mic-key.com/>
- <http://www.nlm.nih.gov/medlineplus/ency/patientinstructions/000165.htm>
- Kimberley Clarke (2010) MIC-KEY care and usage guide. Retrieved January 19, 2012, from <http://www.mic-key.com/resources/mic-keystar-care--usage-guide.aspx>.
- Rosewe Park Cancer Institute. (n.d.). *Jejunostomy tube*. Retrieved January 17, 2012, from <http://www.roswellpark.org/patients/jejunostomy-tube>.



Wilson, D. and Hockenberry, MJ (2007). *Wong's clinical manual of pediatric nursing (7th ed.)*. Denver, CO: CV Mosby

Resource

Bankhead R., Boullata J., Brantley S., Corkins M., Guenter P., Krenitsky J., Lyman B., Metheny N.A., Mueller C., Robbins S., Wessel J.(2009) Enteral nutrition administration. In: A.S.P.E.N. enteral nutrition practice recommendations. JPEN Journal of Parenteral and Enteral Nutrition; 33, 149-58. Retrieved January 17, 2012, from <http://www.ngc.gov/content.aspx?id=14717>.



K. Health Assessment

Definition

Refers to the collection and analysis of information or data about a student's health situation to determine the student's state of health; level of wellness; patterns of functioning; and need for health services, counseling, and education. Health assessment by the school nurse includes data collection, data analysis, and nursing diagnosis. It also includes identification of student health needs that require collaborative management with physicians, other health care providers and school team members. The assessment is systematic, goal oriented, directed by a body of knowledge, and related to both the health and educational needs of the student.

Purpose

Identifies student health needs by obtaining appropriate information about a student's health status, strengths, limitations, and coping mechanisms to manage the student's health problems in the school setting.

Equipment

Student's cumulative health record, nursing record, and progress notes; information from physicians, parents, acute care facilities, other related service providers.

Procedure

For any student with actual or potential health care needs, the school nurse, in collaboration with the family, student, health care providers, and other school staff as appropriate, should:

- Complete the initial health assessment on school entry or reentry.
- Complete the health assessment component for special education or Section 504 eligibility evaluation, if appropriate.
- Develop a health care plan to meet the student's special health needs in school; collaborate with appropriate members of the school team.
- Evaluate the health care services provided to the student periodically.
- Revise the health care plan accordingly.

Select Nursing Considerations

School nurses who only meet minimal qualifications under Connecticut General Statutes



Section 10-212 School Nurses and School Nurse Practitioners may or may not be competent in the health assessment of children and young people ages 0–21, depending on their educational preparation and experience. School nurses who have had no pediatric experience or those who are new to the educational arena, may need assistance from an experienced school nurse or school nurse supervisor to appropriately perform this activity. Supervision by a qualified school nursing supervisor is desirable and recommended.

Delegation Considerations

Health assessment is the licensed function of physicians and registered nurses and can never be delegated to, or assumed by other school personnel. The school nurse and/or school nurse supervisor will consult with the school medical adviser as appropriate. LPNs and appropriately trained paraprofessionals can contribute to the health assessment by gathering data such as height, weight, and vital signs. The registered nurse is the health professional who has the expertise to present health assessment information at early intervention meetings, PPTs, and 504 meetings.



L. Incontinence Care

Definition

An incontinent student is one who is unable to control the passage of urine or feces (stool).

Purpose

To keep the student as clean and dry as possible; to prevent skin breakdown and subsequent infection; to improve the student's acceptance by school peers.

Equipment

Equipment will depend on the age and size of the student. With some students care can be done in a lavatory; with other students it may be necessary to use a cot with incontinence pads, basin, soap and water, disposable wash cloth and towel, plastic bag for disposal and one for soiled clothing, toilet tissue, gloves, diapers if needed, clean clothing.

Procedure

Incontinent care

1. Remove soiled clothing;
2. Clean student's skin with soap and water and pat dry to avoid any irritation to the skin.
3. Observe the student's skin for breakdown or skin irritation.
4. Assist student to put on clean clothing, as needed.

Delegation Considerations

Toileting and care of incontinent students is not a nursing function. Rather, toileting is considered an activity of daily living, including toileting of students with delayed achievement of this developmental task. In most cases, unless there is a specific disability that requires nursing judgment, any related service provider, including paraprofessionals, teacher, or other certified personnel can perform this task. Health aides can also perform the task, although regularly removing a student from the classroom to visit the nurse's office for this reason may not be in keeping with the student's educational goals and objectives.



Encopresis

Encopresis is one of the more frustrating disorders of middle childhood. It is the passing of stools into the underwear or pajamas far past the time of normal toilet training. Encopresis affects about 1.5 percent of young schoolchildren and can create tremendous anxiety and embarrassment for children and their families.

Encopresis is not a disease but rather a symptom of a complex relationship between the body and psychological/environmental stresses. Boys with encopresis outnumber girls by a ratio of 6 to 1, although the reasons for this greater prevalence among males are not understood. The condition is not related to social class, family size, the child's position in the family, or the age of the parents.

(American Academy of Pediatrics. Healthychildren: Soiling (Encopresis). Retrieved on April 20, 2011, from <http://www.healthychildren.org/English/health-issues/conditions/emotional-problems/pages/Soiling-Encopresis.aspx>.)

Select Nursing Considerations

- This procedure should be done *minimally* twice during the school day or more frequently as determined in the individualized health care plan (IHCP).
- Clean clothes and personal supplies are provided by the parent.
- A bowel and bladder training program may be appropriate for this student and should be addressed in an IHCP if needed.
- Encopresis should be considered for younger students particularly (over age 4), but also in students of any age who are incontinent.



M. Injectables: Intramuscular, Subcutaneous Medication or Vaccination Administration

Definition

Injecting a medication or immunization into a muscle or subcutaneous (SC) tissue.

Purpose

To maintain a medication or immunization regime prescribed by an authorized health care provider.

Equipment

The appropriate size sterile needle, syringe, gloves, and alcohol swab.

Procedure

1. Follow “The Six Rights of Medication Administration,” (right medication, right dose, right student, right route, right time, and right approach).
2. Determine the correct size needle and injection site.
3. Medication authorizations for injectable medications in school should specify the injection site options and any other detail specific to that medication that is necessary to ensure safe administration in school.
4. For subcutaneous insulin injections, follow the above procedures and see [chapter 3](#) for specific insulin injection considerations.
5. For intramuscular (IM) injections of epinephrine using an auto-injection device (such as an EpiPen).

Immunization considerations

1. The list of current vaccines and administration considerations is found at <http://www.cdc.gov/vaccines/recs/vac-admin/default.htm>. Access the electronic version to ensure that it reflects the most recent updates.
2. The National Childhood Vaccine Injury Act (NCVIA), enacted in 1986, set forth three basic requirements for all vaccination providers. These apply to school nurses who directly administer a vaccination. When a local health department administers the vaccine at a school, it is responsible for this criteria:



- a. Providers must give the patient (or parent/legal representative of a minor) a copy of the relevant federal “Vaccine Information Statement” (VIS) for the vaccine they are about to receive.
- b. Providers must record certain information about the vaccines administered in the patient’s medical record or a permanent office log, including:
 - i. Name of manufacturer
 - ii. Lot #
 - iii. Expiration date
- c. Providers must document any adverse event following the vaccination that the patient experiences and that becomes known to the provider, whether or not it is felt to be caused by the vaccine, and submit the report to the Vaccine Adverse Event Reporting System (VAERS).
- d. As of April 2008, NCVIA requirements apply to diphtheria, tetanus, pertussis, measles, mumps, rubella, polio, hepatitis A, hepatitis B, *Haemophilus influenzae* type b (Hib), varicella, influenza, pneumococcal conjugate, meningococcal, rotavirus, and human papillomavirus (HPV) vaccine (http://www.immunize.org/guide/aovo7_documents.pdf).

Select Nursing Considerations

Administration of injectable medications or vaccinations in the school setting by a school nurse needs to carefully consider individual factors related to each student. Some questions to consider include:

- Is the administration of this medication part of an IHCP that addresses a chronic disease management or is it a short-term health problem?
- Is the administration of this medication in school necessary for this student to maintain his or her education?
- Are there other options for administration times that do not include school hours?
- Is this the safest option to help manage this particular health issue?

Delegation Considerations

Only a school nurse, RN, or LPN can administer IM or SC medications or immunizations. Exception: If approved by the local or regional board of education, paraprofessionals, in the absence of a school nurse, may only administer medications to a specific student to protect that student from harm or death due to a medically diagnosed allergic condition, including the administration of medications with a cartridge injector, such as an EpiPen (Connecticut General Statutes, Section 20-212a).



References

- Bowden, V.R., and Greenberg, C.S. (2008). *Pediatric Nursing Procedures, 2nd edition*. Philadelphia, PA: Lippincott Williams and Wilkins.
- The National Childhood Vaccine Injury Act (NCVIA). 1986. http://www.cdc.gov/vaccinesafety/Vaccine_Monitoring/history.html#NCVIA
- Vaccine Information Statement <http://www.cdc.gov/vaccines/pubs/vis/>.
- The Regulations of Connecticut State Agencies. *Administration of Medications by School Personnel and Administration of Medication During Before- and After-School Programs and School Readiness Programs*. http://www.sde.ct.gov/sde/lib/sde/PDF/deps/student/health/Medication_Administration_Regs.pdf.

Resource

- State Department of Public Health. Connecticut Immunization Program. <http://www.ct.gov/dph/cwp/view.asp?a=3136&q=466892>.



N. Insulin Pump Management

Definition

The insulin pump is a small, battery-operated device, worn on a belt or in a pocket, which delivers a constant infusion of insulin. It is also used to administer a bolus of insulin to provide coverage for the ingestion of carbohydrates. The insulin is infused subcutaneously via a catheter or needle placed in the abdomen, hip, or thigh (National Diabetes Information Clearinghouse, 2009).

Purpose

Insulin pumps replace the need for periodic injections by delivering rapid acting insulin continuously throughout the day. The use of an insulin pump allows the user to match insulin administration to their lifestyle, rather than adjusting their lifestyle to the administration of insulin. Insulin pumps allow a more “natural” level of insulin in the body.

Equipment

Insulin pump, infusion sets, insulin (ordered by authorized prescriber), adhesive tape or Tegaderm; extra batteries; and gloves (for infusion set change.)

Procedure

1. Programming insulin pump:
 - a. Follow manufacturer’s instructions.
 - b. Follow prescriber’s orders for basal rate as well as for bolus infusions:
 - i. Make sure instructions are available for types of pumps in use in your schools.
2. Changing an infusion set:
 - a. Check with manufacturer’s instructions for changing infusion sets. There are many different types. Some sets are inserted at an angle, some at 90 degrees. Some sets have separate cannulas and insertion devices; some are an all-in-one device.

Delegation Considerations

Only a school nurse, RN, or LPN may program an insulin pump, administer a bolus or change an infusion set. Unlicensed assistive personnel may be trained to assist a capable student to administer a bolus by checking the student’s calculations and numbers. A student specific IHCP and emergency care plan (ECP) should be in place.



Select Nursing Considerations

There are many different manufacturers of insulin pumps. The school nurse needs to be familiar with each particular type he or she handles. Most insulin pump companies provide manuals for their pumps, instructional videos, and in-person training, if requested. Hospitals are another resource that will provide training to school nurses for the consistent care and management of their patients' diabetes.

In case of an insulin pump malfunction or failure, an emergency plan must be in place for administration of insulin to the student (such as an insulin pen).

Reference

National Diabetes Information Clearinghouse (2009). Alternative devices for taking insulin. Retrieved January 19, 2012, from <http://diabetes.niddk.nih.gov/dm/pubs/insulin/>.



O. Intravenous Therapy

Definition

Administration of prescribed fluids via an intravenous route using a pump infusion method.

Purpose

1. To provide or supplement hydration and nutrition by intravenous route, when other feeding routes are ineffective (oral, g-tube).
2. To provide IV medication necessary for a student to be in school.

Equipment

Gloves, IV pole, prescribed solutions (including medication if ordered), clamp, alcohol wipes, disposable IV set up, 2 cc syringe, infusion pump.

Procedure

Intravenous Therapy (IVT)

1. To administer medication through catheter placed in a vein, clean the port with alcohol wipe and administer the medication through the port after expelling all air.
2. To administer IV fluids, connect the fluids directly to the catheter or through an IV pump after cleaning the port with alcohol wipe and expelling all air. Follow doctor's orders for the rate of flow. When the ordered amount of fluids has been administered, disconnect the bag from the port and discard appropriately.

Select Nursing Considerations

Performing a venipuncture requires skills and specialized training. Nurses may contact an area hospital or college for a phlebotomy course as necessary.

Delegation Considerations

Only a school nurse, RN, or LPN can administer IV fluids or medications. Appropriately trained, unlicensed assistive personnel can monitor running IV infusions with supervision, evaluation, and feedback with an IHCP in place.



P. Mechanical Ventilation

Definition

An electric or battery-powered machine that delivers positive pressure to the lungs using a variety of different settings based on the student's individual needs.

Purpose

To aid in maintaining pulmonary gas exchange, acid-base balance, and support the work of breathing either continuously or intermittently based on the student's individual needs.

Methods

In the school setting, there are a variety of portable mechanical ventilation units that can be used with a student; each one requires a connection with a tracheostomy.

Equipment

There are a variety of portable mechanical ventilation machines from a variety of manufacturers that can be used in the school setting. Since this is an area of frequent technological advances, it is recommended that the nurse obtain specific information from a manufacturer for each mechanical ventilation device as well as the medical provider managing the student's care.

Procedures

1. Procedures required for mechanical ventilation in school requires the ability to safely and effectively care for a student with a tracheostomy (see [Tracheostomy Care and Suctioning](#) procedure).
2. Each ventilator requires instructions from the specific manufacturer of the ventilator.
3. Additional procedural considerations include:
 - a. Oxygen administration (see [Oxygen Therapy](#) procedure):
 - i. Most students' mechanical ventilation will require some level of supplemental oxygen. This is based on a student's individual needs.
 - ii. All students require emergency oxygen. Schools must also have on hand, emergency back-up oxygen.
 - b. Pulse Oximetry (see [Pulse Oximetry](#) procedure):
 - i. Students with mechanical ventilation should have their own pulse oximeter.



- ii. A back-up pulse oximeter should be in schools where there is a student with a mechanical ventilator.
- c. Emergency back-up ventilators are generally not indicated in school, however, an emergency back-up source of electricity or a generator is indicated.

Delegation Considerations

The level of continuous skilled assessment required for a student with mechanical ventilation requires a registered nurse, licensed practical nurse (if appropriate), or a respiratory therapist.

Select Nursing Considerations

Each nurse responsible for the care of a student requiring mechanical ventilation must have an understanding of the underlying disease process and reason for requiring a tracheostomy and mechanical ventilation. The nurse must also have a comprehensive understanding of the student's baseline physical exam, including saturation of peripheral oxygen (SpO₂), respiratory effort, breath sounds, pulmonary secretions, and any additional acute or chronic health problem that may affect the student's respiratory status. Training is also required on the specific brand and type of ventilator the student uses in school.



Q. Oral Feeding

Definition

Provide nutrients and fluids to a student who requires assistance putting food in the mouth and swallowing.

Purpose

To maintain adequate nourishment and hydration. To facilitate developmentally appropriate and safe oral motor skills.

Equipment

Adaptive eating and drinking devices; adaptive seating or positioning equipment; measuring containers; and protective barriers for clothing. Nonlatex disposable gloves and suction equipment, as indicated.

Procedure

Refer to Connecticut State Department of Education's *Guidelines for Feeding and Swallowing Programs in Schools*. This document provides comprehensive information that addresses the multiple aspects of oral feeding in school.

Delegation Considerations

This procedure may be performed by licensed, certified, and unlicensed assistive personnel with the appropriate training and supervision.

Select Nursing Considerations

1. Each school should identify its feeding and swallowing team.
2. The school nurse is an integral part of the feeding and swallowing team and can provide assessment of students and training to unlicensed assistive personnel for assisting with feeding students.
3. The feeding and swallowing team responsibilities include:
 - a. Working with staff and families to create safe and effective feeding plans for individual students.



- b. Collaborating with medical providers to determine that a medical evaluation (including swallow studies) indicates that the student can swallow safely according to their plan or orders.
 - c. Identifying a process to ensure that all staff members who feed a student with an individualized feeding plan know that plan and can demonstrate competency in performing that plan.
4. Staff working directly with students should report any concerns about a student's ability to safely feed and swallow to the feeding and swallowing team (CSDE, 2008). Classroom food preparation and cleanup requires careful consideration to maintain sanitary conditions and avoid cross-contamination.

References

- Connecticut State Department of Education. (2008). *Guidelines for Feeding and Swallowing Programs in Schools*. http://www.sde.ct.gov/sde/lib/sde/PDF/DEPS/Special/Feeding_and_Swallowing.pdf.
- Connecticut State Department of Education. (2008). *Guidelines for Feeding and Swallowing Programs in Schools: New Referrals Algorithm*, p. 27.

R. Oral or Inhaled Medication Administration

Definition

Placing medication in a student's mouth to be swallowed or inhaled.

Purpose

To maintain a medication regime prescribed by an authorized health care provider.

Equipment

Based on the medication and the form that the student requires to swallow.

Oral medication

- Liquid medications require a precise measuring device such as a syringe or plastic dose-marked medication cup.
- Pills or tablets may require:
 - Crushing utensil (i.e., mortar and pestle, for those that are appropriate for crushing).
 - A student-specific food substance to mix it with (e.g., applesauce).



Warning: Not all medication is designed to be crushed due to the coating and the pharmacological action of the medication. Serious side effects can occur from administering crushed medication not recommended by the manufacturer.

Inhaled medication

See [Asthma](#) and procedures below for specific inhaled medication technique options.

Procedures

1. The fundamental legal and safe medication administration procedure requires the *Six Rights of Medication Administration*, which includes the
 - a. right medication;
 - b. right dose;
 - c. right student;
 - d. right route;
 - e. right time; and
 - f. right approach.



2. All medications administered in school must adhere to the Regulations of Connecticut State Agencies, *Administration of Medications by School Personnel and Administration of Medication During Before- and After-School Programs and School Readiness Programs* and the district's policies and procedures, including the specific requirements for controlled substances.
3. A medication authorization signed by the prescribing provider and parent/guardian is required for each medication.
4. Prior to administration, each medication, dose, time, and route must be confirmed with the medication authorization.
5. The person administering the medication should be the same person pouring the medication from a container with the student's name and prescription label.
6. An accurate student identification is required.
7. The person administering the medication needs to ensure that the medication was swallowed.
8. Assisting a student to take own medication requires all of the above in addition to the medication authorization signed by the prescribing provider and parent authorizing self- administration of that medication.
9. For *inhaled medication*, follow the above procedures and see the [Asthma](#) section for specific inhaled medication technique options.

Delegation Considerations

Delegation of oral or inhaled medication administration to “qualified personnel” by an RN must be in accordance with the Regulations of Connecticut State Agencies, *Administration of Medications by School Personnel and Administration of Medication During Before- and After-School Programs and School Readiness Programs*. It is important to note that according to Section 10-212a-9 of these regulations, paraprofessionals, if approved by the local or regional board of education, in the absence of a school nurse, may only administer medications to a specific student in order to protect that student from harm or death due to a medically diagnosed allergic condition.



Medication Administration Training of School Personnel

The school nurse is responsible for teaching, assessing, documenting the competency of, and providing ongoing supervision to staff members medication administration is delegated to.

The Regulations of Connecticut State Agencies, Section 10-212a-3. Administration of Medications by School Personnel and Administration of Medication During Before- and After-School Programs and School Readiness Programs: Training of school personnel.



Select Nursing Considerations

Each nurse should consider the individual school environment and student population regarding establishing and maintaining a safe medication administration system. There are a variety of ways to store and organize daily and PRN medications so that legal criteria are met and safe access is available.

Nurses who routinely administer medications to the same students need to consider if their system of medication administration is easily understood by another staff member who may need to fill in when they are not available. Some areas to consider are:

- medication cabinet labels;
- medication cabinet key identification;
- medication pouring organizers;
- the use of medication cards to identify poured medications;
- the use of student pictures on the back of medication cards or in the medication book;
- how students know when to come to the health office for medications or if the medication needs to be administered elsewhere in the school;
- periodic medication counting for each student; and
- a refill request system to ensure continuity with medications required at school.

References

Bowden, V.R., and Greenberg, C.S. (2008). *Pediatric Nursing Procedures, 2nd edition*. Philadelphia, PA: Lippincott Williams and Wilkins.

The Regulations of Connecticut State Agencies. *Administration of Medications by School Personnel and Administration of Medication During Before- and After-School Programs and School Readiness Programs*. http://www.sde.ct.gov/sde/lib/sde/PDF/deps/student/health/Medication_Administration_Regs.pdf



S. Ostomy Management and Care

Definition

An ostomy is a surgically created opening through the skin to the intestine or urinary tract to provide for elimination of bodily wastes. Urinary stomas and colostomies usually drain into a bag (National Library of Medicine, 2011).

Purpose

To maintain continence; to keep the stoma and the surrounding skin in good condition. To encourage self-care as much as developmentally and physically possible; to facilitate acceptance of the student in school; to replace a bag that is leaking.

Equipment

Gloves, scissors; stoma wafer; disposable washcloth; gauze; ostomy bag; skin protectant or barrier

Procedure

Management (Emptying bag)

1. Empty or assist student to empty contents of bag into toilet.
2. Inspect skin around stoma for redness, rash, blistering, lesions, or bleeding.
3. Notify parent if there is any redness, rash, blistering, lesions, or bleeding.
4. Remind student to wash hands when procedure completed.

Care (changing appliance)

1. Carefully remove the used bag and skin barrier by pushing the skin away from the bag, instead of pulling the bag off the skin.
2. Inspect skin for redness, rash, blistering, lesions, or bleeding and notify parent if observed.
3. Cut skin barrier to fit stoma.
4. Pat stoma dry with disposable washcloth, cover the stoma with moistened gauze while awaiting placement of bag.
5. Pat skin dry with disposable washcloth.
6. Apply skin protectant or barrier to skin around stoma.
7. Peel off backing from adhesive.
8. Center the new bag directly over the stoma.



9. Firmly press the bag to the skin barrier so there are no leaks or wrinkles.
10. Remind student to wash hands when procedure completed.

Delegation Considerations

Management may be performed by an RN, LPN, OT, PT, teacher, paraprofessional.

Care of stoma or changing appliance may be performed by a RN, LPN, OT, PT, CNA, or trained paraprofessional.

Select Nursing Considerations

- Health care provider order and parent/guardian authorization is required.
- Developmental and physical limitations of student.
- If unfamiliar, training, and consultation for school nurses, RNs and LPNs may be provided by an ostomy-care nurse specialist.
- Training received by the student and/or family.
- Irritation at or around the stoma, skin breakdown, increased or decreased ostomy output, vomiting, or pain should be reported for treatment.

Reference

National Library of Medicine. (2011). Ostomy. Retrieved January 19, 2012, from <http://www.nlm.nih.gov/medlineplus/ostomy.html>.



T. Oxygen Therapy

Definitions

Oxygen administration refers to a supplemental source of oxygen above the normal 21 percent oxygen concentration found in room air.

Continuous oxygen: The student has a treatment order to be on a continuous source of supplemental oxygen that needs to be maintained throughout the school day and during transportation to and from school.

Intermittent oxygen: The student has a treatment order to use a prescribed amount of PRN oxygen based on objective clinical assessment data (such as decreased SaO_2 , increased respiratory rate, or increased respiratory effort).

Emergency oxygen: Requires a standing physician order to administer oxygen to any student under emergency medical situations (such as seizure activity or acute respiratory distress).

Purpose

Oxygen administration in school is indicated to treat either acute or chronic hypoxia as prescribed by a treatment procedure authorization.

Methods

Nasal Cannula: Plastic tube that connects on one end to an oxygen source (tank) with the other end having two short prongs that each fit into the nostrils. Generally indicated as an option for planned use of continuous or intermittent oxygen.

Mask: A plastic facemask with tubing connected to an oxygen source. The two main sizes of oxygen masks are pediatric and adult. They are generally indicated for emergency situations.

Tracheostomy Mask: A plastic mask designed to fit over a tracheostomy cannula and secured by an elastic strap around the neck (over the tracheostomy ties). This may be indicated for planned use of continuous or intermittent oxygen.

Mechanical Ventilation: A variety of portable mechanical ventilation devices may be used for children who attend school. They are attached to the student via a tracheostomy and may or may not involve the routine delivery of supplemental oxygen.



Ambu Bag (Manual Resuscitation): In a case of extreme medical emergency (i.e., severe oxygen desaturation, impending respiratory failure, or respiratory or cardiac arrest), oxygen can be delivered at full flow (> 10 L/min.) with an Ambu Bag using an appropriately sized sealed face mask or fitted directly onto a tracheostomy cannula.

Equipment

Per provider's order and IHCP and ECP.

Procedure

High pressure tanks (standard metal oxygen tanks)

1. Require a regulator that has:
 - a. A valve to turn the oxygen source on and off.
 - b. A flow meter to measure and adjust the flow of oxygen.
 - c. A pressure gauge to determine the amount of oxygen remaining in the tank.
2. Open the tank by turning the valve at the top counterclockwise until the needle on the pressure gauge moves.
3. Set the flow meter to the prescribed rate (liters/minute) by turning the dial to the number or until the ball rises to the correct level on the scale.
4. If using a nasal cannula:
 - a. Place prongs into nose so they follow the curve of the nostrils.
 - b. Secure around back of ears.
 - c. Adjust below the chin.
5. If using a face mask:
 - a. Place mask over nose and mouth.
 - b. Secure with elastic strap around the head and above the ears.
 - c. The mask needs to be comfortably, but firmly against the face:
 - i. Any space between the mask and face dilutes the intended concentration of oxygen.
 - ii. For students unable to tolerate the elastic strap around their head, the mask can be held against the face without the strap (only appropriate for a limited period of time).
6. If using a tracheostomy mask:
 - a. Follow the same procedure as a facemask, except cover the tracheostomy cannula with the mask and secure it around the neck.
7. If using an Ambu Bag:
 - a. Turn oxygen flow rate > 10 L/min.
 - b. Administer by either face mask or tracheostomy connection:
 - i. Either option requires a tight seal to the airway.



- ii. Rate and force of manual resuscitation breaths is determined by CPR certified personnel.
8. To close the tank:
 - a. Disconnect oxygen from the student;
 - b. Turn valve clockwise until it cannot go any further. The flow meter should steadily decrease to zero, indicating that no oxygen is flowing (or leaking) from the tank (referred to as “bleeding” the tank off).
 - c. Turn the flow meter dial to zero.
9. Tank needs to be stored in a secured upright position to prevent it from falling or tipping over.
10. Storage area for oxygen tank must be free of petroleum products.

Liquid oxygen tanks

1. Portable liquid oxygen tanks can be refilled from a home-based liquid oxygen system.
2. These tanks are student specific and only indicated as part of an IHCP.
3. These tanks are used following the same procedural steps listed above and require the same safety considerations.

Delegation Considerations

1. Initiation of oxygen therapy: registered nurse (RN), practical nurse, (LPN), or respiratory therapist (RT).
2. Monitoring of oxygen therapy:
 - a. Continuous or long-term oxygen use that does *not* require continuous pulse oximetry (see [Pulse Oximetry](#)): RN, LPN, RT, physical therapist, occupational therapist, teacher, or other certified personnel.
 - b. Continuous, intermittent, or emergency that requires *continuous or frequent assessment* of pulse oximetry or respiratory status: RN, LPN, or RT.

Select Nursing Considerations

1. Oxygen may be drying to the airway mucosa. Humidification systems are often indicated with long-term or continuous use.
2. Skin assessments around tubing or elastic straps are indicated.
3. The presence of any source of supplemental oxygen requires strict fire safety guidelines.



Important Safety Precautions:

Numerous safety precautions that are associated with the storage and maintenance of oxygen in the school setting. School districts should consult with their town’s fire marshal.



4. "Oxygen in Use" signs should be posted at the entrance of all building sections, classrooms, or nursing offices; on vehicles during transportation of students; and wherever oxygen is stored or potentially used.
5. Oxygen supply vendor-contact information should be kept readily available.
6. Any oxygen tank that is heard hissing or noted to be leaking needs to be replaced promptly.
7. Checking monthly to ensure that they have an adequate supply to use in an emergency situation is a reasonable option.
8. Emergency ("stock") high-pressure oxygen tanks should not lose oxygen if they are not being used or if they were turned off properly.
9. Tanks noted to be less than half-full or expired should be refilled or replaced.

Reference

Bowden, V.R., and Greenberg, C.S. (2008). *Pediatric Nursing Procedures, 2nd edition*. Philadelphia, PA: Lippincott Williams and Wilkins.



U. Pulse Oximetry

Definition

Pulse oximetry provides estimates of arterial oxyhemoglobin saturation (SaO_2) by utilizing selected wavelengths of light to noninvasively determine the saturation of oxyhemoglobin (SpO_2).

Purpose

Pulse oximetry is used in the school setting as an adjunct to the registered nurse or respiratory therapist's clinical respiratory assessment. The SpO_2 should never be used in isolation to determine the respiratory status of a student. Obtaining an accurate SpO_2 is a skilled level of assessment that requires:

- Demonstrated competency
- A knowledge of the student's baseline SpO_2 (if known)
- The ability to interpret the clinical significance of the SpO_2 for an individual student and their clinical situation.

Methods

Pulse oximetry in the school setting requires a portable pulse oximeter with a probe that generally attaches to the student's finger. These devices are either:

- hand-held with the probe that attaches to the device by a cable; or
- one-piece integrated fingertip devices

Equipment

Pulse Oximeter

Procedure

1. Turn on pulse oximeter.
2. Select a distal extremity (usually a fingertip) that can be held still and is void of nail polish, false nail, moisture, and sweat.
3. Minimize excessive environmental light.
4. An accurate SpO_2 requires that the pulse oximeter is able to consistently detect the student's pulse:



- a. all pulse oximeters have some form of light signal or bar graph that correlates with detecting the pulse; and
- b. a consistent high level of detection for at least 20–30 seconds is necessary to determine an accurate reading.

Continuous Pulse Oximetry

1. If the pulse oximetry is indicated to be *continuous*, the probe needs to be secured in place per manufacturer's instructions.
2. An order for continuous pulse oximetry requires an oximeter with an alarm.
3. Alarm parameters are to be set per the student's IHCP.
4. If the alarm sounds, the student requires immediate assessment to determine if it is a "false alarm" (commonly due to excessive movement) or a true emergency that reflects a sudden deterioration in the student's respiratory status.



An order for continuous pulse oximetry requires an oximeter with an alarm.

Delegation Consideration

Pulse oximetry may be performed by a RN, LPN, or RT.

Select Nursing Considerations

1. Continuous pulse oximetry requires the rotation of probe sites, per IHCP.
2. Pulse oximetry should be available for students who have a tracheostomy, require oxygen supplementation and/or mechanical ventilation, or frequent airway suctioning.
3. The use of pulse oximetry for other common health problems, such as asthma, is generally not indicated.

Reference

Bowden, V.R., and Greenberg, C.S. (2008). *Pediatric Nursing Procedures, 2nd edition*. Philadelphia, PA: Lippincott Williams and Wilkins.



V. Suctioning (non-tracheostomy)

Definitions

Using a battery or electronic vacuum (suction) device to remove upper airway secretions or fluid that the student cannot expectorate spontaneously.

Purpose

To remove secretions or fluid that may contribute to upper airway obstruction, increased respiratory effort, the potential for respiratory distress, aspiration, or increased risk of infection.

Methods

Oropharyngeal Suctioning: Removing secretions or fluid from the mouth and pharynx (anatomic area from the soft palate to the upper most aspect of the esophagus)

Nasopharyngeal Suctioning: Removal of secretions or fluids from either nostril to the pharynx

Equipment

An electric or battery /rechargeable operated portable suction machine with pressure gauge; flexible extension suction tubing; suction catheter sizes per IHCP (8 Fr to 14 Fr are most common); Yankauer catheters may be an option for clearing oral secretions; towel or disposable pad or cloth.

Procedure

Oropharyngeal and Nasopharyngeal Suctioning (general procedures)

1. As with all invasive procedures, carefully consider an appropriate and safe location based on degree of urgency and physical design of the school/class/health office.
2. Using appropriate personal protective equipment.
3. Confirm that respiratory assessment requires suctioning procedure.
4. Ensure that suction machine has the appropriate level of subatmospheric pressure:
 - a. Standard maximal pressure for children ranges from 80–120 mm Hg.
 - b. Maximal pressure can be determined by turning on suction and occluding extension tubing by folding it in half. Pressure reading on gauge when tubing is completely occluded is the maximal suction pressure.



5. The option of using a sterile catheter should be determined per treatment procedure authorization and IHCP. (See procedures specific to oropharyngeal and nasopharyngeal suctioning below.)
6. Positioning of the student is based on the clinical situation:
 - a. Students in wheelchairs or other supportive seating devices can remain sitting upright or reclined up to, but not exceeding, semi-fowlers or 45 degrees.
 - b. Students who are lying either on the floor or health office couch should be turned on their side. This position may be commonly associated with a student experiencing a seizure who may require supplemental oxygen and/or suctioning.
7. Respiratory assessment should be an ongoing process to determine:
 - a. How well the student is tolerating the procedure.
 - b. The amount of time and suction attempts that are clinically indicated.

Oropharyngeal Suctioning

1. Using appropriate personal protective equipment.
2. Attach the specified suction catheter to the suction extension tubing.
3. Start by gently suctioning visible secretions from the oral cavity.
4. Proceed to the pharynx, as clinically indicated, using caution to minimize gagging, which may increase the risk of vomiting.

Nasopharyngeal Suctioning

1. Using appropriate personal protective equipment.
2. Aseptic technique using a sterile catheter is the standard for this procedure.
3. Approximate the insertion length of the catheter by measuring the catheter from the nose to the ear, and use the thumb and forefinger of your nondominant hand to mark the catheter at that point of maximal insertion.
4. Dip the catheter tip in sterile water-soluble lubricant to minimize trauma to the nasal mucosa.
5. Without applying suction gently introduce the catheter into the nostril and slowly proceed along the floor of the nasal cavity.
6. If unable to continue inserting downward toward the pharynx, remove catheter while applying suction and attempt insertion in the other nostril.
7. If able to insert to the pharynx, up to the maximal insertion point, apply suction while rotating and withdrawing catheter.
8. Duration of suction should not exceed 15 seconds.
9. If additional suction passes are required:
 - a. wait at least 30 seconds while performing appropriate aspects of the respiratory assessment and determining the student's toleration of the procedure;
 - b. cleanse the catheter with sterile water; and
 - c. re-lubricate as indicated.



Delegation Consideration

Oropharyngeal or nasopharyngeal suctioning can only be performed by the RN, LPN, or RT.

Select Nursing Considerations

1. Nasopharyngeal suctioning is not commonly performed in school. Students requiring this procedure may have a 1 to 1 (1:1) nurse assigned to them based on nursing assessment.
2. Consider activating EMS/911 for students who experience apnea, unresolved cyanosis, or respiratory/cardiac distress despite appropriate suctioning attempts.
3. Bradycardia may occur as a result of vagal stimulation at the posterior oropharynx with vigorous suctioning.
4. The use of pulse oximetry is an optional component of the respiratory assessment and should be determined in collaboration with the family, authorizing prescriber, and district medical adviser, as indicated.
5. Some children learn to suction their own mouths at home. This practice in the school setting would require very thoughtful consideration and assessment by the school nurse, with authorization from the health care provider and parents.

Reference

Bowden, V.R., and Greenberg, C.S. (2008). *Pediatric Nursing Procedures, 2nd edition*. Philadelphia, PA: Lippincott Williams and Wilkins.



W. Tracheostomy Care and Suctioning

Definitions

Tracheostomy is a surgical opening creating a stoma through the neck into the trachea where a tracheostomy tube can be inserted.

Tracheostomy (“trach”) Tube is a plastic (most common) or metal tube inserted through the tracheostomy stoma that provides a fixed airway to accommodate breathing while bypassing the upper airway. This tube can be used with or without mechanical ventilation or supplemental oxygen, but generally requires at least some means of humidification. There are a variety of tracheostomy tube brands; the most common are Shiley and Bivona. Most pediatric trach tubes consist of a single cannula. If the tube has two cannulas, the inner cannula can be removed for cleaning while the outer cannula stays in place.

Obturator is a small plastic device used as a guide during the insertion of the tracheostomy tube.

Ambu-bag (manual ventilation bag) is a device used to manually instill air into the airway. A universal 15 mm adaptor allows it to fit directly onto the trach tube so that each “squeeze” of the bag correlates with a “breath.” A facemask can also be fitted onto the bag to instill air via the mouth in the event that the tracheostomy tube is occluded or not functioning.

Decannulization is the intentional or accidental removal of the trach tube out of the trachea

Passy-Muir Valve is a one-way valve that fits directly onto a trach tube, allowing air to be inspired through the trach tube, and forcing the exhaled air through the vocal cords and out of the mouth to facilitate vocalization and speech (http://www.passy-muir.com/pdfs/resource_guide.pdf).

Purpose

There are two broad medical indications for a tracheostomy:

1. An acquired or congenital anatomic defect in the upper airway.
2. An inability to maintain adequate respiratory function due to chronic intrapulmonary or extrapulmonary (neuromuscular or metabolic) disease.



Caregivers responsible for the student need to be CPR-certified and specifically trained in routine and emergency tracheostomy care and procedures for each individual student.



Nurses must understand the underlying etiology of the need for each student who has a tracheostomy. A student with a tracheostomy is at risk for life-threatening complications that can be avoided with accurate physical assessment and diligent care of the airway. Proper care of a tracheostomy includes adequate skin care around the stoma and ensures the maintenance of the student's airway.

Equipment

The essential equipment to be kept with the student at all times is as follows:

- gloves;
- portable oxygen with appropriate sized Ambu-bag;
- Appropriate size Ambu-bag facemask (for emergencies when unable to reinsert a new tracheostomy tube;
- portable suction machine that can operate with battery or electricity;
- sterile suction catheters;
- sterile saline vials;
- water-based lubricant;
- two spare tracheostomy tubes — one the size the student currently uses and one that is a size smaller in the event that the tube needs to be changed and there is difficulty passing it through the stoma;
- spare tracheostomy ties;
- blunt scissors;
- personal protective equipment — to be used for all tracheostomy procedures;
- emergency phone numbers; and
- pulse oximeter — may be optional if student is not on oxygen or mechanical ventilation.



Never use an oil-based lubricant, such as Vaseline.

It is recommended that this equipment be stored together in an “emergency travel bag” that is easily transported with the student during transportation and the entire school day. Additional equipment may be indicated per the IHCP.

Procedures

Stoma and skin care

1. The frequency of stoma care and the care of the surrounding skin is based on the individual student's current skin condition and associated factors, such as the amount of secretions and the degree of skin folds around the neck.
2. Ensure all essential equipment or travel bag is within reach prior to initiating stoma and skin care.



3. Use gauze sponges and cotton-tipped swabs with water or a diluted peroxide solution per IHCP:
 - a. Cleanse outer portion of tracheostomy tube and surrounding skin going from using wet to dry sponges or swabs.
 - b. Minimize direct moisture to the tracheostomy ties.
 - c. Drying the skin is vital to maintaining skin integrity.

Changing tracheostomy ties

1. The two most common forms of tracheostomy ties are a soft padded tie with Velcro tabs (most common) or a simple thin cloth or twill tie that requires tying to secure.
2. Changing tracheostomy ties in the school setting is usually not done on a routine basis, rather it is an, as-needed (PRN) procedure based on the integrity of the ties, the skin, or as part of an emergency tracheostomy change;
3. Two people should be present during the procedure in the event of accidental decannulization.
4. A shoulder roll is recommended to assist with the visualization and access to the tracheostomy site.
5. Remove the old ties while holding the tracheostomy tube in place:
 - a. Use caution not to occlude the tracheostomy tube.
 - b. Removal of cloth ties requires the use of a blunt scissor.
 - c. Removal of Velcro tab ties is done by detaching each end of the tie.
6. Skin care is performed as indicated.
7. Maintaining the tracheostomy tube in place is always the priority:
 - a. Insert one end of the tie through the slit opening on the side of the tracheostomy tube.
 - b. Bring the other end of the tie around the back of the neck.
 - c. Repeat with the other end of the tie through the slit opening on the other side of the tracheostomy tube.
 - d. Velcro tabs are fastened back on themselves.
 - e. Cloth ties are secured using a single square knot on the side or back of the neck.
 - f. The ties should allow enough space for fingers between it and the neck.
8. If a split gauze is used around the stoma, replace it now with a clean one.
9. Re-assess the student's respiratory status to ensure that the tracheostomy tube remained in place and patent during the procedure.

Cleaning an Inner Cannula

1. Remove the inner cannula as indicated per manufacturer's instructions.
2. The inner cannula is generally cleansed with a half-strength hydrogen peroxide solution using pipe cleaners to remove any dried secretions from inside the cannula.
3. Thoroughly rinse the cannula with sterile water and dry.
4. Reinsert the inner cannula by turning it 90 degrees from its usual position, introduce the tip into the outer cannula, slowly rotating it back 90 degrees to its final position.
5. Lock the cannula in place per manufacturer's instructions.



Tracheostomy Tube Suctioning

Suctioning is performed based on clinical assessment with consideration of individual student factors and considerations. Many students can cough out their secretions through their tracheostomy tubes without the need for suctioning (this maneuver is synonymous with “blowing their nose”).

1. As with all invasive procedures, carefully consider an appropriate and safe location based on degree of urgency and physical design of the school, student’s classroom, and the health office.
2. Confirm that respiratory assessment requires the suctioning procedure.
3. Emergency travel bag (essential equipment listed above) must be present before suctioning.
4. Ensure the suction machine has the appropriate level of subatmospheric pressure:
 - a. standard maximal pressure for children ranges from 80–100 mm Hg; and
 - b. maximal pressure may be determined by turning on suction and occluding extension tubing by folding it in half. Pressure reading on the gauge when the tubing is completely occluded is the maximal suction pressure.
5. The option of using a sterile catheter should be determined per treatment procedure authorization and IHCP.
6. Positioning of the student is based on the clinical situation:
 - a. students in wheelchairs or other supportive seating devices can remain sitting upright or reclined up to, but not exceeding, semi-fowlers or 45 degrees; and
 - b. students who are lying either on the floor or health office couch should be turned on their side (this position may be commonly associated with a student experiencing a seizure who may require supplemental oxygen and/or suctioning).
7. The respiratory assessment should be an ongoing process to determine:
 - a. how well the student is tolerating the procedure; and
 - b. the amount of time and suction attempts that are clinically indicated.
8. Determine the length of catheter insertion:
 - a. it should be limited to just beyond the distal end of the tracheostomy tube; and
 - b. “deep suctioning” up to or beyond the tracheal carina (point of bronchial bifurcation and tissue resistance) should not be indicated in a school setting, as it may cause epithelial damage.
9. Hold the suction catheter at the point of maximal insertion length.
10. Lubricate the catheter with normal saline.
11. The use of normal saline to lavage the tracheostomy tube needs is based on the IHCP and, if indicated, to assist with the removal of thick secretions, needs to be used judiciously.
12. Remove tracheostomy mask or ventilator connection and promptly insert catheter while gently rotating within the cannula. Do not apply suction during catheter insertion.
13. At point of maximal insertion, apply suction while gently rotating the catheter out of the cannula:



- a. tracheal suctioning should not exceed five seconds; and
 - b. if secretions are visible at the onset of suctioning, an initial shallow pass may be appropriate before proceeding further down the cannula.
14. Rinse the catheter and repeat as indicated based on the clinical assessment and treatment order.
 15. Provide hyperventilation with Ambu-bag, if indicated.
 16. Rinse suction catheter and extension tubing
(Ireton, J., 2007; Cincinnati Children's Hospital, 2009).

Tracheostomy Tube Change

The changing of a tracheostomy tube in the school setting should be considered an *emergency situation* based on clinical assessment and the student's history. Any concern that the situation is potentially life-threatening requires the activation of the EMS/911 system while the procedure is being performed. If there are complications during the procedure, the nurse must have an understanding of the student's underlying need for the tracheostomy and ability to breathe without one. The nurse must be prepared to take control of the situation by acting swiftly, calmly, and clearly. The two most common emergency scenarios are:

- accidental decannulization; and
 - tracheostomy tube obstruction unrelieved by reasonable suction attempts. Obstruction can be caused by thick secretions/mucous plugging, foreign body, or airway granuloma tissue. Airway granuloma tissue can persist to obstruct a new tracheostomy tube, resulting in the highest degree of medical emergency.
1. Ensure the emergency travel bag is present.
 2. Ensure the presence of another responsible adult, preferably another nurse if available.
 3. If not already done, attach Ambu-bag to oxygen with gauge set at > 10 L/min.
 4. If able, position the student supine on the floor with a shoulder roll to gently hyperextend the neck.
 5. Open the new tracheostomy tube that is the same size as is currently in the student. Have the size smaller new tracheostomy tube readily available if needed.
 6. Taking care to not touch the curved part of the tracheostomy tube:
 - a. be sure the obturator is in the tube;
 - b. attach one end of the tracheostomy tie to a slot on the side of the tracheostomy tube;
 - c. lubricate the distal end of the new tracheostomy tube with water-based lubricant; and
 - d. return it to the clean package that it was sealed in.
 7. Remove or cut old tracheostomy ties.
 8. If possible, have assistant hold old tracheostomy tube in place:
 - a. most students will not have cuffed tracheostomy tubes (with a balloon); and
 - b. if this student does, deflate the cuff at this time per manufacturer's instructions.



9. With one hand remove the old tracheostomy tube and set it out of the way.
10. Gently and quickly insert the new tracheostomy tube, pushing back and then down, in an arching motion:
 - a. if unable to insert the new tracheostomy tube, attempt the same procedure using the new tracheostomy that is one size smaller; and
 - b. if still unable to insert a new tracheostomy tube, use the Ambu-bag with facemask as indicated to maintain a stable airway while awaiting the emergency medical system (EMS).
11. Once inserted, immediately remove the obturator (if used).
12. Have assistant continue to hold new tracheostomy in place.
13. Since this procedure done in school would most likely be an emergency situation, provide the student with manual breaths using the Ambu Bag and oxygen while auscultating the lungs to confirm adequate and symmetrical air movement.
14. Continue the respiratory assessment, using pulse oximetry if available to confirm a return to the student's baseline status.
15. Secure the new tracheostomy tube in place by fastening the tracheostomy ties:
16. If this is a cuffed tracheostomy tube, inflate at this time per manufacturer's instructions.
17. Position the student comfortably and observe to ensure he or she remains stable on their baseline level of supplemental or ventilator support (if any).
18. If EMS was activated, the RN in charge can determine, in collaboration with the family and health care provider if necessary, if transportation to the local emergency room is still indicated.
19. Regardless of outcome, notify family and medical provider that student required a tracheostomy change procedure.
(Cincinnati Children's Hospital, 2011)

Delegation Considerations

All students with a tracheostomy require a level of skilled nursing assessment by a RN. Care and management of the student's tracheostomy may be assigned to an LPN during transportation and throughout the school day.

Select Nursing Considerations

See [Oral Feeding](#) for guidelines and references associated with orally feeding a student with a tracheostomy.

- Maintaining adequate hydration is essential to minimize thick and crusting secretions.
- Do not permit the use of powders, aerosols, or any small airborne particles around the student, especially if the tracheostomy tube is not covered with a ventilator, filter, or Passy-Muir valve.



- If foreign material is aspirated into the tracheostomy tube, attempt to suction prior to giving breaths with an Ambu-bag.
- Potential complications related to suctioning are bronchospasm and bleeding, which generally occur as a result of excessive suctioning or insertion of catheter past the distal end of the tracheostomy tube.
- Comprehensive oral hygiene is required for a student with a tracheostomy
- Water activities must be carefully considered and supervised.
- The emergency travel bag should be inspected daily to ensure all used essential supplies have been replaced and are present.
- Gauze used around the tracheostomy tube should be pre-split, not cut, to prevent threads from entering the airway.

References

- Bowden, V.R., and Greenberg, C.S. (2008). *Pediatric Nursing Procedures, 2nd edition*. Philadelphia, PA: Lippincott Williams and Wilkins.
- Ireton, J. (2007). Tracheostomy suction: A protocol for practice. *Paediatric nursing*, 19(10), 14-8.
- Cincinnati Children's Hospital. (2009). Suctioning. Retrieved January 19, 2012, from <http://www.cincinnatichildrens.org/WorkArea/linkit.aspx?LinkIdIdentifier=id&ItemID=88058&libID=87746>.
- Cincinnati Children's Hospital. (2011). Basic Pediatric Tracheostomy Care. Retrieved January 19, 2012, from <http://www.cincinnatichildrens.org/WorkArea/linkit.aspx?LinkIdIdentifier=id&ItemID=88057&libID=87745>.



X. Vagus Nerve Stimulator

Definition

Vagus nerve stimulation (VNS) is a type of treatment in which short bursts of electrical energy are directed into the brain via the vagus nerve, a large nerve in the neck. A battery about the size of a silver dollar is implanted under the skin in the chest. Electrical leads are threaded under the skin and attached to the vagus nerve during the same procedure. The device is programmed to deliver electrical stimulation that can help reduce the frequency of a child's seizures. (Epilepsy Therapy Project [2006]; National Institute of Mental Health, 2009).

Purpose

Vagus nerve stimulators are used to control partial onset seizures (which originate from only one part of the brain) when other methods have been ineffective.

Equipment

Vagus nerve stimulator magnet.

Procedure

When the student has an aura, the magnet is passed over the implanted stimulator to cause an immediate stimulation of the vagus nerve. The stimulator may also be used for students who are having a seizure.

Delegation Considerations

The school nurse, RN, or LPN may use the Vagus nerve stimulator. Appropriately trained, unlicensed assistive personnel may also use the magnet when the student is having a seizure with supervision, evaluation, and feedback and an IHCP in place.

Select Nursing Considerations

As with other medical equipment refer to the manufacturer's instructions for operation. In addition, contact the manufacturer's representative if you need education regarding the unit.



References

- Epilepsy Therapy Project. (2006). Vagus nerve stimulation. Retrieved January 19, 2012, from <http://www.epilepsy.com/epilepsy/Vns>.
- Epilepsy Foundation <http://www.epilepsyfoundation.org/resources/medical/vagus-nerve-stimulation-therapy.cfm>.
- National Institute of Mental Health. (2009). Brain stimulation therapies. Retrieved January 19, 2012, from <http://www.nimh.nih.gov/health/topics/brain-stimulation-therapies/brain-stimulation-therapies.shtml>.
- Gillette Children's Specialty Healthcare. 2012. Vagus Nerve Stimulator. Retrieved on January 23, 2012, from <http://www.gillettechildrens.org/default.cfm?pid=1.17.4.10.1.3.3>.



Appendices



Appendix A

Connecticut Board of Examiners for Nursing. Declaratory Ruling on Delegation by Licensed Nurses to Unlicensed Assistive Personnel. Retrieved on November 23, 2011 from http://www.ct.gov/dph/lib/dph/phho/nursing_board/guidelines/unlicensed_ap_dec_rul.pdf

Appendix B

Connecticut Board of Examiners for Nursing. Declaratory Ruling on LPN Scope of Practice. http://www.ct.gov/dph/lib/dph/phho/nursing_board/guidelines/lpndeclaratoryruling.pdf



Appendix C: Section 504 Parental Rights

Section 504 of the Rehabilitation Act provides services for students identified as having a disability as defined by the Act, which substantially limits a major life activity. You have the following rights:

1. The right to be informed of your rights under Section 504 of the Rehabilitation Act.
2. The right for your child to have equal opportunities to participate in academic, nonacademic and extracurricular activities in your school.
3. The right to be notified about referral, evaluation and programs for your child.
4. The right for your child to be evaluated fairly.
5. The right, if eligible for services under Section 504, for your child to receive accommodations, modifications, and related services that will meet the child's needs as well as the needs of students without disabilities are met.
6. The right for your child to be educated with peers who do not have disabilities as much as possible.
7. The right to an impartial hearing if you disagree with the school regarding your child's educational program.
8. The right to review and obtain copies of your child's records.
9. The right to request attorney fees related to securing your rights under Section 504.
10. The right to request changes in the educational program of your child.



Appendix D: Suggested Qualifications and Role of the School Medical Advisor in the Implementation of the School Health Services Program

(Source: Connecticut Advisory School Health Council, Connecticut State Department of Education, 1997, Revised 2012)

Introduction

Section 10-205 of tulation of 10,000 or more to appoint at least one legally qualified practitioner of medicine as school medical advisor. It is strongly advised by the Connecticut Advisory School Health Council that every town, including those with populations of less than 10,000, appoint a school medical advisor or join with other towns to fill this position.

Boards of educationhe Connecticut General Statutes requires local or regional school boards in towns having a pop, superintendents of schools, local or district health departments, and physicians responsible for school health programs have frequently requested information that describes the role of the school medical advisor. It is to meet this need that a more comprehensive guide on the selection, legal responsibilities and functions of the school medical advisor has been developed.

Qualifications

Physicians appointed to carry out the duties of the school medical advisor should be well qualified and competent in the care of children. The school medical advisor must be licensed to practice medicine in Connecticut. She or he should have the respect and cooperation of the local medical profession, and should be a pediatrician or family medicine practitioner with training in pediatric and adolescent medicine.

Any physician who serves as a school medical advisor should have training in the emotional and physical growth and development of children and should show evidence of continuing medical education and experience in school health, pediatrics or adolescent medicine within the preceding five years.

Any physician who serves as a school medical advisor should have, or have provided for them by the town or district, malpractice insurance in a suitable amount for the scope of services to be provided.

Roles

Administration and Planning

The school medical advisor manages the school health program by:

- Planning the school health program collaboratively with the school nurse supervisor/director;
- Administering the school health program cooperatively with school administrators and the board of education;



- Reviewing, evaluating and revising the school health program with the school nursing supervisor/director and with school administrators on a regular basis,
- Participating in school health activities, such as the school wellness committee or health council and other appropriate committees.

School Health Services

The school medical advisor provides school health services which may include, but not be limited to, the following:

- Assisting the district in obtaining health assessments as required by state statute and local board policy;
- Advising the immunization program as required by state statute and local board policy;
- Consulting for the school nurse supervisor/director in the development of nursing protocols for the assessment and management of students' health care problems;
- Providing consultation and, when appropriate, medical direction to the school nurse supervisor or director regarding in-school management of student medical problems;
- Providing standing orders for medications and medical treatments;
- Participating in establishing screening and referral procedures;
- Reviewing individual student health records as required;
- Consulting with planning and placement teams as needed when medical problems interface with education;
- Directing and implementing the school sports medicine program; and
- Providing to advanced practice nurses consultation and, where appropriate, clinical supervision for medical diagnosis and treatment.

School Environment

The school medical advisor may be asked to consult on the school environment by:

- Making recommendations for appropriate health facilities and equipment; and
- Directing inspection of all school facilities and making recommendations regarding environmental health problems within the school system in consultation with local public health personnel and school nursing personnel.

Consultation

The school medical advisor may provide consultation by:

- Participating in continuing education and in-service programs for school personnel;
- Providing consultation to the local or regional board of education, as needed;
- Providing consultation with regard to the implementation of employee health programs;
- Acting as a resource in the planning and/or implementation of the health education curriculum; and
- Interpreting the school health program and policies to parents, the community, the media and other physicians.



Appendix E: Nurse Practice Act

CHAPTER 378*

NURSING

Located at the Connecticut General Assembly Web site
at <http://www.cga.ct.gov/2011/pub/chap378.htm>

Table of Contents

- Sec. 20-87. Definitions.
- Sec. 20-87a. Definitions. Scope of practice.
- Sec. 20-88. State Board of Examiners for Nursing.
- Sec. 20-89. Salaries and expenses.
- Sec. 20-90. Duties of board.
- Sec. 20-91. Awards in aid of nursing education.
- Sec. 20-91a. Federal funds.
- Sec. 20-92. Examinations.
- Sec. 20-93. Qualifications for examination. Licensure. Fee.
- Sec. 20-94. Licensure without examination. Limited period for licensure without examination for advanced practice registered nurses. Temporary permit.
- Sec. 20-94a. Licensure as advanced practice registered nurse.
- Sec. 20-94b. Nurse anesthetists. Prescriptive authority.
- Sec. 20-94c. Advanced practice registered nurses. Professional liability insurance required.
- Sec. 20-95. Use of title “registered nurse”.
- Sec. 20-96. Licensure as practical nurse. Examinations.
- Sec. 20-97. Licensure without examination. Temporary permit.
- Sec. 20-98. Use of title “practical nurse”.
- Sec. 20-99. Improper professional conduct. Hearing. Appeal. Prohibited conduct.
- Sec. 20-99a. Regulations.
- Sec. 20-100. Notice to Department of Health Services.
- Sec. 20-101. Construction of chapter. Permitted practices. Temporary practice.
- Sec. 20-101a. Determination and pronouncement of death by registered nurse. Regulations.
- Sec. 20-101b. Construction.
- Sec. 20-101c. Prescription forms used by advanced practice registered nurses and nurse-midwives.
- Sec. 20-102. Penalty.
- Sec. 20-102a. Appearance before board concerning application.
- Secs. 20-102b to 20-102z.



Appendix F: Qualifications of a school nurse

11/06/2007 School Nurses and Nurse Practitioners

Department of Public Health. Public Health Code. School Nurses and Nurse Practitioners (10-212-1 to 10-212-7) <http://www.dir.ct.gov/dph/PHC/browse.asp>.

10-212-1. Definitions

“School nurse” means a “nurse” or a “nurse practitioner” who meets the requirements set forth in these regulations.

(Effective September 1, 1982.)

10-212-2. Qualifications of a school nurse

Except as provided in Section 10-212-3, in order to qualify as a school nurse each nurse or nurse practitioner shall meet the following requirements:

(a) Licensure - Each nurse or nurse practitioner shall be a registered professional nurse, designated as R.N., as defined in Section 20-87a of the General Statutes, and currently licensed in the state of Connecticut.

(b) Experience - Each nurse or nurse practitioner shall have at least the equivalent of one year full time working experience as a registered nurse within five (5) years immediately prior to employment as a school nurse.

(c) Education - Each nurse or nurse practitioner shall have academic preparation to include twelve (12) academic credits at a licensed or accredited institution of higher learning or eighteen (18) continuing education units (CEUs) or one hundred eighty (180) workshop or inservice hours distributed as follows:

(1) Six (6) credits or nine (9) CEUs or ninety (90) workshop hours in at least two of the following subject areas:

- (A) Growth and Development
- (B) Health Assessment
- (C) Public or Community Health or School Health

(2) Six (6) credits or nine (9) CEUs or ninety (90) workshop hours in two or more of the following subject areas:

- (A) Administration or Organization of Health or School Services
- (B) Child or Adolescent Psychology
- (C) Crisis Intervention
- (D) Growth and Development
- (E) Handicapping Conditions
- (F) Health Assessment
- (G) Health Education
- (H) Mental Health
- (I) Public or Community Health or School Health
- (J) Sociology
- (K) Sports Medicine

(Effective September 1, 1982.)



10-212-3. Grandparent clause

A nurse or nurse practitioner who meets the licensure requirements of Subsection (a) of Section 10-212-2 of these regulations, who is employed as a nurse in public or nonpublic elementary or secondary schools on the effective date of these regulations, and who has been employed as a nurse in such schools for the equivalent of five years full time shall be considered to have met all the educational qualifications of a school nurse pursuant to Section 10-212-2.

(Effective September 1, 1982.)

10-212-4. Provisional qualifications

A nurse or nurse practitioner who (a) meets the requirements for licensure pursuant to Subsection (a) of Section 10-212-2 of these regulations and (b) who either has (1) the experience required pursuant to Section 10-212-2 or (2) taken three academic credits or four and one-half CEUs or forty-five (45) workshop hours in any area enumerated in Subsection (c) of Section 10-212-2 within five (5) years immediately prior to employment as a school nurse shall be provisionally qualified to serve as a school nurse. Such provisional qualification shall be valid in Connecticut for no more than three (3) years. Upon completion of the requirements for qualification as school nurse, such nurse or nurse practitioner shall no longer be designated as provisionally qualified.

(Effective September 1, 1982.)

10-212-5. Continuing qualification as school nurse

A school nurse qualified pursuant to Sections 10-212-2 or 10-212-3 shall continue to be so qualified, provided that such nurse participates in at least ten hours of professional development programs or activities approved by the local or regional board of education in each two-year period commencing on the effective date of these regulations.

(Effective September 1, 1982.)

10-212-6. Authority of a local or regional board of education to appoint a school nurse

A local or regional board of education may require that each registered nurse providing school health services meets the qualifications as set forth in Section 10-212-2 of these regulations whether employed by the board of education or appointed under contract with a local health agency.

(Effective September 1, 1982.)

10-212-7. Compliance in a different manner

A local or regional board of education of any town having a population of less than ten thousand, which has appointed a legally qualified practitioner of medicine as school medical advisor, may submit a written proposal, for prior approval by the State Board of Education, to document compliance with any requirement of these regulations in a manner different from that specified in these regulations. Such proposal may be approved if it appears that it will substantially meet the goals of these regulations.

(Effective September 1, 1982.)



Glossary



education records: Broadly defined, those records that are 1) directly related to a student, and 2) maintained by an educational agency or institution or by a party acting for the agency or institution. All records, including immunization and other health records, that are directly related to a student and maintained by a school are “education records” under FERPA.

eligible student: A student who is at least 18 years of age or who attends a postsecondary institution at any age.

exposure control plan: The employer’s written program that outlines the protective measures an employer will take to eliminate or minimize employee exposure to blood and OPIM. The exposure control plan must contain at a minimum: an exposure determination that identifies job classifications and, in some cases, tasks and procedures where there is occupational exposure to blood and OPIM; procedures for evaluating the circumstances surrounding an exposure incident; and a schedule of how and when other provisions of the standard will be implemented, including methods of compliance, communication of hazards to employees, and recordkeeping.

free appropriate public education (FAPE): A term used in the elementary and secondary school context; for purposes of Section 504, refers to the provision of regular or special education and related aids and services that are designed to meet individual educational needs of students with disabilities as adequately as the needs of students without disabilities are met and is based upon adherence to procedures that satisfy the Section 504 requirements pertaining to educational setting, evaluation and placement, and procedural safeguards.



FERPA (Family Educational Rights and Privacy Act): A federal law that protects the privacy of students' "education records."

HIPAA (Health Insurance Portability and Accountability Act): a federal law enacted in 1996 to, among other things, improve the efficiency and effectiveness of the health care system through the establishment of national standards and requirements for electronic health care transactions and to protect the privacy and security of individually identifiable health information.

individualized health care plan: A detailed and orderly program of action designed to monitor, prevent, reduce or eliminate identified health problems to maintain or improve a student's health status and level of wellness and to promote his or her learning and positive coping.

medical home: A model for delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective to all children and youths, including children and youths with special health care needs.

related services: A term used in the elementary and secondary school context to refer to developmental, corrective, and other supportive services, including psychological, counseling and medical diagnostic services and transportation.

Response to Intervention: A method of academic intervention used in the United States to provide early, systematic assistance to children who are having difficulty learning. RTI seeks to prevent academic failure through early intervention, frequent progress measurement, and increasingly intensive research-based instructional interventions for children who continue to have difficulty. It is believed that students who do not show a response to effective interventions are likely (or more likely than students who respond) to have biologically based learning disabilities and to be in need of special education.

school nurse: A registered nurse assigned to work in a school.

school nursing: A specialized practice of professional nursing that advances the well being, academic success, and life-long achievement of students.

universal precautions: An approach to infection control. According to the concept of universal precautions, all human blood and certain human body fluids are treated as if known to be infectious for HIV, HBV, and other bloodborne pathogens.

State of Connecticut

Dannel P. Malloy, Governor

State of Board of Education

Allan B. Taylor, Chairperson
Simon Brewer
Ellen Camhi
Joshua Friedman
Theresa Hopkins-Staten, Vice Chairperson
Charles A. Jaskiewicz III
Terry H. Jones
Patricia Keavney-Maruca
Estela López
Patricia B. Luke
Ferdinand Risco Jr.
Joseph J. Vrabely Jr.
Stephen P. Wright

Dr. Robert A. Kennedy (Ex Officio)
President, Connecticut Board of Regents for Higher Education

Stefan Pryor
Commissioner of Education

The State of Connecticut Department of Education is committed to a policy of equal opportunity/affirmative action for all qualified persons. The Department of Education does not discriminate in any employment practice, education program, or educational activity on the basis of race, color, religious creed, sex, age, national origin, ancestry, marital status, sexual orientation, gender identity or expression, disability (including, but not limited to, intellectual disability, past or present history of mental disorder, physical disability or learning disability), genetic information, or any other basis prohibited by Connecticut state and/or federal nondiscrimination laws. The Department of Education does not unlawfully discriminate in employment and licensing against qualified persons with a prior criminal conviction. Inquiries regarding the Department of Education's nondiscrimination policies should be directed to Levy Gillespie, Equal Employment Opportunity Director/American with Disabilities Act Coordinator, State of Connecticut Department of Education, 25 Industrial Park Road, Middletown, CT 06457, 860-807-2101, Levy.Gillespie@ct.gov.

