WEST VIRGINIA
SECRETARY OF STATE

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ADMINISTRATIVE LAW DIVISION

Form #2

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OFFICE OF WEST VIRGINIA SECRETARY OF STATE

NOTICE OF A COMMENT PERIOD ON A PROPOSED RULE

AGENCY: West Virginia Board of Education TITLE NUMBER: 126

RULE TYPE: Legislative; CITE AUTHORITY: W. Va. Constitution, Article XII, §2, W.Va. Code §18-2-5, §18-5-22, §30-7-1, and §30-7a-1

AMENDMENT TO AN EXISTING RULE: YES X NO ____

IF YES, SERIES NUMBER OF RULE BEING AMENDED: 25A

TITLE OF RULE BEING AMENDED: Basic and Specialized Health Care Procedure Manual for West Virginia Public Schools (2422.7)

IF NO, SERIES NUMBER OF NEW RULE BEING PROPOSED: ____

TITLE OF RULE BEING PROPOSED: ____

IN LIEU OF A PUBLIC HEARING, A COMMENT PERIOD HAS BEEN ESTABLISHED DURING WHICH ANY INTERESTED PERSON MAY SEND COMMENTS CONCERNING THESE PROPOSED RULES. THIS COMMENT PERIOD WILL END ON November 30 , 2000 AT 4:45 p.m. .

ONLY WRITTEN COMMENTS WILL BE ACCEPTED AND ARE TO BE MAILED TO THE FOLLOWING ADDRESS:

Ms. Lenore Zedosky

Executive Director , Office of Health Schools

West Virginia Department of Education

1900 Kanawha Boulevard East, Bldg. 6, Room 309

Charleston, West Virginia 25305-0330

THE ISSUES TO BE HEARD WILL BE LIMITED TO THIS PROPOSED RULE.

Dr. David Stewart
State Superintendent of Schools

ATTACH A **BRIEF** SUMMARY OF YOUR PROPOSAL

416.70

Executive Summary
West Virginia Board of Education
Policy 2422.7
Basic and Specialized Health Care
Procedure Manual for West Virginia Public Schools

Background:

WV Code 19-5-22 requires the employment of school nurses. It also requires that a Council of School Nurses be convened by the state board of education. The council is required to prepare a procedure manual and create standards for its use. The original Basic and Specialized Health Care Procedure Manual and governing Policy 2422.7 were written 1989. It has been reviewed every two years and revised as necessary.

Purpose:

The purpose of the manual and policy is to set standards of care for students who have health conditions that must be managed during the school day. The manual is used to assist nurses and others who perform basic and specialized health care procedures for students.

The policy is being revised to reflect current practice standards and several new procedures have been added to the annual, as students are now attending school who need these procedures performed for them.

Impact:

These changes will help school nurses and other school personnel provide for the health and safety needs of West Virginia public school students.

BASIC AND SPECIALIZED

HEALTH CARE PROCEDURE MANUAL

FOR WEST VIRGINIA

PUBLIC SCHOOLS

MAY 1995
Revised September 2000

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 VirginiaSchool 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 September 2000 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 - Partricia 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

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FOREWORD

The initial draft in 1989 of this document was developed 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. The Task Force was composed of school nurses and a special educator, as well as a clinical nurse specialist with expertise in child health care. ~~All members of the Task Force are committed to providing high quality and safe health care to students in both regular and special education~~.

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 it is to be used. They were approved by the West Virginia Board of Education in June of 1990. The manual was updated in 1998 and revised again in 2000.

It is the consensus of the members of the Council of School Nurses ~~and the Task Force~~ that health care in the school setting shall be provided through assessment, planning, and monitoring by the certified school nurse and the student's physician. The health care plan should be developed in cooperation and collaboration with regular and special educators and in consultation with parents.

The Basic and Specialized Health Care Procedure Manual for West Virginia Public Schools shall be utilized as the minimum standard for safe practice as approved by West Virginia Board of Education Policy 2422.7 and adopted by the State Bureau for Public Health in the Specialized Health Procedures in Public Schools Rule, 64 W.Va. CSR 66. All children deserve and can benefit from equal educational opportunities.

David Stewart
~~Henry Marockie~~
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 both regular and special education. 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 a specialized health 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 with the eight RESAs throughout the state where a representative and an alternative were elected from each RESA to serve on this Council.

The Council of School Nurses drafted rules and regulations which were initially adopted by the WV Board of Education in 1990. ~~then revised and re-approved in 1995.~~ They have been revised twice since that time, in 1995 and 2000.

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. Sample forms in the Appendix 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 Council of School Nurses is responsible for assessing the need for revision and periodically updating the manual.

126CSR25

TITLE 126
LEGISLATIVE RULE
BOARD OF EDUCATION

SERIES 25
STANDARDS FOR BASIC AND SPECIALIZED HEALTH CARE PROCEDURES (2422.7)

§126-25-1. General.

1.1. Scope. This legislative rule establishes standards for certified school nurses to assess student health needs and to decide who is best skilled to respond to them.

1.2. Authority. W. Va. Code §§18-2-5, 18-5-22, 30-7-1 and 30-7a-1.

1.3. Filing Date - ~~July 21, 1995.~~

1.4. Effective Date - ~~August 20, 1995.~~

1.5. Adoption by reference. -- Basic and Specialized Health Care Procedure Manual for West Virginia Public Schools.

§126-25-2. Purpose.

2.1. Good health is essential to student learning. This policy establishes the standards that must be followed in providing for students with health care needs. The resulting Basic and Specialized Health Care Procedure Manual for West Virginia Public Schools was designed for use by certified school nurses in West Virginia to assure safe, consistent provision of health care.

§126-25-3. Definitions.

3.1. Basic Health Care Procedures are defined as procedures performed by school personnel to ensure that health and safety needs of students are met.

3.2. Cardiopulmonary Resuscitation (CPR) is defined as possession of a current valid certificate from an approved training program for adult, child and infant CPR, e.g. American Heart Association/American Red Cross.

3.3. School Health Manager is defined as a certified school nurse who reviews and interprets medical data for health-related problems of the students and who coordinates all

school health services.

3.4. Certified School Nurse is defined as a registered professional nurse, who ~~has demonstrated expertise in school health nursing practice. The school nurse must be certified by the West Virginia Department of Education Policy 5219.02 School Nurse Certification and~~ licensed by the West Virginia Board of Examiners for Registered Professional Nurses (W.Va. Code §30-7-1, et seq.), The ~~certified school nurse must be employed by the county board of education or the county health department as specified in Policy 5219.02.~~ who has completed a West Virginia Department of Education approved program as defined in Policy 5100 and meets the requirements for certification contained in Policy 5202. The certified school nurse must be employed by the county board of education or the county health department as specified in W.Va. Code §18-5-22.

3.5. Health Assessment is defined as the process in which the certified school nurse obtains student data. This assessment is comprehensive, systematic and continuous to allow the certified school nurse to make a nursing diagnosis and plan for interventions with the student, family, school staff and physician when necessary.

3.6. Health Care Plan is defined as the written document developed by the certified school nurse which includes a nursing diagnosis, is individualized to the student's health needs and consists of specific goals and interventions delineating the school nursing actions, ~~and~~ delegated procedures and student's role in self care.

3.7. Licensed Practical Nurse is defined as a person who has met all the requirements for licensure as a practical nurse and who engages in practical nursing as defined in W.Va. Code §30-7a-1, et seq.

3.8. Performance Check List is defined as a tool used by the certified school nurse in determining that a school employee meets the minimum standards required to perform specialized health care procedures safely.

3.9. Qualified is defined as the ability to demonstrate competence and skills in the use of equipment and performance of techniques and procedures necessary to provide specialized health care services for individuals with health needs and to demonstrate current knowledge of community emergency medical resources.

3.9.1. Qualified, for the certified school nurse, or other registered nurse or ~~licensed physician~~ licensed practical nurse, shall mean trained in the procedures to a level of competence and safety which meets the objectives of the training and the standards of practice of the profession.

3.9.2. Qualified, for the ~~employed,~~ designated school personnel, shall mean trained in the procedures to a level of competence and safety which meets the objectives

of the training. The training shall be provided by the certified school nurse or an approved program that meets training criteria.

3.10. Related Services are defined as transportation and such developmental, corrective, and other supportive services as are required to assist an eligible exceptional student to benefit from education as defined in policy 2419. The term includes, but is not limited to, audiology, speech and language pathology, psychological services, physical and/or occupational therapy, counseling/social services, school health services, early identification and assessment, medical services for diagnostic or evaluation purposes, and parent training.

3.11. School Employee as defined by W.Va. Code §18-5-22 means teachers, as defined in W.Va. Code §18-1-1, and aides or other service personnel, i.e. secretaries, as defined in W.Va. Code §18a-4-8.

3.12. Specialized Health Care Procedures are defined as procedures prescribed by the student's licensed physician(s) requiring medical and/or health-related training for the individual who performs the procedures.

3.13. Standardized Procedures are defined as those protocols and procedures outlined in the Basic and Specialized Health Care Procedure Manual for West Virginia Public Schools. They constitute the minimum safe standards of practice that are utilized in the provision of basic and specialized health care procedures.

3.14. Supervision of Designated School Employees is defined as periodic on-site review by the certified school nurse and shall include review of the competence of that individual in performing the specialized health care procedure and maintaining appropriate records.

~~3.14.1. Immediate Supervision. A certified school nurse shall be physically present while a procedure is being administered to review, observe and/or instruct the designated school employee's performance of health care services.~~

3.14.1. Direct Supervision. A certified school nurse shall be present on the same school campus as the employee being supervised and available for consultation, and/or referral for appropriate assistance.

3.14.2. Indirect Supervision. A certified school nurse shall be available to the qualified, designated school employee, either in person or through electronic means to provide necessary instruction, consultation, and/or referral for appropriate assistance.

3.15. Training is defined as preparation for the performance of basic and specialized health care procedures.

§126-25-4. State Administrative Procedures.

4.1. Standards of Performance of Care.

4.1.1. The Basic and Specialized Health Care Procedure Manual for West Virginia Public Schools shall be utilized as the minimum standard for safe practice as adopted by the State Division of Health in the Specialized Health Procedures in Public Schools Rule, 64 W. Va. CSR 66, 1992.

4.2. Training Program. Beginning with July 1, 1989, any new employee in the field of special education and all teachers and aides in special education or regular education who provide basic health care procedures for students with special health needs, shall be required to undergo Phase I training or demonstrate competency in performance of Phase I procedures that are applicable to their job assignment. In addition, applicable Phase II training will be required for all school employees performing specialized health care procedures.

4.2.1. Phase I.

a. All employees defined in Section 4.2 must be trained in: Proper hand washing; handling and disposal of body fluids including use and removal of gloves; Body mechanics; Basic first aid including Heimlich Maneuver and CPR; Other basic health care procedure training will be individualized as applicable to employee job assignment.

4.2.2. Phase II.

a. Individualized training in the performance of any one or more specialized health care procedures as applicable to employee job assignment.

4.3. Trainer.

4.3.1. Training and retraining must be provided and/or coordinated by a certified school nurse.

4.4. Performance Assessment.

4.4.1. An assessment of the performance of each procedure shall be completed by the certified school nurse. This assessment shall include the completion of a critical skills performance check sheet and shall be conducted in relation to changes in student health care needs, physician's orders and medical/health technology.

4.5. Supervision.

4.5.1. The category of supervision required (~~immediate,~~ direct, or indirect) in each situation shall be determined by the certified school nurse.

4.6. Training.

4.6.1. Training shall be provided through simulation or use of training models. Initial practice of the procedure shall be simulated or done on models rather than the student, whenever possible.

4.7. Retraining.

4.7.1. Personnel shall be retrained every two years on performance of each specialized health care procedure (beginning 1990-91) that is currently prescribed and being performed by said personnel.

§126-25-5. Organization and Management.

5.1. Personnel Certification.

5.1.1. School employees will be certified for completion of training in Phase I and Phase II as applicable.

a. Phase I certification must assure:

A. Completion of the training program stipulated for all employees defined in Section 4.2, plus those additional procedures necessary for individual job assignment.

B. Demonstrated competency in basic procedure(s) to be performed.

b. Phase II certification must assure:

A. Completion of Phase I as required and applicable to individual job assignment.

B. Completion of training in each individual specialized health care procedure to be performed.

C Demonstrated competency based on a critical skills performance check sheet.

5.2. ~~Awarded Certificate.~~ Training.

5.2.1. The Basic and Specialized Health Care Procedure Manual for West Virginia Public Schools must be used for teaching and training basic and specialized health care procedures. ~~Certificates may only be awarded by:~~ The training may be provided by:

a. Schools of nursing

b. Vocational schools

c. Independent faculty approved by school nurse

d. Certified school nurses

5.3. Changes.

5.3.1. Updating of these Rules will be done by the Council of School Nurses, as outlined in §126-25-8.

§126-25-6. System for School Admission and Care.

6.1. Admission.

6.1.1. For students needing specialized heath care procedures, the certified school nurse shall assess the student, review the physician's orders, and assure implementation of needed health and safety procedures. This assessment shall be completed prior to initial school attendance, and following any absence in which a health condition may have changed, necessitating reevaluation.

6.2. Physician's Orders.

6.2.1. The physician's orders are kept on file in the student's permanent record. These orders are valid for a maximum of one year, unless changed by the physician.

6.3. Delegation.

6.3.1. Certified school nurses shall determine delegation of any aspect of specialized health care.

§126-25-7. Health Care Plan.

7.1. Health Care Plan.

7.1.1. The health care plan must be prepared by the certified school nurse based on assessment of student and/or physician's written orders (see definition).

7.2. Assignment.

7.2.1. A review of the health care plan will be conducted with staff member(s) assigned by administrator to carry out the plan.

7.3. Contents.

7.3.1. The plan should contain:

a. Nursing assessment

b. Nursing diagnosis

c. Goals and expected outcomes

d. Interventions

e. Evaluation

7.4. Review.

7.4.1. Health care plans are reviewed annually or more frequently as the student's condition warrants.

§126-25-8. Quality Assurance.

8.1. A needs assessment developed, implemented and analyzed by the Council of School Nurses shall be the basis for revision of the Basic and Specialized Health Care Procedure Manual for West Virginia Public Schools.

8.2. The Council of School Nurses shall meet at least bi-annually, or more frequently as deemed necessary by the Chair of the Council in consultation with the West Virginia Department of Education for review of certification and training program regarding school employees.

8.3. The certified school nurse shall participate in continuing education programs which provide:

8.3.1. The training needed related to new specialized health care procedures.

8.3.2. ~~In-Service~~ Staff development applicable to effective school health practice.

§126-25-9. School Health Records.

9.1. Confidentiality.

9.1.1. All records are confidential and shall not be released except under existing West Virginia Board of Education policies.

9.2. Documentation.

9.2.1. A log will be maintained for each student needing a specialized health care procedure. It will include date and time procedure was performed, any notes on events and/or interactions and signature of person performing/supervising procedure.

§126-25-10. Staffing Requirements.

10.1. Staffing.

10.1.1. Certified school nurses must be employed in sufficient numbers to ensure adequate provision of services to severely handicapped pupils. Registered nurses have the authority and the ability to teach and to supervise other persons in rendering selected health services and/or procedures.

10.2. Certified School Nurse.

10.2.1. The certified school nurse must have a current license as a registered professional nurse in the State of West Virginia (W.Va. Code §30-7-1, et seq.). The school nurse must be certified as a school nurse by the West Virginia Department of Education (~~SDE~~ Policy ~~5219.02~~ 5202). The certified school nurse must be employed by the county board of education or the county health department (W.Va. Code §18-5-22) which contracts to provide equivalent services to boards of education. Performance of professional nursing service means both independent nursing functions and health related services which require specialized knowledge, judgment, and skills as governed by the West Virginia Nurse Practice Act (W.Va. Code §30-7-1, et seq.) and American Nursing Association "Standards of Professional School Nursing Practice".

10.3. Licensed Practical Nurse.

10.3.1. The practical nurse must be currently licensed in the State of West Virginia (W.Va. Code §30-7a-1, et seq.) and must function under the supervision of the registered professional nurse or licensed physician. The practical nurse shall not function as a school nurse.

10.4. Other School Personnel Providing Health Related Services.

10.4.1. Medical contacts, referrals and interpretations of medical data shall be managed by the certified school nurse. The nurse serves as the manager for health related problems and decisions. In the role of manager, the nurse is responsible for standards of school nurse practice in relation to health appraisal and health care planning. School employees, with the approval of the principal and the county board of education, may elect or in some cases be required to provide approved specialized health care procedures and such procedures shall be delegated by the certified school nurse as deemed appropriate. The school nurse shall provide for training, retraining, and supervision, and, upon completion, certify satisfactory level of competence before school employees perform certain health care procedures.

10.5. Liability.

10.5.1. A physician and/or professional nurse may be held liable for delegating professional responsibilities to individuals not qualified to perform them.

§126-25-11. Student Rights.

11.1. Assignment.

11.1.1. Students are entitled to the assignment of qualified personnel.

11.2. Rights.

11.2.1. Students are afforded the right to privacy, dignity, respect and courtesy, in accordance with Student's Privacy Act.

§126-25-12. Penalties.

12.1. Compliance.

12.1.1. Failure of any school personnel to comply with the above rules will result in personnel disciplinary actions based on state and local Board of Education policy.

§126-25-13. Administrative Due Process.

13.1. Parents/Legal Guardians.

13.1.1. Families dissatisfied with the health care plan and its handling by personnel should:

a. Schedule a meeting with the certified school nurse and school principal or designee.

b. Follow due process procedure as outlined by the WV Board of Education.

c. Appeal unacceptable outcomes at the third step to the State Superintendent of Schools.

SECTION II

PROCEDURES FOR PROVIDING SPECIALIZED HEALTH CARE

A. ANAPHYLACTIC REACTION

I. General Guidelines:

A. Purpose:
1. To be aware of dangers of anaphylactic reactions that can result in life-threatening situations.
2. To obtain history from student and/or parent about any asthmatic condition and any known allergies to medications, foods, pollens, bee stings, etc.
3. To consult with principal and school nurse on policy and procedures to be taken in case of a reaction.

B. Equipment: Medication and/or equipment as prescribed by physician (parent responsibility).

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

II. Procedure: Although it is impossible to prepare for all emergencies of an anaphylactic nature, the following procedures are designed to provide for those emergencies likely to occur in school settings. As the reader will note, several of the steps require the person providing this help to make judgments based on his/her observations and knowledge.

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Determine that student has symptoms of an anaphylactic reaction. Symptoms of anaphylaxis include redness and wheals of the skin, respiratory distress, vascular collapse and occasionally vomiting and abdominal cramps.	When in doubt, treat the person for an anaphylactic reaction.
B. In case of known allergies, designated trained personnel will give appropriate amount of medication prescribed by the student's private physician. In case of unknown allergies, go to Step C.	In cases of known allergies, designated persons will have been instructed in proper procedures for individual student.
C. Establish vital functions: 1. Insure adequate airway. 2. Perform cardiopulmonary resuscitation (CPR) if necessary.	
D. Call Emergency Medical Services and notify parents.	Paramedics will transport student to nearest hospital emergency room. Send all available information with the student to the emergency room.
E. Document procedure on treatment log and report to school nurse.	Record: 1. Date and time. 2. Student's reaction to procedure.

1. EPINEPHRINE AUTO-INJECTOR (EPI-PEN)

I. General Guidelines:

A. Definition: The Epi-Pen Auto-Injector is a disposable drug delivery system with a spring-activated, concealed needle. It is designed for emergency self-administration of epinephrine, in the event of allergic and anaphylactic reactions.

B. Purpose: To administer a single dose of epinephrine in the event of an allergic reaction.

C. Equipment: EPI-PEN as prescribed by physician (parent responsibility).

D. Personnel: At least three (whenever possible) designated trained school personnel under the direct or indirect supervision of the certified school nurse.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Determine student's history of an allergic reaction and physician instruction for use of EPI-PEN.	EPI-PEN Auto-Injectors come in two strengths: 0.3 mg (yellow label) for adolescents and adults and 0.15 mg (white label) for young children (EPI PEN JR.).
B. Store EPI-PEN at room temperature.	All trained persons should know the locationof the EPI-PENs.
C. Routinely check EPI-PEN to make sure solution in Auto-Injector is not discolored. Replace the Auto-Injector if the solution is discolored or contains a precipitate.	Epinephrine is light sensitive and should not be used if discolored.
D. Determine that student has symptoms of an allergic reaction. Signs of an allergic reaction include: dizziness, itching, hives, flushing of skin, wheezing, rapid pulse, thready or unattainable pulse associated with a drop in blood pressure and/or respiratory distress.	Epinephrine is needed only for severe reactions, not for just redness and swelling at site of bee sting. Review Anaphylactic Reaction information.
E. Remove gray, safety cap of EPI-PEN.	
F. Place black tip on thigh at right angle to leg. Do not attempt injection into a vein or into buttocks.	Apply to thigh regardless of what part of the body has been stung.

USE OF EPINEPHRINE AUTO-INJECTOR (EPI-PEN) (Continued)

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
G. Press hard into thigh until Auto-Injector mechanism functions and hold in place for 10 seconds. The EPI-PEN unit should then be removed and discarded in an approved container.	EPI-PEN must be injected into thigh only.
H. Call Emergency Medical Services and monitor student until ambulance arrives.	EMS can be called simultaneously by appropriate school personnel. Paramedics will transport student to nearest hospital emergency room. Send all available information with student.
I. Contact parent or guardian.	
J. Document procedure on treatment log and report to school nurse.	Record: 1. Date and time. 2. Student's reaction to procedure.

B. CATHETERIZATION

1. CLEAN CATHETERIZATION

I. General Guidelines:

1. Clean intermittent catheterization may need to be done at school as ordered by the physician.
2. Students who need catheterization may:
   a. be on a bladder training system.
   b. have no bladder control.
   c. have residual urine.

A. Purpose:

1. To empty the bladder at appropriate intervals.
2. To prevent bladder distension.
3. To reduce chances of a bladder infection.
4. To remove residual urine.

B. Equipment: (Parent responsibility unless noted).

1. Nonsterile gloves (school responsibility).
2. Lubricant.
3. Collection container.
4. Antiseptic wipes.
5. Catheters of appropriate size as ordered by physician.
6. Protective pads.

C. Personnel: Certified school nurse, 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. Assemble equipment in appropriate private location for administration of procedure.	
B. Have student lie on back with knees flexed and separated or position according to health care plan.	This will serve to prevent undesired moisture from soiling the surface beneath the student.
C. Wash hands.	*Refer to Handwashing procedure.*
D. Place protective pad under student's buttocks.	Have adequate staff assistance for this and all procedures.
E. Put on non-sterile gloves.	*Refer to Gloves - Use and Removal procedure.*
F. Open antiseptic wipes.	
G. Open packet of lubricating jelly and squeeze it onto surface of catheter package.	

CLEAN CATHETERIZATION (Continued)

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
H. FOR FEMALES:	
1. Hold labia open.	
2. Using a downward stroke, cleanse each labium with an antiseptic wipe.	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 antiseptic wipe.	Continue holding labia open until catheter is inserted. DO NOT USE FORCE.
4. Lubricate tip of catheter, if necessary.	
5. Insert catheter into urethra until urine flows into appropriate collection container.	Be sure to locate urethra, not vaginal orifice.
I. FOR MALES:	
1. Hold the penis upright and at a right angle to the student's body.	This position will straighten the anterior urethra.
2. Hold the end of the penis between the thumb and fore-finger and cleanse meatus using a circular motion.	Using a clean wipe for each stroke.
3. Holding the penis upright, exert slight pressure to widen the opening.	
4. Lubricate tip of catheter.	
5. Insert catheter into the urethra and place the other end into the collection container. If slight resistance is felt the pull on the penis can be slightly increased as the catheter is withdrawn slightly and then pushed ahead until urine flows.	May have to apply gentle traction or lower penis towards toes. 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.
J. When flow of urine has stopped, gently and slowly withdraw catheter.	Report any changes in urine color, appearance or odor to the certified school nurse.

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
K. Remove all equipment and waste materials and discard appropriately.	
L. Make certain the student is dry and comfortable.	
M. Remove gloves and wash hands.	*Refer to Gloves - Use and Removal procedure and Handwashing procedure.*
N. Document procedure on treatment log.	Record: 1. Date and time. 2. Amount of urine, if required. 3. Color/odor. 4. Student's reaction to the procedure.

2. SELF CATHETERIZATION

I. General Guidelines:

1. Self catheterization may need to be done at school a ordered by the physician.

2. Students who need self catheterization may:
   a. be on bladder training regime.
   b. have no bladder control.
   c. have residual urine.
   d. be learning responsibility for self care.

A. Purpose:

1. To empty the bladder at appropriate intervals.
2. To prevent bladder distension.
3. To reduce chances of bladder infection.
4. To remove residual urine.

B. Equipment: (Parent responsibility unless noted).

1. A catheter (size and type ordered by physician).
2. Antiseptic wipes.
3. Water soluble lubricant.
4. Plastic bag for used catheters.
5. Collecting/measuring container (if appropriate).
6. Nonsterile gloves (school responsibility).

C. Personnel: Certified school nurse, 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. Assemble equipment in an appropriate private location.	Strict cleanliness is necessary to prevent bladder infections.
B. Have student wash hands thoroughly. (Note: Staff should also wash hands and should glove in case staff intervention is necessary.)	*Refer to Handwashing and Gloves - Use and Removal procedures.*
C. Position student appropriately for condition.	
D. Open antiseptic wipes for the student to self cleanse.	
E. Open packet of water soluble lubricating jelly.	

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
F. FOR FEMALES - Instruct student to:	
1. Hold labia open using one hand.	
2. Using a downward stroke, cleanse each labium with antiseptic 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 antiseptic wipe.	Continue holding the labia open until the catheter is inserted.
4. Lubricate the tip of the catheter.	
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. FOR MALES - Instruct student to:	
1. Hold the penis up and at a right angle to his body.	This position will straighten the anterior urethra.
2. Hold the end of the penis between the thumb and the forefinger and cleanse the meatus using a circular motion.	Use a clean wipe for each stroke.
3. Apply lubricant to the tip of the catheter.	
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.
5. Once the urine flows, insert the catheter approximately one more inch.	

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
H. <u>FOR FEMALES AND MALES - Instruct student to:</u> 1. Remove the catheter only after the flow of urine has ceased. 2. Cleanse, dry, and redress. 3. Discard disposable equipment and waste materials and then wash hands.	
I. Remove gloves and wash hands.	*Refer to Gloves - Use and Removal procedure and Handwashing procedure.*
J. Document procedure on treatment log.	Record: 1. Date and time. 2. Amount and characteristics of urine, as required. 3. Any other pertinent information. 4. Student's reaction to procedure.

3. STERILE CATHETERIZATION

I. General Guidelines:

1. Sterile catheterization may be done at school as ordered by the physician.

2. Students requiring catheterization are those who:
   a. have no bladder control.
   b. have residual urine.
   c. are on a bladder training program.

A. Purpose: To empty the bladder at designated intervals, using sterile technique.

B. Equipment: (Parent responsibility unless noted.)
1. Sterile catheter.
2. Sterile drape.
3. Sterile collection container.
4. Sterile antiseptic.
5. Sterile cotton balls.
6. Sterile lubricant.
7. Sterile latex gloves.

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

C. Personnel: Certified school nurse, other RN or LPN, under the direct or indirect supervision of the certified school nurse.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Assemble equipment in appropriate private location.	Close door and/or pull curtain.
B. Wash hands.	*Refer to Handwashing procedure.*
C. Position	
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.
D. Place catheter set between female's thighs.	Placing it close helps to avoid contamination.
E. 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 doubt, THROW IT OUT!

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
F. If catheter is separate, open and place on sterile field in sterile manner.	Do not contaminate by touching.
G. Put on sterile gloves.	Equipment in kit is sterile and must be handled using sterile technique.
H. Open antiseptic and pour over cotton balls.	All preparation of kit must be done before touching the student.
I. Open lubricant and lubricate catheter.	
1. Female: 1 ½ - 2 inches	
2. Male: 4 - 5 inches generously	
J. <u>FOR FEMALES:</u>	
1. Hold labia open.	Consider gloved hand that has touched the student CONTAMINATED. Maintain this position.
2. Using a downward motion, cleanse each labium with a saturated cotton ball held with forceps.	
3. Using downward motion, cleanse urinary meatus with another saturated cotton ball held with forceps.	
K. <u>FOR MALES:</u>	
1. Hold the penis upright and at a right angle to the student's body.	This position will straighten the anterior urethra.
2. Hold the end of the penis between the thumb and fore-finger and cleanse meatus using circular motion with a saturated cotton ball held with forceps.	Swab center first using a new sterile cotton ball each time.
L. Insert sterile lubricated catheter with sterile gloved hand.	In male, may have to apply gentle traction or lower penis towards toes. DO NOT FORCE.
M. Insert until there is urine flow.	If resistance is met, have student take a few deep breaths. Discontinue theprocedure if student has unusual discomfort.

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
N. Allow urine to drain into collection container.	
O. When flow has stopped, slowly withdraw catheter.	
P. Remove all equipment and discard appropriately.	*Refer to Handling and Disposing of Body Fluids procedure.*
Q. Make student dry and comfortable.	
R. Remove gloves and wash hands.	*Refer to Gloves - Use and Removal procedure and Handwashing procedure.*
S. Document procedure on treatment log.	Record: 1. Date and time. 2. Amount of urine, if required. 3. Color/odor. 4. Student's reaction to the procedure.

C. CREDÉ'S METHOD

I. General Guidelines:
1. Credé's procedure must be performed according to physician's special orders.
2. Credé technique may be part of routine daily bladder care.
3. The procedure is done by the student whenever possible.
4. Students who need to have Credé's method performed may:
   a. be diapered.
   b. wear an external collection device.
   c. use toilet or urinal (ambulatory or transfer from wheelchair).

A. Purpose:
1. To express residual urine from the bladder.
2. To reduce chances of bladder infection.
3. To control odors and prevent skin breakdown.

B. Equipment: None is required to carry out this procedure.

C. Personnel: Certified school nurse, 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. Have student in appropriate location that provides privacy for procedure.	
B. Position student lying down or sitting, according to needs.	
C. Apply repeated inward and downward pressure with one or both hands over lower abdomen, just above os pubis, until flow of urine ceases.	Use heel of hand to obtain most effective result.
D. Document procedure on treatment log.	Record: 1. Date and time. 2. Amount of urine expressed. 3. Student's reaction to procedure.

D. ENTERAL FEEDING (TUBE FEEDING)

1. OVERVIEW

Enteral, or tube, feeding is the introduction of fluids, nutrients and/or medication directly into the stomach or duodenum or jejunum. These feedings are indicated for the student who cannot be fed orally but whose gastrointestinal tract is functional.

A. Definitions:

1. Nasogastric (NG): tube passed through the nose or mouth (orogastric) into the stomach and secured in place.

2. Nasoduodenal: tube passed through the nose into duodenum.

3. Nasojejunal: tube passed through the nose into jejunum.

4. Gastrostomy: insertion of a tube, either surgically or via a percutaneous endoscopic procedure, into the stomach.

5. Jejunostomy: insertion of a tube directly into jejunum, either surgically or as a percutaneous endoscopic procedure. Jejunostomy feedings are by continuous infusion. Pump control is favored.

B. Delivery Systems for Feeding Solution:

1. Intermittent or continuous infusion of feeding solution by gravity (accomplished by hanging container of feeding solution from an IV pole and adjusting delivery rate by flow regulator).

2. Continuous feeding by controller feeding pump (allows uniform flow, particularly of viscous solutions).

3. Bolus (feeding solution poured into barrel of 60 ml syringe attached to feeding tube and allowed to infuse by gravity).

C. Special Nursing Considerations:

1. Assess student for abdominal distention, belching, loose stools, flatus, pain and bowel sounds before an enteral feeding. Distended abdomen could indicate an intolerance to a previous feeding.

2. The physician's order for the enteral feeding should include type, amount and frequency of feedings.

3. Explain procedure and purpose to student. Understanding by the student will enhance cooperation.

4. Feedings are administered at room temperature unless otherwise ordered. Allow feedings to sit at room temperature approximately one hour before administering. Excessive heat coagulates feedings. Excessive cold can reduce the flow of digestive enzymes and cause abdominal cramping.

5. Sterile canned or bottled liquid products can be stored at room temperature until opened.. Cover and refrigerate open, unused product labeled with date and time opened. Discard unused product after 24 hours. Examine for thickening, lumps or separation, which may indicate contamination.

6. Nonsterile liquid products must be refrigerated from time of preparation to time of use. Do not store for more than 24 hours. Label with date and time.

7. Including hanging time, feeding solutions are not tobe left at room temperature for more than 8 hours. Enteral formulas are excellent medium for microbial growth and may cause infection of the student or food poisoning due to bacterial enterotoxins.

8. Assist student into sitting or Fowler's position inbed. If sitting position is contraindicated, a slightly elevated right-side lying position may be used. These positions enhance the gravitational flow of the feeding and help prevent aspiration into the lungs.

9. Aspirate before manipulating feeding tube. Use caution while aspirating and flushing feeding tube to prevent potential splash injuries. Observe universal precautions.

10. Prior to each feeding, the RN or LPN only must check to assure that tube is in the stomach by:

    a. Attach distal end of tube to syringe and withdraw plunger. Some gastric contents will fill tube.

    or

    b. Using a stethoscope, listen over the epigastric area of the abdomen while injecting 10 ml of air into tube. Air will make a rushing sound.

    or

    c. Listen to distal end of tube. There will be no sound.

    or

    d. Place end of tube in a glass of water while student exhales. Few, if any, bubbles will appear in water if tube is in stomach. Steady stream of bubbles will appear if tube is in lungs.

11. Aspirate all stomach contents and measure the amount prior to administration of the feeding unless ordered otherwise. This is done to evaluate absorption of the last feeding, i.e., whether undigested formula of a previous feeding remains. Consult with physician on exact amount of undigested formula that is obtained before feeding is to be withheld.

12. Reinstill the gastric contents into the stomach. Remove the syringe bulb or plunger and pour the gastric contents via the syringe into the tube. Discarding of contents could disturb the students electrolyte balance. Consult with physician on exact amount of gastric contents that need to be reinstilled. Reinstilling large amounts of gastric contents will predispose the student to aspiration and stomach distention.

2. BOLUS FEEDINGS USING BULB SYRINGE - ASOGASTRIC/GASTROSTOMY

I. General Guidelines: *Refer to Enteral Feeding (Tube Feeding), Overview*, before proceeding.

A. Purpose: To provide adequate fluid, nutrition, and/or medication for the student who is unable to swallow.

B. Equipment: (Parent responsibility unless noted.)

1. 60 cc syringe with catheter tip.
2. Enteral feeding at room temperature.
3. Syringe bulb or plunger.
4. Container with water.
5. Catheter plug or clamp.
6. Suction machine, if ordered by physician.
7. Disposable gloves (school responsibility).

C. Personnel: Certified school nurse or designated trained school personnel under direct, or indirect supervision of the certified school nurse. **When checking N/G tube placement, only a RN or LPN may perform this step of the procedure.**

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Explain procedure to student.	Use developmentally appropriate language and demonstration.
B. Put on disposable gloves.	*Refer to Gloves - Use and Removal procedure.*
C. Check placement of feeding tube prior to initiating each feeding.	*Refer to Enteral Feeding (Tube Feeding), Overview, Special Nursing Considerations, #10.*
D. Aspirate for residual feedings prior to initiating each feeding.	*Refer to Enteral Feeding (Tube Feeding), Overview, Special Nursing Considerations, #11.*
E. Remove bulb from syringe and connect to a pinched or clamped nasogastric or gastric tube.	Pinching or clamping the tube prevents excess air from entering the stomach, preventing distention.
F. 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 complete. Raise or lower syringe to adjust the flow as needed. Pinch off tubing to stop the flow if the student experiences discomfort. Should student vomit during feeding, pinch tube off and discontinue feeding.	Rapid administration can cause flatus, crampy pain, and/or reflex vomiting.

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
G. After feeding is administered, instill pre-Scribed amount of water through the tube.	Water cleans the lumen of the tube and prevents occlusion.
H. Clamp tube and remove syringe.	Prevent instillation of air into stomach. Clamping prevents reflux of feeding.
I. Care of student.	
1. Post-Feeding care.	
a. Allow student to remain elevated for 30 minutes after feeding, if possible.	This helps prevent vomiting and/or aspiration should student regurgitate.
b. Student may be positioned on right side for 30 minutes to 1 hour after feeding.	This positioning facilitates emptying of stomach contents into small bowel.
c. Student may require burping after feeding.	
d. Observe for student reaction (i.e. restlessness, color change, or distention).	Report to certified school nurse.
2. Daily care.	
a. Give oral hygiene daily.	Oral hygiene is necessary to prevent accumulation of secretions and dryness. Refer to Oral Hygiene procedure.
3. Nasogastric tube.	
a. Clean and lubricate nostrils as needed (at least daily).	Prevents irritation of nasal mucosa.
b. Check skin along twill tape daily, especially over the ear.	This prevents pressure areas.

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
4. Gastrostomy tube.	
1. Cleanse area around gastrostomy with soap and water.	Unless otherwise ordered by physician.
2. Apply dry, sterile dressing, if indicated.	The dressing absorbs any discharge of gastric juices and prevents skin breakdown. Check for physician preference regarding whether or not to use a dressing.
J. Care of equipment.	
1. Wash and rinse all equipment after each feeding.	To prevent accumulation of feeding and growth of bacteria.
2. Remove gloves and wash hands.	Refer to Gloves - Use and Removal procedure and Handwashing procedure.
K. Document procedure on treatment log.	Record: 1. Date and time feeding was given. 2. Type and amount of formula given. 3. Amount of water given. 4. Untoward reactions. 5. Student's reaction to procedure. 6. Signature of caregiver.

3. GASTROSTOMY FEEDING BUTTON

I. General Guidelines: *Refer to Enteral Feeding (Tube Feeding), Overview*, before proceeding.

A. Purpose: To provide adequate fluid, nutrition, and/or medication for the student who is unable to swallow.

B. Equipment: (Parent responsibility unless noted.)

1. 60 cc syringe with catheter tip.
2. Syringe bulb or plunger.
3. Adapter with tubing and clamp.
4. Container with prescribed formula at room temperature.
5. Container with water.
6. Disposable gloves (school responsibility).

C. Personnel: Certified school nurse or designated trained school personnel under ~~immediate~~, direct, or indirect supervision of the certified school nurse.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Preparation of student.	
1. Explain procedure to student.	Use developmentally appropriate language and demonstration.
2.. Position student in a sitting or high Fowler's position in bed. If sitting position is contra-indicated, a slightly elevated, right-side lying position may be used.	These positions enhance the gravitational flow of the feeding and help prevent aspiration into the lungs.
B. Preparation.	
1. Collect equipment and take to student.	Good organization saves time and energy.
2. Put on disposable gloves.	*Refer to Gloves - Use and Removal procedure.*
C. Methods.	
1. Observe for leakage around button.	If leakage exists, notify the certified school nurse who will discuss this with the physician.
2. Attach adapter and catheter to syringe, keeping tube clamped.	
3. Open safety plug and attach adapter and feeding catheter to the button, keeping the tube clamped.	

ESSENTIAL STEPS		KEYPOINTS-PRECAUTIONS
4.	Unclamp and aspirate immediately.	*Refer to Enteral Feeding (Tube Feeding), Overview, Special Nursing Considerations, #11.*
D.	Administration of feeding.	
1.	Check formula expiration date.	
2.	Attach adapter and feeding catheter to syringe, keeping tube clamped.	If you have aspirated, this step is already completed. Be sure tube is clamped close to adapter.
3.	Open the safety plug and attach the adapter and feeding to the button.	
4.	Fill syringe and catheter with formula, keeping clamp closed.	This prevents large amounts of air from entering the stomach.
5.	Hold syringe 3-10 inches above the stomach level. Unclamp tube.	This helps regulate the rate of flow.
6.	Continue to add feeding, keeping solution in syringe at all times until feeding is completed.	This prevents air from entering stomach during feeding. Pinch tube off immediately if student vomits or regurgitates during feeding and discontinue feeding. Call the certified school nurse if this procedure is delegated.
7.	Let feeding flow in by gravity slowly, approximately 20-30 minutes.	This prevents regurgitation, vomiting, and/or diarrhea. Flow rate can be altered by changing the height of the syringe.
8.	When feeding is complete, flush the button with the prescribed amount of tap water.	This keeps tube patent.
9.	Lower syringe below the stomach level to facilitate burping.	This will reduce possibility of vomiting. Burping sounds like a release of air.
10.	Remove adapter and feeding catheter. Snap safety plug in place.	**If anti-reflux valve is functioning properly, formula or food should not return.**
11.	If feeding catheter pops out, clamp immediately, then restart, estimating amount of feeding lost.	If student coughs or is very active, adapter may pop out.

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
E. Care of student.	
1. Post-Feeding care.	
a. Allow student to remain elevated for 30 minutes after feeding.	This helps prevent vomiting and/or aspiration should student regurgitate.
b. Student may be positioned on right side for 30 minutes to 1 hour after feeding.	This position facilitates emptying of stomach contents into small bowel.
c. Observe for student's reaction (i.e. restlessness, color change, or distended abdomen).	Report to certified school nurse.
2. Daily care.	
a. Give oral hygiene daily.	Oral hygiene is necessary to prevent accumulation of secretions and dryness. *Refer to Oral Hygiene procedure.*
b. Cleanse area around gastrostomy button with soap and water.	Unless otherwise ordered by physician.
c. Apply dry, sterile dressing, if indicated.	The dressing absorbs any discharge of gastric juices and prevents skin breakdown. Check for physician preference regarding whether or not to use a dressing.
F. Care of equipment.	
1. Wash and rinse all equipment after each feeding.	To prevent accumulation of feeding and growth of bacteria.
2. Remove gloves and wash hands.	*Refer to Gloves - Use and Removal procedure and Handwashing procedure.*
G. Document procedure on treatment log.	Record: 1. Date and time feeding was given. 2. Type and amount of formula given. 3. Amount of water given. 4. Untoward reactions. 5. Student's reaction to procedure. 6. Signature of caregiver.

4. INSERTING NASOGASTRIC TUBE

I. General Guidelines: *Refer to Enteral Feeding (Tube Feeding), Overview*, before proceeding.

A. Purpose: To administer a feeding or medication directly into the gastrointestinal tract.

B. Equipment: (Parent responsibility unless noted).

1. Nasogastric tube (N/G).
2. Water-soluble lubricant.
3. Clamp for tubing.
4. Towel and emesis basin.
5. Disposable cup with water (school responsibility).
6. Suction machine (if ordered by physician).
7. Nonsterile gloves (school responsibility).
8. Adhesive tape.
9. 20 ml syringe.
10. Straw.

C. Personnel: Certified school nurse or other qualified licensed health professional under the supervision of the certified school nurse.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Explain procedure to student.	Use developmentally appropriate language and demonstration. Determine with the student what sign might be used (i.e. raising the finger) to indicate a need for a pause due to gagging or discomfort.
B. Position student in a sitting or high Fowler's position with neck slightly flexed. Place a towel across chest.	
C. Assess which nostril is most patent.	
D. Put on disposable gloves.	*Refer to Gloves - Use and Removal procedure.*
E. 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.
F. Lubricate about 6-8 inches (15-20 cm) of tube with water-soluble jelly.	Lubrication reduces friction between mucous membrane and tube.
G. Lift head before inserting tube into a nostril. Pass tube gently into the posterior nasopharynx, aiming downward and backward.	Passage of the tube is facilitated by following the natural contours of the body.

ESSENTIAL STEPS		KEYPOINTS-PRECAUTIONS
H.	When tube reaches the pharynx, the student may gag; allow student to rest for a few moments.	Gag reflex is triggered by the presence of the tube.
I.	Have student hold head in a normal position and offer several sips of water sucked through a straw. Advance tube as student swallows.	Normal head position makes swallowing easier.
J.	Continue to advance tube gently each time student swallows.	Mouth breathing and swallowing facilitates passage of tube.
K.	If obstruction appears to prevent tube from passing, DO NOT USE FORCE. Rotate the tube gently. If unsuccessful, remove tube and try other nostril.	
L.	If there are signs of distress (i.e. gasping, coughing, or cyanosis) immediately remove the tube.	Paroxysms of coughing would indicate that the tube is in the trachea.
M.	Check placement of NG tube.	*Refer to Enteral Feeding (Tube Feeding), Overview, Special Nursing Considerations, #10.*
N.	Secure NG tube with tape on bridge of student's nose and side of face.	Do not tape with pressure on nares, as infants are nose breathers.
O.	Secure NG tube to clothing with rubber band or tape and safety pin.	
P.	Discard disposable equipment.	
Q.	Remove gloves and wash hands.	*Refer to Gloves - Use and Removal procedure and Handwashing procedure.*
R.	Document procedure on treatment log.	Record: 1. Date and time. 2. Method used for verification of NG tube placement. 3. Response of student to procedure. 4. Signature of caregiver.

5. SLOW DRIP METHOD - NASOGASTRIC/GASTROSTOMY

I. General Guidelines: *Refer to Enteral Feeding (Tube Feeding), Overview*, before proceeding.

A. Purpose: To provide adequate fluids, nutrition and/or medication for the student who is unable to swallow safely.

B. Equipment: (Parent responsibility unless noted.)

1. 60 cc syringe with catheter tip.
2. Administration set.
3. Container with prescribed formula at room temperature.
4. Container with water.
5. Bottle hanger.
6. Standard or hooks for holding container feeding.
7. Stethoscope.
8. Twill tape.
9. Catheter plug.
10. Suction machine, if ordered by physician.
11. Disposable gloves (school responsibility).

C. Personnel: Certified school nurse or designated trained school personnel under the ~~immediate~~, direct or indirect supervision of the certified school nurse. (See pp II 15-17 and Bolus Feeding Procedure, pp II 18-20)

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Preparation of student.	
1. Explain procedure to student.	Use developmentally appropriate language and demonstration.
2.. Position student in a sitting or high Fowler's position in bed. If sitting position is contra-indicated, a right-side lying position may be used.	These positions enhance the gravitational flow of the feeding and help prevent aspiration into the lungs.
B. Preparation.	
1. Collect equipment and take to student.	Good organization saves time and energy.
2. Put on disposable gloves.	*Refer to Gloves - Use and Removal procedure.*
C. Methods.	
1. Test for placement of nasogastric of gastrostomy tube before each feeding.	*Refer to Enteral Feeding (Tube Feeding), Overview, Special Nursing Considerations, #10,* for proper placement methods.
2. Attach syringe and aspirate for stomach contents.	*Refer to Enteral Feeding (Tube Feeding), Overview, Special Nursing Considerations, #11.*

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
3. Measure any stomach contents.	
4. Return stomach contents to stomach.	*Refer to Enteral Feeding (Tube Feeding), Overview, Special Nursing Considerations, #12.*
5. If stomach contents exceed the amount individually ordered for student by physician, either subtract from feeding or hold feeding, according to doctor's order.	
D. Administration of feeding.	
1. Remove hanger from hook or standard.	
2. Place bottle/bag with prescribed formula in hanger and attach tubing for administering the formula. Check for expiration date of formula.	
3. Close clamp on feeding/ administration tubing.	
4. Hang bottle/bag on hook or standard.	
5. Open clamp on formula tube and allow fluid to fill tubing before attaching to nasogastric or gastrostomy tubing.	Collection of air in tubing should be kept to a minimum.
6. Attach tubing, open clamp, and regulate fluid drip to approximately 60 drops per minute, unless otherwise ordered.	This will help prevent regurgitation, vomiting, and/or diarrhea.
7. Check student frequently.	While monitoring student during feeding and for 20 minutes after completion of feeding, observe for color change, restlessness, and abdominal distention, which would indicate tube displacement and/or overfeeding. If this occurs, stop feeding immediately. NOTE: If the tube should slip out partially during feeding, STOP FEEDING IMMEDIATELY and check for tube placement before proceeding with feeding. If you are unsure of tube placement, remove tube and replace with a new one. (Not applicable to gastrostomy tube).

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
8. When feeding is completed, instill prescribed amount of water to rinse tube.	This keeps tube patent.
9. Allow some of the water to remain within tube and clamp tube.	This prevents air from being introduced into stomach at next feeding.
10. Clean and store feeding equipment and formula according to manufacturer's instructions.	
11. Remove gloves and wash hands.	*Refer to Gloves - Use and Removal procedure and Handwashing procedure.*
E. Post-Feeding care of student.	
1. If it is possible, allow student to remain elevated for 30 minutes after feeding.	The elevation will help prevent vomiting and/or aspiration, if student regurgitates.
2. Student may be positioned on right side for 30 minutes to 1 hour after feeding.	This positioning will facilitate emptying of the stomach contents into the small bowel.
3. Observe for student reactions (i.e. restlessness, color change, or distended abdomen).	Take appropriate action as prescribed by physician.
F. Daily care.	
1. Give oral hygiene.	To prevent accumulation of secretions and dryness. *Refer to Oral Hygiene procedure.*
2. Clean and lubricate nostrils when nasogastric tube is present.	This prevents irritation of nasal mucosa.
3. Check skin along twill tape daily, especially over ear.	This is necessary to prevent pressure areas, especially over ear.
4. Gastrostomy tube:	
a. Do same as above.	To prevent irritation and excoriation from gastric juices.
b. Cleanse area around gastrostomy tube daily.	To absorb any discharge of gastric juices and prevent any skin breakdown or excoriation.
c. Apply dry, sterile dressing, if indicated.	

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
G. Document procedure on treatment log.	Record: 1. Date and time feeding was given. 2. Type and amount of formula given. 3. Amount of water given. 4. Untoward reactions. 5. Student's reaction to procedure. 6. Signature of caregiver.

E. MEASUREMENT OF BLOOD SUGAR

I. General Guidelines:

A. Purpose: To obtain an accurate measurement of the student's blood sugar.

B. Equipment: (Parent responsibility unless noted).
1. Physician's order for procedure and intervention.
2. Blood sugar monitor.
3. Automatic lancet device, if needed.
4. Disposable latex gloves (school responsibility).

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

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Wash hands.	*Refer to Handwashing procedure.*
B. Prepare work area.	Drape work area with paper towels in a well-lighted, clean area.
C. Assemble equipment.	Insert lancet in automatic lancet device. Remove chemstrip, place pad-side up on table surface (if chemstrip is used).
D. Have student wash hands.	*Refer to Handwashing procedure.*
E. Put on disposable latex gloves.	*Refer to Gloves - Use and Removal procedure.*
F. Perform finger puncture and place drop of blood on test strip (if indicated) or into proper port for blood.	Follow directions for specific blood sugar monitor for obtaining readings.
G. Refer to physician's orders for intervention.	
H. Dispose of gloves, chemstrip and used lancet in proper container. Wash hands.	*Refer to Cleaning and Disposing of Body Fluids procedure and Handwashing procedure.*
I. Document procedure on treatment log.	Record: 1. Date and time. 2. Pertinent information. 3. Student's reaction to procedure.

F. GLUCAGON

I. General Guidelines:

A. Purpose: To raise blood glucose level in unresponsive hypoglycemic student.

B. Equipment: Glucagon as prescribed by a physician (parent responsibility).

C. Personnel: Certified school nurse, licensed nated trained school personnel under direct or indirect supervision of the certified school nurse. If possible, at least three persons in the student's school must be trained.

II. Procedure:

ESSENTIAL STEPS		KEYPOINTS-PRECAUTIONS
A.	One staff person notify EMS and the parent while another staff person observes for signs of responsiveness.	Glucagon is needed only for unresponsiveness. If student is able to take food or liquid, treat hypoglycemia with sugar (liquid glucose, icing, candy, sugared beverage, etc.).
B.	Place student on his/her side.	To prevent aspiration.
C.	Obtain medication from designated location in the school.	All designated trained personnel will be aware of location of Glucagon. The required Medication Administration Form must be signed by both parent and physician and on file in the school office.
D.	Prepare injection according to package directions.	Diluting solution may be in a vial or pre-packaged in a syringe.
E.	Withdraw prepared Glucagon from vial.	If withdrawal is difficult, inject ½ to 1 ml air into vial.
F.	Cleanse small area of skin of arm or thigh with alcohol swab.	
G.	Insert the needle under cleansed skin of arm or thigh, applying gentle pressure to the skin.	Injection technique is the same as insulin (subcutaneous).
H.	Withdraw the needle and apply light pressure to the injection site.	To prevent leakage of solution.
I.	Feed the student a snack as soon as he/she awakens.	Student should awaken within 15 minutes of injection. It is vital to arouse the student as quickly as possible and to give additional carbohydrates orally to prevent secondary hypoglycemic reaction.

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
J. Have EMS (or parent) transport student to hospital for further medical treatment.	
K. Document procedure on treatment log.	Record: 1. Date and time. 2. Medication (on medication log). 3. Student's reaction to procedure.

G. Insulin Pump/Bolus
(Continuous Subcutaneous Insulin Injection)

1. General Guidelines:

1.	Purpose:	To maintain euglycemia in the insulin dependent diabetic student.
2.	Equipment:	(Parent responsibility unless noted). 1. Insulin pumps, reservoir and tubing, insulin, dressing, materials specific for student. 2. M.D. orders for procedure and intervention. 3. Disposable gloves (school responsibility).
3.	Personnel:	Certified school nurse orother qualified licensed health care provider such as a RN or LPN under direct or indirect supervision of the certified school nurse.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Wash hands.	*Refer to Handwashing Procedure.*
B. Review M.D. orders for insulin bolus dose instructions.	Dose may vary based on blood glucose results.
C. Put on disposable gloves.	*Refer to Gloves - Use & Removal Procedure.*
D. Obtain Blood Glucose measurement.	*Refer to Measurement or Blood Glucose procedure.*
E. Assess pump set up insertion site on abdomen.	Need to assure patency & placement.
F. Administer bolus dose as per M.D. orders.	*Follow directions for specific insulin pump Bolus procedure.*
G. Assess for symptoms ofa run away pump Hypoglycemia-Treat per M.D. orders Pump Alarms Clicking noise Check basal rate, last bolus dose given	Pump malfunction causing continuous infusion of insulin, leasing to hypoglycemia.
H. Pump should be turned off/suspended should this occur.	
I. Notify parents immediately.	
J. Refer to M.D. orders for intervention.	Student may become rapidly acidotic should this occur.

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS

K. Assess for symptoms of clogged tubing System or pump malfunction
- Hyperglycemia
- Pump not infusing
- Leaks in Infusion set or site
- Empty Syringe

H. INHALATION THERAPY BY MACHINE

I. General Guidelines:

A. Purpose:
1. To administer aerosol medication.
2. To mobilize secretions and aid in expectoration.
3. To improve alveolar ventilation.

B. Equipment: (Parent responsibility unless noted).
1. Machine pumping compressed air (example: Nebulizer). NOTE: Follow instructions for specific machine.
2. Medication as prescribed by physician.
3. Tissues.
4. Wastebasket with plastic lining (school responsibility).
5. Sharps container (school responsibility).
6. Nonsterile gloves (school responsibility).

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

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Assemble equipment in an appropriate location for administration of treatment.	To insure privacy.
B. Wash hands and put on gloves.	*Refer to Handwashing and Gloves - Use and Removal procedures.*
C. Student should be in a sitting position.	Facilitates better ventilation.
D. Connect one end of tubing to machine,the other end to the nebulizer thumb-valve.	
E. Using a clean nebulizer, add prescribed medication as ordered by the physician.	Be familiar with medication, dosage, side effects, precautions, etc.
F. Delivery method:	
1. Face Mask: Insure mask is positioned properly without leakage.	A good seal is necessary for adequate treatment.
2. Mouth Piece: Instruct student to gently bite down on mouth piece, seal lips around it and breathe through mouth only.	Mouth breathing is necessary for adequate delivery of medication with mouth piece.
G. Instruct student to breathe in and out slowly in a relaxed manner until all medication is used.	If student coughs excessively or has respiratory difficulty, stop treatment until symptoms subside.

	ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
H.	Disassemble and clean nebulizer. Clean appropriate parts with soap and water, rinse thoroughly with hot tap water and air dry.	
I.	Properly dispose of contaminated tissues and materials.	*Refer to Cleaning and Disposing of Body Fluids procedure.*
J.	Remove gloves.	*Refer to Gloves - Use and Removal procedure.*
K.	Document procedure on treatment log.	Record: 1. Date and time. 2. Medication (on medication log). 3. Student's response to the procedure.

I. LONG-TERM & EMERGENCY MEDICATION ADMINISTRATION

I. General Guidelines: All qualified and trained personnel must be familiar with their county policy for administering medications. Certain medications must be administered by a certified professional school nurseor other licensed health care provider such as a RN or LPN (i.e. insulin, or new/experimental medications).With the exception of emergency medications (e.g. Epipen or Diastat), the first dose of a medication should never be given at school. Administering medication during school hours or during school-related activities is discouraged unless it is necessary for the critical health and well being of the student.

A. Purpose: To enable students who require medication at specific times during the school day to attend school.

B. Equipment: (Parent responsibility unless noted).
1. Prescribed medication in original pharmacy labeled container.
2. Proper dispensing container (measuring cup/spoon, etc).
3. Signed Administration of Medication forms and Student Medication Log.

C. Personnel: Certified school nurse or designated trained personnel under the direct or indirect supervision of a certified school nurse.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Only the principal and other essential personnel shall be notified of student's requirement for medication while at school.	Confidentiality is essential. Only those with a need to know should be informed in order to protect the rights of the student.
B. The certified school nurse will provide information regarding effective use of medication(s), condition for which medication(s) is prescribed; and possible adverse reactions.	All involved personnel should be informed of potential serious side effects and/or precautions as well as desired effect.
C. Follow step-by-step procedure to properly administer medication:	When receiving packaged, single dose medications, examine administration device and refer to current package inserts when applicable for medication administration.
1. Student's name, medication, dosage, time, and route of administration (i.e. by mouth) must be verified according to the written medication form and the labeled pharmacy 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.

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
1. Insure positive identification of student.	An approved safety check is to ask student's name and other identifying information such as birthdate, parent's name.
3. Whenever possible, a student shall self-administer medication and designated trained personnel shall observe. If a student is unable to take his/her medication, a designated trained personnel will administer the prescribed medicine.	Observation by designated trained personnel is necessary to insure that the student has actually taken the prescribed medicine. This lessens the possibility of a lost pill or that one has not been completely swallowed, etc.
D. Document all required information on the student's medication log at the time the medication is administered.	Use one medication log for each medication being administered.
E. Store medication in a specified, locked place. **Controlled substances must be double locked.** Only designated personnel should have access to the medication.	Locked storage will prevent potential drug abuse and possibility of overdose by student.
F. Observe for desired and/or undesired effects of medication given at school. Report any unusual reactions to the appropriate persons (i.e. parent, school nurse).	This information may be necessary for student's parents and/or physician to evaluate effectiveness.
G. If vomiting should occur after medication is given, DO NOT ADMINISTER ANY MORE MEDICATION. Contact parent and/or certified school nurse.	Parent should always receive notification of a missed dose. The school nurse will need notification in order to observe adverse symptoms.
H. Document procedure on treatment log.	Record: 1. Date and time. 2. Medication (on medication log). 3. Untoward reactions. 4. Student's reaction to procedure.

J. MANUAL RESUSCITATOR

I. General Guidelines:

A. Purpose: To deliver breaths manually when a student is unable to breathe on their 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.

NOTE: Children who have tracheostomies or who use ventilators should have a resuscitation bag with them at all times, if ordered by physician.

B. Equipment: (Parent responsibility unless noted.)
1. Manual resuscitator.
2. Appropriate-sized mask.
3. Adaptor for trach.
4. Oxygen source with appropriate tubing, if needed.
5. Non-sterile gloves (school responsibility).

C. Personnel: Certified school nurse or qualified licensed health care professional under the direct or indirect supervision of the certified school nurse.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Assemble equipment.	Never wait to begin mouth-to-mouth/stoma resuscitation if a manual resuscitator is not immediately available or cannot be used effectively.
B. Preparation:	
1. Wash hands, if possible.	*Refer to Handwashing procedure.*
2. Check that manual resuscitator is functioning properly.	Place adaptor that is connected to the bag against a gauze or tissue in your hand, squeeze bag to be sure it is functioning (you should feel slight resistance).
3. Put on gloves.	*Refer to Gloves - Use and Removal procedure.*
4. Explain procedure to student.	Use developmentally appropriate language and demonstration.
5. Student with tracheostomy:	
a. Position student with neck extended and trach opening exposed, maintaining head tilt with non-dominate hand.	

ESSENTIAL STEPS		KEYPOINTS-PRECAUTIONS
b.	Attach resuscitator to trach tube, using dominate hand.	Hold trach with one hand to prevent accidental dislodgement while attaching adaptor to it.
c.	If the student is able to breathe independently, coordinate the manual breaths with student's own breaths. If the student is unable to breath on own, squeeze the resuscitator bag at a regular rate to deliver prescribed breaths per minute. 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.	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.
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 until relieved by appropriately trained persons.	
F.	Remove gloves and wash hands.	*Refer to Gloves - Use and Removal procedure and Handwashing procedure.*
G.	Document procedure on treatment log.	Record: 1. Date and time. 2. All pertinent information. 3. Student's reaction to procedure.

K. METERED DOSE INHALER (MDI) THERAPY

I. General Guidelines: The metered dose inhaler is a self-contained pressurized canister that contains medication which is suspended in an inert gas. A hand activated valve releases a measured volume of medication and aerosol.

A. Purpose: To deliver a measured dose of medication to a student for inhalation.

B. Equipment: Metered Dose Inhaler (parent responsibility).

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 written physician's order form. Parental signature must also be presenton form.	Policy requires written physician and parental permission to administer medication in the school setting.
B. Observe/Assist student in step-by-step use of MDI as prescribed below or according to physician's written orders. Instruct student to:	It is important that student fully understand procedure to receive the full benefit of the inhalated medication. Use developmentally appropriate language and demonstration.
1. Make sure the canister is firmly and fully inserted into the outer plastic container and shake the inhaler well.	
2. Hold the inhaler between the thumb and forefinger.	Add "Spacer"
3. Inhale deeply and then exhale slowly. Make an "O" shape with their mouth and hold the inhaler 1-2 inches from open mouth.	
4. Inhale slowly and deeply through mouth. After starting to breathe in, press the top of the canister firmly between thumb and fore-finger. Continue inhaling slowly and deeply through mouth.	
5. After breathing in as much as possible, close mouth and hold breath for 5 seconds.	

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
6. Exhale slowly through pursed lips.	
7. If 2 puffs are to be taken, wait approximately 5 minutes between the first and second puff, then repeat steps 1-6.	
8. If 3 puffs are to be taken, wait 1-2 minutes between the first and second puff, and then approximately 5 minutes between the second and third puff, then repeat steps 1-6.	
C. Monitor student for administration technique, cough production and breath sounds before and after the treatment.	Assess whether medication has had the desired or an undesired effect. (Note: an asthmatic student may need further medical attention.)
D. Document procedure on treatment log.	Record: 1. Date and time. 2. Medication (on medication log). 3. Student's reaction to the procedure.

L. ORAL/NASAL SUCTIONING

1. BY MACHINE

I. General Guidelines: A certified school nurse must assess the level of care needed for each individual student. Consideration should be given to the use of a manual suction device, i.e. rubber bulb syringe, whenever possible.

A. Purpose: To provide an adequate airway by clearing the oral cavity of excessive secretions.

B. Equipment: (Parent responsibility unless noted).
1. Suction equipment.
2. Suction catheter.
3. Sterile, distilled water.
4. Disposable gloves.

C. Personnel: Certified school nurse or other qualified licensed health care provider under the supervision of the certified school nurse.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Assemble equipment.	
B. Wash hands.	*Refer to Handwashing procedure.*
C. Turn on suction.	Recommendations for negative pressure: 1. Infants - 60 - 100 mm Hg. 2. Children - 100 - 120 mm Hg. 3. Adults and adolescents - as prescribed by physician.
D. Position child.	Optimal position is on side with head slightly lowered to aid in pooling and draining secretions. Assistance is recommended when suctioning small children.
E. Put on gloves and attach catheter to suction.	*Refer to Gloves - Use and Removal procedure.*
F. Lubricate catheter by submersing end into sterile water and suctioning small amount of sterile water.	Lubrication helps to prevent damage to fragile mucous membranes. Suctioning checks patency of the system.
G. Introduce catheter into oral cavity.	Do not apply suction while introducing catheter. Do not advance further than the back of the mouth, as this may stimulate the gag reflex, cause vomiting, and/or produce laryngospasm.

2. MANUAL TECHNIQUE (BULB SYRINGE)

I. General Guidelines:

A. Purpose: To provide an adequate airway by clearing the oral cavity and/or nasal cavity of excessive secretions.

A bulb syringe or other manual suctioning device is usually adequate and the preferred technique for suctioning the oropharynx and nose.

B. Equipment: (Parent responsibility unless noted).

1. Bulb syringe.
2. Paper towel (school responsibility).
3. Non-waxed paper cups (school responsibility).
4. Water (school responsibility).
5. Disposable, latex gloves (school responsibility).

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

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Assemble equipment.	
B. Wash hands.	*Refer to Handwashing procedure.*
C. 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.
D. Put on gloves.	*Refer to Gloves - Use and Removal procedure.*
E. With bulb compressed, insert tip of bulb syringe into cup of water and release pressure on bulb to suction small amount of water. Discard into cup.	Suctioning checks effectiveness of bulb syringe.
F. Insert tip of bulb syringe into dependent cheek of student.	Secretions will be more accessible on side student's head is positioned.
G. Release pressure on bulb to withdraw secretions.	Avoid grabbing mucous membranes as this may injure tissue.
H. Discard secretions into a cup or paper towel by squeezing bulb several times.	
I. Repeat steps F - H as necessary.	Areas to be suctioned include cheeks and beneath tongue.

MANUAL TECHNIQUE (BULB SYRINGE)(Continued)

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
J. For nasal suction, insert tip of bulb syringe into nares one side at a time. Suction. Discard secretions and then suction other side. Repeat as necessary.	
K. After each use, clean bulb syringe with warm water and soap by flushing several times using above suction technique.	Bulb syringe can be sterilized by placing in boiling water for 10 seconds.
L. Discard disposable equipment. Make sure bulb syringe is ready for reuse. Remove gloves and wash hands.	*Refer to Gloves - Use and Removal procedure and Handwashing procedure.*
M. Document procedure on treatment log.	Record: 1. Date and time. 2. Amount, color, and consistency of secretions. 3. Reaction of student to the procedure.

M. OSTOMY CARE: EMPTYING/CHANGING OF OSTOMY POUCH

I. General Guidelines: Change of ostomy pouch at school is usually needed only because of leakage. An ostomy pouch remains secure from 1 to 7 days. Change of pouch is usually done at home. Irrigation, a procedure used to stimulate evacuation of the bowel, must be done at home.

A. Definition: An ostomy is an artificial opening for urine or feces to come out of the body. The opening is covered by a pouch which serves as a container for waste until it can be emptied.

B. Purpose:
1. To control leakage.
2. To protect and inspect skin.
3. To control odor.
4. To provide comfort and security.
5. To encourage as much self-care as developmentally and physically possible.

C. Equipment: (Parent responsibility unless noted).
1. Extra pouch (clean and reusable or disposable) and belt, if needed.
2. Double-faced adhesive (gasket, wafer, spray or paint-on paste) as prescribed by student's physician.
3. Adhesive remover or solvent, as needed.
4. Soap and washcloth.
5. Skin barrier - tincture of benzoin, karaya (wafers, powder or paste) or other as prescribed by physician.
6. Toilet paper, soft tissue, or other absorbent material.
7. Hypoallergenic tape (1, 1½, or 2 inches or 2.54, 3.8, or 5.08 cm wide)
8. Non-sterile, latex gloves.
9. Container for rinse water.

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

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Assemble equipment in appropriate private location.	Review the physician's orders and the student's individual health care plan.
B. Wash hands.	*Refer to Handwashing procedure.*
C. Position student in either a sitting or lying position.	Encourage the student to do this for self when possible. Use developmentally appropriate language and demonstration.
D. Put on disposable gloves.	*Refer to Gloves - Use and Removal procedure.*

OSTOMY CARE: EMPTYING/CHANGING OF OSTOMY POUCH (Continued)

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
E. <u>To empty</u>:	
1. Open pouch and empty contents into toilet.	
2. Reclose pouch.	
3. Proceed to step "Q."	
F. <u>To change</u>:	
1. Remove ostomy pouch.	Gently peel pouch away from skin, using skin-safe solvent as necessary.
2. Proceed to step "G."	
G. Place absorbent material over stoma to absorb drainage.	It is important to protect the skin from irritating drainage. Absorbent material remains in place until you are ready to attach pouch.
H. Empty ostomy pouch into toilet.	
I. Save reusable pouch or discard disposable pouch.	Know whether pouch is reusable or disposable. Holding reusable pouch over the toilet, rinse with water. Send home in suitable container. Discard empty disposable pouch in waste receptacle.
J. Clean skin thoroughly but gently with washcloth, soap, and water; dry thoroughly. Report evidence of skin breakdown and/or infection to school nurse (or physician, if done by nurse) before proceeding.	Make sure all adhesive is removed from skin, using skin-safe solvent, as needed.
K. Apply skin barrier according to condition and type of pouch.	Cut or mold skin barrier to completely seal skin around stoma. Skin barrier should be at least as large as flange of pouch. Failure to cover all skin surrounding stoma will cause leakage and skin breakdown.
L. Prepare pouch for application.	
1. Cut to fit, if necessary.	Inner flange of pouch should be 1/8-inch (3mm) larger than the stoma. Cut to fit, as needed.
2. Apply additional adhesive, if necessary.	

ESSENTIAL STEPS		KEYPOINTS-PRECAUTIONS
M.	Place pouch securely over skin barrier.	Press flange firmly to completely seal pouch against skin barrier.
N.	If pouch is open-ended, secure open end according to directions (clip, rubber band, etc).	
O.	"Window pane" outer flange of pouch with hypoallergenic tape.	Cut strips of tape 1 inch (2.54 cm) longer than the flange of the pouch. Apply half on skin and half on flange to completely seal flange to skin. Overlap ends of tape.
P.	Attach belt if used.	
Q.	Remove gloves and wash hands.	*Refer to Gloves - Use and Removal procedure and Handwashing procedure.*
R.	Document procedure on treatment log.	Record: 1. Date and time. 2. Pertinent information. 3. Student's reaction to procedure.

N. OXYGEN ADMINISTRATION

I. General Guidelines:

A. Purpose: To prevent and or treat hypoxia or hypoxemia while reducing labored breathing.

B. Equipment: (Parent responsibility unless noted).

1. Oxygen source: portable oxygen tank or cylinder.
2. Pressure gauge.
3. Flow meter for controlling liters of oxygen per minute.
4. Nasal cannula or other form of oxygen mask or adaptor for tracheostomy and disposable connecting tubing.
5. Readily available fire extinguisher. (school responsibility)
6. Precaution sign - NO SMOKING OR OPEN FLAMES ALLOWED. Other hazards should also be listed. (school responsibility)
7. Humidifier filled with distilled water if indicated. (optional)

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

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Check oxygen supply daily to ensure proper amount in storage.	
B. Post any area where oxygen is in use: NO SMOKING OR OPEN FLAMES--FIRE HAZARD--OXYGEN IN USE.	Areas with increased oxygen levels support sudden combustion. Avoid use of oil, grease or petroleum based cleansers around oxygen connections or patient's face (including Chapstik and Vaseline products). Do not use antiseptic tinctures, alcohol, furniture sprays, acetone in the immediate area. Avoid the use of toys that might cause sparks that could ignite. Do not permit any electrical devices on or near oxygen source (within 8 feet is generally recommended.) Custodial staff should be informed of precautions.
C. Operate oxygen units in well ventilated area.	Oxygen will accumulate around immediate area of user. If used in transport, window of vehicle should always be lowered slightly. All units should be "off" when not in use.
D. Oxygen unit should always be in upright position on a smooth flat surface and according to safety standards, large tanks must be chained in one area. Portable units should be secured when being transported.	Oxygen transported on school bus must be secured in accordance with state and county transportation regulations.

OXYGEN ADMINISTRATION (Continued)

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
E. Fire extinguisher should be in immediate area.	
F. To administer oxygen open nasal catheter or mask and connect tubing to nipple of storage tank.	Nasal catheters should be changed or cleaned every week or more often, depending upon the amount of use. Extra changes should be in storage at all times and changed more often during respiratory illnesses of patient to prevent reinfection.
G. If ordered, attach humidifier to oxygen tubing at storage unit. Humidifier will need water added with prolonged use.	Humidifier must be cleaned regularly. The jar should only be filled with distilled water. Bacteria will grow if not cleaned properly.
H. If appropriate, explain procedure to student. Flush line by turning oxygen on and adjust 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.
I. Properly place nasal cannula or other delivery system to the patient's face, adjusting nasal catheter around ears or mask to the nasal bridge to ensure optimal oxygen benefit during admini-stration.	Pressure of cannulas or mask can cause sores--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.
J. Student should be monitored and observed for any change of condition while receiving oxygen.	According to specific needs of the individual student, personnel caring for student daily should be trained regarding how to assess for hypoxia and the complications of oxygen therapy--such as in cystic fibrosis patients.
K. If equipment does not operate properly contact oxygen provider--DO NOT ATTEMPT TO SERVICE EQUIPMENT ON YOUR OWN.	
L. Document procedure on treatment log.	Record: 1. Date and time. 2. Reason for procedure. 3. Pertinent information. 4. Student's reaction to procedure.

O. PEAK FLOW METER

I. General Guidelines: The peak flow meter provides an objective measurement of peak expiratory flow, a valuable indicator of lung function.

A. Purpose:

1. The peak flow meter can be used over a period of time by an asthmatic child to measure and record lung function so that the physician can prescribe the proper treatment.

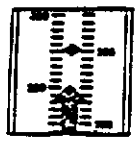
2. During an asthma attack, the peak flow meter can serve as a tool to objectively measure the severity of the child's respiratory distress.

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

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

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Have the student place one of the white mouth pieces on the peak flow meter.	The adult (large) mouth piece fits onto the unit, the pediatric (small) mouth piece fits into the unit.
B. Make sure that the red indicator is at the bottom of the scale.	
C. Hold the peak flow meter vertically, being careful that the student's fingers do not block the opening.	
D. Have student inhale as deeply as possible and place mouth firmly around the mouth piece, making sure lips form a tight seal.	
E. Have student exhale as hard and as fast as possible. This will cause the red indicator to move up the scale.	
F. The final position of the red indicator is the student's peak flow. Record the value along with the date and time.	
G. To repeat the test, slide the red indicator back to the bottom of the scale.	
H. If the student is using this as a measurement tool for physician information, help record the results as ordered by the physician.	



ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
I. If the peak flow meter is to serve as a tool to measure respiratory distress, personnel should have previous documentation as to the normal reading for the student.	
J. Seek medical care for student and notify parent, according to care plan.	
K. Document procedure on treatment log.	Record: 1. Date and time. 2. Reason for procedure. 3. Pertinent information. 4. Student's reaction to procedure.

P. POSTURAL DRAINAGE AND PERCUSSION

I. General Guidelines: Students needing postural drainage have pulmonary disfunction, such as cystic fibrosis, chronic bronchitis, asthma, other pulmonary disorders, muscular dystrophy, cerebral palsy, etc.

Postural drainage may be performed 2-4 times daily before meals depending upon student tolerance and physician's orders.

Additional postural drainage may be indicated when the student is congested or is having respiratory distress.

A. Purpose: To maintain maximum lung capacity by assisting student who is having difficulty raising sputum.

B. Equipment: (School responsibility unless noted).
1. Pillows.
2. Tissues.
3. Plastic lined wastebasket.

C. Personnel: Certified school nurse, 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. May also be performed by the physical therapist or respiratory therapist.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Assemble equipment in appropriate location.	
B. Use the following sequence for percussing each lobe of the lungs:	
1. Place student in appropriate position.	Ten positions are necessary for percussing all lobes of the lungs. Use cupped hands with mod-erate pressure to create hollow sound during percussion. Avoid percussing over kidneys.
2. Percuss lobes for 3 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.)
4. Wash hands at end of session.	*Refer to Handwashing procedure.*

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
C. The 10 positions for percussing students weighing 40 pounds or more are as follows:	NOTE: In all positioning additional pillows may be necessary to obtaindesired 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 flat on back with pillow placed under head and knees.	This position is correct for percussing anterior segments of right and left upper lobes (between clavicle and nipple areas).
4. 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).
5. 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).
6. Position student flat on stomach with pillows under stomach and lower legs/feet.	This position is correct for percussing apical segments of right and left lower lobes (over lower scapular areas).
7. 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).
8. 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).
9. 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).
10. 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).

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
D. 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 outstretched 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.
E. After percussing/coughing in all 10 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 over head 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.

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
5. 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 physician's recommendations.
F. At the end of each day, close liner from wastebasket and secure before disposal.	
G. Document procedure on treatment log.	Record: 1. Date and time. 2. Any pertinent information. 3. Student's reaction to procedure.

Q. TRACHEOSTOMY CARE

1. EMERGENCY CARE AND CLEANING OF TUBE AND STOMA

I. General Guidelines: Maintenance care of tracheostomy is routinely done in the home, but if an emergency arises, this procedure will be performed in the school setting.

Before a student with a tracheostomy is permitted to attend school, the certified school nurse must assess the level of care including emergency care and cleaning of tube and stoma, 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 will be developed.

Only a qualified, licensed health professional trained in emergency care and cleaning of tube and stoma can perform this procedure.

A. Purpose:

1. To maintain an open airway by keeping inner cannula open and free of secretion and exudate.
2. To prevent infection.
3. To prevent irritation of tissue around tracheostomy tube.
4. To maintain airway when there is:
   a. Labored or interrupted breathing.
   b. Excessive discharges or mucous plugs.
   c. Restlessness and/or apprehension.
   d. Dry, crusty secretions around tracheostomy tube.

B. Equipment: (Parent responsibility unless noted).

1. Small disposable tray.
2. Non-waxed disposable cups.
3. Cotton-tipped applicators.
4. Hydrogen peroxide solution, full strength.
5. Pipe cleaners and/or plastic drinking straws.
6. Nonsterile gloves (school responsibility).
7. Twill tape, tracheal ties.
8. Antimicrobial ointments, if ordered by physician.
9. Sterilized tracheostomy dressing, if indicated.
10. Adhesive tape, if needed, to secure dressing.
11. Plastic bag for disposal of wastes (school responsibility).
12. Paper towels (school responsibility).
13. Suctioning supplies and equipment.
14. Clean scissors, if tracheal ties are to be changed.
15. Dental floss for attaching tracheal plug.
16. Sterile saline or water.
17. Extra tracheostomy tube on hand at all times.
18. Disposable forceps.
19. Manual resuscitator, when ordered (i.e. Ambu bag).

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

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Preparation of student:	
1. 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.
2. If student is on ventilator, determine breathing tolerance when off ventilator equipment.	If ventilation is needed during cleaning, the following may be done: a. Plug tracheostomy opening and student ventilates by glosso-pharyngeal breathing (GPD). b. Fit outer cannula. c. Two persons may be needed to complete procedure.
3. Position student with tracheostomy area exposed.	Elevation of head provides drainage of cleansing solution onto the chest rather than into tracheal opening.
B. Assemble equipment.	
C. Method:	
1. Wash hands.	*Refer to Handwashing procedure.*
2. Set out 3 cups.	
3. Fill 1 cup with hydrogen peroxide and 1 with sterile saline.	Normal saline may be used instead of hydrogen peroxide, if indicated.
4. Place 2-4 cotton tipped applicators in third cup.	
5. Put on gloves.	*Refer to Gloves - Use and Removal procedure.*
6. Remove soiled gauze dressing, if used.	Removing soiled dressing reduces contaminates in area to be cleaned.
7. Discard dressing in plastic bag.	
8. Using applicator moistened with hydrogen peroxide, cleanse stoma at least 1 inch (2.54 cm) beyond outer cannula.	Do not wipe over area more than once with the same applicator. Cleanse area next to tube first and proceed outward, using circular motion.

EMERGENCY CARE AND CLEANING OF TUBE AND STOMA (Continued)

ESSENTIAL STEPS		KEYPOINTS-PRECAUTIONS
9.	Discard used applicators into plastic bag.	
10.	Using dry applicator, wipe cleansed area, drying thoroughly.	Rinsing off hydrogen peroxide is not necessary.
11.	Unlock and remove inner cannula, holding outer cannula in place.	If smaller size inner cannula is difficult to remove, use disposable forceps.
12.	Place inner cannula in paper cup filled with hydrogen peroxide.	Be sure cup is filled to completely cover inner cannula.
13.	Soak inner cannula in peroxide (1-5 minutes). NOTE: Sequence of above steps may be altered if inner cannula requires longer time to soak to remove tenacious mucous. Begin with step 11 and continue through 14 and follow with cleaning stomal area (steps 7-11).	Removes mucous by bubbling action.
14.	Remove paper towel from dispenser and lay on flat surface.	
15.	Set paper cup and pipe cleaners on paper towel.	
16.	Cleanse inner cannula with pipe cleaners and/or plastic drinking straw.	Using 2 pipe cleanser or doubling end of pipe cleaners provides more effective cleansing than using one.
17.	Pour sterile saline or water into cup and allow inner cannula to soak a brief time.	
18.	Remove cannula from cup and pour sterile saline or water over it until it is thoroughly clean.	
19.	Shake out excess moisture; put in clean paper cup.	
20.	Pour out any peroxide and saline and discard paper cup and pipe cleaners.	

ESSENTIAL STEPS		KEYPOINTS-PRECAUTIONS
21.	Remove gloves.	*Refer to Gloves - Use and Removal procedure.*
22.	Pick up paper cup with cannula and return to student.	
23.	Suction outer cannula and airway according to appropriate suctioning procedure, if necessary.	Need to hyperoxygenate before suctioning with ventilator or manual resuscitator, i.e. Ambu bag. Have older student take several deep breaths. Suction no longer than 10 seconds.
24.	Replace inner cannula and secure in place.	Replace inner cannula as soon as possible after cleansing to prevent mucous plugs from forming in outer cannula.
25.	Determine by bilateral auscultation that student is ventilating adequately. Attach ventilator if removed prior to cleaning.	
26.	Apply antimicrobial ointment as ordered by physician.	Indiscriminate use of ointments may increase bacterial growth.
27.	Apply gauze dressing, in accordance with physician's preference, to help hold tracheal tube in position or to decrease air leak (physician may prefer not to use dressing).	When secretions are copious the dressings must be changed frequently and the area must be kept dry.
D.	Care of student.	
1.	Check that student is being adequately ventilated (ongoing procedure).	Student on ventilator should not be left alone.
2.	Check that tracheostomy tube is positioned properly.	
E.	Care of equipment.	
1.	Dispose of all supplies after use.	
2.	Wash hands.	*Refer to Handwashing procedure.*
F.	Document procedure on treatment log.	Record: 1. Date and time. 2. Pertinent information. 3. Student's reaction to procedure.

2. EMERGENCY CLEANING OF INNER CANNULA

I. General Guidelines: This procedure is to be used only when a mucous plug is present.

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 will be developed.

Only a qualified, licensed health professional trained in emergency cleaning of inner cannula can perform this procedure.

A. Purpose:
1. To maintain airway by keeping inner cannula open.
2. To clear airway when there is a mucous plug present.
3. To relieve labored or interrupted breathing.
4. To investigate signs of restlessness and/or apprehension.

B. Equipment: (Parent responsibility unless noted).
1. Non-waxed disposable cups.
2. Cotton-tipped applicators.
3. Hydrogen peroxide solution, full strength.
4. Pipe cleaners and/or plastic drinking straws.
5. Nonsterile gloves (school responsibility).
6. Plastic bag.
7. Suctioning supplies and equipment.
8. Clean scissors, if tracheal ties are to be changed.
9. Dental floss for attaching tracheal plug.
10. Sterile saline or water.
11. Extra tracheostomy cannula for particular student.
12. Resuscitation bag, when ordered (such as Ambu bag).

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

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Preparation of student:	
1. Explain procedure to student.	Use developmentally appropriate language and demonstration.
2. If student is on a ventilator, determine breathing tolerance when off the ventilator.	If ventilation is needed during cleaning, the following may be done: Remove plugged inner cannula and replace with extra inner cannula. Two persons may be needed to complete the procedure.
3. Position student with tracheostomy area exposed.	

EMERGENCY CLEANING OF INNER CANNULA (Continued)

ESSENTIAL STEPS		KEYPOINTS-PRECAUTIONS
4.	Check that student is being adequately ventilated.	Be sure to suction thoroughly; auscultate to determine adequate aeration in all lobes of the lungs.
B.	Assemble equipment.	
C.	Method:	
1.	Wash hands.	*Refer to Handwashing procedure.*
2.	Set out 3 paper cups.	
3.	Fill 1 cup with hydrogen peroxide and 1 cup with sterile saline.	
4.	Put on gloves.	*Refer to Gloves - Use and Removal procedure.*
5.	Unlock and remove inner cannula.	If smaller size inner cannula is difficult to remove, use disposable forceps.
6.	Place inner cannula in paper cup filled with hydrogen peroxide.	Be sure cannula is completely covered with solution.
7.	Soak inner cannula in peroxide.	This removes mucous by bubbling action.
8.	Cleanse inner cannula, using pipe cleaners and/or plastic straw.	Using 2 or more pipe cleaners provides more effective cleansing.
9.	Place inner cannula in cup with sterile saline or water.	
10.	Allow cannula to soak a brief time.	
11.	Remove cannula from cup and pour sterile water over it until it is thoroughly clean.	
12.	Shake out excess moisture and place cannula in clean cup.	
13.	Suction outer airway according to appropriate suctioning procedure, if necessary.	Hyperoxygenate per manual resuscitator (i.e. Ambu bag) for 2 minutes before and after suctioning, if prescribed by physician. Suction no longer than 10 seconds at one time. Wait 2-3 minutes between suctionings. Repeat above procedure.

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
14. Replace inner cannula and secure in place.	
15. Attach ventilator, if removed prior to cleaning.	
16. Auscultate lung fields bilaterally with stethoscope to assess bilateral lung fields.	Respirations should be quiet and with less effort.
D. Care of equipment:	
1. Dispose of used supplies.	
2. Wash hands.	*Refer to Handwashing procedure.*
E. Document procedure on treatment log.	Record: 1. Date and time. 2. Amount, color and consistency of secretions. 3. Coughing. 4. Dyspnea. 5. Cyanosis. 6. Any bleeding. 7. Response of student to procedure.

3. EMERGENCY REPLACEMENT OF TRACHEOSTOMY TUBE

I. General 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 dislodged and created an obstruction. If this occurred, the tube must be removed. If the entire tracheostomy tube comes out, it must be replaced immediately. Emergency medical services should be notified of this life-threatening situation.

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 will be developed.

Only a qualified, licensed health professional trained in emergency replacement of tracheostomy tube can perform this procedure.

A. Purpose: To maintain an open airway.

B. Equipment: (Parent responsibility unless noted).

1. Sterile tracheostomy tube (with obturator).
2. Scissors.
3. Twill tape for tying.
4. Suction machine, including collecting bottle and connecting tube.
5. Manual resuscitation bag, when ordered (i.e. Ambu bag).
6. Sterile disposable suction catheters.
7. Nonwaxed disposable cups.
8. Supply of sterile normal saline.
9. Sterile normal saline bullets.
10. Disposable clean latex gloves (school responsibility).
11. Tissues.
12. Plastic lined wastebasket (school responsibility).

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

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Assemble equipment.	
B. Glove immediately.	*Refer to Gloves - Use and Removal procedure.*
C. Reassure student.	Calm and assured approach promotes student cooperation and ease of tube insertion.
D. Position student with head tilted back as far as possible.	

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
E. Open tracheostomy tube package.	
F. Moisten tube and obturator with sterile normal saline, insert tracheostomy tube with obturator.	
G. Holding tracheostomy tube, pull out obturator and insert cannula.	
H. Two persons are necessary for changing tracheostomy tube ties to maintain proper placement of tracheostomy tube while tapes are being secured.	Two people are required to perform procedure, changing ties only if necessary and being careful to minimize movement during replacement. Use ½ inch tape, long enough to tie on the side of the student's neck, with room to insert your little finger between the tie and the student's neck.
I. Secure tracheostomy tube with twill tape (not too tight).	Knot one end of each tape to prevent fraying. Make folds about 1-inch below knot on each tape. Cut a ½ inch slit up the middle of each fold. Have an assistant hold the tracheostomy tube steady while soiled tapes are removed. Take one tape and slip the end that is not knotted through tracheostomy plate slot from the bottom. Feed this end through the slit at the other end and gently pull the tape taut. Repeat the procedure with the other piece of twill tape. Tie the pieces of tape together at side of neck, leaving enough room to insert your little finger between tie and student's neck. The knot may be covered with tape so as to secure.
J. Remove gloves and wash hands.	*Refer to Gloves - Use and Removal procedure and Handwashing procedure.*
K. Document procedure on treatment log.	Record: 1. Date and time. 2. Amount, color and consistency of secretions. 3. Coughing. 4. Dyspnea. 5. Cyanosis. 6. Any bleeding. 7. Response of student to this procedure.

4. TRACHEOSTOMY SUCTIONING

a. CLEAN TECHNIQUE

I. General Guidelines: Before a student with a tracheostomy is permitted to attend school, the certified school nurse must assess the level of care including suctioning requirements, needed for that individual student. Based on this assessment, a plan of care documenting the manner inwhich the suctioning can be safely performed in the school setting will be developed.

Only a qualified, licensed health professional trained in suctioning can perform suctioning.

Encourage student to cough to clear airway and possibly eliminate the need for suctioning; however, some students may not be able to cough.

Clean technique is to be used for suctioning.

Suctioning shall be performed:
1. According to physician's orders.
2. Upon request of student.
3. When noisy, moist respirations occur.
4. When respiratory distress exists.
5. When mucous is visible at trachea opening.

A. Purpose: To maintain an open airway by keeping it clear of excessive secretions.

B. Equipment: (Parent responsibility unless noted).
1. Suction machine, including collecting bottle, connection tube, and adaptor, when needed (to be left at school).
2. Manual resuscitation bag, when ordered (i.e. Ambu bag).
3. Clean suction-catheters.
4. Nonwaxed disposable cups.
5. Supply of normal saline and normal saline bullets (or equivalent).
6. Disposable gloves (school responsibility).
7. Clean tissues or gauze pads.
8. Plastic lined wastebasket (close to equipment for contaminated materials) (school responsibility).
9. Extra set of clean tracheostomy tubes, suction catheters and supplies.

C. Personnel: Certified school nurse, or other qualified licensed health care professional under the supervision of the certified school nurse.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Verify at the beginning of each school day that all equipment and supplies are ready for immediate use.	Use clean catheter each time suctioning is performed.
B. Wash hands prior to suctioning unless it is an emergency and you do not have time to wash your hands.	*Refer to Handwashing procedure.*
C. Assemble and prepare equipment in a clean area.	
1. Fill paper cup with clean/sterile water (as ordered by physician).	Saline is indicated for use when secretions are thick and need to be liquified.
2. Open catheter package by maintaining clean technique.	
3. Prepare saline as directed.	
D. Position student and place tissue or gauze nearby.	Positioning is dependent upon student's condition and physician's recommendations.
E. Put on disposable gloves.	*Refer to Gloves - Use and Removal procedure.*
F. Holding suction tubing, attach catheter to tubing with gloved hand.	Connection tubing is held in one hand. Suction catheter is held in other hand.
G. Place catheter tip in cup of water to draw a small amount of water through it.	This ensures the catheter is open and lubricated.
H. Suction as follows:	
1. Remove inner cannula, if present.	Suction loosens secretions and stimulates coughing.
2. Leave the vent of the catheter open and introduce the catheter into the trachea opening until meeting resistance.	When introducing catheter, **NEVER** cover vent.
3. Withdraw catheter slightly.	This prevents injury to tissues.
4. Place thumb of hand holding connection tubing over vent. Slowly withdraw catheter with hand holding suction catheter.	If catheter remains in one place, the mucous membranes will be drawn against it. This occludes and injures tissues.

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
5. Withdraw catheter immediately when student begins to cough.	Catheter obstructs outer cannula and may interfere with bringing up secretions.
6. Suction no longer than 10 seconds at a time. Allow 3-5 deep breaths between suctioning.	Allow 1-3 minutes between suctioning periods. Prolonged suctioning can cause throat spasm, loss of oxygen, and changes in heart beat.
7. Repeat steps 2-6, as necessary.	Respirations should be quiet and effortless at end of suctioning.
8. If secretions are thick, instill 3-5 cc of sterile saline by normal saline bullet (as ordered by physician) into trachea opening then repeat steps 2-6.	Saline aids in dissolving mucous. This will cause hard coughing; therefore, hold tissue near trachea to catch spray and/or mucous.
9. Supply deep breaths with resuscitation bag between suctioning attempts, if ordered by physician.	Use of resuscitation bag provides deep breathing and/or stabilizes disrupted breathing patterns.
I. Suction sufficient water through catheter to clean out tubing.	
J. Disconnect catheter and flush with tap water and wipe clean.	
K. Discard disposable equipment and remove gloves.	*Refer to Gloves -Use and Removal procedure.*
L. Make sure supplies are replaced and everything is ready for immediate use.	Used catheters are to be sent home for cleaning.
M. Wash hands.	*Refer to Handwashing procedure.*
N. Document procedure on treatment log.	Record: 1. Date and time. 2. Amount, color and consistency of secretions. 3. Coughing. 4. Dyspnea. 5. Cyanosis. 6. Any bleeding. 7. Student's reaction to procedure.
O. At the end of the school day, empty contents of suction bottle into toilet. Wash bottle with soap and water; wear gloves during process.	*Refer to Cleaning and Disposing of Body Fluids procedure.*

b. STERILE TECHNIQUE

I. General Guidelines:

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

Only a qualified, licensed health professional trained in suctioning can perform suctioning.

Encourage student to cough to clear airway and possibly eliminate the need for suctioning; however, some students may not be able to cough.

Avoid unnecessary suctioning to reduce chances of injury and infection.

Aseptic technique is to be used for suctioning.

Suctioning shall be performed:

1. According to physician's orders.
2. Upon request of student.
3. When noisy, moist respirations occur.
4. When respiratory distress exists.
5. When mucous is visible at trachea opening.

A. Purpose:

To maintain an open airway by keeping it clear of excessive secretions.

B. Equipment:

(Parent responsibility unless noted).

1. Suction machine, including collecting bottle, connection tube, and adaptor, when needed (to be left at school).
2. Resuscitation bag, when ordered (such as Ambu bag).
3. Sterile, disposable suction-catheters.
4. Nonwaxed disposable cups.
5. Supply of sterile normal saline.
6. Supply of sterile water (to clear catheter).
7. Normal saline bullets.
8. Disposable, sterile gloves.
9. Clean tissues or gauze pads.
10. Plastic lined wastebasket (kept beside machine and used for contaminated materials - school responsibility).
11. Extra set of sterile tracheostomy tube, suction catheters and supplies.

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

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Verify at the beginning of each school day that all equipment and supplies are ready for immediate use.	Use a disposable sterile catheter and discard after use.
B. Wash hands prior to suctioning unless it is an emergency and you do not have time to wash your hands.	*Refer to Handwashing procedure.*
C. Assemble and prepare equipment in a clean area.	
1. Fill paper cup with sterile water.	Saline is indicated for use when secretions are thick and need to be liquified.
2. Open catheter package without touching catheter.	
3. Fill sterile syringe with saline.	
D. Position student and place tissue or gauze nearby.	Positioning is dependent upon student's condition and physician's recommendations.
E. Put on sterile gloves, maintaining sterile technique.	Gloves are used to keep catheter sterile.
F. Holding suction connection tubing, attach catheter to tubing with gloved hand.	Hand holding connection tubing is no longer sterile. Maintain sterile technique with hand holding the suction catheter.
G. Turn on machine with non-sterile hand.	
H. Place catheter tip in cup of sterile water to draw a small amount of water through.	This makes sure the catheter is open and lubricated.
I. Suction as follows:	
1. Remove inner cannula, if present.	Suction loosens secretions and stimulates coughing.
2. Leave the vent of the catheter open and introduce the catheter into the trachea opening until meeting resistance.	When introducing catheter, **NEVER** cover vent.

ESSENTIAL STEPS		KEYPOINTS-PRECAUTIONS
3.	Withdraw catheter slightly.	This prevents injury to tissues.
4.	Place non-sterile thumb over vent. With sterile gloved hand, slowly withdraw catheter.	If catheter remains in one place, the mucous membranes will be drawn against it. This occludes and injures tissues.
5.	Withdraw catheter immediately when student begins to cough.	Catheter obstructs outer cannula and may interfere with bringing up secretions.
6.	Suction no longer than 10 seconds at a time. Allow 2-3 deep breaths between suctioning.	Allow 1-3 minutes between suctioning periods. Prolonged suctioning can cause throat spasm, loss of oxygen, and changes in heart beat.
7.	Repeat steps 2-6, as necessary.	Respirations should be quiet and effortless at end of suctioning.
8.	If secretions are thick, instill 3-5 cc of sterile saline by normal saline bullet (as ordered by physician) into trachea opening then repeat steps 2-6.	Saline aids in dissolving mucous. This will cause hard coughing; therefore, hold tissue near trachea to catch spray and/or mucous.
9.	Supply deep breaths with resuscitation bag between suctioning attempts, if ordered by physician.	Use of resuscitation bag provides deep breathing and/or stabilizes disrupted breathing patterns.
J.	Suction sufficient water through catheter to clean out tubing.	
K.	Holding catheter in gloved hand, pull gloves off, encasing catheter in glove, and discard them both.	
L.	Discard cup and syringe.	
M.	Recap sterile water and make sure equipment is ready for immediate reuse.	
N.	Wash hands.	*Refer to Handwashing procedure.*

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
O. Document procedure in treatment log.	Record: 1. Date and time. 2. Amount, color and consistency of secretions. 3. Coughing. 4. Dyspnea. 5. Cyanosis. 6. Any bleeding. 7. Response of student to suctioning.
P. At the end of the school day, empty contents of suction bottle into toilet. Wash bottle with soap and water; wear gloves during process.	*Refer to Cleaning and Disposing of Body Fluids and Gloves - Use and Removal procedures.*

R. VAGAL NERVE STIMULATOR WITH MAGNET

I. General Guidelines

Vagal nerve stimulator (VNS) is a surgically implanted device that delivers electronic impulses to the vagus nerve in the neck consisting of a battery 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 neck, the device is implanted by a surgeon and programmed by a neurologist. The device sends an electronic impulse to the left vagus nerve. A hand held magnet triggers the generator to deliver an extra stimulation at a higher output between programmed impulses.

A. Purpose:

VNS provides seizure control by decreasing seizure frequency, severity, and intensity. The decrease of antiepileptic medication use is possible. A hand-held magnet allowsan on-demand stimulation of the vagus nerve to prevent, lessen or interrupt a seizuare as it occurs. If prescribed, the magnet may be used to stop stimulation temporarily.

B. Equipment:

Vagal Nerve Stimulator, surgically implanted and programmed. Magnet provided

C. Personnel:

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

II. Procedure:

	Essential Steps	Keypoints/Precautions
A.	Obtain physician's order and parental signature.	Procedures conducted in the school setting require written physician and parental permission to perform.
B.	Observe/assist student or perform step-by-step use of 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.
	1. Respond to student communication of aura	Parent/physician/student will indicate elements of aura.
	OR	
	2. Observe beginning of seizure activity or seizure already in progress	Parent/physician/student will address specific student behaviors that indicate seizure activity.
	3. Use magnet to activate generator at distance/manner specified, by physician's orders.	General instructions may include: use a "swiping motion" over pulse generator for at least one second, (swipe by saying one one thousand, two one thousand), but no longer than 60 seconds.

ESSENTIAL STEPS	KEYPOINTS/PRECAUTIONS
4. Wait specified time before repeating use.	Wait 60 seconds from original magnet use before "swiping: a second time.
C. Observe monitor student seizure response to magnet use.	Assess whether seizure continues, is lessened or stops completely Follow specific orders for treatment of continuing seizure activity—physician orders need to specify actions to be taken in event seizures continue
D. Document procedure on Seizure Log.	Record: 1. Date and time 2. Student behavior 3. Magnet use 4. Student/seizure response 5. Any additional action taken (Parent called, note to parent, etc.)
E. Precautions of Magnet Use	
1. Keep magnet near student for use.	Magnet should accompany student to locations: Such as cafeteria, playground, PE, music, on school bus, field trips
2. Do not drop magnet.	Can break if dropped on hard surface
3. Do NOT store near: Credit cards, television, computers, computer disks, magnetized lunch cards, microwave ovens, or other magnets **KEEP THEM AT LEAST 10 INCHEDS AWAY FROM THESE ITEMS!**	Magnets will erase/damage electronic components if placed in close proximinty
4. If ordered by physician, magnet may be used by student or designated staff to stop stimulation temporarily.	As vagal nerve stimulation has side effects which can affect voice quality or tingling in throat, it can be stopped while student is singing or eating, etc. Length of time for VNS interruption must be specified by physician orders.
F. Side effects of Vagal Nerve Stimulator Common side effect: - Change in quality of voice - Deepening of hoarseness - Tingling in the throat - Coughing - Feeling out of breath	Occurs when device is delivering stimulation Parent needs to be notified of any observed side effects Parent may need to interact with physician for possible adjustment of stimulation level.

REVISED POLICY 2422.7

TO BE INSERTED UPON APPROVAL

Comment Sheet

Policy 2422.7
Basic and Specialized Health Care
Procedure Manual for West Virginia
Public Schools

Section	Individual Name & Address	Comment
126-25-3 Definitions		
126-25-4 Administrative Procedures		
126-25-5 Organization and Management		
126-25-6 Admission and Care		
126-25-8 Quality Assurance		
126-25-9 School Health Records		
126-25-10 Staffing Requirements		

Specific Procedure	Individual Name & Address	Comment

Return by November 30, 2000
to
Lenore Zedosky, Executive Director
Office of Healthy Schools
Building 6 Room 309
1900 Kanawha Blvd., East
Charleston, WV 25305-0330

Fax: (304) 558-3787
e-mail lzedosky@access.k12.wv.us

FORM HD 201
(10-66)

FISCAL NOTE WORKSHEET
(Submit 4 Copies)

HD NO _____ DRAFT NO _____ BILL NO _____ RESOLUTION NO _____

SUBJECT Basic and Specialized Health Care Procedure Manual FUND _____

SOURCE OF REVENUE: ☐ GENERAL FUND ☐ SPECIAL ☐ OTHER (SPECIFY) _____

COST OF ESTIMATE BASED ON: ☐ AN ORIGINAL ESTIMATE ☐ BUDGET BILL ☐ OTHER (SPECIFY) _____

INCOME ESTIMATE BASED ON: ☐ AN ORIGINAL ESTIMATE ☐ BUDGET BILL ☐ OTHER (SPECIFY) _____

SHOW OVER-ALL EFFECT IN ITEMS 1 AND 2 & GIVE EXPLANATION OF BREAKDOWN BY FISCAL YEAR INCLUDING LONG-RANGE EFFECT

EFFECT OF PROPOSAL	ANNUAL		FISCAL YEAR		
	INCREASE	DECREASE	CURRENT	NEXT	THEREAFTER
1. ESTIMATED TOTAL COST	$	$	$	$	$
PERSONAL SERVICES CURRENT EXPENSES REPAIRS/ALTERATIONS EQUIPMENT OTHER	$	$	$	$	$
2. ESTIMATED TOTAL REVENUES	$	$	$	$	$

3. EXPLANATION OF ABOVE ESTIMATES (INCLUDING LONG-RANGE EFFECT):

No new cost are anticipated.

DATE 10/17/00 AGENCY _____ AUTHORIZED REPRESENTATIVE _____