BASIC AND SPECIALIZED HEALTH CARE PROCEDURE MANUAL FOR WEST VIRGINIA PUBLIC SCHOOLS

May 2015
Office of Special Programs
Teaching and Learning

PROFESSIONAL CREDITS

1989 TASK FORCE FOR MEDICALLY FRAGILE STUDENTS

Chairperson: Jean G. Morris, Kanawha County School Health Services
Sherry Hickman, Public Health School Nurse, Mason County
Brenda Isaac, School Nurse, Kanawha County
Judy Kelly-Minor, Special Educator, Monongalia County
Janis McGinnis, School Nurse, Wood County
Robin McNeely, School Nurse, Wyoming County
Deborah Parsons, School Nurse, Roane County
Carolyn Rice, School Nurse, Putnam County

Consultant: Linda Martel
Clinical Nurse Specialist for Pediatrics
Women's and Children's Hospital
Charleston, WV

1989 Council of School Nurses:

RESA I - Lois McCutcheon, School Nurse, Monroe County
RESA II - Pam Dice, School Nurse, Lincoln County
RESA III - Carolyn Rice, School Nurse, Putnam County
RESA IV - Ella Williams, School Nurse, Nicholas County
RESA V - Janis McGinnis, School Nurse, Wood County
RESA VI - Helen Diserio, School Nurse, Brooke County
RESA VII - Betty Maxwell, School Nurse, Harrison County
RESA VIII - Trina Melody, School Nurse, Mineral County

We are also grateful to the West Virginia School Health Association, American School Health Association, National Association of School Nurses, and West Virginia Nurses Association, members of the West Virginia Medical Association, and the Health Services and Special Education Departments of the West Virginia Department of Education for information and support.

Revised April 1995 by Council of School Nurses:

RESA I - Jane Thompson, School Nurse, Summers County
RESA II - Paula Kay Maynard, School Nurse, Mingo County
RESA III - Angela Cavendar, School Nurse, Kanawha County
RESA IV - Sharon Casto, School Nurse, Nicholas County
RESA V - Janis McGinnis, School Nurse, Wood County
RESA VI - Edna Kettler, School Nurse, Ohio County
RESA VII - Frances Powviriya, School Nurse, Taylor County
RESA VIII - Mary Ellen Clark, School Nurse, Berkeley County

Revised June 2001 by Council of School Nurses:

RESA I - Jane Thompson, Summers County
RESA II - Kathleen Napier, Cabell County
RESA III - Debbie Parsons, Kanawha County
RESA IV - Patricia Withrow - Greenbrier County
RESA V - Cassandra Judge, Jackson County
RESA VI - Carol Mullenbach, Chair, Brooke County
RESA VII - Nancy Bradshaw, Upshur County
RESA VIII - Peggy Wright, Hardy County

Revised June 2004 by Council of School Nurses:

RESA I – Debbie Kaplan, Raleigh County
RESA II – Teresa Ryan (Chair), Lincoln County
RESA III – Connie Harper, Clay County
ESA IV – Rhonda Tabit, Fayette County
RESA V – Janis McGinnis, Wood County
RESA VI – Barbara Hart, Marshall County
RESA VII – Susan Pinto, Monongalia County
RESA VIII – Mary Jane Rinard, Berkeley County

We are also grateful to Janet Allio-Kanawha County School Nurse, Judy Hudson-Wood County School Nurse, Julie Davis-Wood County School Nurse, Nancy Doss-Boone County School Nurse , Becky Wise-Monongalia County Special Education School Nurse, Ann Sammons-President of West Virginia Association of School Nurses and to all School Nurses of West Virginia.

Revised May 2006 by Council of School Nurses:

RESA I – Debbie Kaplan, Raleigh County
RESA II – Teresa Ryan (Chair), Lincoln County
RESA III – Nancy Doss, Boone County
RESA IV – Rhonda Tabit, Fayette County
RESA V – Alisa Shepler, Ritchie County
RESA VI – Diana Baker, Marshall County
RESA VII – Nancy Bradshaw, Upshur County
RESA VIII – Sharon Clark, Mineral County

Reviewed May 2008 by Council of School Nurses:

RESA I – Donna (Susie) Poindexter (Chair), Wyoming County
RESA II – Melinda Gibson, Wayne County
RESA III – Nancy Doss, Boone County
RESA IV – Sarah (Beth) Jordan, Nicholas County
RESA V – Alisa Shepler, Ritchie County
RESA VI – Diana Baker, Marshall County
RESA VII – Nancy Bradshaw, Upshur County
RESA VIII – Sharon Clark (Chair), Mineral County

Revised May 2010 by Council of School Nurses:

RESA I – Donna (Susie) Poindexter (Chair), Wyoming County
RESA II – Melinda Gibson, Wayne County
RESA III – Delberta Riffe, Putnam County
RESA IV – Sarah (Beth) Jordan, Nicholas County
RESA V – Elaine Rinehart, Wirt County
RESA VI – Carol Cipoletti, Brooke County
RESA VII – Debbie Derico, Harrison County
RESA VIII – Debra Stine, Berkley County

Revised November 2014 by Council of School Nurses:

RESA I – Amanda Ashley, Raleigh County
RESA II – Kristi Scaggs (Chair), Logan County
RESA III – Melinda Embrey, Kanawha County
RESA IV – Paula McCoy, Greenbrier County
RESA V – Kristin Stover, Jackson County
RESA VI – Carol Cipoletti, Brooke County
RESA VII – Shalene "Shelly" Kerere, Preston County
RESA VIII – Debra Stine, Berkley County

West Virginia School Nurses Organizational Chart for the Basic and Specialized Health Care Procedure Manual for WV Public Schools

WV Board of Education
Promulgates rules and regulations for training and standards

The Commissioner of the Bureau for Public Health consults with WV Board of Education

WV Department of Education

WV Council of School Nurses

WV School Nurses

FOREWORD

As West Virginia moves toward the vision of "One Voice, One Focus: All Students Achieving," we must remember that improving safe and supportive school environments is a key component in maximizing learning for each student. A priority for success is establishing, ensuring and maintaining environments that are safe, orderly, free of bullying, nurturing, healthy, structured, sustainable, clean and designed to stimulate the creativity and innovation of each learner.

School nurses and other support personnel are the essential staff members that provide specialized services required to advance the well-being, academic success and lifelong achievement of students. These essential supports enhance meaningful parent and community relationships, support the early childhood focus and improve student attendance and graduation rates. This Basic and Specialized Health Care Procedures Manual for West Virginia Public Schools shall be utilized as the minimum standard for safe health care practices as approved by the West Virginia Board of Education's Policy 2422.7 and adopted by the West Virginia Bureau for Public Health in the Specialized Health Procedures in Public Schools Rule, W.Va. 64CSR66.

This document was initially drafted in 1989 by the Task Force for Medically Fragile Students to assist county school personnel in the planning and provision of high quality care for students with special health needs. With the guidance and financial support of the West Virginia Department of Education, the Council of School Nurses revised the draft document. In collaboration with the West Virginia Department of Health and Human Resources, the rules and regulations were written that specify how the document is to be used. The rules were first approved by the West Virginia Board of Education in June of 1990 and have since been updated in 1995,2001,2004,2010 and 2015.

Through this document, the West Virginia Council of School of Nurses has given West Virginia public schools an essential standard of practice and care for school nursing staff and unlicensed support personnel which ensures the welfare and safety of all West Virginia students to implement the " One Voice, One Focus: All Students Achieving" vision. I would like to thank the members of the West Virginia Council of School Nurses for utilizing their knowledge, experience and time to the continuous process of updating this manual. West Virginia students and their families deserve these supports to be successful throughout their public school career.

Michael J. Martirano, Ed.D.
State Superintendent of Schools

INTRODUCTION

Purpose: West Virginia Department of Education Policy 2422.7 - Basic and Specialized Health Care Procedures in West Virginia Public Schools delineates standards for school nurses to assess students' health needs and define nursing responsibility in the provision of care. The accompanying document, Basic and Specialized Health Care Procedure Manual for West Virginia Public Schools, constitutes the minimum safe standards of practice that are utilized in the provision of basic and specialized health care procedures.

Background: School nurses throughout West Virginia have continually expressed concerns about the need to develop a consistent plan to provide high quality and safe health care for students with special health care needs in WV public schools. In 1989, the West Virginia Department of Education convened a Task Force for Medically Fragile Students. The task force was composed of school nurses, a special educator and a clinical nurse specialist with expertise in child health care. This task force developed a draft of this manual of standards for performing basic and specialized health care procedures.

The West Virginia Legislature passed House Bill 2557, W.Va. Code §18-5-22, April 8, 1989. The law states that the school nurse, after assessing the health status of the individual student may delegate and supervise certain health care procedures to a trained school employee who is deemed competent by the school nurse. The statute also mandates that a Council of School Nurses be established. Meetings were held within the eight Regional Education Service Agencies (RESA) throughout the state and a representative and an alternative were elected from each RESA to serve on this Council.

The WV Council of School Nurses drafted rules and regulations, which were initially adopted by the WV Board of Education in 1990. The manual has been revised in 1995, 2001, 2004 and 2006.

Use of the Manual: This manual was designed for school nurses in West Virginia to assure consistent provision of care. The procedures are based on sound nursing practice. As new procedures are prescribed for students in schools, additional guidelines will be written for addition into the manual. Portions of the manual may be copied and left with school personnel for reference. A training checklist for each procedure, sample forms and WV Council of School Nurse recommendations for school health procedures are in the supplemental booklet for WV School Nurses. All material in the supplemental booklet may be used, as printed or redesigned to meet individual needs.

Summary: Policy 2422.7 - Basic and Specialized Health Care Procedures in West Virginia Public Schools and the Basic and Specialized Health Care Procedure Manual for West Virginia Public Schools are the standards that must be followed in providing for students with special health care needs. The WV Council of School Nurses is responsible for assessing the need for revision and periodically updating the manual.

Additional Resources: Please refer to a valid nursing resource for a standard of care guideline, such as the Lippincott Manual by *Williams and Wilkins, Managing School Age Children with a Chronic Health Condition* by Larson, etc., when performing procedures in WV public schools not found in this manual. The WV Council of School Nurses may also assist with research and guidance related to procedures not found in this manual.

TABLE OF CONTENTS

TABLE OF CONTENTS (Continued)

TABLE OF CONTENTS (Continued)

TABLE OF CONTENTS (Continued)

TABLE OF CONTENTS (Continued)

APPENDICES

SECTION I

REQUIRED PROCEDURES

A. HANDLING OF BODY FLUIDS

1. CLEANING AND DISPOSING OF BODY FLUIDS

I. Guidelines: Body fluids include blood, wound drainage, urine, vomitus, stool, tears, saliva, semen, vaginal secretions, mucus, nasal discharge, and sputum.

A. Purpose: To provide training and supervision guidelines for the safe handling of body fluids in the school environment.

B. Equipment: (County responsibility unless noted).

1. Liquid soap.
2. Warm, running water.
3. Paper towels.
4. Disposable medical gloves.
5. Disposable plastic bags.
6. Plastic-lined and covered waste containers.
7. Brooms and dustpans.
8. Mops and buckets.
9. Approved germicidal solution.

C. Personnel: All personnel (refer to WV Board of Education Policy 2423, Communicable Disease Control).

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Wash hands.	Refer to *Hand Washing* and *Gloves - Use and Removal* procedures.
B. Put on gloves when handling or touching body fluids, mucous membranes or non-intact skin of others in the school setting, or handling items or surfaces soiled with body fluids.	Individuals with open skin lesions should cover lesions with a waterproof bandage prior to applying the gloves. Sharp items must be handled with extreme care to avoid puncturing the skin. Sharp items should be disposed of in a sharps container labeled A Contaminated Material". Follow county policy for disposal of contaminated material.
C. Blood and other body fluids can be flushed down the toilet or carefully	

poured down a drain connected to a sanitary sewer.	
D. Other items for disposal that are contaminated with blood or other body fluids that cannot be flushed down the toilet should be wrapped securely in a plastic bag that is impervious and sturdy (not easily penetrated). It should be placed in a second, labeled bag before being discarded in a manner consistent with local regulations for solid waste disposal.	
E. Body fluid spills should be cleaned up promptly, removing all visible debris first.	This prevents multiplying of microorganisms.
F. Use disposable items to handle and absorb body fluid cleanup whenever possible.	All items that are contaminated and that cannot be flushed down the toilet should be disposed of in a sturdy plastic bag that is not easily penetrated, then placed in a second bag for disposal.
G. Cleanse hard, washable surfaces using one bucket to wash and a second bucket to rinse.	Soap helps to remove debris and microorganisms, but if left on the surface may hide microorganisms.
H. Disinfect, using an approved germicide in proper dilution. Rinse only if directed by the germicide manufacturer's instructions. Allow to air dry.	Soak mop, if used, in disinfectant after use.
I. For soft, non-washable surfaces, such as rugs and upholstery, apply sanitary absorbing agent, let dry, and vacuum.	Use broom and dustpan to remove solid materials, if necessary. Rinse dustpan and broom in disinfectant solution.
J. Apply rug or upholstery shampoo as directed by the manufacturer. Revacuum.	When using a sanitizing carpet cleaner method (water extraction), follow directions on label.
K. Handle soiled, washable materials, i.e. clothing and towels, as little as possible, double-bagging as mentioned before.	Send soiled clothing home with the student. Rinse school-owned towels under cold, running water then wash separate from other items. Add 1/2-cup bleach or non-chlorine bleach to wash cycle.

L. Remove and discard gloves, turn inside-out from cuffs, into covered, plastic-lined waste container.	Refer to *Gloves - Use and Removal* procedure.
M. Wash hands.	Refer to *Hand Washing* procedure.

2. GLOVES - USE AND REMOVAL

I. Guidelines: Gloving prevents blood and body fluids, that may contain disease producing microorganisms, from coming in contact with the caregiver's skin and prevents the spread of microorganisms to others.

A. Purpose: To provide training and supervision guidelines for the correct use and removal of gloves in the school setting.

B. Equipment: (County responsibility unless otherwise noted).
1. Disposable gloves designed for medical use. (Vinyl may be preferred over latex because of the potential for allergy).
2. Trash container with heavy plastic liners.

C. Personnel: All personnel.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Wash hands.	Refer to *Hand Washing* procedure.
B. Apply gloves to both hands.	Individuals with open skin lesions should cover lesions with waterproof bandage prior to applying the gloves. Ensure gloves are intact without tears.
C. Gloves must be worn during entire time when handling body fluids.	Gloves are most often worn during diapering, administering first aid, and cleanup of body fluids. Do not touch items with contaminated gloves that you or other people will be touching with your hands later. For example: water faucets, doorknobs, counter tops or other clothing.
D. After all cleanup is finished; partially remove the first glove by pinching the glove at the wrist, being careful to touch only the glove's outside surface. Pull the glove toward the fingertips without completely removing it. The glove is now inside out. With the partially gloved hand, pinch the exterior of the second glove. Pull the second glove toward the fingertips until it is inside out, and remove it completely. Grasp both gloves	Do not touch skin with contaminated gloves.

with your free hand, touching only the clean interior surface of the glove.

E. Drop gloves into plastic-lined trash container.

F. Repeat hand washing. Refer to *Hand Washing* procedure.

3. HAND WASHING

I. Guidelines: The 2002 CDC Guidelines promote the use of alcohol-based hand rubs to promote adherence to hand hygiene in health care settings. In relation to health procedures and needs of the school environment, alcohol-based hand rubs can be used to reduce the transference of microorganisms. Hands must be washed with soap and water prior to beginning any planned procedure or when hands are visibly soiled. Good hand hygiene is the single-most effective procedure to prevent the spread of communicable disease in the school setting.

A. Purpose: To provide training and supervision guidelines for proper hand washing in the school setting.

B. Equipment: (County responsibility unless otherwise noted).

1. Warm, running water.
2. Liquid soap.
3. Paper towels.
4. Alcohol-based hand rub.
5. Waste container with plastic liner.

C. Personnel: All personnel.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Wet hands using warm, running water.	Warm water combined with soap makes better suds than cold water. Running water is necessary to carry away dirt and debris that contain microorganisms.
B. Apply liquid soap and lather well.	Bacteria can grow on bar soap and in soap dishes.
C. Rub hands together in a circular motion for 20 seconds.	Friction from rubbing hands together along with the effect of the soap loosening of the germs from the skin work together with the running water for good hand hygiene. Front and back of hands, between fingers and knuckles, under nails, and the entire wrist area are washed.

D. Rinse hands well under running water.	Let water drain from wrists to fingertips.
E. Dry hands thoroughly with paper towels. Turn off water with paper towel and discard towels in waste container.	Dry skin may be cracked and potentially harbor microorganisms. Lotion is recommended after several hand washings.

OR

A. Apply alcohol-based hand rub to the palm of one hand then rub hands together.	Note: The volume needed to reduce the number of bacteria on hands varies by product.
B. Continue to rub hands together covering all surfaces of hands and fingers until dry.	

B. CPR AND FIRST AID TRAINING

As specified in Policy 2422.7, all employees performing basic and specialized health care procedures in the school setting must be certified in Cardiopulmonary Resuscitation and have up-to-date training in First Aid. Training must be completed every two years except where otherwise specified. Some employees performing basic health care procedures may be exempt from this requirement if it is deemed unnecessary by the certified school nurse.

CPR

To comply with Policy 2422.7, employees specified must be certified in an organized program of Cardiopulmonary Resuscitation training with the airway obstruction intervention. Any national program in which a certificate is awarded is acceptable i.e., American Red Cross, American Heart Association, National Health and Safety, Heart Saver, etc.

FIRST AID

To comply with Policy 2422.7, employees specified must be trained in basic first aid. Certification is recommended but not required. It is necessary, though, for training to be up-to-date.

C. CONFIDENTIALITY

All personnel delivering health care to a student should be aware of the concept of confidentiality and the serious legal consequences of violations of a person's right to confidentiality. Confidentiality in the school setting is defined as the practice of not sharing information about a student or his/her family with anyone who does not have an identified need to know for the purpose of providing for the health and safety and/or educational attainment of that particular student. Information about a student, which has been gathered by examination, observation, conversation, or treatment, is confidential information. School personnel are both legally and morally obligated to keep confidential any information regarding a student's medical condition, illness, or treatment, which is obtained in the normal course of duties. If information about a student is disclosed without the expressed consent of the parent/guardian and/or the student, the individual and facility having made the disclosure may be held liable. Therefore, counties should develop procedures, such as confidentiality contracts, to ensure that students' rights to confidentiality are protected. Please refer to West Virginia State Board of Education Policy 4350 (126CSR94), Procedure for the Collection Maintenance and Disclosure of Student Data and the Family Educational Rights and Privacy Act (FERPA).

References:

West Virginia Department of Education. (2003). State Board of Education Policy 4350-Procedure for Collection, Maintenance, and Disclosure of Student Data. Retrieved on July 22, 2009 from http://wvde.state.wv.us/policies/.

U.S. Department of Education. (2008). Family Educational Rights and Privacy Act (FERPA). Retrieved on July 22, 2009 from http://www.ed.gov/policy/gen/guid/fpco/ferpa/index.html.

SECTION II

BASIC HEALTH CARE PROCEDURES

A. ACTIVITIES OF DAILY LIVING (ADL)

1. AMBULATING WITH ASSISTANCE

a. CANE

I. Guidelines:

A. Definition: A stick used as an aid in walking, usually for a person with one-sided weakness.

B. Purpose: To lessen the force on weight-bearing joints; to give lateral balance while walking;

C. Equipment: (Parent responsibility unless otherwise noted). As prescribed.

D. Personnel: All personnel.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Determine the need for assistance with a cane at school.	Review the physician's orders and the student's health care plan.
B. Obtain a consultation with the physical therapist, if you are unfamiliar with the procedures for using a cane.	The physical therapist can assist and facilitate implementing the physician's orders for ambulation.
C. Tell the student what you will be doing and how he/she can assist.	Use developmentally appropriate language and demonstration.
D. Verify whether the student will use one or two canes.	As ordered by the physician. Two canes are used when the student needs additional support but crutches are not necessary.
E. Confirm the type of cane and the type of handle the student should be using.	As ordered by the physician. Canes are straight, quad, 4-point, and folding. Handles are pistol grip, T-grip, knobbed, and shepherd's crook.
F. Check the fit of the cane for the student's height.	Have student stand with the elbow on stronger side flexed in a 30-degree angle; have the cane tip 6 inches to the side of the little toe; the handle

	should be approximately level with the greater trochanter (hip).
G. Assist the student to walk with a cane.	As ordered by the physician.
1. Hold the cane on the stronger side. 2. Keep the cane fairly close to the body to avoid leaning on it. 3. Simultaneously advance the cane and the weaker leg.	If student cannot hold the cane with the hand opposite the weak leg, he/she can hold it on the same side as the weak leg and advance both cane and weak leg together.
H. Assist the student to go up stairs:	As ordered by the physician.
1. Step up on the stronger leg. 2. Then bring the cane and the weaker leg to that stair.	
I. Assist the student to go down stairs:	Note that the opposite leg is used first in going down stairs as going up stairs.
1. Place the cane and the weaker leg on the lower stair. 2. Step down with the stronger leg.	
J. Arrange for the student to use the school elevator, if elevator is available.	Lessens possibility of injury to student or others on the stairs.
K. Safety points:	
1. Make sure rubber cane tips are in good repair.	They should be wide and provide good traction; replace promptly if worn.
2. Check screws and nuts frequently.	They loosen with usage.
3. Have a designated place in classroom for the cane.	It could be a safety hazard for other students and staff.
4. Keep hands free to maneuver the cane.	Use a backpack to carry personal belongings.

5. Arrange for the student to leave each class early, if necessary	This allows student to be clear of the hall during regular passing period.

b. CRUTCHES

I. Guidelines:

A. Definition: A support used as an aid in walking, most often used in pairs.

B. Purpose: To promote mobility and independence; to prevent injury to an affected limb.

C. Equipment: (Parent responsibility unless otherwise noted).
1. Adjustable crutches.
2. Rubber crutch tips.
3. Axillary arm pads.
4. Safety waist belt.
5. Tape measure, or as ordered.

D. Personnel: All personnel.

E. Note: Type of crutch gaits that may be prescribed by the student's physician or physical therapist:

1. Gait: 4-point alternate crutch gait
   Description: A slow but stable gait; can only be used by the student who can move each leg separately and bear considerable weight on each foot.
   Sequence: Right crutch, left foot; left crutch, right foot.

2. Gait: 2-point alternate crutch gait
   Description: Slightly faster, but requires more balance than 4-point gait.
   Sequence: Right foot and left crutch forward at the same time; left foot and right crutch forward at the same time.

3. Gait: 3-point crutch gait
   Description: Fairly rapid, but requires more strength and balance since the arms must support the entire body weight.
   Sequence: Advance both crutches and the weak or affected foot; transfer the body weight forward to the

crutches; advance the unaffected or good foot forward.

4. Gait: Tripod crutch gaits:
   a. tripod alternate crutch gait
   b. tripod simultaneous crutch gait

   Description: Slow and labored while maintaining tripod position.

   Sequence:
   a. tripod alternate crutch gait - right crutch, left crutch; drag body and legs forward
   b. tripod simultaneous crutch gait - both crutches; drag body and legs forward.

5. Gait: Swinging crutch gaits:
   a. swinging-to gait
   b. swinging-through gait

   Description: Both legs are lifted off the ground simultaneously and swung forward while the student pushes up on the crutches.

   Sequence:
   a. Swinging-to gait - bear weight on good leg; advance both crutches forward simultaneously, while leaning forward, swing the body to a position even with the crutches.
   b. Start with crutches at the side, balancing weight on feet or foot/transfer weight forward; use shoulder and arm strength to swing up and through the crutches, stopping slight in front of the crutches. This is the most rapid and advanced gait. It requires a great deal of shoulder and arm strength. It also requires an excellent sense of balance.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Determine the need for assistance with crutches at school.	Review the physician's orders and the student's health care plan.
B. Obtain a consultation with the physical therapist, if you are unfamiliar with procedures for using crutches.	The physical therapist can assist and facilitate implementing the physician's orders for ambulation.
C. Assist the student with strengthening exercises.	As ordered by the physician.
D. Check the crutches for appropriate length when student is standing erect.	When the crutch tip is 4-inches in front of and 6-inches to the side of toes, the arm piece should be 2-inches from the axilla.
E. Assist the student to stand with balance and stability.	Have the student move forward to the edge of the chair with the strong leg slightly under the seat. Place both crutches in the hand on the side of the affected extremity. Have student push down on the hand pieces while raising the body to a standing position.
F. Check the hand piece so that the student's elbows have 20 to 30 degrees of flexion when the arm piece is 2 finger widths below the axilla.	Prevent brachial nerve paralysis by showing student how to extend and stiffen elbows in order to place body weight on palms, never on axilla.
G. Use the axillary arm pad only if ordered by the physician.	Even though the auxiliary arm pads lessen pressure on the inside of the upper arm and the thoracic wall, their use may encourage the student to rest on them and not put pressure on hands.
H. Check to see that the crutches are labeled with the student's name.	The wrong crutches may fit improperly and make the student prone to fall.
I. Verify that the student is using the crutch gait prescribed by the physician.	Gait varies with the type and severity of the disability, the student's general condition, strength of arms and trunk, extent of balance.
J. Assist the student with stair climbing:	Remember that "the good go up and the bad go down".

1. To go up stairs	Advance the good leg up to the next step, then the crutches and finally the weaker leg.
2. To go down stairs	Place the crutches on the next lower step; then lower the weaker leg and finally step down with the good leg.
K. Arrange for the student to use the school elevator, if elevator is available.	Lessens possibility of injury to student or others on the stairs.
L. Safety points:	
1. Make sure rubber crutch tips are in good repair.	They should be wide and provide good traction; replace promptly if worn.
2. Make sure that the student is wearing good walking shoes. The shoes should have low, broad heels and nonskid soles.	The student's shoes could alter or interfere with his/her ambulation/gait. Proper fitting shoes lessen the possibility of injury while using crutches.
3. Check screws and nuts frequently.	They loosen with usage.
4. Have a designated place in the classroom for the crutches.	They could be a safety hazard for other students and staff.
5. Keep hands free to handle the crutches.	Use a backpack to carry personal belongings.
6. Arrange for the student to leave each class 5 minutes early, if necessary.	This allows student to be clear of the hall during regular passing period.

c. WALKER

I. Guidelines:

A. Definition: A framework used to support a convalescent or handicapped individual while walking.

B. Purpose:
1. To provide more stability than either a cane or crutch.
2. To enable the student to begin ambulation.

C. Equipment: (Parent responsibility unless otherwise noted).
As prescribed.

D. Personnel: All personnel.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Determine the need for assistance with a walker at school.	Review the physician's orders and the student's health care plan.
B. Obtain a consultation with the physical therapist, if you are unfamiliar with the procedures for using a walker.	The physical therapist can assist and facilitate implementing the physician's orders for ambulation.
C. Tell the student what you will be doing and how he/she is to assist.	Use developmentally appropriate language and demonstration.
D. Verify that the student is using the type of walker prescribed by the physician.	Standard walker is a rigid framework, but adjustable in height. Mobile walker has wheels on the legs to roll forward. Rollator walker has wheels in the front and rubber tipped legs in the back. Swivel-type walker is hinged so that the right and left side move independently.
E. Check the walker for appropriate height.	The walker should be fitted to the student. The handles should be level with the top of the femurs at the hip joints. Each elbow should be flexed at 25- to 30- degree angle.
F. Assist the student to walk using the walker.	Start with walker in position. The student should be standing "inside" the walker. Tell

	the student to lift the walker and place it forward so that the back legs of the walker are even with the student's toes. Instruct the student to transfer his/her weight forward slightly to the walker. Instruct the student to walk "into" the walker and not to "shuffle" his/her feet.
G. Do not allow the student to use the walker on stairs.	The walker cannot safely be used on stairs and inclines.
H. Arrange for the student to use the school elevator, if elevator is available.	Without an elevator, student may need to have all classes on the ground floor.
I. Safety points:	
1. Make sure rubber walker tips are in good repair.	They should be wide and provide good traction; replace promptly if worn.
2. Make sure that the student is wearing good walking shoes. The shoes should have low, broad heels and nonskid soles.	The student's shoes could alter or interfere with his/her ambulation/gait. Proper fitting shoes lessen the possibility of injury while using the walker.
3. Check screws and nuts frequently.	They loosen with usage.
4. Have a designated place in the classroom for the crutches.	It could be a safety hazard for other students and staff.
5. Keep hands free to handle the crutches.	Use a backpack to carry personal belongings.
6. Arrange for the student to leave each class 5 minutes early, if necessary.	This allows student to be clear of the hall during regular passing period.

d. WHEELCHAIR

I. Guidelines:

A. Definition: A chair mounted on a frame with 2 large wheels in back and 2 smaller wheels in front for use by an ill or handicapped individual.

B. Purpose: To provide mobility and independence for a non-ambulatory individual and to transport a person who cannot or should not walk.

C. Equipment: (Parent responsibility unless otherwise noted). As prescribed.

D. Personnel: All personnel.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Determine the need for assistance with a wheelchair at school.	Review the physician's orders and the student's health care plan.
B. Verify that the school is fully wheelchair accessible.	If only the ground floor is wheelchair accessible, all the student's classes may have to be on that floor.
C. Obtain a consultation with the physical therapist and/or the wheelchair company, if necessary.	The wheelchair must be ordered or made in the correct size to fit the student and disability.
D. Obtain a consultation with the physical therapist, if you are unfamiliar with the procedures for using a wheelchair.	The physical therapist can assist and facilitate implementing the physician's orders for a wheelchair.
E. Tell the student what you will be doing and how he/she can assist.	Use developmentally appropriate language and demonstration.
F. Assist the student to sit in a wheelchair.	
1. Lock the wheelchair wheels.	
2. Swing foot rests to the outside of the wheelchair.	Have the student do as much of this maneuver as he/she safely can.

3. Remind the student to feel the chair with the back of legs.

4. Tell student to reach back for the arms of the wheelchair.

Make sure student's buttocks are at the back of the chair seat.

5. Shift your weight to your forward leg and guide student as he/she bends knees and sits on the chair.

6. Lift student's legs and swing foot rests back into place in front of the wheelchair; place feet on foot rests.

7. Make sure student is safe and secure.

G. Ambulate the student from bed/resting table to wheelchair.

1. Position the wheelchair next to the bed/resting table at a 45-degree angle; lock the wheels.

Place the wheelchair so that student will move toward his/her strongest side.

2. Move the student to the side of the bed/resting table using the following steps:

Caution: Cots are not recommended (they tip easily). If a cot is used, do not move the child to the edge of the cot. Bring to a sitting position in the middle of the cot. Have the student do as much of the maneuver as he/she safely can.

a. Bring student's head and shoulders toward the edge of the bed/resting table.

b. Bring student's feet and legs to the edge of the bed/resting table; student is now in a curved position.

Pay attention to your body mechanics to protect your back. (Refer to *Body Mechanics* procedure). **Caution:** Personnel will have to adapt lifting mechanics according to the height of the bed/resting table.

c. Slide both your arms under student's hips, then straighten your back while bringing student toward you.

3. Sit the student on the edge of the bed/resting table.

Have the student do as much of this maneuver as he/she safely can.

a. Roll the student on his/her side, facing you; bend his/her knees.

b. Reach one arm over to hold student in back of his/her knees.

c. Place your other arm well under the neck and shoulder area.

d. Shift your weight to your leg nearer the foot of the bed/resting table while swinging the student's legs over the edge of the bed/resting table and pulling shoulders to a sitting position.

Position your feet with a wide base of support and lower your center of gravity by bending your knees.

e. Remain in front of student with both of your hands supporting his/her upper body.

Allow student to sit for 2 minutes while you observe for orthostatic hypotension, dizziness, etc. Do not leave until you are sure student is stable.

4. Assist the student to stand.

Make certain student can safely bear own weight. Have the student do as much of the maneuver as he/she safely can.

a. Position the student's feet so that they will be well grounded.

b. Face the student while firmly grasping each side of the student's rib cage with your hands.

c. Push your knee against one knee of the student.

Your knee is pushed against the student's knee as he or she comes to a standing position.

d. Rock the student forward to a standing position.

e. Ensure that the student's knees are "locked" while standing.

f. Give the student enough time to establish balance.

g. Pivot the student into a sitting position in the chair.

You should be close to the wheelchair with your feet providing a broad base of support.

H. Assist the student to use a transfer (sliding) board.

Definition: A transfer board is a polished, light-weight board used to bridge the gap between bed/resting table and chair or any transfer space.

Purpose: To allow the student to transfer when the muscles needed for lifting off the cot or chair are not strong enough to lift own body weight.

1. Place one side of the board under student's buttocks; place the other side on the surface to which student is going. When transferring by use of a sliding board from a wheelchair to a bed/ resting table, removal of the arm of the wheelchair should be implemented as a safety measure.

Caution: Do not use a transfer board if the child is on a cot. The cot will tip over.

2. Tell student to push up with hands, shift buttocks, and slide or wiggle across the board and off the other end.

I. Wheelchair safety points:

1. Regularly check the rear wheels for movement with the brakes locked.

Brakes become ineffective when they are out of alignment; have brakes repaired.

2. Make sure both feet are on the footrests.

Ask for assistance, if needed.

3. Make sure arms and legs are within the width of the chair when going through a doorway.

4. Always lock the brakes when the wheelchair is stopped.

Even if it is empty.

5. Always push at a walking speed. NEVER FASTER.

Take extra caution on gravel, grass, or uneven ground because the front wheels can get stuck, making the chair tip forward.

6. Never tilt the wheelchair way back, turn sharply, or stop too rapidly.

7. Back a wheelchair down ramps and curbs.

Be sure both wheels go over the curb together so the chair doesn't tip.

8. Push a wheelchair forward going up ramps and curbs.

   Tip the chair back just enough for the front wheels to clear the curb.

9. Always hold onto the wheelchair when pushing it.

2. ASSISTING WITH CLOTHING

I. Guidelines: This procedure is designed for the student who has not developmentally achieved the skill of clothing self, or the student who is physically unable to clothe self.

A. Purpose: To provide training and supervision guidelines to assist and support the student in managing clothing and to help the student reach his/her potential for independence in activities of daily living.

B. Equipment: (Parent responsibility unless otherwise noted).

1. Clothing that is clean, dry, non-restrictive, comfortable, non-irritating to the skin, appropriate to the weather, safe, simple in design, easy to care for, practical for the student's condition.
2. Dressing tools may include a reacher, long-handled shoehorn, elastic shoelaces, button aid, dressing stick, velcro closures, and a mirror.

C. Personnel: All personnel.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Dress the weak or most involved extremity **first.**	Specific techniques will depend on the extent to which the student can move, the type of garment used, and the student's overall condition.
B. Undress the weak or involved extremity **last.**	
C. Obtain a consultation with an occupational therapist for recommendations on assistive devices or techniques to aid the student.	
D. Put clothing within reach and in the order it will be used.	
E. Position the student in front of mirror to help monitor own progress.	
F. Put suggested/prescribed assistive devices near the clothing.	

G. Allow enough time for student to complete task.

H. Follow the same routine each time the student dresses and undresses.

I. Determine student's developmental readiness to assist in dressing.

The following factors indicate readiness:

1. Is able to sit up and maintain balance or perform specific functions while lying on side.
2. Follows directions.
3. Shows which articles of clothing are worn on which parts of the body.
4. Moves arms from side to side and overhead.
5. Imitates another person's motions.
6. Grasps objects with hands.

3. BODY MECHANICS

I. Guidelines: Proper body mechanics should be observed at all times by all personnel, but especially during lifting, transferring, and transporting students.

A. Purpose: To provide training and supervision guidelines to protect personnel from injury and unnecessary fatigue resulting from improper use of muscular and skeletal systems.

B. Equipment: (County responsibility unless otherwise noted).
Lumbar support belts and gait belts (optional or as required by county).

C. Personnel: All personnel.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Stooping.	
1. Position body to provide stable base of support.	Feet apart 8-10 inches, placing one foot slightly forward, balancing weight on both feet and pointing the toes in the direction of movement.
2. Lower body to a stooped position.	Back and trunk straight; knee and hip joints flexed. **DO NOT BEND AT WAIST.**
3. Shift weight.	To advance foot and ball of rear foot.
4. Raise body to a standing position.	Keep back straight; initiate move by extending hip and knee joints (using stronger extensor muscles).
B. Reaching.	
1. Position body with a stable base of support.	Feet apart 8-10 inches, placing one foot slightly forward, balancing weight on both feet and pointing the toes in the direction of movement.
2. Start movement with body in good alignment and balance.	Back and trunk straight.

3. Check distance to be reached to obtain object.	Obtain a footstool or a ladder, if necessary. Avoid reaching above shoulder level when possible to prevent strain.
4. Reach up from a position directly in front of the object.	Have line of gravity centered over center of the footstool; feet in a balanced position. Avoid looking or reaching overhead as this hyperextends neck and spine and makes you less stable.
5. Lift the object from the elevation.	Set muscles to distribute work load over many muscles; use good body alignment.
6. Lower the object.	Use smooth, coordinated movements to prevent jarring and jolting the body.
7. Lower yourself from the ladder or footstool.	Look down and step carefully, watch where you are going.
8. Place the object on a shelf at working level or stoop and lower it to the floor.	Observe good principles of body alignment to prevent strain.
C. Pivoting.	
1. Start with stable base of support.	Feet apart, one foot slightly advanced; knees slightly flexed to allow you to use leg muscles and avoid "locking" or hyperextending the knees.
2. Set trunk and pelvic muscles, thigh and leg muscles.	"Setting" of the muscles makes it easier to turn the body as a single unit and prepares muscles for action.
3. Shift your weight to the ball of each foot.	Shifting of weight allows the heel to lift very slightly, making the turn easier.
4. Pivot or make 90-degree turn on feet in direction you wish to turn.	Move your feet and body as a single unit. Use smooth, coordinated movements to prevent twisting of the trunk.
5. Distribute weight equally on each foot following turn.	To provide a stable base of support and balance for further movements.

D. Lifting and carrying.

1. Start with stable base of support.	Feet apart 8-10 inches, placing one foot slightly forward, balancing weight on both feet and pointing the toes in the direction of movement.
2. Reach for the object.	Bend from the hips and knees to get close to the object. Keep your back straight. **DO NOT BEND AT THE WAIST.**
3. Grasp object in its center of gravity.	
4. Set abdominal and arm muscles.	Prepares the muscles for action and stabilizes muscles.
5. Lift object.	Bring object close to one's line of gravity; flex knees again for more thrust and begin to straighten back, not rigidly straight, in the final position.
6. Carry object.	Carry object near midline of body, large muscles aid in support. Shift object from side to side during period of support. Avoid twisting as you carry. Turn with your feet and entire body when you change direction of movement.
7. Position object as desired.	

E. Pushing and Pulling.

1. Start with stable base of support and good body alignment.	Feet apart 8-10 inches, placing one foot slightly forward, balancing weight on both feet and pointing the toes in the direction of movement.
2. Set trunk and leg muscles.	Stabilizes the body and prepares muscles for action.
3. Lean toward object to push.	Keeps work close to body; encourages good alignment by reducing distance of reach (back straight and erect). Body weight adds greater force and helps move an object.
4. Lean away from object in order to pull.	Keep back straight and erect to apply as much force as possible in the direction of the movement by using the weight.

5. Push or pull by letting your arms, hips, and thighs do most of the work.	The large muscles of the thigh and leg do the work; efficient use of these muscles conserves energy and prevents strain.

4. ORAL FEEDING OF STUDENT

I. Guidelines: Oral feeding of students may be necessary to provide nutrients and fluids to those students who are unable to eat without assistance, to prevent dehydration and fluid retention, and to provide practice in appropriate eating skills.

A. Purpose: To provide training and supervision guidelines for the safe oral feeding of students.

B. Equipment: (Parent responsibility unless otherwise noted).
1. Adaptive eating and drinking devices.
2. Measuring containers (county).
3. Towel to protect clothing (county).
4. Disposable, pre-moistened wipes (county).
5. Disposable medical gloves (county).

C. Personnel: All personnel.

II. Procedure:

ESSENTAL STEPS	KEYPOINTS-PRECAUTIONS
A. Determine the need to feed the student at school. Confer with parents to obtain adequate information. Obtain **Special Dietary Needs Physician's Medical Statement** for diet instructions and alterations.	Review the licensed prescriber's orders, if applicable, and the student's health care plan.
B. Determine if suctioning and/or postural drainage are necessary before feeding.	Routine postural drainage and suctioning may be scheduled, if necessary, prior to feeding to lessen the chance of vomiting. Refer to *Postural Drainage and Percussion* and *Oral Suctioning* procedures.
C. Arrange for consultation with the physical therapist or occupational therapist, if needed.	They can assist nurse in advising staff on appropriate feeding techniques and assistive devices.
D. Explain the procedure to the student.	Use developmentally appropriate language.

E. Wash hands and put on gloves, if appropriate.	Refer to *Hand Washing* and *Gloves – Use and Removal* procedures.
F. Choose an area of the classroom or lunchroom that has the most suitable atmosphere for this task.	Area should be calm and organized yet allows the student to observe other students also eating.
G. Place the student in a sitting position if this is allowed.	Observe safety measures. Provide foot, trunk, and head support for the student. Do not allow neck to hyperextend as this interferes with swallowing. Keep chin at midline and forward, chin pointing to chest.
H. Wash the student's hands and face, if necessary.	This is especially important if the student will be assisting with feeding.
I. Place a towel on the student's chest.	To protect clothing.
J. Provide oral hygiene as needed.	This may stimulate the student's appetite by increasing student's ability to taste and enjoy the sensation of eating.
K. Measure food, if required, and bring it to the student's table.	Have hot foods hot, cold foods cold, and cut into small bite-sized pieces or proper consistency, if needed. Foods need to be of consistency that will hold bolus form until swallowed.
L. Feed the student slowly, Place a small amount of food on the utensil. Fill the spoon or fork about 1/3 - 1/2 full. Feed the student with the tip of the utensil; Hold the utensil at a 90 degree right angle to the student's mouth.	Hurry and impatience create frustration. Wipe drops from the bottom of the spoon. Allow the student to perform as much self-feeding as can be managed.
M. Check to see if the student needs assistance with opening mouth, chewing, swallowing, or controlling tongue thrust.	Observe feeding behaviors. Review the physician's orders and the student's health care plan.
N. Offer the student liquids throughout the meal.	Use a lightweight, sturdy cup with lid, a drinking straw or tube (unless the student has dysphagia), offered at the side of the mouth, or other adaptive device to assist

	drinking. If needed, guide the student's hand as the cup is brought to mouth.
O. Praise and encourage the student's efforts.	
P. Remove uneaten food from the student's table. Measure it if required. Return it to the kitchen for storage or discard it in an appropriate container.	Refer to *Cleaning and Disposing of Body Fluids* procedure.
Q. Provide oral hygiene and brush the student's teeth.	Refer to *Oral Hygiene* procedure.
R. Wash the student's face and hands. Remove the protective covering from clothing.	
S. Remove your gloves, if used. Wash hands.	Refer to *Gloves - Use and Removal* and *Hand Washing* procedures.
T. Have the student resume scheduled classroom activity.	Student should remain upright after eating.
U. Document feeding on the student's individual treatment record.	Record: 1. Date and time. 2. Amount of food and fluids ingested (measured if required). 3. Quality of the feeding activity. 4. Any problems or milestones. 5. Signature of personnel performing procedure.
V. Summarize the student's need for and apparent benefit (or lack of benefit) from being fed at school.	

SPECIAL DIETARY NEEDS MEDICAL STATEMENT

Student' s Name_____ **DOB**_____ **School**_____ **County**_____ **WVEIS#**_____

* Does this patient have a disability that affects her/his diet? Yes or No Diagnosis _____

*Does this patient have a non-disabling medical condition that affects his/her diet? Yes or No Diagnosis _____

Did you refer this patient's family to receive diet education? Yes or No

If yes, to whom: ☐**MD** ☐ **RN** ☐ **RD** ☐ **CDE** Name_____ Phone _____

Diet Information sent to: ☐**School Nurse** ☐ **School Cook** ☐**Child Nutrition Director** ☐**Principal** ☐**Other**

PLEASE MARK ONLY THE AREAS THAT APPLY:

Schools or sites may make substitutions for individuals with a non-disabling medical condition who are unable to consume the regular meal because of medical or other special dietary needs.

☐ FOOD ALLERGIES:

- _____
- _____
- _____
- _____

☐ SUBSTITUTIONS MUST BE LISTED

- _____
- _____
- _____

☐ CALORIC REQUIREMENTS: Please indicate the calories for each meal provided at school.

Daily Total	Breakfast	Lunch	Snack
1200	_____	_____	_____
1500	_____	_____	_____
1800	_____	_____	_____
2000	_____	_____	_____

☐ SODIUM RESTRICTION (Specify Milligrams):_____

☐ CARBOHYDRATE COUNTING (Specify Grams):

Breakfast _____ Lunch _____

☐ OTHER RESTRICTIONS:

- _____
- _____
- _____

☐ TEXTURE CONSISTENCIES for swallowing or chewing difficulties

SOLIDS	LIQUIDS
☐ Regular Chopped	☐ Regular Consistency
☐ Mechanical soft with ground meat	☐ Honey Consistency
☐ Mechanical soft with chopped meat	☐ Nectar Consistency
☐ Pureed	☐ Pudding Consistency

☐ NUTRITIONAL SUPPLEMENTS TO BE PROVIDED AT SCHOOL OR SITE **(for Breakfast and Lunch Only)**

Please specify amount and frequency of feeding

Oral Feedings/Tube Feedings_____ _____

*Additional Comments:_____

Disability

- If an individual with a disability requires a special diet, the United States Department of Agriculture requires a medical statement form completed and signed by a licensed physician: medical doctor (MD) or doctor of osteopathic medicine (DO). An updated medical statement must be provided annually or when any change is prescribed.

Non-Disabled Medical Condition

- If an individual has a medical condition requiring a special diet and is medically certified, the school food service **may** make substitutions to the regular diet on a case by case basis. A medical statement is required and must be completed by a medical doctor (MD), doctor of osteopathic medicine (DO), physician's assistant (PA), or nurse practitioner (ANP) and include substitutions to the regular menu. An updated medical statement must be provided annually or when any change is prescribed.

*** See Attached Definitions.**

Sign Here:_____ _____

Provider Name & Title (print) Parent/Guardian Name (print)

_____ _____

Signature/Date Signature/Date

_____ _____

Provider Phone Parent/Guardian Phone

Children with Disabilities and Special Dietary Needs

DEFINITIONS OF DISABILITY AND OF OTHER SPECIAL DIETARY NEEDS

Rehabilitation Act of 1973 and the ***Americans with Disabilities Act*** Under Section 504 of the *Rehabilitation Act of 1973*, and the *Americans with Disabilities Act* (ADA) of 1990, a "person with a disability" means any person who has a physical or mental impairment which substantially limits one or more life activities, has a record of such an impairment, or is regarded as having such an impairment. The term "physical or mental impairment" includes many diseases and conditions, a few of which may be:

Orthopedic, visual, speech, and hearing impairments;	Metabolic diseases, such as diabetes or phenylkentonuria (PKU)
Cerebral palsy;	Heart disease
Epilepsy;	Food anaphylaxis (severe food allergy)
Muscular dystrophy;	Mental retardation;
Multiple sclerosis	Emotional illness
Cancer	Drug addiction and alcoholism
Specific learning disabilities	HIV disease
Tuberculosis	

Please refer to the Acts noted above for a more detailed explanation. Major life activities covered by this definition include caring for one's self, eating, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

Individuals with Disabilities Education Act The term child with a "disability" under Part B of the Individuals with *Disabilities Education Act* (IDEA) means a child evaluated in accordance with IDEA as having one or more of the recognized thirteen disability categories and who, by reason thereof, needs special education and related services. IDEA recognizes thirteen disability categories which establish a child's need for special education and related services. These disabilities include:

Autism	Deaf-blindness
Deafness or other hearing impairments	Mental Retardation
Orthopedic impairments	Emotional disturbance
Specific learning disabilities	Speech or language impairment
Traumatic brain injury	Multiple disabilities
Other health impairments due to chronic or acute health problems, such as asthma, diabetes, nephritis, sickle cell anemia, a heart condition, epilepsy, rheumatic fever, hemophilia, leukemia, lead poisoning, tuberculosis	Visual impairment; including blindness , which adversely affects a child's educational performance.

Attention deficit disorder or attention deficit hyperactivity disorder may fall under one of the thirteen categories. Classification depends upon the particular characteristics associated with the disorder and how the condition manifests itself in the student, which determines the category. The Individualized Education Program or IEP means a written statement for a child with a disability that is developed, reviewed and revised in accordance with the IDEA and its implementing regulations. The IEP is the cornerstone of the student's educational program that contains the program of special education and related services to be provided to a child with a disability covered under the IDEA.

Physician's Statement for Children with Disabilities

USDA regulations 7 CFR Part 15b require substitutions or modifications in school meals for children whose disabilities restrict their diets. A child with a disability **must** be provided substitutions in foods when that need is supported by a statement signed by a licensed physician. The physician's statement must identify:

- The child's disability;
- An explanation of why the disability restricts the child's diet;
- The major life activity affected by the disability;
- The food or foods to be omitted from the child's diet, and the food or choice of foods that must be submitted.

Other Special Dietary Needs

The school food service **may** make food substitutions, at their discretion, for individual children who do not have a disability, but who are medically certified as having a special medical or dietary need. Such determinations are only made on a case-by-case basis. This provision covers those children who have food intolerances or allergies but do not have life-threatening reactions (anaphylactic reactions) when exposed to the food(s) to which they have problems.

Reference: Accommodating Children with Special Needs: Guidance for School Foods Service Staff, United States Department of Food and Nutrition Service, Fall 2001; http://www.fns.usda.gov/cnd/Guidance/default.htm
CP May 13, 2010

Release of Information for Specialist

The following child is a participant in one of the United Stated Department of Agriculture (USDA) programs: National School Lunch Program School Breakfast Program, After-school Snack Program, Summer Food Service Program or the Child and Adult Care Food Program. USDA regulations 7CFR Part 15B requires substitution or modifications in school/program meals for children whose disabilities restrict their diets. A child with a disability must be supplied substitutions in foods when that need is supported by a statement signed by a licensed physician. Food allergies which may result in severe, life-threatening (anaphylactic) reaction, also meet the definition of "disability", and the substitutions prescribed by the licensed physician/medical authority would be made.

Part 1: To be completed by Parent/Guardian

Child's Name:

Date of Birth: M F

Name of School/Center/Program:

Grade Level/Classroom:

Parent's/Guardian's Name:

([ ])
Home Phone

([ ])
Work Phone

Address

City, ST ZIP Code

In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Privacy Act I hereby authorize (*Physician's name)*

_____

_____

to release such protected health information of my child as is necessary for the specific purpose of Special Diet information to _____ (*Insert School/Program Name*) and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning my child, with the school program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for my child. I understand that permission to release this information may be rescinded at any time except when the information has already been released. My permission to release this information will expire on _____. (*Insert date)*

This information is to be released for the specific purpose of Special Diet information.

The undersigned certifies that he/she is the parent; guardian or representative of the person listed on this document and has the legal authority to sign on behalf of that person.

Parent/Guardian Name: Print:_____

Parent/Guardian Name: Signature:_____

Date:_____

5. ORAL HYGIENE

I. Guidelines: Oral hygiene of students is necessary to maintain the teeth, mouth, and gums in a healthy condition; to lessen offensive mouth odor by decreasing the bacterial count; to prevent inflammation and infection of the oral structures; to stimulate the appetite; and, to provide a sense of health and comfort.

A. Purpose: To provide training and supervision guidelines for the performance of safe oral hygiene of students.

B. Equipment: (Parent responsibility unless otherwise noted).
1. Student's own soft-bristled toothbrush or tooth sponge.
2. Toothpaste.
3. Towel (county).
4. Glass (county).
5. Empty basin (county).
6. Drinking straw (county).
7. Mirror (county).
8. Plastic-lined waste container (county).
9. Disposable medical gloves (county).

C. Personnel: All personnel.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Observe the student to determine the need for oral hygiene at school.	Review the student's health care plan and Individualized Education Program (IEP) as applicable.
B. Tell the student what you will be doing and how student can help.	Teach and encourage the student to do own care whenever possible. Use developmentally appropriate language. Student should have own toothbrush or tooth sponge, with an adaptive handle if needed.
C. Arrange for privacy.	Use a portable screen if possible.
D. Gather the equipment and supplies.	Arrange equipment on a clean work surface near the student.
E. Position the student appropriately.	An ambulatory or wheelchair student may go to the sink; a non-ambulatory student may sit

	in semi-Fowler's position (back and head raised to about a 70-degree angle to the cot's surface). A helpless student should be positioned on side.
F. Wash your hands; wash the student's hands. Put on gloves.	Refer to *Hand Washing, Gloves - Use and Removal,* and *Cleaning and Disposing of Body Fluids* procedures.
G. Drape the towel across the student's chest.	To protect clothing.
H. Place a mirror in front of the student.	To aid the student in performing the procedure.
I. Offer the student water to rinse mouth. Have student swish and expectorate.	Use a drinking straw, if needed. Student must expectorate into sink or basin.
J. Moisten the toothbrush; apply a small amount of toothpaste.	
K. Assist the student to systematically brush all surfaces of teeth. Place the toothbrush at an angle against the gum line; gently scrub by wiggling the brush in short, circular strokes on the surface of each tooth; use the end of the brush in the same manner on the inside of the front teeth; scrub the chewing surfaces. Give the student water from a cup to rinse the mouth. Hold the emesis basin under the student's chin and instruct him or her to expel the mouth secretions into the basin.	Refer to the health care plan for any specific instructions. A student with limited mobility benefits from an electric toothbrush with a small, soft brush and an adaptive handle. Offer tissues/napkins to allow the student to wipe his/her mouth and chin.
L. Discard used supplies in waste container. Clean and store reusable equipment.	Obtain a new toothbrush at least each 9 weeks. Refer to *Cleaning and Disposing of Body Fluids* procedure and *Gloves - Use and Removal* procedures.
M. Wash hands.	Refer to *Hand Washing* procedure.
N. Document procedure on the student's individual treatment record.	Record: 1. Date and time. 2. Pertinent information. 3. Signature of personnel performing procedure.

6. PEDICULOSIS DETECTION

I. Guidelines:

A. Purpose: To identify active cases of pediculosis as early as possible to prevent epidemics, to reduce absenteeism and to promote an optimal level of health in the school setting.

B. Equipment: (County responsibility unless otherwise noted).
1. Disposable screening tools (individualized to meet needs).
   - wooden sticks, tongue depressors, and/or Q-tips
   - gloves
   - magnifying glass
2. Work area with sufficient lighting for screening.
3. Hand disinfectant.

C. Personnel: Certified school nurse, other licensed healthcare provider such as an RN or LPN or designated trained school personnel under the direct or indirect supervision of the certified school nurse.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS - PRECAUTIONS
A. Screen in natural light (near window) or with magnification lamp.	Provides clearest visibility for easier identification.
B. Use disposable screening tools as needed.	This aids in separating the hair, increasing visibility and decreasing cross contamination.
C. Begin by separating hairs over ears, near the crown and back of neck. If no louse or nits are found, continue to examine all areas of the head.	Lice prefer areas of higher humidity and temperature. A louse is a tiny, six legged, visible insect. Color may vary from white to gray to brown.
D. Differentiate nits from psuedonits.	Nits are tiny oval shaped specks, whitish tan in color, cemented to the hair shaft close to the scalp. Psuedonits can be hair products; dandruff, hair casts or desquamated epithelial cells, which are easily removed by blowing, rubbing or brushing. Nits must be removed from hair shaft with fine tooth comb or fingernails.

E. If pediculosis is detected, follow the recommended guidelines of County Health Department and/or County Board of Education for management, treatment, and education.

7. SAFETY WHILE USING ASSISTIVE DEVICES

I. Guidelines: Assistive devices consist of, but are not limited to, cane, crutches, walker, wheelchair, and prosthetic limbs

A. Purpose: To plan for safety within the school environment by assessing the environment, schedule needs, and student capabilities, and identifying persons to assist the student in implementation of safety measures, and identifying adaptations to be made to enhance student safety.

B. Equipment: As prescribed by a health professional

C. Personnel: All teaching staff-professional and service, internal agencies providing services to student, Occupational Therapist, and Physical Therapist.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS/PRECAUTIONS
A. Identify essential personnel and plan a meeting prior to student's first day of class.	School, transportation, lunchroom, and any other personnel who will share responsibility for the student.
B. Environmental Concerns: 1. Target potential dangers in classroom, lunchroom, restroom, hallway traffic, outside travel related to schedule such as, but not limited to, external classrooms, Vo-Tech, etc. 2. Review class schedule to: a. make modifications adaptations for P.E., music, etc. b. plan for change of classes, regarding backpack, early dismissal from class, lunch tray assistance, etc.	Staff in specifically stated locations would identify areas of concern and develop a safety plan.
C. Transportation Concerns:	All personnel involved with student must be made aware of his/her need for modifications.

1. Prior to the first day of school, a plan will be in place that includes: a. Advance notification to transportation department describing type of modifications necessary for bus transport. b. When and where student will be picked up and dropped off. c. Who will be responsible for initiating and implementing plan.	Team members will include school administrator, transportation staff, teachers, bus drivers, bus aides, and other professional and service personnel as required.
D. Field Trips: Advance notice to school health and other services that provide care to the student at school.	At least 10 days advance notice should be provided to assure appropriate accommodations can be arranged so student may participate in the field trip activities.
E. Identify key school personnel responsible for dissemination of health information to the school nurse.	Building administrator should be aware of any changes or increased needs of the student and provide this information to the school nurse as soon as possible.
F. Student Behavior: 1. Observe student response to temporary or permanent changes in mobility. 2. Discuss with teachers, parents, and health care providers ways to assist the student through these changes.	Identification of positive or negative response to mobility change can help to reduce anxiety and problems for student and staff.
G. Staff training related to medical condition.	Provide plan of care and intervention guide to all staff enrolled with the care of the student. Schedule training as needed for staff providing medical interventions.
H. Documentation of Health Care Plan.	

8. SKIN CARE AND POSITIONING FOR PREVENTION OF PRESSURE AREAS

I. Guidelines: Consistent, practical measures for good skin care should be carried out for limited mobility students and/or students who wear braces or other orthopedic devices.

A. Purpose: To provide training and supervision guidelines for skin care and positioning to prevent skin breakdown caused by pressure that impairs circulation and poor skin hygiene.

B. Equipment: (Parent responsibility unless otherwise noted).
1. Braces or orthopedic devices.
2. Prescribed skin care products.
3. Pillow(s) and other positioning devices.
4. Soap and water (county).

C. Personnel: All personnel.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Determine the need for special skin care on an individualized basis.	If skin breakdown is already present, review the licensed prescriber's orders and the student's health care plan.
B. Inspect skin daily for signs of pressure (redness, swelling, heat, and irritation).	Pressure areas most often occur in skin over a bony prominence, in areas of frequent moisture, and areas where braces and other orthopedic devices rub. Report breaks in skin or continued discoloration to parent/guardian and school nurse for physicians follow-up.
C. Relieve pressure by:	
1. Changing student's position at least every 2 hours.	Change of position prevents prolonged pressure on skin. Refer to *Body Mechanics* procedure.
2. Assisting wheelchair student to shift weight every 15 minutes and being out of wheelchair 1 to 2 times daily.	Encourage use of gel-type flotation pad, fleeces, or water-filled seats in wheelchair.
3. Keeping clothing, linens, or cloth padding wrinkle-free.	Wrinkles cause pressure on the skin.

D. Maintain good skin hygiene:

1. Wash skin after toileting or when otherwise soiled, using mild soap and water, rinsing well, then blot dry with a soft towel. Moistened, disposable wipes can be used in place of soap and water.	Ascertain that the child has no allergy to the soap available. Parent must provide special soaps, lotions, and/or moistened, disposable wipes. Constant moisture, especially from toileting, causes excoriation of the skin.
2. Keep protective pads and clothing, including underwear, clean and dry. Moisture may be from toileting, perspiration, food and water spills, etc.	Moisture irritates the skin making it more susceptible to damage. Avoid plastic covered seats and pads, which do not allow evaporation of moisture from the skin.
3. Use care not to drag the student when moving and when providing and removing the bedpan.	Shearing forces are created by friction that pull and stretch tissue and injure blood vessels and tissue.
4. Encourage good nutrition and adequate fluid intake.	This is essential to skin health. The physician may order a high-protein, high-calorie diet with food supplements.
5. Check the folds of the body for signs of skin breakdown, i.e. under the breasts, between the folds of the buttocks, and between the thighs.	Heavy skin folds may result in friction where body parts rub together, and where moisture is trapped.
6. Provide for exercise, both passive and active, as prescribed or allowed by the students physician.	The physical therapist may need to be involved to direct a schedule or make suggestions to help the student reach his/her potential of movement. Exercise improves muscular, skin, and vascular tone.
7. Document observations and interventions to prevent pressure sores on the student's individual treatment record.	Record: 1. Date and time. 2. Observations, actions, and results. 3. Student's reaction to and participation in the procedure. 4. Signature of personnel performing procedure.
8. If there is evidence of infection, such as open ulcer with drainage or odor, student may need to be excluded from school.	

9. TOILETING

I. Guidelines: Some students may require assistance with bowel and bladder elimination during the school day. A bowel and/or bladder training program may be utilized for certain students. Toileting may require a bedpan, urinal and/or disposable diapers or briefs. The student may need an individualized program of elimination training.

A. Purpose: To provide training and supervision guidelines to provide care for students requiring assistance with toileting in the school setting.

B. Equipment: (Parent responsibility unless otherwise noted).

1. Bedpan and/or urinals.
2. Disposable diapers or briefs.
3. Disposable pre-moistened wipes.
4. Clean underwear, if indicated.
5. Disposable underpads.
6. Disposable medical gloves (county).
7. Changing mat or table with protective cover (county).
8. Equipment for hand washing (refer to *Hand Washing* procedure*)*.
9. Covered waste container with doubled plastic liner (county).
10. Approved germicidal solution (county).

C. Personnel: All personnel.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
a. BEDPAN	
A. Determine the need for the student to use a bedpan at school. Student should assist with procedure as physically capable.	Review physician's orders and student's health care plan.
B. Provide privacy for the student.	Privacy aids relaxation and assists evacuation of bowel and bladder.
C. Assemble the necessary equipment. Have the student wash hands, if	Encourage the student to assist as much as he/she is able.

assisting. Undress the student, as needed, maintaining privacy.

D. Wash hands and put on disposable gloves.

Refer to *Hand Washing* and *Gloves - Use and Removal* procedures.

E. Place student on changing table or mat in supine position.

1. Have student lie on back with knees flexed and rest his/her weight on the heels; if unable then turn student on side facing you.

Allow the student to assist with as much of the procedure as possible.

2. Place protector on the changing table or mat under student's hips.

3. If student is able to assist, place one of your hands under small of back. On signal, help student lift hips. Slip bedpan under hips with your other hand.

4. For the student unable to assist, place bedpan on buttocks and turn student on to bedpan.

Check to see that the bedpan is properly adjusted.

5. Raise the student to a sitting position, if allowed, with supports at back. Drape for privacy.

Sitting is a natural position for voiding and/or bowel elimination.

6. Put toilet paper where it can be reached by the student.

7. Leave the area to provide privacy, **unless the student should not be left alone**.

Do not leave the student on the bedpan any longer than is necessary.

8. If the student is unable to clean self, use the toilet tissue or warm, moist washcloth to clean. Place soiled tissue in the pan, unless collecting a specimen.

Wipe female students from front to back to avoid bringing fecal contaminants from the rectum to the vaginal/urethral area.

9. When the student is finished, ask the student to flex his/her knees and

Use disposable underpad to protect furniture from moisture and spills. Cover the bedpan

place your hand under the lower back to help lift hips so that the pan does not pull against skin. Remove the bedpan, cover and place on a protected surface. Hold the bedpan flat on the changing table or mat to avoid spilling the contents while rolling the student off of the bedpan.	with newspaper or a disposable bedpan cover.
10. Remove the disposable underpad and redress the student.	Refer to *Assisting with Clothing* procedure.
11. Allow the student to wash hands. Assist into a comfortable position.	Use a disposable, moistened wipes or warm, soapy washcloth if student cannot be brought to a sink. Rinse and dry hands.
12. Take the bedpan to the bathroom. Note the appearance of the urine and/or stool. Empty the contents into the toilet.	If the student is on recorded intake and output, measure the urine.
13. Clean the bedpan by rinsing and disinfecting with approved germicidal solution.	Refer to *Cleaning and Disposing of Body Fluids* procedure.
14. Cover the bedpan and store it appropriately.	
F. Remove gloves and wash hands.	Refer to *Gloves - Use and Removal* and *Hand Washing* procedures.
G. Document procedure on student's individual treatment record.	Record: 1. Date and time. 2. Description and amount of urine and/or stool, if needed. 3. Any problems and students response to this procedure. 4. Signature of personnel performing procedure.

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
b. URINAL	
A. Determine the need for the student to use a urinal at school.	Review the physician's orders and the student's health care plan.
B. Provide privacy for the student.	Privacy aids relaxation and assists emptying of the bladder.
C. Assemble the necessary equipment. Have the student wash hands. Undress the student as needed, maintaining privacy.	Encourage the student to assist as much as he is able.
D. Wash hands and put on gloves	Refer to *Hand Washing* and *Gloves - Use and Removal* procedures.
E. Place disposable underpad under penis and across thighs, if needed. Place urinal in position.	Assist the student if he is unable to do by himself.
F. If not already sitting, raise the student to a sitting position, if allowed, with supports at his back. Drape student for privacy.	Sitting is a natural position for voiding.
G. Leave the area to give the student privacy**, unless he/she should not be left alone.**	Do not leave the student with the urinal any longer than necessary.
H. Remove the urinal, cover and place on a protected surface.	Use disposable underpad to protect furniture from moisture and spills. Cover opening of urinal.
I. Note condition of student's skin and genitalia. Cleanse and provide skin care, if needed.	
J. Remove the disposable underpad and redress the student.	Refer to *Assisting with Clothing* procedure.
K. Allow the student to wash hands and help him to get into a comfortable position.	Use disposable, moistened wipes, if the student cannot be brought to a sink.

L. Take the urinal to the bathroom. Note the appearance of the urine. Empty the contents into the toilet.	If the student is on recorded intake and output, measure the urine. Refer to *Cleaning and Disposing Fluids* procedure.
M. Clean the urinal by rinsing and disinfecting with approved germicidal solution.	Refer to *Cleaning and Disposing of Body Fluids* procedure.
N. Cover urinal and store it appropriately.	
O. Remove gloves and wash hands.	Refer to *Gloves - Use and Removal* and *Hand Washing* procedures.
P. Document procedure on the student's individual treatment record.	Record: 1. Date and time. 2. Description and amount of urine, if needed. 3. Any problems and student's ability to perform this procedure. 4. Signature of personnel performing procedure.

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
c. USE OF DISPOSABLE DIAPERS/BRIEFS	
A. Place student on clean changing table or mat with protective covering. Privacy should be maintained.	Table or mat should have been cleaned with an approved germicidal solution. Never leave student unattended while on the changing table.
B. Wash hands and put on gloves.	Refer to *Hand Washing* and *Gloves - Use and Removal* procedures.
C. Remove soiled diaper and place in plastic bag.	Refer to *Cleaning and Disposal of Body Fluids* procedure. Disposable diaper/brief should be checked every 2 hours and changed as needed.
D. Cleanse perineum and buttocks thoroughly with disposable wipes. Use ointments and powders only when ordered by licensed prescriber and provided by a parent. Apply clean diaper or brief.	Always wash from front to back, especially with girls, to prevent vaginal and urinary infections.
E. Clean changing table or mat with germicidal solution.	This prevents cross-contamination to other children.
F. Remove gloves and wash hands.	Refer to *Gloves - Use and Removal* and *Hand Washing* procedures.
G. Note and report any abnormal conditions to school nurse and parent/guardian.	Blood or streaks of blood on diaper; watery, liquid stool; mucus or pus in stool; skin rashes/bruises, or breaks in skin; and unusually foul or strong odors.
H. Document procedure on student's individual treatment record.	Record: 1. Date and time. 2. Any pertinent information. 3. Signature of personnel performing procedure.

d. FEMININE HYGIENE

I. Guidelines: Female students with chronic health conditions or disabilities may be unable to perform proper cleaning and feminine hygiene practices after toileting. This procedure is intended to assist female students in preventing cross-contamination of body fluids, decreasing odor and reducing the incidence of infection.

A. Purpose: To provide training and supervision guidelines for assisting students with feminine hygiene in the school setting.

B. Equipment: (Parent responsibility unless otherwise noted).
1. Sanitary napkins.
2. Disposable, pre-moistened wipes.
3. Clean undergarments when indicated.
4. Disposable gloves (county).
5. Covered waste container with double plastic liner (county).

C. Personnel: All personnel.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Assure privacy.	
B. Wash hands and put on gloves.	Refer to *Hand Washing* and *Gloves - Use and Removal* procedures.
C. Undress student as needed and remove soiled sanitary pad. Place in plastic-lined waste container.	Refer to *Cleaning and Disposing of Body Fluids* procedure.
D. Cleanse perineum after bowel/bladder elimination with moistened disposable wipes.	Never use soap inside the labia. This causes irritation and may make the student more prone to infection.
E. Wipe from the vulva toward the anal area (front to back).	This prevents the transfer of fecal contaminants to the urethra or vagina.
F. Discard the used wipe after each cleansing stroke, in the plastic-lined, covered waste container.	

G. Apply clean sanitary napkin to clean undergarment and assist with redressing.	Pad should be changed at least every 4 hours, or as often as necessary to prevent odor and soiling of clothing. School nurse and student's parent/guardian should be made aware of excessive bleeding or any strange tissue, color or odor. Refer to *Assisting with Clothing* procedure.
H. Remove undergarments if soiled and rinse in cold water. Place wet garment(s) in plastic bag to be sent home.	Soiled undergarments will have a foul odor and will prevent the clean pad from adhering.
I. Remove gloves and wash hands.	Refer to *Gloves - Use and Removal* and *Hand Washing* procedures.
J. Document procedure on student's individual treatment record.	Record: 1. Date and time. 2. Any pertinent information. 3. Signature of personnel performing procedure.

B. MECHANICAL LIFT

I. Guidelines: The mechanical lift is a device that allows a student to be lifted and transferred safely with a minimum amount of physical effort.

A. Purpose: To provide training and supervision guidelines for the safe use of a mechanical lift.

B. Equipment: (Parent responsibility unless otherwise noted).
1. Mechanical lift.
2. Instruction manual for specific lift.

C. Personnel: Certified school nurse, physical therapist, occupational therapist, or designated trained school personnel under the direct or indirect supervision of the certified school nurse.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Assemble all necessary lift equipment and any supplies needed to perform procedure.	The lift is for transferring only. It is not a transporting device.
B. Inspect the mechanical lift before each use. 1. Check all bolts for tightness. 2. Make sure the boom and mast will not rotate. 3. Check that casters/wheels turn freely. 4. Check lift for braking mechanism.	
C. Follow manufacturer's instruction manual for transfer.	
D. Follow manufacturer's instruction manual for maintenance of equipment.	
E. Develop a plan for emergency use of mechanical lift.	Several school personnel need to be trained on use of the lift in the event of an emergency or untrained substitute personnel assigned to the student or classroom.

C. ORTHOPEDIC DEVICE

I. Guidelines: The orthopedic device provides support or stability to a limb, joint, or body segment as well as maintaining body alignment. The orthopedic device may need to be removed and reapplied as part of the student's routine day. The device should be used as prescribed by the physician.

A. Purpose: To provide training and supervision guidelines for the safe use of orthopedic devices in the school setting.

B. Equipment (Parent responsibility unless otherwise noted).
1. Orthopedic device prescribed for student.
2. Routine orthopedic furniture such as:
   a. Standing table.
   b. Wheelchair accessible table.
3. Stockinette, if indicated.

C. Personnel: Certified school nurse, other licensed health care providers such as a RN, LPN, physical therapist or occupational therapist, or designated trained school personnel under the direct or indirect supervision of the certified school nurse.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Removing the device:	
1. Loosen all the straps and attachments of the device.	
2. Lift the limb carefully out of the device.	Avoid scraping the skin with the device. If student can remove own device, supervise to ensure protection of the skin, especially in areas without sensation.
3. Inspect skin and observe for: a. Changes in skin color b. Redness c. Pain d. Stiffness e. Swelling	Refer to *Skin Care and Positioning for Prevention of Pressure Areas* procedure.

B. Report any changes to school nurse and parent/guardian.	
C. Reapply device:	
1. Make sure skin is clean and dry.	
2. Use stockinette or thin material between skin and device.	This material will absorb perspiration and allow the skin to breathe. Make sure the material is smooth without wrinkles or objects such as buttons.
3. Check that device is put on properly.	Physician's order will specify proper application. Improper fit may cause pressure areas.
4. Fasten straps securely.	May fasten lightly and go back to tighten into place.
D. Document procedure on student's individual treatment record.	Record: 1. Date and time. 2. Condition of skin. 3. Fit of device. 4. Signature of personnel performing procedure.
E. Major concerns:	
1. Observe for proper fit and report abnormal findings to school nurse and parent/guardian.	Proper fit decreases the possibility of pressure sores.
2. Encourage good hygiene.	Good hygiene aids in preventing skin breakdown.

D. PASSIVE RANGE OF MOTION EXERCISES

I. Guidelines: Passive Range of Motion exercises may be done as part of the student's routine day to increase and/or maintain flexibility and movement. Because there may be wide variation in student mobility, Range of Motion (ROM) exercises should be done as ordered by a licensed prescriber.

A. Purpose: To provide training and supervision guidelines for school personnel performing passive range of motion exercises to students.

B. Equipment: (County responsibility unless otherwise noted).

1. Table or mat as needed.
2. Disposable medical gloves (only if there is wound drainage or skin lesions).
3. Approved germicidal solution.

C. Personnel: Certified school nurse, other licensed health care providers such RN, LPN, physical therapist or occupational therapist, or designated trained school personnel under the direct or indirect supervision of the certified school nurse.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Review written orders from licensed prescriber.	Each student's ROM exercises will be individualized.
B. Explain procedure to student.	Use developmentally appropriate language and demonstration.
C. Position student in appropriate position.	Correct body alignment is important to prevent injury.
D. Support the extremity at the joint with one hand while moving the extremity smoothly, slowly and gently through its range of motion.	Watch student for any evidence of pain or discomfort. Motion should be stopped at the point of pain.
E. Avoid moving joint beyond free range of motion. Do not force movement.	Forcing movement may cause injury to joint.

F. Document procedure on student's individual treatment record.	Record: 1. Date and time. 2. Student's reaction to procedure. 3. Extremity or joint to which ROM was performed. 4. Signature of personnel performing procedure.

SECTION III

SPECIALIZED HEALTH CARE PROCEDURES

A. ENTERAL FEEDING (TUBE FEEDING)

1. ENTERAL FEEDING VIA GASTROSTOMY TUBE BOLUS METHOD

I. Guidelines: Enteral or tube feeding is the introduction of fluids, nutrients and/or medication directly into the stomach, duodenum or jejunum for the student with a functional gastrointestinal tract who is unable to swallow. A gastrostomy tube (G-tube) is a flexible catheter held in place by a balloon or a widened flat "mushroom" at the end of the tip of the tube inside the stomach. The tube remains in place at all times and is closed between feedings to prevent leakage of stomach contents. Bolus feedings are allowed to infuse by gravity and provide a specified amount of feeding solution via a syringe attached to the feeding tube.

A. Purpose: To provide training and supervision guidelines for the safe administration of enteral feedings via a G-tube (bolus method) in the school setting and during co-curricular events.

B. Equipment: (Parent responsibility unless otherwise noted).

1. Prescribed enteral feeding. (county if special diet).
2. 60 cc syringe with catheter tip.
3. Syringe bulb or plunger.
4. Catheter plug or clamp.
5. Suction machine, if ordered by physician.
6. Sterile dressing, if needed.
7. Tape.
8. Container for water.
9. Disposable medical gloves (county).
10. Stethoscope (county).

C. Personnel: Certified school nurse, other licensed health care provider such as a RN or LPN or designated, trained school personnel under the direct or indirect supervision of the certified school nurse. The student may perform this procedure independently if ordered by licensed prescriber.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain orders from licensed prescriber and written parent/guardian consent.	All specialized procedures performed in the school setting must have written orders and parent/guardian consent.
B. Elevate student's head to 30-45 degrees or assist to a sitting position. If a sitting position is contraindicated, a right side-lying position may be used.	Sitting position enhances the gravitational flow and helps prevent aspiration.
C. Ensure that prescribed feeding is at room temperature. Check expiration date. Check for thickening, lumps or separation.	Excessive heat coagulates feeding. Excessive cold can reduce flow of digestive enzymes and cause abdominal cramping. Texture changes may indicate contamination.
D. Wash hands and put on gloves.	Refer to *Hand Washing* and *Gloves - Use and Removal* procedures.
E. Check student for abdominal distention, belching, loose stools, flatus or pain.	May indicate intolerance to previous feeding.
F. Remove cap or plug from G-tube and insert a catheter-tipped syringe into the end of feeding tube.	
G. Check placement of feeding tube prior to initiating each feeding by unclamping the tubing and injecting10 cc of air into G-tube while listening with a stethoscope for a whooshing sound over the epigastric area of the abdomen.	Ensuring proper placement prior to each feeding prevents inadvertent administration of feeding outside the stomach. **NOTE: PROCEDURE MAY BE PERFORMED BY DESIGNATED TRAINED PERSONNEL UNDER THE DIRECT OR INDIRECT SUPERVISION OF THE CERTIFIED SCHOOL NURSE.**
H. Aspirate and measure residual feedings after confirming G-tube placement. Adjust the feeding volume according to orders if residual is present.	Aspirating and measuring residual feedings is done to evaluate the absorption of previous feedings. If the residual is greater than recommended, hold feeding, wait 30-45 minutes and recheck.
I. Re-instill the gastric contents into the stomach. Clamp or pinch tube.	Returning aspirated contents prevents fluid and electrolyte imbalance.

J. Disconnect the syringe. Remove bulb or plunger from the syringe and reconnect the syringe to a pinched or clamped G-tube.	Pinching or clamping the tube prevents excessive air from entering the stomach and helps prevent distention.
K. Unclamp tube and allow bubbles to escape. Add feeding to syringe barrel, allowing feeding to flow slowly. Continue to add feeding and keep solution in syringe at all times until feeding is completed. Pinch off tubing to stop the flow if the student experiences discomfort. Clamp tube and discontinue feeding if student should vomit during the feeding.	Administering the feeding rapidly can cause flatus, abdominal cramping and/or reflux vomiting. Raise or lower syringe to adjust flow as needed.
L. Instill prescribed amount of water after feeding is administered.	Instilling water after the feeding cleans the lumen of the tube and prevents occlusion.
M. Vent G-tube by opening G-tube to air if ordered.	Venting allows drainage of fluid or release of gas bubbles in the stomach.
N. Clamp tube, remove barrel of syringe and reinsert cap or plug into end of tubing.	
O. Care of the Student:	
1. Allow student to remain elevated for 30 minutes after feeding if possible.	Remaining in an elevated position helps prevent vomiting and/or aspiration if student should regurgitate.
2. Student may be positioned on right side for 30 minutes to 1 hour after feeding.	The right side-lying position facilitates emptying of the stomach contents into the small bowel.
3. Cleanse area around G-tube with soap and water unless otherwise ordered. Apply dry, sterile dressing if indicated and secure with tape.	Covering the insertion site with a dressing absorbs any discharge of gastric juices and prevents skin breakdown.
4. Make sure tubing is secure and tucked inside clothing, not inside diaper or underwear.	Tubing may be pinned or taped to shirt.

P. Wash all reusable equipment with warm soapy water after each feeding, rinse thoroughly and dry. Store in a clean area.	Prevents the accumulation of feeding and growth of bacteria.
Q. Remove gloves and wash hands.	Refer to *Gloves – Use and Removal and Hand Washing* procedures.
R. Document procedure on student's individual treatment record.	Record: 1. Date and time feeding was administered. 2. Type and amount of formula. 3. Amount of water given. 4. Amount of residual. 5. Student's response to procedure. 6. Any other pertinent information. 7. Signature of personnel performing procedure.

2. ENTERAL FEEDING VIA GASTROSTOMY TUBE SLOW DRIP AND/OR CONTINUOUS METHOD

I. Guidelines: Enteral or tube feeding is the introduction of fluids, nutrients and/or medication directly into the stomach, duodenum or jejunum for the student with a functional gastrointestinal tract who is unable to swallow. A gastrostomy tube (G-tube) is a flexible catheter held in place by a balloon or a widened flat "mushroom" at the end of the tip of the tube inside the stomach. The tube remains in place at all times and is closed between feedings to prevent leakage of stomach contents. Slow-drip and/or continuous feedings are infused by gravity or via an infusion pump.

A. Purpose: To provide training and supervision guidelines for the safe administration of enteral feedings via a G-tube (slow drip and/or continuous method) in the school setting and during co-curricular events.

B. Equipment: (Parent responsibility unless otherwise noted).

1. Prescribed enteral feeding (county if special diet).
2. 60 cc syringe with catheter tip (plunger type).
3. G-tube plug or clamp.
4. Suction machine, if ordered by physician.
5. Administration set with pump, if ordered.
6. Manufacturer's instruction booklet for pump and suction equipment.
7. Sterile dressing, if needed.
8. Tape.
9. Container for water. .
10. Stethoscope (county).
11. Disposable medical gloves (county).

C. Personnel: Certified school nurse, other licensed health care provider such as a RN or LPN or designated, trained school personnel under the direct or indirect supervision of the certified school nurse. The student may perform this procedure independently if ordered by licensed prescriber.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain written orders from licensed prescriber and parent/guardian written consent.	All specialized procedures performed in the school setting must have written orders and parent/guardian written consent.
B. Elevate student's head to 30-45 degrees or assist to a sitting position. If a sitting position is contraindicated, a right side-lying position may be used.	Sitting position enhances the gravitational flow and helps prevent aspiration.
C. Ensure that prescribed feeding is at room temperature. Check expiration date. Check for thickening, lumps or separation.	Excessive heat coagulates feeding. Excessive cold can reduce flow of digestive enzymes and cause abdominal cramping. Texture changes may indicate contamination.
D. Wash hands and put on gloves.	Refer to *Hand Washing* and *Gloves - Use and Removal* procedures.
E. Check student for abdominal distention, belching, loose stools, flatus or pain.	May indicate intolerance to previous feeding.
F. Remove cap or plug from G-tube and insert a catheter-tipped syringe into the end of feeding tube.	
G. Check placement of feeding tube prior to initiating each feeding by unclamping the tubing and injecting10 cc of air into G-tube while listening with a stethoscope for a whooshing sound over the epigastric area of the abdomen.	Ensuring proper placement prior to each feeding prevents inadvertent administration of feeding outside the stomach. **NOTE: PROCEDURE MAY BE PERFORMED BY DESIGNATED TRAINED PERSONNEL UNDER THE DIRECT OR INDIRECT SUPERVISION OF THE CERTIFIED SCHOOL NURSE.**
H. Aspirate and measure residual feedings after confirming placement. Adjust the feeding volume according to orders if residual is present.	Aspirating and measuring residual feedings is done to evaluate the absorption of previous feedings. If the residual is greater than recommended, hold feeding, wait 30-45 minutes and recheck.
I. Re-instill the gastric contents into the stomach. Clamp or pinch tube.	Returning aspirated contents prevents fluid and electrolyte imbalance.

J. Clamp the G-tube and disconnect the syringe.

K. Administration of feeding:

1. Remove hanger from hook or standard.

2. Place bottle/bag with prescribed formula in hanger and attach administration set, making sure tubing is clamped.

3. Hang bottle/bag on hook or standard.

4. Open clamp on administration set tube and prime tube by allowing fluid to fill tubing before attaching to G- tube. Prime tubing according to manufacturer's instructions if using pump.

   Clearing the tubing of air by priming with feeding prevents excessive amounts of air from being instilled into stomach before feeding.

5. Attach tubing to G-tube and tape securely. Unclamp G-tube. Open clamp of feeding container tubing and regulate fluid drip to approximately 60 drops per minute, unless otherwise ordered, or set pump according to manufacturer's instructions.

   Regulating the flow will help prevent discomfort. Administering the feeding rapidly can cause flatus, abdominal cramping and/or reflux vomiting.

6. Check student frequently. Pinch off tubing to stop the flow if the student experiences discomfort. Clamp tubes and discontinue feeding if student should vomit during the feeding.

L. Clamp G-tube and feeding container tubing and disconnect.

M. Insert syringe into G-tube, unclamp and instill prescribed amount of water after feeding is administered.

   Cleans the lumen of the tube and prevents occlusion.

N. Vent G-tube by opening G-tube to air if ordered.	Venting allows drainage of fluid or release of gas bubbles in the stomach.
O. Care of the Student:	
1. Allow student to remain elevated for 30 minutes after feeding if possible.	Remaining in an elevated position helps prevent vomiting and/or aspiration if student should regurgitate.
2. Student may be positioned on right side for 30 minutes to 1 hour after feeding.	The right side-lying position facilitates emptying of the stomach contents into the small bowel.
3. Cleanse area around G-tube with soap and water, unless otherwise ordered. Apply dry, sterile dressing if indicated.	Covering the insertion site with a dressing absorbs any discharge of gastric juices and prevents skin breakdown.
4. Make sure tubing is secure and tucked inside clothing, not inside diaper or underwear.	Tubing may be pinned or taped to shirt.
P. Wash all reusable equipment with warm soapy water after each feeding, rinse thoroughly and dry. Store in a clean area.	Prevents the accumulation of feeding and growth of bacteria.
Q. Remove gloves and wash hands.	Refer to *Gloves – Use and Removal* and *Hand Washing* procedures.
R. Document procedure on student's individual treatment record.	Record: 1. Date and time feeding was administered. 2. Type and amount of formula. 3. Amount of water given. 4. Amount of residual. 5. Student's response to procedure. 6. Any other pertinent information. 7. Signature of personnel performing procedure.

3. ENTERAL FEEDING VIA GASTROSTOMY BUTTON BOLUS METHOD

I. Guidelines: Enteral or tube feeding is the introduction of fluids, nutrients, and/or medication directly into the stomach, duodenum or jejunum for the student with a functional gastrointestinal tract who is unable to swallow. A gastrostomy is a surgical opening into the stomach through the surface of the abdomen. A gastrostomy button is a skin-level, "T"- shaped plastic device held in place by a mushroom-shaped dome or fluid filled balloon inside the stomach. The device remains in place at all times and is capped between feedings by an attached safety plug. In addition, the dome has an anti-reflux valve to further prevent leakage of stomach contents. A feeding is administered by inserting a small tube into the device. When the feeding is complete, the tube is removed and the safety plug is closed. Bolus feedings are allowed to infuse by gravity and provide a specified amount of feeding solution via a syringe attached to the feeding tube.

A. Purpose: To provide training and supervision guidelines for the safe administration of enteral feedings via a gastrostomy button (bolus method) in the school setting and during co-curricular events.

B. Equipment: (Parent responsibility unless otherwise noted)

1. Prescribed enteral feeding at room temperature (county if special diet).
2. 60 cc syringe with catheter tip (bulb or plunger type).
3. Adapter with tubing and clamp.
4. Sterile dressing, if indicated.
5. Tape or adhesive dressing.
6. Container for water.
7. Stethoscope (county).
8. Disposable medical gloves (county).

C. Personnel: Certified school nurse, other licensed health care provider such as a RN or LPN or designated trained school personnel under direct or indirect supervision of the certified school nurse. The student may perform this procedure independently if ordered by licensed prescriber.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain written orders from licensed prescriber and parent/guardian written consent.	All specialized procedures performed in the school setting must have written orders and parent/guardian written consent.
B. Elevate student's head to 30-45 degrees or assist to a sitting position. If sitting position is contraindicated, a right side-lying position may be used.	Sitting position enhances the gravitational flow and helps prevent aspiration.
C. Ensure that prescribed feeding is at room temperature. Check expiration date. Check for thickening, lumps or separation.	Excessive heat coagulates feeding. Excessive cold can reduce flow of digestive enzymes and cause abdominal cramping. Texture changes may indicate contamination.
D. Wash hands and put on gloves.	Refer to *Hand Washing* and *Gloves - Use and Removal* procedures.
E. Check student for abdominal distention, belching, loose stools, flatus or pain.	Distended abdomen could indicate intolerance to previous feeding.
F. Observe for leakage around button.	Notify certified school nurse if leakage exists for further instructions.
G. Attach adapter with tubing to syringe, keeping tube clamped.	
H. Open safety plug and insert adapter into the button, keeping the tube clamped. Unclamp and aspirate immediately, if ordered. If aspiration is not required, move to step J.	**Aspirating and measuring residual feedings is not generally required or recommended.** It may be done to evaluate the absorption of previous feedings. Consult with licensed prescriber for verification of preference. If the residual is greater than recommended, hold feeding, wait 30-45 minutes and recheck.
I. Re-instill the gastric contents into the stomach. Clamp or pinch tube.	Prevents fluid and electrolyte imbalance.
J. Remove bulb or plunger from syringe and fill syringe with feeding solution, keeping tubing clamped.	Pinching or clamping the tube prevents excessive air from entering the stomach and helps prevent distention.
K. Unclamp tubing, allowing feeding to flow slowly. Continue adding feeding	Hold syringe 3-10 inches above the stomach level. Raise or lower syringe to adjust flow as

to syringe, keeping syringe partially filled at all times until feeding is complete.	needed. Administering the feeding rapidly can cause flatus, abdominal cramping and/or reflux vomiting.
Pinch off tubing to stop the flow if the student experiences discomfort. Clamp tubing and discontinue feeding if student should vomit during the feeding.	Clamp immediately if tubing pops out, then reinsert, estimating the amount of feeding lost.
L. Flush with prescribed amount of water after feeding is administered.	Instilling water after the feeding cleans the lumen of the tube and prevents occlusion.
M. Lower syringe below the stomach level to facilitate burping.	Venting allows drainage of fluid or release of gas bubbles in the stomach.
N. Remove adapter and feeding catheter. Snap safety plug in to place.	Capping with anti-reflux valve prevents formula from returning.
O. Care of the Student:	
1. Allow student to remain elevated for 30 minutes after feeding if possible.	Remaining in an elevated position helps prevent vomiting and/or aspiration if student should regurgitate.
2. Cleanse area around gastrostomy button with soap and water unless otherwise ordered. Apply dry, sterile dressing if indicated. Secure with tape or adhesive dressing as ordered.	Covering the insertion site with a dressing absorbs any discharge of gastric juices and prevents skin breakdown.
P. Wash all equipment with warm soapy water after each feeding, rinse thoroughly and dry. Store in a clean place.	Prevents the accumulation of feeding and growth of bacteria.
Q. Remove gloves and wash hands.	Refer to *Gloves – Use and Removal* and *Hand Washing* procedures.
R. Document procedure on student's individual treatment record.	Record: 1. Date and time feeding was administered. 2. Type and amount of formula. 3. Amount of water given. 4. Amount of residual. 5. Student's response to procedure. 6. Any other pertinent information. 7. Signature of personnel performing procedure.

4. ENTERAL FEEDING VIA GASTROSTOMY BUTTON SLOW DRIP AND/OR CONTINUOUS METHOD

1. Guidelines: Enteral or tube feeding is the introduction of fluids, nutrients, and/or medication directly into the stomach, duodenum or jejunum for the student with a functional gastrointestinal tract who is unable to swallow. A gastrostomy is a surgical opening into the stomach through the surface of the abdomen. A gastrostomy button is a skin-level, "T"-shaped plastic device held in place by a mushroom-shaped dome or fluid-filled balloon inside the stomach. The device remains in place at all times and is capped between feedings by an attached safety plug. In addition, the dome has an anti-reflux valve to further prevent leakage of stomach contents. A feeding is administered by inserting a small tube into the device. When the feeding is complete, the tube is removed and the safety plug is closed. Slow-drip and/or continuous feedings are allowed to infuse by gravity or via a feeding pump and provide a specified amount of feeding solution.

A. Purpose: To provide training and supervision guidelines for the safe administration of enteral feedings via a gastrostomy button (slow drip and/or continuous) in the school setting and during co-curricular events.

B. Equipment: (Parent responsibility unless otherwise noted).
   1. Prescribed enteral feeding (county if special diet).
   2. 60 cc syringe with catheter tip (bulb or plunger type).
   3. Adapter with tubing and clamp.
   4. Administration set with pump, if ordered.
   5. Manufacturer's instruction booklet for pump.
   6. Container for water.
   7. IV pole or standard for holding container (county).
   8. Stethoscope (county).
   9. Disposable medical gloves (county).

C. Personnel: Certified school nurse, licensed health care provider such as a RN or LPN or designated, trained school personnel under the direct or indirect supervision of the certified school nurse. The student may perform this procedure independently if ordered by licensed prescriber.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain orders from licensed prescriber and written parent/guardian consent.	All specialized procedures performed in the school setting must have written orders and parent/guardian consent.
B. Elevate student's head to 30-45 degrees or assist to a sitting position. If sitting position is contraindicated, a right side-lying position may be used.	Sitting position enhances the gravitational flow and helps prevent aspiration.
C. Ensure that prescribed feeding is at room temperature. Check expiration date. Check for thickening, lumps or separation.	Excessive heat coagulates feeding. Excessive cold can reduce flow of digestive enzymes and cause abdominal cramping. Texture changes may indicate contamination.
D. Wash hands and put on gloves.	Refer to *Hand Washing* and *Gloves - Use and Removal* procedures.
E. Check student for abdominal distention, belching, loose stools, flatus or pain.	May indicate intolerance to previous feeding.
F. Observe for leakage around button.	Notify certified school nurse if leakage exists for further instructions.
G. Attach adapter with tubing to syringe, keeping tubing clamped.	
H. Open safety plug and insert adapter into the button, keeping the tube clamped. Unclamp and aspirate immediately, if ordered. If aspiration is not required move to step J.	**Aspirating and measuring residual feedings is not generally required or recommended.** It may be done to evaluate the absorption of previous feedings. Consult with licensed prescriber for verification of preference. If the residual is greater than recommended, hold feeding, wait 30-45 minutes and recheck.
I. Re-instill the gastric contents into the stomach. Clamp or pinch tube.	Prevents fluid and electrolyte imbalance.
J. Attach adapter and tubing to administration set, keeping tube clamped.	Pinching or clamping the tube prevents excessive air from entering the stomach and helps prevent distention.

K. Administration of feeding:

1. Remove hanger from hook or standard.

2. Place bottle/bag with prescribed formula in hanger and attach administration set making sure tubing is clamped.

3. Hang bottle/bag on hook or standard at height required to achieve prescribed flow. Open clamp on administration set and prime tubing by allowing fluid to fill tubing and then re-clamping tubing. If a feeding pump is used, place tubing into pump mechanism and set for proper flow rate. Prime according to manufacturer's instructions.

   Clearing the tube of air by priming with feeding prevents excessive amounts of air from being instilled into stomach before feeding.

4. Open the safety plug and insert the adapter into the button. Unclamp tubing and administer at prescribed rate. Pinch off tubing or turn off pump to stop the flow if the student experiences discomfort. Clamp tubing and discontinue feeding if student should vomit during the feeding.

   Administering the feeding rapidly can cause flatus, abdominal cramping and/or reflux vomiting.

   Clamp immediately if feeding catheter pops out, then reinsert, estimating the amount of feeding lost.

L. Flush with prescribed amount of water after feeding is administered.

   Cleans the lumen of the tube and prevents occlusion.

M. Lower feeding bottle or bag below the stomach level to facilitate burping.

   Venting allows drainage of fluid or release of gas bubbles in the stomach.

N. Remove adapter from button. Snap safety plug into place.

   Capping with anti-reflux valve prevents formula from returning.

O. Care of the Student:

1. Allow student to remain elevated for 30 minutes after feeding if possible.

   Remaining in an elevated position helps prevent vomiting and/or aspiration if student should regurgitate.

2. Cleanse area around gastrostomy button with soap and water unless otherwise ordered.

3. Apply dry, sterile dressing if indicated. Secure with tape or adhesive dressing as ordered.

Covering the insertion site with a dressing absorbs any discharge of gastric juices and prevents skin breakdown.

P. Wash all equipment with warm soapy water after each feeding and rinse thoroughly and dry. Store in a clean area.

Prevents the accumulation of feeding and growth of bacteria.

Q. Remove gloves and wash hands.

Refer to *Gloves – Use and Removal* and *Hand Washing* procedures.

R. Document procedure on student's individual treatment record.

Record:

1. Date and time feeding was administered.
2. Type and amount of formula.
3. Amount of water given.
4. Amount of residual.
5. Student's response to procedure.
6. Any other pertinent information.
7. Signature of personnel performing procedure.

5. ENTERAL FEEDINGS VIA NASOGASTRIC TUBE BOLUS METHOD

I. Guidelines: Enteral or tube feeding is the introduction of fluids, nutrients and/or medication directly into the stomach, duodenum or jejunum for the student with a functional gastrointestinal tract who is unable to swallow. A nasogastric (NG) tube is passed through the nose or mouth into the stomach and secured in place. Bolus feedings are allowed to infuse by gravity and provide a specified amount of feeding solution via a syringe attached to the feeding tube.

A. Purpose: To provide training and supervision guidelines for the safe administration of enteral feedings via a nasogastric tube (bolus method) in the school setting and during co-curricular events.

B. Equipment: (Parent responsibility unless otherwise noted).
1. Prescribed enteral feeding (county if special diet).
2. 60 cc syringe with catheter tip (bulb or plunger type).
3. Catheter plug or clamp.
4. Suction machine and equipment, if ordered.
5. Container for water.
6. Stethoscope (county).
7. Disposable medical gloves (county).

C. Personnel: Certified school nurse, licensed health care provider such as a RN or LPN or designated, trained school personnel under the direct or indirect supervision of the certified school nurse. NASOGASTRIC TUBE PLACEMENT MAY BE CHECKED BY RN OR LPN ONLY.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain written orders from licensed prescriber and parent/guardian written consent.	All specialized procedures performed in the school setting must have written orders and parent/guardian consent.
B. Elevate student's head to 30-45 degrees or assist to sitting position. If sitting position is contraindicated, a right side-lying position may be used.	Sitting position enhances the gravitational flow and helps prevent aspiration.
C. Ensure that prescribed feeding is at room temperature. Check expiration	Excessive heat coagulates feeding. Excessive cold can reduce flow of digestive enzymes

date. Check for thickening, lumps or separation.	and cause abdominal cramping. Texture changes may indicate contamination.
D. Wash hands and put on gloves.	Refer to *Hand Washing* and *Gloves - Use and Removal* procedures.
E. Check student for abdominal distention, belching, loose stools, flatus, or pain.	May indicate intolerance to previous feeding.
F. Check placement of feeding tube prior to initiating each feeding:	Ensuring proper placement prior to each feeding prevents inadvertent administration of feeding into lungs and avoids aspiration.
1. Insert tip of syringe into nasogastric tube.	**NOTE: ONLY AN RN OR LPN CAN DETERMINE NG TUBE PLACEMENT. PLACING THE END OF THE TUBE INTO A GLASS OF WATER IS NOT CURRENT RECOMMENDED PRACTICE.**
2. Inject 10 cc of air into NG tube while listening with a stethoscope for a whooshing sound over the epigastric area of the abdomen.	
G. Aspirate and measure residual feedings after confirming tube placement. Adjust the feeding volume according to orders if a residual is present.	Aspirating and measuring residual feedings is done to evaluate the absorption of previous feedings. If the residual is greater than recommended, hold feeding, wait 30-45 minutes and recheck.
H. Re-instill the gastric contents into the stomach. Clamp or pinch tube.	Prevents fluid and electrolyte imbalance.
I. Remove bulb or plunger from syringe.	
J. Add feeding to syringe barrel and unclamp tube, allowing feeding to flow slowly. Continue to add feeding, keeping solution in syringe at all times until feeding is complete. Pinch off tubing to stop the flow if the student experiences discomfort. Clamp tube and discontinue feeding if student should vomit during feeding.	Administering feeding rapidly can cause flatus, abdominal cramping and/or reflux vomiting. Raise or lower syringe to adjust the flow as needed.
K. Instill prescribed amount of water after feeding is administered.	Cleans the lumen of the tube and prevents occlusion.
L. Clamp tube and remove syringe.	Clamping the tube prevents reflux and instillation of air into stomach.

M. Care of the student:

Post-Feeding care:

1. Allow student to remain elevated for 30 minutes after feeding if possible.	Remaining in an elevated position helps prevent vomiting and/or aspiration if student should regurgitate.

Daily care:

1. Perform oral hygiene.	Prevents accumulation of secretions and dryness. Refer to *Oral Hygiene* procedure.
2. Clean and lubricate nostrils as needed (at least daily).	Prevents irritation of nasal mucosa.
3. Ensure that tubing is securely in place.	Prevents accidental removal and discomfort.
N. Remove gloves and wash hands.	Refer to *Gloves - Use and Removal* and *Hand Washing* procedures.
O. Wash all equipment with warm soapy water after each feeding, rinse thoroughly and dry. Store in a clean area.	Prevents the accumulation of feeding and growth of bacteria.
P. Document procedure on student's individual treatment record.	Record: 1. Date and time feeding was administered. 2. Type and amount of formula. 3. Amount of water given. 4. Amount of residual. 5. Student's response to procedure. 6. Any other pertinent information. 7. Signature of personnel performing procedure.

6. ENTERAL FEEDINGS VIA NASOGASTRIC TUBE SLOW DRIP AND/OR CONTINUOUS FEEDING

I. Guidelines: Enteral or tube feeding is the introduction of fluids, nutrients and/or medication directly into the stomach, duodenum or jejunum for the student with a functional gastrointestinal tract who is unable to swallow. A nasogastric (NG) tube is passed through the nose or mouth into the stomach and secured in place. Continuous feedings are infused by gravity or via an infusion pump.

A. Purpose: To provide training and supervision guidelines for the safe administration of enteral feedings via a NG tube (slow drip and/or continuous) in the school setting and during co-curricular events.

B. Equipment: (Parent responsibility unless otherwise noted)

1. Prescribed enteral feeding (county if special diet).
2. 60 cc syringe with catheter tip (bulb or plunger type).
3. Catheter plug or clamp.
4. Suction machine and equipment, if ordered.
5. Administration set with pump, if ordered.
6. Manufacturer's instruction booklets for pump and suction equipment.
7. IV pole or standard for holding container (county)
8. Container for water.
9. Stethoscope (county).
10. Disposable medical gloves (county).

C. Personnel: Certified school nurse, licensed health care provider such as a RN or LPN or designated trained school personnel under the direct or indirect supervision of the certified school nurse. **NASOGASTRIC TUBE PLACEMENT MAY BE CHECKED BY RN OR LPN ONLY.**

II. Procedure:

ESSENTIAL STEPS	KEYPOINT-PRECAUTIONS
A. Obtain written orders from licensed prescriber and parent/guardian written consent.	All specialized procedures performed in the school setting must have written orders and parent/guardian written consent.
B. Elevate student's head to 30-45 degrees or assist to sitting position.	Sitting position enhances the gravitational flow and helps prevent aspiration into the lungs.
C. Ensure that prescribed feeding is at room temperature. Check expiration date. Check for thickening, lumps or separation.	Excessive heat coagulates feeding. Excessive cold can reduce flow of digestive enzymes and cause abdominal cramping. Texture changes may indicate contamination.
D. Wash hands and put on gloves.	Refer to *Hand Washing* and *Gloves - Use and Removal* procedures.
E. Check student for abdominal distention, belching, loose stools, flatus, or pain.	May indicate intolerance to previous feeding.
F. Check placement of feeding tube prior to initiating each feeding: 1. Insert tip of syringe into nasogastric tube. 2. Inject 10 cc of air into NG tube while listening with a stethoscope for a whooshing sound over the epigastric area of the abdomen.	Ensuring proper placement prior to each feeding prevents inadvertent administration of feeding into lungs and avoids aspiration. **NOTE: ONLY A RN OR LPN CAN DETERMINE NG TUBE PLACEMENT. PLACING THE END OF THE TUBE INTO A GLASS OF WATER IS NOT CURRENT RECOMMENDED PRACTICE.**
G. Aspirate and measure residual feedings after confirming tube placement. Adjust the feeding volume according to orders if a residual is present.	Aspirating and measuring residual feedings is done to evaluate the absorption of previous feedings. Hold the feeding if the residual is greater than recommended, wait 30-45 minutes and recheck.
H. Re-instill the gastric contents into the stomach. Clamp or pinch tube.	Prevents fluid and electrolyte imbalance.
I. Administration of feeding: 1. Remove hanger from hook or standard.	

2. Place bottle/bag with prescribed formula in hanger and attach administration set, making sure tubing is clamped.

3. Hang bottle/bag on hook or standard.

4. Open clamp on formula tube and prime tube by allowing fluid to fill tubing before attaching to NG tube. Prime tubing according to manufacturer's instructions if using a pump.

   Clearing tubing of air by priming with feeding prevents excessive amounts of air from being instilled into stomach before feeding.

5. Attach formula tube to NG tube, open clamp, and regulate fluid drip to approximately 60 drops per minute, unless otherwise ordered, or set pump according to manufacturer's instructions.

6. Check student frequently. Pinch off tubing to stop the flow if the student experiences discomfort. Clamp tube and discontinue feeding if student should vomit during feeding.

   Regulating the flow will help prevent regurgitation, vomiting, and/or diarrhea.

J. Insert syringe into NG tube and instill prescribed amount of water after feeding is administered.

   Cleans the lumen of the tube and prevents occlusion.

K. Allow some of the water to remain within NG tube and clamp or plug tubing.

   Prevents air from being introduced into the stomach at the next feeding.

L. Care of the student:

Post-Feeding care:

1. Allow student to remain elevated for 30 minutes after feeding if possible.

   Remaining in an elevated position helps prevent vomiting and/or aspiration if student should regurgitate.

Daily care:

1. Perform oral hygiene. — Prevents accumulation of secretions and dryness. Refer to *Oral Hygiene* procedure.
2. Clean and lubricate nostrils as needed (at least daily). — Prevents irritation of nasal mucosa.
3. Ensure that tubing is securely in place. — Prevents accidental removal and discomfort.

M. Remove gloves and wash hands. — Refer to *Gloves-Use and Removal* and *Hand Washing* procedures.

N. Wash all equipment with warm soapy water after each feeding, rinse thoroughly and dry. Store in a clean place. — Prevents the accumulation of feeding and growth of bacteria.

O. Remove gloves and wash hands. — Refer to *Gloves – Use and Removal* and *Hand Washing* procedures.

P. Document procedure on student's individual treatment record. — Record:

1. Date and time feeding was administered.
2. Type and amount of formula.
3. Amount of water given.
4. Amount of residual.
5. Student's response to procedure.
6. Any other pertinent information.
7. Signature of personnel performing procedure.

7. INSERTING A NASOGASTRIC TUBE

I. Guidelines: The nasogastric (NG) tube is used for the introduction of fluids, nutrients and/or medications directly into the stomach for the student who cannot be fed orally, but whose gastrointestinal tract is functional. A NG tube is passed through the nose or mouth into the stomach and secured in place. Only a RN or LPN can reinsert a NG tube in the school setting with orders from a licensed prescriber.

A. Purpose: To provide training and supervision guidelines for the insertion of a nasogastric tube in the school setting and during co-curricular events.

B. Equipment: (Parent responsibility unless otherwise noted).

1. Nasogastric tube.
2. Water-soluble lubricant.
3. Clamp for tubing.
4. Suction machine, if ordered.
5. 20 ml syringe.
6. Adhesive tape, hypoallergenic tape ½ and 1 inch (county).
7. Straw (county).
8. Towel and emesis basin (county).
9. Disposable cup for water (county).
10. Waste container with plastic liners (county).
11. Disposable medical gloves (county).

C. Personnel: Certified school nurse or other licensed health care provider such as a RN or LPN under the direct or indirect supervision of the certified school nurse.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain written orders from licensed prescriber and written parent/guardian consent.	All specialized procedures performed in the school setting must have written orders from a licensed prescriber and parent/guardian consent.
B. Explain procedure to student.	Use developmentally appropriate language and demonstration. Determine with the student which sign might be used (i.e., raising the finger) to indicate a need for a pause due to gagging or discomfort.
C. Assemble equipment.	

D. Wash hands and put on gloves.	Refer to *Hand Washing* and *Gloves – Use and Removal* procedures.
E. Position student in a sitting or high Fowler's position with neck slightly flexed. Place a towel across chest.	Sitting with neck flexed facilitates passage of tube into esophagus.
F. Inspect nostrils with open light, observing for obstruction, occlude each nostril and have student breathe to determine which nostril is most patent.	
G. Inspect tube for defects such as holes or rough edges.	
H. Mark the distance tube is to be passed by measuring from the earlobe to the bridge of the nose then add the distance from the bridge of the nose to the bottom of the xiphoid process and mark with tape.	Provides for correct position of tube
I. Coil the first 3-4 inches of tube around fingers.	Curving tubing facilitates tube passage.
J. Lubricate about 6-8 inches (15-20 cm) of tube with water-soluble jelly.	Lubrication reduces friction between mucous membranes and tube.
K. Tilt student's head slightly backward before inserting tube into a nostril. Pass tube gently into the posterior nasopharynx, aiming downward and backward.	Passing of the tube is facilitated by following the natural contour of the body.
L. Allow student to rest for a few moments. When tube reaches the pharynx, student may gag.	Gag reflex is triggered by the presence of the tube.
M. Tilt head slightly forward and offer several sips of water through a straw. Advance tube as student swallows.	Flexing the neck facilitates swallowing by occluding airway so tube is less likely to pass into trachea.
N. Continue advancing tube gently each time student swallows.	Mouth breathing and swallowing facilitates passage of tube.

O. Stop advancing tube if obstruction appears to prevent tube from passing. DO NOT FORCE. Rotate the tube gently. If unsuccessful, remove tube and try other nostril.

P. Advance the tube when student swallows until the tape mark reaches the student's nostril.

Q. Remove tube immediately if there are signs of distress (i.e., gasping, coughing, or cyanosis).

Refer to *Enteral Feeding-Nasogastric Tube-Bolus Method* procedure.

R. Check the placement of NG tube by:

1. Ask student to talk.

If student cannot talk, NG tube may be coiled in back of throat.

2. Insert tip of syringe into the end of the NG tube.

3. Inject 10 cc of air while listening for whooshing sound over the left upper quadrant of the abdomen.

Placing the end of the tube into a glass of water is not current recommended practice.

Clamp the tube after correct placement is confirmed.

S. Secure NG tube with tape on bridge of student's nose.

Do not tape with pressure on nares to prevent airway obstruction.

T. Secure NG tube to clothing with rubber band or tape and safety pin.

Securing to clothing prevents accidental removal.

U. Discard disposable equipment.

Refer to *Cleaning and Disposing of Body Fluids* procedure.

V. Remove gloves and wash hands.

Refer to and *Gloves-Use and Removal* and *Hand Washing* procedures.

W. Document procedure on student's individual treatment record.

Record:

1. Date and time.
2. Method used for verification of NG tube placement.
3. Response of student to procedure.
4. Signature of personnel performing procedure.

8. OSTOMY CARE: EMPTYING/CHANGING OF OSTOMY POUCH

I. Guidelines: An ostomy is an artificial opening for urine or feces to be eliminated from the body. The opening is covered by a pouch, which serves as a container for waste until it can be emptied. Changing an ostomy at school is usually needed only because of leakage. An ostomy pouch usually remains secure for 1-7 days. Pouching systems vary according to student and manufacturer needs. Systems may be 1 or 2 pieces, disposable or reusable. Steps listed in this procedure may be adapted to the type of system being used.

A. Purpose: To provide training and supervision guidelines for the management of emptying or changing an ostomy system in the school setting and during co-curricular events.

B. Equipment: (Parent responsibility unless otherwise noted)

1. Pouching system (skin barrier wafer and pouch).
2. Adhesive remover
3. Stomahesive paste, if ordered.
4. Measuring guide.
5. Belt, if required.
6. Skin protectant, if ordered.
7. Stomahesive powder, if ordered.
8. Mirror, if needed.
9. Soap and warm water (county).
10. Disposable medical gloves (county).
11. Disposable underpad, if needed (county).

C. Personnel: Certified school nurse, licensed health care provider such as RN or LPN, or designated trained school personnel under direct or indirect supervision of the certified school nurse.
The student may perform this procedure independently if ordered by licensed prescriber.

II. Procedure

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain written order from licensed prescriber and parent/guardian consent.	All specialized procedures performed in the school setting must have written orders from a licensed prescriber and parent/guardian consent.
B. Assemble equipment in appropriate private location	Specific equipment may vary. Provide privacy for the student.
C. Position student in relaxed position.	Encourage the student to do as much for himself/herself as possible. Use developmentally appropriate language.
D. Wash hands and put on gloves.	Refer to *Hand Washing* and *Gloves – Use and Removal* procedures.
E. To empty:	
1. Open pouch and empty contents into toilet or other recommended receptacle.	Emptying contents may prevent leakage and odor. Refer to *Cleaning and Disposing of Body Fluids* procedure.
2. Close pouch.	
F. To change:	
1. Remove pouching system by gently peeling pouch away from skin.	Use skin safe solvent, if necessary.
2. Place absorbent material over stoma.	Place absorbent material over stoma to keep irritating drainage off the skin until replacement of pouch is ready.
3. Empty ostomy pouch into toilet. If reusable, rinse with water over toilet and put in suitable container to send home. If disposable, discard in lined waste receptacle.	Know whether pouch is to be returned home. Refer to *Cleaning and Disposing of Body Fluids* procedure.
4. Clean skin thoroughly but gently with soap and water.	Make sure all adhesive is removed from skin using skin-safe solvent if needed.

5. Dry thoroughly.	Unit will not adhere to damp skin. Report evidence of skin breakdown and/or infection to parent/guardian and school nurse.
6. Measure stoma with measuring guide. Trace the opening onto the paper backing of the pouch.	The opening should be 1/8 inch larger than the stoma.
7. Cut along the tracing, smoothing any jagged edges with fingers or scissors, and remove the white paper backing from the skin barrier.	Jagged edges can irritate the ostomy or skin and result in a poor seal.
8. Apply stomahesive paste to the back of the skin barrier at the edge of the cut opening and set aside for one minute.	Allow some time for paste to "ready".
9. Apply skin protectant, if ordered, and allow to dry.	Protectants prevent a breakdown of skin.
10. Place the skin barrier wafer over the stoma and press gently against it for 30 seconds, especially around the stoma.	This needs to be well adhered to the skin to support the pouch after it is applied.
11. Secure the pouch onto the skin barrier wafer making sure it is secured all around.	Completely seal the pouch against the skin barrier wafer.
G. Secure lower opening of pouch with clamp or be sure adapter is closed.	Pouch should be secured in place, able to contain drainage and be emptied as needed.
H. Remove gloves and wash hands.	Refer to *Gloves -Use and Removal* and *Hand Washing* procedures.
I. Document procedure on student's individual treatment record.	Record: 1. Date and time. 2. Pertinent information. 3. Signature of personnel performing procedure.

A. GENERAL GUIDELINES FOR DIABETIC MANAGEMENT

I. Guidelines:

Diabetes is a disease in which the body does not make or properly use insulin, a hormone needed to convert sugar, starches, and other food into energy. People with diabetes have increased blood glucose sugar levels because they lack insulin, have insufficient insulin, or are resistant to insulin's effects. Diabetes can lead to serious health problems. Effective diabetes management is to control blood glucose levels by keeping them within a target range that is determined for each child. Optimal blood glucose control helps promote normal growth and development and allows for optimal learning. Generally, food raises blood sugar while exercise and insulin or diabetes pills will lower blood sugar. Balancing all of these factors may be difficult while maintaining good glucose control. It is important to recognize when the student needs assistance.

A. Purpose:

To provide training and supervision guidelines for the care and safety of the diabetic student in the school setting and during co-curricular events.

B. Equipment:

(Parent responsibility unless otherwise noted).

1. Glucometer with strips and lancets.
2. Emergency sugar source and snacks.
3. Insulin source with proper delivery system, (i.e., syringes, insulin pen, pump).
4. Alcohol or other cleansing agent.
5. Sharps container (county).
6. Disposable medical gloves (county).

C. Personnel:

Certified school nurse, other licensed health care provider such as a RN or LPN, or designated trained school personnel under direct or indirect supervision of the certified school nurse.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain diabetic history from parent/ student.	History should include the student's usual signs and symptoms of abnormal blood sugars, student's ability to recognize the symptoms and how to treat.
B. Provide training for school personnel on characteristics of hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar), and management for each one.	A general training will prepare school personnel to identify and provide emergency care for the diabetic student.
C. Assess school day activities.	An overview of the mealtimes and activity times can help identify possible times of blood glucose fluctuations.
1. Review student's daily schedule.	A careful review of the daily routine: placement of meals, snacks, physical activity, sports participation, and after school practices and activities. Modifications in daily schedule which can impact blood glucose results are 2 hour delays, early dismissals, food events included in curriculum, etc.
2. Plan for co-curricular activities.	Advance notice is needed to prepare for the needs of the student.
D. Prepare school staff for prescribed procedures during the school day.	Procedures require inservice specific to each student and include universal precautions, appropriate disposal of sharps, hand washing and gloving.
1. Blood glucose measurement and/or interpretation of reading for student.	Remain alert to unusual behavior by student, which can indicate the need for blood glucose measurement. **Always refer to licensed prescriber's orders.**
2. Recognition of extremes of blood glucose: a. Hypoglycemia	Requires immediate treatment to protect student from dangerously low blood glucose.

b. Hyperglycemia	Hyperglycemia or high blood glucose may be caused by too little insulin, too much food, or decreased exercise or activity, illness, infection, injury, stress or emotional upset.
3. Appropriate treatment for extreme blood glucose readings.	Blood glucose can rapidly rise if insulin has not been received by syringe/insulin pump or if the student is experiencing physical or emotional stress which can cause the insulin not to work effectively. Management of blood glucose can be effectively treated in the school setting. **Refer to the student's licensed prescriber's orders, the school health care plan and intervention guide.**
E. Document procedure on student's individual treatment record.	Record: 1. Date and time. 2. Student's behavior. 3. Blood glucose reading. 4. Action taken. 5. Student's response. 6. Any other pertinent information. 7. Signature of personnel performing procedure.

B. MEASUREMENT OF BLOOD SUGAR WITH GLUCOMETER

I. Guidelines: Some students may need to test his/her blood for a reading that indicates an accurate level of glucose. This will give important information regarding his/her current health status and if an intervention is required to return the child's blood glucose to euglycemia (near normal blood glucose).

A. Purpose: To provide training and supervision guidelines to measure students blood glucose levels in the school setting and during co-curricular events.

B. Equipment: (Parent responsibility unless otherwise noted).
1. Glucometer and manufacturer's instruction booklet.
2. Glucometer strips, if needed.
3. Automatic lancet device, if needed.
4. Alcohol wipes, if needed.
5. Adhesive bandage, if needed.
6. Cotton balls, gauze, or tissues.
7. Approved sharps container (county).
8. Disposable medical gloves (county).

C. Personnel: Certified school nurse, other licensed health care provider such as a RN or LPN, or designated trained personnel under the direct or indirect supervision of the certified school nurse. The student may perform this procedure independently if ordered by licensed prescriber.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain licensed prescriber's order and parent/guardian written consent.	All specialized procedures conducted in the school setting require written licensed prescriber orders and parent/guardian consent.
B. Prepare work area.	Drape work area with paper towels in a well-lighted, clean area.
C. Assemble equipment.	Follow manufacturer's instructions for specific glucometer and lancet device.
D. Prepare the meter for use.	Follow manufacturer's instructions for specific machine.

E. Have student cleanse hands or use alcohol wipes on chosen puncture site, if needed.	Washing in warm water will increase the blood flow to the finger.
F. Wash hands and put on disposable gloves.	Refer to *Hand Washing* and *Gloves - Use and Removal* procedures.
G. Perform puncture and place drop of blood on test strip or proper port.	Follow directions for specific monitor. Finger puncture should be lateral to fingertip. Most inaccurate glucose readings are a result of insufficient blood samples.
H. Cover lanced area with gauze or tissue until bleeding stops. Apply adhesive bandage, if needed.	Prevent contamination of blood to other surfaces.
I. Refer to intervention guide for appropriate actions to take with regard to blood glucose reading.	
J. Dispose of chemstrip, lancet, and any material potentially contaminated with blood.	Dispose of lancet in sharps container and chemstrip in appropriate container. Refer to *Cleaning and Disposing of Body Fluids* procedure.
K. Remove gloves and wash hands.	Refer to *Gloves - Use and Removal* and *Hand Washing* procedures.
L. Document procedure on student's individual treatment record.	Record: 1. Date and time. 2. Blood glucose reading. 3. Action taken and student's response. 4. Signature of personnel performing procedure.

C. INSULIN ADMINISTRATION BY INJECTION

I. Guidelines: Insulin therapy involves the subcutaneous injection of insulin to reduce hyperglycemia and inhibit lipolysis and ketogenesis.

A. Purpose. To provide training and supervision guidelines for the safe administration of insulin by injection in the school setting and during co-curricular events.

B. Equipment: (Parent responsibility unless noted).
1. Sliding scale and/or algorithm prescribed by health care provider.
2. Insulin as prescribed by health care provider.
3. Insulin syringe with needle or insulin pen.
4. Cotton ball and alcohol or alcohol wipe, if recommended.
5. Sharps container (county).
6. Disposable medical gloves (county).

C. Personnel: Certified school nurse, or other licensed health care provider such as a RN or LPN under the direct or indirect supervision of the certified school nurse. The student may perform this procedure independently if ordered by licensed prescriber. **NO ASPECT OF THIS PROCEDURE MAY BE DELEGATED TO UNLICENSED PERSONNEL.**

II Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain written orders from licensed prescriber and parent/guardian written consent to perform procedure.	All specialized procedures performed in the school setting must have written orders and parent/guardian written consent.
B. Read the licensed prescriber's order and document the newest glucose measurement. Review the prescribed sliding scale and/or algorithm and calculate the dosage needed, if applicable.	This will ensure accuracy and safety in delivery of the correct dosage. Insulin dosage may not be calculated by unlicensed personnel.
C. Wash hands.	Refer to *Long-term Medication Administration* procedure. Refer to *Hand Washing* procedure.

D. Wipe the bottle cap with alcohol and draw up insulin or set pen to required dosage.	Refer to manufacturer's instructions for insulin pen usage.
E. Select a clean area of subcutaneous tissue, remembering to rotate injection sites. You may wipe with alcohol.	Systematic rotation of sites will keep the skin supple and favor uniform absorption of insulin. Absorption is quicker from the abdomen and arms than the thighs and buttocks.
F. Inject insulin.	Thin people will require pinching a skin fold and injecting at 45 degrees. Injecting at 90 degrees into taut skin is recommended for heavier people. Avoid pinching skin tightly to avoid trauma. Aspiration is not necessary.
G. Withdraw and dispose of needle and syringe.	Ensure the needle is placed in an approved sharps container.
H. Document procedure on student's individual treatment record.	Record: 1. Date and time. 2. Amount and type of insulin given. 3. Injection site. 4. Any other pertinent information. 5. Signature of personnel performing procedure.
I. Additional Considerations	
1. Date insulin bottle or pen when opened.	Insulin should be discarded after 28 days.
2. Label insulin with student's name.	Prevents medication errors.
3. Store insulin according to manufacturer's recommendations.	Some insulin may require refrigeration.
4. When mixing insulin, withdraw clear insulin first and then withdraw cloudy insulin.	Prevents dosage errors.

D. INSULIN INJECTION BY PEN

I. Guidelines: Insulin therapy involves the subcutaneous injection of insulin to reduce hyperglycemia and inhibit lipolysis and ketogenesis. The insulin pen allows convenient, accurate, and portable insulin delivery. They come prefilled and are disposable when empty. Multiple doses are possible with each pen or cartridge holding 300 units.

A. Purpose: To provide training and supervisory guidelines for the safe administration of insulin via injection with a pen device in the school setting and during co-curricular events.

B. Equipment: (Parent responsibility unless noted)

1. Sliding scale and/or algorithm prescribed by licensed provider.
2. Insulin pen as prescribed by a licensed provider.
3. Pen needle.
4. Alcohol wipe or cotton ball and alcohol, if recommended.
5. Sharps container (county)
6. Disposable medical gloves (county)

C. Personnel: Certified school nurse, or other licensed health care provider such as a RN or LPN under the direct or indirect supervision of the certified school nurse. The student may perform this procedure independently if ordered by the licensed provider. **NO ASPECT OF THIS PROCEDURE MAY BE DELEGATED TO UNLICENSED PERSONNEL.**

II. Procedure

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain written orders from licensed prescriber and parent or guardian written consent to perform procedure.	All specialized procedures performed in the school setting must have written orders and parent or guardian written consent.
B. Read the licensed prescriber's order and document the newest glucose measurement. Review the prescribed	This will ensure accuracy and safety in delivery of the correct dosage. Insulin dosage may not be calculated by unlicensed

sliding scale and/or algorithm and calculate the dosage needed, if necessary.	personnel. Insulin dosage changes are not to be accepted if coming from parent or guardian. Refer to *Long-term Medication Administration* procedure.
C. Wash hands and put on gloves	Refer to *Hand Washing* and *Gloves– Use and Removal* procedures.
D. Check the drug label to be sure it is what is prescribed.	
E. Check the expiration date on the pen.	Do not use cartridge if it has been used beyond number of days recommended for particular pen.
F. Remove pen cap.	
G. Look at insulin.	Regular, Humalog, Novolog, Apidra, Lantus, and Levemir should be clear. Do not use if cloudy, discolored, or appears to have pieces in it. NPH, 75/25, 70/30, or 50/50 will appear cloudy and white.
H. Intermediate or mixed insulins should be gently mixed before use.	
I. Remove the protective pull tab from the needle and screw it onto the pen until snug.	This is the "air shot" or safety shot. Repeat this step if needed until a drop appears.
J. Remove both the plastic outer cap and inner needle cap.	
K. Look at the dose window and turn the dosage knob to "2" units. Holding the pen with the needle pointing upwards, press the button until at least a drop of insulin appears.	
L. Dial the number of units you need to administer.	

M. Decide where on the body you will give the injection. Be sure to give the injection in a different place each time. You may stay in the same general area but at least 1 inch from the last injection, scars, and naval.	Rotation of injections prevents lipodystrophy. (Thickening – lipohypertrophy and thinning – lipoatrophy of the injection areas.
N. Inject insulin at a 45 – 90 degree angle.	Pinch up the skin around the site being injected and hold firmly. The new shorter needles may be injected at a 90 degree angle.
O. Press the button all the way returning to zero, and keep pressing for six to ten seconds before withdrawing from skin.	Aspiration is not necessary.
P. Remove needle from pen.	If bleeding occurs when the needle is withdrawn, apply gentle pressure with a cotton swab. Do not rub site.
Q. Document procedure on student's individual treatment record.	Dispose of needle in a sharps container.
R. Additional Considerations 1. Date insulin cartridge when opened and start using. 2. Label insulin pen with student's name. 3. Store opened pens at room temperature. Unopened pens should be stored in the refrigerator at about 40 F. Avoid exposure to temperature extremes.	Record: 1. Date and Time 2. Amount and type of insulin given. 3. Injection site. 4. Any other pertinent info. 5. Signature of personnel performing procedure. Insulin cartridge should be discarded after 28 days. Prevents medication errors. This prevents damage or breakdown of the insulin which decreases effectiveness.

E. ADMINISTRATION OF INSULIN BY PUMP (CONTINUOUS SUBCUTANEOUS INSULIN INFUSION)

I. Guidelines: The insulin pump is a programmable microcomputer which delivers a continuous subcutaneous injection of buffered, rapid acting insulin. The insulin pump is about the size of a pager, powered by a battery and capable of delivering exact amounts of insulin, in as small as 0.1 unit ($1/10^{th}$ of a unit). Delivery occurs from the reservoir or cartridge contained in the pump through a specialized tubing (or infusion set) to the subcutaneous site which is usually in the abdomen (other sites may be used). An introducing needle is used initially to insert the infusion set into the selected site; the needle is removed after placement. Insulin is pumped through this tubing at a prescribed rate of infusion. This basal rate mimics the small amount of insulin which is continuously secreted by a healthy pancreas. When food is ingested, the grams of carbohydrates are calculated and a prescribed amount of insulin is given by bolus dose to maintain a prescribed blood glucose level. If the blood glucose level exceeds acceptable levels a correction bolus may be prescribed.

A. Purpose: To provide training and supervision guidelines for the safe use of the insulin pump in the school setting and during co-curricular events.

B. Equipment: (Parent responsibility unless otherwise noted).

1. Insulin pump with buffered insulin and manufacturer's instruction booklet.
2. Extra batteries and any other materials specific to student for pump maintenance.
3. Injectable insulin and syringes in event of pump failure.
4. Glucometer, lancets, glucometer strips, and alcohol wipes.
5. Emergency oral glucose source.
6. Glucagon emergency injection kit, if ordered.
7. Sharps container (county).
8. Disposable medical gloves (county).
9. Protected location, box or container for supplies (county).

C. Personnel Certified school nurse or other licensed health care provider, such as RN or LPN, under the direct or indirect supervision of the certified school nurse or student independently, as prescribed by a licensed prescriber.
NO ASPECT OF THIS PROCEDURE MAY BE DELEGATED TO UNLICENSED PERSONNEL.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain licensed prescriber's order and parent/guardian written consent.	Procedures conducted in the school setting require written licensed prescriber's orders and parent/guardian consent.
B. Assemble equipment.	
C. Wash hands and put on gloves.	Refer to *Hand Washing* and *Gloves-Use and Removal* procedures.
D. Obtain blood glucose measurement and review licensed prescriber's orders.	Refer to *Measurement of Blood Sugar by Glucometer* procedure.
E. Assess pump insertion site.	To assure patency and placement.
F. Administer bolus dose as ordered by licensed prescriber.	Refer to manufacturer's instruction booklet.
G. Document procedure on student's individual treatment record.	Record: 1. Date and time. 2. Blood glucose measurement. 3. Amount of bolus insulin. 4. Any other pertinent information. 5. Signature of personnel performing procedure.
H. Special Considerations:	
1. Hypoglycemia	
a. Assess for "runaway" pump.	Pump malfunction causing continuous infusion of insulin, leading to hypoglycemia. Signs of a runaway pump may also include pump alarms and clicking noise. Also, check basal rate and last bolus dose given.
b. Turn off or suspend pump if malfunction occurs.	Refer to Manufacturer's instruction booklet.
c. Notify parent/guardian and school nurse.	

d. Refer to student's emergency plan for interventions.	Student may need to ingest rapid-acting glucose. Refer to *Glucagon Administration* procedure for unresponsive student.
2. Hyperglycemia.	Signs may include: pump not infusing, leaks in infusion set or site and/or empty insulin cartridge.
a. Assess for clogged tubing system or pump malfunction.	
b. Notify parent/guardian and school nurse.	Infusion set and/or insertion site may **ONLY BE CHANGED BY PARENT.** Student may change infusion set and/or insertion site with an order from the licensed prescriber. **SCHOOL PERSONNEL CANNOT CHANGE OR INSERT INFUSION SET.**
c. Administer insulin by injection for hyperglycemia, according to licensed prescriber's order.	Refer to *Insulin Administration by Injection* procedure.

F. CONTINUOUS GLUCOSE MONITORING (CGM)

I. Guidelines: Glucose monitoring helps people with diabetes manage the disease and avoid its associated problems. A person can use the results of glucose monitoring to make decisions about food, physical activity, and medications (trends of glucose levels). CGM identifies trends in interstitial blood glucose and is used to better understand high and low glucose trends particularly in nighttime hypoglycemia. However, a capillary blood glucose is still considered best practice and required for interventions (treatment of high or low blood glucose). CGM systems use a tiny sensor inserted under the skin to check glucose levels in tissue fluid. The sensor stays in place for several days to a week and then must be replaced. The transmitter sends information about glucose levels via radio waves from the sensor to a wireless monitor that is an independent device or built into an insulin pump. These monitoring devices may be set to alarm if the glucose is trending too high or too low. Depending on the manufacturer, the CGM device may communicate with the insulin pump and suspend the insulin pump if a low trend is not reversed in a certain amount of time.

A. Purpose: To provide training and supervision guidelines to measure trending of student's glucose levels for better diabetes management.

B. Equipment: (Parent responsibility unless otherwise noted).
1. CGM monitor (Either independent monitor or built into an insulin pump)
2. Sensor and transmitter.

C. Personnel: Certified School Nurse, other licensed health care provider such as a RN or LPN, or designated trained personnel under the direct or indirect supervision of the Certified School Nurse. The student may perform this procedure independently if ordered by licensed prescriber.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain licensed prescriber's order and parent/guardian written	All specialized procedures conducted in the school setting require written licensed prescriber orders and parent or guardian consent.
B. Obtain CGM reading from monitor or insulin pump to interstitial view fluid glucose levels.	Finger stick is not required for this reading.
C. If CGM alarms a finger stick blood glucose monitor (BGM) is required follow measurement of blood glucose (BG) with meter procedure.	Calibration of CGM with BGM may be required. The alarm is based on delayed trending of interstitial fluid glucose NOT blood glucose and **SHOULD NOT BE USED TO DETERMINE TREATMENT.**

D. Document procedure on student's individual treatment record.	Record: 1. Date and time 2. Glucose reading 3. Action taken and student's response. 4. Signature of personnel performing procedure.

G. GLUCAGON ADMINISTRATION

I. Guidelines: Glucagon is a hormone made in the pancreas, which frees sugar that is stored in the liver and raises the blood glucose level. Glucagon is used in an emergency situation to raise the blood glucose level in an unresponsive, hypoglycemic student.

A. Purpose: To provide training and supervision guidelines for the administration of Glucagon in the school setting and during co-curricular events.

B. Equipment: (Parent responsibility unless otherwise noted).
1. Glucagon emergency kit.
2. Alcohol wipes (county).
3. Sharps container (county).
4. Disposable medical gloves (county).

C. Personnel: Certified school nurse, other licensed health care provider such as a RN or LPN, or designated trained school personnel under the direct or indirect supervision of the certified school nurse. If possible, at least three school personnel in the student's school should be trained.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain order from a licensed prescriber and parent/guardian written consent.	All specialized procedures performed in the school setting require written licensed prescriber's orders and parent/guardian consent.
B. Obtain Glucagon and ensure proper storage.	Store at room temperature or refrigerate. Avoid direct sunlight. Check expiration date.
C. Develop a written emergency plan for Dele gated personnel to follow.	All designated trained personnel will be aware of storage location of Glucagon.
D. Prepare to administer Glucagon when student becomes unresponsive: 1. Establish unresponsiveness. 2. Call EMS. 3. Obtain medication. 4. Notify parent/guardian and school nurse.	Glucagon is needed only for unresponsiveness. If the student is able to take food or liquid, treat hypoglycemia with 10-15 grams of fast-acting carbohydrates (i.e., half-cup juice, four sugar cubes, icing, etc.)

5. Place student on his/her side. 6. Prepare injection according to manufacturer's instructions.	To prevent aspiration. Nausea and vomiting is a common side effect after administration of Glucagon. Diluting solution may be in a vial or prepackaged in a syringe.
E. Put on gloves.	Refer to *Gloves – Use and Removal* procedure.
F. Select a clean area of subcutaneous tissue on upper arm or thigh. You may cleanse with alcohol wipe if area is not clean.	Cleansing with alcohol has not been shown to decrease infection rates.
G. Insert the needle and inject Glucagon.	Thin people will require pinching a skin fold and injecting at 45 degrees, while injecting at 90 degrees into taut skin is recommended for heavier people. Avoid pinching the skin tightly to avoid trauma. Aspiration is not necessary.
H. Withdraw and dispose of needle and syringe.	Ensure that needle and syringe are placed in a sharps container.
I. Remove gloves and wash hands.	Refer to *Gloves – Use and Removal and Hand Washing* procedures.
J. Document procedure on student's individual treatment record.	Record: 1. Date and time. 2. Amount given. 3. Injection site. 4. Any other pertinent information. 5. Signature of personnel performing procedure.
K. Monitor student for signs of responsiveness and/or respiratory and cardiac arrest until emergency personnel arrive.	Student should regain consciousness in 15 minutes and needs to be fed additional simple and complex carbohydrates to prevent another hypoglycemic episode. You must be prepared to administer CPR. After administering glucagon, student must be transported to hospital.

A. LONG-TERM MEDICATION ADMINISTRATION

I. Guidelines: The administration of long-term medication enables students who require medication at specific times during the school day to attend school. All personnel who administer medication must be familiar with state and county policies for administering medications. Certain medications must be administered by a certified school nurse or other licensed health care provider such as a RN or LPN (i.e. insulin or new/experimental medications). The first dose of a medication should never be given at school. Administering medication during school hours or during school-related events is discouraged unless it is necessary for the optimal health and well being of the student.

A. Purpose: To provide training and supervision guidelines for long-term medication administration in the school setting and during co-curricular events.

B. Equipment: (Parent responsibility unless otherwise noted).
1. Prescribed medication in original pharmacy-labeled container.
2. Appropriate dosing device (ex. syringe, cup).
3. Secure storage area (county responsibility).

C. Personnel: Certified school nurse, other licensed health care provider such as a RN or LPN, designated trained school personnel under the direct or indirect supervision of the certified school nurse or student as ordered by licensed prescriber.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain order from a licensed prescriber and parent/guardian written consent to perform procedure.	All specialized procedures performed in the school setting require a written order from a licensed prescriber and parent/guardian consent.
B. Assess the need for medication administration during the school day.	Medication should be given at home whenever possible.

C. Obtain medication from parent/guardian.	Refer to county medication policy for approved methods of delivering medication to school. The school nurse should be notified immediately by designated school personnel of any change in the medication order.
D. Store medication in a designated locked area. Controlled substances must be double locked. Only designated personnel should have access to the medication.	Locked storage will prevent potential drug abuse, theft, and possibility of overdose.
E. Remove medication from storage area and verify student's name, medication, dosage, time and route of administration according to the written medication order and the pharmacy-labeled container.	An approved safety check is to read the prescribed medication container 3 times. Parents must send medication in a properly labeled container from the pharmacy. Check for possible drug allergies.
F. Wash hands. Put on gloves, if needed.	Refer to *Hand Washing* and *Gloves-Use and Removal* procedures.
G. Ensure positive identification of student.	An approved safety check is to ask student's name and other identifying information such as birth date or parent/guardian name. Photo identification may be used.
H. Allow the student to self-administer whenever possible under the observation of trained personnel. If a student is unable to take his/her medication, a designated trained person will administer the prescribed medicine.	Observation by designated trained personnel is necessary to ensure that the student has actually taken the prescribed medicine. This lessens the possibility of a lost pill or that one has been hidden and not swallowed.
I. Document procedure on the student's individual treatment record. Use a separate record for each medication.	Record: 1. Date and time. 2. Amount given. 3. Other pertinent information. 4. Signature of personnel performing procedure.
J. Observe student's response to medication. Document and report to parent/guardian and school nurse.	This information may be necessary for student's parent/guardian and/or licensed prescriber to evaluate effectiveness.

K. Additional considerations:

1. If vomiting should occur after medication is given, **DO NOT GIVE ADDITIONAL MEDICATION.**	Notify parent/guardian and school nurse.
2. Students who have asthma medication must have a written order from a licensed prescriber to carry and self-administer. The student must also demonstrate the ability and understanding to self-administer asthma medication by passing an assessment by the school nurse evaluating the student's technique of self-administration and level of understanding of the appropriate use of the medicine.	See W.Va. Code §18-5-22b.
3. Ensure that student's medication is taken on all co-curricular events. Ensure that medication is stored at correct temperature and is under control of designated school personnel.	
4. Parent/guardian is responsible for maintaining supply of medication at school. Failure to provide appropriate medications may constitute medical neglect and a referral to Child Protective Services may be warranted.	

B. EMERGENCY MEDICATION ADMINISTRATION

I. Guidelines: Emergency medication administration enables students who require medication for life-threatening emergencies to attend school. All personnel who administer medication must be familiar with state and county policies for administering medications. Certain medications may only be administered by a certified school nurse or other licensed health care provider such as a RN or LPN.

A. Purpose: To provide training and supervision guidelines for the administration of emergency medication in the school setting and during co-curricular events.

B. Equipment: (Parent responsibility unless otherwise noted).
1. Prescribed medication in original pharmacy-labeled container.
2. Sharps container (county).
3. Secure storage area (county).

C. Personnel: Certified school nurse, other licensed health care provider such as a RN or LPN, designated trained school personnel under the direct or indirect supervision of the certified school nurse, or student with permission of a licensed prescriber and certified school nurse.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain order from a licensed prescriber and parent/guardian written consent.	All specialized procedures performed in the school setting require a written order for a licensed prescriber and parent/guardian consent.
B. Assess the need for emergency medication in the school setting.	Refer to county policy.
C. Obtain medication from parent/guardian.	Refer to county policy for approved method(s) of delivering medication to school.
D. Take the following steps when emergency occurs:	
1. Have someone call EMS, the parent/guardian and the school nurse.	Provides additional help as soon as possible.
2. Place student on his/her side.	Prevents aspiration.

3. Remove medication from storage area and verify student's name, medication, dosage, time and route of administration according to the written medication order and the pharmacy-labeled container.	An approved safety check is to read the prescribed medication container 3 times. Parents must send medication in a properly labeled container from the pharmacy. Check for possible drug allergies.
4. Ensure positive identification of student.	Approved safety check is to ask student's name and other identifying information such as birth date and parent/guardian name. Personnel should become familiar with the student, as student may be unable to identify himself/herself during an emergency. Photo identification may be helpful.
5. Administer medication or assist student with self-administration and note the time the medication was given. In most cases, students will be unable to self-administer.	Refer to specific procedure (i.e., *Glucagon Administration*, *Epinephrine Autoinjector*, *Epinephrine Twinject* or *Administration of Rectal Diazepam*).
6. Dispose of used needle and syringe in a sharps container. Double bag other containers and place in the trash.	Refer to *Cleaning and Disposing of Body Fluids* procedure.
E. Document procedure on student's individual treatment record.	Record: 1. Date and time. 2. Medication and dosage. 3. Other pertinent information. 4. Signature of personnel performing procedure.
F. Observe student's response to medication and document.	This information may be necessary for the student's parent/guardian and/or licensed prescriber to evaluate effectiveness.
G. Monitor until emergency personnel arrive.	Follow specific instructions in student's individualized emergency plan.

C. ADMINISTERING MEDICATIONS THROUGH GASTROSTOMY/N-G TUBE

I. Guidelines: Enteral or tube feeding is the introduction of fluids, nutrients and/or medication directly into the stomach, duodenum or jejunum for the student with a functional gastrointestinal tract who is unable to swallow. The primary goal when administering medication through a gastric tube is to optimize the drug's therapeutic action without interfering with enteral nutrition.

A. Purpose: To provide training and supervision guidelines for the safe administration of medication via a gastric tube in the school setting and during co-curricular events.

B. Equipment: (Parent responsibility unless otherwise noted).

1. Prescribed medication.
2. 60 cc syringe with catheter tip.
3. Syringe bulb or plunger.
4. Catheter plug or clamp.
5. Container for water.
6. Disposable medical gloves (county).
7. Stethoscope (county).

C. Personnel: Certified school nurse, other licensed health care provider such as a RN or LPN or designated, trained school personnel under the direct or indirect supervision of the certified school nurse. The student may perform this procedure independently if ordered by licensed prescriber.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain orders from licensed prescriber and written parent/guardian consent.	All specialized procedures performed in the school setting must have written orders and parent/guardian consent.

B. Verify medication order before administering via gastric tube.	*Long Term Medication Administration* procedure. **PRIOR TO ADMINISTERING MEDICATION VIA GASTRIC TUBE IT MAY BE NECESSARY TO CONSULT WITH A PHARMACIST FOR SAFETY AND PROCEDURE REQUIREMENTS FOR SPECIFIC MEDICATION.**
C. Wash hands and put on gloves	Refer to *Handwashing* and *Gloves – Use and Removal* procedures.
D. Prepare medication for administration.	If more than one medication is to be administered, each medication must be prepared and administered separately. Thirty (30) cc of water should be instilled between each medication.
1. Tablet – crush tablet into fine power and mix with 30 cc of warm water until all dissolved.	If tablet is enteric coated or sustained-release form do not crush.
2. Capsule with powder inside: pull capsule apart, pour into cup, and mix with 30 cc warm water until dissolved.	Ensure capsule is not an extended- release medication.
3. Capsule with liquid: make a pinhole in one end of capsule and squeeze contents into small cup and mix with 30 cc of water.	Ensure capsule is not an extended- release medication.
4. Capsule with granules: check with licensed prescriber or pharmacist before giving. Medication may clog tube or be contraindicated.	**NOTE:** Extended release medications should not be pulled apart for administration into feeding tubes.

5. Liquid: mix with 30 cc of water to thin.	Not all liquid forms are suitable for administering through a gastric tube. Consult with licensed prescriber or pharmacist.
E. Elevate student's head to 30-45 degrees or assist in sitting position. If a sitting position is contraindicated, a right side-lying position may be used.	Sitting position enhances the gravitational flow and helps prevent aspiration.
F. Wash hands and put on gloves.	Refer to *Handwashing* and *Gloves-Use and Removal Procedures.*
G. Check placement of feeding tube prior to administering the medication by unclamping the tubing and injecting 10 cc of air into the gastric tube while listening with a stethoscope for a whooshing sound over the left upper quadrant of the abdomen.	Ensuring proper placement prevents inadvertent administration of medication outside of the stomach. **NOTE: ONLY AN RN OR LPN CAN DETERMINE NG TUBE PLACEMENT. PLACING THE END OF THE TUBE INTO A GLASS OF WATER IS NOT CURRENT RECOMMENDED PRACTICE.**
H. Aspirate and measure residual feedings confirming ~~G~~-gastric tube placement, if ordered. If not go to L.	Aspirating and measuring residual feedings is done to evaluate the absorption of previous feedings. If residual is greater than recommended, hold medication. Wait 30-45 minutes and recheck.
I. Re-instill gastric contents into the stomach. Clamp or pinch tube.	Returning aspirated contents prevents fluid and electrolyte imbalance.
J. Disconnect the syringe. Draw up 30 cc of tap water into the syringe, unclamp tube, attach syringe to gastric tube and gently flush. Remove syringe.	Flushing will clear tube of any gastric content and allow medication to move through tube easier.
K. Remove plunger from syringe and re-insert syringe into gastric tube.	

L Put the correct amount of medication into the syringe and allow to flow by gravity.	
M. Pour 30 cc of water into gastric tube after medication is instilled.	Instilling water after the medication helps clean the lumen of the tube and prevent occlusion.
N. Clamp tube, remove barrel of syringe and reinsert cap or plug into end of tubing.	
O. Care of Student	
1. Allow student to remain elevated for 30 minutes after medication is administered if possible.	Remaining in an elevated position helps prevent vomiting and/or aspiration if student should regurgitate.
2. Cleanse area around gastric tube with soap and water as needed. Apply dry dressing if indicated and secure with tape.	Covering the insertion site with a dressing absorbs any discharge of gastric juices and prevents skin breakdown.
3. Make sure tubing is secure and tucked inside clothing but not inside diaper or underwear.	Tubing may be pinned or taped to shirt.
P. Wash all reusable equipment with warm soapy water after each use, rinse thoroughly and dry. Store in a clean area.	Prevents the growth of bacteria.
Q. Remove gloves and wash hands.	Refer to *Gloves-Use and Removal and Handwashing* procedures.
R. Document procedure on student's individual treatment record.	Record: 1. Date and time medication was administered. 2. Amount of water given. 3. Amount of residual if ordered. 4. Student's response. 5. Any other pertinent information 6. Signature of personnel performing procedure.

A. SEIZURE MANAGEMENT

I. Guidelines: Seizures are caused by a sudden alteration in the normal electrical activity of the brain, which results in observable changes in body behavior and function. Epilepsy is a chronic disorder of the brain, which may result in recurrent seizures. Seizures may also occur as a result of acute injury or trauma to the brain. Causes may include: head injury, tumors, metabolic disorders, drug toxicity or withdrawal, infection, fever or psychogenic.

A. Purpose: To provide training and supervision guidelines for seizure management in the school setting and during co-curricular events.

B. Equipment: Medication and/or equipment ordered by licensed prescriber.

C. Personnel: Certified school nurse, other licensed health care providers, or designated trained school personnel under the direct or indirect supervision of the certified school nurse.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Provide training for school personnel on types, characteristics, and management of seizures.	A general training will prepare school personnel to identify and provide emergency care for a student having a seizure. Seizures may occur for the first time at school.
B. Obtain seizure history from parent/guardian and student.	History should include type of seizures, typical seizure behavior and postictal state, history of recurrent seizures or status epilepticus, medications and/or other forms of treatment.
C. Obtain orders from licensed prescriber and parent/guardian written consent for seizure management.	Information will provide guidelines for treatment or use of other measures (i.e., vagus nerve stimulator, rectal diazepam). Any physical limitations or restrictions should be noted.
D. Review student's schedule and assess environment in which services may be required.	This information will aid in developing an intervention guide for classroom, cafeteria, gym, playground, etc. Check mode of

	transportation and include appropriate personnel in training (i.e., bus drivers).
E. Develop a written emergency plan for student in cooperation with parent/guardian and physician.	Plan should be specific for type of seizure and include intervention guidelines, emergency contact numbers, criteria for calling EMS, and plan for care after seizure. Steps to be followed can be posted in the classroom and on the school bus. Downloadable forms http://www.epilepsyfoundation.org/answerplace
F. Provide a safe environment and prevent injury to student:	Assess student's schedule and plan for all areas where student may have seizure. Evaluate school environment for safety factors (i.e., stairways, playground equipment, etc.)
1. Assist to floor or guide away from harmful objects.	Provides a safe environment to prevent injury during the seizure.
2. Do not put anything in student's mouth during seizure.	Reinforce that student cannot "swallow his tongue".
3. Protect head during seizure.	Place hands or small pillow under head.
4. Do not attempt to restrain movements.	Restraining movements can cause fractures or muscle injury.
5. Turn head to side after seizure.	Prevents aspiration and promotes drainage from mouth.
6. Observe closely for respiratory distress or failure.	Begin CPR and call EMS if breathing stops or severe respiratory distress occurs. Administer oxygen if ordered. Refer to *Oxygen Administration* procedure.
7. Do not attempt to make the student swallow, eat, drink, or take medication during the seizure.	Prevents choking.
8. Allow the student to continue to rest for at least 30 minutes with or without cyanosis require immediate medical attention.	Monitoring seizure reoccurrence or complications.

9. If Diastat or Oxygen administered or seizures lasting >15-30 minutes with or without cyanosis require immediate medical attention with EMS and ER follow up.	EMS or ER for further treatment or testing.
G. Train designated staff to administer medication and/or other treatments if ordered.	Refer to *Emergency Medication Administration, Administration of Rectal Diazepam* and/or *Vagus Nerve Stimulator with Magnet* procedures.
H. Determine trigger factors for seizures in school setting.	Identify situations or triggers in the school environment that may be altered to reduce or prevent seizures (i.e., skipped meals, fatigue, stress, etc.).
I. Document procedure on student's individual treatment record.	Seizure record should include: 1. Date and time of onset. 2. Length of seizures. 3. Loss of Consciousness 4. Description of seizure activity. 5. Cyanosis, incontinence of urine or stool, vomiting, and the events of the postictal period. 6. Actions taken and student response. 7. Signature of personnel performing procedure.

B. ADMINISTRATION OF RECTAL DIAZEPAM

I. Guidelines: Rectal Valium (diazepam) Delivery System (i.e., DIASTAT®) is a gel formulation of diazepam, which is administered rectally to stop prolonged seizure activity. Rectal diazepam is intended to treat a distinct cluster of seizures that can be distinguished from the student's ordinary seizure activity and is intended for emergency use only. Rectal diazepam should begin to work within 5 to 15 minutes after proper administration.

A. Purpose: To provide training and supervision guidelines for safe administration of rectal diazepam in the school setting and during co-curricular events.

B. Equipment:
1. Rectal Diazepam Delivery System (parent/guardian responsibility). Diazepam gel is single-dose prefilled rectal delivery system.
2. Gloves (county responsibility).

C. Personnel: Certified school nurse or other licensed health care provider such as a RN or LPN who are under the direct or indirect supervision of the certified school nurse. The administration of rectal diazepam can only be delegated to unlicensed school personnel when there is a written physician order that indicates rectal diazepam may be administered by unlicensed school personnel. If the physician writes an order for rectal diazepam to be administered by unlicensed school personnel, the school nurse completes a thorough assessment of the student (using the Safe Scale tool) prior to identifying school personnel to be trained. The certified school nurse has the final determination that administration of rectal diazepam cannot be delegated to unlicensed school personnel. School personnel trained to administer rectal diazepam must be CPR certified. All school personnel working with said student should be familiar with basic and first aid for seizures. Annual retraining in rectal diazepam administration is required. Seizure emergency treatment plan or Electronic Health Care Plan (EHCP) that is individualized to identify the student's unique needs must be disseminated to staff.

II. Procedure

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain physician's order for rectal diazepam and parent /guardian written consent for administration. The physician's order must specify if rectal diazepam may be administered by unlicensed personnel.	Physician's order should give specific instructions when to treat seizure activity and frequency of rectal diazepam administration. If the student is under the care of a neurologist for seizures, it is recommended that the neurologist write the order for rectal diazepam.
B. Obtain student history of seizure activity and previous response to rectal diazepam.	Information will aid school nurse in determining if procedure can be delegated to unlicensed school personnel. May refer to **Safe Scale** for sample assessment tool.
C. Evaluate school setting and student's schedule to determine where procedure may be performed.	Information will aid school nurse in planning for evacuation of other students to ensure privacy of student receiving rectal diazepam.
D. Develop written emergency plan for delegated personnel to follow. Look at seizure emergency treatment plan form.	Plan should include evacuation method for other students, criteria for administering rectal diazepam, guidelines for calling Emergency Medical Services, and emergency contact numbers of parents/guardians. Also the plan should include the type of seizure, description, usual seizure duration and frequency, loss of awareness and guidelines following a seizure. Refer to *seizure management treatment plan.*
E. Train designated unlicensed school personnel to administer rectal diazepam and to monitor student response.	Reinforce that physician's orders will be specific for each student's situation. Determine that unlicensed personnel can distinguish between seizure types. The school nurse or delegated personnel must be able to: (a) recognize seizure activity and patterns, (b) administer medication as ordered by medical provider, and (c) determine when to call emergency medical services for assistance.
F. Obtain rectal diazepam and ensure proper storage.	Rectal diazepam must be kept in locked location and stored at room temperature, unless student has an order from physician to carry medication (refer to Policy 2422.8). Plan for proper storage when transporting (i.e., field trips, etc.). Check

	expiration date and have parent/guardian replace when expired.
G. Assess student and provide safety measures for student during seizure.	Assessment ensures student meets criteria for administering rectal diazepam per physician orders. Refer to *Seizure Management* procedure for safety issues during seizure.
H. Administer rectal diazepam if student's seizure activity meets criteria established by physician's order. Once rectal diazepam is administered the role of the school nurse or designated personnel includes monitoring vital signs, seizure activity, potential adverse events, and postictal conditions and communicating with a parent/guardian and the treating physician, as outlined in the seizure emergency treatment plan.	Review emergency plan and physician's orders. Treatment should begin within 5-10 minutes of onset of seizures to avoid complications. Baseline rates should be established. Diazepam can decrease respiratory effort. Refer to **Report of Administration of Rectal Diazepam**.
1. Check student's pulse and respiration rate before administering rectal diazepam.	Position reduces risk of aspiration and places student in correct position for rectal diazepam administration.
2. Place student in side-lying position facing person who will administer medication.	Follow plan for evacuation. Do not leave student alone. Plan for another staff member to obtain medication and notify EMS. Use of "walkie-talkies", cell phones, etc. should be considered in planning for care of the student.
3. Assure privacy.	Refer to *Gloves – Use and Removal* procedure.
4. Obtain rectal diazepam and notify Emergency Medical Services (EMS).	Refer to manufacturer's patient information instruction.
	Facilitates insertion of syringe and reduces risk of injury.
5. Put on gloves.	Aids in visualization of rectum and reduces risk of injury.
6. Remove protective cover and seal pin from syringe.	Allows for visualization of rectum.
7. Lubricate tip of syringe with lubricating jelly.	Rim of syringe should be snug against rectal opening to prevent leakage and ensure complete dose administered.

8. Remove necessary clothing and bend upper leg forward to expose rectum.

9. Separate buttocks to expose rectum.

10. Insert syringe tip gently into rectum.

11. Count slowly to three (3) out loud while gently pushing plunger in until it stops.

12. Count slowly to three (3) before removing syringe from rectum.

13. Count slowly to three (3) while holding buttocks together to prevent leakage.

I. Monitor student carefully after administering rectal diazepam and wait for EMS to arrive on the scene.

Do not leave student unattended. Monitor pulse and respiratory rate carefully. Provide CPR if indicated.

J. Document activity on student's individual treatment record. Refer to **Report of Administration of Rectal Diazepam**.

Record:

1. Description of seizure activity. Date, time and length of seizure.
2. Time of administration of rectal diazepam.
3. Student response to medication.
4. Pulse and respiration rate. When diazepam is given vital signs need assessed every 5-15 minutes. Assessments need to be made for 4 hours after diazepam is given.
5. Signature of personnel performing procedure.

K. Additional considerations:

1. Rectal diazepam should not be used more than five (5) times per month or administered more than once every five (5) days.

These guidelines were established by the manufacturer to prevent development of tolerance to the drug. School nurse and parent/guardian shall develop a mechanism to communicate when rectal diazepam has been used outside the school setting.

2. Assess for patterns of seizure activity in school setting.	Determine specific triggers for seizures and make modifications when possible to reduce incidence of seizures and decrease need for rectal diazepam. (i.e., computer monitors, fatigue, smells, lights, etc.)
3. Plan for care of student during transport on school bus.	Determine if unlicensed designated school personnel will be accompanying student on bus. Educate appropriate personnel on actions to follow in an emergency.
4. Plan for field trips or other co-curricular activities in which student may participate.	Consideration should include transporting medication safely, ability to contact EMS, and privacy of student.
5. Monitor student's weight periodically. Rectal diazepam dosage is based on age/weight.	Student's dosage needs may change and rectal diazepam needs to be replaced accordingly.

L. WV RN Board's Scope and Delegation Booklet outlines the duty of the registered nurse to decide if tasks should be delegated. W. Va. Code §18-5-22 provides that medication may be administered by "school personnel who are designated, qualified, trained and authorized to administer medications to students." W. Va. 126CSR25A authorizes the RN to determine if the administration of prescribed medication may be safely delegated to designated qualified personnel.

SAFE SCALE

This scale was prepared to assist the school nurse in assessment of the student who has a physician order to receive rectal diazepam in the school environment. The total number of points possible is 56. The higher the student's score is on the scale, the more likely the student will actually require administration of rectal diazepam in the school setting. However, the scale is not intended to determine whether the administration of rectal diazepam can or can not be delegated to a non-licensed person. The purpose of the scale is to assist the school nurse in evaluating the student and the potential problems, concerns, and issues that are specific to the individual student. It is possible that the student may have a low score on this scale, but other factors may influence the decision as to whether or not the procedure may be delegated to a non-licensed school personnel.

SEIZURE:

What is the most frequent type of seizure that the child has?

_____ Absence (1)
_____ Simple Partial (2)
_____ Complex Partial (3)
_____ Tonic Clonic (4)

Even though the student is on seizure medication, does the student still have breakthrough seizures?

_____ Yes (3)
_____ No (0)

Has the student ever had a seizure at school?

_____ Yes (3)
_____ No (0)

ADMINISTRATION OF MEDICATION OR USE OF VAGUS NERVE SIMULATOR (VNS):

How many seizure medications does the child take? (other than rectal diazepam)

_____ One (1)
_____ Two (2)
_____ More than 2 (3)

Has rectal diazepam ever been administered?

_____ Yes (5)
_____ No (0)

Has rectal diazepam ever been administered at school?

_____ Yes (5)
_____ No (0)

Has respiratory depression ever occurred after the administration of rectal diazepam.

_____ Yes (5)
_____ No (0)

Does student have VNS?

_____ Yes (5)
_____ No (0)

FREQUENCY:

How often does the student have seizures at school?

_____ daily (5)
_____ weekly (4)
_____ 1-2 times monthly (3)
_____ monthly (2)
_____ 1-2 yearly (1)
_____ never (0)

How often does the student have seizures at home?

_____ daily (5)
_____ weekly (4)
_____ 1-2 times monthly (3)
_____ monthly (2)
_____ 1-2 yearly (1)
_____ never (0)

ENVIRONMENT:

How often has rectal diazepam been administered at home?

_____ never (0)
_____ once (1)
_____ two or more times (2)
_____ monthly (3)
_____ weekly (4)
_____ other _____

How often has rectal diazepam been administered at school?

_____ never (0)
_____ once (1)
_____ two or more times (2)
_____ monthly (3)
_____ weekly (4)
_____ other _____

How far is the school from the nearest hospital?

_____ 1-10 miles (1)
_____ 11-20 miles (3)
_____ more than 21 miles (5)

TOTAL SCORE:_____

REPORT OF ADMINISTRATION OF SEIZURE RESUCE MEDICATION (such as DISASTAT and VERSED)

Date:_____

Student's Name:_____ DOB:_____

Parent's Name:_____ DOB:_____

Nurse's Name:_____ DOB:_____

Student's Normal Pulse:_____ Respiratory Rate:_____Student's Weight_____
(Breathing rate and weight should be obtained at beginning of school year & mid-year)

Time seizure begin:_____

Seizure Description:_____

_____

Time given:_____ Medication Administered:_____

Respiratory Rate:

Time	Respiratory Rate	Pulse	Comments	Time	Respiratory Rate	Pulse	Comments

Observation made:

_____

_____

_____

Time 911 Called:_____ Time Arrived:_____

Time Parent Contacted:_____

_____ _____

Signature of Personnel Completing Form Date

C. ADMINISTRATION OF INTRANASAL MIDAZOLAM

I. Guidelines: Intranasal midazolam is administered intranasal to stop prolonged seizure activity. Intranasal midazolam is intended to treat a distinct cluster of seizures that can be distinguished from the student's ordinary seizure activity and is intended for emergency use only. Intranasal midazolam should begin to work within 2-5 minutes.

A. Purpose: To provide training and supervision guidelines for safe administration of intranasal midazolam in the school setting and during co-curricular activities.

B. Equipment:
1. Midazolam of appropriate concentration for nasal medication delivery.
2. Syringe and needle/needleless device to draw up the medication
3. Atomizer
4. Gloves (county responsibility)
5. Midazolam in prefilled syringes as prescribed by a licensed provider. All you would need to do at that point is connect the atomizer and deliver the correct dose for child. In situations where the entire volume might not be appropriate, the syringe can have an indelible mark or piece of tape applied by the clinician or pharmacy at the appropriate dosage so provider knows how much to give. Make sure the proper dosing (concentration) is purchased.
6. Consideration:
   - Ambu Bag
   - Face Mask

C. Personnel: Certified school nurse, or other licensed health care provider such as a RN or LPN, who is under the direct or indirect supervision of a certified school nurse.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain physician's order for intranasal midazolam and parent/guardian written consent for administration.	Physician's order should give specific instructions when to treat seizure activity and frequency of intranasal midazolam administration. If the student is under the care of a neurologist, it is recommended that the neurologist write the order for the intranasal midazolam.
B. Obtain student history of seizure activity and previous response to intranasal midazolam.	May refer to Safe Scale for sample assessment tool.
C. Evaluate school setting and student's schedule to determine where procedure may be performed.	Information will aid school nurse in planning for evacuation of other students to ensure privacy of student receiving intranasal midazolam.
D. Develop written emergency plan for personnel to follow. No delegation of intranasal midazolam medication to unlicensed personnel.	Plan should include evacuation method for other students, criteria for administering intranasal midazolam, guidelines for calling Emergency Medical Services and emergency contact numbers of parents/guardians.
E. Train designated RNs and LPNs to administer versed to monitor student's response. **Intranasal midazolam CANNOT be delegated in the WV Public School setting.**	Reinforce that physician's order will be specific for each student's situation. Determine that unlicensed personnel can distinguish between seizure types. School personnel must be able to administer midazolam as demonstrated and follow instructions provided (see visual). School nurse or delegated personnel must be able to: (a) recognize seizure activity and patterns, (b) administer medication as ordered by medical provider, and (c) determine when to call emergency medical services for assistance.
F. Obtain midazolam and ensure proper storage.	Midazolam should be kept in locked location and stored at room temperature, unless student has an order from physician to carry medication (refer to policy 2422.8). Plan for proper storage when transporting (i.e. field

	trips, etc.). Check expiration date and have parent/guardian replace when expired.
G. Assess student and provide safety measures for student during seizure.	Assessment ensures student meets criteria for administration of midazolam per physical orders. Refer to *Seizure Management* procedure for safety issues during seizure.
H. Administer intranasal midazolam if student's seizure activity meets criteria established by physician's order. 1. Check student's pulse and respiration rate before administering midazolam. Keypoint: Baseline rates should be established. 2. Place student in supine position. 3. Assure privacy. Keypoint: Follow plan for evacuation. 4. Obtain intranasal midazolam and notify Emergency Medical Services (EMS). Keypoint: Do not leave student alone. Plan for another staff member to obtain medication and notify EMS. Use of "walkie-talkies", cell phones, etc. should be considered in planning for care of the student. 5. Put on gloves. Keypoint: Refer to *Gloves-Use and Removal* procedure. 6. With student in supine position use one hand and hold crown of head stable, place tip of atomizer snugly against the nostril and aim slightly up and outward (towards the top of the ear on the same side). 7. Briskly compress the syringe plunger to deliver half of the medication into the nostril. 8. Move the device to the opposite nostril and administer the remaining medication into that nostril.	Review emergency plan and physician's orders. Treatment should begin within 5 minutes.

I. Monitor student carefully after administering midazolam and wait for EMS to arrive on scene.	Do not leave student unattended. Place student in left lateral position. Monitor pulse and respiratory rate carefully. Provide CPR if indicated.
J. Documents activity on student's individual treatment record.	Record: 1. Description of seizure activity. 2. Date, time and length of seizure. 3. Time of administration of midazolam. 4. Student response to medication. 5. Pulse and respiration rate. 6. Signature of personnel performing procedures.
K. Additional Considerations:	
1. Assess mucous membranes for open sores or areas of irritation.	Mucous membranes which have open sores or irritation may alter the absorption rate of the medication and cause discomfort to the student.
2. Assess for patterns of seizure activity in school setting.	Determine specific triggers for seizures and make modifications when possible to reduce incidence of seizures and decrease need for midazolam. (i.e. computer monitors, fatigue, smells, lights, etc.).
3. Plan for care of student during transport on school bus.	Educate appropriate personnel on actions to follow in an emergency.
4. Plan for field trips or other co-curricular activities in which student may participate.	Consideration should include transporting medications safely, ability to contact EMS, and privacy of student.

ADMINISTRATION OF INTRANASAL MEDICATION

Basic Intranasal Medication Delivery Materials:

1. Syringe and needle/needleless device to draw up the medication
2. Atomizer
3. Medication of appropriate concentration for nasal medication delivery
    - High concentration - Low volume
    - Ideal volume 0.2 to 0.3 ml per nostril
    - Maximum volume 1 ml per nostril

Procedure:

1. Aspirate the proper volume of highly concentrated medication required to treat the patient – (an extra 0.1 ml of medication should be drawn up to account for the dead space within the atomizer at the end of the procedure.)

2. Twist off/remove the syringe from the needle/needleless device

3. Attach the atomizer tip via Luer lock mechanism – it twists into place.
    - Slip Luer is also effective as long as the tip is firmly seated on the syringe tip

4. Using your free hand to hold the crown of the head stable, place the tip of the atomizer snugly against the nostril aiming slightly up and outward (towards the top of the ear on the same side – this photo in error).

5. Briskly compress the syringe plunger to deliver half of the medication into the nostril.

6. Move the device over to the opposite nostril and administer the remaining medication into that nostril.

REPORT OF ADMINISTRATON OF SEIZURES RESCUE MEDICATION OR DIASTAT/VERSED

Date: _____

Student's Name:_____ DOB_____

Parent Name: _____Phone Number: _____

Nurse Name: _____ Phone Number: _____

Student's Normal Pulse: _____ Respiratory Rate: _____ Student's Weight _____

Time Seizure began: _____

Seizure Description _____

_____

Time Sublingual Klonopin given: _____OR

Time Buccal Klonopin given: _____

Vital signs charted below:

Time	Respiratory Rate	Pulse	Comments	Time	Respiratory Rate	Pulse	Comments

Observation Made: _____

_____

_____

Time 911 Called: _____ Time EMS Arrived_____

Time Parent Contacted: _____

_____ _____

Signature of Personnel Completing Form Date

D. ADMINISTRATION OF SUBLINGUAL/BUCCAL WAFER KLONOPIN

I. Guidelines: Sublingual and buccal medications are administered by placing them in the mouth, either under the tongue or between the gum and the cheek. The medications dissolve rapidly and are absorbed through the mucous membranes of the mouth, where they enter into the bloodstream.

A. Purpose: To provide training and supervision guidelines for safe administration of Klonopin Wafer sublingual or buccal route in the school setting and during co-curricular events.

B. Equipment: Prescribed medication and physician orders (Parent/guardian responsibility). Wafer needs protected from light. Be cognizant of age appropriateness based on research.

C. Personnel: Certified School Nurse, or other licensed health care provider such as a RN or LPN, who are under the direct or indirect supervision of the certified school nurse. The administration of Klonopin Wafer sublingual or buccal route can only be delegated to unlicensed school personnel when there is a written physician order that indicates Klonopin Wafer may be administered by unlicensed school personnel. If the physician writes an order for Klonopin Wafer to be administered by unlicensed school personnel, the school nurse should complete a thorough assessment of the student (using the safe scale tool) prior to identifying school personnel to be trained. The certified school nurse has the final determination that administration of Klonopin Wafer cannot be delegated to unlicensed school personnel. School personnel trained to administer Klonopin Wafer must be CPR certified. All school personnel working with said student should be familiar with basic first aid for seizures. Annual retraining in Klonopin Wafer administration is required. Seizure emergency treatment plan or EHCP that is individualized to identify the student's unique needs must be disseminated to staff.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain physician's order for sublingual or buccal Klonopin Wafer and parent/guardian written consent for administration.	Physician's order should give specific instructions when to treat seizure activity and frequency of Klonopin Wafer. If student is under care of neurologist for seizures, it is recommended that the neurologist write the orders for the Klonopin Wafer.
B. Obtain student history of seizure activity and previous response to Klonopin Wafer.	Information will aid school nurse in determining if procedure can be delegated to unlicensed school personnel. May refer to the SAFE SCALE for sample assessment tool.
C. Evaluate school setting and student's schedule to determine where procedure may be performed.	Information will aid school nurse in planning for evaluation of other students to ensure privacy of student receiving Klonopin Wafer.
D. Develop written emergency plan for delegated personnel to follow. Look at seizure emergency treatment plan form.	Plan should include evacuation method for other students, criteria for administering sublingual/buccal Klonopin Wafer, guidelines for calling Emergency Medical Services, and emergency contact numbers of parent/guardians. Type of seizure, description, usual seizure duration and frequency and loss of awareness. Guidelines following a seizure. Refer to seizure emergency treatment plan.
E. Train designated unlicensed school personnel to administer Klonopin Wafer and to monitor student's response.	Reinforce that physician's order will be specific for each student's situation. Determine that unlicensed personnel can distinguish between seizure types. School personnel must be able to administer Klonopin Wafer as demonstrated and follow instructions provided (see visual). School nurse or delegated personnel must be able to: (a) recognize seizure activity and patterns, (b) administer medication as ordered by medical provider, and (c) determine when to call emergency medical services for assistance.
F. Obtain Klonopin Wafer and ensure proper storage.	Klonopin Wafers must be kept in locked location, must be protected from light, and stored at room temperature, unless student has

	an order from physician to carry medication (refer to Policy 2422.8). Plan for proper storage when transporting (i.e., field trips, etc.). Check expiration date and have parent/guardian replace when expired.
G. Assess student and prove safety measures for student during seizure.	Assessment ensures student meets criteria for administering Klonopin Wafer per physician orders. Refer to Seizure Management procedure for safety issues during seizures.
H. Administer sublingual/buccal Klonopin Wafer if student's seizure activity meets criteria established by physician's order.	Review emergency plan and physician's orders. Treatment should begin within 2-3 minutes of onset of seizures to avoid complications.
1. Check Student's pulse and respiratory rate before administering Klonopin Wafer.	Baseline rate should be established.
2. Place student in a sitting position to prevent accidental aspiration of the medication.	
3. Assure Privacy	
4. Obtain Klonopin Wafer and notify Emergency Medical Services (EMS)	Do not leave student alone. Plan for other staff member to obtain medication and notify EMS. Use of "walkie-talkies", cell phones, etc. should be considered in planning for care of the student.
5. Put on Gloves.	Refer to gloves-use and removal procedure.
6. Remove Klonopin Wafer from package.	
7. For SUBLINGUAL: Have the student open his or her mouth and raise the tongue. The tablet should then be placed under the tongue. For BUCCAL: Have student open his or her mouth. Tablet should be placed between the gum and the wall of the cheek.	Administration: follow instructions of sublingual/buccal Klonopin Wafer

8. With mouth closed, the tablet should be held in this position for 5-10 minutes, or until it have dissolved. SWALLOWING THE MEDICATION SHOULD BE PREVENTED.

Buccal or sublingual medication should not be used when a student is uncooperative or unconscious.

Student should not eat or drink, chew or swallow until the medication has been absorbed.

NOTE: Sublingual/buccal Klonopin Wafers should not be administered if the gums or mucous membranes have open sores or irritations.

I. Monitor student carefully after administering sublingual/buccal Klonopin Wafer and wait for EMS to arrive on the scene.

Do not leave student unattended. Monitor Pulse and Respiratory rate carefully. Provide CPR as indicated.

J. Document activity on student's individual treatment record.

Record:
1. Description of seizure activity,
2. Date, time, and length of seizure.
3. Time of administration of Klonopin Wafer.
4. Student response to medication.
5. Pulse and respiratory rate.
6. Signature of personnel performing procedure.

K. Additional Considerations:

1. Klonopin Wafer should not be administered if gums or mucous membranes have open sores or areas of irritation.

Gums or mucous membranes which have open sores or irritation may alter the absorption rate of the medication and cause discomfort for the student.

2. Assess for patterns of seizure activity in school setting.

Determine specific triggers for seizures and make modifications when possible to reduce incidence of seizures and decrease need for Klonopin Wafers (i.e. computer monitors, fatigue, smells, lights, etc.).

3. Plan of care of student during

transport on school bus.	
4. Plan for field trips or other co-curricular activities in which student may participate.	Determine if unlicensed designated personnel will be accompanying student on bus. Educate appropriate personnel of actions to follow in an emergency. Consideration should include transporting medication safely, ability to contact EMS, and privacy of student.

E. ADMINISTRATION OF SUBLINGUAL/BUCCAL ATIVAN

I. Guidelines: Sublingual and buccal medications are administered by placing them in the mouth, either under the tongue or between the gum and the cheek. The medications dissolve rapidly and are absorbed through the mucous membranes of the mouth, where they enter into the bloodstream.

A. Purpose: To provide training and supervision guidelines for safe administration of Ativan sublingual or buccal route in the school setting and during co-curricular events.

B. Equipment: Prescribed medication and physician orders (Parent/guardian responsibility). Be cognizant of age appropriateness based on research.

C. Personnel: Certified school nurse, or other licensed health care provider such as a RN or LPN, who is under the direct or indirect supervision of the certified school nurse. The administration of sublingual or buccal Ativan can only be delegated to unlicensed school personnel when there is a written physician order that indicates buccal Ativan may be administered by unlicensed school personnel. If the physician writes an order for buccal Ativan to be administered by unlicensed school personnel, the school nurse should complete a thorough assessment of the student prior to identifying school personnel to be trained. The certified school nurse has the final determination that administration of buccal Ativan cannot be delegated to unlicensed school personnel. School personnel trained to administer buccal Ativan must be CPR certified.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain physician's order for Sublingual or buccal Ativan and parent/guardian written consent for administration. The physician's order must specify if Sublingual/buccal Ativan may be administered by unlicensed personnel	Physician's order should give specific instructions when to treat seizure activity and frequency of Ativan. If student is under care of neurologist for seizures, it is recommended that the neurologist write the orders for the Ativan.
B. Obtain student history of seizure activity and previous response to Ativan.	Information will aid school nurse in determining if procedure can be delegated to

	unlicensed school personnel. May refer to the SAFE SCALE for sample assessment tool.
C. Evaluate school setting and student's schedule to determine where procedure may be performed.	Information will aid school nurse in planning for evaluation of other students to ensure privacy of student receiving Ativan.
D. Develop written emergency plan for delegated personnel to follow. Look at seizure emergency treatment plan form.	Plan should include evacuation method for other students, criteria for administering sublingual/buccal Ativan guidelines for calling Emergency Medical Services, and emergency contact numbers of parent/guardians. The plan should include the type of seizure, description, usual seizure duration and frequency and loss of awareness. Refer to seizure emergency treatment plan.
E. Train designated unlicensed school personnel to administer Ativan and to monitor student's response.	Reinforce that physician's order will be specific for each student's situation. Determine that unlicensed personnel can distinguish between seizure types. School personnel must be able to administer Ativan as demonstrated and follow instructions provided (see visual). School nurse or delegated personnel must be able to: (a) recognize seizure activity and patterns, (b) administer medication as ordered by medical provider, and (c) determine when to call emergency medical services for assistance.
F. Obtain Ativan and ensure proper storage.	Ativan must be kept in locked location, must be protected from light, and stored at room temperature, unless student has an order from physician to carry medication (refer to Policy 2422.8). Plan for proper storage when transporting (i.e., field trips, etc.). Check expiration date and have parent/guardian replace when expired.
G. Assess student and prove safety measures for student during seizure.	Assessment ensures student meets criteria for administering Ativan per physician orders. Refer to Seizure Management procedure for safety issues during seizures.
H. Administer sublingual/buccal Ativan if student's seizure activity meets	Review emergency plan and physician's orders. Treatment should begin within 2-3

criteria established by physician's order.	minutes of onset of seizures to avoid complications.
1. Check Student's pulse and respiratory rate before administering sublingual/buccal Ativan.	Baseline rate should be established.
2. Place student in a sitting position to prevent accidental aspiration of the medication.	
3. Assure Privacy	Positioning: student should be sitting up to prevent aspiration.
4. Obtain Ativan and notify Emergency Medical Services (EMS)	Do not leave student alone. Plan for other staff member to obtain medication and notify EMS. Use of "walkie-talkies", cell phones, etc. should be considered in planning for care of the student.
5. Put on Gloves.	Refer to gloves-use and removal procedure.
6. Remove Ativan from package	Administration: follow instructions of sublingual/buccal Ativan.
7. For SUBLINGUAL: Have the student open his or her mouth and raise the tongue. The tablet should then be placed under the tongue. For BUCCAL: Have student open his or her mouth. Tablet should be placed between the gum and the wall of the cheek.	
8. With mouth closed, the tablet should be held in this position for 5-10 minutes, or until it have dissolved. **SWALLOWING THE MEDICATION SHOULD BE PREVENTED.** **Buccal or sublingual medication should not be used when a student is uncooperative or**	

unconscious.

Student should not eat or drink, chew or swallow until the medication has been absorbed.

NOTE: Sublingual/buccal Ativan should not be administered if the gums or mucous membranes have open sores or irritations.

I. Monitor student carefully after administering sublingual/buccal Ativan and wait for EMS to arrive on the scene.

Do not leave student unattended. Monitor pulse and respiratory rate carefully. Provide CPR as indicated.

J. Document activity on student's individual treatment record.

Record:
1. Description of seizure activity.
2. Date, time, and length of seizure.
3. Time of administration of Ativan.
4. Student response to medication.
5. Pulse and respiratory rate.
6. Signature of personnel performing procedure.

K. Additional Considerations:

1. Ativan should not be administered if gums or mucous membranes have open sores or areas of irritation.

   Gums or mucous membranes which have open sores or irritation may alter the absorption rate of the medication and cause discomfort for the student.

2. Assess for patterns of seizure activity in school setting.

   Determine specific triggers for seizures and make modifications when possible to reduce incidence of seizures and decrease need for Ativan (i.e. computer monitors, fatigue, smells, lights, etc.).

3. Plan of care of student during transport on school bus.

4. Plan for field trips or other co-curricular activities in which student may participate.

   Determine if unlicensed designated personnel will be accompanying student on bus. Educate appropriate personnel of actions to follow in an emergency.

   Consideration should include transporting medication safely, ability to contact EMS, and privacy of student.

HOW TO ADMINISTER SUBLINGUAL AND BUCCAL MEDICATION

Sublingual and buccal medications are administered by placing them in the mouth, either under the tongue (sublingual) or between the gum and the cheek (buccal). The medications dissolve rapidly and are absorbed through the mucous membranes of the mouth, where they enter into the bloodstream.

PROCEDURE:

Perform hand hygiene

Organize equipment

Verify Student

Prepare medication adhering 8 rights of drug administration

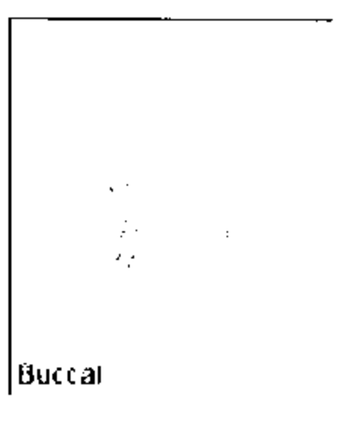
Put gloves on

Have student in sitting position

FOR SUBLINGUAL: 

Have the student open his or her mouth and raise the tongue.

The tablet should then be place under the tongue.

FOR BUCCAL: 

Have the student open his or her mouth.

The tablet should be placed between the gum and the wall of the cheek.

For optimal absorption: With the mouth closed, the tablet should be held in this position for 5-10 minutes, or until it has dissolved. Should dissolve within 20 sec-2min.

PRECAUTIONS

Medication should not be administered if the gums or mucous membranes have open sores or areas of irritation. Rather, the physician should be notified, and medication held. Medication should not be used when a student is uncooperative or unconscious. The student should not eat, drink, chew, or swallow until the medication has been absorbed, swallowing the medication must be prevented, as it will decrease the drug's effectiveness.

F. VAGUS NERVE STIMULATOR WITH MAGNET

I. Guidelines

Vagus nerve stimulator (VNS) is a surgically implanted device that delivers electrical impulses to the left vagus nerve in the neck. VNS provides seizure control by decreasing seizure frequency, severity and intensity. It consists of a battery-operated generator and a computer chip implanted in the chest or under the left arm and a pair of wires or leads that run under the skin and are attached to the vagus nerve in the left side of the neck. The device is implanted by a surgeon and programmed by a neurologist to deliver an electrical impulse to the vagus nerve. The device is programmed to deliver stimulation 24 hours a day. Usually 30 seconds on and 5 minutes off. The vagus stimulator implant also has a magnet tool to control the device externally. A hand- held magnet triggers the generator to deliver an extra electrical stimulation at a higher output between programmed impulses to prevent, lessen or interrupt a seizure in progress. If prescribed, the magnet may be used to stop stimulation temporarily. The use of VNS may reduce the dosage of antiepileptic medication in some users. The magnet tool triggers the device to deliver extra electrical stimulation between cycles when a seizure occurs. The magnet can also be used to stop stimulation by tapping it in place over the device (with parental permission to adhere to confidentially laws, students, teachers, and school staff can be taught about the magnet).

A. Purpose: To provide training and supervision guidelines for the use of the magnet to control seizure activity in the student with a VNS.

B. Equipment: (Parent responsibility unless otherwise noted).

1. Vagus Nerve Stimulator, surgically implanted and programmed, and the magnet provided by the manufacturer.
2. Manufacturer's instruction booklet.

C. Personnel: Certified school nurse or other licensed health care provider such as a RN or LPN, designated, trained school personnel under the direct or indirect supervision of the certified school nurse. The student may perform this procedure independently if ordered by licensed prescriber.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain physician's written order and parent /guardian written consent.	All specialized procedures performed in the school setting require written physician's orders and parent/guardian written consent.
B. Observe or assist student or perform step-by-step use of the magnet according to physician's orders.	Review of student's health care plan, intervention guide, and documentation of training in magnet use is necessary for each student. Student should wear Medic-Alert bracelet or necklace.
1. Respond to student communication of aura.	Parent/guardian, student or physician will indicate elements of aura. Refer to *Seizure Management* procedure for care of student having a seizure.
OR	
2. Observe beginning of seizure activity or seizure already in progress	Parent/guardian, student or physician will identify specific student behaviors that indicate seizure activity.
3. Use magnet to activate generator at distance/manner specified.	Follow manufacturer's instructions for use of magnet. General instructions may include: use a slow "swiping motion" over pulse generator for at least one second, (swipe by saying one-one thousand, two-one thousand).
4. Wait specified time before repeating use.	Wait 60 seconds from original magnet use before "swiping" a second time.
C. Observe student response and monitor seizure activity response to magnet use.	Note whether seizure continues, is lessened or stops completely. Follow specific orders of physician for treatment if seizure activity continues.
D. Document procedure on student's individual treatment record.	Record: 1. Date and time. 2. Student behavior. 3. Student/seizure response. 4. Any other pertinent information, 5. Signature of personnel performing procedure.

E. Additional considerations:

1. Keep magnet near student for use.	Magnet should be with student in all locations (i.e., cafeteria, playground, PE, co-curricular activities, and on school bus).
2. Do not drop magnet.	May break if dropped on hard surface
3. Do NOT store near: credit cards, televisions, computers, computer disks, magnetized lunch cards, microwave ovens, or other magnets. **KEEP THEM AT LEAST 10 INCHES AWAY FROM THESE ITEMS!**	Magnets will erase or damage electronic components if placed in close proximity to those items.
4. If ordered by physician, magnet may be used by student or designated staff to stop stimulation temporarily.	VNS has side effects that can affect voice quality or tingling in the throat. It can be stopped while student is singing or eating, etc. Length of time for VNS interruption must be specified by physician orders but should be for no more than four hours of continuous magnet activation.

F. Observe for side effects of Vagus Nerve Stimulator. These may include:

1. Change in quality of voice.
2. Deepening of hoarseness.
3. Tingling in the throat.
4. Coughing.
5. Feeling out of breath.

Side effects occur when device is delivering stimulation. Parent/guardian needs to be notified of any observed side effects. Parent/guardian may need to contact physician for possible adjustment of stimulation level.

G. Keep devices with strong electromagnetic fields at least 6 inches away from student's chest. These may include strong magnets, hair clippers, vibrators or loudspeakers.

Such devices may cause the pulse generator to start suddenly.

A. ANAPHYLACTIC REACTION

I. Guidelines: Although it is impossible to prepare for all emergencies of an anaphylactic nature, the following procedure is designed to provide for those emergencies likely to occur in school settings. Anaphylaxis is a severe, allergic reaction caused by exposure to a substance to which a person has hypersensitivity. An anaphylactic reaction is a life-threatening medical emergency requiring immediate treatment. Allergens which may cause an anaphylactic reaction include but are not limited to: stinging insects, medications, foods, exercise latex and unknown causes.

A. Purpose: To provide training and supervision guidelines for personnel providing care for an anaphylactic reaction in the school setting and during curricular events.

B. Equipment: Medication and/or equipment as prescribed by physician (parent responsibility for medically diagnosed anaphylactic shock reactions and schools responsibility for optional stock epinephrine for non-diagnosed anaphylactic reactions).

C. Personnel: Certified school nurse licensed healthcare provider such as RN or LPN, or designated qualified personnel under the direct or indirect supervision of the certified school nurse. The student may perform this procedure independently if ordered by licensed prescriber.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Develop a written emergency plan for students with a documented history of anaphylactic reaction or potential for anaphylaxis in conjunction with student, parent/guardian and school administrator/principal.	Plan should include step-by-step instructions to follow and emergency phone numbers. Student should be encouraged to wear Medic-Alert bracelet or carry card with pertinent information.
B. Determine that student has symptoms of an anaphylactic reaction. Symptoms may include: hives, itching, flushing of skin; swelling of lips, tongue, hands or feet; wheezing, shortness of breath, coughing, or hoarseness; headache; nausea and/or vomiting; abdominal cramps; sense of	When in doubt, treat the person for an anaphylactic reaction. Student may have rapid reaction after contact with allergen. Delayed reaction (1-2 hours after exposure) may occur. A reaction that occurs quickly tends to be more serious.

impending doom; or, loss of consciousness.	
C. In cases of known allergies, designated-trained personnel will give appropriate amount of medication ordered by the licensed prescriber. In case of unknown allergies, go to Step D and E.	In cases of known allergies, designated persons will have been instructed in proper procedures for individual student. Refer to *Emergency Medication Administration,—and Epinephrine Auto-injector*
D. For schools wishing to voluntarily maintain and use epinephrine auto-injectors, in accordance with WV Code § 18-5-22c, for emergency care or treatment of anaphylactic reactions, develop a written emergency plan for students or school personnel without a known history of anaphylactic reactions and training designated qualified personnel.	Plan should include step-by-step instructions to follow, emergency phone numbers and include: Physician standing orders and protocols; acquisition of stock and replacement medication; storage of stock in a secure location assessable by medical personnel and authorized nonmedical personnel and not by students; training of designated nonmedical school personnel in the administration of epinephrine auto-injector; parental notification; and reporting of incidents of anaphylactic reactions resulting in the administration of school maintained epinephrine to the West Virginia Poison Center.
E. Establish vital functions: 1. Maintain adequate airway. 2. Perform cardiopulmonary resuscitation (CPR) if necessary.	
F. Call Emergency Medical Services and notify parent/guardian and school nurse.	Emergency medical personnel must transport the student to the nearest emergency room after receiving medication even if symptoms have subsided. Send all available information with student to emergency room.
G. Document procedure on student's individual treatment record.	Record: 1. Date and time. 2. Symptoms observed. 3. Treatment provided. 4. Student's response to procedure. 5. Signature of personnel performing procedure.

H. Report to West Virginia Poison Center at 1-800-222-1222.

6. Report incident to the West Virginia Poison Center at 1-800-222-1222; information to be provided includes: name, age, gender, date and time incident occurred, symptoms observed, response to procedure, dose of epinephrine administered, and name of person administering the epinephrine.

Report:

Information to be provided includes: student name, age, and gender, date and time incident occurred, symptoms observed, student's response to procedure, dose of epinephrine administered and name of personnel administering the epinephrine. The West Virginia Poison Center will provide reports to each school or local education agency upon request and annually to the West Virginia State Superintendent of Schools.

B. EPINEPHRINE AUTO-INJECTORS

I. Guidelines: The epinephrine auto-injector system is a disposable, prefilled drug delivery system with a spring-activated, concealed needle and is the preferred method of delivery in the school setting. Epinephrine Auto-Injectors come in two strengths: 0.3 mg for adolescents and adults (weighing 66 pounds or more) and 0.15 mg for young children (weighing between 33 and 66 pounds). It is designed for emergency self-administration of epinephrine in the event of allergic and anaphylactic reactions.

A. Purpose: To provide training and supervision guidelines for the safe administration of epinephrine by injection in the school setting and during co-curricular events.

B. Equipment:

1. Epinephrine auto-injector delivery system as prescribed by physician (parent responsibility for medically diagnosed anaphylactic shock reactions and schools responsibility for optional stock epinephrine for non-diagnosed anaphylactic reactions).

C. Personnel: Certified school nurse, other licensed health care providers such as a RN or LPN, at least three designated personnel under the direct or indirect supervision of the certified school nurse. The student may perform this procedure independently if ordered by licensed prescriber.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Determine student's history of an allergic reaction and obtain order from licensed prescriber and instructions for use of epinephrine auto-injector.	Identification of the known allergen will aid in developing the Health Care Plan. All specialized procedures performed in the school setting require written orders from a licensed prescriber and parent/guardian consent. All known medically diagnosed anaphylactic reactions require a parent/guardian consent and prescribed medications supplied by the parent/guardian.

B. Store epinephrine auto-injector at room temperature in a dark place i.e. keep in light-protective covering.	All trained personnel should know the location of the epinephrine auto-injector. The epinephrine auto-injector must be maintained at the correct temperature on co-curricular trips and during transport.
C. Check epinephrine auto-injector routinely to make sure solution in auto-injector is not discolored, contains a precipitate, or expired.	Epinephrine is light sensitive and should not be used if discolored, has a precipitate, or is expired. Have the epinephrine auto-injector replaced.
D. Train designated personnel to identify anaphylactic reactions and to administer the epinephrine auto-injector.	Refer to *Anaphylactic Reaction* procedure.
E. Prepare written intervention guide and emergency plan for each individual student with medically diagnosed anaphylactic reactions and if applicable, prepare standing emergency plan for optional stock epinephrine.	Plan should include emergency contact numbers, step-by-step instructions to administer the epinephrine auto-injector, and names of trained designated personnel.
F. Remain with student while sending someone to obtain the medication, call EMS and notify the parent/guardian and the school nurse.	Student must be sent to the Emergency room after administration for further evaluation. Additional medication and treatment may be needed.
G. Provide for student safety before administering the epinephrine.	Have student lie down, elevate feet~~, and~~ maintain open airway. Student may faint or become unconscious.
The following are specific to common brand products.	

EpiPen Auto-injector:

• Form a fist around the auto-injector, black tip down. With your other hand remove the gray safety cap from the epinephrine auto-injector.	Use caution after the gray safety cap is removed; the auto-injector is engaged and may be accidentally discharged.
• Place black tip on the middle of the outer thigh at a right angle to the leg then press firmly and hold in place for 10 seconds. Do not attempt to inject medication into a vein or into the buttocks.	Apply to thigh regardless of what part of the body has been stung or come into contact with an allergen.
• Remove the auto-injector from the thigh.	
• Massage the area for 10 seconds	Massage promotes absorption of the medication.

Auvi-Q Auto-injector:

• Pull Auvi-Q" from the outer case then pull off red safety guard.	
• Place black end against the middle of the outer thigh (through clothing, if necessary), then press firmly and hold in place for 5 seconds.	The epinephrine auto-injector can be injected through clothing in an emergency. Avoid heavy seams.
• Remove the auto-injector from the thigh.	
H. Place the unit back into the carrying tube/case and send the used auto-injector with the EMS transporting the student to the emergency room.	Safety measure to prevent reuse of the auto-injector and needle sticks.
I. Document procedure on student's individual treatment record.	Record: 1. Date and time 2. Symptoms observed 3. Interventions taken. 4. Student's reaction response 5. Signature of personnel performing procedure. 6. Record date, time, representative taking epinephrine report during notification to West Virginia Poison Control Center.

J. Report to West Virginia Poison Center at 1-800-222-1222.	Report: Information to be provided includes: student name, age, and gender, date and time incident occurred, symptoms observed, student's response to procedure, dose of epinephrine administered and name of personnel administering the epinephrine. The West Virginia Poison Center will provide reports to each school or local education agency upon request and annually to the West Virginia State Superintendent of Schools.

C. INHALATION THERAPY BY MACHINE

I. Guidelines: Inhalation therapy by machine may be necessary to administer aerosol medication, mobilize secretions and aid in expectoration and improve alveolar ventilation.

A. Purpose: To provide training and supervision guidelines for administering inhalation therapy by machine in the school setting and during co-curricular events.

B. Equipment: (Parent responsibility unless otherwise noted).
1. Inhalation therapy machine with manufacturer's instruction booklet.
2. Nebulizer medication
3. Prescribed medication.
4. Tissues.
5. Wastebasket with plastic lining (county).
6. Disposable medical gloves (county).

C. Personnel: Certified school nurse, licensed health care provider such as a RN, LPN, respiratory therapist or designated trained school personnel under the direct or indirect supervision of the certified school nurse. The student may perform this procedure independently if ordered by licensed prescriber.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain written order from licensed prescriber and written parent/guardian consent.	All specialized procedures performed in the school setting require licensed prescriber orders and parent/guardian consent.
B. Assemble equipment in an appropriate location for administration of treatment.	To ensure privacy.
C. Wash hands and put on gloves.	Refer to *Hand Washing* and *Gloves – Use and Removal* procedures.
D. Position student in a sitting or high-fowlers or semi-fowlers position.	Proper positioning facilitates better ventilation.
E. Connect tubing.	Refer to manufacturer's instruction booklet.
F. Add prescribed medication to clean chamber.	Ensure chamber is clean. Be familiar with medication, dosage, side effects, precautions, etc.

G. Use the ordered delivery method:	
1. Facemask: Ensure mask is positioned properly without leakage.	A good seal is necessary for adequate treatment.
2. Mouthpiece: Instruct student to gently bite down on mouthpiece, seal lips around it and breathe through mouth only.	Mouth breathing is necessary for adequate delivery of medication with mouthpiece.
H. Instruct student to take in a deep breath from the mouthpiece, hold breathe briefly and then relax. Repeat until medication is completely administered.	Discontinue treatment if student coughs excessively or has respiratory difficulty until symptoms subside.
I. Disassemble circuit and clean machine.	Refer to manufacturer's instructions for cleaning of machine and nebulizer circuit.
J. Dispose of contaminated tissues and materials.	Refer to *Cleaning and Disposing of Body Fluids* procedure.
K. Remove gloves and wash hands.	Refer to *Gloves - Use and Removal* and *Hand Washing* procedures.
L. Document procedure on student's individual treatment record.	Record: 1. Date and time. 2. Type and amount of medication. 3. Student's response to the procedure. 4. Signature of personnel performing procedure.

D. MANUAL RESUSCITATOR

I. Guidelines:

A manual resuscitator (i.e., Ambu Bag) is a device to deliver breaths manually when a student is unable to breathe on his/her own.

Situations where a manual resuscitator may be used include:

- student having difficulty breathing on own.
- ventilator malfunctions.
- student stops breathing and needs to be resuscitated.
- during suctioning/or transport situation

NOTE: CHILDREN WHO HAVE TRACHEOSTOMIES OR WHO USE VENTILATORS SHOULD HAVE A RESUSCITATION BAG WITH THEM AT ALL TIMES.

A. Purpose: To provide training and supervision guidelines for using a manual resuscitator in the school setting and during co-curricular events.

B. Equipment: (Parent responsibility unless otherwise noted).

1. Manual resuscitator.
2. Appropriate-sized mask or appropriate size trach adaptor.
3. Oxygen source with appropriate tubing, if needed.
4. Disposable medical gloves (county).

C. Personnel: Certified school nurse, other licensed health care provider such as RN, LPN or respiratory therapist under the direct or indirect supervision of the certified school nurse.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain written orders from licensed prescriber and written parent/guardian consent.	All specialized procedures performed in the school setting require written licensed prescriber's orders and parent/guardian consent.
B. Maintain equipment in easily accessible location.	Initiate rescue breathing if a manual resuscitator is not immediately available. Ensure equipment is properly assembled.

C. Preparation:

1. Wash hands and put on gloves.	Refer to *Hand Washing and Gloves – Use and Removal* procedures.
2. Check manual resuscitator for proper functioning by placing adaptor that is connected to the bag against a gauze or tissue in your hand and squeezing bag.	Feeling slight resistance indicates proper functioning.
3. Explain procedure to student.	
4. Delivery by mask:	
a. Ensure open airway.	
b. Position mask securely over mouth and nose.	
5. Delivery by tracheostomy:	
a. Position student with neck extended and trach opening exposed.	Proper positioning ensures open airway.
b. Attach resuscitator to trach tube. Squeeze the resuscitator bag in coordination with student's respiratory effort.	Hold trach with one hand to prevent accidental dislodgement while attaching adaptor to it. Give a breath by squeezing the resuscitator bag as the student begins to inhale (chest begins to rise). If you feel resistance and/or the student looks distressed, be sure you are giving breaths with the student's own effort and that the tube is patent.
c. Notify EMS, parent/guardian and school nurse.	
d. Squeeze resuscitator bag at a recommended rate if student is not breathing spontaneously.	Allow ample time between respirations for passive exhalation and bag re-expansion. If the student has no breathing rate prescribed, a standard range of breaths per minute is 16-20 for children and 12-16 for adolescents and adults.

D. Check effectiveness of ventilation.	Observe student's face, lip color, and level of consciousness. Make sure student's chest rises with each inflation and falls during passive exhalation.
E. Continue bagging in an emergency until relieved by appropriately trained persons or until student resumes adequate, spontaneous respirations.	
F. Clean equipment and reassemble for use.	
G. Remove gloves and wash hands.	Refer to *Gloves - Use and Removal* and *Hand Washing* procedures.
H. Document procedure on student's individual treatment record.	Record: 1. Date and time. 2. All pertinent information. 3. Student's response to procedure. 4. Signature of personnel performing procedure.

E. MECHANICAL VENTILATOR

I. Guidelines: The mechanical ventilator device functions as a substitute for the bellows action of the thoracic cage and diaphragm. Ventilators differ and must be operated according to manufacturer's directions. Standard ventilator features should be checked daily upon arrival to school.

A. Purpose: To provide training and supervision guidelines for safe mechanical ventilation of the student in the school setting and during co-curricular events.

B. Equipment: (Parent responsibility unless otherwise indicated).

1. Student specific ventilator.
2. Spare, appropriate-sized adaptor for tracheostomy.
3. Appropriate ventilator tubing.
4. Oxygen source with appropriate tubing, if needed.
5. Appropriate-sized resuscitation bag with student at all times.
6. Manufacturer's instruction booklet.
7. Humidification source.
8. Suctioning equipment.
9. Saline dosettes, as ordered.
10. Back-up battery.
11. Other adaptors needed for a particular student.
12. Pulse oximeter, as ordered.
13. Carbon dioxide analyzer, as ordered.
14. Stethoscope (county).
15. Accessible functioning electrical outlets (county).
16. Emergency power supply (county).

C. Personnel: Certified school nurse or other licensed health care provider such as a RN, LPN, or respiratory therapist under the direct or indirect supervision of the certified school nurse.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain written physician's orders and parent/guardian written consent to perform procedure.	All specialized procedures performed in the school setting require written orders and parent/guardian consent.
B. Follow manufacturer's instructions for specific ventilator.	Since there are different types and models of ventilators available, always refer to manufacturer's book. Refer to **Ventilator Machines and Circuit Skills Checklist.**

C. Check and document ventilator settings daily per physician's orders. Assess proper functioning of ventilator and humidifier.	Do not change settings unless ordered by physician. A copy of the current ordered ventilator settings should be posted on the ventilator. Follow manufacturer's directions to change settings if ordered.
D. Check tubing to tracheostomy for patency.	Tubing must be clear of obstructions to provide proper oxygenation.
E. Assess student's respiratory rate, lung sounds, skin color and mental alertness as indicated.	Routine monitoring ensures that proper oxygenation and respirations are occurring.
F. Monitor student's oxygen (0_2) and carbon dioxide ($C0_2$) levels according to physician's orders.	May use pulse oximeter and $C0_2$ analyzer. This ensures proper oxygenation and ventilation is occurring.
G. Suction tracheostomy as needed or ordered.	Airway must be patent to ensure adequate oxygen delivery. Refer to *Tracheostomy Suctioning* procedure.
H. Document information on student's individual treatment record.	Record: 1. Date and time. 2. Ventilator settings. 3. Assessment findings. 4. Signature of personnel performing procedure.
I. Establish vital functions in case of ventilator mechanical failure:	Refer to **Possible Problems When Using a Ventilator That Requires Immediate Attention** and **Ventilator Troubleshooting Alarms Skills Checklist.**
1. Maintain adequate airway.	
2. Perform cardio-pulmonary resuscitation (CPR) if necessary.	Refer to *Manual Resuscitator* procedure.
3. Use established nursing emergency care plan.	
4. Call Emergency Medical services (EMS) and notify parents.	Paramedics will transport student to nearest hospital emergency room. Send all available information to the emergency room.
J. Access emergency power source if electrical power goes out or ventilator battery fails.	Use manual resuscitator until ventilator is functioning properly. Refer to *Manual Resuscitator* procedure.

Student's Name

Person trained:

Position:

VENTILATOR MACHINE AND CIRCUIT

Skills Checklist

Instructor:

Explanation/Return Demonstration	Expl/ Demo Date	Explanation/Return Demonstration					
		Date	Date	Date	Date	Date	Date
A. States name and purpose of procedure							
B. Describes machine components and settings: 1. Power source							
a. Internal battery							
b. External battery							
c. Accessible, functioning electrical outlets							
d. Back-up battery							
e. Emergency power supply							
2. Oxygen source (if needed)							
a. Connection to ventilator and spare tubing							
b. Oxygen supply, spare tank, and gauge							
c. Flow (LPM) and percentage of oxygen							
3. Humidification source:							
a. Passive condenser, heat moisture exchanger (hme) or heated humidifier							
4. Tidal Volume							
5. Respiratory_Rate/frequency							
6. Patient pressure nanometer							
7. Peak inspiratory pressure (PIP)							
8. Positive end-expiratory pressure (PEEP)							
9. Ventilator mode							
10. Inspiratory time							
11. High-pressure alarm							
12. Low-pressure alarm							
13. Power source alarm							
C. Describes ventilator circuit components: 1. Patient pressure tubing							
2. Patient port							
3. Exhalation valve							
4. PEEP valve							
5. Additional adaptors							
D. Go Bag supplies (see p. 335), including: 1. Manual resuscitation bag with adaptor or mask							

(Continued)

Format adapted from Children's Hospital Chronic Illness Program, Ventilator Assisted Care Program. (1987). *Getting it started and keeping it going: A guide for respiratory home care of the ventilator assisted individual.* New Orleans, LA: Author; adapted by permission.

VENTILATOR MACHINE AND CIRCUIT

Student's Name

Skills Checklist

Explanation/Return Demonstration	Expl/ Demo Date	Explanation/Return Demonstration					
		Date	Date	Date	Date	Date	Date
2. Spare tracheostomy tube and supplies							
3. Suctioning supplies							

Checklist content approved by: _____

Parent/Guardian signature: _____ Date: _____

POSSIBLE PROBLEMS WHEN USING A VENTILATOR THAT REQUIRE IMMEDIATE ATTENTION

Observations	***Reason/Action***
Student appears to be in distress . Increased shortness of breath . Agitation . Blueness or pallor of lips, fingernail beds . Retractions (e.g., pulling in of chest muscles) . Confusion . Rapid or pounding pulse . Rapid respiratory rate (tachypnea)	Immediately check and reassure the student. Call for assistance. Never leave the student alone. The symptoms may be caused by . Occlusion of the tracheostomy tube by a plug or secretions . A dislodged tube or other airway problems . Student may be coughing or doing something else to raise pressure transiently
	The symptoms may also be caused by ventilator malfunction: . The exhalation valve may be obstructed . The student may be disconnected from ventilator Check to see that the power source is functioning and that oxygen supply is adequate Disconnect the student from the ventilator and use manual resuscitation bag if needed while attending to the student's needs
The tracheostomy tube is dislodged	Replace the tube
The tracheostomy tube is blocked	Attempt to suction; instill normal sterile saline if indicated. If unsuccessful, replace tube
The student has increased secretions	Suction the tracheostomy
The student is wheezing	Administer bronchodilators by nebulizer if ordered and suction as necessary
The student continues to be in distress or becomes unconscious	Continue using manual resuscitator and ***activate emergency procedure***.
Distress is relieved by disconnecting from ventilator and using manual resuscitation	Check the ventilator while using the manual resuscitator to assist the student's breathing. Check circuit, valves and tubing for leaks, obstruction or water condensation in tubing. If unable to locate and correct problem with ventilator, continue using resuscitation bag and call the home care company, family and other health care providers as specified in student-specific guidelines. ***Activate emergency plans.***
The power supply is not functioning	Ventilate student with manual resuscitator until back-up power supply is in operation.

An alarm is activated:

. Low pressure alarm/apnea alarm is a continuous audible alarm and is usually accompanied by a flashing red light on the ventilator front panel.

Always check student first. Remove the student from ventilator and give breaths with resuscitator bag and then check the ventilator.

This alarm may be activated by the following:

. The student may be disconnected from the ventilator
. The exhalation valve is not working (wet or punctured).
. The tracheostomy tube is no longer in place
. The circuit tubing is no longer attached or is loose
. Water is present in pressure or exhalation tubing
. Humidifier is improperly attached or leaking
. Accidental change in ventilator settings

Test system after cause of problem is found and fixed. Place student back on ventilator.

. High-pressure alarm is an ***intermittent alarm*** usually accompanied by a flashing red light

Note: If the condition that caused this alarm to be triggered is stopped with the next breath, the audible alarm will stop but the visual alarm will need to be reset.

Always check student first, remove the student from ventilator and give breaths with resuscitator bag and then check ventilator.

This alarm may be activated by the following:

. The student may need to be suctioned for secretions or a mucus plug
. This may indicate increased resistance or obstruction
. The head moisture exchanger (HME) may be occluded by secretions or water
. The circuit tubing may be blocked by water or pinched off.
. The exhalation valve may be obstructed.
. The tracheostomy tube may be out of alignment.
. The student may be coughing or doing something else to raise pressure transiently (.i.e., sneezing, talking, laughing).
. Accidental change in ventilator settings.

Test system after cause of problem is found and fixed. Place student back on ventilator.

. Power alarm is ***continuous*** usually accompanied by a flashing light as well.

Check to see that power source is functioning (e.g., ac power, internal and external battery). The alarm may sound if power source is interrupted (e.g., power failure, battery change). If all three power sources fail, remove student from ventilator. Give breaths with resuscitator bag and ***activate the emergency plan***.

Student's Name

Person trained:

Position:

VENTILATOR TROUBLESHOOTING ALARMS

Skills Checklist

Instructor:

Explanation/Return Demonstration	Expl/ Demo Date	Explanation/Return Demonstration					
		Date	Date	Date	Date	Date	Date
A. States name and purpose of procedure							
B. Steps							
1. Identifies which alarm is sounding							
2. Checks student first if *low-pressure* alarm sounds							
3. Removes student from ventilator and gives breaths with resuscitator bag.							
4. Checks for leaks, if student is fine:							
a. Student disconnected							
b. Disconnected tubing							
c. Kinked tubing							
d. Punctured tubing							
e. Water in exhalation valve							
f. Hole in exhalation valve							
g. Loose-fitting heater humidification source							
h. Check ventilator settings							
5. Tests system after leak is found (Occlude student end of circuit and wait for high-pressure alarm to sound.)							
6. Places student back on ventilator							
7. Checks student first if a *high-pressure* alarm sounds							
8. Checks activity of student:							
a. Needs suctioning							
b. Blocked tracheostomy tube							
c. Coughing							
d. Sneezing							
e. Talking							
f. Laughing							
g. Crying							
h. Hiccups							
I. Body position							
j. Holding breath							
9. Suctions, if needed							
10. Realigns or changes tracheostomy tube, if needed.							
11. Removes student from ventilator and gives breaths with resuscitator bag.							

Format adapted from Children's Hospital Chronic Illness Program, Ventilator Assisted Care Program. (1987). *Getting it started and keeping it going: guide for respiratory home care of the ventilator assisted individual.* New Orleans, LA: Author; adapted by permission.

Student's Name

VENTILATOR TROUBLESHOOTING ALARMS

Skills Checklist

Explanation/Return Demonstration	Expl/ Demo Date	Explanation/Return Demonstration					
		Date	Date	Date	Date	Date	Date
12. Checks ventilator for obstructions; if student is okay:							
a. Kinks in tubing							
b. Water in tubing							
c. Blocked exhalation valve							
d. Accidental change in ventilator settings							
13. Places student back on ventilator once problem is solved after checking high-pressure circuit							
14. Checks the following if power source alarm is on:							
a. AC power							
b. Internal battery							
c. External battery							
15. Removes student from ventilator if all three systems fail and gives breaths with resuscitator bag.							
16. If bagging is required for longer than 15 minutes, adds drops of saline for humidity or puts passive condenser on resuscitation bag and continues to bag; follows emergency plan.							

Checklist content approved by: _____

Parent/Guardian signature: _____ Date: _____

F. METERED DOSE INHALER THERAPY (MDI)

I. Guidelines: The metered dose inhaler is a self contained pressurized canister that contains medication which is suspended in an inert gas or other propellant. A hand activated valve releases a measured volume of medication and propellant. MDIs differ by brand and must be operated according to manufacturer's directions. Recent changes in the type of propellant used in most MDIs (i.e. Hydrofluoroalkane or HFA) have precipitated alteration of priming and usage from older versions of the device.

A. Purpose: To provide training and supervision guidelines for safe administration of inhaler and to deliver a measured dose of medication to a student for inhalation.

B. Equipment: (Parent responsibility unless otherwise noted).
1. Metered Dose Inhaler.
2. Holding Chamber/Spacer (if ordered)

C. Personnel: Certified school nurse or designated trained school personnel under direct or indirect supervision of the certified school nurse or student with permission of a licensed prescriber, parent/guardian and certified school nurse.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain written licensed prescriber's order and parent/guardian written consent.	All specialized procedures performed in the school setting require written licensed prescriber's orders and parent/guardian consent.
B. Wash hands if assisting with Metered Dose Inhaler.	Refer to *Hand Washing* procedure.
C. Observe or assist student to use MDI, according to licensed prescriber's order. Closed mouth method should be used.	WV Code §18-5-22b requires a certified school nurse to assess student to carry and self-administer.
D. Obtain and document Peak Flow reading pre and post MDI treatment, if ordered.	Refer to *Peak Flow Meter* procedure.
E. Instruct student to:	

1. Insert canister firmly and fully into the outer plastic container. Shake the inhaler well. Attach holding chamber/spacer, if ordered.	Student should be standing or sitting upright. Refer to MDI manufacturer instructions for proper MDI priming and use.
2. Remove cap from mouthpiece and hold canister upright.	Verify that there is nothing blocking the aperture where the spray comes out.
3. Hold inhaler between the thumb and forefinger.	
4. Instruct student to inhale deeply and then exhale slowly.	
5. Instruct student to make an "O" shape with his/her mouth and place the inhaler in the mouth placing lips and teeth around the inhaler opening.	Closed mouth method should be used. If using a holding chamber/spacer mouthpiece in mouth with MDI inserted into the opposite end.
6. Press down firmly on the top of the canister with index finger. While breathing in deeply and slowly through mouth.	
7. Continue to inhale. Have the student try to hold breath for a minimum of 5-10 seconds. Remove inhaler from mouth and release finger from canister before breathing out.	
8. Exhale slowly through pursed lips.	
9. Wait 1-minute and shake the inhaler before taking next inhalation. Follow the same instructions for second inhalation.	Replace mouthpiece cap after each use.
10. Wait 5 minutes between the second and third puff if 3 puffs are prescribed.	
11. Instruct student to rinse mouth and spit with water thoroughly if the medication is a corticosteroid.	Rinsing mouth with water after MDI use prevents oral infection and tooth decay.

12. Clean MDI after use by wiping mouthpiece with a clean dry cloth.	Clean holding chamber/spacer by following manufacturer's instructions.
13. Discard canister when empty and request replacement from parent/guardian.	
F. Monitor student for administration technique.	Provide feedback on technique.
G. Document procedure on student's individual treatment record.	Record: 1. Date and time. 2. Medication. 3. Any pertinent information. 4. Student's response to procedure. 5. Signature of personnel performing or assisting with procedure.

G. ORAL SUCTIONING

I. Guidelines: Oral suctioning by machine or bulb syringe may be necessary to clear the oral cavities of excessive secretions and to provide an adequate airway.

A. Purpose: To provide training and supervision guidelines for oral suctioning in the school setting and during co-curricular events.

B. Equipment: (Parent responsibility unless otherwise noted).
1. Suction machine or bulb syringe.
2. Yankauer suction catheter device.
3. Water (county).
4. Container for water (county).
5. Disposable cup (county).
6. Goggles (county).
7. Disposable medical gloves (county).

C. Personnel: Certified school nurse or other qualified licensed health care provider such as, a RN or LPN, respiratory therapist and designated trained school personnel under the direct or indirect supervision of the certified school nurse or student independently as ordered by licensed prescriber.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain a written order from a licensed prescriber and written consent from parent/guardian.	All specialized procedures performed in the school setting require written licensed prescriber's orders and parent/guardian consent.
B. Assemble equipment.	
C. Wash hands and put on gloves and goggles.	Refer to *Hand Washing* and *Gloves – Use and Removal* procedures.
D. Position child.	Optimal position is on side with head slightly lowered to aid in pooling and draining secretions. Assistance to hold student is recommended when suctioning small children.

E. Suctioning with Bulb Syringe:

1. Compress bulb. Insert tip of syringe into cup of water. Release pressure on bulb to suction small amount of water. Discard into cup.	Suctioning checks effectiveness of bulb syringe.
2. Compress bulb. Insert tip of bulb syringe into dependent cheek of student. Areas to be suctioned include cheeks and beneath tongue.	Secretions will be more accessible on side student's head is positioned. Avoid grabbing membranes to prevent injury to tissue.
3. Release pressure on bulb to withdraw secretions.	
4. Discard secretions into a cup or paper towel by squeezing bulb several times.	
5. Repeat steps 2-4 as necessary.	Areas to be suctioned include cheeks and beneath tongue
6. Clean bulb syringe, after use, with warm soapy water. Flush several times using suctioning technique. Rinse with clear water.	
7. Discard disposable equipment. Make sure bulb syringe is ready to re-use.	

F. Suctioning by machine:

1. Turn on suction machine. <u>Attach Yankauer to suction tubing.</u>	Do not advance further than the back of the mouth, as this may stimulate the gag reflex, cause vomiting, and/or produce laryngospasm. Limit areas to be suctioned to cheeks, beneath tongue and the back of the mouth.
2. Introduce <u>Yankauer</u> suction device into oral cavity.	
3. Suction water to clear <u>Yankauer</u> suction device of secretions.	
4. Repeat steps 2-3 as necessary. Allow 2-3 minutes between suctioning.	

5. Clean Yankauer suction device with warm soapy water and rinse with clear water.	Refer to *Handling of Body Fluids* procedure. Refer to *Cleaning and Disposing of Body Fluids* procedures.
6. Discard disposable equipment.	
7. Empty contents of suction bottle into toilet at the end of the school day.	
8. Wash bottle with warm soapy water. Wear gloves and goggles during the process.	
G. Remove gloves and wash hands.	Refer to *Gloves – Use and Removal* and *Hand Washing* procedures.
H. Document on student's individual treatment record.	Record: 1. Date and time. 2. Amount, color, and consistency of secretions. 3. Student's response to procedure 4. Any pertinent information 5. Signature of personnel performing procedure.

H. OXYGEN ADMINISTRATION

I. Guidelines: Oxygen may need to be administered to prevent and/or treat hypoxia or hypoxemia while reducing labored breathing. Oxygen administration requires attention to environmental concerns for the safety of the student for whom it is prescribed and other members in the school setting. Awareness of the presence of oxygen is essential for all individuals who use the building. The location of oxygen tanks and fire safety equipment must be considered. Collaboration with community agencies that supply oxygen is essential in planning for the care of the student.

A. Purpose: To provide training and supervision guidelines for the safe use of oxygen in the school setting and during co-curricular events.

B. Equipment: (Parent responsibility unless otherwise noted).

1. Oxygen source – portable oxygen tank or cylinder with tank wrench, if needed.
2. Pressure gauge.
3. Flowmeter.
4. Appropriate-sized delivery system (i.e., nasal cannula, facemask or tracheostomy adaptor).
5. Disposable connecting tubing.
6. Humidifier with distilled water, if ordered.
7. Backup delivery system and oxygen source for emergency.
8. Emergency manual resuscitator (i.e., ambu bag).
9. Appropriate fire extinguisher (county).
10. Appropriate warning signage (county).

C. Personnel: Certified school nurse, other licensed health care providers such as a RN, LPN or respiratory therapist or other designated trained school personnel under the direct or indirect supervision of the certified school nurse.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain order from licensed prescriber and parent/guardian written consent.	All specialized procedures performed in the school setting require written licensed prescriber's order and parent/guardian consent.
B. Assess environment for:	Potential sources of fire must be considered for the safe storage and use of oxygen in the school setting. A non-handicapped accessible building may limit student's ability to easily access certain areas in the school building.
1. Building accessibility for student's use of oxygen.	
2. Location of exits, fire extinguishers.	
3. Risks of flammability (i.e., electrical sparks/smoking).	
4. Arrangements for tank security.	Oxygen supports combustion. Ensure that proper signs are posted "No Smoking or Open Flames - Oxygen in Use" and/or "Oxygen in Use – Fire Hazard".
5. Arrangements for adequate ventilation of storage area for tank.	Recognize that concentrated oxygen accumulates in the immediate area of use, thus adequate ventilation is essential.
C. Review student's daily schedule	Consider activities and locations in the school setting. Address need for assistance with oxygen tank, managing school books and supplies. Develop an emergency plan for the student in the event of emergency evacuation from building.
D. Identify school personnel responsible for student safety.	Oxygen administration requires specialized in-service to assure safe use of oxygen and continual monitoring of the student's status.
E. Wash hands.	Refer to *Hand Washing* procedure.
F. Assemble equipment.	Check equipment for proper functioning upon arrival to school and as needed throughout the day. **DO NOT ATTEMPT TO SERVICE EQUIPMENT ON YOUR OWN.**

G. Connect tubing to oxygen source.	Nasal cannula should be changed or cleaned every week or more often, depending upon the amount of use. Extra equipment should be in storage at all times and changed more often during respiratory illness of student to prevent re-infection.
H. Attach humidifier, if ordered, to oxygen tubing.	Follow manufacturer's instructions for humidifier maintenance and cleaning instructions.
I. Flush line by turning oxygen on and adjusting flow rate to ordered level. Feel for oxygen flow through tubing.	Oxygen is prescribed and administered like a drug with flow dosage measured in liters per minute or percentage of oxygen.
J. Place nasal cannula or face mask on the student's face or attach the tracheostomy adaptor. Adjust nasal cannula around ears or facemask to the nasal bridge to ensure optimal oxygen benefit during oxygen administration.	Pressure of cannula or facemask can cause skin breakdown. Observe and administer skin care as needed. Prolonged administration by mask will require periodic mask removal to dry face and massage skin. It will also cause eyes to dry excessively if mask fits improperly.
K. Monitor student for any change in condition while receiving oxygen.	Personnel caring for student should check skin and lip color, respiratory effort, activity tolerance, etc.
L. Document on student's individual treatment record.	Record: 1. Date and time. 2. Amount of oxygen intake. 3. Oxygen flow rate in liters/min or percentage. 4. Any other pertinent information. 5. Signature of personnel performing procedure.
M. Additional Considerations:	Avoid use of products containing oil, grease or petroleum-based cleaners near oxygen (i.e., Vaseline, Chapstick, etc.). Do not use antiseptic tinctures, alcohol, furniture sprays, or acetone in the immediate area. Avoid toys, electronic games or devices, cell phones or objects, which may cause sparks that could ignite. Do not permit electrical devices on or near oxygen sources. Note: depending on type of facemask used, a proper liter per minute flow must be achieved

to reduce risk of Carbon Dioxide (CO2) retention in the mask and thus breathed in by the student. Refer to manufacturer instructions. Rule of thumb: if facemask is a standard simple mask, keep liter flow at least at 5 liters per minute to reduce risk.

I. PEAK FLOW METER

I. Guidelines: The peak flow meter (PMF) provides an objective measurement of peak expiratory flow (indicated in liters per minute), a valuable indicator of lung function. It can be used over a period of time by an asthmatic child to measure and record lung function so that the licensed prescriber can order the proper treatment. During an asthma attack, the peak flow meter can serve as a tool to objectively measure the severity of the child's respiratory distress.

A. Purpose: To provide training and supervision guidelines for the use of a peak flow meter in the school setting and during co-curricular events.

B. Equipment: A peak flow meter (parent responsibility unless otherwise noted).

C. Personnel: Certified school nurse, licensed health care provider such as a RN, LPN or respiratory therapist or designated, trained school personnel under the direct or indirect supervision of the certified school nurse. The student may perform this procedure independently if ordered by licensed prescriber.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain order from a licensed prescriber and parent/guardian written consent.	All specialized procedures performed in the school setting require a written order from a licensed prescriber and parent/guardian consent.
B. Have student stand (preferred) or sit upright (feet flat on floor).	Most devices do not require assembly, however due to variations by manufacturer, some devices may require an adapter such as adult (large) or pediatric (small) mouthpiece that fits into the unit.
C. Instruct the student to place the mouthpiece on the peak flow meter.	Some devices are only for younger children and have lower peak flow meter readings. Those approved for all ages will have ranges from 60 liters/min to 800 liters/min on the device.

D. Ensure that the indicator (typically red) is at the bottom of the scale.

E. Hold the peak flow meter according to manufacturer's instructions, being careful that the student's fingers do not block the opening.

F. Instruct the student to inhale as deeply as possible and place mouth firmly around the mouthpiece, making sure lips form a tight seal.

Make sure student's mouth is empty of food before beginning maneuver. Make sure student is not blocking opening with tongue, teeth, or lips as this will reduce the peak expiratory flow reading.

G. Instruct the student to exhale as hard and as fast as possible. This will cause the red indicator to move up the scale. The final position of the red indicator is the student's peak expiratory flow.

H. Note the measurement that the indicator is pointing to on the number scale. Repeat steps D – G two more times. Record the *highest* number. Do not average them.

Wait 10 – 15 seconds between measurements. Observe effort and comprehension of student. Provide reinforcement for improved performance of maneuver.

I. Pre and Post inhaled medication. Per licensed prescriber's order or other criteria, provide student inhaled medication. Repeat peak flow meter steps D - G three more times. Record the highest number (do not average).

The peak flow meter should be performed before inhaled medication and then 10-15 minutes following inhaled medication to measure response to medication and need to provide additional medication treatment, or the need to begin the student's emergency plan. If the student is using this as a measurement tool for a licensed prescriber's information, help record the results as ordered.

J. Refer to student's intervention guide or emergency plan for instructions related to peak flow value.

If the peak flow meter is to serve as a tool to measure respiratory distress, personnel should have previous documentation as to the normal range for the student or refer to Chart of Average peak flow rate for healthy children and teenagers.

K. Document procedure on student's individual treatment record.

Record:

1. Date and time.
2. Peak flow reading pre and post.
3. Other pertinent information.
4. Student's response to procedure.

5. Signature of personnel performing procedure.

L. Refer to manufacturer's instructions if student has an electronic peak flow meter.

J. PHRENIC NERVE STIMULATOR

I. Guidelines: A phrenic nerve stimulator (PNS) is a device that provides electrical stimulation of a student's phrenic nerve to contract the diaphragm rhythmically and produce breathing in students who have hypoventilation. The stimulator consists of surgically implanted electrodes that attach to the phrenic nerve either in the neck or in the thorax. The receivers may be implanted on the outer sides of the lower rib cage below the clavicles, on the abdominal muscles or at another appropriate site. The energy transfer coils are attached to the skin by adhesives over the implanted receivers. The cables of the coils are then connected to the control unit of the stimulator. The stimulator uses two rechargeable batteries. (Refer to photo).

A. Purpose. To provide training and supervision guidelines for the care of a student with a phrenic nerve stimulator in the school setting and during co-curricular events.

B. Equipment: (Parent responsibility unless otherwise indicated).

1. Phrenic nerve stimulator surgically implanted and programmed by the physician.
2. Portable stimulus controller with attachments (receivers, antenna and cable).
3. Programming unit with its connecting cable.
4. Energy transfer coils.
5. 9-volt rechargeable batteries.
6. Carbon dioxide analyzer.
7. Pulse oximeter.
8. Manufacturer's instruction booklet.
9. Manual ventilator (e.g., Ambu-bag).
10. Mechanical ventilator.
11. Stethoscope (county).

C. Personnel: Certified school nurse, other licensed health care providers such as a RN or LPN or student independently, if ordered by the physician, under the direct or indirect supervision of the certified school nurse.

II Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain physician's orders and written parent/guardian consent to perform procedure.	Procedures performed in the school setting require physician's orders and parent/guardian consent.
B. Monitor pacer operation, carbon dioxide and oxygen levels upon student's arrival at school. Make adjustments to settings as indicated by physician's orders throughout the day. 1. Check that the antenna rings are over the receivers and secured to the abdomen. 2. Check cable connection to pacer box. 3. Check controlling unit for battery function and rate settings.	Review student's health care plan, intervention guide, and physician's orders for prescribed settings. Settings will be altered to compensate for student's level of activity (i.e., PE, recess, etc.)
C. Refer to manufacturer's instructions when making adjustments to PNS.	Every pacing device is different and manufacturer's instructions may vary.
D. Assess for signs of PNS malfunction. Observe for: 1. Asymmetry of chest movements or inadequate student ventilation. 2. Chest expansion. 3. Skin color	Troubleshooting List: 1. Check airway patency and suction if necessary. 2. Reposition student. 3. Check cable connections between pacer box and antenna rings. 4. Check that antenna rings are over the receivers and secured to abdomen. 5. Switch the cable connections at the pacer box. 6. Check battery and change if necessary. 7. Manually ventilate student and place on ventilator, notify physician, parent/guardian and school nurse.

E. Document information on student's individual treatment record.

Record:

1. Date and time.
2. Student's pulse oximeter and carbon dioxide readings.
3. Respiratory rate/pacer setting.
4. Any other pertinent information.
5. Signature of personnel performing procedure.

F. Other Considerations:

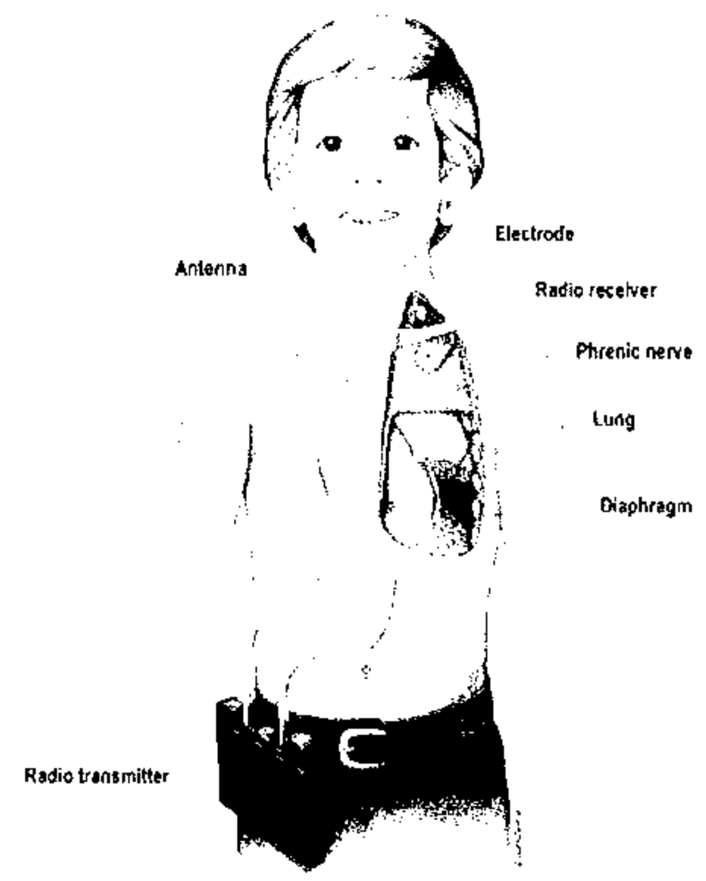
1. Use caution when handling the pacing unit.

The pacing unit is very fragile and costly. Pacing unit should be stored in a belly pack, small backpack, or stable container to avoid any severe blows to the pacer. Pacing unit settings can only be changed and the unit handled by the school nurse, other licensed health care provider or student independently if ordered by physician.

2. Turn off pacing unit before performing tracheal suctioning on the student.

Refer to *Tracheostomy Suctioning* (Sterile) procedure.

REMEMBER TO TURN ON PACING UNIT AFTER COMPLETING SUCTIONING.



K. POSTURAL DRAINAGE AND/OR PERCUSSION

I. Guidelines: Percussion and/or postural drainage is indicated for students with pulmonary dysfunction, such as cystic fibrosis, chronic bronchitis, asthma, other pulmonary disorders, cerebral palsy, etc. to maintain maximum lung capacity by assisting the student to loosen and expectorate mucus and sputum.

Chest physiotherapy devices and Therapy Vests are commonly used. See licensed prescriber's order and manufacturer instructions on use.

Follow the licensed prescriber's orders for frequency and duration of treatment.

A. Purpose: To provide training and supervision guidelines for performing percussion and/or postural drainage in the school setting and during co-curricular events.

B. Equipment: (Parent responsibility unless otherwise noted).
1. Percussion equipment, if ordered.
2. Table or mat (county).
3. Pillows (county).
4. Tissues (county).
5. Waste container with plastic liner (county).
6. Approved germicidal solution (county).

C. Personnel: Certified school nurse, other licensed health care provider such as a RN, LPN, respiratory therapist or physical therapist or designated, trained school personnel under the direct or indirect supervision of the certified school nurse

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain written order from licensed prescriber and parent/guardian written consent.	All specialized procedures performed in the school setting require a written order from a licensed prescriber and parent/guardian consent.
B. Wash hands.	Refer to *Hand Washing* procedure.
C. Assemble equipment in appropriate location.	Allow for student's privacy.

D. Use the following sequence for percussing each lobe of the lungs:

1. Place student in appropriate position.

Eight positions are necessary for percussing all lobes of the lungs. Use cupped hands with moderate pressure to create hollow sounds during percussion. Avoid percussing over kidneys, spine, liver and spleen.

2. Percuss lobes for 1-2 minutes over appropriate area.

3. Instruct student to cough into tissue following each percussion. Discard used tissues into lined wastebasket. Use vibration (applying pressure to appropriate lobe during coughing).

Initial coughing attempts may not produce sputum. As further positioning and percussion are provided, coughing will become more productive. (Use of vibration may break bones when students have abnormal bone conditions or are receiving medication such as steroids.)

E. The 8 positions for percussing students weighing 40 pounds or more are as follows:

Additional pillows may be necessary for all positions to obtain desired elevation, depending upon student's weight.

1. Position student on stomach with right side of torso and right arm on pillow.

This 1/4 turn of body is the correct position for percussing posterior segment of right upper lobe (over right upper scapular area).

2. Position student on stomach with left side of torso and left arm elevated on pillow.

This 1/4 turn with head and shoulder elevation is the correct position for percussing posterior segment of left upper lobe (over upper left scapular area). The left bronchus is more vertical, thus requiring a nearly 45-degree elevation.

3. Position student on back. Turn hips 1/4 turn to the right. Elevate hips 10-12 inches with pillows. Use additional pillows, as needed, to hold hips to the right.

This position is correct for percussing lingula process of left lung (from left armpit to nipple area).

4. Position student on back. Turn hips 1/4 turn to the left. Elevate hips 10-15 inches with pillows. Use additional pillows, as needed, to hold hips to the left.

This position is correct for percussing middle lobe of right lung (from right armpit to nipple area).

5. Position student on back. Elevate hips 16-18 inches with pillows.

This position is correct for percussing anterior basal segment of right and left lower lobes (over lower chest area below nipples).

6. Position student on stomach. Elevate hips 16-18 inches with pillows.

This position is correct for percussing posterior basal segments of right and left lower lobes (over lower chest areas - avoid kidneys).

7. Position student on right side. Elevate hips 16-18 inches with pillows.

This position is correct for percussing lateral basal segment of left lower lobe (over left side from beneath armpit to end of rib cage).

8. Position student on left side. Elevate hips 16-18 inches with pillows.

This position is correct for percussing lateral basal segment of right lower lobe (over right side from beneath armpit to end of rib cage).

F. The techniques for percussing students under 40 pounds (18 kg) and other students in a sitting position are as follows:

1. Person who does the percussing sits in chair with legs out-stretched at 45-degree angle and with bottom of feet braced against solid, upright object. Place pillow in front of your knees. Place student face down on your lap with chin resting on the pillow.

This position is correct for percussing posterior basal segments of lower lobes (over area from lower scapulae to end of rib cage).

NOTE: Young children and infants usually have no upper lobe involvement requiring percussion. Percuss with light pressure.

2. Seated as before, hold student face up on your lap, with head resting on pillow.

This position is correct for percussing anterior segments of lower lobes (over area from below nipple to end of rib cage).

NOTE: For babies, be sure head is firmly supported in both positions and percuss with light pressure.

G. After percussing/coughing in all 8 positions, assist student with 5 breathing techniques.

Percussion assists the student in raising sputum from the lung. This is the optimal time to accomplish maximum aeration of the lungs.

1. Encourage diaphragmatic breathing (breathing with diaphragm instead of chest). Repeat about 15 times.

Check for correct breathing pattern by holding hand at upper abdomen and feeling it rise and fall while chest is still. Encourage diaphragmatic breathing at all times.

2. Have student raise arms overhead while breathing in and have student lower arms while breathing out. Repeat about 15 times.	Maintain breathing pattern while performing this exercise. Encourage this type of breathing in functional activities, such as combing hair, lifting, etc.
3. Have student extend arms outward while breathing in and have student put arms across chest while breathing out. Repeat about 15 times.	Maintain breathing pattern while performing this exercise. Encourage slow expiration.
4. Encourage student to use prolonged expiration, i.e. pursed lip breathing. Repeat several times.	This assists student in emptying the lungs.
6. Assist student in progressive relaxation using several techniques: a. Imagery (think of pleasant thoughts, such as the beach, fresh air, etc.). b. Autogenic phrasing (feel hands getting warm and heavy to promote relaxation, etc.). c. Progressive muscular relaxation (contract right arm, relax right arm, repeat for left arm, etc.).	This procedure assists student to minimize asthmatic attacks or other respiratory distress symptoms. Progressive relaxation is used along with appropriate licensed prescriber's recommendations.
H. Discard contaminated articles.	Refer to *Cleaning and Disposing of Body Fluids* procedure.
I. Wash hands.	Refer to *Hand Washing* procedure.
J. Document procedure on student's individual treatment record.	Record: 1. Date and time. 2. Any other pertinent information. 3. Student's response to procedure. 4. Signature of personnel performing procedure.

L. TRACHEOSTOMY CARE

1. EMERGENCY CARE AND CLEANING OF TRACHEOSTOMY TUBE AND STOMA

I. Guidelines:

Maintenance care of the tracheostomy is routinely done in the home. This procedure will only be done in the school setting in an emergency situation. Emergency care and cleaning of the tracheostomy and stoma may be necessary to maintain an open airway by keeping the inner cannula patent and free of secretions and exudate, to prevent infection and to prevent irritation of tissue around the tracheostomy tube. Signs and symptoms of an inadequate airway may include labored or interrupted breathing, excessive secretions or mucus plugs and restlessness or apprehension.

Before the student with a tracheostomy is permitted to attend school, the certified school nurse must assess the level of care needed by the individual student including, but not limited to, emergency care and cleaning of the tube and stoma. Based on this assessment, an individualized plan of care must be developed documenting the manner in which this procedure can be safely performed in the school setting. Designated, trained personnel performing this procedure should adhere to sterile technique as much as possible during the emergency situation.

THIS PROCEDURE CAN ONLY BE DELEGATED TO A QUALIFIED, LICENSED HEALTH CARE PROVIDER.

A. Purpose:

To provide training and supervision guidelines for emergency care and cleaning of a tracheostomy tube and stoma in the school setting and during co-curricular events.

B. Equipment:

(Parent responsibility unless otherwise noted).

1. Sterile towel.
2. Sterile gauze sponges (12).
3. Sterile cotton swabs.
4. Non-waxed disposable cups.
5. Hydrogen peroxide, if ordered.
6. Pipe cleaners.
7. Sterile saline.
8. Antiseptic solution and/or ointment, if ordered.
9. Tracheostomy tie tapes or commercially available tracheostomy securing device.

10. Sterile tracheostomy dressing, if indicated.
11. Suctioning supplies and equipment.
12. Manual resuscitator (i.e., Ambu bag).
13. Extra tracheostomy tube on hand at all times.
14. Clean scissors.
15. Stethoscope (county).
16. Face shield or goggles (county).
17. Paper towels (county).
18. Disposable medical gloves (county).
19. Waste container with plastic liners (county).

C. Personnel: Certified school nurse or other qualified licensed health care provider such as a RN, LPN or respiratory therapist under the direct or indirect supervision of the certified school nurse.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS – PRECAUTIONS
A. Obtain orders from licensed prescriber and written parent/guardian consent.	All procedures performed in the school setting require written licensed prescriber's orders and parent/guardian consent.
B. Explain procedure to student.	Use developmentally appropriate language and demonstration. If student is spastic, restless, agitated, or confused, assistance may be needed to ensure safety.
C. Determine if student can be taken off ventilator during procedure.	If ventilation is needed during cleaning, the following may be done: a. Plug tracheostomy opening and have student ventilate by glossopharyngeal breathing. b. Fit outer cannula to ventilator. c. Use manual resuscitator.
D. Position student with tracheostomy area exposed.	Elevation of head provides drainage of cleansing solution onto the chest rather than into the tracheal opening.
E. Assess condition of stoma and examine neck for subcutaneous emphysema.	Report any signs of skin breakdown, infection or air leak into subcutaneous tissue to licensed prescriber.

F. Wash hands and put on face shield.	Refer to *Hand Washing* procedure. Face shield prevents secretions from getting into eyes.
G. Suction trachea and pharynx thoroughly before tracheostomy care.	Clears airway and keeps area clean longer. Refer to *Tracheostomy Suctioning* procedure.
H. Assemble equipment for cleaning tube and stoma:	Equipment can be purchased in a kit. All supplies should be kept in a readily accessible place for emergency care.
1. Place sterile towel on student's chest under tracheostomy site.	Provides sterile field.
2. Open 4 gauze sponges and pour saline and/or hydrogen peroxide, if ordered, on them.	Aids in removal of mucus and crust. Normal saline may be used instead of hydrogen peroxide, if indicated.
3. Open 2 gauze sponges and pour antiseptic solution on them, if ordered.	Antiseptic solution may not be necessary for clean, healed stoma.
4. Open 2 gauze sponges and keep dry.	
5. Open 2 gauze sponges and pour sterile saline on them.	
6. Place tracheostomy tie tapes on field, if indicated.	Tie tapes should be changed if soiled.
7. Open sterile swabs.	
8. Pour hydrogen peroxide, if ordered, into one cup and sterile saline into second cup.	This will be used to soak inner cannula to remove mucus.
I. Put on non-sterile gloves, remove and discard soiled gauze dressing, if used.	Refer to *Gloves – Use and Removal* and *Cleaning and Disposing of Body Fluids* procedures.
J. Remove gloves and cleanse hands.	Refer to *Hand Washing* procedure. Alcohol-based hand rubs may be used.
K. Put on sterile gloves.	Refer to *Gloves – Use and Removal* procedure.

L. Clean the stoma:	Designate the hand you clean with as contaminated and use the other hand as sterile for handling sterile equipment.
1. Wipe the external end of the tube with 2 gauze sponges with sterile saline and/or hydrogen peroxide, if ordered, and discard.	Sterile saline and/or hydrogen peroxide may help loosen dry crusted secretions.
2. Wipe the stoma area with 2 gauze sponges soaked with sterile saline and/or hydrogen peroxide, if ordered, and discard.	Do not wipe over area more than once with the same gauze. Cleanse area next to tube first and proceed outward, using a circular motion.
3. Loosen and remove crust with sterile cotton swabs.	
4. Wipe the stoma area with 2 sterile saline soaked sponges and discard.	
5. Wipe the stoma area with 2 dry sterile gauze sponges.	Ensure all hydrogen peroxide, if used, is removed.
6. Cleanse stoma with sterile gauze soaked in antiseptic solution and dry, if ordered, for infected wound. Apply thin layer of antibiotic ointment with a sterile cotton swab, if ordered.	Ensure dryness of the area. Wetness promotes infection and irritation. Optional step. Review orders from licensed prescriber for specific treatment.
M. Clean the tracheostomy tube:	Some tubes may have a disposable inner cannula. Remove and replace with new cannula touching only the external portion. Lock it securely into place.
1. Unlock, and remove inner cannula, holding inner cannula in place.	Use your contaminated hand when removing the cannula. After cleaning the cannula, handle with your sterile hand.
2. Place inner cannula in sterile saline or ½ sterile saline and ½ hydrogen peroxide, if ordered, to soak.	Be sure inner cannula is covered with solution. This removes mucus by bubbling action.
3. Clean inner cannula with pipe cleaners with your sterile hand to remove dry, crusted material.	Using 2 or more pipe cleaners provides more effective cleansing.

4. Place inner cannula into cup with sterile saline after it is clean, using your sterile hand.	Rinse thoroughly to remove all peroxide.
5. Tap or shake out excess moisture from inner cannula and reinsert into outer cannula.	Suction outer cannula before reinsertion if necessary. Refer to *Tracheostomy Suctioning* procedure.
6. Lock inner cannula securely into place.	Replace inner cannula as soon as possible after cleansing to prevent mucus plugs from forming in the outer cannula.

N. Replace soiled tie tapes:

1. Summon help if not already there to secure ties.	Prevents accidental dislodgement of tube and decreases irritation and coughing due to manipulation of the tube.
2. Cut soiled tie tapes while holding tube securely with your other hand. Remove old tie tapes carefully.	
3. Cut two sections of twill tape that together can encircle the student's neck and have room to be tied together at the side of the neck or place velcro tie.	Alternate side each time to prevent irritation and pressure areas. Two fingers should fit between tapes and neck when secured properly.
4. Make folds about 1 inch at the end of each tape. Cut a ½ inch slit up the middle of each fold.	Ensure trach is being held in place.
5. Take one tape and slip the end through tracheostomy plate slot from the bottom. Feed this end through the slit at the other end and gently pull the tape taut.	
6. Grasp slit end of clean tape and pull through opening on side of tracheostomy tube.	
7. Pull other end of tape securely through the slit end of the tape.	
8. Repeat steps 5 - 7 on other side.	

9. Tie tapes at the side of the neck in a square knot.

O. Cleanse the inner cannula only if mucus plug is present. Omit steps for cleaning stoma and replacing tie tapes.

P. Determine by bilateral auscultation that student is ventilating adequately. Attach ventilator if removed prior to cleaning.

Check that tracheostomy tube is positioned properly.

Q. Place gauze dressing, if ordered, between the stoma site and the tracheostomy tube to absorb secretions and prevent irritation of the stoma.

The use of gauze around the stoma site may not be necessary. Some studies suggest that the dressing keeps the area moist and dark and promotes infection. Follow licensed prescriber's orders for individual student

R. Dispose of all supplies in appropriate container.

Refer to *Cleaning and Handling of Body Fluids* procedure.

S. Remove face shield and gloves and wash hands.

Refer to *Gloves – Use and Removal* and *Hand Washing* procedures.

T. Document procedure on student's individual treatment record.

Record:

1. Date and time.
2. Any pertinent information.
3. Student's response to procedure.
4. Signature of personnel performing procedure.

2. EMERGENCY REPLACEMENT OF TRACHEOSTOMY TUBE

I. Guidelines: Tracheostomy tubes should not be changed in the school setting except in an emergency. An example of such an emergency would be if the tube became completely dislodged, or partially dislodged creating an obstruction at which point it may need to be removed. If the entire tube comes out it must be replaced immediately. Like most medical equipment, there is some variety in types of tubes . Some may have cannulas while others do not and they may or may not have an inflatable cuff. It is important to become familiar with a particular student's equipment. Emergency medical services should be notified if a tracheostomy becomes dislodged.

Before a student with a tracheostomy is permitted to attend school, the certified school nurse must assess the level of care needed for that individual student. Based on this assessment, a plan of care documenting the manner in which this procedure can be safely performed in the school setting must be developed.

A. Purpose: To provide training and supervision guidelines for the safe replacement of a tracheostomy tube in the school setting and during co-curricular events.

B. Equipment: (Parent responsibility unless otherwise noted).

1. Sterile tracheostomy tube (with obturator). A tube the same size the child is using and one smaller size should be available.
2. Scissors.
3. Twill tape/velcro ties or commercially available tracheostomy securing device.
4. Suction machine, including collecting bottle and connecting tube.
5. Manual resuscitation bag.
6. Sterile disposable suction catheters.
7. Non-waxed disposable cups.
8. Supply of sterile normal saline.
9. Paper towels (county).
10. Disposable medical gloves (county).
11. Plastic lined wastebasket (county).
12. Stethoscope (county).
13. Face shield or goggles (county).

C. Personnel: Certified school nurse or other qualified licensed health care professional such as an RN or LPN with current training in replacing a tracheostomy tube under the direct or indirect supervision of the certified school nurse.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain written orders from licensed prescriber and parent/guardian written consent to perform procedure.	All specialized procedures performed in the school setting must have written orders and parent/guardian written consent. Such an order should be on file for any student with a trach at school.
B. Assemble equipment.	Equipment should be readily available in case of emergency.
C. Glove immediately and put on face shield.	Refer to *Gloves-Use and Removal.*
D. Reassure student.	Calm and assured approach promotes student cooperation and ease of tube insertion.
E. Position student with head tilted back as far as possible.	Proper positioning eases reinsertion.
F. Open tracheostomy tube package.	
G. Moisten tube and obturator with sterile normal saline.	Lubricating eases insertion.
H. Insert tracheostomy tube with obturator into trach opening in neck from which previous trach has just been removed.	The new tube should be the same size as previous one and should fit in much the same way. One that is one size smaller should be available as well, if the first one proves difficult to insert.
I. Hold tracheostomy tube, pull out the obturator and insert cannula.	Some trach tubes may not have a cannula. Familiarity with a student's equipment prior to an emergency is imperative.
J. Hold on to the newly placed tube carefully at its insertion sight. Minimize movement as much as possible.	Student is likely to cough with the insertion of the new tube and you must hold it in place until properly secured.

K. Assess respiratory status. Suction or use manual resuscitator as indicated.	Check lung sounds, respiratory rate and efforts. Refer to *Tracheostomy Suctioning* and *Manual Resuscitation* procedures.
L. Replace trach ties, if needed, or secure tube with velcro or other trach device:	
1. Summon help if not already there to secure ties.	Procedure works best if assistant is available to help hold trach securely and assist with placement of ties.
2. Cut two sections of twill tape that together can encircle the student's neck and have room to be tied together at the side of the neck.	
3. Knot one end of each tape.	Prevents fraying.
4. Make folds about 1 inch at the end of each tape. Cut a ½-inch slit up the middle of each fold.	Ensure tube is being held in place.
5. Take one tape and slip the end through tracheostomy plate slot from the bottom. Feed this end through the slit at the other end and gently pull the tape taut.	
6. Tie tapes together at side of neck.	Leave enough room to insert finger under tape easily to avoid pressure on neck.
M. Replace soiled tie tapes:	
1. Summon help if not already there to secure ties.	Prevents accidental dislodgement of tube and decreases irritation and coughing due to manipulation of the tube.
2. Cut soiled while holding tube securely with your other hand. Remove old carefully.	
3. Cut two sections of twill tape that together can encircle the student's neck and have room to be tied together at the side of the neck or place velcro tie.	Alternate side each time to prevent irritation and pressure areas. Two fingers should fit between tapes and neck when secured properly.

4. Make folds about 1 inch below knot on each tape. Cut a ½ inch slit up the middle of each fold.	Ensure trach is being held in place.
5. Take one tape and slip the end through tracheostomy plate slot from the bottom. Feed this end through the slit at the other end and gently pull the tape taut.	
6. Grasp slit end of clean tape and pull through opening on side of tracheostomy tube.	
7. Pull other end of tape securely through the slit end of the tape.	
8. Repeat step 5 - 7 on other side.	
9. Tie tapes at the side of the neck in a square knot.	
N. Determine by bilateral auscultation that student is ventilating adequately. Attach ventilator if removed prior to cleaning.	Check that tracheostomy tube is positioned properly.
O. Place gauze dressing, if ordered, between the stoma site and the tracheostomy tube to absorb secretions and prevent irritation of the stoma.	The use of gauze around the stoma site may not be necessary. Some studies suggest that the dressing keeps the area moist and dark and promotes infection. Follow licensed prescriber's orders for individual student
P. Remove face shield and gloves and wash hands.	Refer to *Gloves-Use and Removal* and *Hand Washing* procedure.
Q. Document procedure on student's individual treatment record.	Record: 1. Date and time. 2. Circumstance of emergency reinsertion. 3. Pertinent information. 4. Signature of personnel performing procedure.

3. TRACHEOSTOMY SUCTIONING STERILE TECHNIQUE

I. Guidelines:

Tracheal suctioning is a means of clearing the airway of secretions or mucus. This may be done by using a vacuum-type device inserted through the tracheostomy. Tracheal suctioning is performed when a student cannot adequately clear secretions on his or her own. Depending on student's age, he/she may be able to request suctioning when needed or assist with procedure. The certified school nurse must assess and develop a plan of care for the student with a tracheostomy before he/she attends school.

Indications for suctioning may include the following:

a. Noisy, rattling breath sounds.
b. Visible secretions (i.e., mucus) filling opening of tracheostomy.
c. Signs of respiratory distress (e.g., difficulty breathing, agitation, paleness, excessive coughing, cyanosis, nasal flaring, retracting).
d. No air moving through tracheostomy.
e. Before eating or drinking if needed.
f. After respiratory treatments.
g. As ordered by licensed prescriber.

Encouraging student to cough to clear the airway may possibly eliminate the need for suctioning. However, some students may not be able to cough. Avoid unnecessary suctioning to reduce chances of injury and/or infection. Verify that all equipment and supplies are ready for use at the beginning of the day.

A. Purpose: To provide training and supervision guidelines for performing sterile tracheostomy suctioning in the school setting and during co-curricular events.

B. Equipment: (Parent Responsibility).

1. Portable suction machine, including collection bottle, connecting tubing and adaptor.
2. Portable oxygen source with tubing and adaptors.
3. Manual suction as back-up.
4. Appropriate-sized sterile suction catheters.
5. Sterile saline or sterile water to clear catheter.
6. Sterile container for saline or water.
7. Self-inflating manual resuscitation bag with trach adaptor.

8. Saline dosettes, if ordered.
9. Syringe to inflate or deflate cuff, if used.

(County Responsibility)
1. Sterile container for saline or water.
2. Waste container with plastic liner.
3. Disposable sterile medical gloves.
4. Paper towels or lint free gauze.
5. Goggles or face shield.
6. Stethoscope.
7. Alcohol pads.

C. Personnel: Certified school nurse or other licensed health care provider such as a RN, LPN or respiratory therapist. **NO PART OF THIS PROCEDURE MAY BE DELEGATED TO UNLICENSED PERSONNEL.**

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS- PRECAUTIONS
A. Obtain a written order from a licensed prescriber and parent/guardian written consent.	All specialized procedures performed in the school setting require written licensed prescriber's orders and parent/guardian consent.
B. Position student for suctioning.	Place in semi-fowler's or sitting position if condition allows.
C. Wash hands and put on goggles or face shield.	Refer to *Hand Washing* procedure.
D. Turn on suction machine and check for function. Adjust machine to ordered vacuum settings.	
E. Encourage student to cough and deep breathe to expel secretions. Manually ventilate with resuscitation bag, if indicated.	Deep breathing or ventilating will oxygenate lungs and loosen secretions. Coughing may eliminate need for suctioning. Auscultate lungs with stethoscope to assess respiratory effort.
F. Open suction catheter or kit.	Peel paper back without touching the inside of the package or catheter to maintain sterility.

G. Open saline dosette, if ordered.	
H. Fill container with sterile saline or sterile water.	This will be used to moisten the catheter and to clear out secretions in the catheter.
I. Put on sterile gloves.	Refer to *Gloves -Use and Removal* procedure.
J. Hold end of suction catheter in dominant sterile hand and attach it to the suction machine tubing held in non-dominant hand.	The dominant hand should remain sterile. It should not touch anything but the catheter. The non-dominant hand will be used to turn on switches and perform other activities. Leave the other end of catheter in its covering to maintain sterility.
K. Disconnect tubing from tracheostomy if student is on a mechanical ventilator, CPAP device or oxygen. Attach manual resuscitator bag to tracheostomy tube. Ventilate and oxygenate with bag 4-5 times to approximate student's tidal volume. In spontaneously breathing student, coordinate manual ventilations with student's own respiratory effort.	Ventilating before suctioning prevents hypoxemia. Use non-sterile hand to perform this step. Refer to *Manual Resuscitator* and *Oxygen Administration* procedures.
L. Remove suction catheter from package. Hold suction catheter 2-3 inches from tip with sterile hand and insert in to sterile saline or water. Cover vent hole with thumb to suction a small amount of solution through catheter.	This tests that suction is functioning.
M. Gently insert suction catheter as far as possible into artificial airway without applying suction. Most students will cough when catheter touches carina.	Do not insert catheter beyond the distal end of trach tube. If inserted too deeply, this can cause bronchospasm. Never apply suction while passing catheter into the airway. This will decrease student's oxygen level.
N. Withdraw catheter 2-3 cm. and cover vent hole (apply suction). Quickly rotate catheter with sterile hand while it is being withdrawn. Withdraw within 5-10 seconds.	Rotating the catheter gently between thumb and index finger while suctioning and withdrawing helps to reach all secretions and prevents damage to tracheal mucosa.
O. Suction sufficient amount of sterile water or saline from container to clear tubing of secretions.	

P. Allow student to deep breathe or give 4 - 5 breaths with resuscitator bag between suctioning attempts.	The student needs to clear lungs of carbon dioxide and get oxygen into lungs.
Q. Open normal saline dosette and instill 3-5 ml. into tracheostomy with non-sterile hand, if ordered. Manually ventilate with resuscitation bag to disperse saline.	This helps to loosen and thin out thick or dry secretions. Never instill sterile water into tracheostomy. Instill saline during inspiration to prevent blowing back out of the tube.
R. Repeat suctioning procedure if needed to clear airway. (Steps M – P).	Continue suctioning passes up to a total of four times (bagging the ventilated student between passes) until airway is clear of secretions. Rinse catheter between passes by inserting tip into container of sterile water or saline and applying suction. If appropriate, ask student if they need repeated suctioning.
S. Give student 4 - 5 "sigh" breaths with manual resuscitator when suctioning is complete.	Sighing is done by depressing the bag slowly and completely with two hands. This allows for maximal lung expansion and prevents atelectasis.
T. Reconnect student to mechanical ventilator, CPAP device or oxygen when suctioning is completed.	
U. Disconnect catheter from suction tubing. Holding catheter in gloved hand, pull gloves off, encasing catheter in glove and discard. Discard all disposable equipment.	Refer to *Cleaning and Handling of Body Fluids* and *Gloves - Use and Removal* procedures.
V. Turn off suction machine. Clean adapter of manual resuscitator with alcohol. Empty suction bottle and wash with warm soapy water at end of day.	If collection bottle is disposable, follow recommended manufacturer's instructions. Refer to *Cleaning and Handling of Body Fluids* procedure.
W. Wash hands. Remove goggles or face shield.	Refer to *Hand Washing* procedure.
X. Document procedure on student's individual treatment record.	Record: 1. Date and time. 2. Amount, color, and consistency of secretions. 3. Student's response to treatment. 4. Other pertinent information. 5. Signature of personnel performing procedure.

M. NASOPHARYNGEAL SUCTIONING

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

A. Purpose: To remove secretions or fluid that may contribute to upper airway obstruction (nose and pharynx), increased respiratory effort, the potential for respiratory distress, aspiration, or increased risk of infection.

B. Equipment:
1) An electric or battery /rechargeable operated portable suction machine with pressure gauge;
2) Flexible extension suction tubing;
3) Suction catheter sizes per IHCP (8 Fr to 14 Fr are most common);
4) Yankauer catheters may be an option for clearing oral secretions;
5) Towel or disposable pad or cloth; and
6) Gloves (county responsibility)

C. Personnel: Certified school nurse, or other licensed health care provider such as a RN or LPN, who are under the direct or indirect supervision of a certified school nurse.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain a written order from a licensed prescriber for nasopharyngeal suctioning and written consent from parent/guardian.	All specialized procedures performed in the school setting require written licensed prescriber's orders and parent/guardian consent. Physician's order should give specific instructions related to frequency of suctioning.
B. Obtain student history of airway obstruction and previous response to nasopharyngeal suctioning.	Confirm that respiratory assessment requires suctioning procedure.
C. Evaluate school setting and student's schedule to determine where procedure may be performed.	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.

D. Develop written emergency plan for personnel to follow.	Plan should include evacuation method for other students, criteria for administering nasopharyngeal suctioning, guidelines for calling Emergency Medical Services and emergency contact numbers of parents/guardians.
E. Train designated RNs and LPNs to administer nasopharyngeal suctioning and to monitor student's response.	Reinforce that physician's order will be specific for each student's situation. Determine that unlicensed personnel can distinguish signs and symptoms for need to suction student and determine when to call emergency medical services for assistance.
G. Assess equipment and provide safety measures for student during suctioning.	Ensure that suction machine has the appropriate level of subatmospheric pressure: Standard maximal pressure for children ranges from 80–120 mm Hg. 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.
H. Position the student for optimal suctioning.	Positioning of the student is based on the clinical situation: 1. Students in wheelchairs or other supportive seating devices can remain sitting upright or reclined up to, but not exceeding, semi-fowlers or 45 degrees. 2. Students who are lying either on the floor or health office couch should be turned on his/her side. This position may be commonly associated with a student experiencing a seizure who may require supplemental oxygen and/or suctioning.
I. Provide an ongoing assessment of students respiratory status	Respiratory assessment should be an ongoing process to determine: 1. How well the student is tolerating the procedure; and 2. The amount of time and suction attempts that are clinically indicated.

J. Wash hands	Refer to *Hand Washing* and *Gloves – Use and Removal* procedures.
K. Use appropriate personal protective equipment.	
L. Aseptic technique using a sterile catheter is the standard for this procedure.	Keypoint: Refer to *Gloves-Use and Removal* procedure.
M. 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.	The option of using a sterile catheter should be determined per physician orders, parent authorization and school nurse assessment of student and environment.
N. Dip the catheter tip in sterile water-soluble lubricant to minimize trauma to the nasal mucosa.	If unable to continue inserting downward toward the pharynx, remove catheter while applying suction and attempt insertion in the other nostril. If able to insert to the pharynx, up to the maximal insertion point, apply suction while rotating and withdrawing catheter.
O. Without applying suction gently introduce the catheter into the nostril and slowly proceed along the floor of the nasal cavity.	
P. Duration of suction should not exceed 15 seconds.	If additional suction passes are required: wait at least 30 seconds while performing appropriate aspects of the respiratory assessment and determining the student's toleration of the procedure; cleanse the catheter with sterile water; and re-lubricate as indicated.
Q. Monitor student carefully to ensure oxygenation, stabilized airway and heart rate.	
R. Discard disposable equipment.	Refer to *Cleaning and Disposing of Body Fluids* procedures.
S. Remove gloves and wash hands.	Remove gloves and wash hands.
T. Documents activity on student's individual treatment record.	Record: 1) Amount and color of sputum. 2) Date and time of suctioning. 4) Student response to suctioning.

5) Pulse and respiration rate.
6) Signature of personnel performing procedures.

U. Additional Considerations:

1. Consider activating EMS/911 for students who experience apnea, unresolved cyanosis, or respiratory/cardiac distress despite appropriate suctioning attempts.

2. Bradycardia may occur as a result of vagal stimulation at the posterior oropharynx with vigorous suctioning.

3. 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.

4. Some children learn to suction on his/her own 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.

A. CATHETERIZATION

1. CLEAN INTERMITTENT CATHETERIZATION

I. Guidelines: Clean intermittent catheterization may need to be done at school to empty the bladder at appropriate intervals. Intermittent catheterization prevents bladder distension; reduces chances of a bladder infection and removes residual urine. Students who need catheterization may be on a bladder-training program, have a neurogenic bladder or have residual urine. Encourage the student to assist as much as possible.

A. Purpose: To provide training and supervision guidelines for the performance of clean intermittent catheterization in the school setting and during co-curricular events.

B. Equipment: (Parent responsibility unless otherwise noted).
1. Catheters of appropriate size as ordered.
2. Lubricant, if needed.
3. Disposable underpads, if indicated.
4. Disposable, pre-moistened wipes.
5. Collection container.
6. Disposable non-sterile medical gloves (county).

C. Personnel: Certified school nurse, other licensed health care provider such as a RN or LPN, or designated trained school personnel under the direct or indirect supervision of the certified school nurse, or student with permission of a licensed prescriber and certified school nurse.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain orders from licensed prescriber and written parent/guardian consent.	All specialized procedures performed in the school setting require written licensed prescriber's orders and parent/guardian consent.
B. Assemble equipment in appropriate private location for performance of procedure.	
C. Wash hands.	Refer to *Hand Washing.*

D. Have student lie on back with knees flexed and separated, or position according to student's need. Undress student as needed, maintaining privacy.	If female is unable to spread legs, place on side with knee of top leg flexed. Have adequate staff assistance for this and all procedures. Refer to *Assisting with Clothing* procedure
E. Place disposable underpad beneath student's buttocks.	This will serve to prevent undesired moisture from soiling the surface beneath the student.
F. Open disposable wipes.	
G. Put on gloves.	*Refer to "Gloves-Use and Removal procedure.*
H. Open or obtain catheter from storage.	Catheters may be washed with warm, soapy water and dried for reuse. Check licensed prescriber's orders.
I. Use lubricant if ordered and squeeze it onto a clean surface.	This step may be optional.
J. FOR FEMALES:	
1. Hold labia open with one hand.	This hand is considered unclean and should not be used to handle equipment.
2. Using the other hand, cleanse the labia with a disposable wipe in downward stroke.	Stroke downward using a clean wipe for each stroke to prevent infection. Repeat as necessary to cleanse adequately.
3. Using downward stroke, cleanse urinary meatus with another disposable wipe.	Continue holding labia open until catheter is inserted. **DO NOT USE FORCE.**
4. Lubricate tip of catheter, if ordered.	
5. Place container for collection of urine.	
6. Insert catheter into urethra until urine flows into appropriate collection container.	Be sure to locate urethra, not vaginal orifice.
K. FOR MALES:	
1. Hold the penis upright between the thumb and forefinger and cleanse meatus using a circular motion.	This position will straighten the anterior urethra. Use a clean disposable wipe for each stroke.

2. Holding the penis upright, exert slight pressure to widen the opening.

3. Lubricate tip of catheter, if ordered.

4. Place container for collection of urine.

5. Insert catheter into the urethra and place the other end into the container for collection. If slight resistance is felt, reposition the penis as the catheter is withdrawn then slightly push ahead until urine flows.

The catheter will advance easily until resistance is met at the sphincter. DO NOT FORCE. Instruct the student to breathe deeply to relax the perineal muscles and overcome resistance to entry. Discontinue the procedure if student has unusual discomfort.

L. Suprapubic Catheters:

1. Cleanse around the stoma with a disposable wipe and discard into an appropriate container.

Use a clean wipe for each stroke.

2. Lubricate tip of catheter, if ordered.

3. Insert catheter slowly into stoma, until urine begins to flow into collection container.

M. Advance catheter approximately one inch further after urine begins to flow.

Ensures proper positioning in the bladder.

N. Withdraw catheter slowly when flow of urine has stopped.

Report any changes in urine color, appearance or odor to the certified school nurse. Pockets of residual urine may drain during removal of catheter. Leave catheter in place until flow of urine has stopped.

O. Remove all equipment and materials and discard appropriately.

Refer to *Cleaning and Disposing of Body Fluids* procedure.

P. Redress student making certain the student is dry and comfortable.

Refer to *Assisting with Clothing and Toileting* procedures.

Q. Remove gloves and wash hands.

Refer to *Gloves - Use and Removal* and *Hand Washing* procedures.

R. Document procedure on student's individual treatment record.	Record: 1. Date and time. 2. Amount of urine, if ordered. 3. Characteristics of urine or any other pertinent information. 4. Student's response to the procedure. 5. Signature of personnel performing procedure.

2. SELF-CATHETERIZATION

I. Guidelines: Self-catheterization may need to be done at school to empty the bladder at appropriate intervals. Self-catheterization prevents bladder distension, reduces chances of bladder infection and removes residual urine. Students who need to perform self-catheterization may be on a bladder-training program, have no bladder control, have residual urine or be learning responsibility for self-care.

A. Purpose: To provide training and supervision guidelines to assist the student with self-catheterization in the school setting and during co-curricular events.

B. Equipment: (Parent responsibility unless otherwise noted).
1. Catheters (size and type ordered by licensed prescriber).
2. Disposable pre-moistened wipes.
3. Water soluble lubricant, if ordered.
4. Plastic bag for used catheters.
5. Collecting/measuring container (if appropriate).
6. Disposable non-sterile medical gloves (county).

C. Personnel: Certified school nurse, other licensed health care provider such as a RN or LPN, or designated trained school personnel under the direct or indirect supervision of the certified school nurse. The student may perform this procedure independently if ordered by licensed prescriber.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain orders from licensed prescriber and written parent/guardian consent.	All specialized procedures performed in the school setting require written licensed prescriber's orders and parent/guardian consent.
B. Assemble equipment in an appropriate private location.	Strict cleanliness is necessary to prevent bladder infections.
C. Have student wash hands thoroughly. (Note: Staff should also wash hands and should glove in case staff intervention is necessary.)	Refer to *Hand Washing* and *Gloves - Use and Removal* procedures.

D. Position student appropriately for condition. Assist with undressing as needed, maintaining privacy.	Refer to *Assisting with Clothing* procedure.
E. Open disposable wipes for the student to self cleanse.	
E. Open packet of water-soluble lubricating jelly, if ordered.	
F. <u>FOR FEMALES - Instruct student to</u>:	
1. Hold labia open using one hand.	
2. Using a downward stroke, cleanse each labium with disposable wipe.	Stroke downward using a clean wipe for each stroke to prevent infection. Repeat as necessary to cleanse area adequately.
3. Using a downward stroke, cleanse urinary meatus with third disposable wipe.	Continue holding the labia open until the catheter is inserted.
4. Lubricate the tip of the catheter, if ordered.	
5. Hold the catheter as if it were a pencil or a dart and insert it into urethra until urine flows freely into appropriate collection container.	Be sure it is inserted into the urethra not the vaginal orifice. DO NOT FORCE.
G. <u>FOR MALES - Instruct student to:</u>	
1. Hold the penis upright between the thumb and the forefinger and cleanse the meatus using a circular motion.	This position will straighten the anterior urethra. Use a clean wipe for each stroke.
2. Apply lubricant to the tip of the catheter, if ordered.	
3. Place container for collection of urine.	
4. Hold the penis upright and exert slight pressure to widen the urethral opening and insert the catheter until urine begins to flow.	The catheter will advance easily until resistance is met at the sphincter. DO NOT FORCE. Have student breathe deeply to relax perineal muscles and bare down slightly.

5. Insert the catheter approximately one more inch once the urine flows.	Ensures proper catheter position in the bladder.
H. SUPRAPUBIC CATHETERS – Instruct the student to:	
1. Cleanse around the stoma with a disposable wipe and discard into an appropriate container.	Use a clean wipe for each stroke and cleanse outward from the stoma.
2. Lubricate tip of catheter, if ordered.	
3. Insert catheter slowly into stoma, until urine begins to flow into collection container.	
I. FOR FEMALES AND MALES - Instruct student to:	
1. Remove the catheter only after the flow of urine has ceased.	
2. Cleanse, dry, and redress, assisting as necessary.	Refer to *Assisting with Clothing* and *Toileting* procedures.
3. Discard disposable equipment and waste materials.	Refer to *Cleaning and Disposing of Body Fluids* procedure.
J. Remove gloves and wash hands.	Refer to *Gloves - Use and Removal* and *Hand Washing* procedures.
K. Document procedure on student's individual treatment record.	Record: 1. Date and time. 2. Amount and characteristics of urine, as required. 3. Any other pertinent information. 4. Student's response to procedure. 5. Signature of personnel assisting with procedure.

3. STERILE CATHETERIZATION

I. Guidelines: Sterile catheterization may need to be done at school as ordered by a licensed prescriber for students who have no bladder control, have residual urine or are on a bladder training program.

A. Purpose: To provide training and supervision guidelines for sterile catheterization in the school setting and during co-curricular events.

B. Equipment: (Parent responsibility unless otherwise noted).

1. Sterile catheter.
2. Sterile drape.
3. Sterile collection container.
4. Sterile antiseptic.
5. Sterile cotton balls.
6. Sterile lubricant.
7. Sterile medical gloves.
8. Disposable under pad, if needed.

All of the above materials are usually supplied in a kit.

C. Personnel: Certified school nurse or other licensed health care provider such as a RN or LPN, under the direct or indirect supervision of the certified school nurse.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain orders from licensed prescriber and written parent/guardian consent.	All specialized procedures performed in the school setting require written licensed prescriber's orders and parent/guardian consent.
B. Assemble equipment in appropriate private location.	
C. Wash hands.	Refer to *Hand Washing* procedure.
D. Position student and assist with undressing as needed, maintaining privacy.	Refer to *Assisting with Clothing* procedure.

1. Males: Back (Supine). 2. Females: On back with knees flexed and feet about two feet apart.	If female is unable to spread legs, place on side with knee of top leg flexed.
E. Place catheter set between female's thighs.	Placing it close helps to avoid contamination.
F. Open sterile catheter tray by folding top layer away from your body and bottom layer towards body.	Check expiration date. Touch only outside of wrapper. Do not turn back on sterile field. Avoid talking, coughing, or sneezing over sterile field. If in <u>doubt</u>, THROW IT OUT!
G. Open and place catheter on sterile field in sterile manner, if packaged separately.	Do not contaminate by touching.
H. Put on sterile gloves.	Equipment in kit is sterile and must be handled using sterile technique.
I. Open antiseptic and pour over cotton balls or open antiseptic swabs.	All preparation of kit must be done before touching the student.
J. Open lubricant and lubricate catheter generously, if ordered. 1. Female: 1 ½ - 2 inches 2. Male: 4 - 5 inches	
K. <u>FOR FEMALES:</u> 1. Hold labia open with one hand.	Consider gloved hand that has touched the student CONTAMINATED. Maintain this position.
2. Cleanse the labia with a saturated cotton ball held with forceps or antiseptic swab in a downward motion.	Stroke downward using a clean cotton ball or swab for each stroke to prevent infection.
3. Cleanse urinary meatus with another saturated cotton ball held with forceps or antiseptic swab in a downward motion.	

L. <u>FOR MALES:</u>

1. Hold the penis upright between the thumb and forefinger and cleanse meatus using circular motion with a saturated cotton ball held with forceps or antiseptic swab.

This position will straighten the anterior urethra.

Swab center first using a new sterile cotton ball or swab each time.

M. Insert sterile lubricated catheter into the urethra with sterile gloved hand making sure the other end of the catheter is placed in the collection container.

In male, may have to reposition the penis as the catheter is slightly withdrawn and then pushed ahead until urine flows. DO NOT FORCE. If resistance is met, have student take a few deep breaths. Discontinue the procedure if student has unusual discomfort.

N. Insert catheter until there is urine flow.

Advance catheter approximately one inch to ensure placement in bladder.

O. Allow urine to drain into collection container.

P. Withdraw catheter slowly when flow has stopped.

Pockets of residual urine may drain during removal of catheter. Leave catheter in place until fully drained.

Q. Remove all equipment and discard appropriately.

Refer to *Cleaning* and *Disposing of Body Fluids* procedure.

R. Remove gloves and wash hands.

Refer to *Gloves - Use and Removal* and *Hand Washing* procedures.

S. Redress, making sure student is dry and comfortable.

Refer to *Assisting with Clothing and Toileting procedures.*

T. Document procedure on student's individual treatment record.

Record:

1. Date and time.
2. Amount of urine, if required.
3. Color and odor.
4. Student's response to the procedure.
5. Signature of personnel performing procedure.

4. CONDOM CATHETERIZATION

I. Guidelines: Condom catheterization may need to be done at school to assist the incontinent male and empty the bladder at appropriate intervals. For males, a male incontinence device reduces the risk of infection from catheterization, promotes bladder retraining when possible, helps prevent skin breakdown, and helps increase the student's self-esteem.

A. Purpose: To provide training and supervision guidelines for the performance of condom catheterization in the school setting and during co-curricular events.

B. Equipment: (Parent responsibility unless otherwise noted).

1. Condom catheter
2. Hypoallergenic tape
3. Extension tubing
4. Commercial adhesive strip or skin bond cement
5. Elastic adhesive or Velcro if needed
6. Basin
7. Soap (school)
8. Gloves (school)
9. Disposable wipes (school)

C. Personnel: Certified school nurse, or other licensed health care provider such as an RN, LPN, or designated trained school personnel under the direct supervision, or indirect supervision of the certified school nurse with the permission of a licensed provider and certified school nurse.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain orders from licensed prescriber and written parent/guardian written consent.	All specialized procedures performed in the school setting require written licensed prescriber's orders and parent/guardian consent
B. Wash hands and put on gloves	Refer to *Hand Washing* and *Gloves – Use and Removal* procedures.
C. Assemble equipment including basin with lukewarm water in appropriate	

private location for performance of procedure.

D. If circumcised, wash with soap and water and dry. If not circumcised, gently retract foreskin and clean beneath it. Rinse well, but don't dry, and replace foreskin to avoid penile constriction. If necessary, clip hair from the base of the shaft of the penis to prevent adhesive strip or skin bond cement from pulling the pubic hair.

Moisture provides lubrication and prevents friction during foreskin replacement

E. If you are using a precut commercial adhesive strip, insert the glans penis through its opening and position the strip 1 inch from the scrotal area. If using uncut adhesive, cut the strip to fit around the shaft of the penis, Remove the protective covering from one side of the adhesive strip and press this side firmly to the side of the penis to enhance adhesion. Remove the covering from the other side of the strip. If commercial adhesive strip isn't available, apply skin bond cement and let it dry for a few minutes.

F. Position the rolled condom at the tip of the penis and leaving one half inch between the tip of the condom and the penis with its drainage opening at the urinary meatus.

G. After the condom catheter is in place, secure it with a hypoallergenic tape or an incontinence sheath holder.

H. Using extension tubing, connect the condom catheter to the leg bag or drainage bag. Remove and discard gloves.

REMOVING THE DEVICE:

F. Wash hands and put on gloves. Simultaneously unroll the condom catheter and the adhesive strip off the penis and discard them. If using skin bond cement instead of adhesive strip, use a solvent. Also remove and discard the incontinence sheath holder.

G. Clean the penis with disposable wipe.

H. Check for swelling or signs of skin breakdown.

I. Remove the leg bag by closing the drain clamp, unlatching the leg straps and disconnecting the extension tubing at the top of the bag.

J. Discard your gloves.

B. CREDE'S METHOD

I. Guidelines: Crede's method is a manual procedure used to express residual urine from the bladder, to reduce the chance of bladder infection, to control odors and to prevent skin breakdown. Crede's technique may be part of routine daily bladder care and should be done by the student whenever possible.

A. Purpose: To provide training and supervision guidelines for performing Crede's method in the school setting and during co-curricular events.

B. Equipment: None is needed to carry out this procedure.

C. Personnel: Certified school nurse, other licensed health care provider such as a RN or LPN, designated trained school personnel, or the student independently under the direct or indirect supervision of the certified school nurse, or student with permission of a licensed prescriber and certified school nurse.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain order from licensed prescriber and parent/guardian written consent.	All specialized procedures performed in the school setting require written order from a licensed prescriber and parent/guardian consent.
B. Provide student privacy for procedure.	
C. Position student according to needs.	
D. Apply repeated inward and downward pressure gently with one or both hands over lower abdomen, beginning in the umbilical area and progressing down toward the symphysis pubis.	Use heel of hand to obtain most effective result.
E. Continue the procedure as long as urine can be manually expressed.	

F. Document procedure on student's individual treatment record.

Record:

1. Date and time.
2. Amount of urine expressed, if ordered.
3. Characteristics of urine and any other pertinent information.
4. Signature of personnel performing procedure.

APPENDIX A

REFER TO:

West Virginia State Legislature Home Page - WV State Code Section at http://www.legis.state.wv.us/WVCODE/Code.cfm.

APPENDIX B

REFER TO:

West Virginia State Department of Education Home Page - Policy Section at http://wvde.state.wv.us/policies/.