WEST VIRGINIA
SECRETARY OF STATE

JOE MANCHIN III

ADMINISTRATIVE LAW DIVISION

Form #5

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2004 SEP 15 P 1:38

OFFICE WEST VIRGINIA
SECRETARY OF STATE

NOTICE OF AGENCY ADOPTION OF A PROCEDURAL OR INTERPRETIVE RULE OR A LEGISLATIVE RULE EXEMPT FROM LEGISLATIVE REVIEW

AGENCY: West Virginia Board of Education TITLE NUMBER: 126

CITE AUTHORITY: W.Va. Constitution, Article XII, §2 and W.Va. Code §§18-2-5, 18-5-22, 18-5-22a, 18-5-22b, 30-7-1 et seq. and 30-7A-1 et seq.

RULE TYPE: PROCEDURAL _____ INTERPRETIVE _____

EXEMPT LEGISLATIVE RULE X

CITE STATUTE(s) GRANTING EXEMPTION FROM LEGISLATIVE REVIEW
W.Va. Code §§29A-3B-1, et seq.; *W.Va. Board of Education v. Hechler*, 180 W.Va. 451; 376 S.E.2d 839 (1988).

AMENDMENT TO AN EXISTING RULE: YES X NO _____

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

TITLE OF RULE BEING AMENDED: Standards for Basic and Specialized Health Care Procedures (2422.7)

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

TITLE OF RULE BEING PROPOSED: _____

THE ABOVE RULE IS HEREBY ADOPTED AND FILED WITH THE SECRETARY OF STATE. THE EFFECTIVE DATE OF THIS RULE IS October 15, 2004.

David Stewart
State Superintendent of Schools

EXECUTIVE SUMMARY
WEST VIRGINIA DEPARTMENT OF EDUCATION

Policy Number Title:

Policy 2422.7
Basic and Specialized Health Care Procedures

Background:

The number of basic and specialized health care procedures provided to students in West Virginia's public schools continues to increase each year based on information gathered through the School Nurse Needs Assessment. The certified school nurse oversees the delivery of each of these procedures and delegates certain procedures to unlicensed personnel. The Basic and Specialized Health Care Procedure Policy and accompanying manual outlines the safe and standard procedures to follow for performing and delegating each procedure. W.Va. Code §18.5.2 creates the Council of School Nurses and specifies that the review and revision of the Basic and Specialized Health Care Procedure Manual is a function of the Council.

Proposals:

This revision of Policy 2422.7 clarifies the training that is required for all personnel performing basic and specialized procedures. In addition, the manual has been revised to update existing and add new procedures to accommodate advances in medical technology.

Impact:

The proposed revision to Policy 2422.7 will provide better consistency and safety across the state by clarifying training requirements for personnel performing basic and specialized health care procedures. The newly added procedure of Diastat Administration will allow nurses to safely delegate this procedure thereby allowing students to be served with existing staff resources.

Comments:

During the thirty-day public comment period, a total of five comments were received. Minimum changes have been made to the policy to accommodate those comments that were accepted. I respectfully request that the Board approve Policy 2422.7 Standards for Basic and Specialized Health Care Procedures with the recommended changes.

TITLE 126
LEGISLATIVE RULE
BOARD OF EDUCATION

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

§126-25A-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. Constitution, Article XII, §2, W.Va. Code §§18-2-5, 18-5-22, 18-5-22a, 18-5-22b, 30-7-1, et seq. and 30-7A-1, et seq.

1.3. Filing Date. - September 15, 2004.

1.4. Effective Date. - October 15, 2004.

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

§126-25A-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.

§126-25A-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. Certified School Nurse is defined as a registered professional nurse, who is licensed by the West Virginia Board of Examiners for Registered Professional Nurses (W.Va. Code §30-7-1, et seq.), who has completed a West Virginia Department of Education approved program as defined in the West Virginia Board of Education Policy 5100: Approval of Educational Personnel Preparation

Programs (W.Va.126CSR114), and meets the requirements for certification contained in West Virginia Board of Education Policy 5202: Minimum Requirements for the Licensure of Professional/Paraprofessional Personnel and Advanced Salary Classifications (W.Va. 126CSR136) (hereinafter 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.

3.4. Contracted Licensed Health Care Provider is defined as a licensed health care provider, as set forth in Section 3.9 of this policy, providing health care services under contract with county boards of education. Health care services may be contracted after the ratio of one nurse for every 1,500 students, kindergarten through seventh grade, is provided to county schools.

3.5. Contracted School Nurse is defined as an employee of a public health department providing services under a contract with a county board of education to provide services considered equivalent to those required in W.Va. Code §18-5-22.

3.6. First Aid is defined as a training course in emergency treatment that is administered to an injured or sick person before professional medical care is available. This training will be coordinated by the school nurse.

3.7. Health Assessment is defined as the process by which the certified school nurse obtains student health 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 licensed prescriber when necessary.

3.8. 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, delegated procedures and student's role in self care.

3.9. Licensed Health Care Provider is defined as a medical doctor or doctor of osteopathy, podiatrist, registered nurse, practical nurse, registered nurse practitioner, physician assistant, dentist, optometrist, pharmacist or respiratory care professional licensed under Chapter Thirty of W.Va. Code.

3.10. 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 under the direction of a Registered Professional Nurse as defined in W.Va. Code §30-7A-1, et seq.

3.11. Licensed Prescriber is defined as a licensed health care provider with the authority to prescribe medication and health care procedures.

3.12. 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 safely perform basic and/or specialized health care procedures.

3.13. 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 basic and/or specialized health care services for individuals with health needs and to demonstrate current knowledge of community emergency medical resources.

3.14. 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 West Virginia Board of Education Policy 2419: Regulations for the Education of Exceptional Students (W.Va.126CSR16) (hereinafter 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.

3.15. Retrained is defined as a proper demonstration and/or instruction, as deemed necessary by the certified school nurse.

3.16. School Employee as defined by W.Va. Code §18-5-22 means teachers, as defined in W.Va. Code §18-1-1, secretaries, as defined in W.V. Code §18A-4-8 and aides, as defined in W.Va. Code §18A-4-8.

3.17. School Health Manager is defined as a certified school nurse who reviews and interprets medical data related to student health problems and coordinates all school health services.

3.18. School Related Events is defined as any curricular or co-curricular activity, as defined by West Virginia Board of Education Policy 2510: Assuring the Quality of Education: Regulations for Education Programs (W.Va. 126CSR42), that is conducted outside of the school environment and/or instructional day. Examples of co-curricular activities include the following: band and choral presentations; theater productions; science or social studies fairs; mathematics field days; career/technical student organizations' activities; or other activities that provide in-depth exploration or understanding of the content standards and objectives appropriate for the students' grade levels.

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

3.20. Supervision of Designated School Employees is defined as periodic on-site review and documentation by the certified school nurse verifying the competency of that individual in performing basic and/or specialized health care procedures and maintaining appropriate records.

3.21. 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.

3.22. 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.

3.23. Training is defined as instruction and demonstration provided to designated school employees in preparation to be qualified for the performance of basic and/or specialized health care procedures.

3.24. School Personnel, as referred to in this policy and the Basic and Specialized Health Care Procedure Manual, includes any school employee, as defined in W.Va. Code §18-5-22 that is not a licensed health care provider but has been designated, trained and deemed competent by a certified school nurse and approved by a school administrator to provide basic and/or specialized health care procedure(s) to students in West Virginia public schools.

§126-25A-4. State Administrative Procedures.

4.1. 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. School employees who provide basic and/or specialized health care procedures for students with special health needs, shall undergo training or demonstrate competency in the performance of Required procedures that are set forth in Section 4.2.1 of this policy. In addition, applicable Basic and/or Specialized training will be required for all school employees performing health care procedures.

4.2.1. Required training: All employees defined in Section 4.2 must be trained in:

a. Handling and disposal of body fluids;

b. Basic first aid;

c. CPR;

d. Confidentiality.

A. Employees performing basic health care procedures may be exempt from Required training of first aid and CPR, if deemed unnecessary by the certified school nurse.

4.2.2. Basic training: Individualized training in the performance of any one or more basic health care procedures as applicable to employee job assignment.

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

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

4.4. 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 list and shall be conducted in relation to changes in student health care needs, licensed prescriber's orders and medical/health technology.

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

4.6. 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. Personnel shall be retrained, every two years on performance of all basic and/or specialized health care procedures that are currently prescribed and being performed by said personnel.

§126-25A-5. Organization and Management.

5.1. School employees will be certified for completion of Required training and applicable basic and/or specialized health care procedures.

5.1.1. Required training certification must assure:

a. Completion of Required training program stipulated for all employees defined in Section 4.2.

b. Demonstrated competency in Required training to be performed in Section 4.2.1.

5.1.2. Basic and Specialized certification must assure:

a. Completion of Required training program stipulated for all employees defined in Section 4.2. Completion of training in all basic and/or specialized health care procedures to be performed.

b. Demonstrated competency based on a performance checklist.

5.2. 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. The training may be provided by:

5.2.1. Schools of nursing;

5.2.2. Vocational schools;

5.2.3. Independent faculty approved by a certified school nurse;

5.2.4. Certified school nurses;

5.2.5. Public health department;

5.2.6. Contracted school nurse;

5.2.7. Contracted licensed health care provider.

5.3. This policy/rule will be updated, as necessary, by the Council of School Nurses, as outlined in §126-25A-8.

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

6.1. For students needing specialized heath care procedures, the certified school nurse shall assess the student, review the licensed prescriber's order 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. The licensed prescriber'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 licensed prescriber.

6.3. Certified school nurses shall determine delegation of any aspect of basic and/or specialized health care.

§126-25A-7. Health Care Plan.

7.1. A health care plan is required for all students receiving specialized health care procedure(s) during the school day and school related events.

7.2. The health care plan must be prepared by the certified school nurse based on assessment of student and/or a written order by a licensed prescriber.

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

7.4. The plan should contain:

7.4.1. Nursing assessment,

7.4.2. Nursing diagnosis,

7.4.3. Goals and expected outcomes,

7.4.4. Interventions and

7.4.5. Evaluation.

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

§126-25A-8. Quality Assurance.

8.1. A needs assessment conducted by county school nurses within each Regional Education Service Agency (RESA) will be the basis for revision of the Basic and Specialized Health Care Procedure Manual for West Virginia Public Schools. The Basic and Specialized Health Care Procedure Manual for West Virginia Public Schools will be revised, as deemed necessary, by the West Virginia Council of School Nurses based on the needs assessments conducted by school nurses.

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(s) regarding school employees designated to perform basic and/or specialized health care procedures.

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

8.3.1. Training related to new specialized health care procedures.

8.3.2. Staff development applicable to effective school health practice.

8.4. The certified school nurse must develop a monitoring system with appropriate timeframes to ensure safety and effective monitoring of the delegation of all basic and/or specialized health care procedures.

§126-25A-9. School Health Records.

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

9.2. An individual record 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.

§126-25A-10. Staffing Requirements.

10.1. 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. 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 as set forth in Policy 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 the National Association of School Nurses, Inc. "Scope and Standards of Professional School Nursing Practice".

10.3. The licensed 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. 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 basic and/or specialized health care procedures. A qualified designated school employee may be deemed not qualified in the performance of delegated basic and/or specialized health care procedures based on the ongoing monitoring and supervision by the school nurse.

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

§126-25A-11. Student Rights.

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

11.2. Students are afforded the right to privacy, dignity, respect and courtesy, in accordance with The Family Education Rights and Privacy Act (FERPA) (20 U.S.C. §1232g; 34 CFR Part 99).

§126-25A-12. Penalties.

12.1. 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.

§126-25A-13. Administrative Due Process.

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

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

13.1.2. Follow due process procedure as outlined in the Policy 2419 and/or in the West Virginia Board of Education Policy 7211: Appeals Procedures for Citizens (W.Va. 126CSR188).

13.1.3. Appeal unacceptable outcomes at the fourth step to the State Superintendent of Schools.

§126-25A-14. Severability.

14.1. If any provision of this rule or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of this rule.

BASIC AND SPECIALIZED

HEALTH CARE PROCEDURE MANUAL

FOR WEST VIRGINIA

PUBLIC SCHOOLS

AUGUST 2004

PROFESSIONAL CREDITS

1989 TASK FORCE FOR MEDICALLY FRAGILE STUDENTS

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

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

1989 Council of School Nurses:

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

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

Revised April 1995 by Council of School Nurses:

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

Revised June 2001 by Council of School Nurses:

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

Revised June 2004 by Council of School Nurses:

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

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

West Virginia School Nurses Organizational Chart for the Basic and Specialized Health Care

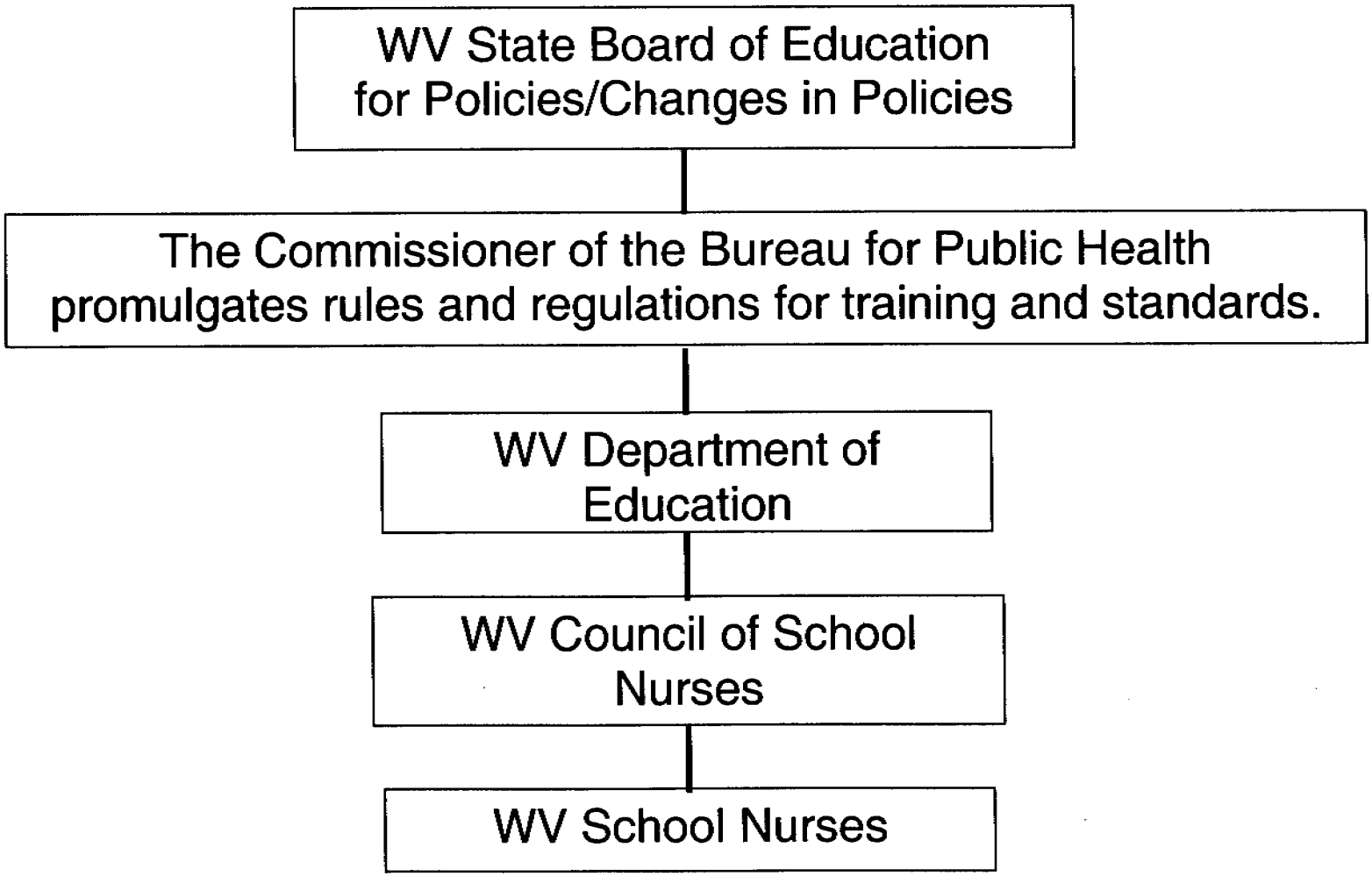

TABLE OF CONTENTS

TABLE OF CONTENTS (Continued)

TABLE OF CONTENTS (Continued)

TABLE OF CONTENTS (Continued)

TABLE OF CONTENTS (Continued)

APPENDICES

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.

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 1995, 2001 and revised again in 2004.

It is the consensus of the members of the Council of School Nurses 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
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 specialized health care procedures.

The West Virginia Legislature passed House Bill 2557, W.Va. Code §18-5-22, April 8, 1989. The law states that the school nurse, after assessing the health status of the individual student may delegate and supervise certain health care procedures to a trained school employee who is deemed competent by the school nurse. The statute also mandates that a Council of School Nurses be established. Meetings were held 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. The manual has been revised in 1995, 2001 and 2004.

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.

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Bob Wise
Governor

Paul L. Nusbaum
Secretary

August 18, 2004

Dr. David Stewart
Superintendent of Schools
West Virginia Department of Education
Capitol Complex
Building 6, Room 358
Charleston, West Virginia 25305

Dear Dr. Stewart:

Attached are the collected comments and recommendations of the Bureau for Public Health regarding the latest (2004) updates of the *Basic Specialized Health Care Procedure Manual for Public Schools*. We were happy to review this from the public health perspective. We support your approach of working closely with the child physician to assure appropriate, child-specific clinical care.

In order to gain a multi-disciplinary perspective several offices within the bureau reviewed the manual, including programs in Surveillance and Disease Control; Maternal, Child, and Family Health; and Health Promotion. Conclusions: (1) From the public health perspective, the Council of School Nurses did an outstanding job in updating the manual to reflect current policy and practice; (2) As always, we are pleased by the long standing cooperation that exists between the Bureau for Public Health and the Department of Education in promoting a healthier generation of young West Virginians.

Sincerely,

Catherine Slemp, MD, MPH
Acting State Health Officer

CS:pc

cc: Chris Curtis
Jim Cook

BUREAU FOR PUBLIC HEALTH
505 Capitol Street, Suite 200
Charleston, West Virginia 25301
Telephone: (304) 558-1218 Fax: (304) 558-0464

TITLE 126
LEGISLATIVE RULE
BOARD OF EDUCATION

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

§126-25A-1. General.

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1.3. Filing Date. - September 15, 2004.

1.4. Effective Date. - October 15, 2004.

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3.6. First Aid is defined as a training course in emergency treatment that is administered to an injured or sick person before professional medical care is available. This training will be coordinated by the school nurse.

3.7. Health Assessment is defined as the process by which the certified school nurse obtains student health 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 licensed prescriber when necessary.

3.8. 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, delegated procedures and student's role in self care.

3.9. Licensed Health Care Provider is defined as a medical doctor or doctor of osteopathy, podiatrist, registered nurse, practical nurse, registered nurse practitioner, physician assistant, dentist, optometrist, pharmacist or respiratory care professional licensed under Chapter Thirty of W.Va. Code.

3.10. 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 under the direction of a Registered Professional Nurse as defined in W.Va. Code §30-7A-1, et seq.

3.11. Licensed Prescriber is defined as a licensed health care provider with the authority to prescribe medication and health care procedures.

3.12. 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 safely perform basic and/or specialized health care procedures.

3.13. 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 basic and/or specialized health care services for individuals with health needs and to demonstrate current knowledge of community emergency medical resources.

3.14. 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 West Virginia Board of Education Policy 2419: Regulations for the Education of Exceptional Students (W.Va.126CSR16) (hereinafter 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.

3.15. Retrained is defined as a proper demonstration and/or instruction, as deemed necessary by the certified school nurse.

3.16. School Employee as defined by W.Va. Code §18-5-22 means teachers, as defined in W.Va. Code §18-1-1, secretaries, as defined in W.V. Code §18A-4-8 and aides, as defined in W.Va. Code §18A-4-8.

3.17. School Health Manager is defined as a certified school nurse who reviews and interprets medical data related to student health problems and coordinates all school health services.

3.18. School Related Events is defined as any curricular or co-curricular activity, as defined by West Virginia Board of Education Policy 2510: Assuring the Quality of Education: Regulations for Education Programs (W.Va. 126CSR42), that is conducted outside of the school environment and/or instructional day. Examples of co-curricular activities include the following: band and choral presentations; theater productions; science or social studies fairs; mathematics field days; career/technical student organizations' activities; or other activities that provide in-depth exploration or understanding of the content standards and objectives appropriate for the students' grade levels.

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

3.20. Supervision of Designated School Employees is defined as periodic on-site review and documentation by the certified school nurse verifying the competency of that individual in performing basic and/or specialized health care procedures and maintaining appropriate records.

3.21. 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.

3.22. 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.

3.23. Training is defined as instruction and demonstration provided to designated school employees in preparation to be qualified for the performance of basic and/or specialized health care procedures.

3.24. School Personnel, as referred to in this policy and the Basic and Specialized Health Care Procedure Manual, includes any school employee, as defined in W.Va. Code §18-5-22 that is not a licensed health care provider but has been designated, trained and deemed competent by a certified school nurse and approved by a school administrator to provide basic and/or specialized health care procedure(s) to students in West Virginia public schools.

§126-25A-4. State Administrative Procedures.

4.1. 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. School employees who provide basic and/or specialized health care procedures for students with special health needs, shall undergo training or demonstrate competency in the performance of Required procedures that are set forth in Section 4.2.1 of this policy. In addition, applicable Basic and/or Specialized training will be required for all school employees performing health care procedures.

4.2.1. Required training: All employees defined in Section 4.2 must be trained in:

a. Handling and disposal of body fluids;

b. Basic first aid;

c. CPR;

d. Confidentiality.

A. Employees performing basic health care procedures may be exempt from Required training of first aid and CPR, if deemed unnecessary by the certified school nurse.

4.2.2. Basic training: Individualized training in the performance of any one or more basic health care procedures as applicable to employee job assignment.

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

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

4.4. 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 list and shall be conducted in relation to changes in student health care needs, licensed prescriber's orders and medical/health technology.

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

4.6. 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. Personnel shall be retrained, every two years on performance of all basic and/or specialized health care procedures that are currently prescribed and being performed by said personnel.

§126-25A-5. Organization and Management.

5.1. School employees will be certified for completion of Required training and applicable basic and/or specialized health care procedures.

5.1.1. Required training certification must assure:

a. Completion of Required training program stipulated for all employees defined in Section 4.2.

b. Demonstrated competency in Required training to be performed in Section 4.2.1.

5.1.2. Basic and Specialized certification must assure:

a. Completion of Required training program stipulated for all employees defined in Section 4.2. Completion of training in all basic and/or specialized health care procedures to be performed.

b. Demonstrated competency based on a performance checklist.

5.2. 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. The training may be provided by:

5.2.1. Schools of nursing;

5.2.2. Vocational schools;

5.2.3. Independent faculty approved by a certified school nurse;

5.2.4. Certified school nurses;

5.2.5. Public health department;

5.2.6. Contracted school nurse;

5.2.7. Contracted licensed health care provider.

5.3. This policy/rule will be updated, as necessary, by the Council of School Nurses, as outlined in §126-25A-8.

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

6.1. For students needing specialized heath care procedures, the certified school nurse shall assess the student, review the licensed prescriber's order 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. The licensed prescriber'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 licensed prescriber.

6.3. Certified school nurses shall determine delegation of any aspect of basic and/or specialized health care.

§126-25A-7. Health Care Plan.

7.1. A health care plan is required for all students receiving specialized health care procedure(s) during the school day and school related events.

7.2. The health care plan must be prepared by the certified school nurse based on assessment of student and/or a written order by a licensed prescriber.

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

7.4. The plan should contain:

7.4.1. Nursing assessment,

7.4.2. Nursing diagnosis,

7.4.3. Goals and expected outcomes,

7.4.4. Interventions and

7.4.5. Evaluation.

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

§126-25A-8. Quality Assurance.

8.1. A needs assessment conducted by county school nurses within each Regional Education Service Agency (RESA) will be the basis for revision of the Basic and Specialized Health Care Procedure Manual for West Virginia Public Schools. The Basic and Specialized Health Care Procedure Manual for West Virginia Public Schools will be revised, as deemed necessary, by the West Virginia Council of School Nurses based on the needs assessments conducted by school nurses.

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(s) regarding school employees designated to perform basic and/or specialized health care procedures.

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

8.3.1. Training related to new specialized health care procedures.

8.3.2. Staff development applicable to effective school health practice.

8.4. The certified school nurse must develop a monitoring system with appropriate timeframes to ensure safety and effective monitoring of the delegation of all basic and/or specialized health care procedures.

§126-25A-9. School Health Records.

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

9.2. An individual record 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.

§126-25A-10. Staffing Requirements.

10.1. 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. 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 as set forth in Policy 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 the National Association of School Nurses, Inc. "Scope and Standards of Professional School Nursing Practice".

10.3. The licensed 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. 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 basic and/or specialized health care procedures. A qualified designated school employee may be deemed not qualified in the performance of delegated basic and/or specialized health care procedures based on the ongoing monitoring and supervision by the school nurse.

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

§126-25A-11. Student Rights.

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

11.2. Students are afforded the right to privacy, dignity, respect and courtesy, in accordance with The Family Education Rights and Privacy Act (FERPA) (20 U.S.C. §1232g; 34 CFR Part 99).

§126-25A-12. Penalties.

12.1. 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.

§126-25A-13. Administrative Due Process.

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

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

13.1.2. Follow due process procedure as outlined in the Policy 2419 and/or in the West Virginia Board of Education Policy 7211: Appeals Procedures for Citizens (W.Va. 126CSR188).

13.1.3. Appeal unacceptable outcomes at the fourth step to the State Superintendent of Schools.

§126-25A-14. Severability.

14.1. If any provision of this rule or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of this rule.

SECTION I

REQUIRED PROCEDURES

A. HANDLING OF BODY FLUIDS

1. CLEANING AND DISPOSING OF BODY FLUIDS

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

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

B. Equipment: (County responsibility unless noted).

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

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

II. Procedure:

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

poured down a drain connected to a sanitary sewer.

D. Other items for disposal that are contaminated with blood or other body fluids that cannot be flushed down the toilet should be wrapped securely in a plastic bag that is impervious and sturdy (not easily penetrated). It should be placed in a second, labeled bag before being discarded in a manner consistent with local regulations for solid waste disposal.

E. Body fluid spills should be cleaned up promptly, removing all visible debris first.

This prevents multiplying of microorganisms.

F. Use disposable items to handle and absorb body fluid cleanup whenever possible.

All items that are contaminated and that cannot be flushed down the toilet should be disposed of in a sturdy plastic bag that is not easily penetrated, then placed in a second bag for disposal.

G. Cleanse hard, washable surfaces using one bucket to wash and a second bucket to rinse.

Soap helps to remove debris and microorganisms, but if left on the surface may hide microorganisms.

H. Disinfect, using an approved germicide in proper dilution. Rinse only if directed by the germicide manufacturer's instructions. Allow to air dry.

Soak mop, if used, in disinfectant after use.

I. For soft, non-washable surfaces, such as rugs and upholstery, apply sanitary absorbing agent, let dry, and vacuum.

Use broom and dustpan to remove solid materials, if necessary. Rinse dustpan and broom in disinfectant solution.

J. Apply rug or upholstery shampoo as directed by the manufacturer. Revacuum.

When using a sanitizing carpet cleaner method (water extraction), follow directions on label.

K. Handle soiled, washable materials, i.e. clothing and towels, as little as possible, double-bagging as mentioned before.

Send soiled clothing home with the student. Rinse school-owned towels under cold, running water then wash separate from other items. Add 1/2-cup bleach or non-chlorine bleach to wash cycle.

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

2. GLOVES - USE AND REMOVAL

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

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

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

C. Personnel: All personnel.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Wash hands.	Refer to *Hand Washing* procedure.
B. Apply gloves to both hands.	Individuals with open skin lesions should cover lesions with waterproof bandage prior to applying the gloves.
C. Gloves must be worn during entire time when handling body fluids.	Gloves are most often worn during diapering, administering first aid, and cleanup of body fluids. Do not touch items with contaminated gloves that you or other people will be touching with your hands later. For example: water faucets, doorknobs, counter tops or other clothing.
D. After all cleanup is finished; pull the first glove off "inside out" from the cuff end carefully. When removing second glove, continue to grasp first glove and pull second glove from cuff to envelope the first glove. First glove should be inside second glove and only the interior of the second glove will be exposed.	Do not touch skin with contaminated gloves.

E. Drop gloves into plastic-lined trash container.

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

3. HAND WASHING

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

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

B. Equipment: (County responsibility unless otherwise noted).
1. Warm, running water.
2. Liquid soap.
3. Paper towels.
4. Alcohol-based hand rub.
5. Waste container with plastic liner.

C. Personnel: All personnel.

II. Procedure:

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

D. Rinse hands well under running water.

Let water drain from wrists to fingertips.

E. Dry hands thoroughly with paper towels. Turn off water with paper towel and discard towels in waste container.

Dry skin may be cracked and potentially harbor microorganisms. Lotion is recommended after several hand washings.

OR

A. Apply alcohol-based hand rub to the palm of one hand then rub hands together.

Note: The volume needed to reduce the number of bacteria on hands varies by product.

B. Continue to rub hands together covering all surfaces of hands and fingers until dry.

B. CPR AND FIRST AID TRAINING

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

CPR

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

FIRST AID

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

C. CONFIDENTIALITY

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

SECTION II

BASIC HEALTH CARE PROCEDURES

A. ACTIVITIES OF DAILY LIVING (ADL)

1. AMBULATING WITH ASSISTANCE

a. CANE

I. Guidelines:

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

B. Purpose: To lessen the force on weight-bearing joints; to give lateral balance while walking; to produce forward momentum or forward restraint during ambulation.

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

D. Personnel: All personnel.

II. Procedure:

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

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

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

b. CRUTCHES

I. Guidelines:

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

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

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

D. Personnel: All personnel.

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

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

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

3. Gait: 3-point crutch gait
   Description: Fairly rapid, but requires more strength and balance since the arms must support the entire body weight.
   Sequence: Both crutches and the weaker extremity are moved forward simultaneously; then the stronger extremity is moved forward

while putting most of the body weight on the arms.

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

   Description: Slow and labored while maintaining tripod position.

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

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

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

   Sequence:
   a. Swinging-to gait - bear weight on good leg; advance both crutches forward simultaneously, while leaning forward, swing the body to a position even with the crutches.
   b. Swinging-through gait - advance both crutches forward; lift both legs off the ground and swing forward landing in advance of the crutches; bring crutches forward rapidly to prevent being caught off balance.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Determine the need for assistance with crutches at school.	Review the physician's orders and the student's health care plan.

B. Obtain a consultation with the physical therapist, if you are unfamiliar with procedures for using crutches.	The physical therapist can assist and facilitate implementing the physician's orders for ambulation.
C. Assist the student with strengthening exercises.	As ordered by the physician.
D. Check the crutches for appropriate length when student is standing erect.	When the crutch tip is 4-inches in front of and 6-inches to the side of toes, the arm piece should be 2-inches from the axilla.
E. Assist the student with the tripod stance to stand with balance and stability.	Wearing well-fitted, low-heeled and rubber soled shoes, stand with feet slightly apart and crutches placed 6 to 10-inches in front of and to the side of toes.
F. Check the hand piece so that the student's elbows have 20 to 30 degrees of flexion when the arm piece is 2 finger widths below the axilla.	Prevent brachial nerve paralysis by showing student how to extend and stiffen elbows in order to place body weight on palms, never on axilla.
G. Use the axillary arm pad only if ordered by the physician.	Even though the auxiliary arm pads lessen pressure on the inside of the upper arm and the thoracic wall, their use may encourage the student to rest on them and not put pressure on hands.
H. Check to see that the crutches are labeled with the student's name.	The wrong crutches may fit improperly and make the student prone to fall.
I. Verify that the student is using the crutch gait prescribed by the physician.	Gait varies with the type and severity of the disability, the student's general condition, strength of arms and trunk, extent of balance.
J. Assist the student with stair climbing:	Remember that "the good go up and the bad go down".
1. To go up stairs	Advance the good leg up to the next step, then the crutches and finally the weaker leg.
2. To go down stairs	Place the crutches on the next lower step; then lower the weaker leg and finally step down with the good leg.

K. Arrange for the student to use the school elevator, if elevator is available.	Lessens possibility of injury to student or others on the stairs.
L. Safety points:	
1. Make sure rubber crutch tips are in good repair.	They should be wide and provide good traction; replace promptly if worn.
2. Check screws and nuts frequently.	They loosen with usage.
3. Have a designated place in the classroom for the crutches.	They could be a safety hazard for other students and staff.
4. Keep hands free to handle the crutches.	Use a backpack to carry personal belongings.
5. Arrange for the student to leave each class 5 minutes early, if necessary.	This allows student to be clear of the hall during regular passing period.

c. WALKER

I. Guidelines:

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

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

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

D. Personnel: All personnel.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Determine the need for assistance with a walker at school.	Review the physician's orders and the student's health care plan.
B. Obtain a consultation with the physical therapist, if you are unfamiliar with the procedures for using a walker.	The physical therapist can assist and facilitate implementing the physician's orders for ambulation.
C. Tell the student what you will be doing and how he/she is to assist.	Use developmentally appropriate language and demonstration.
D. Verify that the student is using the type of walker prescribed by the physician.	Standard walker is a rigid framework, but adjustable in height. Mobile walker has wheels on the legs to roll forward. Rollator walker has wheels in the front and rubber tipped legs in the back. Swivel-type walker is hinged so that the right and left side moves independently.
E. Check the walker for appropriate height.	Have the student stand erect in line with the rear legs of the walker; elbows should be flexed about 30-degrees when hands are on the grips.
F. Assist the student to walk using the walker.	Place the walker forward less than an arm's length; take a step with each leg; the student's

	body should not be in contact with the front cross bar.
G. Do not allow the student to use the walker on stairs.	The walker cannot safely be used on stairs and inclines.
H. Arrange for the student to use the school elevator, if elevator is available.	Without an elevator, student may need to have all classes on the ground floor.
I. Safety points:	
1. Make sure rubber walker tips are in good repair.	They should be wide and provide good traction; replace promptly if worn.
2. Check screws and nuts frequently.	They loosen with usage.
3. Have a designated place in the classroom for the walker.	It could be a safety hazard for other students and staff.
4. Keep hands free to maneuver the walker.	Use a backpack to carry personal belongings.
5. Arrange for the student to leave each class 5 minutes early, if necessary.	This allows student to be clear of the hall during regular passing period.

d. WHEELCHAIR

I. Guidelines:

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

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

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

D. Personnel: All personnel.

II. Procedure:

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

3. Tell him to reach back for the arms of the wheelchair.

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

   Place buttocks at the back of the chair seat.

5. Make sure student is safe and secure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I. Assist the student to stand.

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

1. Lock wheelchair wheels.

2. Tell the student to move to the front of the wheelchair and put hands on the wheelchair arms.

3. Place one of your knees between student's knees; if student has a weak knee, brace it with your knee.

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

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

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

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

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

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

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

K. Wheelchair safety points:

1. Regularly check the rear wheels for movement with the brakes locked.	Brakes become ineffective when they are out of alignment; have brakes repaired.
2. Make sure both feet are on the footrests.	Ask for assistance, if needed.
3. Make sure arms and legs are within the width of the chair when going through a doorway.	
4. Always lock the brakes when the wheelchair is stopped.	
5. Always push at a walking speed. NEVER FASTER.	Even if it is empty.
6. Never tilt the wheelchair way back, turn sharply, or stop too rapidly.	Take extra caution on gravel, grass, or uneven ground because the front wheels can get stuck, making the chair tip forward.
7. Back a wheelchair down ramps and curbs.	
8. Push a wheelchair forward going up ramps and curbs.	Be sure both wheels go over the curb together so the chair doesn't tip.
9. Always hold onto the wheelchair when pushing it.	Tip the chair back just enough for the front wheels to clear the curb.

2. ASSISTING WITH CLOTHING

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

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

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

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

C. Personnel: All personnel.

II. Procedure:

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

G. Allow enough time for student to complete task.

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

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

The following factors indicate readiness:

1. Is able to sit up and maintain balance or perform specific functions while lying on side.

2. Follows directions.

3. Shows which articles of clothing are worn on which parts of the body.

4. Move arms from side to side and overhead.

5. Imitates another person's motions.

6. Grasps objects with hands.

3. BODY MECHANICS

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

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

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

C. Personnel: All personnel.

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Stooping.	
1. Position body to provide stable base of support.	Feet apart, one foot slightly forward. Provides better lateral stability.
2. Lower body to a stooped position.	Back and trunk straight; knee and hip joints flexed.
3. Shift weight.	
4. Raise body to a standing position.	To advance foot and ball of rear foot. Keep back straight; initiate move by extending hip and knee joints (using stronger extensor muscles).
B. Reaching.	
1. Position body with a stable base of support.	Feet apart, one foot slightly advanced.
2. Start movement with body in good alignment and balance.	Back and trunk straight.
3. Check distance to be reached to obtain object.	Obtain a footstool or a ladder, if necessary. Avoid reaching above shoulder level when possible to prevent strain.

4. Reach up from a position directly in front of the object.	Have line of gravity centered over center of the footstool; feet in a balanced position. Avoid looking or reaching overhead as this hyperextends neck and spine and makes you less stable.
5. Lift the object from the elevation.	Set muscles to distribute work load over many muscles; use good body alignment.
6. Lower the object.	Use smooth, coordinated movements to prevent jarring and jolting the body.
7. Lower yourself from the ladder or footstool.	Look down and step carefully, watch where you are going.
8. Place the object on a shelf at working level or stoop and lower it to the floor.	Observe good principles of body alignment to prevent strain.

C. Pivoting.

1. Start with stable base of support.	Feet apart, one foot slightly advanced; knees slightly flexed to allow you to use leg muscles and avoid "locking" or hyperextending the knees.
2. Set trunk and pelvic muscles, thigh and leg muscles.	"Setting" of the muscles makes it easier to turn the body as a single unit and prepares muscles for action.
3. Shift your weight to the ball of each foot.	Shifting of weight allows the heel to lift very slightly, making the turn easier.
4. Pivot or make 90-degree turn on feet in direction you wish to turn.	Move your feet and body as a single unit. Use smooth, coordinated movements to prevent twisting of the trunk.
5. Distribute weight equally on each foot following turn.	To provide a stable base of support and balance for further movements.

D. Lifting and carrying.

1. Start with stable base of support.	Feet apart, one foot slightly advanced.

2. Reach for the object.	Back, hips, and knees flexed.
3. Grasp object in its center of gravity.	
4. Set abdominal and arm muscles.	Prepares the muscles for action and stabilizes muscles.
5. Lift object.	Bring object close to one's line of gravity; flex knees again for more thrust and begin to straighten back, not rigidly straight, in the final position.
6. Carry object.	Carry object near midline of body, large muscles aid in support. Shift object from side to side during period of support.
7. Position object as desired.	

E. Pushing and Pulling.

1. Start with stable base of support and good body alignment.	Feet apart, one foot slightly advanced; keep body erect.
2. Set trunk and leg muscles.	Stabilizes the body and prepares muscles for action.
3. Lean toward object to push.	Keeps work close to body; encourages good alignment by reducing distance of reach (back straight and erect). Body weight adds greater force and helps move an object.
4. Lean away from object in order to pull.	Keep back straight and erect to apply as much force as possible in the direction of the movement by using the weight.
5. Push or pull by letting your arms, hips, and thighs do most of the work.	The large muscles of the thigh and leg do the work; efficient use of these muscles conserves energy and prevents strain.

4. ORAL FEEDING OF STUDENT

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

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

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

C. Personnel: All personnel.

II. Procedure:

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

F. Choose an area of the classroom or lunchroom that has the most suitable atmosphere for this task.	Area should be calm and organized yet allows the student to observe other students also eating.
G. Place the student in a sitting position if this is allowed.	Observe safety measures. Provide foot, trunk, and head support for the student. Do not allow neck to hyperextend as this interferes with swallowing. Keep chin at midline and forward, chin pointing to chest.
H. Wash the student's hands and face, if necessary.	This is especially important if the student will be assisting with feeding.
I. Place a towel on the student's chest.	To protect clothing.
J. Provide oral hygiene as needed.	This may stimulate the student's appetite by increasing student's ability to taste and enjoy the sensation of eating.
K. Measure food, if required, and bring it to the student's table.	Have hot foods hot, cold foods cold, and cut into small bite-sized pieces or proper consistency, if needed. Foods need to be of consistency that will hold bolus form until swallowed.
L. Feed the student slowly, with a small amount of food on the utensil, inserting it on alternate sides of the mouth.	Hurry and impatience create frustration. Wipe drops from the bottom of the spoon. Allow the student to perform as much self-feeding as can be managed.
M. Check to see if the student needs assistance with opening mouth, chewing, swallowing, or controlling tongue thrust.	Observe feeding behaviors. Review the physician's orders and the student's health care plan.
N. Offer the student liquids throughout the meal.	Use a lightweight, sturdy cup with lid, a drinking straw or tube, offered at the side of the mouth, or other adaptive device to assist drinking. If needed, guide the student's hand as the cup is brought to mouth.
O. Praise and encourage the student's efforts.	
P. Remove uneaten food from the student's table. Measure it if required. Return it	Refer to *Cleaning and Disposing of Body Fluids* procedure.

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

SPECIAL DIETARY NEEDS
PHYSICIAN'S MEDICAL STATEMENT

Name_____ Date of Birth_____

Circle the correct response. Does this patient have a disability that affects her/his diet? Yes or No

Circle the correct response. Did you refer this patient to a dietitian for diet consultation? Yes or No

If yes, please indicate the consulting dietitian_____

Diagnosis or Medical Condition_____

PLEASE MARK ALL AREAS BELOW THAT APPLY, SIGN AND DATE.

DIET RESTRICTIONS

Caloric Requirements for Diabetes		1200	1500	1800	2000	2200	Other _____
Caloric Requirements for Weight Gain		1500	1800	2000	2200	_____	Other _____
Caloric Requirements for Weight Loss		1200	1500	1800	2000	_____	Other _____
Sodium Restriction	NAS	250	500	1000	1500	2000	Other _____

Fat Restriction and/or Cholesterol Restriction_____

Other Restrictions_____

FOOD ALLERGIES

Food(s) Patient Can Not Have	Substitutions
_____	_____
_____	_____
_____	_____

TEXTURE CONSISTENCIES

Solids		Liquids	
Regular Chopped	_____	Regular	_____
Mechanical Soft with ground meat	_____	Nectar/Syrup	_____
		Honey	_____
Mechanical Soft with chopped meat	_____	Pudding	_____

NUTRITIONAL SUPPLEMENTS TO BE PROVIDED AT SCHOOL OR SITE

Oral Feedings _____

Section 504 of the Rehabilitation Act of 1973 assures disabled individuals access to meals. If an individual has a disabling conc that limits one or more major life activities and requires a special diet, a physician's statement is required. Schools or sites may m substitutions for non-disabled individuals who are unable to consume the regular meal because of medical or other special die needs. A statement from a recognized medical authority, e.g., a medical doctor (MD), doctor of osteopathic medicine (DO), registe nurse (RN), physician's assistant (PA), nurse practitioner (RNC) or registered dietitian (RD), is required.

_____ _____

Signature & Title Date

Phone Number_____

5. ORAL HYGIENE

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

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

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

C. Personnel: All personnel.

II. Procedure:

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

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

6. PEDICULOSIS DETECTION

I. Guidelines:

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

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

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

II. Procedure:

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

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

7. SAFETY WHILE USING ASSISTIVE DEVICES

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

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

B. Equipment: As prescribed by a health professional

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

II. Procedure:

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

1. Prior to the first day of school, a plan will be in place that includes:

   a. Advance notification to transportation department describing type of modifications necessary for bus transport.

   b. When and where student will be picked up and dropped off.

   c. Who will be responsible for initiating and implementing plan.

Team members will include, but school administrator, transportation staff, teachers, bus drivers, bus aides, and other professional and service personnel as required.

D. Field Trips:

Advance notice to school health and other services that provide care to the student at school.

At least 10 days advance notice should be provided to assure appropriate accommodations can be arranged so student may participate in the field trip activities.

E. Identify key school personnel responsible for dissemination of health information to the school nurse.

Building administrator should be aware of any changes or increased needs of the student and provide this information to the school nurse as soon as possible.

F. Student Behavior:

1. Observe student response to temporary or permanent changes in mobility.

2. Discuss with teachers, parents, and health care providers ways to assist the student through these changes.

Identification of positive or negative response to mobility change can help to reduce anxiety and problems for student and staff.

G. Staff training related to medical condition.

Provide plan of care and intervention guide to all staff enrolled with the care of the student. Schedule training as needed for staff providing medical interventions.

H. Documentation of Health Care Plan.

8. SKIN CARE AND POSITIONING FOR PREVENTION OF PRESSURE AREAS

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

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

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

C. Personnel: All personnel.

II. Procedure:

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

D. Maintain good skin hygiene:

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

9. TOILETING

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

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

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

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

C. Personnel: All personnel.

II. Procedure:

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

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

D. Wash hands and put on disposable gloves.

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

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

1. Have student lie on back with legs flexed, if unable then turn student on side facing you.

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

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

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

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

Check to see that the bedpan is properly adjusted.

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

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

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

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

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

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

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

9. When the student is finished, place your hand under the lower back to help lift hips so that the pan does not

Use disposable underpad to protect furniture from moisture and spills. Cover the bedpan with newspaper or a disposable bedpan cover.

pull against skin. Remove the bedpan, cover and place on a protected surface. Hold the bedpan flat on the changing table or mat to avoid spilling the contents while rolling the student off of the bedpan.

10. Remove the disposable underpad and redress the student.

Refer to *Assisting with Clothing* procedure.

11. Allow the student to wash hands. Assist into a comfortable position.

Use a towelette or warm, soapy washcloth if student cannot be brought to a sink. Rinse and dry hands.

12. Take the bedpan to the bathroom. Note the appearance of the urine and/or stool. Empty the contents into the toilet.

If the student is on recorded intake and output, measure the urine.

13. Clean the bedpan by rinsing and disinfecting with approved germicidal solution.

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

14. Cover the bedpan and store it appropriately.

F. Remove gloves and wash hands.

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

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

Record:

1. Date and time.
2. Description and amount of urine and/or stool, if needed.
3. Any problems and student's response to this procedure.
4. Signature of personnel performing procedure.

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

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

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

d. FEMININE HYGIENE

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

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

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

C. Personnel: All personnel.

II. Procedure:

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

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

B. MECHANICAL LIFT

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

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

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

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

II. Procedure:

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

C. ORTHOPEDIC DEVICE

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

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

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

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

II. Procedure:

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

B. Report any changes to school nurse and parent/guardian.

C. Reapply device:

1. Make sure skin is clean and dry.

2. Use stockinette or thin material between skin and device.

This material will absorb perspiration and allow the skin to breathe. Make sure the material is smooth without wrinkles or objects such as buttons.

3. Check that device is put on properly.

Physician's order will specify proper application. Improper fit may cause pressure areas.

4. Fasten straps securely.

May fasten lightly and go back to tighten into place.

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

Record:

1. Date and time.
2. Condition of skin.
3. Fit of device.
4. Signature of personnel performing procedure.

E. Major concerns:

1. Observe for proper fit and report abnormal findings to school nurse and parent/guardian.

Proper fit decreases the possibility of pressure sores.

2. Encourage good hygiene.

Good hygiene aids in preventing skin breakdown.

D. PASSIVE RANGE OF MOTION EXERCISES

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

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

B. Equipment: (County responsibility unless otherwise noted).
1. Table or mat as needed.
2. Disposable medical gloves (only if there is wound drainage or skin lesions).
3. Approved germicidal solution.

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

II. Procedure:

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

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

Record:

1. Date and time.
2. Student's reaction to procedure.
3. Extremity or joint to which ROM was performed.
4. Signature of personnel performing procedure.

SECTION III

SPECIALIZED HEALTH CARE PROCEDURES

A. ENTERAL FEEDING (TUBE FEEDING)

1. ENTERAL FEEDING VIA GASTROSTOMY TUBE BOLUS METHOD

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

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

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

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

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

II. Procedure:

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

B. Elevate student's head to 30-45 degrees or assist to a sitting position. If a sitting position is contraindicated, a right side-lying position may be used.	Sitting position enhances the gravitational flow and helps prevent aspiration.
C. Ensure that prescribed feeding is at room temperature. Check expiration date. Check for thickening, lumps or separation.	Excessive heat coagulates feeding. Excessive cold can reduce flow of digestive enzymes and cause abdominal cramping. Texture changes may indicate contamination.
D. Wash hands and put on gloves.	Refer to *Hand Washing* and *Gloves - Use and Removal* procedures.
E. Check student for abdominal distention, belching, loose stools, flatus or pain.	May indicate intolerance to previous feeding.
F. Remove cap or plug from G-tube and insert a catheter-tipped syringe into the end of feeding tube.	
G. Check placement of feeding tube prior to initiating each feeding by unclamping the tubing and injecting10 cc of air into G-tube while listening for a whoosing sound over the epigastric area of the abdomen with a stethoscope.	Ensuring proper placement prior to each feeding prevents inadvertent administration of feeding outside the stomach. NOTE: PROCEDURE MAY BE PERFORMED BY DESIGNATED TRAINED PERSONNEL UNDER THE DIRECT OR INDIRECT SUPERVISION OF THE CERTIFIED SCHOOL NURSE.
H. Aspirate and measure residual feedings after confirming G-tube placement. Adjust the feeding volume according to orders if residual is present.	Aspirating and measuring residual feedings is done to evaluate the absorption of previous feedings. If the residual is greater than recommended, hold feeding, wait 30-45 minutes and recheck.
I. Re-instill the gastric contents into the stomach. Clamp or pinch tube.	Returning aspirated contents prevents fluid and electrolyte balance.
J. Disconnect the syringe. Remove bulb or plunger from the syringe and reconnect the syringe to a pinched or clamped G-tube.	Pinching or clamping the tube prevents excessive air from entering the stomach and helps prevent distention.
K. Unclamp tube and allow bubbles to escape. Add feeding to syringe barrel, allowing feeding to flow slowly.	Administering the feeding rapidly can cause flatus, abdominal cramping and/or reflux vomiting.

Continue to add feeding and keep solution in syringe at all times until feeding is completed. Pinch off tubing to stop the flow if the student experiences discomfort. Clamp tube and discontinue feeding if student should vomit during the feeding.	Raise or lower syringe to adjust flow as needed.
L. Instill prescribed amount of water after feeding is administered.	Instilling water after the feeding cleans the lumen of the tube and prevents occlusion.
M. Vent G-tube by opening G-tube to air if ordered.	Venting allows drainage of fluid or release of gas bubbles in the stomach.
N. Clamp tube, remove barrel of syringe and reinsert cap or plug into end of tubing.	
O. Care of the Student:	
1. Allow student to remain elevated for 30 minutes after feeding if possible.	Remaining in an elevated position helps prevent vomiting and/or aspiration if student should regurgitate.
2. Student may be positioned on right side for 30 minutes to 1 hour after feeding.	The right side-lying position facilitates emptying of the stomach contents into the small bowel.
3. Cleanse area around G-tube with soap and water unless otherwise ordered. Apply dry, sterile dressing if indicated and secure with tape.	Covering the insertion site with a dressing absorbs any discharge of gastric juices and prevents skin breakdown.
4. Make sure tubing is secure and tucked inside clothing, not inside diaper or underwear.	Tubing may be pinned or taped to shirt.
P. Wash all reusable equipment with warm soapy water after each feeding, rinse thoroughly and dry. Store in a clean area.	Prevents the accumulation of feeding and growth of bacteria.
Q. Remove gloves and wash hands.	Refer to *Gloves – Use and Removal* and *Hand Washing* procedures.

R. Document procedure on student's individual treatment record.	Record: 1. Date and time feeding was administered. 2. Type and amount of formula. 3. Amount of water given. 4. Amount of residual. 5. Student's response to procedure. 6. Any other pertinent information. 7. Signature of personnel performing procedure

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

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

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

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

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

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

II. Procedure:

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

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

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

3. Hang bottle/bag on hook or standard.

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

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

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

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

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

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

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

   Cleans the lumen of the tube and prevents occlusion.

N. Vent G-tube by opening G-tube to air if ordered.

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

O. Care of the Student:

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

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

2. Student may be positioned on right side for 30 minutes to 1 hour after feeding.

   The right side-lying position facilitates emptying of the stomach contents into the small bowel.

3. Cleanse area around G-tube with soap and water, unless otherwise ordered. Apply dry, sterile dressing if indicated.

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

4. Make sure tubing is secure and tucked inside clothing, not inside diaper or underwear.

   Tubing may be pinned or taped to shirt.

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

   Cleaning equipment prevents the accumulation of feeding and growth of bacteria.

Q. Remove gloves and wash hands.

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

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

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

3. ENTERAL FEEDING VIA GASTROSTOMY BUTTON BOLUS METHOD

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

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

B. Equipment: (Parent responsibility unless otherwise noted)

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

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

II. Procedure:

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

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

tubing and discontinue feeding if student should vomit during the feeding.

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

Instilling water after the feeding cleans the lumen of the tube and prevents occlusion.

M. Lower syringe below the stomach level to facilitate burping.

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

N. Remove adapter and feeding catheter. Snap safety plug in to place.

Capping with anti-reflux valve prevents formula from returning.

O. Care of the Student:

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

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

2. Cleanse area around gastrostomy button with soap and water unless otherwise ordered. Apply dry, sterile dressing if indicated. Secure with tape or adhesive dressing as ordered.

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

P. Wash all equipment with warm soapy water after each feeding and rinse thoroughly.

Cleaning equipment prevents the accumulation of feeding and growth of bacteria.

Q. Remove gloves and wash hands.

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

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

Record:

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

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

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

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

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

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

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS/PRECAUTIONS

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

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

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

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

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

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

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

Cleans the lumen of the tube and prevents occlusion.

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

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

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

Capping with anti-reflux valve prevents formula from returning.

O. Care of the Student:

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

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

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

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

Covering the insertion site with a dressing absorbs any discharge of gastric juices and

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

5. ENTERAL FEEDINGS VIA NASOGASTRIC TUBE BOLUS METHOD

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

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

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

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

II. Procedure:

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

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

M. Care of the student:

Post-Feeding care

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

Daily care

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

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

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

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

B. Equipment: (Parent responsibility unless otherwise noted)

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

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

II. Procedure:

ESSENTIAL STEPS	KEYPOINT/PRECAUTIONS
A. Obtain written orders from licensed prescriber and parent/guardian written consent.	All specialized procedures performed in the school setting must have written orders and parent/guardian written consent.
B. Elevate student's head to 30-45 degrees or assist to sitting position.	Sitting position enhances the gravitational flow and helps prevent aspiration into the lungs.

C. Ensure that prescribed feeding is at room temperature. Check expiration date. Check for thickening, lumps or separation.

Excessive heat coagulates feeding. Excessive cold can reduce flow of digestive enzymes and cause abdominal cramping. Texture changes may indicate contamination.

D. Wash hands and put on gloves.

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

E. Check student for abdominal distention, belching, loose stools, flatus, or pain.

May indicate intolerance to previous feeding.

F. Check placement of feeding tube prior to initiating each feeding:

Ensuring proper placement prior to each feeding prevents inadvertent administration of feeding into lungs and avoids aspiration.

1. Insert tip of syringe into nasogastric tube.

2. Inject 10 cc of air into NG tube while listening for a whoosing sound over epigastric area of abdomen with a stethoscope.

NOTE: ONLY A RN OR LPN CAN DETERMINE NG TUBE PLACEMENT. PLACING THE END OF THE TUBE INTO A GLASS OF WATER IS NOT CURRENT RECOMMENDED PRACTICE.

G. Aspirate and measure residual feedings after confirming tube placement. Adjust the feeding volume according to orders if a residual is present.

Aspirating and measuring residual feedings is done to evaluate the absorption of previous feedings. Hold the feeding if the residual is greater than recommended, wait 30-45 minutes and recheck.

H. Re-instill the gastric contents into the stomach. Clamp or pinch tube.

Prevents fluid and electrolyte imbalance.

I. Administration of feeding:

1. Remove hanger from hook or standard.

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

3. Hang bottle/bag on hook or standard.

4. Open clamp on formula tube and prime tube by allowing fluid to fill

Clearing tubing of air by priming with feeding prevents excessive amounts of air from being

tubing before attaching to NG tube. Prime tubing according to manufacturer's instructions if using a pump.	instilled into stomach before feeding.
5. Attach formula tube to NG tube, open clamp, and regulate fluid drip to approximately 60 drops per minute, unless otherwise ordered, or set pump according to manufacturer's instructions.	Regulating the flow will help prevent regurgitation, vomiting, and/or diarrhea.
6. Check student frequently. Pinch off tubing to stop the flow if the student experiences discomfort. Clamp tube and discontinue feeding if student should vomit during feeding.	
J. Insert syringe into NG tube and instill prescribed amount of water after feeding is administered.	Cleans the lumen of the tube and prevents occlusion.
K. Allow some of the water to remain within NG tube and clamp or plug tubing.	Prevents air from being introduced into the stomach at the next feeding.
L. Care of the student:	
Post-Feeding care:	
1. Allow student to remain elevated for 30 minutes after feeding if possible.	Remaining in an elevated position helps prevent vomiting and/or aspiration if student should regurgitate.
Daily care:	
1. Perform oral hygiene.	Prevents accumulation of secretions and dryness. Refer to *Oral Hygiene* procedure.
2. Clean and lubricate nostrils as needed (at least daily).	Prevents irritation of nasal mucosa.
3. Ensure that tubing is securely in place.	Prevents accidental removal and discomfort.
M. Remove gloves and wash hands.	Refer to *Gloves-Use and Removal* and *Hand Washing* procedures.

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

7. INSERTING A NASOGASTRIC TUBE

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

1. Purpose: To provide training and supervision guidelines for the insertion of a nasogastric tube in the school setting.

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

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

II. Procedure:

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

C. Assemble equipment.	
D. Wash hands and put on gloves.	Refer to *Hand Washing* and *Gloves – Use and Removal* procedures.
E. Position student in a sitting or high fowler's position with neck slightly flexed. Place a towel across chest.	Sitting with neck flexed facilitates passage of tube into esophagus.
F. Inspect nostrils with open light, observing for obstruction, occlude each nostril and have patient breathe to determine which nostril is most patent.	
G. 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.
H. Coil the first 3-4 inches of tube around fingers.	Curving tubing facilitates tube passage.
I. Lubricate about 6-8 inches (15-20 cm) of tube with water-soluble jelly.	Lubrication reduces friction between mucous membranes and tube.
J. Tilt student's head slightly backward before inserting tube into a nostril. Pass tube gently into the posterior nasopharynx, aiming downward and backward.	Passing of the tube is facilitated by following the natural contour of the body.
K. Allow student to rest for a few moments. When tube reaches the pharynx, student may gag.	Gag reflex is triggered by the presence of the tube.
L. Tilt head slightly forward and offer several sips of water through a straw. Advance tube as student swallows.	Flexing the neck facilitates swallowing by occluding airway so tube is less likely to pass into trachea.
M. Continue advancing tube gently each time student swallows.	Mouth breathing and swallowing facilitates passage of tube.
N. Stop advancing tube if obstruction appears to prevent tube from passing. DO NOT FORCE. Rotate the tube	

gently. If unsuccessful, remove tube and try other nostril.

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

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

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

Q. Check the placement of NG tube by:. .

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

1. Insert catheter into NG tube.

2. Inject 10 cc of air while listening for whoosing sound over epigastric areas of abdomen.

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

Clamp the tube after correct placement is confirmed.

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

Do not tape with pressure on nares, as infants are nose breathers.

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

Securing to clothing prevents accidental removal.

T. Discard disposable equipment.

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

U. Remove gloves and wash hands.

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

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

Record:

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

8. OSTOMY CARE: EMPTYING/CHANGING OF OSTOMY POUCH

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

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

B. Equipment: (Parent responsibility unless otherwise noted)

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

C. Personnel: Certified School Nurse, licensed health care provider such as RN or LPN, or designated trained school personnel under direct or indirect supervision of Certified School Nurse, or student independently as prescribed by physician.

II. Procedure

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain written order from licensed prescriber and parent/guardian consent.	All specialized procedures performed in the school setting must have written orders from a licensed prescriber and parent/guardian consent.
B. Assemble equipment in appropriate private location.	Specific equipment may vary. Provide privacy for the student.

C. Position student in relaxed position.	Encourage the student to do as much for himself/herself as possible. Use developmentally appropriate language.
D. Wash hands and put on gloves.	Refer to *Hand Washing* and *Gloves – Use and Removal* procedures.
E. To empty:	
1. Open pouch and empty contents into toilet or other recommended receptacle.	Emptying contents may prevent leakage and odor. Refer to *Cleaning and Disposing of Body Fluids* procedure.
2. Close pouch.	
F. To change:	
1. Remove pouching system by gently peeling pouch away from skin.	Use skin safe solvent, if necessary.
2. Place absorbent material over stoma.	Place absorbent material over stoma to keep irritating drainage from the skin until replacement of pouch is ready.
3. Empty ostomy pouch into toilet. If reusable, rinse with water over toilet and put in suitable container to send home. If disposable, discard in lined waste receptacle.	Know whether pouch is to be returned home. Refer to *Cleaning and Disposing of Body Fluids* procedure.
4. Clean skin thoroughly but gently with soap and water.	Make sure all adhesive is removed from skin using skin-safe solvent if needed.
5. Dry thoroughly.	Unit will not adhere to damp skin. Report evidence of skin breakdown and/or infection to parent/guardian and school nurse.
6. Measure stoma with measuring guide. Trace the opening onto the paper backing of the pouch.	The opening should be 1/8 inch larger than the stoma.
7. Cut along the tracing, smoothing any jagged edges with fingers or scissors, and remove the white paper backing from the skin barrier.	Jagged edges can irritate the ostomy or skin and result in a poor seal.

8. Apply stomahesive paste to the back of the skin barrier at the edge of the cut opening and set aside for one minute.	Allow some time for paste to "ready".
9. Apply skin protectant, if ordered, and allow to dry.	Protectants prevent a breakdown of skin.
10. Place the skin barrier wafer over the stoma and press gently against it for 30 seconds, especially around the stoma.	This needs to be well adhered to the skin to support the pouch after it is applied.
11. Secure the pouch onto the skin barrier wafer making sure it is secured all around.	Completely seal the pouch against the skin barrier wafer.
G. Secure lower opening of pouch with clamp or be sure adapter is closed.	Pouch should be secured in place, able to contain drainage and be emptied as needed.
H. Remove gloves and wash hands.	Refer to *Gloves -Use and Removal* and *Hand Washing* procedures.
I. Document procedure on student's individual treatment record.	Record: 1. Date and time. 2. Pertinent information. 3. Signature of personnel performing procedure.

A. GENERAL GUIDELINES FOR DIABETIC MANAGEMENT

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

A. Purpose: To provide training and supervision guidelines for the care and safety of the diabetic student in the school setting.

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

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

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS/PRECAUTIONS
A. Obtain diabetic history from parent/ student.	History should include the student's usual signs and symptoms of abnormal blood sugars, student's ability to recognized the symptoms and how to treat.
B. Provide training for school personnel on characteristics of hypoglycemia (low blood sugar) and hyperglycemia (high	A general training will prepare school personnel to identify and provide emergency care for the diabetic student.

blood sugar), and management for each one.	
C. Assess school day activities.	An overview of the mealtimes and activity times can help identify possible times of blood glucose fluctuations.
1. Review student's daily schedule.	A careful review of the daily routine: placement of meals, snacks, physical activity, sports participation, and after school practices and activities. Modifications in daily schedule which can impact blood glucose results are 2 hour delays, early dismissals, food events included in curriculum, etc..
2. Plan for co-curricular activities.	Advance notice is needed to prepare for the needs of the student.
D. Prepare school staff for prescribed procedures during the school day.	Procedures, which require inservice specific to each student, but include universal precautions, appropriate disposal of sharps, hand washing and gloving.
1. Blood glucose measurement and/or interpretation of reading for student.	Remain alert to unusual behavior by student, which can indicate the need for blood glucose measurement. ***Always refer to licensed prescriber's orders.**
2. Recognition of extremes of blood glucose: a. Hypoglycemia	Requires immediate treatment to protect student from dangerously low blood glucose.
b. Hyperglycemia	Hyperglycemia or high blood glucose may be caused by too little insulin, too much food, or decreased exercise or activity, illness, infection, injury, stress or emotional upset. Blood glucose can rapidly rise if insulin has not been received by syringe/insulin pump or if the student is experiencing, physical or emotional stress which can cause the insulin not to work effectively.

3. Appropriate treatment for extreme blood glucose readings.

Management of blood glucose can be effectively treated in the school setting. **Refer to the student's licensed prescriber's orders, the school health care plan and intervention guide.**

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

Record:

1. Date and time.
2. Student's behavior.
3. Blood glucose reading.
4. Action taken.
5. Student's response.
6. Any other pertinent information.
7. Signature of personnel performing procedure.

B. MEASUREMENT OF BLOOD SUGAR WITH GLUCOMETER

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

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

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

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

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain licensed prescriber's order and parent/guardian written consent.	All specialized procedures conducted in the school setting require written licensed prescriber orders and parent/guardian consent.
B. Prepare work area.	Drape work area with paper towels in a well-lighted, clean area.
C. Assemble equipment.	Follow manufacturer's instructions for specific glucometer and lancet device.
D. Prepare the meter for use.	Follow manufacturer's instructions for specific machine.
E. Have student cleanse hands or use alcohol wipes on chosen puncture site, if	Washing in warm water will increase the blood flow to the finger.

needed.

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

C. INSULIN ADMINISTRATION BY INJECTION

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

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

B. Equipment: (Parent responsibility unless noted).

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

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

II Procedure:

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

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

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

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

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

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

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

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

II. Procedure:

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

2. Hyperglycemia.

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

E. GLUCAGON ADMINISTRATION

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

A. Purpose: To provide training and supervision guidelines for the administration of Glucagon in the school setting.

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

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

II. Procedure:

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

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

A. LONG-TERM MEDICATION ADMINISTRATION

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

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

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

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

II. Procedure:

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

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

2. Students who have asthma medication must have a written order from a licensed prescriber to carry and self-administer. The student must also demonstrate the ability and understanding to self-administer asthma medication by passing an assessment by the school nurse evaluating the student's technique of self-administration and level of understanding of the appropriate use of the medication.

See WV Code 18-5-22b.

B. EMERGENCY MEDICATION ADMINISTRATION

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

A. Purpose: To provide training and supervision guidelines for the administration of emergency medication in the school setting.

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

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

II. Procedure:

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

parent/guardian and the school nurse.

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

A. ADMINISTRATION OF RECTAL DIAZEPAM

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

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

B. Equipment:
1. Rectal Diazepam Delivery System (parent/guardian responsibility).
2. Gloves (county responsibility).

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

II. Procedure

ESSENTIAL STEPS	KEYPOINTS – PRECAUTIONS
A. Obtain physician's order for rectal diazepam and parent /guardian written consent for administration. The physician's order must specify if rectal diazepam may be administered by unlicensed personnel.	Physician's order should give specific instructions when to treat seizure activity and frequency of rectal diazepam administration. If the student is under the care of a neurologist for seizures, it is recommended that the neurologist write the order for rectal diazepam.

B. Obtain student history of seizure activity and previous response to rectal diazepam.	Information will aid school nurse in determining if procedure can be delegated to unlicensed school personnel. May refer to **Safe Scale** for sample assessment tool.
C. Evaluate school setting and student's schedule to determine where procedure may be performed.	Information will aid school nurse in planning for evacuation of other students to ensure privacy of student receiving rectal diazepam.
D. Develop written emergency plan for delegated personnel to follow.	Plan should include evacuation method for other students, criteria for administering rectal diazepam, guidelines for calling Emergency Medical Services, and emergency contact numbers of parents/guardians.
E. Train designated unlicensed school personnel to administer rectal diazepam and to monitor student response.	Reinforce that physician's orders will be specific for each student's situation. Determine that unlicensed personnel can distinguish between seizure types.
F. Obtain rectal diazepam and ensure proper storage.	Rectal diazepam must be kept in locked location and stored at room temperature, unless student has an order from physician to carry medication (refer to Policy 2422.8). Plan for proper storage when transporting (i.e., field trips, etc.). Check expiration date and have parent/guardian replace when expired.
G. Assess student and provide safety measures for student during seizure.	Assessment ensures student meets criteria for administering rectal diazepam per physician orders. Refer to *Seizure Management* procedure for safety issues during seizure.
H. Administer rectal diazepam if student's seizure activity meets criteria established by physician's order.	Review emergency plan and physician's orders. Treatment should begin within 5-10 minutes of onset of seizures to avoid complications.
1. Check student's pulse and respiration rate before administering rectal diazepam.	Baseline rates should be established. Diazepam can decrease respiratory effort. Refer to **Report of Administration of Rectal Diazepam**.
2. Place student in side-lying position facing person who will administer medication.	Position reduces risk of aspiration and places student in correct position for rectal diazepam administration.
3. Assure privacy.	Follow plan for evacuation.

4. Obtain rectal diazepam and notify Emergency Medical Services (EMS).	Do not leave student alone. Plan for another staff member to obtain medication and notify EMS. Use of "walkie-talkies", cell phones, etc. should be considered in planning for care of the student.
5. Put on gloves.	Refer to *Gloves – Use and Removal* procedure.
6. Remove protective cover and seal pin from syringe.	Refer to manufacturer's patient information instruction.
7. Lubricate tip of syringe with lubricating jelly.	Facilitates insertion of syringe and reduces risk of injury.
8. Remove necessary clothing and bend upper leg forward to expose rectum.	Aids in visualization of rectum and reduces risk of injury.
9. Separate buttocks to expose rectum.	Allows for visualization of rectum.
10. Insert syringe tip gently into rectum.	Rim of syringe should be snug against rectal opening to prevent leakage and ensure complete dose administered.
11. Count slowly to three (3) out loud while gently pushing plunger in until it stops.	
12. Count slowly to three (3) before removing syringe from rectum.	
13. Count slowly to three (3) while holding buttocks together to prevent leakage.	
I. Monitor student carefully after administering rectal diazepam and wait for EMS to arrive on the scene.	Do not leave student unattended. Monitor pulse and respiratory rate carefully. Provide CPR if indicated.
J. Document activity on student's individual treatment record. Refer to **Report of Administration of Rectal Diazepam**.	Record: 1. Description of seizure activity. 2. Date, time and length of seizure. 3. Time of administration of rectal diazepam. 4. Student response to medication. 5. Pulse and respiration rate.

6. Signature of personnel performing procedure.

K. Additional considerations:

1. Rectal diazepam should not be used more than five (5) times per month or administered more than once every five (5) days.	These guidelines were established by the manufacturer to prevent development of tolerance to the drug. School nurse and parent/guardian shall develop a mechanism to communicate when rectal diazepam has been used outside the school setting.
2. Assess for patterns of seizure activity in school setting.	Determine specific triggers for seizures and make modifications when possible to reduce incidence of seizures and decrease need for rectal diazepam. (i.e., computer monitors, fatigue, smells, lights, etc.)
3. Plan for care of student during transport on school bus.	Determine if unlicensed designated school personnel will be accompanying student on bus. Educate appropriate personnel on actions to follow in an emergency.
4. Plan for field trips or other co-curricular activities in which student may participate.	Consideration should include transporting medication safely, ability to contact EMS, and privacy of student.
5. Monitor student's weight periodically. Rectal diazepam dosage is based on age/weight.	Student's dosage needs may change and rectal diazepam needs to be replaced accordingly.

B. PHRENIC NERVE STIMULATOR

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

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

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

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

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

II Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain physician's orders and written parent/guardian consent to perform	Procedures performed in the school setting require physician's orders and parent/guardian

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

dioxide readings.
3. Respiratory rate/pacer setting.
4. Any other pertinent information.
5. Signature of personnel performing procedure.

F. Other Considerations:

6. Use caution when handling the pacing unit.

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

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

Refer to *Tracheostomy Suctioning* (Sterile) procedure.

REMEMBER TO TURN ON PACING UNIT AFTER COMPLETING SUCTIONING.

PHRENIC NERVE STIMULATOR

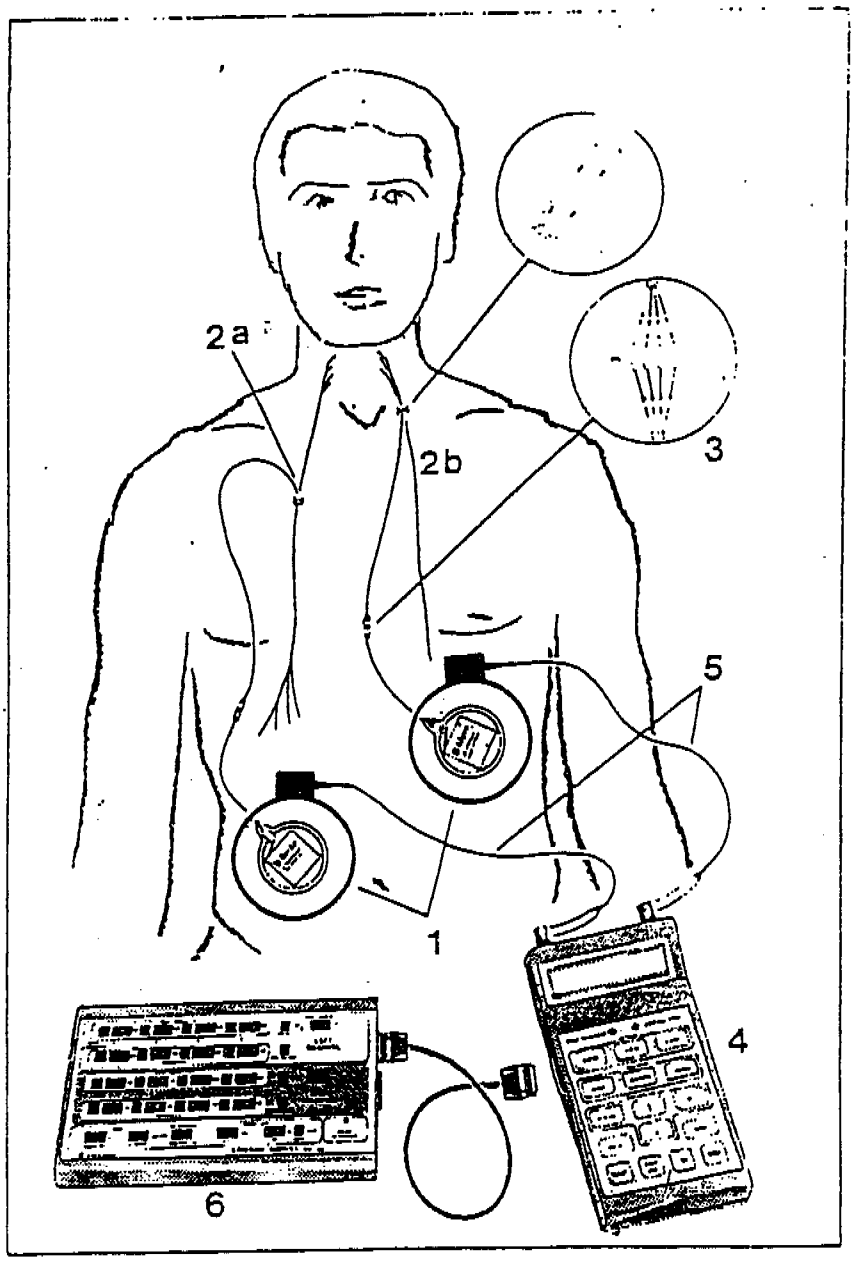

Fig. 1. PNS equipment and two possible different sites of implantation in the patient.

1: Implanted stimulators shown inside the outside energy transfer coils.
2a: Stimulation electrode implanted on the phrenic nerve in the upper thorax.
2b: Electrode implanted in the neck. In the enlargement the position of electrode buttons in relation to the nerve.
3: Implanted connections, details in the enlargement.
4: The controlling unit.

C. SEIZURE MANAGEMENT

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

A. Purpose: To provide training and supervision guidelines for seizure management in the school setting.

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

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

II. Procedure:

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

E. Develop a written emergency plan for student in cooperation with parent/guardian and physician.	Plan should be specific for type of seizure and include intervention guidelines, emergency contact numbers, criteria for calling EMS, and plan for care after seizure.
F. Provide a safe environment and prevent injury to student:	Assess student's schedule and plan for all areas where student may have seizure. Evaluate school environment for safety factors (i.e., stairways, playground equipment, etc.)
1. Assist to floor or guide away from harmful objects.	Provides a safe environment to prevent injury during the seizure.
2. Do not put anything in student's mouth during seizure.	Reinforce that student cannot "swallow his tongue".
3. Protect head during seizure.	Place hands or small pillow under head.
4. Do not attempt to restrain movements.	Restraining movements can cause fractures or muscle injury.
5. Turn head to side after seizure.	Prevents aspiration and promotes drainage from mouth.
6. Observe closely for respiratory distress or failure.	Begin CPR and call EMS if breathing stops or severe respiratory distress occurs. Administer oxygen if ordered. Refer to *Oxygen Administration* procedure.
G. Train designated staff to administer medication and/or other treatments if ordered.	Refer to *Emergency Medication Administration, Administration of Rectal Diazepam* and/or *Vagus Nerve Stimulator with Magnet* procedures.
H. Determine trigger factors for seizures in school setting.	Identify situations or triggers in the school environment that may be altered to reduce or prevent seizures (i.e., skipped meals, fatigue, stress, etc.).
I. Document procedure on student's individual treatment record.	Seizure record should include: 1. Date and time of onset. 2. Length of seizures. 3. Description of seizure activity. 4. Actions taken and student response. 5. Signature of personnel performing procedure.

D. VAGUS NERVE STIMULATOR WITH MAGNET

I. Guidelines

Vagus nerve stimulator (VNS) is a surgically implanted device that delivers electrical impulses to the left vagus nerve in the neck. VNS provides seizure control by decreasing seizure frequency, severity and intensity. It consists of a battery-operated generator and a computer chip implanted in the chest or under the left arm and a pair of wires or leads that run under the skin and are attached to the vagus nerve in the left side of the neck. The device is implanted by a surgeon and programmed by a neurologist to deliver an electrical impulse to the vagus nerve. A hand-held magnet triggers the generator to deliver an extra electrical stimulation at a higher output between programmed impulses to prevent, lessen or interrupt a seizure in progress. If prescribed, the magnet may be used to stop stimulation temporarily. The use of VNS may reduce the dosage of antiepileptic medication in some users.

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

B. Equipment: (Parent responsibility unless otherwise noted).
1. Vagus Nerve Stimulator, surgically implanted and programmed, and the magnet provided by the manufacturer.
2. Manufacturer's instruction booklet.

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

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain physician's written order and parent /guardian written consent.	All specialized procedures performed in the school setting require written physician's orders and parent/guardian written consent.
B. Observe or assist student or perform step-by-step use of the magnet according to physician's orders.	Review of student's health care plan, intervention guide, and documentation of training in magnet use is necessary for each

	student. Student should wear Medic-Alert bracelet or necklace.
1. Respond to student communication of aura. OR	Parent/guardian, student or physician will indicate elements of aura. Refer to *Seizure Management* procedure for care of student having a seizure.
2. Observe beginning of seizure activity or seizure already in progress	Parent/guardian, student or physician will identify specific student behaviors that indicate seizure activity.
3. Use magnet to activate generator at distance/manner specified.	Follow manufacturer's instructions for use of magnet. General instructions may include: use a slow "swiping motion" over pulse generator for at least one second, (swipe by saying one-one thousand, two-one thousand).
4. Wait specified time before repeating use.	Wait 60 seconds from original magnet use before "swiping" a second time.
C. Observe student response and monitor seizure activity response to magnet use.	Note whether seizure continues, is lessened or stops completely. Follow specific orders of physician for treatment if seizure activity continues.
D. Document procedure on student's individual treatment record.	Record: 1. Date and time 2. Student behavior. 3. Student/seizure response. 4. Any other pertinent information, 5. Signature of personnel performing procedure.
E. Additional considerations:	
1. Keep magnet near student for use.	Magnet should be with student in all locations (i.e., cafeteria, playground, PE, co-curricular activities, and on school bus).
2. Do not drop magnet.	May break if dropped on hard surface
3. Do NOT store near: credit cards, televisions, computers, computer disks, magnetized lunch cards, microwave ovens, or other magnets.	Magnets will erase or damage electronic components if placed in close proximity to those items.

KEEP THEM AT LEAST 10 INCHES AWAY FROM THESE ITEMS!

4. If ordered by physician, magnet may be used by student or designated staff to stop stimulation temporarily.

VNS has side effects that can affect voice quality or tingling in the throat. It can be stopped while student is singing or eating, etc. Length of time for VNS interruption must be specified by physician orders but should be for no more than four hours of continuous magnet activation.

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

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

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

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

Such devices may cause the pulse generator to start suddenly.

A. ANAPHYLACTIC REACTION

I. Guidelines: Although it is impossible to prepare for all emergencies of an anaphylactic nature, the following procedure is designed to provide for those emergencies likely to occur in school settings. Anaphylaxis is a severe, allergic reaction caused by exposure to a substance to which a person has hypersensitivity. An anaphylactic reaction is a life-threatening, medical emergency requiring immediate treatment. Common allergens, which may cause an anaphylactic reaction, include: stinging insects, medications, foods, exercise and latex.

A. Purpose: To provide training and supervision guidelines for personnel providing care for a student with an anaphylactic reaction in the school setting.

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

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

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Develop a written emergency plan for students with a documented history of anaphylactic reaction or potential for anaphylaxis in conjunction with student, parent/guardian and principal.	Plan should include step-by-step instructions to follow and emergency phone numbers. Student should be encouraged to wear Medic-Alert bracelet or carry card with pertinent information.
B. Determine that student has symptoms of an anaphylactic reaction. Symptoms may include: hives, itching, flushing of skin; swelling of lips, tongue, hands or feet; wheezing, shortness of breath, coughing, or hoarseness; headache; nausea and/or vomiting; abdominal cramps; sense of impending doom; or, loss of consciousness.	When in doubt, treat the person for an anaphylactic reaction. Student may have rapid reaction after contact with allergen. Delayed reaction (1-2 hours after exposure) may occur.
C. In cases of known allergies, designated-trained personnel will give appropriate	In cases of known allergies, designated persons will have been instructed in proper procedures

amount of medication ordered by the licensed prescriber. In case of unknown allergies, go to Step D.	for individual student. Refer to *Emergency Medication Administration* and *Epinephrine Auto-injector* procedures.
D. Establish vital functions: 1. Maintain adequate airway. 2. Perform cardiopulmonary resuscitation (CPR) if necessary.	
E. Call Emergency Medical Services and notify parent/guardian and school nurse.	Emergency medical personnel must transport the student to the nearest emergency room after receiving medication even if symptoms have subsided. Send all available information with student to emergency room.
F. Document procedure on student's individual treatment record.	Record: 1. Date and time. 2. Symptoms observed. 3. Treatment provided. 4. Student's response to procedure. 5. Signature of personnel performing procedure.

B. EPINEPHRINE AUTO-INJECTOR

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

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

B. Equipment: (Parent responsibility unless otherwise noted).
1. Epinephrine auto-injector delivery system.
2. Sharps container (county).
3. Alcohol prep pads (county)

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

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Determine student's history of an allergic reaction and obtain order from licensed prescriber and instructions for use of epinephrine auto-injector. Obtain parent/guardian's written consent to perform procedure.	Identification of the known allergen will aid in developing the Health Care Plan. All specialized procedures performed in the school setting require written orders from a licensed prescriber and parent/guardian consent.
B. Store epinephrine auto-injector at room temperature in a dark place. Keep in light-protective covering.	All trained personnel should know the location of the epinephrine auto-injector. The epinephrine auto-injector must be maintained at the correct temperature on co-curricular trips and during transport.
C. Check epinephrine auto-injector routinely to make sure solution in auto-injector is not discolored, contains a	Epinephrine is light sensitive and should not be used if discolored, has a precipitate, or is expired. Have the parent/guardian replace the

precipitate, or expired.	epinephrine auto-injector.
D. Train designated personnel to identify anaphylactic reactions and to administer the epinephrine auto-injector.	Refer to *Anaphylactic Reaction* procedure.
E. Prepare written intervention guide and emergency plan for each individual student.	Plan should include emergency contact numbers, step-by-step instructions to administer the epinephrine auto-injector, and names of trained personnel.
F. Remain with student while sending someone to obtain the medication, call EMS and notify the parent/guardian, and the school nurse.	Student must be sent to the Emergency room after administration for further evaluation. Additional medication and treatment may be needed.
G. Provide for student safety before administering the epinephrine	Have student lie down, elevate feet, and maintain open airway in preparation for injecting the epinephrine. Student may faint or become unconscious.
H. Remove the gray safety cap from the epinephrine auto-injector.	Use caution after the gray safety cap is removed; the auto-injector is engaged and may be accidentally discharged.
I. Place black tip on the outer thigh at a right angle to the leg. Do not attempt to inject medication into a vein or into the buttocks.	Apply to thigh regardless of what part of the body has been stung or come into contact with an allergen.
J. Press hard into thigh until auto-injector mechanism functions and hold in place for 10 seconds. The epinephrine auto-injector unit should then be removed and discarded into sharps container. Massage the injection area for 10 seconds.	The area may be wiped with alcohol before injection if easily accessible. The epinephrine auto-injector can be injected through clothing in an emergency. Avoid heavy seams.
K. Document procedure on student's individual treatment record.	Record: 1. Date and time. 2. Symptoms observed. 3. Interventions taken. 4. Student's reaction/response to treatment. 5. Signature of personnel performing. procedure.

C. INHALATION THERAPY BY MACHINE

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

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

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

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

II. Procedure:

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

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

D. MANUAL RESUSCITATOR

I. Guidelines: A manual resuscitator (i.e., Ambu Bag) is a device to deliver breaths manually when a student is unable to breathe on 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.
- during suctioning/transport situation

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

A. Purpose: To provide training and supervision guidelines for using a manual resuscitator in the school setting.

B. Equipment: (Parent responsibility unless otherwise noted).
1. Manual resuscitator.
2. Appropriate-sized mask or appropriate size trach adaptor.
3. Oxygen source with appropriate tubing, if needed.
4. Disposable medical gloves (county).

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

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain written orders from licensed prescriber and written parent/guardian consent.	All specialized procedures performed in the school setting must have written orders and parent/guardian consent.
B. Maintain equipment in easily accessible location.	Initiate rescue breathing if a manual resuscitator is not immediately available. Ensure equipment is properly assembled.
C. Preparation:	
1. Wash hands and put on gloves.	Refer to *Hand Washing and Gloves – Use and*

Removal procedures.

2. Check manual resuscitator for proper function by placing adaptor that is connected to the bag against a gauze or tissue in you hand and squeezing bag.

   Feeling slight resistance indicates proper functioning.

3. Explain procedure to student.

4. Delivery by mask:

   a. Ensure open airway.

   b. Position mask securely over mouth and nose.

5. Delivery by tracheostomy:

   a. Position student with neck extended and trach opening exposed.

      Proper positioning ensures open airway.

   b. Attach resuscitator to trach tube. Squeeze the resuscitator bag in coordination with student's respiratory effort.

      Hold trach with one hand to prevent accidental dislodgement while attaching adaptor to it. Give a breath by squeezing the resuscitator bag as the student begins to inhale (chest begins to rise). If you feel resistance and/or the student looks distressed, be sure you are giving breaths with the student's own effort and that the tube is patent.

   c. Notify EMS, parent/guardian and school nurse.

   d. Squeeze resuscitator bag at a recommended rate if student is not breathing spontaneously.

      Allow ample time between respirations for passive exhalation and bag re-expansion. If the student has no breathing rate prescribed, a standard range of breaths per minute is 16-20 for children and 12-16 for adolescents and adults.

D. Check effectiveness of ventilation.

   Observe student's face, lip color, and level of consciousness. Make sure student's chest rises with each inflation and falls during passive exhalation.

E. Continue bagging in an emergency until relieved by appropriately trained persons or until student resumes adequate, spontaneous respirations.

F. Clean equipment and reassemble for use.

G. Remove gloves and wash hands.

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

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

Record:

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

E. MECHANICAL VENTILATOR

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

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

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

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

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

II. Procedure:

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

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

J. Access emergency power source if electrical power goes out or ventilator battery fails.	Use manual resuscitator until ventilator is functioning properly. Refer to *Manual Resuscitator* procedure.

Student's name: _____

Person trained: _____

Position: _____

Ventilator Machine and Circuit Skills Checklist

Instructor: _____

Explanation/Return Demonstration	Expl./ Demo. Date	Explanation/Return Demonstration					
		Date	Date	Date	Date	Date	Date
A. States name and purpose of procedure							
B. Describes machine components and settings:							
1. Power source							
a. Internal battery							
b. External battery							
c. Accessible, functioning electrical outlets							
d. Back-up battery							
e. Emergency power supply							
2. Oxygen source (if needed)							
a. Connection to ventilator and spare tubing							
b. Oxygen supply, spare tank, and gauge							
c. Flow (LPM) and percentage of oxygen							
3. Humidification source:							
a. Passive condensor							
4. Volume							
5. Rate							
6. Patient pressure manometer							
7. Peak inspiratory pressure (PIP)							
8. Positive end expiratory pressure (PEEP)							
9. Ventilator mode							
10. Inspiratory time							
11. High-pressure alarm							
12. Low-pressure alarm							
13. Power source alarm							
C. Describes circuit components:							
1. Patient pressure tubing							
2. Patient port							
3. Exhalation valve							
4. PEEP valve							
5. Additional adaptors							
D. Go-Bag supplies (see p. 355), including:							
1. Manual resuscitation bag with adaptor or mask							

(continued)

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

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Ventilator Machine and Circuit
Skills Checklist

Student's name: _____

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

Checklist content approved by:

Parent/Guardian signature _____ Date _____

Possible Problems When Using a Ventilator that Require Immediate Attention

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

An alarm is activated:

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

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

This alarm may be activated by the following:

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

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

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

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

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

This alarm may be activated by the following:

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

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

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

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

Student's name: _____

Person trained: _____

Position: _____

Ventilator Troubleshooting Alarms
Skills Checklist

Instructor: _____

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

(continued)

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

Ventilator Troubleshooting Alarms
Skills Checklist

Student's name: _____

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

Checklist content approved by:

Parent/Guardian signature _____ Date _____

F. METERED DOSE INHALER THERAPY (MDI)

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

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

B. Equipment: (Parent responsibility unless otherwise noted).
Metered Dose Inhaler

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

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain written licensed prescriber's order and parent/guardian written consent.	Policy requires written order and written parent/guardian permission.
B. Wash hands if assisting with Metered Dose Inhaler.	Refer to *Hand Washing* procedure.
C. Observe or assist student to use MDI, according to licensed prescriber's order.	WV Code §18-5-22b requires a certified school nurse to assess student to carry and self-administer.
D. Obtain and document Peak Flow, if ordered.	Refer to *Peak Flow* procedure.
E. Instruct student to:	
1. Insert canister firmly and fully into the outer plastic container. Shake the inhaler well. Attach spacer, if ordered.	Student should be standing or sitting upright.
2. Remove cap from mouthpiece and hold canister upright.	

3. Hold inhaler between the thumb and forefinger.

4. Instruct student to inhale deeply and then exhale slowly. Make an "O" shape with their mouth and hold inhaler 1-2 inches from open mouth.

Instruct student to make and "O" shape with their mouth and hold 1-2 inches from open mouth if using MDE or place spacer in mouth, if ordered.

5. Press down firmly on the top of the canister with index finger. While breathing in deep and slow through mouth.

6. Continue to inhale and then try to hold breath for 5-10 seconds. Remove inhaler from mouth and release finger from canister before breathing out.

7. Exhale slowly through pursed lips.

8. Wait 1-2 minutes and shake the inhaler before taking next inhalation. Follow the same instructions for second inhalation.

Replace mouthpiece cap after each use.

9. Wait 5 minutes between the second and third puff; if 3 puffs are prescribed.

10. Instruct student to rinse mouth thoroughly.

Rinsing after MDI use prevents oral infection and tooth decay.

11. Clean MDI thoroughly after use.

12. Discard canister when empty and request replacement from parent/guardian.

F. Monitor student for administration technique.

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

Record:
1. Date and time.
2. Medication.
3. Any pertinent information.
4. Student's response to procedure.

G. ORAL SUCTIONING

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

A. Purpose: To provide training and supervision guidelines for oral suctioning in the school setting.

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

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

II. Procedure:

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

1. Compress bulband. Insert tip of syringe into cup of water. Release pressure on bulb to suction small amount of water. Discard into cup.	Suctioning checks effectiveness of bulb syringe.
2. Compress bulband. Insert tip of bulb syringe into dependent cheek of student. Areas to be suctioned include cheeks and beneath tongue.	Secretions will be more accessible on side student's head is positioned.
3. Release pressure on bulb to withdraw secretions.	Avoid grabbing mucus membranes as this may injure tissue.
4. Discard secretions into a cup or paper towel by squeezing bulb several times.	
5. Repeat steps 2-4 as necessary.	Areas to be suctioned include cheeks and beneath tongue
6. Clean bulb syringe, after use, with warm soapy water. Flush several times using suctioning technique. Rinse with clear water.	
7. Discard disposable equipment. Make sure bulb syringe is ready to reuse.	
F. Suctioning by machine:	
1. Turn on suction machine.	
2. Introduce Yaunker suction device into oral cavity.	Do not advance further than the back of the mouth, as this may stimulate the gag reflex, cause vomiting, and/or produce laryngospasm. Limit areas to be suctioned to cheeks, beneath tongue and the back of the mouth.
3. Suction water to clear Yaunker device of secretions.	
4. Repeat steps 2-3 as necessary. Allow 2-3 minutes between suctioning.	
5. Clean Yaunker suction device.	
6. Discard disposable equipment.	Refer to *Handling of Body Fluids* procedure.
7. Empty contents of suction bottle into toilet at the end of the school day.	Refer to Hand Washing and Cleaning *and Disposing of Body Fluids* procedures.

8. Wash bottle with warm soapy water. Wear gloves and goggles during the process.

G. Remove gloves and wash hands.

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

H. Document on student's individual treatment record.

Record:

1. Date and time.
2. Amount, color, and consistency of secretions.
3. Student's response to procedure
4. Any pertinent information
5. Signature of personnel performing procedure.

H. OXYGEN ADMINISTRATION

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

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

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

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

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

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS/PRECAUTIONS
A. Obtain order from licensed prescriber and parent/guardian written consent.	All specialized procedures performed in the school setting require written licensed prescriber's order and parent/guardian consent.
B. Assess environment for:	Potential sources of fire must be considered for the safe storage and use of oxygen in the school setting. A non-handicapped accessible building may limit student's ability to easily
1. Building accessibility for student's use of oxygen.	

	access certain areas in the school building.
2. Location of exits, fire extinguishers.	
3. Risks of flammability (i.e., electrical sparks/smoking.	
4. Arrangements for tank security.	Oxygen supports combustion. Ensure that proper signs are posted "No Smoking or Open Flames - Oxygen in Use" and/or "Oxygen in Use – Fire Hazard".
5. Arrangements for adequate ventilation of storage area for tank.	Recognize that concentrating oxygen accumulates in the immediate area of use, thus adequate ventilation is essential.
C. Review student's daily schedule	Consider activities and locations in the school setting. Address need for assistance with oxygen tank, managing school books and supplies. Develop an emergency plan for the student in the event of emergency evacuation from building.
D. Identify school personnel responsible for student safety.	Oxygen administration requires specialized in-service to assure safe use of oxygen and continual monitoring of the student's status.
E. Wash hands.	Refer to *Hand Washing* procedure.
F. Assemble equipment.	Check equipment for proper functioning upon arrival to school and as needed throughout the day. DO NOT ATTEMPT TO SERVICE EQUIPMENT ON YOUR OWN.
G. Connect tubing to oxygen source.	Nasal catheters should be changed or cleaned every week or more often, depending upon the amount of use. Extra equipment should be in storage at all times and changed more often during respiratory illness of student to prevent re-infection.
H. Attach humidifier, if ordered, to oxygen tubing.	Follow manufacturer's instructions for humidifier maintenance and cleaning instructions.
I. Flush line by turning oxygen on and adjusting flow rate to ordered level. Feel for oxygen flow through tubing.	Oxygen is prescribed and administered like a drug with flow dosage measured in liters per minute or percentage of oxygen.

J. Place nasal cannula or face mask on the student's face or attach the tracheostomy adaptor. Adjust nasal cannula around ears or facemask to the nasal bridge to ensure optimal oxygen benefit during oxygen administration.

Pressure of cannula or facemask can cause skin breakdown. Observe and administer skin care as needed. Prolonged administration by mask will require periodic mask removal to dry face and massage skin. It will also cause eyes to dry excessively if mask fits improperly.

K. Monitor student for any change in condition while receiving oxygen.

Personnel caring for student should check skin and lip color, respiratory effort, activity tolerance, etc.

L. Document on student's individual treatment record.

Record:

1. Date and time.
2. Amount of oxygen intake.
3. Oxygen flow rate in liters/min or percentage.
4. Any other pertinent information.
5. Signature of personnel performing procedure.

M. Additional Considerations:

Avoid use of products containing oil, grease or petroleum-based cleaners near oxygen (i.e., Vaseline, Chapstick, etc.). Do not use antiseptic tinctures, alcohol, furniture sprays, or acetone in the immediate area. Avoid toys, electronic games or devices, cell phones or objects, which may cause sparks that could ignite. Do not permit electrical devices on or near oxygen sources.

I. PEAK FLOW METER

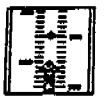
I. Guidelines: The peak flow meter provides an objective measurement of peak expiratory flow, a valuable indicator of lung function. It can be used over a period of time by an asthmatic child to measure and record lung function so that the licensed prescriber can order the proper treatment. During an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

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

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

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

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain order from a licensed prescriber and parent/guardian written consent.	All specialized procedures performed in the school setting require a written order for a licensed prescriber and parent/guardian consent.
B. Instruct the student to place the mouthpiece on the peak flow meter.	The adult (large) mouthpiece fits onto the unit, the pediatric (small) mouthpiece fits into the unit.
C. Ensure that the red indicator is at the bottom of the scale.	
D. Hold the peak flow meter vertically, being careful that the student's fingers do not block the opening.	
E. Instruct the student to inhale as deeply as possible and place mouth firmly around the mouthpiece, making sure lips form a tight seal.	

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

G. Document the reading on the student's individual treatment record and repeat two times to confirm results. Repeat steps C - F.

Wait 10 – 15 seconds between measurements.

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

If the student is using this as a measurement tool for a licensed prescriber's information, help record the results as ordered.

If the peak flow meter is to serve as a tool to measure respiratory distress, personnel should have previous documentation as to the normal range for the student.

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

Record:

1. Date and time.
2. Peak flow reading.
3. Other pertinent information.
4. Student's response to procedure.
5. Signature of personnel performing procedure.

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

J. PERCUSSION AND/OR POSTURAL DRAINAGE

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

Percussion and/or postural drainage may be performed 2-4 times daily before meals depending upon student tolerance and licensed prescriber's orders.

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

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

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

II. Procedure:

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

1. Place student in appropriate position.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Have student raise arms overhead while breathing in and have student lower arms while breathing out. Repeat about 15 times.	Maintain breathing pattern while performing this exercise. Encourage this type of breathing in functional activities, such as combing hair, lifting, etc.
3. Have student extend arms outward while breathing in and have student put arms across chest while breathing out. Repeat about 15 times.	Maintain breathing pattern while performing this exercise. Encourage slow expiration.
4. Encourage student to use prolonged expiration, i.e. pursed lip breathing. Repeat several times.	This assists student in emptying the lungs.
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 licensed prescriber's recommendations.
H. Discard contaminated articles.	Refer to *Cleaning and Disposing of Body Fluids* procedure.
I. Wash hands.	Refer to *Hand Washing* procedure.
J. Document procedure on student's individual treatment record.	Record: 1. Date and time. 2. Any other pertinent information. 3. Student's response to procedure. 4. Signature of personnel performing procedure.

K. TRACHEOSTOMY CARE

1. EMERGENCY CARE AND CLEANING OF TRACHEOSTOMY TUBE AND STOMA

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

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

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

A. Purpose: To provide training and supervision guidelines for emergency care and cleaning of a tracheostomy tube and stoma in the school setting.

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

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

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

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

II. Procedure:

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

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

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

cleaners with your sterile hand to remove dry, crusted material.	effective cleansing.
4. Place inner cannula into cup with sterile saline after it is clean, using your sterile hand.	Rinse thoroughly to remove all peroxide.
5. Tap or shake out excess moisture from inner cannula and reinsert into outer cannula.	Suction outer cannula before reinsertion if necessary. Refer to *Tracheostomy Suctioning* procedure.
6. Lock inner cannula securely into place.	Replace inner cannula as soon as possible after cleansing to prevent mucus plugs from forming in the outer cannula.
N. Replace soiled tie tapes:	
1. Summons help if not already there to secure ties.	Prevents accidental dislodgement of tube and decreases irritation and coughing due to manipulation of the tube.
2. Cut soiled while holding tube securely with your other hand. Remove old carefully.	
3. Cut two sections of twill tape that together can encircle the student's neck and have room to be tied together at the side of the neck or place velcro tie.	Alternate side each time to prevent irritation and pressure areas. Two fingers should fit between tapes and neck when secured properly.
4. Make folds about 1 inch at the end of each tape. Cut a ½ inch slit up the middle of each fold.	Ensure trach is being held in place.
5. Take one tape and slip the end through tracheostomy plate slot from the bottom. Feed this end through the slit at the other end and gently pull the tape taut.	
6. Grasp slit end of clean tape and pull through opening on side of tracheostomy tube.	
7. Pull other end of tape securely through the slit end of the tape.	

8. Repeat step 5 and 7 on other side.

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

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

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

Check that tracheostomy tube is positioned properly.

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

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

R. Dispose of all supplies in appropriate container.

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

S. Remove gloves and wash hands.

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

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

Record:

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

K. TRACHEOSTOMY CARE

2. EMERGENCY REPLACEMENT OF TRACHEOSTOMY TUBE

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

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

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

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

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

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

II. Procedure:

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

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

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

K. TRACHEOSTOMY CARE

3. TRACHEOSTOMY SUCTIONING STERILE TECHNIQUE

I. Guidelines:

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

Indications for suctioning may include the following:

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

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

A. Purpose:

To provide training and supervision guidelines for performing sterile tracheostomy suctioning in the school setting.

B. Equipment:

(Parent Responsibility).

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

7. Self-inflating manual resuscitation bag with trach adaptor.
8. Saline dosettes, if ordered.
9. Syringe to inflate or deflate cuff, if used.

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

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

II. Procedure:

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

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

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

2. Amount, color, and consistency of secretions.
3. Student's response to treatment.
4. Other pertinent information.
5. Signature of personnel performing procedure.

B. CATHETERIZATION

1. CLEAN CATHETERIZATION

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

A. Purpose: To provide training and supervision guidelines for the performance of clean catheterization in the school setting.

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

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

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain orders from licensed prescriber and written parent/guardian consent.	All specialized procedures performed in the school setting require written licensed prescriber's orders and parent/guardian consent.
B. Assemble equipment in appropriate private location for performance of procedure.	
C. Wash hands and put on gloves.	Refer to *Hand Washing* and *Gloves – Use and Removal* procedures.
D. Have student lie on back with knees flexed and separated, or position	If female is unable to spread legs, place on side with knee of top leg flexed. Have adequate

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

3. Lubricate tip of catheter, if ordered.

4. Place container for collection of urine.

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

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

K. Suprapubic Catheters:

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

Use a clean wipe for each stroke.

2. Lubricate tip of catheter, if ordered.

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

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

Ensures proper positioning in the bladder.

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

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

N. Remove all equipment and waste materials and discard appropriately.

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

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

Refer to *Assisting with Clothing and Toileting* procedures.

P. Remove gloves and wash hands.

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

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

Record:

1. Date and time.
2. Amount of urine, if ordered.
3. Characteristics of urine or any other

pertinent information.

4. Student's response to the procedure.
5. Signature of personnel performing procedure.

2. SELF-CATHETERIZATION

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

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

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

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

II. Procedure:

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

E. Open disposable wipes for the student to self cleanse.

E. Open packet of water-soluble lubricating jelly, if ordered.

F. FOR FEMALES - Instruct student to:

1. Hold labia open using one hand.

2. Using a downward stroke, cleanse each labium with disposable wipe.

Stroke downward using a clean wipe for each stroke to prevent infection. Repeat as necessary to cleanse area adequately.

3. Using a downward stroke, cleanse urinary meatus with third disposable wipe.

Continue holding the labia open until the catheter is inserted.

4. Lubricate the tip of the catheter, if ordered.

5. Hold the catheter as if it were a pencil or a dart and insert it into urethra until urine flows freely into appropriate collection container.

Be sure it is inserted into the urethra not the vaginal orifice. DO NOT FORCE.

G. FOR MALES - Instruct student to:

1. Hold the penis upright between the thumb and the forefinger and cleanse the meatus using a circular motion.

This position will straighten the anterior urethra. Use a clean wipe for each stroke.

2. Apply lubricant to the tip of the catheter, if ordered.

3. Place container for collection of urine.

4. Hold the penis upright and exert slight pressure to widen the urethral opening and insert the catheter until urine begins to flow.

The catheter will advance easily until resistance is met at the sphincter. DO NOT FORCE. Have student breathe deeply to relax perineal muscles.

5. Insert the catheter approximately one more inch once the urine flows.

Ensures proper catheter position in the bladder.

H. SUPRAPUBIC CATHETERS – Instruct the student to:

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

   Use a clean wipe for each stroke and cleanse outward from the stoma.

2. Lubricate tip of catheter, if ordered.

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

I. FOR FEMALES AND MALES - Instruct student to:

1. Remove the catheter only after the flow of urine has ceased.

2. Cleanse, dry, and redress, assisting as necessary.

   Refer to *Assisting with Clothing* and *Toileting* procedures.

3. Discard disposable equipment and waste materials and then wash hands.

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

J. Remove gloves and wash hands.

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

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

   Record:
   1. Date and time.
   2. Amount and characteristics of urine, as required.
   3. Any other pertinent information.
   4. Student's response to procedure.
   5. Signature of personnel assisting with procedure.

3. STERILE CATHETERIZATION

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

A. Purpose: To provide training and supervision guidelines for sterile catheterization in the school setting.

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

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

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

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

II. Procedure:

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

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

thumb and forefinger and cleanse meatus using circular motion with a saturated cotton ball held with forceps or antiseptic swab.	urethra. Swab center first using a new sterile cotton ball or swab each time.
M. Insert sterile lubricated catheter into the urethra with sterile gloved hand making sure the other end of the catheter is placed in the collection container.	In male, may have to reposition the penis as the catheter is slightly withdrawn and then pushed ahead until urine flows. DO NOT FORCE. If resistance is met, have student take a few deep breaths. Discontinue the procedure if student has unusual discomfort.
N. Insert catheter until there is urine flow.	Advance catheter approximately one inch to ensure placement in bladder.
O. Allow urine to drain into collection container.	
P. Withdraw catheter slowly when flow has stopped.	Pockets of residual urine may drain during removal of catheter. Leave catheter in place until fully drained.
Q. Remove all equipment and discard appropriately.	Refer to *Cleaning* and *Disposing of Body Fluids* procedure.
R. Redress, making sure student dry and comfortable.	Refer to *Assisting with Clothing* and *Toileting* procedures.
S. Remove gloves and wash hands.	Refer to *Gloves - Use and Removal* and *Hand Washing* procedures.
T. Document procedure on student's individual treatment record.	Record: 1. Date and time. 2. Amount of urine, if required. 3. Color and odor. 4. Student's response to the procedure. 5. Signature of personnel performing procedure.

C. CREDE'S METHOD

I. Guidelines: Crede's method is a manual procedure used to express residual urine from the bladder, to reduce the chance of bladder infection, to control odors and to prevent skin breakdown. Crede's technique may be part of routine daily bladder care and should be done by the student whenever possible.

A. Purpose: To provide training and supervision guidelines for performing Crede's method in the school setting.

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

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

II. Procedure:

ESSENTIAL STEPS	KEYPOINTS-PRECAUTIONS
A. Obtain order from licensed prescriber and parent/guardian written consent.	All specialized procedures performed in the school setting require written order from a licensed prescriber and parent/guardian consent.
B. Provide student privacy for procedure.	
C. Position student according to needs.	
D. Apply repeated inward and downward pressure gently with one or both hands over lower abdomen, beginning in the umbilical area and progressing down toward the symphysis pubis.	Use heel of hand to obtain most effective result.
E. Continue the procedure as long as urine can be manually expressed.	
F. Document procedure on student's individual treatment record.	Record: 1. Date and time. 2. Amount of urine expressed, if ordered. 3. Characteristics of urine and any other

pertinent information.

4. Signature of personnel performing procedure.

APPENDIX A

§16-3-4. Compulsory immunization of school children; information disseminated; offenses; penalties.

Whenever a resident birth occurs, the state director of health shall promptly provide parents of the newborn child with information on immunizations mandated by this state or required for admission to a public school in this state.

All children entering school for the first time in this state shall have been immunized against diphtheria, polio, rubeola, rubella, tetanus and whooping cough. Any person who cannot give satisfactory proof of having been immunized previously or a certificate from a reputable physician showing that an immunization for any or all diphtheria, polio, rubeola, rubella, tetanus and whooping cough is impossible or improper or sufficient reason why any or all immunizations should not be done, shall be immunized for diphtheria, polio, rubeola, rubella, tetanus and whooping cough prior to being admitted in any of the schools in the state. No child or person shall be admitted or received in any of the schools of the state until he or she has been immunized as hereinafter provided or produces a certificate from a reputable physician showing that an immunization for diphtheria, polio, rubeola, rubella, tetanus and whooping cough has been done or is impossible or improper or other sufficient reason why such immunizations have not been done. Any teacher having information concerning any person who attempts to enter school for the first time without having been immunized against diphtheria, polio, rubeola, rubella, tetanus and whooping cough shall report the names of all such persons to the county health officer. It shall be the duty of the health officer in counties having a full-time health officer to see that such persons are immunized before entering school: **Provided,** That persons enrolling from schools outside of the state may be provisionally enrolled under minimum criteria established by the director of the department of health so that the person's immunization may be completed while missing a minimum amount of school: **Provided, however,** That no person shall be allowed to enter school without at least one dose of each required vaccine.

In counties where there is no full-time health officer or district health officer, the county commission or municipal council shall appoint competent physicians to do the immunizations and fix their compensation. County health departments shall furnish the biologicals for this immunization free of charge.

Health officers and physicians who shall do this immunization work shall give to all persons and children a certificate free of charge showing that they have been immunized against diphtheria, polio, rubeola, rubella, tetanus and whooping cough, or he or she may give the certificate to any person or child whom he or she knows to have been immunized against diphtheria, polio, rubeola, rubella, tetanus and whooping cough. If any physician shall give any person a false certificate of immunization against diphtheria, polio, rubeola, rubella, tetanus and whooping cough, he or she shall be guilty of a misdemeanor, and, upon conviction, shall be fined not less than twenty-five nor more than one hundred dollars.

Any parent or guardian who refuses to permit his or her child to be immunized against diphtheria, polio, rubeola, rubella, tetanus and whooping cough, who cannot give satisfactory proof that the child or person has been immunized against diphtheria, polio, rubeola, rubella, tetanus and whooping cough previously, or a certificate from a reputable physician showing that immunization for any or all is impossible or improper, or sufficient reason why any or all immunizations should not be done, shall be guilty of a misdemeanor, and except as herein otherwise provided, shall, upon conviction, be punished by a fine of not less than ten nor more than fifty dollars for each offense.

§16-3-4a. Compulsory testing for tuberculosis of school children and school personnel; X rays required for reactors; suspension from school or employment for pupils and personnel found to have tuberculosis in a communicable stage.

(a) All students transferring from a school located outside this state shall furnish a certificate from a licensed physician stating that a tuberculin skin test approved by the director of the department of health has been made within four months prior to the beginning of the school year, unless such pupil has moved to this state from another state less than four months prior to starting the school year, in which event such pupil shall have such test as soon in advance of the start of the school as is reasonable, or if the school year has already started, the pupil shall take such test within one month of the time he enters school.

(b) Test results must be recorded on the certificate required by subsection (a). Positive reactors to the skin test must be immediately evaluated by a physician and, if medically indicated, X rayed, and receive periodic X rays thereafter, when medically indicated. Pupils found to have tuberculosis in a communicable stage will not be allowed to attend school until their disease has been arrested and is no longer communicable.

(c) All school personnel shall have an approved tuberculin skin test at time of employment and once every two years or more frequently if medically indicated. Positive reactors to the skin test are to be immediately referred to a physician for evaluation and indicated treatment or further studies. School personnel found to have tuberculosis in a communicable stage shall have their employment discontinued or suspended until their disease has been arrested and is no longer communicable. School personnel who have not had the required examination will be suspended from employment until reports of examination are confirmed.

(d) The county health officer shall be responsible for arranging proper follow-up of school personnel and students who are unable to obtain physician evaluation for a positive tuberculin skin test.

(e) The state commissioner of the bureau of public health shall have the authority to require selective testing of school children for tuberculosis when there is reason to believe that such children may have been exposed to the tuberculosis organism.

§18-2-9. Required courses of instruction; violation and penalty.

(a) In all public, private, parochial and denominational schools located within this state there shall be given prior to the completion of the eighth grade at least one year of instruction in the history of the state of West Virginia. Such schools shall require regular courses of instruction by the completion of the twelfth grade in the history of the United States, in civics, in the constitution of the United States, and in the government of the state of West Virginia for the purpose of teaching, fostering and perpetuating the ideals, principles and spirit of political and economic democracy in America and increasing the knowledge of the organization and machinery of the government of the United States and of the state of West Virginia. The state board of education shall, with the advice of the state superintendent of schools, prescribe the courses of study covering these subjects for the public schools. It shall be the duty of the officials or boards having authority over the respective private, parochial and denominational schools to prescribe courses of study for the schools under their control and supervision similar to those required for the public schools. To further such study, every high school student eligible by age for voter registration shall be afforded the opportunity to register to vote pursuant to section twenty-two, article two, chapter three of this code.

(b) The state board of education shall cause to be taught in all of the public schools of this state the subject of health education, including instruction in any of the grades six through twelve as deemed appropriate by the county board, on (1) the prevention, transmission and spread of acquired immune deficiency syndrome and other sexually transmitted diseases and (2) substance abuse, including the nature of alcoholic drinks and narcotics, tobacco products, and other potentially harmful drugs, with special instruction as to their effect upon the human system and upon society in general. The course curriculum requirements and materials for such instruction shall be adopted by the state board by rule in consultation with the department of health.

An opportunity shall be afforded to the parent or guardian of a child subject to instruction in the prevention, transmission and spread of acquired immune deficiency syndrome and other sexually transmitted diseases to examine the course curriculum requirements and materials to be used in such instruction. The parent or guardian may exempt such child from participation in such instruction by giving notice to that effect in writing to the school principal.

(c) Any person violating the provisions of this section shall be guilty of a misdemeanor, and, upon conviction thereof, shall be fined not exceeding ten dollars for each violation, and each week during which there is a violation shall constitute a separate offense. If the person so convicted occupy a position in connection with the public schools, that person shall automatically be removed from such position and shall be ineligible for reappointment to that or a similar position for the period of one year.

§18-5-15d. In-service training programs in the prevention, transmission, spread and treatment of acquired immune deficiency syndrome; parent attendance.

Under guidelines established by the department of education in consultation with the department of health, training programs on the prevention, transmission, spread and treatment of acquired immune deficiency syndrome shall be provided by the county boards as in-service training for all school personnel. The county boards shall encourage the attendance of parents at these programs and notify such parents to the fullest extent practicable, including notification in written form and by publication.

§18-5-17. Compulsory preenrollment hearing, vision and speech and language testing; developmental screening for children under compulsory school age.

(a) All children entering public school for the first time in this state shall be given prior to their enrollments screening tests to determine if they might have vision or hearing impairments or speech and language disabilities. County boards of education may provide, upon request, such screening tests to all children entering nonpublic school. County boards of education shall conduct these screening tests for all children through the use of trained personnel. Parents or guardians of children who are found to have vision or hearing impairments or speech and language disabilities shall be notified of the results of these tests and advised that further diagnosis and treatment of the impairments or disabilities by qualified professional personnel is recommended.

(b) County boards of education shall provide or contract with appropriate health agencies to provide, upon the request of a parent or guardian residing within the district, developmental screening for their child or children under compulsory school attendance age: Provided, That a county board is not required to provide such screening to the same child more than once in any one school year. Developmental screening is the process of measuring the progress of children to determine if there are problems or potential problems or advanced abilities in the areas of understanding language, perception through sight, perception through hearing, motor development and hand-eye coordination, health, and psycho-social or physical development. The boards shall coordinate the provision of developmental screening with other public agencies and the interagency plan for exceptional children under section eight, article twenty of this chapter to avoid the duplication of services and to facilitate the referral of children and their parents or guardians who need other services. The county boards shall provide notice to the public of the availability of these services.

(c) The state board of education is hereby authorized to promulgate rules consistent with this section. The state superintendent is directed to apply for federal funds, if available, for the implementation of the requirements of this section.

§18-5-22. Medical and dental inspection; school nurses; specialized health procedures; establishment of council of school nurses.

(a) County boards shall provide proper medical and dental inspections for all pupils attending the schools of their county and have the authority to take any other action necessary to protect the pupils from infectious diseases, including the authority to require from all school personnel employed in their county, certificates of good health and of physical fitness.

(b) Each county board shall employ full time at least one school nurse for every one thousand five hundred kindergarten through seventh grade pupils in net enrollment or major fraction thereof: *Provided,* That each county shall employ full time at least one school nurse: *Provided, however,* That a county board may contract with a public health department for services considered equivalent to those required by this section in accordance with a plan to be approved by the state board: *Provided further,* That the state board shall promulgate rules requiring the employment of school nurses in excess of the number required by this section to ensure adequate provision of services to severely handicapped pupils.

(c) Any person employed as a school nurse must be a registered professional nurse properly licensed by the West Virginia board of examiners for registered professional nurses in accordance with article seven, chapter thirty of this code.

(d) Specialized health procedures that require the skill, knowledge and judgment of a licensed health professional, may be performed only by school nurses, other licensed school health care providers as provided for in this section, or school employees who have been trained and retrained every two years who are subject to the supervision and approval by school nurses. After assessing the health status of the individual student, a school nurse, in collaboration with the student's physician, parents and in some instances an individualized education program team, may delegate certain health care procedures to a school employee who shall be trained pursuant to this section, considered competent, have consultation with, and be monitored or supervised by the school nurse: *Provided,* That nothing in this section prohibits any school employee from providing specialized health procedures or any other prudent action to aid any person who is in acute physical distress or requires emergency assistance. For the purposes of this section "specialized health procedures" means, but is not limited to, catheterization, suctioning of tracheostomy, naso-gastric tube feeding or gastrostomy tube feeding. "School employee" means "teachers", as defined in section one, article one of this chapter and "aides", as defined in section eight, article four, chapter eighteen-a of this code. Commencing with the school year beginning on the first day of July, two thousand two, "school employee" also means "secretary I", "secretary II" and "secretary III", as defined in section eight, article four, chapter eighteen-a of this code: *Provided, however,* That a "secretary I", "secretary II" and "secretary III" shall be limited to the dispensing of medications.

(e) Any school service employee who elects, or is required by this section, to undergo training or retraining to provide, in the manner specified in this section, the specialized health care procedures for those students for which the selection has been approved by both the principal and the county board, shall receive additional pay of at least one pay grade higher than the highest pay grade for which the employee is paid: *Provided,* That any training required in this section may be considered in lieu of required in-service training of the school employee and a school employee may not be required to elect to undergo the training or retraining: *Provided, however,* That commencing with the first day of July, one thousand nine hundred eighty-nine any newly employed school employee in the field of special education is required to undergo the training and retraining as provided for in this section: *Provided further,* That if an employee who holds a class title of an aide

is employed in a school and the aide has received the training, pursuant to this section, then an employee in the field of special education is not required to perform the specialized health care procedures.

(f) Each county school nurse, as designated and defined by this section, shall perform a needs assessment. These nurses shall meet on the basis of the area served by their regional educational service agency, prepare recommendations and elect a representative to serve on the council of school nurses established under this section.

(g) There shall be a council of school nurses which shall be convened by the state board of education. This council shall prepare a procedural manual and shall provide recommendations regarding a training course to the commissioner of the bureau for public health who shall consult with the state department of education. The commissioner then has the authority to promulgate a rule in accordance with the provisions of article three, chapter twenty-nine-a of this code, to implement the training and to create standards used by those school nurses and school employees performing specialized health procedures. The council shall meet every two years to review the certification and training program regarding school employees.

(h) The state board of education shall work in conjunction with county boards to provide training and retraining every two years as recommended by the council of school nurses and implemented by the rule promulgated by the commissioner.

§18-5-22a. Policy for the administration of medications.

All county boards of education shall develop a specific medication administration policy which establishes the procedure to be followed for the administration of medication at each school.

No school employee shall be required to administer medications: **Provided,** That nothing herein shall prevent any school employee to elect to administer medication after receiving training as provided herein: **Provided, however,** That any school employee in the field of special education whose employment commenced on or after the first day of July, one thousand nine hundred eighty-nine, may be required to administer medications after receiving training as provided herein.

ENROLLED

COMMITTEE SUBSTITUTE

FOR

H. B. 4271

(By Delegates Foster, Palumbo, Hatfield and Iaquinta)

[Passed March 12, 2004; in effect July 1, 2004.]

AN ACT to amend the code of West Virginia, 1931, as amended, by adding thereto a new section, designated §18-5-22b, relating to permitting public and private school students to self-administer asthma medication when certain conditions are met; providing for revocation of permission; limiting liability for injury; providing certain definitions; and providing for state board rule.

Be it enacted by the Legislature of West Virginia:

That the code of West Virginia, 1931, as amended, be amended by adding thereto a new section, designated §18-5-22b, to read as follows:

ARTICLE 5. COUNTY BOARD OF EDUCATION.

§18-5-22b. Providing for self-administration of asthma medication; definitions; conditions; indemnity from liability; rules.

(a) For the purposes of this section, the following words have the meanings specified unless the context clearly indicates a different meaning:

(1) "Medication" means asthma medicine, prescribed by:

(A) A physician licensed to practice medicine in all its branches; or

(B) A physician assistant who has been delegated the authority to prescribe asthma medications by a supervising physician; or

(C) An advanced practice registered nurse who has a written collaborative agreement with a collaborating physician. Such agreement shall delegate the authority to prescribe the medications for a student that pertain to the student's asthma and that have an individual prescription label.

(2) "Self-administration" or "self-administer" means a student's discretionary use of prescribed asthma medication.

(b) A student enrolled in a public, private, parochial or denominational school located within this state may possess and self-administer asthma medication subject to the following conditions:

(1) The parents or guardians of the student have provided to the school:

(A) A written authorization for the self-administration of asthma medication; and

(B) A written statement from the physician or advanced practice registered nurse which contains the name, purpose, appropriate usage and dosage of the student's medication and the time or times at which, or the special circumstances under which, the medication is to be administered;

(2) The student has demonstrated the ability and understanding to self-administer asthma medication by:

(A) Passing an assessment by the school nurse evaluating the student's technique of self-administration and level of understanding of the appropriate use of the asthma medication; or

(B) In the case of nonpublic schools that do not have a school nurse, providing to the school from the student's physician or advanced practice registered nurse written verification that the student has passed such an assessment; and

(3) The parents or guardians of the student have acknowledged in writing that they have read and understand a notice provided by the county board or nonpublic school that:

(A) The school, county school board or nonpublic school and its employees and agents are exempt from any liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of asthma medication by the student; and

(B) The parents or guardians indemnify and hold harmless the school, the county board of education or nonpublic school and its employees or guardians and agents against any claims arising out of the self-administration of the medication by the student.

(c) The information provided to the school pursuant to subsection (b) of this section shall be kept on file in the office of the school nurse or, in the absence of a school nurse, in the office of the school administrator.

(d) Permission for a student to self-administer asthma medication is effective for the school year for which it is granted and shall be renewed each subsequent school year if the requirements of this section are met.

(e) Permission to self-administer medication may be revoked if the administrative head of the school finds that the student's technique of self-administration and understanding of the use of the asthma medication is not appropriate or is willfully disregarded.

(f) A student with asthma who has met the requirements of this section may possess and use asthma medication:

(1) In school;

(2) At a school-sponsored activity;

(3) Under the supervision of school personnel; or

(4) Before or after normal school activities, such as before school or after school care on school operated property.

(g) The state board shall promulgate rules necessary to effectuate the provisions of this section in accordance with the provisions of article three-b, chapter twenty-nine-a of this code.

ARTICLE 7.

REGISTERED PROFESSIONAL NURSES.

Code of State Rules References. — Contested case hearing procedure, 19 CSR 5, effective February 7, 1993.

Disciplinary action, 19 CSR 9, effective May 1, 2001.

Standards for professional nursing practice, 19 CSR 10, effective April 1, 1994.

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§ 30-7-1. Definitions.

As used in this article the term:

(a) "Board" shall mean the West Virginia board of examiners for registered professional nurses;

(b) The practice of "registered professional nursing" shall mean the performance for compensation of any service requiring substantial specialized judgment and skill based on knowledge and application of principles of nursing derived from the biological, physical and social sciences, such as responsible supervision of a patient requiring skill in observation of symptoms and reactions and the accurate recording of the facts, or the supervision and teaching of other persons with respect to such principles of nursing, or in the administration of medications and treatments as prescribed by a licensed physician or a licensed dentist, or the application of such nursing procedures as involve understanding of cause and effect in order to safeguard life and health of a patient and others;

(c) "Temporary permit" means a permit authorizing the holder to practice registered professional nursing in this state until such permit is no longer effective or the holder is granted a license by the West Virginia state board of examiners for registered professional nurses. (1945, c. 96, § 1; 1965, c. 120; 1992, c. 163.)

W. Va. Law Review. — Note, "Nursing Malpractice—The Nurse's Duty to Follow Orders," 90 W. Va. L. Rev. 1291 (1988).

Hurney, "Hospital Liability in West Virginia," 95 W. Va. L. Rev. 943 (1993).

In general. — A registered nurse may legally administer intravenous fluids and injections containing medications as prescribed by written or oral order of a physician. 47 Op. Att'y Gen. 101 (1956).

Medicaid reimbursement. — Certified pediatric nurse practitioners or family nurse practitioners, who are licensed to practice registered nursing in West Virginia and who fulfill the criteria established by the West Virginia board of examiners for registered professional nurses for announcement of advanced practice, may seek medicaid reimbursement for those services which are consistent with both their certification and with state law, and which are approved for reimbursement under the state medicaid plan. Op. Att'y Gen., November 1, 1991.

Obligation to carry out orders. — A registered professional nurse is obligated to carry out the orders of a properly certified physician assistant as long as the nurse believes the physician assistant to be authorized to give such orders and as long as the nurse, in the exercise of professional judgment, believes the orders to be in the best interests of the patient. Op. Att'y Gen., Apr. 18, 1986, No. 40.

Applied in Taylor v. Cabell Huntington Hosp., 208 W. Va. 128, 538 S.E.2d 719 (W. Va. 2000).

Cited in Stewart v. West Va. Bd. of Exmrs. for Registered Professional Nurses, 197 W. Va. 386, 475 S.E.2d 478 (1996).

§ 30-7-2. License required to practice.

In order to safeguard life and health, any person practicing or offering to practice registered professional nursing in this state for compensation shall hereafter be required to submit evidence that he or she is qualified so to practice, and shall be licensed as hereinafter provided. After the thirtieth day of June, one thousand nine hundred sixty-five, it shall be unlawful for any person not licensed under the provisions of this article to practice or to offer to practice registered professional nursing in this state, or to use any title, sign, card or device to indicate that such person is a registered professional nurse: Provided, That any professional nurse holding an active, unencumbered license to practice in another state, who accompanies a patient to whom he or she administers nursing care while such patient is in transit or being transported into, out of, or through this state, may practice without a license issued under this article with the following limitations: (a) Such nurse may only administer nursing care to the patient whom they are accompanying in this state; and (b) under no circumstances is any such nurse authorized to practice nursing in this state for longer than forty-eight hours within any three-month period; and (c) under no circumstances shall any such nurse hold him or herself out as a registered professional nurse licensed in this state. Such forty-eight hour period shall commence and run from the time such nurse first enters the borders of this state in the company of his or her patient and therefrom run continuously, whether or not such nurse dispenses nursing care, until such forty-eight hour period has elapsed. (1945, c. 96, § 2; 1965, c. 120; 1994, c. 128.)

Stated in Stewart v. West Va. Bd. of Exmrs. for Registered Professional Nurses, 197 W. Va. 386, 475 S.E.2d 478 (1996).

§ 30-7-3. Board of examiners for registered professional nurses.

The governor shall appoint, by and with the advice and consent of the Senate, a board consisting of five members who shall constitute and be known as the West Virginia board of examiners for registered professional nurses.

Appointments hereunder shall be made by the governor, by and with the advice and consent of the Senate, from lists submitted to the governor by the West Virginia nurses' association. Such lists shall contain the names of at least three persons eligible for membership for each membership or vacancy to be filled and shall be submitted to the governor on or before the first day of June of each year and at such other time or times as a vacancy on the board shall exist. Appointments under the provisions of this article shall be for a term of five years each or for the unexpired term, if any, of the present members. Any member may be eligible for reappointment, but no member shall serve longer than two successive terms. Vacancies shall be filled in the same manner as is provided for appointment in the first instance. The governor may remove any member for neglect of duty, for incompetence, or for unprofessional or dishonorable conduct.

Each member of the board hereafter appointed shall (a) be a citizen of the United States and a resident of this state, (b) be a graduate from an accredited educational program in this or any other state for the preparation of practitioners of registered professional nursing, or be a graduate from an accredited college or university with a major in the field of nursing, (c) be a graduate from an accredited college or university, (d) be a registered professional nurse licensed in this state or eligible for licensure as such, (e) have had at least five years of experience in teaching in an educational program for the preparation of practitioners of registered professional nursing, or in a combination of such teaching and either nursing service administration or nursing education administration, and (f) have been actually engaged in registered professional nursing for at least three within the past five years preceding his or her appointment or reappointment.

Each member of the board shall receive fifty dollars for each day actually spent in attending meetings of the board, or of its committees, and shall also be reimbursed for actual and necessary expenses: Provided, That the per diem increased by this amendment shall be effective upon passage of this article. (1945, c. 96, § 6; 1965, c. 120; 1972, c. 93; 1981, c. 180.)

§ 30-7-4. Organization and meetings of board; quorum; powers and duties generally; executive secretary; funds.

The board shall meet at least once each year and shall elect from its members a president and a secretary. The secretary shall also act as treasurer

of the board. The board may hold such other meetings during the year as it may deem necessary to transact its business. A majority, including one officer, of the board shall constitute a quorum at any meeting. The board is hereby authorized and empowered to:

(a) Adopt and, from time to time, amend such rules and regulations, not inconsistent with this article, as may be necessary to enable it to carry into effect the provisions of this article;

(b) Prescribe standards for educational programs preparing persons for licensure to practice registered professional nursing under this article;

(c) Provide for surveys of such educational programs at such times as it may deem necessary;

(d) Accredit such educational programs for the preparation of practitioners of registered professional nursing as shall meet the requirements of this article and of the board;

(e) Deny or withdraw accreditation of educational programs for failure to meet or maintain prescribed standards required by this article and by the board;

(f) Examine, license and renew the licenses of duly qualified applicants;

(g) Conduct hearings upon charges calling for discipline of a licensee or revocation or suspension of a license;

(h) Keep a record of all proceedings of the board;

(i) Make a biennial report to the governor;

(j) Appoint and employ a qualified person, who shall not be a member of the board, to serve as executive secretary to the board;

(k) Define the duties and fix the compensation for the executive secretary; and

(*l*) Employ such other persons as may be necessary to carry on the work of the board.

The executive secretary shall possess all of the qualifications prescribed in section three [§ 30-7-3] for members of the board, except that he or she shall (a) have had at least eight years of experience in the practice of registered professional nursing since graduation from a college or university, at least five of which shall have been devoted to the teaching in or to the administration of an educational program for the preparation of practitioners of registered professional nursing, or to a combination of such teaching and administration, and (b) shall have been actively engaged in the practice of registered professional nursing for at least five years preceding his or her appointment by the board.

All fees and other moneys collected by the board pursuant to the provisions of this article shall be kept in a separate fund and expended solely for the purpose of this article. No part of this special fund shall revert to the general funds of this state. The compensation provided by this article and all expenses incurred under this article shall be paid from this special fund. No compensation or expense incurred under this article shall be a charge against the general funds of this state. (1945, c. 96, § 6; 1965, c. 120.)

Code of State Rules References. — Accreditation of schools policies and criteria for the evaluation and accreditation of colleges, departments or schools of nursing, 19 CSR 1, effective April 10, 2000.

Announcement of advanced practice, 19 CSR 7, effective July 1, 1991.

Continuing education, 19 CSR 11, effective April 5, 1995.

§ 30-7-5. Schools of nursing; accreditation; standards; surveys and reports; failure to maintain standards.

An institution desiring to be accredited by the board for the preparation of practitioners of registered professional nursing shall file an application therefor with the board, together with the information required and a fee of fifty dollars. It shall submit written evidence that: (a) It is prepared to give a program of nursing education which meets the standards prescribed by the board; and (b) it is prepared to meet all other standards prescribed in this article and by the board.

Instruction and practice may be secured in one or more institutions approved by the board. Such institution or institutions with which the school is to be affiliated shall be surveyed by the executive secretary of the board, who shall submit a written report of the survey to the board. If, in the opinion of the board, the requirements for an accredited school to prepare practitioners of registered professional nursing are met, it shall approve the school as an accredited school. From time to time as deemed necessary by the board, it shall be the duty of the board, through its executive secretary, to survey all such schools. Written reports of such surveys shall be submitted to the board. If the board determines that any such accredited school is not maintaining the standards required by this article and by the board, notice thereof in writing specifying the defect or defects shall be immediately given to the school. A school which fails to correct these conditions to the satisfaction of the board within a reasonable time shall be removed from the list of accredited schools. (1945, c. 96, § 8; 1965, c. 120.)

Assignment of right to operate school. — The right, the privilege, or the authority granted by the board to a doctor to operate a school of nursing owned and conducted by him in connection with his hospital as an accredited school, could not have been, and was not, assigned by the transfer of the hospital and the school to a corporation. Any assignment, by the conveyance to the corporation, of the right, the privilege or the authority granted to the doctor to operate or treat the school as an accredited school was of no effect and vested no such right, privilege, or authority in the corporation, but terminated such right, privilege, or authority and rendered it inoperative. State ex rel. Gordon Mem. Hosp. v. West Virginia State Bd. of Exmrs., 136 W. Va. 88, 66 S.E.2d 1 (1951).

Change of ownership. — The West Virginia state board of examiners for registered nurses has authority to promulgate regulations governing accreditation of schools of nursing when a change in ownership of the school is contemplated. 44 Op. Att'y Gen. 379 (1952).

Nature of approval of school. — The approval which the statute authorizes the board to give to a school of nursing which complies with the requirements of the statute and of the board is a particular personal right or privilege or authority. Though technically not a license, in the sense in which that term is used in the statute with reference to nurses, it closely resembles, partakes of the nature of, and has many characteristics in common with, a license, which is generally regarded as a special privilege of personal trust and confidence which cannot be assigned or transferred without the consent of the licensing authority. State ex rel. Gordon Mem. Hosp. v. West Virginia State Bd. of Exmrs., 136 W. Va. 88, 66 S.E.2d 1 (1951).

Removal of school from accredited list. — The action of the board in undertaking to remove from its list of accredited schools the

school of nursing owned by the petitioner was quasi-judicial in character, which may be controlled in a proper proceeding in prohibition by a person entitled to maintain it, if the board, in so acting, usurps or abuses its power, is without jurisdiction to take such action, or having jurisdiction, exceeds its legitimate powers. State ex rel. Gordon Mem. Hosp. v. West Virginia State Bd. of Exmrs., 136 W. Va. 88, 66 S.E.2d 1 (1951).

Proceedings for revocation of approval. — See §§ 30-1-8, 30-1-9, and the notes thereto.

§ 30-7-6. Qualifications; licensure; fees; temporary permits.

To obtain a license to practice registered professional nursing, an applicant for such license shall submit to the board written evidence, verified by oath, that he or she (a) is of good moral character; (b) has completed an approved four-year high school course of study or the equivalent thereof, as determined by the appropriate educational agency; and (c) has completed an accredited program of registered professional nursing education and holds a diploma of a school accredited by the board.

The applicant shall also be required to pass a written examination in such subjects as the board may determine. Each written examination may be supplemented by an oral examination. Upon successfully passing such examination or examinations, the board shall issue to the applicant a license to practice registered professional nursing. The board shall determine the times and places for examinations. In the event an applicant shall have failed to pass examinations on two occasions, the applicant shall, in addition to the other requirements of this section, present to the board such other evidence of his or her qualifications as the board may prescribe.

The board may, upon application, issue a license to practice registered professional nursing by endorsement to an applicant who has been duly licensed as a registered professional nurse under the laws of another state, territory or foreign country if in the opinion of the board the applicant meets the qualifications required of registered professional nurses at the time of graduation.

The board may, upon application and proper identification determined by the board, issue a temporary permit to practice registered professional nursing by endorsement to an applicant who has been duly licensed as a registered professional nurse under the laws of another state, territory or foreign country. Such temporary permit authorizes the holder to practice registered professional nursing in this state while the temporary permit is effective. A temporary permit shall be effective for ninety days, unless the board revokes such permit prior to its expiration, and such permit may not be renewed. Any person applying for a temporary license under the provisions of this paragraph shall, with his or her application, pay to the board a nonrefundable fee of ten dollars.

Any person holding a valid license designated as a "waiver license" may submit an application to the board for a license containing no reference to the fact that such person has theretofore been issued such "waiver license." The provisions of this section relating to examination and fees and the provisions of all other sections of this article shall apply to any application submitted to the board pursuant to the provisions of this paragraph.

Any person applying for a license to practice registered professional nursing under the provisions of this article shall, with his or her application, pay to the board a fee of forty dollars: Provided, That the fee to be paid for the year commencing the first day of July, one thousand nine hundred eighty-two, shall be seventy dollars: Provided, however, That the board in its discretion may, by rule or regulation, decrease either or both said license fees. In the event it shall be necessary for the board to reexamine any applicant for a license, an additional fee shall be paid to the board by the applicant for reexamination: Provided further, That the total of such additional fees shall in no case exceed one hundred dollars for any one examination.

Any person holding a license heretofore issued by the West Virginia state board of examiners for registered nurses and which license is valid on the date this article becomes effective shall be deemed to be duly licensed under the provisions of this article for the remainder of the period of any such license heretofore issued. Any such license heretofore issued shall also, for all purposes, be deemed to be a license issued under this article and to be subject to the provisions hereof.

The board shall, upon receipt of a duly executed application for licensure and of the accompanying fee of seventy dollars, issue a temporary permit to practice registered professional nursing to any applicant who has received a diploma from a school of nursing approved by the board pursuant to this article after the date the board last scheduled a written examination for persons eligible for licensure: Provided, That no such temporary permit shall be renewable nor shall any such permit be valid for any purpose subsequent to the date the board has announced the results of the first written examination given by the board following the issuance of such permit. (1945, c. 96, § 4; 1965, c. 120; 1972, c. 93; 1981, c. 180; 1992, c. 163.)

Editor's notes. — Concerning the reference to "the date this article becomes effective," Acts 1965, c. 120, provided that this article take effect June 9, 1965.

Licensing examinations. — See 44 Op. Att'y Gen. 267 (1951).

§ 30-7-7. Qualifications and licensure of persons not citizens of United States.

The board may, upon application, issue a license to practice registered professional nursing by endorsement to any person who is not a citizen of the United States of America if such person (a) has been duly licensed as a registered professional nurse under the laws of another state, territory or foreign country, and (b) shall, in any such state, territory or foreign country, have passed a written examination in the English language which, in the opinion of the board, is comparable in content and scope to the type of written examination which is authorized in the second paragraph of section six [§ 30-7-6] of this article.

All other provisions of this article shall be applicable to any application for or license issued pursuant to this section. (1945, c. 96, § 3; 1965, c. 120; 1971, c. 123.)

§ 30-7-8. Renewal of licenses; reinstatement; fees; penalties; inactive list.

The license of every person licensed and registered under the provisions of this article shall be annually renewed except as hereinafter provided. At such time or times as the board in its discretion may determine, the board shall mail a renewal application to every person whose license was renewed during the previous year and every such person shall fill in such application blank and return it to the board with a renewal fee of twenty-five dollars within thirty days after receipt of said renewal application: Provided, That the board in its discretion by rule may increase or decrease the renewal fee. Upon receipt of the application and fee, the board shall verify the accuracy of the application and, if the same be accurate, issue to the applicant a certificate of renewal for the current year. Such certificate of renewal shall entitle the holder thereof to practice registered professional nursing for the period stated on the certificate of renewal. Any licensee who allows his or her license to lapse by failing to renew the license as provided above may be reinstated by the board on satisfactory explanation for such failure to renew his or her license and on payment to the board of the renewal fee hereinabove provided and a reinstatement fee of fifty dollars. Any person practicing registered professional nursing during the time his or her license has lapsed shall be considered an illegal practitioner and shall be subject to the penalties provided for violation of this article. A person licensed under the provisions of this article desiring to retire from practice temporarily shall send a written notice of such desire to the board. Upon receipt of such notice the board shall place the name of such person upon the inactive list. While remaining on this list the person shall not be subject to the payment of any renewal fees and shall not practice registered professional nursing in this state. When the person desires to resume active practice, application for renewal of license and payment of the renewal fee for the current year shall be made to the board. (1945, c. 96, § 5; 1951, c. 150; 1957, c. 130; 1965, c. 120; 1972, c. 93; 1992, c. 163.)

§ 30-7-9. Contents of license or certificate.

Each license or certificate issued by the board shall bear a serial number, the full name of the applicant, the date of expiration of any such license and the date of issuance of any such certificate, the seal of the board, and shall be signed by the executive secretary of the board. (1965, c. 120.)

§ 30-7-10. Use of title "registered nurse" and abbreviation thereof.

Any person who holds a license to practice registered professional nursing in this state shall have the right to use the title "registered nurse" and the abbreviation "R.N." No other person shall assume such title or use such abbreviation or any other words, letters, signs or devices to indicate that the person using the same is a registered professional nurse. (1945, c. 96, § 3; 1965, c. 120.)

§ 30-7-11. Denial, revocation or suspension of license; grounds for discipline.

The board shall have the power to deny, revoke or suspend any license to practice registered professional nursing issued or applied for in accordance with the provisions of this article, or to otherwise discipline a licensee or applicant upon proof that he or she:

(a) Is or was guilty of fraud or deceit in procuring or attempting to procure a license to practice registered professional nursing; or

(b) Has been convicted of a felony; or

(c) Is unfit or incompetent by reason of negligence, habits or other causes; or

(d) Is habitually intemperate or is addicted to the use of habit-forming drugs; or

(e) Is mentally incompetent; or

(f) Is guilty of conduct derogatory to the morals or standing of the profession of registered nursing; or

(g) Is practicing or attempting to practice registered professional nursing without a license or reregistration; or

(h) Has wilfully or repeatedly violated any of the provisions of this article. (1945, c. 96, § 11; 1965, c. 120.)

Nonresident nurse. — The board of examiners for registered nurses may proceed to revoke the West Virginia license of a nonresident registered nurse. 47 Op. Att'y Gen. 60 (1956).

Revocation in another state. — The revocation of a license of a nurse in another state is not grounds in itself for revocation of her West Virginia license. 47 Op. Att'y Gen. 60 (1956).

Applied in Stewart v. West Va. Bd. of Exmrs. for Registered Professional Nurses, 197 W. Va. 386, 475 S.E.2d 478 (1996).

§ 30-7-12. Exceptions.

This article shall not be construed to prohibit:

(a) The furnishing of nursing assistance in an emergency; or

(b) The practice of nursing incidental to a program of study by students enrolled in a nursing education program accredited by the board; or

(c) The practice of any legally qualified nurse of another state who is employed by the United States or any bureau, division or agency thereof, while in the discharge of his or her official duties. (1945, c. 96, § 10; 1965, c. 120.)

§ 30-7-13. Prohibitions and penalties.

It shall be a misdemeanor for any person, including any corporation or association, to:

(a) Sell or fraudulently obtain or furnish any nursing diploma, license or record or aid or abet therein; or

(b) Practice registered professional nursing under cover of any diploma, license or record illegally or fraudulently obtained or signed or issued or under fraudulent representation; or

(c) Practice registered professional nursing unless duly licensed to do so under the provisions of this article; or

(d) Use in connection with his or her name any designation tending to imply that he or she is licensed to practice registered professional nursing unless duly licensed so to practice under the provisions of this article; or

(e) Practice registered professional nursing during the time his or her license issued under the provisions of this article shall be suspended or revoked; or

(f) Conduct a nursing education program for the preparation of registered professional nursing practitioners unless such program has been accredited by the board; or

(g) Otherwise violate any provisions of this article.

Upon conviction, each such misdemeanor shall be punishable by a fine of not less than twenty-five nor more than two hundred fifty dollars. (1945, c. 96, § 12; 1965, c. 120.)

§ 30-7-14. Injunction or other relief against unlawful acts.

The practice of registered professional nursing by any person who has not been licensed under the provisions of this article, or whose license has expired or has been suspended or revoked, is hereby declared to be inimical to the public health and welfare and to be a public nuisance. Whenever in the judgment of the board any person has engaged in, is engaging in or is about to engage in the practice of registered professional nursing without holding a valid license hereunder, or has engaged, is engaging or is about to engage in any act which constitutes, or will constitute, a violation of this article, the board may make application to the appropriate court having equity jurisdiction for an order enjoining such practices or acts, and upon a showing that such person has engaged, is engaging or is about to engage, in any such practices or acts, an injunction, restraining order, or such other order as the court may deem appropriate shall be entered by the court.

The remedy provided in this section shall be in addition to, and not in lieu of, all other penalties and remedies provided in this article. (1965, c. 120.)

§ 30-7-15. Administration of anesthetics.

In any case where it is lawful for a duly licensed physician or dentist practicing medicine or dentistry under the laws of this state to administer anesthetics, such anesthetics may lawfully be given and administered by any person (a) who has been licensed to practice registered professional nursing under this article, and (b) who holds a diploma or certificate evidencing his or her successful completion of the educational program of a school of anesthesia duly accredited by the American association of nurse anesthetists: Provided, That such anesthesia is administered by such person in the presence and under the supervision of such physician or dentist. (1945, c. 96, § 9; 1965, c. 120.)

Authority to administer. — Qualified nurses may administer anesthetics under the direction of and in the presence of a licensed dental surgeon, for the purpose of assisting in any of the operations which such surgeon is authorized to perform. 45 Op. Att'y Gen. 467 (1953).

The language of this section must necessarily

include the authority for registered nurses to administer endotracheal and spinal anesthesia.
46 Op. Att'y Gen. 202 (1955).

§ 30-7-15a. Prescriptive authority for prescription drugs; collaborative relationship with physician requirements; promulgation of rules; classification of drugs to be prescribed; coordination with other boards; coordination with board of pharmacy.

(a) The board may, in its discretion, authorize an advanced nurse practitioner to prescribe prescription drugs in a collaborative relationship with a physician licensed to practice in West Virginia and in accordance with applicable state and federal laws. An authorized advanced nurse practitioner may write or sign prescriptions or transmit prescriptions verbally or by other means of communication.

(b) For purposes of this section an agreement to a collaborative relationship for prescriptive practice between a physician and an advanced nurse practitioner shall be set forth in writing. Verification of such agreement shall be filed with the board by the advanced nurse practitioner. The board shall forward a copy of such verification to the board of medicine. Collaborative agreements shall include, but not be limited to, the following:

(1) Mutually agreed upon written guidelines or protocols for prescriptive authority as it applies to the advanced nurse practitioner's clinical practice;

(2) Statements describing the individual and shared responsibilities of the advanced nurse practitioner and the physician pursuant to the collaborative agreement between them;

(3) Periodic and joint evaluation of prescriptive practice; and

(4) Periodic and joint review and updating of the written guidelines or protocols.

(c) The board shall promulgate legislative rules in accordance with the provisions of chapter twenty-nine-a [§§ 29A-1-1 et seq.] of this code governing the eligibility and extent to which an advanced nurse practitioner may prescribe drugs. Such rules shall provide, at a minimum, a state formulary classifying those categories of drugs which shall not be prescribed by advanced nurse practitioners, including, but not limited to, Schedules I and II of the Uniform Controlled Substances Act, anticoagulants, antineoplastics, radiopharmaceuticals and general anesthetics. Drugs listed under schedule III shall be limited to a seventy-two hour supply without refill.

(d) The board shall consult with other appropriate boards for the development of the formulary.

(e) The board shall transmit to the board of pharmacy a list of all advanced nurse practitioners with prescriptive authority. The list shall include:

(1) The name of the authorized advanced nurse practitioner;

(2) The prescriber's identification number assigned by the board; and

(3) The effective date of prescriptive authority. (1992, c. 164.)

Code of State Rules References. — Limited prescriptive authority for nurses in advanced practice, 19CSR8, effective June 15, 1993.

W. Va. Law Review. — Hurney, "Hospital Liability in West Virginia," 95 W. Va. L. Rev. 943 (1993).

§ 30-7-15b. Eligibility for prescriptive authority; application; fee.

An advanced nurse practitioner who applies for authorization to prescribe drugs shall:

(a) Be licensed and certified in West Virginia as an advanced nurse practitioner holding a baccalaureate degree in science or the arts;

(b) Not be less than eighteen years of age;

(c) Provide the board with evidence of successful completion of forty-five contact hours of education in pharmacology and clinical management of drug therapy under a program approved by the board, fifteen hours of which shall be completed within the two-year period immediately before the date of application;

(d) Provide the board with evidence that he or she is a person of good moral character and not addicted to alcohol or the use of controlled substances; and

(e) Submit a completed, notarized application to the board, accompanied by a fee of one hundred twenty-five dollars. (1992, c. 164.)

§ 30-7-15c. Form of prescriptions; termination of authority; renewal; notification of termination of authority.

(a) Prescriptions authorized by an advanced nurse practitioner must comply with all applicable state and federal laws; must be signed by the prescriber with the initials "A.N.P." or the designated certification title of the prescriber; and must include the prescriber's identification number assigned by the board.

(b) Prescriptive authorization shall be terminated if the advanced nurse practitioner has:

(1) Not maintained current authorization as an advanced nurse practitioner; or

(2) Prescribed outside the advanced nurse practitioner's scope of practice or has prescribed drugs for other than therapeutic purposes; or

(3) Has not filed verification of a collaborative agreement with the board.

(c) Prescriptive authority for an advanced nurse practitioner must be renewed biennially. Documentation of eight contact hours of pharmacology during the previous two years must be submitted at the time of renewal.

(d) The board shall notify the board of pharmacy and the board of medicine within twenty-four hours after termination of, or change in, an advanced nurse practitioner's prescriptive authority. (1992, c. 164.)

§ 30-7-16. General law applicable.

Except to the extent that the provisions of this article may be inconsistent therewith, the board shall conform to the requirements prescribed in article one [§§ 30-1-1 et seq.] of this chapter. (1965, c. 120.)

In general. — Article one of this chapter, §§ 30-1-1 et seq., which deals generally with state boards of examination or registration, applies to the state board of examiners for registered nurses. State ex rel. Gordon Mem. Hosp. v. West Virginia State Bd. of Exmrs., 136 W. Va. 88, 66 S.E.2d 1 (1951).

Cited in Stewart v. West Va. Bd. of Exmrs. for Registered Professional Nurses, 197 W. Va. 386, 475 S.E.2d 478 (1996).

§ 30-7-17. Continuation of board.

Pursuant to the provisions of article ten [§§ 4-10-1 et seq.], chapter four of this code, the board of examiners for registered professional nurses shall continue to exist until the first day of July, two thousand ten, unless sooner terminated, continued or reestablished pursuant to that article. (1965, c. 120; 2002, c. 241.)

Effect of amendment of 2002. — Acts 2002, c. 241, effective May 21, 2002, substituted "Continuation of board" for "Severability" in the section heading and substituted the present language for the former which contained a severability clause for the provisions in article seven.

§ 30-7-18. Nursing shortage study commission; legislative findings; members, appointment and expenses; duties.

(a) The Legislature finds the following:

(1) Health care services are becoming complex and it is increasingly difficult for patients to access integrated services;

(2) Quality of patient care is jeopardized because of insufficient nursing staff;

(3) To ensure the adequate protection of patients in acute care settings, it is essential that qualified registered nurses and other licensed nurses be accessible and available to meet the needs of patients;

(4) In West Virginia, and across the country, concerns about an increasing nursing shortage continue to grow;

(5) A number of factors contribute to the growing shortages in qualified nursing personnel;

(6) The way care is delivered has changed dramatically over the last decade with more people being treated in outpatient settings, shorter and more intense lengths of stay in acute and long-term care settings, and the development of alternatives to nursing home care;

(7) These changes have led to a number of employment options becoming available to nurses that did not exist previously, making it difficult for employers of nurses to recruit and retain qualified nursing personnel;

(8) Severe cutbacks in the federal medicare program, state budgetary pressures related to the medicaid program and continued pressure from insurers to reduce their costs and to retrospectively deny payment for services rendered, have: (A) Made it extremely difficult for many providers to keep up with other employers in salaries and benefits and to recruit and retain qualified nursing personnel; and (B) increased stresses in the work environment;

(9) The increasing reliance on temporary employment agencies to meet nursing personnel needs further complicates the situation as continuity of care is disrupted, quality of patient care is jeopardized, and costs pressures are further increased; and

(10) Because of the multifaceted nature of these problems, it is critical that all of the interested and affected parties cooperate and collaborate in the development of solutions.

(b) A nursing shortage study commission shall be created by the West Virginia board of examiners for registered professional nurses. The board shall appoint eleven members to the commission. The board shall appoint:

(1) Two individuals who are on the board of examiners for registered professional nurses, one of which is employed in a school of nursing;

(2) Two individuals that are employed as registered professional nurses in a hospital and who work primarily providing direct patient care;

(3) Two registered professional nurses who work as long-term care nurses, one of whom works in a nursing home and one of whom works for a home health agency, both of whom work primarily providing direct patient care;

(4) One administrator of a hospital in this state;

(5) One doctoral prepared nurse researcher;

(6) One nursing home administrator; and

(7) Two representatives of the public not currently or previously employed in hospital, nursing home or for a related entity.

(c) Members of the commission are not entitled to compensation for services performed as members, but are entitled to reimbursement for all reasonable and necessary expenses actually incurred in the performance of their duties. Six of the appointed members is a quorum for the purpose of conducting business. The board shall designate a chair, who is not a public official. The commission shall conduct all meetings in accordance with the open meeting law pursuant to article nine-a [§§ 6-9A-1 et seq.], chapter six of this code.

(d) The commission shall:

(1) Study the nursing shortage in West Virginia and ways to alleviate it, including, but not limited to:

(A) Evaluating mechanisms currently available in the state and elsewhere intended to enhance education, recruitment, and retention of nurses in the workforce and to improve quality of care;

(B) Assessing the impact of shortages in nursing personnel on access to, and the delivery of, quality patient care;

(C) Developing recommendations on strategies to reverse the growing shortage of qualified nursing personnel in the state, including:

(i) Determining what changes are needed to existing programs, current scholarship programs and funding mechanisms to better reflect and accommodate the changing health care delivery environment and to improve quality of care to meet the needs of patients;

(ii) Facilitating career advancement within nursing;

(iii) Identifying more accurately specific shortage areas in a more timely manner;

(iv) Attracting middle and high school students into nursing as a career; and

(v) Projecting a more positive and professional image of nursing.

(2) Report to the Legislature by the first day of February, two thousand two, its findings and recommendations on or before the first day of February each year thereafter. (2001, c. 231.)

Effective dates. — Acts 2001, c. 231, provided that the act take effect July 13, 2001.

ARTICLE 7A.

PRACTICAL NURSES.

Code of State Rules References. — Continuing education, 18CSR2, effective May 1, 1998.

Fees for service rendered by the board, 10CSR4, effective May 1, 1995.

Policies regulating licensure of the licensed practical nurses, 10CSR2, effective May 24, 2001.

Intravenous fluids. — Administration of intravenous fluids by practical nurses. Op. Att'y Gen., Sept. 29, 1982, No. 5.

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§ 30-7A-1. Definitions.

(a) The term "practical nursing" means the performance for compensation of selected nursing acts in the care of the ill, injured or infirm under the direction of a registered professional nurse or a licensed physician or a licensed dentist, and not requiring the substantial specialized skill, judgment and knowledge required in professional nursing.

(b) The term "practical nurse" means a person who has met all the requirements for licensure as a practical nurse and who engages in practical nursing as hereinabove defined.

(c) The term "board" as used in this article, shall mean the board of examiners for licensed practical nurses as set forth in section five [§ 30-7A-5] of this article. (1957, c. 131; 1967, c. 152.)

"Practical nursing" construed. — Practical nurses are not limited in the tasks they may perform to those skills acquired as part of their formal training prior to licensure, but may perform selected nursing acts "in the care of the ill, injured or infirm," as long as such acts comport with the requirement of this section that they be "under the direction of a registered professional nurse or a licensed physician or a licensed dentist, and not requiring the substan-

tial specialized skill, judgment, or knowledge required in professional nursing." Op. Att'y Gen., Sept. 29, 1982, No. 5.

§ 30-7A-2. Use of title "licensed practical nurse"; who may practice.

Any person who is qualified to serve as a practical nurse under the provisions of this article shall be known as a licensed practical nurse or otherwise known as a L.P.N. After the thirtieth day of June, one thousand nine hundred sixty-eight, no other person shall engage in practical nursing nor assume such title nor use such abbreviation or any other words, letters, figures, signs, or devices to indicate that the person using the same is a licensed practical nurse or a practical nurse: Provided, however, That any person holding a valid license to practice practical nursing in this state as of the effective date of this article [July 1, 1967] shall be deemed to be a licensed practical nurse under the provisions of this article. (1957, c. 131; 1967, c. 152.)

Editor's notes. — Concerning the reference to "the effective date of this article," Acts 1967, c. 152, which amended and reenacted this article and added the language, became effective July 1, 1967.

§ 30-7A-3. Qualifications of applicants for license.

Except as otherwise provided in section six [§ 30-7A-6] of this article, any person desiring to obtain a license to practice practical nursing shall submit to the board satisfactory evidence that he or she: (a) Is of good moral character; (b) has acquired at least a tenth grade education or its equivalent; (c) has completed a course of study in an accredited school for practical nurses as defined by the board and holds a diploma therefrom; and (d) has completed such other general educational requirements as may be prescribed by the board. (1957, c. 131; 1967, c. 152.)

§ 30-7A-4. Application for license or registration; examination fee.

The provisions of section six [§ 30-1-6], article one, chapter thirty of the code shall apply to this article, except that an applicant for license as a practical nurse shall pay such fee as the board shall prescribe. (1957, c. 131; 1967, c. 152.)

§ 30-7A-5. Board of examiners; powers; duties.

The governor shall appoint, by and with the advice and consent of the senate, seven citizens of the state of West Virginia who shall constitute the "West Virginia state board of examiners for licensed practical nurses" and they shall be charged with the duty of administering the provisions of this article. Of the seven members so appointed two shall be licensed practical nurses, one of whom shall be a graduate of an approved school of practical nursing, and both of whom shall have had not less than five years' experience as licensed

practical nurses, two shall be registered professional nurses, at least one of whom shall be experienced in practical nurse education; one shall be a doctor of medicine; one shall be a hospital administrator actively engaged as such in this state and one shall be a vocational educator. Such appointments shall be for terms of five years each, except that in the initial appointments, one licensed practical nurse and one registered professional nurse shall be appointed for a term of five years, one licensed practical nurse and one registered professional nurse shall be appointed for a term of four years, the doctor of medicine shall be appointed for a term of three years, the hospital administrator shall be appointed for a term of two years and the vocational educator shall be appointed for a term of one year. The practical nurses so to be appointed, initially and subsequently, shall be selected by the governor from a list to be submitted to him by the Licensed Practical Nurses' Association of West Virginia, Inc., which list shall contain the names of at least two licensed practical nurses for each board member so to be appointed, who shall have been licensed by examination and who shall have not less than five years' experience as a licensed practical nurse. The doctor of medicine so appointed shall be selected by the governor from two nominations submitted to him by the West Virginia state medical association; each registered professional nurse so appointed shall be selected by the governor from two nominations submitted to him by the West Virginia Nurses Association, Inc.; the hospital administrator shall be appointed by the governor from two nominations submitted to him by the West Virginia hospital association; and the vocational educator shall be appointed by the governor from two nominations submitted to him by the state board of education. Any member of the board may be eligible for reappointment, but no member shall serve more than two successive terms. The board is hereby authorized to appoint and employ a qualified person to perform the duties of executive secretary and to act as educational advisor to the board. Such secretary shall act under the direction of the board. The board shall furnish the secretary a headquarters and shall provide such office equipment and clerical assistance as the duties of the office may require. The board shall have power to appoint such nurses, deputies, clerks, assistants, inspectors and employees as shall be necessary for the proper exercise of the powers and duties of the board. The compensation and expenses of the members of the board and its appointees and employees shall be paid out of such funds as are allocated to the board in its annual budget. The secretary shall keep the records of proceedings of the board, and shall keep a registry of the names and addresses of all practical nurses registered under this article, which registry shall be a public record. Said board shall hold not less than two regular meetings each year and such additional meetings at such times and places as the board may determine. The board is authorized to adopt and, from time to time, to revise such rules and regulations not inconsistent with this article, as may be necessary to enable it to carry into effect the provisions hereof. The board shall prescribe curricula and standards for schools and courses preparing persons for licensure under this article. It shall survey such schools and courses at such times as it may deem necessary. It shall survey and accredit such schools, clinical practice areas and courses as meet the requirements of

this article and of the board. It shall examine, license and renew the license of duly qualified applicants. (1957, c. 131; 1967, c. 152.)

Code of State Rules References. — Continuing competence, 10 CSR 6, effective May 24, 2001.

Legal standards of nursing practice for the licensed practical nurse, 10 CSR 3, effective May 24, 2001.

Policies and procedures for development and maintenance of educational programs in practical nursing, 10 CSR 1, effective May 24, 2001.

Regulation of administration of intravenous fluids. — Subject to certain restrictions, the board is empowered to regulate administration of intravenous fluids by licensed practical nurses, and may proceed by either policy statement or regulation to clarify the proper scope of practical nursing practice with respect to administration of intravenous fluids. Op. Att'y Gen., Sept. 29, 1982, No. 5.

§ 30-7A-6. Examination and licensure of practical nurses; present practitioners.

The applicant, except as hereinafter provided, shall be required to pass a written examination in such subjects as the board shall determine. Each written examination may be supplemented by such oral or practical examination as the board may deem necessary. The board shall determine the times and places for the examination. Notices of examination shall be sent by mail to each person known by the secretary to be an applicant for an examination or registration at least thirty days previous to any such scheduled examination. Upon the applicant's successful completion of an appropriate examination as prescribed by the board and satisfaction of the other requirements of this article, the board shall issue to the applicant a license to practice practical nursing. The board shall issue such license by endorsement to any applicant who has been duly licensed or registered as such, or to a person entitled to perform similar services under a different title, in another state, territory or foreign country if, in the opinion of the board, the applicant meets the other requirements for licensed practical nurses in this state. On or before the thirtieth day of June, one thousand nine hundred sixty-eight, any practical nurse who exhibits proof, satisfactory to the board, that he or she has been engaged in practical nursing in this state for a period of three years and who satisfactorily completes an appropriate examination as prescribed by the board shall be issued a license by waiver by said board, which shall be so designated on its face.

Any person obtaining a license by waiver who has completed extension courses equal in theory to those for the graduate practical nurses, as determined by the board, may at any time thereafter take the examination prescribed by the board for graduate practical nurses and obtain a license without the designation of "waiver" thereon. (1957, c. 131; 1967, c. 152.)

Application for license by waiver signed by doctors of osteopathy. — The board of examiners for practical nurses was required to honor properly submitted applications for licenses by waiver if such applications were duly verified by two doctors of osteopathy. 48 Op. Att'y Gen. 97 (1959) (opinion issued prior to 1967 amendment).

§ 30-7A-7. Renewal or reinstatement of license.

The license of every person licensed under the provisions of this article shall expire on the thirtieth day of June, next following the date of license. In order for such license to be renewed, the licensee shall comply with such rules and regulations of the board as are applicable to renewals. The renewal fee for all licenses shall be five dollars, subject to change by the board. Upon receipt of the renewal fee the board shall issue to the licensee a certificate of renewal for the current year, beginning July first and expiring June thirtieth of the following year. Such certificate shall render the holder thereof a legal practitioner for the period stated on the certificate of renewal. Any licensee who allows his or her license to lapse by failing to renew the license as provided above may be reinstated by the board on satisfactory explanation for such failure to renew his or her license and on payment of a reinstatement fee of five dollars, subject to change by the board, in addition to the renewal fee hereinbefore set out. Any person practicing practical nursing during the time his or her license has lapsed shall be considered an illegal practitioner and shall be subject to the penalties provided for violation of this article. A person licensed under the provisions of this article desiring to retire from practice temporarily shall give written notice of such desire to the board. Upon receipt of such notice the board shall place the name of such person upon the nonpracticing list. While remaining on this list the person shall not be subject to the payment of any renewal fees and shall not practice as a licensed practical nurse in the state. When such person desires to resume practice, application for renewal of license and payment of the renewal fee for the current year shall be made to the board. (1957, c. 131; 1967, c. 152.)

§ 30-7A-8. Schools of practical nursing.

The board shall prescribe curricula and standards for schools, clinical practice areas and courses preparing persons for licensure under this article; it shall provide for surveys of such schools, clinical practice areas and courses at such times as it may deem necessary. It shall accredit such schools, clinical practice areas and courses as meet the requirements of this article and of the board. An institution desiring to conduct a school of practical nursing to be accredited by the board as such shall file an application therefor with the board, together with the information required and such fee as may be prescribed by the board. It shall submit satisfactory evidence that: (1) It is prepared to give the course of instruction and practical experience in practical nursing as prescribed in the curricula adopted by the board; and (2) it is prepared to meet other standards established by this law and by the board.

A survey of the institution or institutions, with which the school is to be, or is, affiliated, shall be made by the executive secretary of the board. The executive secretary shall submit a written report of the survey to the board. If, in the opinion of the board, the requirements for an accredited school of practical nursing are met, it shall approve the school as an accredited school of practical nursing. From time to time as deemed necessary by the board, it shall be the duty of the board, through its executive secretary, to survey all schools

of practical nursing in the state. Written reports of such surveys shall be submitted to the board. If the board determines that any accredited school of practical nursing is not maintaining the standards required by the statutes and by the board, notice thereof in writing specifying the defect or defects shall be immediately given to the school. A school which fails to correct these conditions to the satisfaction of the board within a reasonable time shall be removed from the list of accredited schools of practical nursing and shall be in violation of this article. Nothing contained in this article shall infringe upon the rights or power of the state board of education, or county boards of education to establish and conduct a program of practical nurse education or other health occupation so long as the prescribed curricula meets the requirements of the board. (1957, c. 131; 1967, c. 152.)

§ 30-7A-9. Construction of article; acts not prohibited.

The provisions of this article shall not be construed as prohibiting:

(1) The care of a sick, disabled, injured, crippled or infirm person by a member or members of such person's family, or by close relatives, or by domestic servants, housekeepers or household aides thereof, whether employed regularly or because of emergency circumstances due to illness or other disabilities.

(2) The work and services of auxiliary hospital personnel, such as nursing aides, maids, orderlies, technicians, volunteer workers and other like hospital employees.

(3) Practical nursing by students enrolled in accredited schools for practical nursing incidental to their course of study.

(4) Practice of nursing in this state by any legally qualified practical nurse of another state or country for a period not to exceed six months or whose engagement requires such practical nurse to accompany and care for a patient temporarily residing in this state during the period of such engagement.

(5) Nursing services rendered by a graduate of an approved school of practical nursing working under qualified supervision during the period between completion of his or her course of nursing education and notification of the results of the first licensing examination following graduation. In cases of hardship and upon petition to the board, the board may grant an extension of such period to such graduate. (1957, c. 131; 1967, c. 152.)

§ 30-7A-10. Disciplinary proceeding; grounds for discipline.

The board shall have the right, in accordance with rules and regulations promulgated under the provisions of article three [§§ 29A-3-1 et seq.], chapter twenty-nine-a of this code, to refuse to admit an applicant for the licensure examination for the hereinafter stated reasons, and also the board shall have the power to revoke or suspend any license to practice practical nursing issued by the board in accordance with the provisions of this article, or to otherwise discipline a licensee upon satisfactory proof that the person: (1) Is guilty of

fraud or deceit in procuring or attempting to procure a license to practice practical nursing; or (2) is convicted of a felony; or (3) is habitually intemperate or is addicted to the use of habit-forming drugs; or (4) is mentally incompetent; or (5) is guilty of professional misconduct as defined by the board; or (6) who practices or attempts to practice without a license or who willfully or repeatedly violates any of the provisions of this article. (1957, c. 131; 1967, c. 152; 1986, c. 135.)

§ 30-7A-11. Prohibited acts; penalties.

It shall be a misdemeanor for any person, firm, corporation or association of persons to: (1) Sell or fraudulently obtain or furnish any nursing diploma, license or record or aid or abet therein; or (2) practice practical nursing unless duly licensed to do so under the provisions of this article; or (3) use in connection with his or her name any designation tending to imply that he or she is a licensed practical nurse unless duly licensed so to practice under the provisions of this article; or (4) practice practical nursing during the time his or her license issued under the provisions of this article shall be suspended or revoked; or (5) conduct a school of practical nursing or a course for training of practical nurses unless the school or course has been accredited by the board; or (6) otherwise violate any provision of this article.

Any person convicted of any such misdemeanor shall be punishable by a fine of not less than twenty-five nor more than one hundred dollars. (1957, c. 131; 1967, c. 152.)

§ 30-7A-12. Continuation of board.

Pursuant to the provisions of article ten [§§ 4-10-1 et seq.], chapter four of this code, the board of examiners for licensed practical nurses shall continue to exist until the first day of July, two thousand ten, unless sooner terminated, continued or reestablished pursuant to that article. (1957, c. 131; 1967, c. 152; 2002, c. 297.)

Effect of amendment of 2002. — Acts 2002, c. 297, effective May 9, 2002, substituted "Continuation of board" for "Severability" in the section heading and substituted the present language for the former which contained a severability clause for the provisions in article seven-a.

ARTICLE 8.

OPTOMETRISTS.

State of West Virginia

Criteria for Determining Scope of Practice for Licensed Nurses

and

Guidelines for Determining Acts That May Be Delegated or Assigned By Licensed Nurses

Printed January 2001

CRITERIA FOR DETERMINING

SCOPE OF PRACTICE FOR LICENSED NURSES

AND

GUIDELINES FOR DETERMINING ACTS

THAT MAY BE DELEGATED OR ASSIGNED

BY LICENSED NURSES

Revised by:
The West Virginia Board of Examiners
for Registered Professional Nurses
and
The West Virginia State Board of Examiners
for Licensed Practical Nurses
as of November, 2000

TABLE OF CONTENTS

INTRODUCTION

The intent of this document is to present a process to determine acts that are appropriate to nursing at various levels and acts appropriate for delegation to the licensed practical nurse as well as to those acts appropriate for assignment to unlicensed assistive personnel. Individuals are encouraged to consult the law, applicable rules and Board position statements in making a practice decision. Related position statements are included in the Appendix of this document.

Changes designed to improve health care delivery while reducing costs are occurring in health care organizations throughout West Virginia and the nation. Changes being considered, such as cross-training, decentralization and expanded use of unlicensed personnel to deliver health care services could lead to role confusion. These changes challenge the traditional roles of health care providers. In view of the mandates of the West Virginia Board of Examiners for Registered Professional Nurses and the West Virginia State Board of Examiners for Licensed Practical Nurses to act in the best interest of public safety and health, the respective boards support beneficial change which involves professional collaboration to deliver competent care and treatment of the client in a safe, professional and cost effective manner.

Licensed individuals should provide care in circumstances consistent with educational preparation and ongoing validation of competency. The guidelines contained in this document provide comprehensive criteria and examples for use in the decision making process required to determine acts that are appropriate to nursing at various levels and acts appropriate for delegation to the licensed practical nurse as well as to those acts appropriate for assignment to unlicensed assistive personnel. These guidelines may be used as a guide for licensees who wish to engage in safe nursing practice and who wish to minimize the possibility of malpractice litigation. The guidelines, however, do not have the force and effect of law except as provided through the Legal Standards of Practice, 19 CSR 10 and 10 CSR 3.

"Many nurses would like a 'yes' or 'no' answer to questions about the delegation of nursing practice, however, in most cases it is not that simple. In reality, the answer to most questions is 'it depends'. It depends upon the complexity of the task to be delegated. It depends upon the care needs of the client, as assessed by the registered professional nurse. It depends upon the educational preparation, skills, and ability of the licensed practical nurse or unlicensed person to whom the task is to be delegated/assigned. And, it depends upon the availability and accessibility of essential resources including supervision, while the task is being performed. **Nursing judgment is the essential element in every delegation or assignment decision."** [1]

Licensees are encouraged to read this entire document then refer back to the portions that will assist in making a final decision. Thus, this document is best used when an individual has the time to review all related information so the foundation for decision making is present when a quick decision is required.

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1 "Nursing Standards & Delegation: A Guide to Ohio Board of Nursing Rules", Ohio Board of Nursing, April 1, 1998

DEFINITIONS

Accountability	Being responsible or answerable for actions or inactions of self or others; in the context of delegated or assigned to another.
Assignment	Appoint to a duty; to specify a task or amount of work to be undertaken.
Competence	Possessing verifiable knowledge and skill to perform an activity or task safely and effectively.
Delegation	Entrust to another; the act of empowering to act for another; to specify functions to others answerable for completion. Each person involved in the delegation process is accountable for his or her own actions or inactions and is potentially liable if competent, safe care is not provided.
Invasive	Penetration of the skin or mucous membranes for the purpose of introducing foreign material into the body.
OHFLAC	Office of Health Facility Licensure and Certification; a division of the West Virginia Department of Health and Human Resources responsible for promulgation of Rules regulating various types of health care facilities.
Responsible	Liable to legal review or in the case of fault to penalties; able to answer for one's conduct or obligation; able to choose for one's self right from wrong.
Sterile Procedure	Utilization of technique that maintains a microorganism-free environment for all or any portion of the procedure.
Unlicensed Assistive Personnel (UAP)	Any unlicensed person, regardless of title, to whom nursing tasks are delegated or ass igned.

CRITERIA FOR DETERMINING SCOPE OF PRACTICE FOR THE LICENSED NURSE

You may use the process explained below to determine, on an individual basis, if a specific activity or task is within the scope of practice for a registered professional nurse or a licensed practical nurse.

I. DEFINE THE ISSUE

Clearly define the activity or task to be performed. Steps essential in this process include:

A. CLARIFICATION OF THE ISSUE: What is the issue or problem? Gather facts that may influence the decision. Are there written policies and procedures available that relate to this act? Is this a new expectation or just new to you? What is the decision to be made and where, (in what setting or organization), will it take place? Has the issue been discussed previously?

B. ASSESSMENT OF SKILLS AND KNOWLEDGE: What skills and knowledge are required? Do you possess those skills? Who is available to assist you who has that skill and knowledge? Is that person accessible to you?

C. IDENTIFICATION OF OPTIONS: What are possible solutions? What are the risks? What are the implications of your decision: How serious are the consequences? Should you choose to perform an act, you are responsible for performing it at an acceptable level of quality.

II. REVIEW EXISTING LAWS, POLICIES, AND STANDARDS OF NURSING PRACTICE

Once the problem has been clearly defined, review existing laws, policies, and standards of nursing practice:

A. Definitions of nursing practice (§30-7-1.b) or advanced nursing practice (19 CSR 7) and the Legal Standards of Practice for the Registered Professional Nurse (19 CSR 10). (**Appendix H, page 36 & Appendix I, pages 37-39)**

B. Definition of practice for the licensed practical nurse (§30-7A-1.a) and Legal Standards of Practice for the Licensed Practical Nurse (10 CSR 3). **(Appendix H, page 36 & Appendix J, pages 40-42)**

C. Medication Administration by Unlicensed Personnel (WV Code §16-50-1 et.seq.) **(Appendix C, pages 24-28)**

D. Standards of practice of a national nursing specialty organization.

E. Positive and conclusive data in nursing literature and supported by nursing research.

F. Established policy and procedure of employing facility or agency.

Following a review of these items ask yourself the following questions:

A. Is the act expressly addressed in existing law or rules and regulations for your licensure category? Is the activity or task consistent with the scope of practice for a registered nurse or a licensed practical nurse?

B. Is the activity or task within the accepted standards of care? Would a reasonable and prudent nurse with similar training and experience perform the activity under similar circumstances?

III. MAKING THE DECISION

After defining the issue and reviewing significant materials, a decision must be made. To facilitate this process, ask yourself the following questions:

A. What is the best decision? When should it be done? By whom? What are the implications of your decision? How will you evaluate your decision? Is the act within the scope of practice for a registered nurse, or is it an advanced practitioner role? Should it be performed by the licensed practical nurse or can it be performed by an unlicensed individual?

B. Do you personally possess the depth and breadth of knowledge to perform the activity or task safely and effectively as demonstrated by knowledge acquired in a pre-licensure, post-basic or continuing education program?

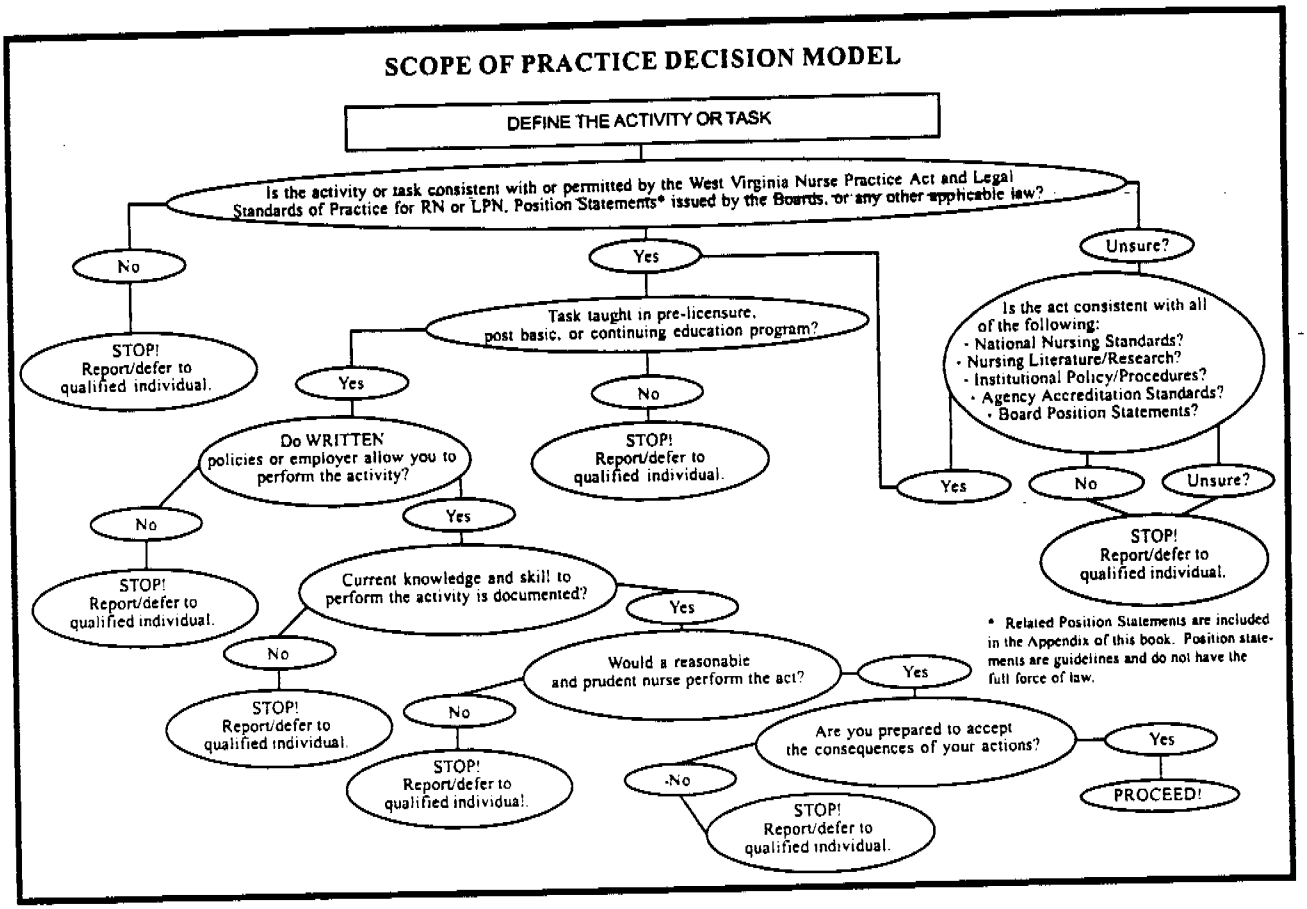
C. Do you personally possess current clinical competence to perform the activity or task safely?

D. Are you physically and mentally capable of performing the activity safely?

E. Are you prepared to accept the consequences of your actions and assume accountability for provision of safe care?

If you answered in the affirmative to all of the questions above, you may perform the activity or task.

NOTE: A Scope of Practice Decision Model follows


SCOPE OF PRACTICE DECISION MODEL
DEFINE THE ACTIVITY OR TASK
Is the activity or task consistent with or permitted by the West Virginia Nurse Practice Act and Legal Standards of Practice for RN or LPN, Position Statements* issued by the Boards, or any other applicable law?
No
Yes
Unsure?
STOP! Report/defer to qualified individual.
Task taught in pre-licensure, post basic, or continuing education program?
Yes
No
Do WRITTEN policies or employer allow you to perform the activity?
STOP! Report/defer to qualified individual.
Is the act consistent with all of the following:
- National Nursing Standards?
- Nursing Literature/Research?
- Institutional Policy/Procedures?
- Agency Accreditation Standards?
- Board Position Statements?
Yes
No
Unsure?
STOP! Report/defer to qualified individual.
No
Yes
STOP! Report/defer to qualified individual.
Current knowledge and skill to perform the activity is documented?
Yes
No
STOP! Report/defer to qualified individual.
Would a reasonable and prudent nurse perform the act?
Yes
No
STOP! Report/defer to qualified individual.
Are you prepared to accept the consequences of your actions?
Yes
No
PROCEED!
STOP! Report/defer to qualified individual.
* Related Position Statements are included in the Appendix of this book. Position statements are guidelines and do not have the full force of law.

GUIDELINES FOR DETERMINING ACTS THAT MAY BE DELEGATED OR ASSIGNED BY THE LICENSED NURSE

Members of the West Virginia Board of Examiners for Registered Professional Nurses and the West Virginia State Board of Examiners for Licensed Practical Nurses provide the following descriptive guidelines for nursing practice and delegation/assignment decision model which are supported by the definitions of practice and the legal standards of practice for the registered professional nurse and licensed practical nurse.

The Boards of Nursing have chosen to provide general guidelines for delegation of nursing acts to nursing care providers, rather than creating a long list of permissible and prohibited acts.

The following guidelines are intended to serve as a basis for:

- guiding registered nurses and licensed practical nurses in determining their own scope of practice, and
- guiding registered nurses in determining activities that may and may not be delegated and/or assigned, and
- guiding registered nurses in determining who among the available work force may perform certain nursing acts, and
- guiding employers when developing policies relating to provision of nursing care.

Scope of practice for a provider of nursing care should be built on a solid foundation of beginning, entry-level practice.

Registered nurses and licensed practical nurses should concentrate on performance of entry level skills during the first six (6) to twelve (12) months of practice.

*** NURSING PRACTICE ASSIGNED TO UNLICENSED ASSISTIVE PERSONNEL IS LIMITED TO PERFORMANCE OF THE BASIC NURSING CARE SERVICES, SUCH AS TAKING VITAL SIGNS, PROVIDING PERSONAL HYGIENE, COMFORT, NUTRITION, AMBULATION AND ENVIRONMENTAL SAFETY AND PROTECTION. UNLICENSED WORKERS ARE **PROHIBITED** FROM PERFORMING ANY LICENSED NURSING FUNCTION THAT IS SPECIFICALLY DEFINED FOR LICENSED NURSES IN THE NURSING PRACTICE ACTS OR RULES OF THE BOARDS OF NURSING, EXCEPT AS SPECIFICALLY PROVIDED IN WV CODE §16-5O-1 ET.SEQ..

THERE IS A NEED AND A PLACE FOR COMPETENT, APPROPRIATELY SUPERVISED, UNLICENSED ASSISTIVE PERSONNEL IN THE DELIVERY OF AFFORDABLE, QUALITY HEALTH CARE. HOWEVER, IT MUST BE REMEMBERED THAT UNLICENSED ASSISTIVE PERSONNEL ARE TO **ASSIST—NOT REPLACE—THE NURSE**. THUS, UNLICENSED ASSISTIVE PERSONNEL SHOULD BE ASSIGNED TO THE NURSE TO ASSIST WITH PATIENT CARE RATHER THAN BE INDEPENDENTLY ASSIGNED TO THE PATIENTS.

REGISTERED NURSE RESPONSIBILITY AS A SUPERVISOR OF DELEGATED OR ASSIGNED ACTIVITIES

The focus of registered professional nursing is on the application of substantial specialized knowledge, judgment and nursing skill in the assessment, analysis, planning, implementation and evaluation of nursing care. The registered nurse is responsible and accountable for:

a. Clinical decision making regarding nursing care

b. Assuring that care is provided in a safe and competent manner

c. Determining which nursing acts in the implementation of care can be delegated or assigned and to whom

d. Providing direction and assistance, periodic observation and evaluation of effectiveness of acts performed by those under supervision

Only those nursing activities commensurate with the educational preparation and demonstrated ability of the person who will perform the act may be delegated or assigned.

FIVE RIGHTS OF DELEGATION/ASSIGNMENT

1. RIGHT TASK
   One that is delegable or assignable for a specific patient.

2. RIGHT PERSON
   Right person is delegating or assigning the right task to the right person to be performed on the right person.

3. RIGHT DIRECTION/COMMUNICATION
   Clear, concise description of the task, including its objective, limits and expectations.

4. RIGHT SUPERVISION
   Appropriate monitoring, evaluation, intervention, as needed and feedback.

5. RIGHT CIRCUMSTANCES
   Appropriate patient setting, available resources, etc.

GUIDELINES FOR DELEGATION OF NURSING ACTS TO THE LICENSED PRACTICAL NURSE.

The decision to delegate should be consistent with the time-honored and well established nursing process, i.e., appropriate assessment, planning, implementation and evaluation by the nurse delegator. This necessarily precludes a complete listing of tasks that can be routinely and uniformly delegated for all patients in all situations. Rather, the nursing process and decision to delegate must be based on careful analysis of the patient and circumstances. The authority and qualifications of the proposed nurse delegator are critical to delegation decisions. The Five Rights of Delegation may facilitate appropriate delegation decisions. Consequences of error and patient health and safety must be evaluated with each decision.

1. Delegation of acts beyond those taught in the basic educational program for the LPN should be based on a conscious decision of the registered nurse.

- Practice beyond entry level for the LPN should not be automatic nor should it be based solely on length of experience.

2. Practice beyond entry level **must** be competency based.

- Competency based practice is defined by structured educational activities which include assessment of learning and demonstration of skills.

3. Records of educational activities designed to enhance entry level knowledge, skill and ability **must** be maintained.

- The employer and the employee must maintain records which include an outline of the educational content and an evaluation of achievement of educational objectives and demonstrated skills.

4. Competency based enhancement of practice must be reviewed periodically by the registered nurse.

- Practice beyond the entry level should be more closely supervised.

5. Practice is limited to those activities addressed in the written policies and procedures of the employing agency.

- Job descriptions and employing agency policies should specifically address functions that the LPN will be expected to perform as a part of basic, as well as enhanced practice. Policies should also address the conditions under which the procedures and services are to be performed.

ACTIVITIES THAT MAY BE DELEGATED TO THE LPN

Activities appropriate for delegation should be those that, after careful evaluation by the supervising registered nurse, are expected to contain **only one option**.

That is, the LPN is expected to be able to proceed through the established steps of an activity without encountering an unexpected response or reaction and competence in performance of the activity has been demonstrated.

ACTIVITIES THAT SHOULD NOT BE DELEGATED TO THE LPN

Activities that are not appropriate for delegation to an LPN are those that are likely to present decision making options, requiring in depth assessment and professional judgment in determining the next step to take as the provider proceeds through the steps of the activity.

GUIDELINES FOR ASSIGNMENT OF NURSING ACTS TO UNLICENSED ASSISTIVE PERSONNEL

Appropriate acts for assignment to unlicensed assistive personnel are those acts taught in a basic nurse aide training program which include collecting vital signs, personal hygiene, comfort, nutrition, rehabilitation, safety and protection. Except as specifically provided in law. (WV Code §16-50-1 et.seq.)

ACTIVITIES THAT MAY BE ASSIGNED TO AN UNLICENSED PERSON

Activities appropriate for assignment to an unlicensed person should be those tasks relating to personal hygiene, ambulation and body movement, nutrition, elimination and maintenance of a safe environment for stable, uncomplicated clients. Tasks delegated should not have potential for jeopardizing client welfare and should not require nursing judgment. Except as specifically provided in law. (WV Code §16-50-1 et.seq.)

ACTIVITIES THAT SHOULD NOT BE ASSIGNED TO AN UNLICENSED PERSON

Activities that are not appropriate for assignment to an unlicensed person are those that require nursing judgment and skill and have substantial potential to jeopardize client safety and welfare. Except as specifically provided in law. (WV Code §16-50-1 et.seq.)

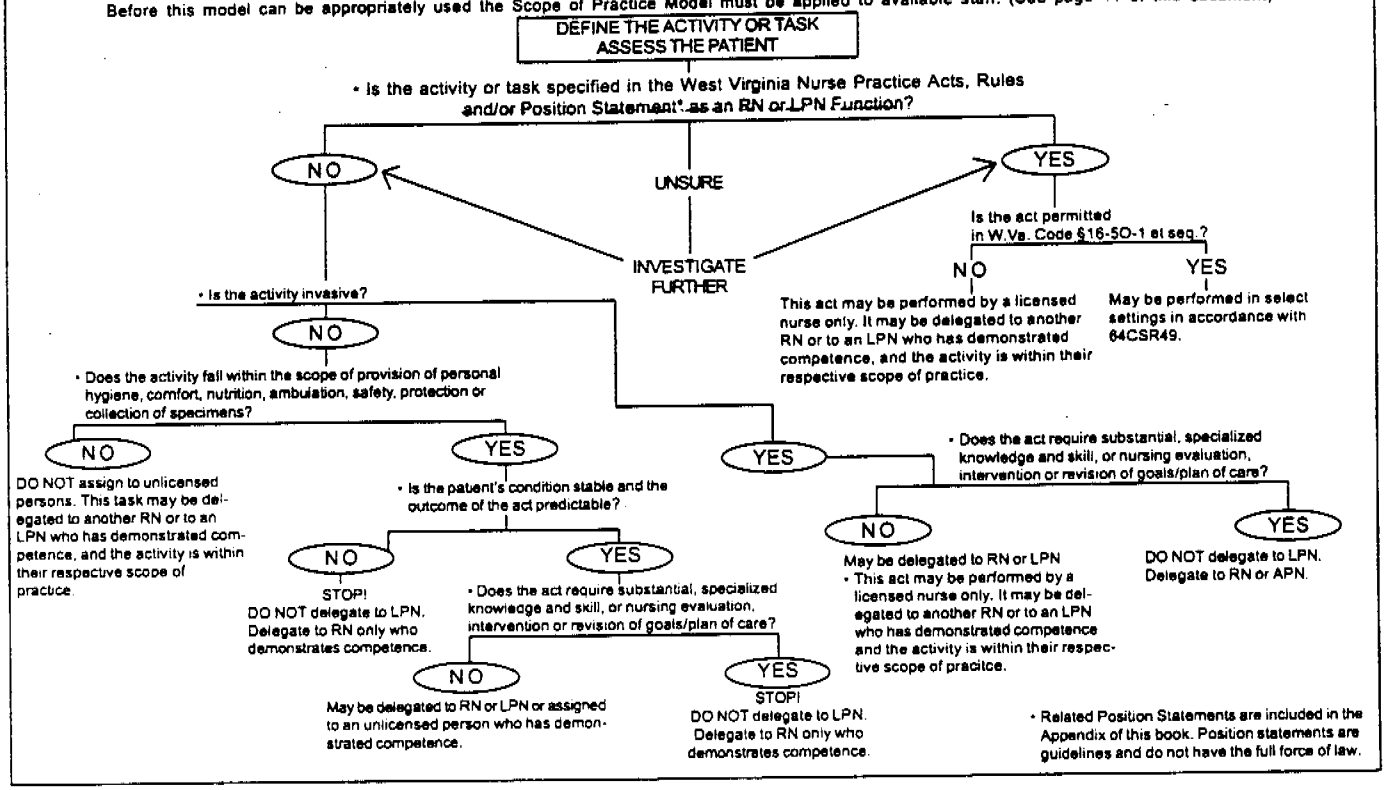
CLIENT SELF-CARE

The performance of nursing acts by the client for self-care or by the client's family members does not constitute delegation or assignment of nursing acts to unlicensed personnel for compensation. Client and family education is a part of nursing practice. Nurses may teach and supervise the performance of activities by clients and family members who have demonstrated a willingness and an ability to perform the activity.

NOTE: A Delegation/Assignment Decision Model follows

DELEGATION/ASSIGNMENT DECISION MODEL

Before this model can be appropriately used the Scope of Practice Model must be applied to available staff. (See page 11 of this document)

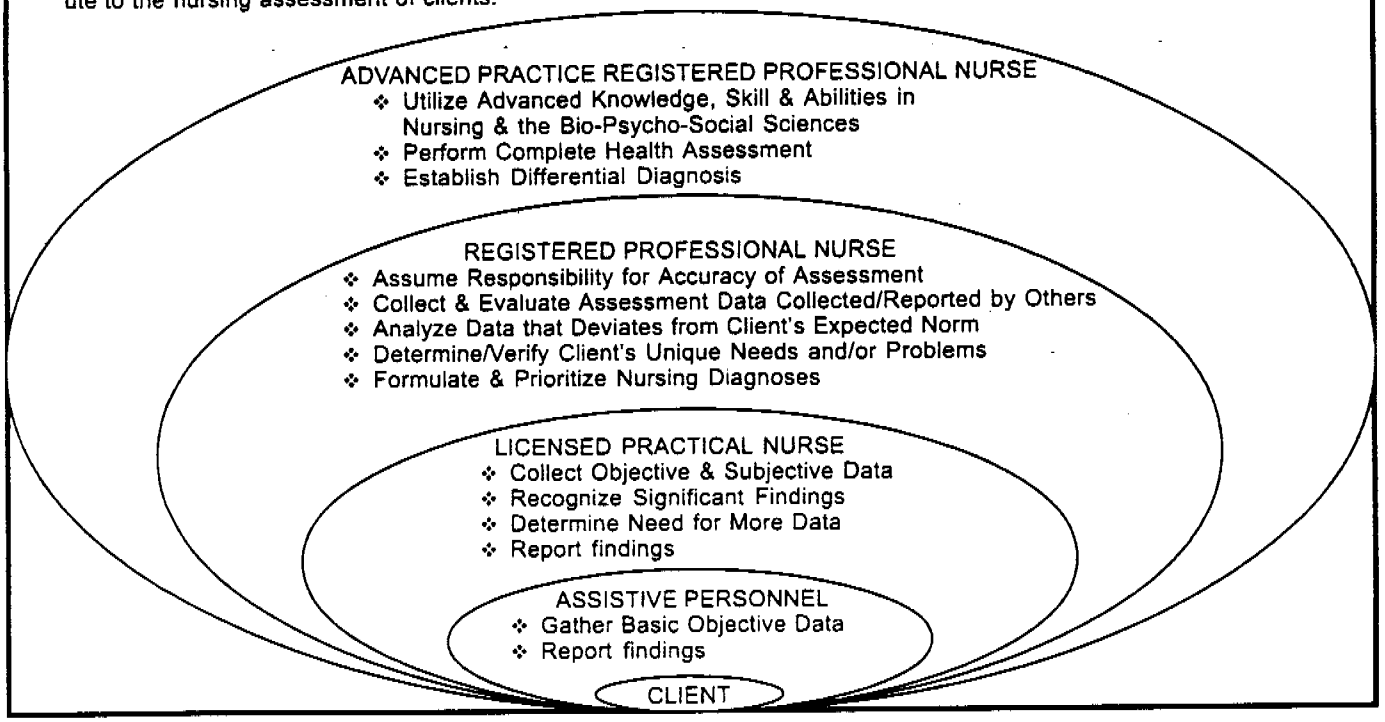


• Related Position Statements are included in the Appendix of this book. Position statements are guidelines and do not have the full force of law.

APPENDIX

ASSESSMENT FRAMEWORK FOR LEVELS OF NURSING CARE PROVIDERS

Assessment framework for levels of nursing care providers identifies the roles of various individuals who contribute to the nursing assessment of clients.



Appendix B

WEST VIRGINIA BOARD OF EXAMINERS
FOR REGISTERED PROFESSIONAL NURSES
101 Dee Drive
Charleston, West Virginia 25311-1620

POSITION STATEMENT

THE ROLE OF THE REGISTERED PROFESSIONAL NURSE AND THE LICENSED PRACTICAL NURSE IN INTRAVENOUS THERAPY

In response to the numerous inquiries the Board has received concerning the role of the practical nurse in the administration of intravenous therapy and in the management of the patient receiving intravenous therapy the Board issues the following clarification of its position statement.

The registered nurse is responsible and accountable for the administration and clinical management of intravenous therapy. The registered nurse may delegate selected activities associated with the administration and management of intravenous therapy to a licensed practical nurse qualified by education and experience. The delegation of these activities is based upon the registered nurse's judgement, policy and procedure of the institution and standards of nursing practice.

A 1982 opinion from the West Virginia Attorney General's office states: "Inherent in the definition of the registered professional nurse is the responsibility for administration (management) of the application of all nursing procedures, including intravenous therapy. The licensed practical nurse may, under the direction of a registered professional nurse, perform selected acts, which could conceivably include procedural aspects of intravenous therapy . However, performance of procedural aspects of intravenous therapy by a licensed practical nurse does not relieve the registered professional nurse of responsibility provided for in law, for assigning the procedure to the licensed practical nurse. (underscoring provided for emphasis.) The registered nurse must know that the licensed practical nurse has the appropriate education and demonstrable skills to perform the act. Regardless of who performs the act or procedure, the registered professional nurse retains the responsibility for supervision of the patient, including observation of symptoms and reactions and supervisions of other persons (including the LPN) with respect to application of nursing procedures."

The above statement is a reprint of a Position Statement provided by the Board in March, 1983, Revised December 4, 1989 and printed in the RN Newsletter Spring, 1990; Reviewed and Reaffirmed, June 14, 1999.

ARTICLE 50.

MEDICATION ADMINISTRATION BY UNLICENSED PERSONNEL.

§ 16-50-1. Short title.

This article may be cited as the "Medication Administration by Unlicensed Personnel Act." (1997, c. 101.)

§ 16-50-2. Definitions.

As used in this article, unless a different meaning appears from the context, the following definitions apply:

(a) "Administration of medication" means:

(1) Assisting a person in the ingestion, application or inhalation of medications, including prescription drugs, or in the use of universal precautions rectal or vaginal insertion of medication, according to the legibly written printed directions of the attending physician or authorized practitioner, or as written on the prescription label; and

(2) Making a written record of such assistance with regard to each medication administered, including the time, route and amount taken: Provided, Thus for purposes of this article, "administration" does not include judgement evaluations, assessments, injections of medication, monitoring of medication self-administration of medications, including prescription drugs and self injection of medication by the resident.

(b) "Authorizing agency" means the department's office of health facility licensure and certification.

(c) "Department" means the Department of Health and Human Resources.

(d) "Facility" means an ICF/MR, a personal care home, residential board and care home, behavioral health group home, private residence in which health care services are provided under the supervision of a registered nurse or an adult family care home that is licensed by or approved by the department.

(e) "Facility staff member" means an individual employed by a facility but does not include a health care professional acting within the scope of a professional license or certificate.

(f) "Health care professional" means a medical doctor of osteopathy, a podiatrist, registered nurse, practical nurse, registered nurse practitioner,

physician's assistant, dentist, optometrist or respiratory care professional licensed under chapter thirty [§ 30-1-1 et seq.] of this code.

(g) "ICF/MR" means an intermediate care facility for the mentally retarded which is certified by the department.

(h) "Medication" means a drug, as defined in section one hundred one [§ 60A-1-101], article one, chapter sixty-a of this code, which has been prescribed by a duly authorized health care professional to be ingested through the mouth, applied to the outer skin, eye or ear, or applied through nose drops, vaginal or rectal suppositories.

(i) "Registered professional nurse" means a person who holds a valid license pursuant to article seven [§ 30-7-1 et seq.], chapter thirty of this code.

(j) "Resident" means a resident of a facility.

(k) "Secretary" means the secretary of the Department of Health and Human Resources or his or her designee.

(l) "Self-administration of medication" means the act of a resident, who is independently capable of reading and understanding the labels of drugs ordered by a physician, in opening and accessing prepackaged drug containers, accurately identifying and taking the correct dosage of the drugs as ordered by the physician, at the correct time and under the correct circumstances.

(m) "Supervision of self-administration of medication" means a personal service which includes reminding residents to take medications, opening medication containers for residents, reading the medication label to residents, observing residents while they take medication, checking the self administered dosage against the label on the container and reassuring residents that they have obtained and are taking the dosage as prescribed. (1997, c. 101.)

§ 16-50-3. Administration of medications in facilities.

(a) The secretary is authorized to establish and implement a program for the administration of medications in facilities. The program shall be developed and conducted in cooperation with the appropriate agencies, advisory bodies and boards.

(b) Administration of medication pursuant to this article shall be performed only by:

(1) Registered professional nurses;

(2) Other licensed health care professionals; or

(3) Facility staff members who have been trained and retrained every two years and who are subject to the supervision of and approval by a registered professional nurse.

(c) Subsequent to assessing the health status of an individual resident, a registered professional nurse, in collaboration with the resident's attending physician and the facility staff members, may recommend that the facility authorize a facility staff member to administer medication if the staff member:

(1) Has been trained pursuant to the requirements of this article;

(2) Is considered by the registered professional nurse to be competent;

(3) Consults with the registered professional nurse or attending physician on a regular basis; and

(4) Is monitored or supervised by the registered professional nurse.

(d) Nothing in this article may be construed to prohibit any facility staff

member from administering medications or providing any other prudent emergency assistance to aid any person who is in acute physical distress or requires emergency assistance.

(e) Supervision of self-administration of medication by facility staff members who are not licensed health care professionals may be permitted in certain circumstances, when the substantial purpose of the setting is other than the provision of health care. (1997, c. 101.)

§ 16-50-4. Exemption from licensure; statutory construction.

(a) Any individual who is not otherwise authorized by law to administer medication may administer medication in a facility if he or she meets the requirements and provisions of this article. Any person who administers medication pursuant to the provisions of this article shall be exempt from the licensing requirements of chapter thirty [§ 30-1-1 et seq.] of this code.

(b) All licensed health care professionals as defined in this article remain subject to the provisions of their respective licensing laws.

(c) Notwithstanding any other provision of law to the contrary, the provisions of this article shall not be construed to violate or be in conflict with any of the provisions of articles seven or seven-a [§ 30-7-1 et seq. or § 30-7A-1 et seq.], chapter thirty of this code. (1997, c. 101.)

§ 16-50-5. Instruction and training.

(a) The office of health facility licensure and certification shall establish a council of nurses to represent the facilities and registered professional nurses affected by the provision of this article. The council of nurses shall prepare a procedural manual and recommendations regarding a training course to the secretary of the department of health and human resources. The council shall meet every two years to review the training curricula, competency evaluation procedures and rules implemented by the secretary, and shall make recommendations as deemed necessary.

(b) The department shall develop and approve training curricula and competency evaluation procedures for facility staff members who administer medication pursuant to the provisions of this article. The department shall consider the recommendations of the council of nurses and shall consult with the West Virginia board of examiners for registered nurses in developing the training curricula and competency evaluation procedures.

(c) The program developed by the department shall require that any person who applies to act as a facility staff member authorized to administer medications pursuant to the provisions of this article shall:

(1) Hold a high school diploma or general education diploma;

(2) Be trained or certified in cardiopulmonary resuscitation and first aid;

(3) Participate in the initial training program developed by the department;

(4) Pass a competency evaluation developed by the department; and

~~(5) Subsequent to initial training and evaluation, participate~~ in a retraining program every two years.

(d) Any facility may offer the training and competency evaluation program developed by the department of its facility staff members. The training and com-

petency programs shall be provided by the facility through a registered professional nurse.

(e) A registered nurse who is authorized to train facility staff members to administer medications in facilities shall:

(1) Possess a current active West Virginia license is good standing to practice as a registered nurse;

(2) Have practiced as a registered professional nurse in a position or capacity requiring knowledge of medications for the immediate two years prior to being authorized to train facility staff members; and

(3) Be familiar with the nursing care needs of residents of facilities as described in this article. (1997, c. 101.)

§ 16-50-6. Availability of records; eligibility requirements of facility staff.

(a) Any facility which authorizes unlicensed staff members to administer medications pursuant to the provisions of this article shall make available to the authorizing agency a list of the individual facility staff members authorized to administer medications.

(b) A facility may permit a facility staff member to administer medications in a single specific agency only after compliance with all of the following:

(1) The staff member has successfully completed a training program and received a satisfactory competency evaluation as required by the provisions of this article;

(2) The facility determines there is no statement on the state administered nurse aide registry indicating that the staff member has been the subject of finding of abuse or neglect of a long-term care facility resident or convicted of the misappropriation of such a resident's property;

(3) The facility staff member has had a criminal background check or if applicable, a check of the state police abuse registry, establishing that the individual has been convicted of no crimes against person or drug related crimes;

(4) The medication to be administered is received and maintained by the facility staff member in the original container in which it was dispensed by a pharmacist or the prescribing health care professional; and

(5) The facility staff member has complied with all other applicable requirements of this article, the rules adopted pursuant to this article and such other criteria, including minimum competency requirements, as are specified by the authorizing agency. (1997, c. 101.)

§ 16-50-7. Oversight of medication administration by unlicensed personnel.

(a) Each facility in which medication is administered by unlicensed personnel shall establish in policy an administrative monitoring system. The specific requirements of the administrative policy shall be established by the department through rules proposed pursuant to section eleven [§ 16-50-11] of this article.

(b) Monitoring of facility staff members authorized pursuant to this article shall be performed by a registered professional nurse employed or contracted by the facility. (1997, c. 101.)

§ 16-50-8. Withdrawal of authorization.

The registered professional nurse who monitors or supervises the facility staff members authorized to administer medication pursuant to this article may withdraw authorization for a facility staff member if the nurse determines that the facility staff member is not performing medication administration in accordance with the training and written instruction. The withdrawal of the authorization shall be documented and shall be relayed to the facility and the department in order to remove the facility staff member from the list of authorized individuals. (1997, c. 101.)

§ 16-50-9. Fees.

The department may set and collect fees necessary for the implementation of the provisions of this article pursuant to rules authorized by section eleven [§ 16-50-11] of this article. (1997, c. 101.)

§ 16-50-10. Limitations on medication administration.

The following limitations apply to the administration of medication by facility staff members:

(a) Injections or any parenteral medications may not be administered:

(b) Irrigations or debriding agents used in the treatment of a skin condition or minor abrasions may not be administered;

(c) No verbal medication orders may be accepted, no new medication orders shall be transcribed and no drug dosages may be converted and calculated; and

(d) No medications ordered by the physician or a health care professional with legal prescriptive authority to be given "as needed" may be administered unless the order is written with specific parameters which preclude independent judgment. (1997, c. 101.)

§ 16-50-11. Rules.

The department shall promulgate emergency rules pursuant to the provisions of section fifteen [§ 29A-3-15], article three, chapter twenty-nine-a of this code as may be necessary to implement the provisions of this article. Subsequently, the department may propose rules for legislative approval in accordance with the provisions of article three [§ 29A-3-1 et seq.], chapter twenty-nine-a of this code. (1997, c. 101.)

APPENDIX D

WEST VIRGINIA STATE BOARD OF EXAMINERS FOR LICENSED PRACTICAL NURSES

The following are statements originally issued by West Virginia State Board of Examiners for Licensed Practical Nurses in June, 1977, in response to frequent requests.

Administration of Intravenous Fluids

The law in West Virginia is not specific in that duties that may be performed by a licensed practical nurse are not listed. The West Virginia State Board of Examiners for Licensed Practical Nurses can only recommend that licensed practical nurses perform duties and procedures for which training has been provided during the 12 month training program. The administration of I.V. fluids is not a part of the standard curriculum for accredited schools of practical nursing in West Virginia. However, if written hospital policy permits, additional training has been received and can be verified, providing there is adequate supervision and the licensed practical nurse is willing to accept responsibility, it is not illegal for a licensed practical nurse to perform more difficult procedures, such as administration of I.V. fluids.

Verbal and Telephone Orders

The West Virginia State Board of Examiners for Licensed Practical Nurses does not have a specific policy or rule in reference to this procedure. The following rules, however, apply in specific practice settings and under selected circumstances:

General Hospitals: 64 CSR 12, West Virginia Legislative Rules, Department of Health and Human Resources, Hospital Licensure, 1994, section 10.3.8 states in part "Verbal and telephone orders shall be given to licensed or registered health care professionals in the area of training and professional expertise of the individuals, if authorized by the medical staff policies: Provided, however, that any verbal or telephone order may be given to a registered professional nurse".

Nursing Homes: 64 CSR 13, Legislative Rules, Department of Health and Human Resources, Nursing Home Licensure, 1997, section 11.4.b. states in part "A physician's verbal or telephone order for medications or treatments may be received only by a licensed nurse". This rule appears to permit both registered professional nurses and licensed practical nurses to take verbal or telephone orders in a nursing home. A second rule, 9.7.a. states in part "Any accident or change in a resident's condition shall be reported immediately to a registered professional nurse who shall notify the attending physician".

Other Work Settings: Consult policies of the employer and rules of appropriate accrediting or certifying agencies to determine whether the L.P.N. may take verbal or telephone orders.

(IVTHERAP): Approved: 6/77
Revised and reaffirmed: 2/89, 2/90, 6/93, 6/94, 10/98

APPENDIX E

DELEGATION BY SCHOOL NURSES OF ADMINISTRATION OF MEDICATION IN EMERGENCY SITUATIONS

The West Virginia Board of Examiners for Registered Professional Nurses has considered two separate inquiries related to the authority of certified school nurses to delegate the administration of student medications to a teacher or other school employee. After reviewing the questions and available information, the Board offers the following guidance:

Under ideal circumstances, a nurse should be physically present in each school, or at least in each school in which a child requiring performance of specialized nursing functions is educated. Again under ideal circumstances, a Registered Professional Nurse should be responsible for the administration of all medications to children who require medication during the school day. The Board recognizes that these ideal circumstances do not yet exist. While practices may be developed to enable a minimum standard for safe care to be met, it is not the Board's intent to advocate anything less than the highest possible standard of care.

Injectable Medications (emergent):

It is recognized that particular health problems may precipitate emergency situations requiring immediate treatment. Emergency situations are situations which cannot be predicted to occur at a particular time, or with a great degree of regularity, and which require definitive treatment within a very narrow period of minutes to avoid severe and perhaps permanent harm. Specific health problems or illnesses may create a high likelihood of the occurrence of such emergencies; to this extent, the emergency may be "predictable" because the underlying illness predisposes to its occurrence.

For students in whom there is a predisposition to an emergency health problem, including but not limited to profound hypoglycemia in the student known to be a diabetic, or anaphylactic reaction in the student with a history of such reaction, it is acceptable for the certified school nurse to delegate administration of medications used to treat such emergencies to qualified professional school employees, to provide for the safety of the student. Such delegation, consistent with the general guidelines set forth above, must be at the absolute discretion of the certified school nurse.

As the general discussion indicates, a written request and baseline information should be submitted by the parent(s), signed by the physician. In addition to training related to the illness and the medication, the designee who will administer the medication should demonstrate understanding of additional information. Additional understanding must include a clear comprehension of the indications for administration of the emergency medication, ability to perform an appropriate assessment to determine the need for the emergency medication, demonstrate and verbalization of proper preparation and administration of the emergency medication, and knowledge of responses to the medication. The designee who will administer the emergency medication should also understand that, in any instance that such medication is given, the student must be entered into the formal health care system for evaluation and

follow up, most likely by utilization of the "911" or other emergency medical response system. Documentation of events preceding the medication, during administration, and the time and personnel that assume care of the student following the episode should be completed as soon as possible after care for the student has been assumed by emergency medical or other health care personnel. Documentation should be delayed until it is clear that the professional school employee is no longer required to assist in providing care to or information regarding the student.

Issued: March, 1993; Revised and Reaffirmed March 21, 1996; June 14, 1999.

APPENDIX F

POSITION STATEMENT
EMERGENCY MEDICAL SERVICE PERSONNEL
EMPLOYED IN HOSPITAL EMERGENCY DEPARTMENTS

Consistent with applicable law, the West Virginia Board of Examiners for Registered Professional Nurses is issuing this statement to direct Registered Professional Nurses who work with Emergency Medical Services personnel in hospital settings, including hospital Emergency Departments. Registered Professional Nurses are not authorized to delegate professional duties to Emergency Medical Services personnel.

Professional nursing functions, including tasks which require assessment, planning, and professional judgement, must remain the responsibility of the Registered Professional Nurse. The Registered Professional Nurse must not delegate professional functions to caregivers not qualified as professional nurses.

Registered Professional Nurses, including those nurses that practice in emergency settings, must recognize their specialized skill and expertise, and seek to deliver no less than that high level of skill and expertise to any patient/client that comes within their care. To delegate professional nursing functions on the premise that they represent mere "tasks" belies the practice and professionalism of the registered nurse; while performing a "task", a registered nurse is also educating, assessing, reassuring, and planning. To delegate the mere "task" fails to also assign responsibility for the concurrent functions, and thus deprives the patient of the fullest scope of qualified emergency care.

Laws that establish pre-hospital practice standards for Emergency Medical Services personnel cannot be presumed to authorize comparable practice in the hospital Emergency Department. The emphasis and standard of care changes when the patient/client travels from the pre-hospital to the hospital setting. Practice standards which authorize certain pre-hospital care, often to save life or limb, cannot be considered to meet the higher standard of care which applies once the patient has been received in a hospital or other facility, in which additional resources and personnel are available.

Patient care in the Emergency Department must be coordinated by a Registered Professional Nurse, who defines the standards of care and scope of practice for all nursing and assistive personnel. While other participants in the health care process may provide assistance in defining the role(s) of the non-RN caregiver in the Emergency Department, the final responsibility for delegating patient care activities must remain with the Registered Professional Nurse who serves as Department Manager/Coordinator.

This statement represents the consistent position of the West Virginia Board of Examiners for Registered Professional Nurses. It is issued at present not to represent a change, but because it has come to the attention of the Board that confusion may exist in this area.

Issued: March 19, 1993; Reviewed and Reaffirmed, March 21, 1996; December 4, 1998.

APPENDIX G

PORTION OF TITLE 10 LEGISLATIVE RULES WEST VIRGINIA STATE BOARD OF EXAMINERS FOR LICENSED PRACTICAL NURSES SERIES 1
POLICIES AND PROCEDURES FOR DEVELOPMENT AND MAINTENANCE OF EDUCATIONAL PROGRAMS IN PRACTICAL NURSING

8.3 Curriculum content

8.3.1 The faculty may make major curriculum changes only after written consultation with the Board's Executive Secretary or the Board.

8.3.2 The master plan shall provide evidence that the curriculum is designed to meet the objectives of the program and shall identify that:

(a) classroom and clinical instruction meet the physical and psychosocial needs of all age groups;
(b) concurrent learning experiences in theory and clinical practice emphasize basic nursing principles and procedures related to nursing;
(c) clinical practice begins the third week of the program to facilitate concurrent learning;
(d) basic concepts of nutrition, anatomy, physiology, pharmacology, mental health, communications, history and trends in nursing, vocational responsibilities and family living are integrated into the program;
(e) learning is arranged to progress from simple procedures to complex procedures; and
(f) clinical instruction is included for all medical, surgical, geriatric, mental health, maternal infant care, and pediatric areas.

The faculty shall utilize acute, long-term and community health facilities and agencies in the program if appropriate learning experiences are available. The faculty shall utilize specialty areas, such as intensive care, coronary care and emergency rooms in the program only with faculty supervision and after providing written justification to the Board.

8.4 The Board suggests the following subjects and instructional hours.

Subject	Actual Instructional Time
Principles and Fundamentals	200
Social Science Integrated	150
Body Structure	60
Nutrition and Diet Therapy	40
Pharmacology	80
Medical-Surgical	450
Geriatrics	100
Mental Health	100
Obstetrics	60
Pediatrics	60
Total Instructional Hours	1,300

The faculty shall devote not less than one fourth (1/4) nor more than one half (1/2) of the actual instructional time to theory unless faculty provide written justification to the Board and the variation is approved by the Board.

APPENDIX H

DEFINITIONS OF PRACTICE

REGISTERED PROFESSIONAL NURSE - LICENSED PRACTICAL NURSE

(1) Registered Professional Nurse:

The practice of "registered professional nursing" shall mean the performance for compensation of any service requiring substantial specialized judgment and skill based on knowledge and application of principles of nursing derived from biological, physical and social sciences, such as responsible supervision of a patient requiring skill in observation of symptoms and reactions and the accurate recording of the facts, or the supervision and teaching of other persons with respect to such principles of nursing, or in the administration of medications and treatments as prescribed by a licensed physician or a licensed dentist, or the application of such nursing procedures as involve understanding of cause and effect in order to safeguard life and health of a patient and others. (Code of WV 30-7-1)

(2) Licensed Practical Nurse:

The term "practical nursing" means the performance for compensation of selected nursing acts in the care of the ill, injured or infirm under the direction of a registered professional nurse or licensed physician or a licensed dentist, and not requiring the substantial specialized skill, judgment and knowledge required in professional nursing. (Code of WV 30-7A-1)

APPENDIX I

TITLE 19
LEGISLATIVE RULES
WEST VIRGINIA BOARD OF EXAMINERS FOR REGISTERED PROFESSIONAL NURSES

SERIES 10

STANDARDS FOR PROFESSIONAL NURSING PRACTICE

§19-10-1. General.

1.1 Scope.- This rule establishes standards for safe practice for the registered professional nurse, and serves as a guide for the Board in evaluating nursing care to determine if it is safe and effective.

1.2 Authority.-W.Va Code § 30-7-4

1.3 Filing Date.- March 31, 1994.

1.4 Effective Date.- April 1, 1994.

§19-10-2 Standards Related to the Registered Professional Nurse's Responsibility to Implement the Nursing Process.

2.1 The registered professional nurse shall conduct and document nursing assessments of the health status of individuals and groups by:

2.1.1 Collecting objective and subjective data from observations, examinations, interviews, and written records in an accurate and timely manner. The data includes but is not limited to:

2.1.1.a The client's knowledge and perception about health status and potential, or maintaining health status;

2.1.1.b Consideration of the client's health goals;

2.1.1.c The client's biophysical and emotional status;

2.1.1.d The client's growth and development;

2.1.1.e The client's cultural, religious and socioeconomic background;

2.1.1.f The client's ability to perform activities of daily living;

2.1.1.g The client's patterns of coping and interacting;

2.1.1.h Environmental factors (e.g. physical, social,emotional and ecological);

2.1.1.i Available and accessible human and material resources;

2.1.1.j The client's family health history; and

2.1.1.k The information collected by other health team members.

2.1.2 Sorting, selecting, reporting and recording the data: and,

2.1.3 Continously validating, refining and modifying the data by utilizing all available resources, including interaction with the client, the

client's family and significant others, and health team members.

2.2 The registered professional nurse shall establish and document nursing diagnoses and/or client care needs which serve as the basis for the plan of care.

2.3 The registered professional nurse shall identify expected outcomes individualized to the client and set realistic and measurable goals to implement the plan of care.

2.4 The registered professional nurse shall develop and modify the plan of care based on assessment and nursing diagnosis and/or patient care needs. This includes:

2.4.1 Identifying priorities in the plan of care;

2.4.2 Prescribing nursing intervention(s) based upon the nursing diagnosis and/or patient care needs;

2.4.3 Identifying measures to maintain comfort, to support human functions and responses, to maintain an environment conducive to well being, and to provide health teaching and counseling.

2.5 The registered professional nurse shall implement the plan of care by:

2.5.1 Initiating nursing interventions through:

2.5.1.a Writing nursing orders and/or directives;

2.5.1.b Providing direct care;

2.5.1.c Assisting with care; and

2.5.1.d Delegating and supervising nursing care activities;

2.5.2 Providing an environment conductive to safety and health;

2.5.3 Documenting nursing interventions and responses to care; and

2.5.4 Communicating nursing interventions and responses to care to other members of the health care team.

2.6 The registered professional nurse shall evaluate patient outcomes and the responses of individuals or groups to nursing interventions. Evaluation shall involve the client, the client's family and significant others, and health team members.

2.6.1 Evaluation data shall be documented and communicated to other members of the health care team.

2.6.2 Evaluation data shall be used as a basis for reassessing the client's health status, modifying nursing diagnosis and/or patient care needs, revising plans of care, and prescribing changes in nursing interventions.

§19-10-3 Standards Related to the Registered Professional Nurse's Responsibility as a Member of the Nursing Profession.

3.1 The registered professional nurse shall know the status and rules governing nursing and function within the legal boundaries of nursing practice.

3.2 The registered professional nurse shall accept responsibility for his or her individual nursing actions and competence.

3.3 The registered nurse shall obtain instruction and supervision as necessary when implementing nursing techniques or practices.

3.4 The registered professional nurse shall function as a member of the health care team.

3.5 The registered professional nurse shall collaborate with other members of the health team to provide optimum patient care.

3.6 The registered professional nurse shall consult with nurses and other health team members and make referrals as necessary.

3.7 The registered professional nurse shall contribute to the formulation, interpretation, implementation and evaluation of the objectives and policies related to nursing practice within the employment setting.

3.8 The registered professional nurse shall participate in the systematic evaluation of the quality and effectiveness of nursing practice.

3.9 The registered professional nurse shall report unsafe nursing practice to the Board and unsafe practice conditions to recognized legal authorities.

3.10 The registered professional nurse shall delegate to another only those nursing measures which that person is prepared or qualified to perform.

3.11 The registered professional nurse shall supervise others to whom nursing interventions are delegated.

3.12 The registered professional nurse shall retain professional accountability for nursing care when delegating nursing interventions.

3.13 The registered professional nurse shall conduct practice without discrimination on the basis of age, race, religion, gender, sexual preference, socio-economic status, national origin, handicap, or disease.

3.14 The registered professional nurse shall respect the dignity and rights of clients regardless of social or economic status, personal attributes, or nature of the client's health problems.

3.15 The registered professional nurse shall respect the client's right to privacy by protecting confidential information unless obligated by law to disclose the information.

3.16 The registered professional nurse shall respect the property of clients, family, significant others, and the employer.

3.17 The registered professional nurse assuming advanced practice shall be qualified to do so through education and experience as set forth in West Virginia Code 30-7-1 et seq. and the rule governing Announcement of Advanced Practice, 19 WV CSR 7.

APPENDIX J

10 CSR 3

TITLE 10
LEGISLATIVE RULES
STATE BOARD OF EXAMINERS
FOR LICENSED PRACTICAL NURSES
SERIES 3

LEGAL STANDARDS OF NURSING PRACTICE FOR THE LICENSED PRACTICAL NURSE

§10-3-1. General.

1.1. Scope. -- This legislative rule establishes minimum standards of safe practice of the Licensed Practical Nurse.

1.2. Authority. -- WV Code §30-7A-5

1.3. Filing Date. -- May 6, 1997

1.4. Effective Date. -- June 1, 1997

§10-3-2. Purpose of Standards.

The purpose of this rule is:

2.1. To establish minimum acceptable levels of nursing practice for the Licensed Practical Nurse; and

2.2. To serve as a guide for the Board to evaluate the practice of the Licensed Practical Nurse to determine if the practice is safe and effective.

§10-3-3. Standards Related to the Licensed Practical Nurses' Contribution to, and Responsibility for, the Nursing Process.

The Licensed Practical Nurse practicing under the direction of a Registered Professional Nurse, licensed physician or licensed dentist shall:

3.1. Contribute to the nursing assessment by collecting, reporting and recording objective and subjective data in an accurate and timely manner. Data collection includes, but is not limited to observations of:

3.1.1. the condition or change in condition of a client; and

3.1.2. signs and symptoms of deviation from normal health status;

3.2. Participate in the development of the strategy of care in consultation with other nursing personnel. Participation in the development of a strategy of care includes:

3.2.1. contributing to the identification of priorities;

3.2.2. contributing to setting realistic and measurable goals; and

3.2.3. contributing to the selection of nursing interventions which include measures to maintain comfort, support human functions and responses, maintain an environment conductive to well being, and provide health teaching and counseling;

3.3. Provide nursing care under the direction of a registered professional nurse by:

3.3.1. caring for clients whose conditions are stabilized or predictable;

3.3.2. assisting with clients whose conditions are critical and/or fluctuating under the direct supervision of the registered professional nurse;

3.3.3. implementing nursing care according to the priority of needs and established practices;

3.3.4. providing an environment conducive to safety and health;

3.3.5. documenting nursing interventions and responses to care; and

3.3.6. communicating nursing interventions and responses of care to appropriate members of the health team.

3.4. Assign components of nursing care to other qualified persons; and

3.5. Contribute to the evaluation of the responses of individuals and groups to nursing interventions by:

3.5.1. monitoring the responses to nursing interventions;

3.5.2. documenting and communicating assessment data to appropriate members of the health care team; and

3.5.3. contributing to the modification of the strategy of health care on the basis of the assessment data.

§10-3-4. Standards Relating to the Licensed Practical Nurse's Responsibilities as a Member of the Health Care Team.

The Licensed Practical Nurse shall:

4.1. be familiar with the statutes and rules governing nursing;

4.2. function within the legal boundaries of practical nursing practice;

4.3. accept responsibility for individual nursing actions, competencies and behavior;

4.4. function under the direction of a registered professional nurse, licensed physician or licensed dentist;

4.5. consult with the registered professional nurse to seek guidance in delivery of nursing care as necessary;

4.6. obtain instruction and supervision as necessary from the registered professional nurse when implementing nursing techniques or practices;

4.7. supervise and retain accountability for tasks assigned to other qualified persons;

4.8. function as a member of the health team;

4.9. contribute to the formulation, interpretation, implementation and evaluation of the objectives and policies related to practical nursing practice within the employment setting;

4.10. participate in the evaluation of nursing through peer review;

4.11. report unsafe nursing practice to the board and unsafe practice conditions to recognized legal authorities;

4.12. conduct practice without discrimination on the basis of age, race, religion, sex, sexual preference, national origin or handicap;

4.13. respect the dignity and rights of clients regardless of social or economic status, personal attributes or the nature of the health problem;

4.14. respect the client's right to privacy by protecting confidential information, unless obligated by law to disclose the information;

4.15. respect the property of employers, clients and their families; and

4.16. participate in relevant continuing competence activities to maintain current knowledge and skill levels in practical nursing as required in 10 CSR 6, Continuing Competence.

REFERENCES

1. Alaska Board of Nursing, Scope of Practice Licensed Practical Nurse, September 1991.

2. Arizona State Board of Nursing, A Decision-Making Model for Determining RN/LPN Scope of Practice, May 20, 1993.

3. Idaho Board of Nursing, Guidelines for the Delegation of Nursing Activities, August 11, 1994.

4. Kentucky Board of Nursing, Scope of Practice Determination Guidelines, April 1995.

5. National Council of State Board of Nursing, Inc., Professional Accountability - Using the Collaboration Model for the Identification of Strategies for the Promotion of Professional Accountability, 1995.

6. National Council of State Boards of Nursing, Inc., National Council of State Boards of Nursing, Inc., Delegation: Concepts and Decision-Making Process, November 21, 1995.

7. National Council of State Boards of Nursing, Inc., Report of the Task Force to Identify Core Competencies for Nurse Practitioners, 1995.

8. National Council of State Boards of Nursing, Inc., Test Plan for the National Council Licensure Examination for Practical Nurses NCLEX-RN, October 1996 & 1999.

9. National Council of State Boards of Nursing, Inc., Test Plan for the National Council Licensure Examination for Registered Nurses NCLEX-RN, effective Date: April 1995 & 1998.

10. National Council of State Boards of Nursing, Inc., Nurse Aide Competency Evaluation Program (NACEP), Evaluation Blueprint, Effective May 1997.

11. National Council of State Boards of Nursing, Inc., Role Delineation Study: Nursing Activities Performed by Nurses Aides, Licensed Practical/ Vocational Nurses, Registered Nurses and Advanced Practice Registered Nurses, 1995.

12. National Council of State Boards of Nursing, Inc., Job Analysis, Nurse Aides Employed in Nursing Homes, Home Health Care Agencies and Hospitals, 1998.

13. National Council of State Boards of Nursing, Inc., Final Report of the Logical Job Analysis Study of Entry-level Nurse Practitioner Practice and Related Test Plan Development, Chauncey Group International, 1997.

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15. National Council of State Boards of Nursing, Inc., Job Analysis, Newly Licensed Entry-Level Registered Nurses, 1992 & 1996.

16. National Council of State Boards of Nursing, Inc., Summary of Responses to November, 1994 LPN/LVN Scope of Practice Questionnaire, June 12, 1995.

17. Nevada State Board of Nursing, Determining Your Scope of Practice, March 29, 1995.

18. North Dakota Board of Nursing, Decision-Making Model for Determining LPN/RN/APRN Legal Scope of Practice in North Dakota, September 9, 1994.

19. Ohio Board of Nursing, Scope of Practice Decision-Making Model, November 1994.

20. Ohio Board of Nursing, Standards & Delegation: A Guide to Ohio Board of Nursing Rules, April 1, 1998.

21. QUIN Council of Nursing, Guidelines for the Registered Nurse in Determining Scope of Practice, Florida Nurses Association, August 1996.

22. Merriam-Webster's Collegiate Dictionary, Tenth Edition, Merriam-Webster, Inc., 1998.

23. West Virginia Code § 30-7 (RN) and 30-7A (LPN).

24. Legislative Rules Title 19 (RN) and Title 10 (LPN).

25. West Virginia Code and Rules related to health care such as Health Facilities Licensure and Certification (Licensing of hospitals, nursing homes, etc., as well as certification of nursing assistants) ; Education (School Nurse); Board of Pharmacy (appropriate handling of drugs). This reference is not exhaustive.

APPENDIX B

TITLE 126
LEGISLATIVE RULE
WEST VIRGINIA BOARD OF EDUCATION

SERIES 50A
AIDS EDUCATION POLICY (2422.4)

§126-50A-1. General.

1.1. Scope. -- This legislative rule requires establishment of county policies related to AIDS education.

1.2. Authority. -- W. Va. Code §§18-2-5, 18-2-7, 18-2-9, 18-5-15d, 18-5-34.

1.3. Filing Date. -- August 8, 1989.

1.4. Effective Date. -- September 20, 1989.

§126-50A-2. Applicability.

Effective January 1, 1989 each of the fifty-five county boards of education will include AIDS prevention education in subject areas where it is appropriate such as health, science, developmental guidance, and social studies. The goal of this policy is to assist in the protection of students by providing them with the knowledge and skills necessary to avoid behaviors that will put them at risk of infection with the human immunodeficiency virus (HIV).

The rapid spread of this disease makes it necessary to develop policy that will assure that effective AIDS prevention programs are in place.

§126-50A-3. Components.

The following components shall be addressed in each county board policy:

3.1. The integration of AIDS prevention education into health education in grades 6-12 and into other current programs of study such as science, developmental guidance and social studies as deemed appropriate by the county board of education.

3.2. Provision for all school staff to receive inservice training about:

3.2.1. the nature of the AIDS epidemic and means of controlling its spread.

3.2.2. the role of the school in providing education to prevent transmission.

3.3. Assurance that educational personnel responsible for classroom instruction receive staff development that will enable them to implement effective AIDS education.

3.3.1. Assurance that the programs be taught by qualified professionals who periodically participate in staff development activities that will provide current information related to AIDS education.

3.4. Assurance that the program is comprehensive and provides not only knowledge about the disease AIDS, but also has a focus on behaviors and skills necessary to prevent exposure to the virus. Guidelines, such as those published by the Centers for Disease Control in the January 29, 1988, MMWR, should be used in curriculum development.

3.5. Assurance that high school students, who have completed the health and science course requirement for graduation, receive appropriate AIDS prevention education.

3.6. Assurance that parents or guardians may attend staff development.

3.7. Provision for parents/guardians to examine curricular materials and exempt their

child from AIDS instruction by giving written notice to the principal.

§126-50A-4. Policy Implementation.

4.1. Each county should seek assistance of school leaders and community representatives in developing appropriate curricula.

4.2. A completed comprehensive health education curriculum, which includes AIDS education, is to be submitted to the State Superintendent of Schools by July 1, 1989.

4.3. Inclusion of AIDS education in curricular areas such as science, social studies and developmental guidance is warrented to assure total understanding of the disease and its consequences.

4.4. Technical assistance in curriculum development and staff development will be provided by the West Virginia Department of Education upon request.

NOTE: The following document is recommended for use in policy development and curriculum design.

Guidelines for Effective School Health Education to Prevent the Spread of AIDS. MMWR. Vol. 37: No. S-2 Supplement. January 29, 1988. (Published by Centers for Disease Control, Center for Health Promotion and Education. Atlanta, GA 30333).

TITLE 126
LEGISLATIVE RULE
WEST VIRGINIA BOARD OF EDUCATION

SERIES 50B
EXCLUSION OF STUDENTS FROM ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) AND SEXUALLY TRANSMITTED DISEASE (STD) INSTRUCTION IN HEALTH EDUCATION CLASSES (2422.45)

§126-50B-1. General.

1.1. This legislative rule requires that students be excluded from instruction at parents' request.

1.2. Authority. – W. Va. Code §18-2-9.

1.3. Filing Date. -- January 18, 1990.

1.4. Effective Date. -- March 2, 1990.

§126-50B-2. Applicability.

The following policy has been written to assist in the implementation of WV Code §18-2-9, related to exclusion of students from health education class instruction about AIDS and other sexually transmitted diseases. The penalty for non-compliance with the provisions in the law could mean removal from public school employment.

All of the public schools must teach health education which includes instruction in any of grades six through twelve in the prevention, transmission and spread of AIDS and other sexually transmitted diseases. The W.Va. Board of Education approved Health Education Program of Study constitutes the course curriculum requirements. Materials used, including textbooks, should be aligned with learning outcomes. Counties must develop a comprehensive curriculum based on the health learning outcomes.

"An opportunity shall be afforded to the parent or guardian of a child subject to instruction in the prevention, transmission and spread of acquired immune deficiency syndrome and other sexually transmitted diseases to examine the course curriculum requirements and materials to be used in such instruction. The parent or guardian may exempt such child from participation in such instruction by giving notice to that effect in writing to the school principal." (§18-2-9)

§126-50B-3. Components.

Thus, the following shall be instituted:

3.1. Provisions and procedures for parent or guardian review of materials and curriculum shall be made on a county basis.

3.2. A form shall be developed for parents who request that their child be excluded (sample attached). This will assure a clear understanding of how individuals will be handled. The form should include the following information:

a. Health class assignments from which student will be excused.

b. Information that clarifies that an alternate assignment will be given.

c. Information that indicates that annual review of materials and requests for exclusion are necessary.

3.3. Once the parents' request has been received, it is the responsibility of the school principal to communicate this information to all appropriate personnel. The classroom teacher and

other personnel are then responsible for assuring that the parents' request is honored.

3.4. For students who are to be excluded, an alternative learning experience shall be assigned. Credit may not be withheld for students excluded, but completion of alternative assignments is required.

TITLE 126
LEGISLATIVE RULES
BOARD OF EDUCATION

SERIES 23
SUBSTANCE ABUSE POLICY (2422.5)

§126-23-1. General

1.1. Scope - This legislative rule requires establishment of county policies related to use of controlled substances.

1.2. Authority - W. Va. Code §18-2-9

1.3. Filing Date - December 27, 1982

1.4. Effective Date - February 27, 1983

§126-23-2. Applicability

Effective January 1, 1982 each of the fifty-five (55) counties will adopt a controlled substance abuse policy that relates to the well being of the individual students, staff members, and the school population in general. The policy should provide a consistent means for handling drug related difficulties while recognizing the needs and rights of all parties involved, within the confines of the law and sensible judgment.

The potential for substance abuse occurs within many school populations. This problem makes it necessary for counties to develop a policy that is preventive and protective of the health, safety, and welfare of students, faculty, school property, and the educational process.

§126-23-3. Components

The following components shall be addressed in each county's policy

1. general definitions of controlled substances, etc., drugs, alcohol, prescription medication, non-prescription medicine;

2. prevention measures such as instructional programs for K-12 health growth and development (see State Code of West Virginia §18-2-9);

3. corrective measures such as:

a. appropriate and immediate action to be taken, such as notify the principal, the counselor, or the nurse or seek emergency medical care;

b. staff members to be involved in working with substance abuse, such as teacher, principal, counselor, and nurse;

c. notification of parents, as required when a student is to be suspended;

d. notification of law enforcement officals when appropriate;

e. appropriate disciplinary action as determined by county discipline procedures and those in the Rights and Responsibilities of Public School Students in West Virginia;

f. nature of help to be offered or provided, such as drug counseling, modification of the education program or referral to an outside agency;

4. procedures for the development of the policy

Each county should seek the assistance of school personnel and community leaders in developing the substance abuse policy. Technical assistance will be provided by the West Virginia Department of Education to any county making a written request.

Policies are to be submitted to the State Superintendent of Schools for approval on or before January 1, 1982.

126CSR27

TITLE 126
LEGISLATIVE RULE
BOARD OF EDUCATION

SERIES 27
MEDICATION ADMINISTRATION (2422.8)

§126-27-1. General.

1.1. Scope. – This legislative rule establishes standards for administration of all medication in the West Virginia public school system.

1.2. Authority. – W.Va. Constitution, Article XII, §2 and W.Va. Code §§18-1-1, 18-2-5, 18-5-22, 18-5-22a, 18-5-22b, 18A-4-8, and 30-7-1, et seq.

1.3. Filing Date. – April 19, 2004

1.4. Effective Date. – July 1, 2004

1.5. Repeal of Former Rule. – None. This is a new policy.

§126-27-2. Purpose.

2.1. Good health and safety are essential to student learning. The administration of medication to students during the school day should be discouraged unless absolutely necessary for the student's health. Administration of medication during the school day is essential to allow some students to attend school. This policy establishes the standards that must be followed when any medication is required to be administered during attendance at school or school related events and to provide for emergency medication administration, when necessary.

2.2. An objective of this medication administration policy is to promote individual responsibility. This can be achieved by educating students and their families.

§126-27-3. Application.

3.1. These regulations apply to school nurses, administrators, other authorized school employees, contracted school nurses, and contracted licensed health care providers (as specified in W.Va. Code §18-5-22a) administering medication to students in the West Virginia public school system.

3.2. County Boards of Education shall develop or amend medication administration policies to meet or exceed the standards set forth in W.Va. Code §18-5-22a as well as the components set forth in this policy.

3.3. The West Virginia Department of Education (WVDE) may issue and periodically update advisories to provide guidance on the administration of medication to students in the West Virginia public school system.

3.4. This policy shall not impact the operating procedures of School Based Health Centers. It is not the intent of this policy to interfere with existing policies and procedures of health care providers managing School Based Health Centers.

§126-27-4. Definitions.

4.1. "Administration of medication" means a health care procedure, which may be performed by school personnel who are designated, qualified, trained and authorized to administer medications to students.

4.2. "Administrator's designee" means an employee (excluding the school nurse or contracted provider of nursing services) who is designated by the building administrator, is trained to administer non-prescribed medication, and agrees to administer non-prescribed medications.

4.3. "Contracted licensed health care provider" means a licensed health care provider, as set forth in Section 4.6 of this policy, providing health care services under a contract with county boards of education. Health care services may be contracted after the ratio of one nurse for every 1,500 students, kindergarten through seventh grade, is provided to county schools.

4.4. "Contracted school nurse" means an employee of a public health department providing services under a contract with a county board of education to provide services considered equivalent to those required in W.Va. Code §18-5-22.

4.5. "Designated qualified personnel" means an employee or contracted provider who agrees to administer medications, is authorized by the administrator, successfully completes training as defined in West Virginia Board of Education Policy 2422.7 – Standards for Basic and Specialized Health Care Procedures (126CSR25A), hereinafter Policy 2422.7, and is qualified for the delegation of the administration of prescribed medications.

4.6. "Licensed health care provider" means a medical doctor or doctor of osteopathy, podiatrist, registered nurse, practical nurse, registered nurse practitioner, physician assistant, dentist, optometrist, pharmacist or respiratory care professional licensed under Chapter Thirty of W.Va. Code.

4.7. "Licensed prescriber" means licensed health care providers with the authority to prescribe medication.

4.8. "Long-term and Emergency Prescribed Medication" means medication ordered by a licensed prescriber that is used to treat acute and chronic health conditions including both daily and PRN (as needed) medication.

4.9. "Medication document" means the individual medication record or medicine log used to record the administration of medication to a student.

4.10. "Non-prescribed Medication" means medication and food supplements that have been approved by the Food and Drug Administration and may be obtained over-the-counter (OTC) without a prescription from a licensed prescriber.

4.11. "Parent/Guardian Authorization Form" means a form completed and signed by parent/guardian in order to authorize medication administration to said parent's/guardian's child. The form must include the following: student name; date; allergies; medication name, dosage, time and route; intended effect of medication; other medication(s) taken by student; and parent/guardian signature.

4.12. "Prescribed Medication" means medication with a written order signed by a licensed prescriber.

4.13. "School Based Health Centers" means clinics located in schools that: 1) are sponsored and operated by community based health care organizations; 2) provide primary health care services (including but not limited to diagnosis and treatment of acute illness, management of chronic illness, physical exams, immunizations, and other preventive services) to students who are enrolled in the health center; and 3) follow state and federal laws, policies, procedures, and professional standards for provision of medical care.

4.14. "School Nurse" is defined as a registered professional nurse, licensed by the West Virginia Board of Examiners for Registered Professional Nurses (W.Va. Code §30-7-1, et seq.), who has completed a West Virginia Department of Education approved program as defined in West Virginia Board of Education Policy 5100 – Approval of Educational Personnel Preparation Programs (126CSR114) and meets the requirements for certification contained in West Virginia Board of Education Policy 5202 – Minimum Requirements for the Licensure of Professional/Paraprofessional Personnel and Advanced Salary Classification (126CSR136). The 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.

4.15. "School-related event" means any curricular or co-curricular activity, as defined in West Virginia Board of Education Policy 2510 – Assuring the Quality of Education: Regulations for Education Programs (126CSR42), that is conducted outside of the school environment and/or instructional day. Examples of co-curricular activities include the following: band and choral presentations; theater productions; science or social studies fairs; mathematics field days; career/technical student organizations' activities; or other activities that provide in-depth exploration or understanding of the content standards and

objectives appropriate for the students' grade levels.

4.16. "Self-administration" means medication administered by the student under the supervision of the school nurse, designated qualified personnel, administrator or administrator's designee. The self-administration of prescribed medication may also include medication taken by a student in an emergency or an acute situation (e.g., rescue inhaler).

§126-27-5. Authorization.

5.1. Authorized personnel include trained school nurses, other licensed health care providers, administrators, teachers, aides and secretaries as defined in W.Va. Code §§18-1-1, 18A-4-8 and 18-5-22.

§126-27-6. Roles and Responsibilities.

6.1. Role of the school administrator(s).

6.1.1. Provide for appropriate, secure, and safe storage and access of medications.

6.1.2. Provide a clean, safe environment for medication administration.

6.1.3. Provide a mechanism for safely receiving, counting and storing medications.

6.1.4. Provide a mechanism for receiving and storing appropriate medication authorization forms.

6.1.5. Select potential candidates for medication administration (prescribed and non-prescribed).

6.1.6. Assign qualified employees, who meet a satisfactory level of competence for prescribed medication administration as defined in Policy 2422.7 and non-prescribed medication as determined by the WVDE.

6.1.7. Coordinate development of procedures for the administration of medication during school-related events with classroom teachers, school nurses, parents/guardians, designated qualified personnel and administrator's designees.

6.2. Role of the school nurse and contracted licensed health care provider.

6.2.1. Determine if the administration of prescribed medication may be safely delegated to designated qualified personnel, as defined in Section 4.4.

6.2.2. Contact the parent/guardian or licensed health care provider to clarify any questions about prescribed medication that is to be administered in the West Virginia public school system.

6.2.3. Manage 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, health care planning and maintenance of complete and accurate documentation. For students needing long-term and emergency prescription medication to attend school, the school nurse shall assess the student, review the licensed prescriber's orders, assure implementation of needed health and safety procedures, and develop a health care plan.

6.2.4. Utilize the "West Virginia Board of Examiners for Registered Professional Nurses Guidelines for Determining Acts that May be Delegated or Assigned by Licensed Nurses", January 2001, and any revisions thereof, as the mechanism for determining whether or not the administration of prescribed medications may be delegated.

6.2.5. Provide and/or coordinate training, as defined in Policy 2422.7, for all school employees designated to administer prescribed medication.

6.2.6. Validate and document student knowledge and skills related to self-administration of prescribed medication.

6.3. Role of designated qualified personnel/administrator's designee.

6.3.1. Successfully complete the Cardiopulmonary Resuscitation (CPR), First Aid, and the medication administration portion of training, as defined in Policy 2422.7.

6.3.2. Store and administer medication, complete the medication document and report medication incidents as outlined in Sections 7.4. and 8.5.

6.4. Role of the parent/guardian.

6.4.1. Administer the initial dose of any medication at home, except for emergency medications and unless otherwise directed by the licensed prescriber and/or a court order.

6.4.2. Complete and sign a parent/guardian authorization form (to be designed by each county), which indicates student name; date; allergies; medication name; dosage, time, and route; intended effect of medication; other medication(s) taken by student; and parent/guardian signature.

6.4.3. Provide school with completed licensed prescriber authorization form for prescribed medication(s).

6.4.4. Supply medication and ensure that medication arrives safely at school in a current and properly labeled container (see Sections 7.2 and 8.3). Give the medication to the person authorized by the administrator to receive, store, and administer medication. Maintain effective communication pertaining to medication administration.

6.4.5. Replenish long-term and emergency prescribed medication as needed.

6.4.6. Retrieve unused or outdated medicine from school personnel no later than thirty days after the authorization to give the medication expires or on the last day of school.

6.5. Role of the student.

6.5.1. Consume the medication in the specified manner, in as much as his/her age, development and maturity permit.

6.5.2. Self-administer prescribed emergency or acute medications, such as but not limited to a Epi-pen or ibuprofen when the prescription indicates that said student must maintain possession of the medication. The student must be able to bring the medication to school, carry the medication in a safe and responsible manner, and use the medication only as prescribed. At the discretion of county boards of education, high school students (not below grade 9) may be allowed to carry and self-administer non-prescribed medication (OTC) with parent/guardian authorization, unless restricted by the administrator.

§126-27-7. Administration of Prescribed Medication.

7.1. Prescribed medications shall be administered after written authorization from a licensed prescriber and parent/guardian are received.

7.2. Prescribed medication shall be in the originally labeled container, which includes the following:

7.2.1. Prescribed medication(s) from a pharmacy

a. student's name,

b. name of the medication,

c. reason(s) for the medication (if to be given only for specific symptoms),

d. dosage, time and route,

e. reconstitution directions, if applicable, and

f. the date the prescription and/or medication expires.

7.2.2. Prescribed Over-the-Counter Medication(s)

a. student's name (affixed to original manufacturer's bottle),

b. name of the medication,

c. reason(s) for the medication (if to be given only for specific symptoms),

d. dosage, time and route,

e. reconstitution directions, if applicable, and

f. the date the prescription and/or medication expires.

7.3. Medication administration steps must be followed exactly as outlined in Policy 2422.7.

7.3.1. Medication administration must take place in a clean and quiet environment where privacy may be established and interruptions are minimal.

7.3.2. The school nurse is to be contacted immediately when a prescribed medication's appearance or dosage is questioned. The school nurse shall take the appropriate steps to assure the medication is safe to administer.

7.3.3. The school nurse is to be contacted immediately when a student's health condition suggests that it may not be appropriate to administer the medication.

7.3.4. When a student's medical condition requires a change in the medication dosage or schedule, the parent must provide a new written authorization form from a licensed prescriber and container. This must be given to designated personnel within an appropriate time frame.

7.4. Medication administration incidents include, but are not limited to, any deviation from the instructions provided by the licensed health care provider. The school nurse and administrator shall be contacted immediately in the event of a medication incident. The school nurse or administrator shall do the following:

7.4.1. Contact the physician and parent/guardian, if necessary.

7.4.2. Implement the school nurse or administrator recommendation/licensed prescriber order in response to a medication incident.

7.4.3. Document all circumstances, orders received, actions taken and student's status.

7.4.4. Submit a written report to the administrator and county superintendent at the time of the incident. The report should include the name of the student, the parent/guardian name and phone number, a specific statement of the medication incident, who was notified, and what remedial actions were taken.

7.5. Self-administration of asthma medication shall be permitted in accordance with W.Va. Code §18-5-22b after the following conditions are met:

7.5.1. A written authorization is received from the parent/guardian for self-administration of asthma medication.

7.5.2. A written statement is received from a licensed prescriber which contains the student name, purpose, appropriate usage, dosage, time or times at which, or the special circumstances under which the medication is to be administered.

7.5.3. The student has demonstrated the ability and understanding to self-administer asthma medication by passing an assessment by the school nurse evaluating the student's technique of self-administration and level of understanding of the appropriate use of the asthma medication.

7.5.4. The parent/guardian has acknowledged in writing that they have read and understand a notice provided by the county board of education stating that the school, county school board and its employees and agents are exempt from any liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of asthma medication.

7.5.5. The permission to self-administer asthma medication shall be effective for the school year for which it is granted and all documents related to the self-administration of asthma medication shall become part of the student health record.

7.5.6. The permission to self-administer asthma medication may be revoked if the school administrator finds that the student's technique and understanding of the use of asthma medication is not appropriate or is willfully disregarded.

§126-27-8. Administration of Non-Prescription Medication.

8.1. Non-prescribed medications shall be administered only after meeting the following requirements:

8.1.1. Parent/guardian authorization form is provided.

8.1.2. The school administrator has the authority to determine if the administration of the non-prescribed medication may be safely delegated to the administrator's designee as defined in Section 4.2.

8.1.3. The school administrator has the authority to contact the parent/ guardian or a licensed health care provider to clarify any questions about the medication being administered.

8.2. Any non-prescribed medication(s) must be provided by the parent/guardian.

8.3. Non-prescribed medication shall be in the manufacturer's original packaging clearly marked with the following:

8.3.1. student's name (affixed to original manufacturer's bottle),

8.3.2. name of medication,

8.3.3. ingredients,

8.3.4. dosage, time and route,

8.3.5. reconstitution directions, if applicable, and

8.3.6. medication expiration date.

8.4. Medication administration steps must be followed exactly as outlined by the WVDE.

8.4.1. Medication administration must take place in a clean and quiet environment where privacy may be established and interruptions are minimal.

8.4.2. The parent/guardian is to be contacted immediately when a medication's appearance or dosage is questioned. The administrator's designee shall take the appropriate steps to assure the medication is safe to administer.

8.4.3. The parent/guardian is to be contacted immediately when a student's health condition suggests that it may not be appropriate to administer the medication.

8.5. Medication administration incidents include, but are not limited to, any deviation from the instructions provided by the parent/ guardian. The school administrator shall be contacted immediately in the event of a medication incident. The school administrator will then contact the parent/ guardian, if necessary. The school administrator or designee shall:

8.5.1. Implement the parent's/guardian's recommended response to a medication incident.

8.5.2. Document all circumstances, orders received, actions taken and student's status.

8.5.3. Submit a written report to the administrator and county superintendent at the time of the incident. The report should include the name of the student, the parent/guardian name and phone number, a specific statement of the medication incident, who was notified, and what remedial actions were taken.

8.5.4. When a parent/guardian authorizes a non-prescribed medication to be given in addition to a known prescribed medication, the administrator or school nurse shall validate the safety of multiple medications. At times, this validation process may require a licensed provider order.

§126-27-9. Medication Storage, Inventory, Access and Disposal.

9.1. Each school shall designate space in the building to store student medication, at the correct temperature, in a secure, locked, clean cabinet or refrigerator, as required.

9.2. All medication shall be entered on a medication inventory and routinely monitored for expiration and disposal.

9.3. Access to medications shall be under the authority of the administrator of the school in conjunction with the school nurse assigned to that school. If there is a full-time school nurse assigned to the building, the school nurse shall have authority over the access to prescribed medications.

9.4. An appropriate supply of long-term and emergency prescribed medication may be maintained at the school in amounts not to exceed school dosages within each calendar month.

9.5. School personnel shall dispose of unused or outdated medicine unclaimed by the parent/guardian no later than 30 days after the parent/guardian medication authorization expires or on the last day of school.

9.6. Medication disposal shall be done in a manner in which no other individual has access to any unused portion. Two individuals will witness the disposal of the medication and the procedure must be documented on the appropriate form related to the specific student.

§126-27-10. Confidentiality and Documentation.

10.1. Student information related to diagnosis, medications ordered and medications given must be maintained according to The Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. §1232g; 34 CFR Part 99) and in such a manner that no one could view these records without proper authorization as specified in West Virginia Board of Education Policy 4350 - Procedures for the Collection, Maintenance and Disclosure of Student Data (126CSR94).

10.2. Documentation of medication administration shall include the following information:

10.2.1. student name,

10.2.2. medication(s) name,

10.2.3. dosage, time and route of medication('s) administration,

10.2.4. reaction(s) or untoward effects,

10.2.5. reason(s) the medication was not administered; and

10.2.6. date and signature of person administering medication.

§126-27-11. Consequences of Policy Violation.

11.1. If a student violates the policy regarding medication administration, action will be based upon West Virginia Board of Education Policy 4373 - Student Code of Conduct (126CSR99) and/or West Virginia Board of Education Policy 2422.5 - Substance Abuse (126CSR23).

11.2. Failure of school personnel to comply with the above rules shall result in personnel disciplinary actions based on West Virginia Board of Education Policy 5310 - Performance Evaluation of School Personnel (126CSR142) and West Virginia Board of Education Policy 5902 - Employee Code of Conduct (126CSR162).

§126-27-12. Severability.

12.1. If any provision of this rule or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of this rule.

TITLE 126
LEGISLATIVE RULE
BOARD OF EDUCATION

SERIES 51
COMMUNICABLE DISEASE CONTROL POLICY (2423)

§126-51-1. General.

1.1. Scope. -- The legislative rule requires establishment of county policies related to communicable disease control.

1.2. Authority. -- W. Va. Code §§18A-5-1, 16-3-4; 16-3-4a; 16-3-5; 16-3C-1 thru 16-3C-9, 18-2-5; 18-5-9; 18-5-22 and 18-5-34.

1.3. Filing Date. -- June 5, 1991.

1.4. Effective Date. -- July 15, 1991.

§126-51-2. Applicability.

Effective July 1, 1989 each of the fifty-five (55) county boards of education will adopt or amend communicable disease policies to reflect understanding of disease transmission in the school setting and to reflect understanding of students/staff rights to attend school or remain employed. The goal of the policy is to protect individual students, staff members and the school population in general. The policy should provide consistent means for handling reports of infections/diseases such as AIDS, Hepatitis B or other like diseases and for decision making related to remaining in the school.

The potential for unnecessary exclusion from the school setting is cause for concern. This problem makes it necessary for counties to develop a policy that is protective of the educational process and the rights, health and safety of students and staff.

§126-51-3. Components.

The following components shall be addressed in each county board policy:

3.1. Distinctions will be made related to diseases that are communicable in the school setting versus those known not to be spread by casual contact, e.g., AIDS, Hepatitis B and other like diseases.

A communicable disease is defined as a disease which may be transmitted directly or indirectly from one individual to another. Diseases such as streptococcal sore throat and influenza can be spread by discharge from nose or throat, either by droplet through the air, or by contact with objects contaminated by these discharges. Thus, they can be spread by casual contact such as that occurs in a school setting. AIDS is spread by direct blood transmission into the blood stream of another and by semen or vaginal fluid contact. Hepatitis A can be spread by direct or indirect contact with feces while Hepatitis A can be spread by direct contact with semen and blood. These diseases do not pose a risk in school if body fluids such as blood and feces are correctly handled.

3.2. Each reported case of disease known not to be spread by casual contact will be validated by a designated individual such as a school nurse.

3.3. Procedures for case decision making will be outlined and will be consistent with current laws and regulations, both state and federal.

State Laws §§18A-5-1; 16-3-4; 16-3-4a; 16-3-5; 16-3C-1 thru 16-3C-9 and 18-5-22 and 18-20-5.

Federal regulations: PL 94-142--Education of the Handicapped Act: Federal 504 Regulations - Vocational Rehabilitation Act of 1973.

3.4. Confidentiality procedures will be

outlined and strictly followed.

For reference see: Family Educational Rights and Privacy: Final Regulations. Part II, 34 CFR Part 99. Federal Register, April 11, 1988.

3.5. Prevention methods such as instructional programs and environmental sanitation (cleaning up of body fluid spills).

§126-51-4. Policy Implementation.

4.1. Each county should seek the assistance of school personnel, public health and medical personnel and community leaders in developing the communicable disease policy. Technical assistance will be provided by the West Virginia Department off Education to any county upon request.

4.2. Policies are to be submitted to the State Superintendent of Schools for approval on or before August 1, 1989.

Model Communicable Disease Policy

COMMUNICABLE DISEASE CONTROL POLICY

The County School System win work cooperatively with the County Health Department to enforce and adhere to the West Virginia Codes: §§18a-5-1; 16-3-4; 16-3-4A; 16-3-5; 16-3c-1 thru 16-3C-9, 18-2-5, 18-5-9; 18-5-22 and 18-5-34 for prevention, control and containment of communicable disease in schools. Decisions related to student or employee attendance will be based on P.L. 94-142 and Federal 504 Regulations.

1. Students are expected to be in compliance with the required immunization schedule. The building principal is required under State Statute §16-3-4 to exclude children from school attendance who are out of compliance with the immunizations required by this act. School personnel will cooperate with county/state health personnel in completing and coordinating all immunization data, waivers and exclusions.

2. The teacher shall exclude from the school any pupil or pupils known to have or suspected of having any infectious disease or infestation known to be spread by casual contact. The superintendent has the authority to exclude a staff member from school when reliable evidence or information from a qualified source confirms him/her of having a communicable disease or infestation that is known to be spread by any form of casual contact and is considered a health threat to the school population. Such a student or staff member shall be excluded unless their physician approves school attendance and the condition is no longer considered contagious. All reportable communicable diseases will be referred to the County Health Department.

3. When reliable evidence or information from a qualified source confirms that a student/staff member is known to have a communicable disease or infection that is known not to be spread by casual contact, * i.e., HIV Infections, Hepatitis B and other like diseases, the decision as to whether the affected person will remain in the school setting will be addressed on a case by case basis by a review panel to ensure due process. (Protocol and review panel membership outlined in Appendix A.)

4. If a decision is made to exclude a child from school who is HIV positive or has AIDS, final approval of this decision must be made by the WV Department of Health (§16-3C-6).

5. Mandatory screening for communicable diseases that are known not to be spread by casual contact is not warranted as a condition for school entry or for employment or continued employment, nor is it legal based on §16-3C-1.

6. Irrespective of the disease presence, routine procedures shall be used and adequate sanitation facilities will be available for handling blood or body fluids within the school setting or school busses. School personnel will be trained in the proper procedures for handling blood and body fluids and these procedures will be strictly adhered to by all school personnel. (See Appendix B, Routine Procedures for Sanitation and Hygiene-Handling Body Fluids.)

7. All persons' privileged with any medical information that pertains to students or staff members shall be required to treat all proceedings, discussions and documents as confidential information. Before any medical information is shared with anyone in the school setting a "Need to Know" review shall be made which includes the parent/guardian, student if over eighteen (18), employee or their representative as outlined in the West Virginia Procedures for the Collection. Maintenance and Disclosure of Student Data and Family Educational Rights and Privacy Act 1988.

8. Instruction on the principal modes by which communicable diseases, including, but not limited to, Acquired Immunodeficiency Syndrome (AIDS) are spread and the best methods for the restriction and prevention of these diseases shall be taught to students and inservice education provided to all staff members as specified in §§18-2-9 and 15-5-15d.

*CASUAL CONTACT --- Refers to day-to-day interaction between HIV-infected individuals and others in the home, at school or in the work place. It does not include intimate contact, such as sexual or drug use interactions, and it implies closer contact than chance passing on a street or sharing a subway car.

This definition is from the book, AIDS: A GUIDE FOR SURVIVAL, published by The Harris County Medical Society and the Houston Academy of Medicine, 1987, and provided by the West Virginia State Medical Association.

Appendix A

PROTOCOL FOR COMMUNICABLE DISEASES KNOWN NOT TO BE SPREAD BY CASUAL CONTACT

1. The Review Panel

1.1. Communicable diseases that are known not to be spread by casual contact, e.g., AIDS, Hepatitis B, and other like diseases will be addressed on a case by case basis by a review panel.

1.2. Panel Membership

1.2.1. The physician treating the individual.

1.2.2. A health official from the State or County Health Department who is familiar with the disease.

1.2.3. A child/employee advocate (e.g.. school nurse, counselor, child advocate, social worker, employee representative, etc., from in or outside the school setting).

1.2.4. A school representative familiar with the child's behavior in the school setting or the employee's work situation (in most cases, the building principal or in the case of a special education student, a special education representative may be more appropriate).

1.2.5. Either the parent/guardian of child, student if over 18, employee, or their representative.

1.2.6. The county superintendent or designee.

1.3. The superintendent or designee will assign a panel member to record the proceedings.

1.4. The superintendent or designee will designate the chair of the panel. The chair is responsible for assuring a due process hearing that is fair and just. The chair shall serve as a neutral hearing officer to ensure an impartial hearing for all interests concerned.

1.5. The chair of the review panel will designate the panel member who will write the "Proposal for Decision."

2. Case Review Process

2.1. Upon learning of a student/staff member within the County School System who has been identified by a qualified source as having a communicable disease that is known not to be spread by casual contact, the superintendent shall:

Immediately consult with the physician of the student/staff member and/or health official from the State or County Health Department to obtain information as to whether the student/staff member is generally well enough to remain in school during the review panel process. The superintendent will confirm whether the student/staff member has evidence of an existing condition that could be transmitted by casual contact in the school setting.

If the student/staff member's physician or the health department physician indicates the student/staff

member is well enough to remain in the school setting and poses no immediate health threat through casual contact to the school population because of their illness, the student/staff member shall be allowed to remain in the school setting while the review panel meets.

If the student/staff member's physician or the health department official indicates the student/staff member is currently not well enough to remain in the school setting and/or that the affected individual currently has evidence of an illness or infection that poses a potential health threat through casual contact to the school population, the student/staff member shall be excluded from the school setting while the review panel meets. in the health department official recommends exclusion because a public health threat exists, the review panel will discuss the conditions under which the individual may return to school

2.2. Immediately contact the review panel members to convene a meeting to explore aspects of the individual's case.

2.3. Submit to the parent/guardian or infected person, in writing, a notice of their rights as a review panel member and the method of appeal.

3. The Review Panel Process

3.1. The Review Panel shall meet within 24-48 hours* (excluding weekends or holidays) to review the case. The following aspects should be considered in that review:

3.1.1. The circumstances in which the disease is contagious to others.

3.1.2 Any infections or illnesses the student/staff member could have as a result of the disease that would be contagious through casual contact in the school situation.

3.1.3. The age, behavior and neurologic development of the student.

3.1.4. The expected type of interaction with others in the school setting and the implications to the health and safety of those involved.

3.1.5. The psychological aspects for both the infected individual and others concerning the infected person remaining in the school setting.

3.1.6. Consideration of the existence of contagious diseases occurring within the school population while the infected person is in attendance.

3.1.7. Consideration of a potential request by the person with the disease to be excused from attendance in school or on the job.

3.1.8. The method of protecting the student/staff member's right to privacy, including maintaining confidential records.

3.1.9 Recommendations as to whether the student/staff member should continue in the school setting, or if currently not attending, under what circumstances he/she may return.

3.1.10. Recommendations as to whether a restrictive setting or alternative delivery of school programs is advisable.

3.1.11. Determination of whether an employee would be at risk of infection through casual contact when delivering an alternative educational program.

3.1.12. Determination of when the case should be reviewed again by the panel.

3.1.13. Any other relevant information.

*See 3.4 of Appendix A.

3.2. Proposal for Decision

3.2.1. Within three (3) school days after converting the panel, the superintendent shall be provided with a written record of the proceedings and the "Proposal for Decision." The Proposal serves as a recommendation to the superintendent. It is based on the information brought out in the review panel process and will include the rationale for the recommendation concerning school attendance for the student or continuation of employment for the staff member. If there is a minority viewpoint by panel members following the review process, that should also be included in the report.

3.2.2. If the Proposal for Decision is to exclude the affected person from the school setting because of an existing condition that is known to be spread by casual contact and is considered a health threat to the school community, the Proposal for Decision shall include the conditions under which the exclusion will be reconsidered.

3.2.3 The parent/guardian, or affected person will be given a copy of the Proposal. The review panel members will be given the opportunity to review the content of the Proposal for Decision.

3.3. The Superintendent's Decision

3.3.1. The superintendent shall either affirm, modify, or take exception to the Proposal for Decision within three (3) school days after receipt of the Proposal for Decision unless a rehearing request on that Proposal has been made. (see Appeal Process, Rehearing Request.)

3.3.2. In the event the superintendent takes exception to the Proposal of Decision, he/she shall prepare a written statement that sets forth the reasons for the exceptions and the basis for that decision.

3.3.3. The parent/guardian or affected person and the Health Department official will be given a copy of the Superintendent's Decision. The other review panel members will be given the opportunity to review the content of the superintendent's Decision.

3.4. If the affected person is a special education student, the superintendent shall convene an Individualized Education Planning Committee meeting to determine the appropriate program and services for the student based on the panel's recommendations and the superintendent's decision. Placement of the student in the interim shall be based upon the recommendation of the superintendent and the attending physician.

4. Appeal Process

4.1. Rehearing Request

4.1.1. The parent, guardian, or affected person who considers the Proposal for Decision unjust may request a rehearing, in writing, directed to the chair of the review panel within three (3) school days of the date of the Proposal for Decision. Grounds for requesting a rehearing are limited to: (1) new evidence or information that is important to the decision; or (2) substantial error of fact.

4.1.2. The chair, within three (3) school days from the date of receipt of the request for rehearing shall either grant or deny the request for rehearing, if the request for rehearing is denied, the chair shall immediately submit the Proposal for Decision to the superintendent. If the request for rehearing is granted, the chair shall reconvene the same panel that originally heard the matter within five (5) school days of the date the hearing is granted.

4.1.3. Within three (3) school days after the rehearing the chair shall submit the Proposal for Decision to the superintendent. The parent/guardian or affected person will be given a copy of the Proposal. The review panel members will be given the opportunity to review the content of the Proposal for Decision.

4.2. Request for Reconsideration of Superintendents Decision

4.2.1. The parent, guardian or affected person may request a reconsideration of the Superintendent's Decision within three (3) school days of the date the Superintendent's Decision was issued. The request shall be in writing and shall allege that the Decision contains a substantial error of fact or that the Decision is against the great weight of the evidence as set forth in the Proposal for Decision.

4.2.2. An oral presentation by the parent/guardian, affected person or their representative may be granted by the superintendent.

4.2.3. The superintendent shall grant or deny the request for reconsideration within three (3) school days after receipt of the request or within three (3) school days following the oral presentation, whichever is applicable.

4.3. Request for a Board Decision

The parent/guardian, affected person or their representative may make a final written appeal to the president of the Board of Education with five (5) school days after the Superintendent's Decision. The Board shall meet within three (3) school days and hear the student/staff member's appeal along with the Proposal for Decision and Superintendent's Decision. Within two (2) school days of the hearing, the Board shall render its decision in writing with copies sent to the superintendent, health department official, and parent/guardian or affected person.

4.4. Review Panel Request for Appeal

If the Proposal for Decision or the Superintendent's Decision is contrary to the majority opinion of the review panel, a majority of the panel has the right to appeal either decision in the same manner stated in the "Appeal Process."

4.5. Extenuating Circumstances

Circumstances may warrant extended time lines if complete medical information is not available.

5. General

5.1. If the student with the disease is not attending school, the district will provide an alternative delivery of school programs.

5.1.1. If the panel determines there is no risk of infection to the employee, the employee will be expected to participate in the delivery of the alternative program.

5.1.2. If the review panel determines there is a risk of infection through casual contact to the employee while delivering this program, the employee may be allowed the option not to serve in the situation. Alternative methods for delivery of school programs should be explored by the IEP team.

5.2. The review panel member who is serving as the advocate for the infected individual (or another person designated by the panel) will serve as the liaison between the student/staff member, family and attending physician as it relates to the school setting.

5.3. Employees of the district shall be expected to teach and provide other normal personal contract services in school to a student or to work with a school employee determined to have a disease known not to be communicable by casual contact unless a determination to the contrary has been made by the review panel.

6. Confidentiality

All persons involved in these procedures shall be required to treat all proceedings, deliberations, and documents as confidential information. Records of the proceedings and the decisions will be kept by the superintendent in a sealed envelope with access limited to only those persons receiving the consent of the parent/guardian or infected person as provided by the Employee Right to Know Act, and the Family Education Rights and Privacy Act.

Appendix B

Routine Procedures for Sanitation and Hygiene - Handling Body fluids

Purpose

To insure that body fluids involving blood, vomitus, urine, feces, semen, saliva, and nasal discharges are handled properly.

Those Affected

All school staff should be alerted to dangers of infections (see Table 1) from body fluids. School nurses, custodians, bus drivers, school aids, and teachers should be particularly alert to the proper techniques in handling and disposal of materials.

Equipment Needed

Soap
Water
Paper Towels
Disposable Gloves
Disposal Bags
Dust Pans
Buckets (two)
Mops

Disinfectants should be one of the following classes:

a. Phenolic germicidal detergent in a 1% aqaeous solution (e.g., Lysol*)

b. Isopropol alcohol 70% full strength

c. Sodium hypochorite solution (household bleach), 1 part bleach to 9 parts water. (Example: 1 ½ cups bleach to one (1) gallon of water. Needs to be prepared fresh daily.

d. Iodophor germicidal detergent with 500ppm available iodine (e.g., Wescodyne*)

e. Sanitary absorbing agent (Chlora Sorb*, X-O Order Away*)

*Brand names are used as examples and are not endorsement of products.

Procedures

1. General.

a. Wear disposable gloves before making contact with body fluids during care, treatment, and an cleaning procedures.

b. Discard gloves after each use, or if they are torn.

c. Wash hands after handling fluids and contaminated articles; whether or not gloves are worn.

d. Discard disposal items including diapers, tampons, used bandages and dressings in plastic-lined trash container with lid. Close bags, place inside a second clean plastic bag, label "contaminated material" and discard to be incinerated.

e. Do not reuse plastic bags.

f. Use disposable items to handle body fluids whenever possible.

g. Use paper towels to pick up and discard any solid waste materials such as vomitus or feces.

h. Daily use items that routinely come in contact with body fluids should be disposable, including diapers and disposable bibs for pre-school or developmentally delayed students who drool excessively.

2. Handwashing

a. Use soap and warm running water. Soap suspends easily removable soil and microorganisms allowing them to be washed off.

b. Rub hands together for approximately ten (10) seconds to work up a lather.

c. Scrub between fingers, knuckles, backs of hands, and nails.

d. Rinse hands under warm running water. Running water is necessary to carry away debris and dirt.

e. Use paper towels to thoroughly dry hands.

f. Now turn off water with towel.

g. Discard paper towels without touching waste container.

3. For Washable Surfaces

a. For tables, desks, etc.:

(1) Use Lysol, or household bleach solution of one part bleach to nine parts waters, mixed fresh.

(2) Rinse with water if so directed or disinfectant.

(3) Allow to air dry.

(4) When bleach solution is used, handle carefully.

(a) Gloves should be worn since the solution is irritating to skin.

(b) Avoid applying on metal since it will corrode most metals.

b. For floors:

(1) One of the most readily available and effective disinfectants is the bleach solution (1-1/2 cups bleach to one (1) gallon water).

(2) Use the two (2) bucket system--bucket to wash the soiled surface and one bucket to rinse as follows:

(a) In bucket #1, dip, wring, mop up vomitus, blood.

(b) Dip, wring and mop once more.

(c) Dip, wring out mop in bucket #1.

(d) Put mop into bucket #2, (rinse bucket) that has clean disinfectant (such as Lysol, bleach solution).

(e) Mop or rinse area.

(f) Return mop to bucket #1 to wring out. This will keep rinse bucket clean for second spill in the area.

(g) After all spills are cleaned up, proceed with #3.

(3) Soak mop in the disinfectant after use.

(4) Disposable cleaning equipment and water should be placed in a toilet or plastic bag as appropriate.

(5) Rinse non-disposable cleaning equipment (dust pans, buckets) in disinfectant.

(6) Dispose disinfectant solution down a drain pipe. Flush with water.

(7) Remove gloves, if worn, and discard in appropriate receptacle.

(8) Wash hands as described in #2.

4. <u>For Non-Washable Surfaces (rugs, upholstery)</u>

a. Apply sanitary absorbing agent, let dry, vacuum.
b. If necessary, use broom and dust pan to remove solid materials.

c. Apply rug or upholstery shampoo as directed. Revacuum according to directions on shampoo.

d. If a sanitizing carpet cleaner only available by water extraction method is used, follow the directions on the label.

e. Clean dustpan and broom, if used. Rinse in disinfectant solution.

f. Air dry.

g. Wash hands as described in #2.

5. For soiled washable materials (clothing, towels, diapers, etc.)

a. Rinse item under running water using gloved hands, if appropriate.

b. Place item in plastic bag and seal until item is washed. Plastic bags containing soiled, washable material must be clearly identified if outside laundry service is used.

c. Wash hands as described in #2.

d. Wipe sink with paper towels, discard towels.

e. Wash soiled items separately, washing and drying as usual.

f. If material is bleachable, add 1/2 cup bleach to the wash cycle. Otherwise, add 1/2 cup nonchlorine bleach (Clorox 11, Borateem) to the wash cycle.

g. Discard plastic bag.

h. Wash hands as described in #2, after handling soiled items.

6. Daily use items - disposable diapers, bibs.

a. Wear disposable gloves.

b. Place soiled diaper/bib in plastic bag.

c. Continue wearing gloves while cleaning the child, then discard into the plastic bag. Close bag.

d. At end of day, place plastic bag containing soiled diapers/bibs, etc., inside a clean plastic bag. Label and dispose of as in item 1.d.

TABLE 1

TRANSMISSION CONCERNS IN THE SCHOOL SETTING
BODY FLUID SOURCES OF INFECTIOUS AGENTS

BODY FLUID SOURCE	ORGANISM OF CONCERN	TRANSMISSION CONCERN
Blood cuts/abrasions nosebleeds menses contaminated needle	Hepatitis B Virus AIDS Virus Cytomegalovirus Syphilis	Bloodstream inoculation through cuts/abrasions on hands, rectum, vagina Direct blood stream Inoculation
*Feces incontinence	Salmonella Bacteria Shigella Bacteria Rotavirus Hepatitis A Virus Hepatitis B Virus	Oral inoculation from contaminated hands
*Urine incontinence	Cytomegalovirus	Bloodstream, oral and mucus membrane Inoculation from hands
*Respiratory Secretions	Mononucleosis Virus Common Cold virus Influenza Virus	Oral inoculation from contaminated hands
*Saliva	Hepatitis B Virus	Bloodstream inoculation through bites
*Vomitus	Gastrointestinal virus, e-g. , (Norwalk agent Rotavirus)	Oral inoculation from contaminated hands
Semen	Hepatitis B Virus AIDS Virus Gonorrhea Syphilis	Sexual Contact

*Possible transmission of AIDS is currently thought to be of little concern from these sources.

126CSR28

TITLE 126
PROCEDURAL RULE
BOARD OF EDUCATION

SERIES 28
West Virginia's Universal Access to Early Education System (2525)

§126-28-1. General.

1.1. Scope. - -This procedural rule establishes the criteria for approving and operating programs for four year old children and three year old children as mandated under federal law and herein after is referred to as West Virginia's Pre-k System (WV Pre-k).

1.2. Authority. - - W.Va. Constitution, Article XII, §2 and W.Va. Code §§16-3-4, 18-2-5, 18-5-18c, 18-2E-1et seq., 18-5-17, and 18-5-44. All requirements of this policy are mandated components unless otherwise noted.

1.3. Filing Date. - - January 13, 2003

1.4. Effective Date. - - February 12, 2003

1.5. Repeal of former rule. - - None. This is a new rule.

§126-28-2. Guidelines.

2.1. WV Pre-k classrooms shall:

2.1.1. be voluntary and based on the choice of the parent or guardian.

2.1.2. be readiness programs that are designed to meet the needs of all eligible children.

2.1.3. utilize developmentally appropriate curriculum and a learning approach based on scientific research about how children learn.

2.1.4. provide the building blocks for literacy.

2.1.5. view children within the context of their family.

2.1.6. incorporate content standards and objectives, curriculum, and assessment as tools for measuring the child's progress on the continuum of development and individualizing educational opportunities.

2.1.7 employ staff with strong professional education preparation in child development and early childhood education.

2.1.8 build on what children already know in order to consolidate their learning and foster acquisition of new concepts and skills.

2.1.9. incorporate meaningful ways of communicating with and involving parent/guardian/family.

2.1.10. evaluate program success for meeting the needs of the child.

2.1.11. establish teacher/child ratios and class size according to recommended guidelines.

2.1.12 maximize existing community, state and federal resources.

2.1.13 be an integral part of the West Virginia birth to kindergarten system of education and care.

2.1.14 take place in safe and healthy environments.

2.1.15. be inclusive of all children.

§126-28-3. Definitions.

3.1. *Approved funding sources* means any funds used directly to support WV Pre-k classrooms for eligible children including school aid formula, Head Start funds, Even Start funds, Temporary Assistance to Needy Families, Child Care Development Funds, funds under the Elementary and Secondary Education Act, funds provided by the School Building Authority, funds under the Individuals with Disabilities Education Act, and any other private or public funds.

3.2. *Approved WV Pre-k participating programs* shall mean providers of early care and education services including, but not limited to, childcare, private preschool, Head Start, county school systems, and community-based programs that meet or exceed all of the requirements of this policy and are a part of a county's collaborative plan. Approved WV Pre-k participating programs can be counted in the school aid funding formula and are eligible to receive funds through contractual agreements with or direct administration by the county school system.

3.3. *Collaborative Setting* means a classroom of WV Pre-k children whose services are supported by two or more partners. This could range from contracting with the county Board of Education for shared resources such as a certified teacher or classroom space to fully integrated, inclusive settings that combine a variety of funding sources and resources (including space),

shared staffing responsibilities, and shared supervision and implementation of the program by two or more partners.

3.4. *Contracted program* shall mean any program that qualifies as an approved WV Pre-k participating program by meeting all of the requirements of this policy and has a contractual agreement with the county school system under the county collaborative plan to operate a classroom specific to this policy.

3.5. *County collaborative plan* means the plan each county school board is required to submit detailing an analysis of facility and personnel needs, an analysis of demographics of the county related to the early childhood program implementation, financial requirements for implementation and potential sources of funding to assist implementation, details of how the county board will cooperate and collaborate with other early childhood programs, specific timelines for implementation, and any other requirements of this policy.

3.6. *Developmentally appropriate* means early childhood programming, curricula, and activities that address the stages of each child's cognitive, physical, social/emotional, and cultural development.

3.7. *Eligible child* shall mean any child, regardless of ability, who is four by the first day of September of the year he/she is to enroll or whose enrollment is mandated under state and/or federal law. If it is in the best interest of the child, as determined by mutual agreement between the teacher and parent/guardian, the child may remain in the program for longer than one year. Because WV Pre-k is designed to prepare children to be successful in kindergarten, children may not be excluded based on developmental delays including toilet training. Children who are five by September 1 shall be enrolled in kindergarten, instead of WV Pre-k, unless the teacher and parent deem kindergarten placement for that child not in the best interest of the child and documented through an approved assessment.

3.8. *Minimum program availability* means offering each preschool class a minimum twelve hours per week on consecutive days during the school year calendar.

3.9. *West Virginia's Pre-k* means kindergarten for eligible children and may include, but is not limited to, developmental kindergartens, four-year-old kindergarten, and other programs provided by approved WV Pre-k participating programs that provide developmental readiness services for eligible children in West Virginia.

§126-28-4. Parent/Guardian Involvement and Family Support.

4.1. Parent/guardian involvement and family support must include:

4.1.1. a minimum of two parent/guardian/family face to face conferences annually. Home visits are recommended for these conferences.

4.1.2. documented methods of communicating with parent/guardian such as newsletters, child activity reports, phone calls, home visits, e-mail and conferences.

4.1.3. services to children and their families necessary to support the child in his/her transition into, participation in, and transition out of the program.

4.1.4. for children who come from homes where languages other than English are spoken, support services including communication that is comprehensible and supportive of both the native language and English language development.

4.1.5. support services pursuant to 126CSR16,West Virginia Board of Education Policy 2419 - Regulations for the Education of Exceptional Students, for preschool children with disabilities which are integrated into the program and provided in accordance with the needs specified in the child's Individualized Education Program.

4.1.6. opportunities for parents/guardians/family to participate in decision making about their child's education.

4.1.7 parents/guardians/families are welcomed as visitors and encouraged to observe children in the classroom and to participate with children in group activities.

§126-28-5. Attendance.

5.1. Enrollment in an approved participating WV Pre-k program is voluntary; however, once the child is enrolled, attendance must follow West Virginia Code §18-8-1, et seq., which allows the program administrator (i.e. principal, director, executive director), teacher and parent/guardian to disenroll the child if they concur that requiring further attendance for that school year is not in the best interest of the child.

5.2. Each county must make reasonable efforts to ensure that the parent/guardian and other family members, as appropriate, understand about the availability of services, the attendance policy and the benefits of childhood education.

5.3. Each county must include in its plan a provision for working with families whose children are chronically absent and/or tardy.

§126-28-6. Collaboration and the County Plan.

6.1. Each county board of education must submit a county plan (an original and six copies) to the Secretary of the West Virginia Department of Health and Human Resources. The initial plan is due June 27, 2003. All county plans are to be prepared in accordance with the County Plan for Services to Eligible Children document (attached).

6.2 Once the county plans are approved by the Secretary of the West Virginia Department of Health and Human Resources, the plans will be forwarded by the Secretary's office to the West Virginia Board of Education for approval. If a county plan is not approved, it will be returned to the county board of education with an explanation and instructions for re-submission.

6.3. Changes, updates and amendments to the county plans are to be submitted to the West Virginia Department of Health and Human Resources and the West Virginia Department of Education by February each year until 2013 or until such time as the county offers universal access to a high quality program, as defined by this policy, for all eligible children in that county (see section 19.4).

6.4. In order to support counties in the effort to maximize existing resources by 2012-2013 or by full implementation, no less than 50% of the classrooms for eligible children must be provided through contractual agreements with community programs, including but not limited to Head Start and child care, unless the county collaborative team can document that those programs do not exist in that county, can never meet the mandates of this policy, or choose not to participate. Counties shall explore all feasible supports to enable community partners to meet the requirements of this policy, including providing certified teachers in community programs, before determining that programs cannot meet the mandates. This may not be construed to mean that counties will provide education services in public school settings only and contract out support services but rather that 50% of the classrooms for eligible children must be contracted with qualifying providers in collaborative settings. This ratio of community to public school providers can only be decreased with the written permission of both the West Virginia Board of Education and the Secretary of the West Virginia Department of Health and Human Resources. When the county school system includes the eligible children attending in an approved, contracted community program in the count for the school aid funding formula, a portion of the money generated by the formula must be used through the contractual agreement to insure that the requirements of this policy are met and adhered to for the length of the contract. Counties must begin phasing in providing services in collaborative settings by the school year beginning 2004.

6.5. The county collaborative planning team must include, at a minimum, representation from: the county school system preschool program, the county school system preschool special needs program, a licensed community child care program in that county not operated by the county school system, the Head Start program in that county, the local department of health and human resources, and a parent/guardian of a preschool child. Due to the nature of child care, every licensed child care program in that county must be extended an invitation to participate on the planning team. Documentation of this invitation and the response shall be submitted with the plan.

6.6. Other recommended members of the county collaborative planning team may include a representative from the West Virginia Birth to Three program, the parent/guardian educator resource centers, child care resource and referral agencies, Family Resource Networks,

early parent/guardian education, local apprenticeship for child development specialist council, health, Starting Points, business, faith based early childhood program providers, community action, child abuse prevention agencies, higher education, and/or other community organizations that work with young children and their families providing support and education.

6.7. Development of the county plan through the county collaborative planning team should utilize an existing early childhood collaborative unless there is no such collaborative in that county.

6.8. Any member of the county collaboration planning team that will provide services to eligible children in that county must follow all rules and regulations as outlined in the state policy.

6.9. The County collaborative plan must include documentation by each participating partner of his or her role in the development of the county collaborative plan.

6.10. County plans will include a list of all programs invited to participate in the planning process regardless of whether the program chose to participate.

§126-28-7. Waivers.

7.1. The West Virginia Board of Education may grant a county board a waiver from full implementation of WV Pre-k in a county if the state board finds that all of the following conditions are met:

7.1.1. The county does not have sufficient facilities available; or

7.1.2. The county does not have and has not had available funds sufficient to implement the program; and

7.1.3. The county has not experienced a decline in enrollment at least equal to the total number of students to be enrolled; and

7.1.4. Other agencies have not made sufficient funds or facilities available to assist in implementation.

7.2. A county seeking a waiver must apply with the supporting data to meet the criteria for which they are eligible on or before the twenty-fifth day of March for the following school year.

7.3. The State Superintendent of Schools shall notify the county that the requested waiver was denied or granted on or before the fifteenth day of April of that same year.

§126-28-8. Personnel Standards.

8.1. Teachers must hold a qualifying certification/endorsement, specifically, a teaching certification/ endorsement in early education (also called early childhood education), Prek-k endorsement, Preschool Special Needs or birth to five.

8.2. A full-time permit shall be issued and valid for one school year and shall expire on the thirtieth day of June. An educator employed on or after the first day of January may be issued a Permit valid until June 30 of the following year. All requirements for the Professional Teaching Certificate must be completed within five years of the original issuance of the Full-Time Permit. See 126CSR136, West Virginia Board of Education Policy 5202 - Minimum Requirements for the Licensure of Professional/Paraprofessional Personnel and Advanced Salary Classification, Section 15. Full-time permits will be issued for:

8.2.1. persons with degrees in elementary education, child and family studies with an emphasis on early childhood education, or child development, or

8.2.2. persons with a Board of Regents degree with a specialization in early childhood/child development who are employed by a community program, or

8.2.3. persons with an AA in child development/early childhood or occupational development with an emphasis on child development/early childhood and one year of early education teaching experience who are employed by a community program.

8.3 Persons who are employed to meet the staff/child ratios but are not certified teachers such as aides, assistants, or paraprofessionals must meet the criteria set forth in the West Virginia State Registry and Training System (WV STARS) career pathway level II. Level II is defined as persons who are at least 18 years old with a high school diploma or equivalent and 0-1 years of experience and possess the ability to understand and practice the core competencies with direction and instruction or through sponsorship of a professional organization or qualified mentor (attached). Aides and assistants must have an individualized staff development plan for specifying his/her planned progression on the career in order to attain pathway level V within five years.

§126-28-9. Regulation of Facilities.

9.1. All approved participating WV Pre-k programs, see definitions, that are included in the county collaborative plan must meet the requirements as set forth in the West Virginia Department of Health and Human Resources Rule, Day Care Center Licensing, 78CSR1, or any rule promulgated to replace and/or update 78CSR1Public schools or other programs who are exempt under West Virginia Department of Health and Human Resources Rule, Day Care Center Licensing 78CSR1 or its replacement must meet the requirements set forth in that rule. In the case of public schools, West Virginia Department of Health and Human Resources Child Care Licensing staff will conduct monitoring visits of all areas related to the WV Pre-k program and any recommendations for action will be made to the Office of Education Performance Audits.

Failure to correct any non-compliance findings within 18 months could jeopardize the approval of the county collaborative plan. Programs that wish to participate in WV Pre-k, but would otherwise be exempt under 78CSR1 except public schools, shall be licensed by the West Virginia Department of Health and Human Resources.

§126-28-10. Standards for Preparing Students.

10.1. Programs participating in the county's collaborative plan must adhere to the West Virginia Department of Education's developmental continuum contained in the content standards and objectives for eligible children's programs which are aligned with the Head Start outcomes framework and kindergarten content standards and objectives. The content standards and objectives for programs serving eligible children are written to reflect a developmental continuum that enhances successful transition into kindergarten. Children shall be assessed on their individual developmental progress along the developmental continuum.

§126-28-11. Curriculum and Assessment.

11.1. Once the list of accepted comprehensive curricula systems, curriculum enhancements, and comprehensive assessment systems is adopted, only comprehensive curricula systems, curriculum enhancements, comprehensive assessment systems that are included on the adopted list may be used by programs participating in the county plan.

11.2. Comprehensive curricula systems, curriculum enhancements and comprehensive assessment systems will be approved following the process established by the West Virginia Department of Education, including, preschool special education, for adoption of instructional materials.

11.3. Curriculum and assessment, along with the content standards and objectives, will be parts of an inter-related system that measures the child's progress on a continuum of development and are utilized to individualize the children's educational opportunities.

11.4. A comprehensive curricula system must at a minimum meet the following standards:

11.4.1. include a philosophy, goals and objectives based on current knowledge of child development and learning styles and reflect an understanding of how children learn and develop by:

a. addressing the developmental needs of eligible children through practices that are consistent with current, nationally recognized, most effective practice.

b. valuing exploration, creativity and construction as the child's primary learning approaches.

c. engaging children actively in the learning process and providing them with opportunities to make meaningful choices.

d. responding to individual children's interest, strengths and needs based on ongoing observation and assessment.

e. supporting children so they view themselves as part of a larger community.

11.4.2. be balanced and designed to achieve the long-range goals for social, emotional, physical, cognitive and academic (early literacy, early numeracy, and language) achievement by:

a. incorporating a wide variety of learning experiences, materials and equipment, and instructional strategies that are responsive to the differences in prior learning experiences, maturation rates, and learning styles young children bring to the classroom.

b. supporting a balance of large and fine motor activities, quiet and active times, individual and small and large group activities, child initiated and adult initiated activities, planned and spontaneous activities, and indoor and outdoor opportunities.

c. addressing the development of knowledge and understanding, processes and skills, dispositions and attitudes.

11.4.3. integrate development of all domains, abilities, and content that is relevant, engaging, and meaningful to young children by:

a. meeting the developmental continuum contained in the content standards and objectives for eligible children as prescribed by the West Virginia Board of Education.

b. building on what children already know in order to consolidate their learning and foster the acquisition of new concepts and skills.

c. reflecting the needs and interest of individual children in the group by including the immediate environment and world with which the children are acquainted.

d. supporting integration of curriculum content through use of a planning organizer (such as themes, projects, key experiences, or webs).

e. including materials and activities that reflect a variety of cultures, languages, ages, abilities, and beliefs.

11.4.4. emphasize the development of thinking, reasoning and problem-solving skills through strategies such as open-ended questions, investigation, imaginative and dramatic play, and peer interactions.

11.4.5. promote flexibility and adaptation to unique needs of children and families where ongoing observation and assessment are used to determine appropriate planning and adaptations for varied learning styles, temperaments, abilities, and languages or modes of communication by:

a. integrating curriculum and assessment that benefits the child.

b. making opportunities for all children, regardless of ability, to participate in all activities through appropriate adaptations or modifications of activities, assistive technology, materials and/or learning environments.

11.4.6. design a learning environment that supports the curriculum and allows children of all abilities to make choices, to discover, to explore, and to solve problems by:

a. assuring children's health and safety.

b. clearly defining learning centers and incorporating them into the classroom.

c. organizing and labeling materials and equipment and making them accessible to all children.

d. incorporating non-stereotypical images in all elements of the environment.

e. supplying a sufficient quantity and variety of appropriate materials.

f. rotating the availability of materials.

g. supporting a child's needs for privacy and a safe place to be alone.

h. introducing children to the unfamiliar.

11.4.7. support the importance of learning during routine times of the day and meeting the physiological needs of children by:

a. promoting consistency in schedules and routines and facilitating smooth transitions.

b. supporting continuity between home and school.

c. encouraging children's participation in routines to develop responsibility and independence.

d. recognizing the integral role of adults during routine times.

e. allowing for flexibility and adaptations for individual children.

f. supporting positive health and nutrition practices.

g. providing daily rest times for children in programs operating more than four hours/day and allowing non-nappers to engage in quiet activities.

11.4.8. promote, through a variety of strategies, the essential role of families as partners in planning and implementing their child's care and education.

11.4.9. emphasize the value of social interaction to learning in all domains and promote frequent, responsive, respectful interactions between children, staff and children, and staff and families.

11.4.10. recognize the role of children's psychological safety in learning and include guidance techniques that support children.

11.4.11. promote the use of developmentally appropriate curriculum and assessment principles to determine how technology is incorporated into the classroom environment. Technology should be used as a complement to, not substitute for, effective teaching or good curriculum.

11.4.12. include a comprehensive assessment system that evaluates the program's success in meeting the needs of young children, for helping them be ready to succeed in school, and documents the child's individual progress on the continuum of development by:

a. supporting the child's development and learning without threatening their psychological safety or feelings of self-esteem.

b. supporting the parent/guardian relationships with their children.

c. demonstrating the child's overall strengths and progress.

d. encouraging self-evaluation by the child.

e. relying on demonstrated performance of real, not contrived, activities.

f. utilizing a variety of tools and processes.

g. allowing for differences in learning style and rate.

h. incorporating a mechanism for sharing with and feedback from the parents/guardians.

i. including the parent/guardian as collaborative partners.

11.5. The curriculum will be a part of the inter-related approach of using curriculum, assessment and content standards and objectives to facilitate the individualization and direction of classroom programming.

11.5.1. Program components must include learning centers, incorporated within the classroom, designed to support literacy, early numeracy, and language, such as:

a. blocks and construction,

b. books,

c. manipulatives,

d. science and nature,

e. writing,

f. role playing,

g. physical activity

h. art,

i. music.

11.6. Classroom design and program implementation for eligible children must exclude the use of student desks, work sheets, long periods of sitting, use of shaming to discipline, withholding of food or bathroom privileges, or any other practice that is not appropriate for the ages/stages of the children or is harmful psychologically or physically.

§126-28-12. Transition and Continuity.

12.1. Each program participating in the county plan must have a written and implemented plan for transitioning children into the WV Pre-k system and out of the WV Pre-k system into kindergarten. At a minimum the plan will include:

12.1.1. an opportunity for the child and his/her family to visit the setting into which the child is transitioning, i.e. WV Pre-k or kindergarten classroom.

12.1.2. written information to parent/guardian and/or other family members as appropriate about Pre-k or kindergarten registration and what to expect in the Pre-k or kindergarten.

12.1.3. an opportunity for teachers/providers in the WV Pre-k system and into kindergarten and eligible programs in that county to meet annually to discuss how to facilitate successful transition and support the reciprocity of readiness practices.

12.1.4. a county system for transferring assessment data, including but not limited to portfolios, on each child who has participated in a eligible program to the kindergarten teacher to assist the kindergarten teacher in identifying areas of development and areas for growth to meet the individual needs of each child.

12.1.5. policies and procedures for the transition of children with Individualized Education Programs out of the WV Pre-k system and into kindergarten and children from the WV Birth to Three system will follow all state and federal requirements.

12.1.6. transition planning which follows the *West Virginia Childhood Transition Checklist* (attached).

12.1.7. To the extent possible, programs will be designed to minimize the number of settings in which a child receives education and care services. Parent/guardian should be given options to enroll their child in a program that meets the needs of the family and supports consistency and continuity for the child. Placement shall not be limited to the local school district in which the child lives if openings are available in participating programs within that county that better meet the child and family's needs.

§126-28-13. Inclusive Environments.

13.1. County plans will outline the county's process for providing fully inclusive early childhood classrooms with appropriate supports for children with identified special education needs. Proximity does not guarantee inclusion.

13.2. Socioeconomic level, ability, and/or funding streams should not be viewed as deterrents to providing fully inclusive programs.

§126-28-14. Staff Development and Training.

14.1. Each county plan will include a plan for providing a minimum of 18 hours annually for staff development related to high quality programming for eligible children based on a

professional development needs assessment and including a minimum of six hours of education on issues related to young children with special needs.

14.2. Professional development opportunities will follow the West Virginia State Training and Registry System (S.T.A.R.S.) training process (attached).

14.3. Every WV Pre-k teacher and assisting staff including aides, assistants, and paraprofessionals, must complete a total of 36 hours of training based upon the West Virginia curriculum/assessment standards over a 24 month period and provided by the employer or made accessible through the professional development section of the county collaborative plan. Thirty-six hours is the minimum and does not preclude teachers and assisting staff from taking a college credit bearing course of 45 hours on the West Virginia curriculum/assessment standards.

§126-28-15. Transportation.

15.1. For programs participating in the county collaborative plan, transportation is considered a support, not a mandated service unless it is a related service for children with disabilities in accordance with state and federal requirements.

15.2. Participating programs should make every effort to coordinate transportation systems to support families whose children would not otherwise be able to participate.

15.3. All participating programs must, at a minimum, follow the requirements of their primary funding source or the West Virginia TransporTots document, whichever is more stringent.

§126-28-16. Program Oversight.

16.1. Local program oversight, including but not limited to staff evaluation and discipline, will be specified within the resulting collaborative agreements of each participating program in the county plan.

16.2. The West Virginia Board of Education or its designee and the Secretary of the West Virginia Department of Health and Human Resources or his/her designee will maintain state oversight.

16.3. On or before the second day of January, 2004, the Secretary of the West Virginia Department of Health and Human Resources and the West Virginia State Superintendent of Schools will submit a report to the Legislative Oversight Commission on Educational Accountability and the joint committee on government and finance which addresses, at a minimum:

16.3.1. a summary of the approved county plans for providing the early childhood education programs under this policy.

16.3.2. an analysis of the total cost to the state and counties of implementing the plans.

16.3.3. a separate analysis of the impact of plans on counties with increased enrollment.

16.3.4. an analysis of the affect of the programs on the maximization of the use of federal funds for early childhood programs.

16.4 On or before the first day of December, 2004, and each year thereafter, the West Virginia State Board of Education shall report to the Legislative Oversight Commission on Educational Accountability.

§126-28-17. Financing.

17.1. Neither the West Virginia Board of Education nor the West Virginia Department of Education may provide any funds to any county for the purpose of implementing this policy unless the county has an approved plan as outlined herein.

17.2. Each county must include in the county collaborative plan an explanation of how money generated through the implementation of the eligible program will be used to support the participating programs in the county including contractual community programs and county school system provided programs.

17.3. If programs are a part of the collaborative county plan and provide education services to eligible children that can be counted in the county school aid funding formula, those services must be provided at no cost to the parent/guardian of the children.

§126-20-18. Health and Safety.

18.1. WV Pre-k classrooms shall limit classroom size to no more than twenty children per classroom. Ratios shall be maintained at 1 adult: 10 children with one adult being a certified teacher in accordance with §126-28-8, Personnel Standards.

18.2. If WV Pre-k classrooms are operating for more than four hours, meals must be provided in accordance with the guidelines set forth under the West Virginia Department of Education child and adult food program. Programs operating less than four hours will provide a snack as prescribed the West Virginia Department of Education child and adult food program.

18.3. Immunization. All children entering an approved participating WV Pre-k program shall follow the guidelines of the primary (providing 51% or more of the funding that year) funding source for that setting regarding immunization. Participating programs that operate within a public school facility must follow West Virginia Code §16-3-4.

18.4. Health Screenings. All children entering an approved participating WV Pre-k program shall be screened for impairments or delays in hearing, vision, speech, language, development, and dental health. Programs shall adhere to the deadlines as prescribed by their primary funding source (providing 51% or more of the funding for that year). Programs operated by the county board of education shall adhere to West Virginia Code §18-5-17.

§126-28-19. Program Evaluation.

19.1. Beginning with the school year which starts in August 2004, all participating programs shall use the Early Childhood Environment Rating Scale (ECERS, Harms, Clifford, and Cryer, 1998) as a guidance tool to evaluate the programs success in meeting the needs of the children. The results of the evaluation will be submitted annually by the 30th day of June to the West Virginia Department of Education, Coordinator of Early Childhood, Building 6, Room 318, 1900 Kanawha Boulevard, East, Charleston, WV 25305-0330.

19.2. Programs will be assessed using the ECERS by a trained outside evaluator every five years or if concerns from the West Virginia Department of Education, West Virginia Department of Health and Human Resources or county board warrant assessment.

19.3. At which time the state has money and manpower to provide monitoring using the ECERS, programs may be required to have a trained outside evaluator evaluate the program more frequently.

19.4. At which time a county has fully implemented their county collaborative plan and all eligible children in that county have access to a WV Pre-k classroom, the county board of education is required to annually submit a copy of the ECERS evaluation for each approved participating WV Pre-k program, a summary of the WV Pre-k services provided in the county, a contractual agreement for each community partner providing services as an approved participating WV Pre-k program provider, the total number of WV Pre-k children served in each county, the number of WV Pre-k children with identified special education needs, the staff development opportunities provided through the county collaborative plan and the number of staff who participated in those staff development opportunities, and number of children who transitioned into kindergarten to the Early Childhood Coordinator of the West Virginia Department of Education, by the 30th day of June (format attached). A copy of the report must be sent by the 30th day of June to the West Virginia Department of Health and Human Resources, Early Childhood Division.

19.5. The state shall develop and institute a system of longitudinal, scientific-based research to track learner outcomes, family satisfaction, program continuity and related variables in order to evaluate program impact, as funds become available. The system shall be designed in such a way to be of benefit on both the county and state level.

County Plan for Services to Eligible Preschool Children - 2003/04

County _____ **Date Submitted** _____

County Superintendent of Schools _____

Designated Contact Person Regarding Application _____

Address _____ **State** _____ **Zip Code** _____

Phone _____ **Fax** _____

Email address _____

Core Partner Representatives Participating on Collaborative Planning Committee:

Core Partner	Signature	Printed Name	Agency
Public School Preschool			
Public School Preschool Special Needs			
Head Start			
Local DHHR Representative			
Licensed Child Care*			
Parent/Guardian of a preschool child			

Note: all core partners must attach a signed letter of agreement to the county plan documenting their participation in the plan

development process.
* Due to the nature of child care, every licensed child care program in the county must be extended an invitation to participate on the county planning team. Documentation of this invitation and the response must be submitted with the plan (2525 6.5 pg 5)

Other Partners participating on Collaborative Planning Committee (Note, these may include but not be limited to: a representative from the county Birth to Three program, Starting Points, Parent/Guardian Educator Resource Center representative, Child Care Resource and Referral agencies, Family Resource Networks, Early Parent/Guardian Education, local Apprenticeship For Child Development Specialist Council, health agencies, business, faith based early childhood program providers, Community Action Agency, child abuse prevention agencies, higher education, and/or other community organizations that work with young children and their families providing support and education)

Signature	Printed Name	Agency

Additional signature pages can be attached, if necessary.

Collaborative Plan Development: Describe the process utilized for plan development (agencies invited, number of meetings held, roles of participants, etc.):

Part I. Needs Assessments and Conclusions:

The needs assessment for this plan should be built on current data and may use needs assessments that have already been conducted for other purposes by participating agencies. The needs assessment for this plan shall include information about demographics of the county related to the early childhood program implementation, financial requirements for implementation, and potential sources of funding to assist implementation.

A. Assessment of the estimated number of four year old children in your county in relation to your school attendance areas (as defined by the School Building Authority) over the next 5 years (2003-2007):

Projected Number of Four Year Old Children Per School Year					
School Attendance Area	**2003**	**2004**	**2005**	**2006**	**2007**
Total Projected Number					

B. Assessment of Current Early Childhood Programs. What four-year-old services are available in each school attendance area? (Head Start, Child Care, Private Preschool, Preschool Special Education, etc.)

Program Name	School Attendance Area	Type of Service*	Child Care Licensed/ Meets Licensing Y or N	No. Hrs/Day Days/Wk.	Transp. Provided Y or N	No. 3 year olds enrolled	No. 4 year olds enrolled	Adult/child ratio	Specific Curriculum Utilized

* Indicate type of service, ie. HS - Head Start, CC - Child Care, PSP - Public School Preschool, SN - Public School Preschool Special Needs, PPS - Private Preschool, etc. Where combination/collaborative programs exist, indicate initials of all participating partners.

C. Assessment of teacher certifications/qualifications:

›gram	Certified				Eligible for Permit					
	A.	B.	C.	D.	E.	F.	G.	H.	I.	J.

Key: **A** - Early Education Certification; **B** - Prek-K Endorsement; **C** - Birth to Five Certification; **D** - Preschool Special Needs; **E** - Elementary Education; **F** - Child and Family Studies with Early Childhood Education; **G** - Child Development; **H** - Board of Regents Degree with Early Childhood/Child Development; **I** - AA Degree in Child Development/Early Childhood Plus One Year Early Education Teaching Experience; **J** - AA Degree in Occupational Development with Emphasis on Child Development/Early Childhood Plus One Year Early Education Teaching Experience

Analyze the assessment information indicated in A, B, and C above to determine findings, conclusions, and priorities for the development of your county plan for 2003-2004:

Analysis	Findings	Conclusions	Priority
Demographics - number of anticipated 4 year olds.			
Current Early Childhood Program Analysis			
Teacher Certifications / Qualifications			

Part II. Early Childhood Education Implementation Plan

The overall goal of West Virginia's Pre-K program is to provide, beginning no later than the school year 2012 - 2013, quality comprehensive early childhood education programs for all children who have attained the age of four prior to the first day of September of the school year in which the pupil enters the early childhood education program

Based upon the needs assessment information compiled and conclusions and priorities established, identify your objectives and activities for school year 2003/2004 in order to comply with 126CSR126 West Virginia's Access to Early Education System (2525). Use the following format for each objective and related activities. In developing the county system for providing Universal Pre-K, provide specific details regarding the following sections of the procedural rule: 126-28-6 Collaboration and the County Plan, 126-28-12 Transition and Continuity, 126-28-13 Inclusive Environments, 126-28-14 Staff Development and Training, 126-28-15 Transportation, 126-28-16 Program Oversight, 126-28-17, 126-20-18.3 and .4 Health and Safety, and 126-28-19 Program Evaluation.

OBJECTIVE: _____			
ACTIVITIES	**PERSON/AGENCY RESPONSIBLE**	**TIME LINE**	**COST ESTIMATES/ RESOURCES**

Use a separate form for each objective

BUDGET AND R OURCE PLAN

Indicate below the defined objectives and activities, the source of funds and/or resources, the dollar amounts budgeted and/or committed to achieve the implementation of this plan.

Objective #	Activity	Source	Budgeted Amount/Resource Committed

Statement o ssurances

The submission of this plan signed by participating core partners along with the County Superintendent of Schools assures that WV Pre-K programs will comply with the following sections of Title 126 Procedural Rule Board of Education, Series 28, West Virginia's Universal Access to early Education System (2525):

(Note: All other sections of 126-28 (2525) must be addressed in Part II of this plan)

126-28-2. Guidelines

126-28-4. Parent/Guardian Involvement and Family Support

126-28-5. Attendance

126-28-8. Personnel Standards

126-28-9. Regulation of Facilities

126-28-10. Standards for Preparing Students

126-28-11. Curriculum and Assessment

County Superintendent of Schools _____

Printed Name _____ **Date Submitted** _____

WEST VIRGINIA STATE TRAINING & REGISTRY SYSTEM (STARS)
CAREER PATHWAY LEVEL DESCRIPTIONS

These competency levels and appropriate developmental practices describe expected attributes, skills and abilities of all people who work with young children (ages birth through eight years) and their families. Training and understanding of core competencies is the same for all who work in an early childhood setting. The level of competence, skills, abilities and understanding increases as staff/providers become more experienced and assume more responsibility, especially in the areas of programming, advocacy, training and supervision. A supervisor is to have a higher level of education and/or more years of experience than the person being supervised.

Eight levels of competency reflect experience and/or formal educational accomplishments. Individuals at all levels must have no criminal record and be in good health. An early care and education field refers to a credential, college credits or degree in child development, Birth through 4 certification, early childhood, child and family studies, and early childhood special education. Relevant occupational experience refers to working with or on behalf of children, ages birth through 8, and their families through: a) direct work with young children and families; b) supervision, leadership or management; c) program coordination, development or regulation; d) training, instruction or technical assistance; and e) evaluation or research. This Career Pathway does not replace licensing or certification requirements that may be expected for specific positions (i.e. certified public school teacher, WV Birth to Three credentialing requirements, etc.).
The abilities in each level are cumulative. Individuals must demonstrate proficiency in the core competency abilities listed in each previous level as well as in their level of professional development.

Level I:
Individuals at this level must be at least 16 years of age and be enrolled in high school or GED preparation classes. They *conform* to Core Competencies by following the directions and instructions of their supervisors.

Level II:
Individuals at this level must be at least 18 years of age, have a high school diploma or its equivalent and have an interest in working with young children. Staff/providers at this level have 0-1 year of experience working with young children and will assist other staff/providers. They *understand and practice* Core Competencies with direction and instruction from their supervisors or through sponsorship/affiliation with a professional association or qualified mentor.

Level III:
Staff/providers must have:

1. The West Virginia Training Certificate in Early Care and Education (WVTCECE), which is awarded for completion of 120 hours of STARS training. Training for WVTCECE is provided by STARS trainers at registered workshops and training programs throughout the state. Recognition certificates are issued for each 30 hours of STARS training completed. Training hours obtained through the WV Infant/Toddler Training (One Step At A Time) and the WV Educare Orientation program will count towards the WVTCECE.

or

2. Completed at least 120 training hours required for the Child Development Associate (CDA) certificate, as certified by CDA instructors,

or

3. Completed 3 semesters of the registered Apprenticeship for Child Development Specialists (ACDS) program,

or

4. Completed the WV Department of Education Early Childhood & Education Services area of study through participating vocational and high schools, as certified by the participating school and the Department of Education.

Staff/providers at this level *practice programming* which conforms to the Core Competencies.

Level IV:

Staff/providers must have:

1. A Child Development Associate (CDA) certificate,

or

2. 12 college credits in early care and education course work and a minimum of 300 clock hours of relevant occupational experience,*

or

3. Four completed semesters of the registered Apprenticeship for Child Development Specialist (ACDS) program. A certificate of completion of 4 semesters of ACDS training is required from the ACDS instructor.

or

4. Ten (10) years of relevant occupational experience* (this experience exemption expires on January 1, 2003).

Staff/providers at this level *practice and implement programming* which conforms to Core Competencies.

Level V:

Staff/providers must have:

1. A registered Apprenticeship for Child Development Specialist (ACDS) certificate from the Department of Labor or Department of Education,

or

2. Other comparable certificate program in child development,

or

3. 28-63 semester hours of college credit, with a minimum of 9 credit hours of early care and education course work,

or

4. 28-63 semester hours of college credit and 1 year of relevant occupational experience (minimum of 1200 clock hours per year),*

or

5. Fifteen (15) years of relevant occupational experience* (this experience exemption expires on January 1, 2003).

Staff/providers at this level *plan and adapt programming* which conforms to the Core Competencies.

Level VI:
Staff/providers must have:

1. An Associate Degree in an early care and education field,*

or

2. An Associate degree with a minimum of 12 credit hours of early care and education course work,

or

3. An Associate degree and two years of relevant occupational experience,*

or

4. Completed at least 64 college credits and have two years of relevant occupational experience,*

or

5. Completed at least 64 college credits with a minimum of 12 credit hours of early care and education course work.

Staff/providers at this level *make curricular decisions* which conform to Core Competencies.

Level VII - Bachelor's Degree:
Staff/providers must have:

1. A Bachelor's Degree in an early care and education field,

or

2. A Bachelor's degree with a minimum of 15 hours of early care and education course work which includes either at least 90 contact hours of practicum experience with young children or one year of relevant occupational experience,

or

3. A Bachelor's degree and three years of relevant occupational experience.*

Staff/provides at this level *develop, select, and evaluate the early care and education program* to ensure it conforms to core competencies. In addition, they *apply theory into practice and help others understand this application of theory.*

Level VIII - Advanced Degree:
Staff/providers must have:

1. A Master's Degree or other advanced degree in an early care and education field,*

or

2. An advanced degree with a minimum of 18 hours of early care and education course work which includes either at least 90 contact hours of practicum experience with young children or one year of relevant occupational experience,

or

3. An Advanced degree and five years of relevant occupational experience.*

Staff/providers at this level *are directly involved in the activities of state, regional and/or national groups* who advocate for children and *contribute to the formation, evaluation and implementation of policies within the field of early childhood.*

*** An early care and education field refers to a credential, college credits or degree in child development, Birth through 4 certification, early childhood, child and family studies, and early childhood special education.**
*** Experience exemption: Staff/providers with 10 or 15 years of prior, relevant occupational experience may bypass formal credentialing and educational requirements and advance to Level III or Level IV, respectively. This exemption clause will expire on January 1, 2005.**
*** Relevant occupational experience refers to a minimum of 1200 clock hours per year working with or on behalf of children, ages birth through 8, and their families through: a) direct work with young children and families; b) supervision, leadership or management; c) program coordination, development or regulation; d) training, instruction or technical assistance; e) evaluation or research.**

WEST VIRGINIA STARS

State Training and Registry System

Professional development for early care and education

LEVEL VIII
Requirements: Advanced degree in an early care and education field* ***OR*** Advanced degree with 18 credit hours in early care and education & either 90 practicum contact hours or 1 year of relevant occupational experience ***OR*** Advanced degree & 5 years of relevant occupational experience.
Abilities: Directly involved in the activities of state, regional and/or national groups; contribute to the formation, evaluation & implementation of policies within the field.

LEVEL VII
Requirements: Bachelor's degree in an early care and education field* ***OR*** Bachelor's degree with 15 credit hours in early care and education & either 90 practicum contact hours or 1 year of relevant occupational experience ***OR*** Bachelor's degree & 3 years of relevant occupational experience. ***Abilities***: Develop, select and evaluate the child care program; apply theory into practice.

LEVEL VI
Requirements: Associate degree in an early care and education field* ***OR*** Associate degree with 12 hours in early care and education courses ***OR*** Associate degree & 2 years of relevant occupational experience ***OR*** ≥ 64 college credits & 2 years of relevant occupational experience ***OR*** ≥ 64 college credits in a related field with 12 hours in early care and education courses. ***Abilities***: Make curricular decisions which conforms to Core Competencies.

LEVEL V
Requirements: Registered Apprenticeship for Child Development Specialist (ACDS) certificate ***OR*** other comparable certificate program in early care & education ***OR*** 28-63 college credits, with 9 credit hours in early care & education ***OR*** 28-63 college credits & 1 year of relevant occupational experience ***OR*** fifteen (15) years of relevant occupational experience.* ***Abilities***: Plan and adapt programming which conforms to Core Competencies.

LEVEL IV
Requirements: Child Development Associate (CDA) certificate ***OR*** 12 college credits in early care and education & 300 clock hours of relevant occupational experience* ***OR*** 4 completed semesters of the ACDS program ***OR*** ten (10) years of relevant occupational experience.*
Abilities: Practice and implement programming which conforms to Core Competencies.

Level III
Requirements: West Virginia Training Certificate in Early Care and Education (WVTCECE) which includes completion of 120 clock hours of approved training through WV STARS ***OR*** ≥ 120 completed training hours required for the Child Development Associate (CDA) ***OR*** 3 completed semesters of the Registered Apprenticeship for Child Development Specialist (ACDS) program ***OR*** completed the WV DOE Early Childhood & Educational Services area of study through participating vocational schools.
Abilities: Practice programming which conforms to Core Competencies.

LEVEL II
Requirements: At least 18 years old with a high school diploma or equivalent and 0-1 years of experience.
Abilities: Understand and practice Core Competencies with direction and instruction or through sponsorship/affiliation with a professional organization or qualified mentor.

LEVEL I
Requirements: At least 16 years old & enrolled in High School or GED preparation classes.
Abilities: Conform to Core Competencies by following supervisory direction and instruction.

★ *The experience exemption clause to advance to Level IV or V with 10 or 15 years of experience expires on January 1, 2005.*
★ *An early care and education field refers to a credential, college credits or degree in child development, Birth through 4 certification, early childhood, child and family studies, and early childhood special education. This Career Pathway does not replace licensing or certification requirements that may be expected for specific positions (i.e. certified public school teacher, WV Birth to Three credentialing requirements).*

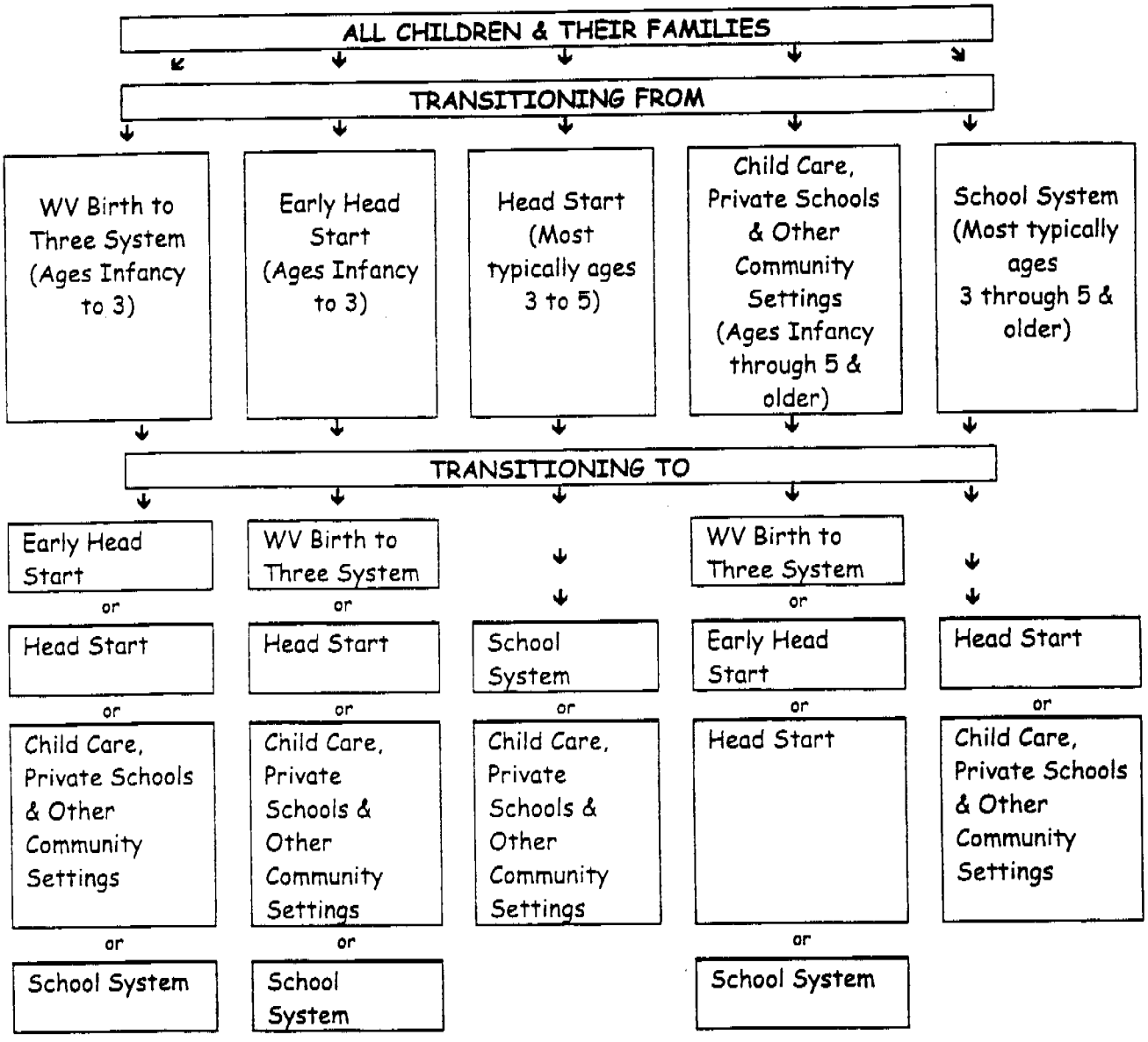
Relevant occupational experience refers to working with or on behalf of children, ages birth through 8, and their families through: a) direct work with young children and families; b) supervision, leadership or management; c) program coordination, development or regulation; d) training, instruction or technical assistance; e) evaluation or research.

06/02

WV EARLY CHILDHOOD TRANSITION CHECKLIST

The purpose of this checklist is to assist local agencies in supporting children and families as they transition to and from a variety of settings: WV Birth To Three System, School System, Head Start and Child Care. It identifies key activities for such transitions, some legally required and some reflecting effective practice (offered here as guidance). The user of this checklist is encouraged to consult specific federal, state, and local legal requirements to ensure that procedures are in full compliance. Four (4) different checklists are provided here for transitions to or from: (1) WV Birth to Three System; (2) Early Head Start and/or Head Start; (3) Child Care, Private Schools and Other Community Settings; and (4) School System (Preschool, Kindergarten, or Other Grades). To use the checklist:

1. Select one (1) checklist per child, choosing the checklist(s) appropriate for the child's situation. Enter child/program information at the top of the page.
2. Keep the checklist in the child's record as a tool to track each activity to make sure it is completed. When complete, put a check in the "completed" column and date(s) of activities in the "timelines" column. Add notes as needed.



WV EARLY CHILDHOOD TRANSITION CHECKLIST
TRANSITIONING FROM THE WV BIRTH TO THREE SYSTEM

CHILD _____ PARENT _____

DOB _____ AGENCY _____ CONTACT PERSON _____

These activities are appropriate for ALL children transitioning TO or FROM ANY setting.		
Completed	**Activity**	**Timelines**
	Provide parents with information on programs and/or services including enrollment requirements and registration.	
	Communicate with agency staff to facilitate continuity of programming and/or services.	
	Provide transition related training to prepare staff a) to follow appropriate procedures and b) to support children and families in the transition process.	
	Provide training for parents regarding transition process and future options. Include interagency partners in the training.	
	Involve parents in transition planning: a) to advocate for children b) communicate with personnel in the next service setting	
	Plan activities to prepare child for the next service setting.	
	Arrange visits to the next service setting for children, families, and staff from the sending program or service.	
	Coordinate with other agencies to transfer relevant records to next service setting.	
	Release demographic information/screening evaluation to the next service setting with parental permission as necessary.	

For Children and Families Transitioning From WV Birth to Three System		
Completed	**Activity**	**Timelines**
	Conduct transition planning with parent. Add plan to Individual Family Service Plan (IFSP).	At least 10 months prior to 3rd birthdate.
	Service coordinator contacts all appropriate "potential" receiving agencies that family wants invited to a face-to-face transition-planning meeting, including one or more of the following: ___ school system ___ Early Head Start/Head Start ___ child care, private schools and other community settings ___ other agencies for support needed by family Provide packet of information on the child to potential receiving agencies with parental consent.	

For Children and Families Transitioning From WV Birth to Three System - continued		
Completed	**Activity**	**Timelines**
	Provide training for parents regarding transition process and future service options. Involve interagency partners in this training such as one or more of the following: __ school system (required if child suspected to have a disability) __ Early Head Start/Head Start __ child care and other community settings and/or __ family support or other behavioral health services __ child care, private schools and other community settings	Start at least 10 months before 3rd birthdate and continue through transition process
	Release demographic information to the school system or other identified receiving agencies with parent permission. Include releases needed for next service setting as appropriate.	4 months prior to 3rd birthdate or earlier for summer or fall DOB.
	Conduct 90 day face-to-face meeting with all appropriate receiving programs (Early Head Start/Head Start, School System, Family Support, Child Care, Private Schools, Other Community Settings etc.) to discuss: 1. Child's program options from 3rd birthdate through remainder of school year 2. Updating of transition plan by interagency partners with family to address: a. activities which will prepare the child and family for the transition and b. strategies for sharing information among sending and receiving agencies	At least 90 days and up to 6 months prior to 3rd birthdate - or earlier to ensure that an Individualized Education Program (IEP) can be in place by the child's 3rd birthdate. These timelines for schools may be different for Head Start.
	Participate in or release information concerning screening / assessment / evaluation, reports etc. to receiving agencies as required or authorized by parent.	According to local interagency agreement timelines and early enough to allow IEP to be in place by 3rd birthdate
	Participate with team to determine need for further assessment.	
	Participate in IFSP/IEP meeting.	

NOTES:

WV EARLY CHILDHOOD TRANSITION CHECKLIST
TRANSITIONING FROM EARLY HEAD START/ HEAD START

CHILD _____ PARENT _____

DOB _____ AGENCY _____ CONTACT PERSON _____

These activities are appropriate for ALL children transitioning TO or FROM ANY setting.		
Completed	**Activity**	**Timelines**
	Provide parents with information on programs and/or services including enrollment requirements and registration.	
	Communicate with agency staff to facilitate continuity of programming and/or services.	
	Provide transition related training to prepare staff a) to follow appropriate procedures and b) to support children and families in the transition process.	
	Provide training for parents regarding transition process and future options. Include interagency partners in the training.	
	Involve parents in transition planning: a) to advocate for children b) communicate with personnel in the next service setting	
	Plan activities to prepare child for the next service setting.	
	Arrange visits to the next service setting for children, families, and staff from the sending program or service.	
	Coordinate with other agencies to transfer relevant records to next service setting.	
	Release demographic information/screening evaluation to the next service setting with parental permission as necessary.	

For Children and Families Transitioning From Early Head Start (Ages Infancy to 3) or Head Start (Most typically ages 3 to 5)		
Completed	**Activity**	**Timelines**
	Initiate meetings to discuss developmental progress of individual children among parents and professionals.	Early Head Start - at least 6 months prior to 3rd birthdate
	Obtain the from parent consent/authorization for release of information for a referral.	Mail within 10 days of parent's signature
	Release relevant assessment, health records, etc.	
	Participate in Individual Family Service Plan (IFSP)/Individualized Education Program (IEP) meeting.	

NOTES:

WV EARLY CHILDHOOD TRANSITION CHECKLIST
TRANSITIONING TO OR FROM CHILD CARE, PRIVATE SCHOOLS OR OTHER COMMUNITY SETTINGS

CHILD _____ PARENT _____

DOB _____ AGENCY _____ CONTACT PERSON _____

These activities are appropriate for ALL children transitioning TO or FROM ANY setting.		
Completed	**Activity**	**Timelines**
	Provide parents with information on programs and/or services including enrollment requirements and registration.	
	Communicate with agency staff to facilitate continuity of programming and/or services.	
	Provide transition related training to prepare staff a) to follow appropriate procedures and b) to support children and families in the transition process.	
	Provide training for parents regarding transition process and future options. Include interagency partners in the training.	
	Involve parents in transition planning: a) to advocate for children b) communicate with personnel in the next service setting	
	Plan activities to prepare child for the next service setting.	
	Arrange visits to the next service setting for children, families, and staff from the sending program or service.	
	Coordinate with other agencies to transfer relevant records to next service setting.	
	Release demographic information/screening evaluation to the next service setting with parental permission as necessary.	

NOTES:

WV EARLY CHILDHOOD TRANSITION CHECKLIST
TRANSITIONING TO THE SCHOOL SYSTEM
(PRESCHOOL, KINDERGARTEN, OR OTHER PROGRAMS FOR CHILDREN WITH AND WITHOUT DISABILITIES)

CHILD _____ PARENT _____

DOB _____ AGENCY _____ CONTACT PERSON _____

These activities are appropriate for ALL children transitioning TO or FROM ANY setting including school settings for students with and without disabilities.		
Completed	**Activity**	**Timelines**
	Provide parents with information on programs and/or services including enrollment requirements and registration.	
	Communicate with agency staff to facilitate continuity of programming and/or services.	
	Provide transition related training to prepare staff a) to follow appropriate procedures and b) to support children and families in the transition process.	
	Provide training for parents regarding transition process and future options. Include interagency partners in the training.	
	Involve parents in transition planning: a) to advocate for children b) communicate with personnel in the next service setting	
	Plan activities to prepare child for the next service setting.	
	Arrange visits to the next service setting for children, families, and staff from the sending program or service.	
	Coordinate with other agencies to transfer relevant records to next service setting.	
	Release demographic information/screening evaluation to the next service setting with parental permission as necessary.	

For Children & Families Being Referred for Transition to Special Education Services in the School System: children ages 3 through 5 & older having or suspected of having a disability		
Completed	**Activity**	**Timelines**
	Receive referral demographic information from family or agency from which child is transitioning.	10 months prior to 3rd birthdate (if transitioning from WV Birth to Three)
	Participate in meeting with parents and referring agency (example: 90 day face-to-face for WV Birth to Three or meeting with Head Start, Child Care, Private School or Other Community Agency)	

For Children & Families Being Referred for Transition to Special Education Services in the School System: children ages 3 through 5 & older having or suspected of having a disability - continued		
Completed	**Activity**	**Timelines**
	Review current evaluation data and determine evaluation data needed. (Example: from WV Birth to Three or Head Start)	
	Obtain parental permission for needed evaluation and ensure due process rights and parental input. (Example: parent questionnaire)	From receipt of parental permission to eligibility meeting is 80 calendar days
	Conduct evaluation / assessment including involvement of other agencies' staff as necessary.	Within overall timelines as noted above.
	Schedule Eligibility Meeting and/or a meeting for both eligibility determination and Individualized Education Program (IEP) development.	Within overall timelines as noted above.
	Participate in Eligibility Meeting or Eligibility/IEP meeting.	Within overall timelines as noted above.
	Schedule IEP team meeting (if not done as part of Eligibility Meeting).	30 calendar days following Eligibility Meeting
	Conduct IEP team meeting with participants. *NOTE: Follow guidelines assuring parental participation as outlined in 2419.* (State Department of Education Regulations for the Education of Exceptional Students)	
	Determine placement settings based on options as outlined in 2419.	

NOTES:

County Collaborative Annual Report for

Approved participating WV Pre-k classrooms

Program Year _____

County Submitting _____

- ❑ Annual Early Childhood Environmental Rating Scale self-assessment.
- ❑ A summary of the WV Pre-k classroom services provided in the county.
- ❑ Collaborative agreements for each approved participating WV Pre-k provider.
- ❑ Total number of children served in WV Pre-k classrooms.
- ❑ Number of children served in WV Pre-k classrooms with identified special needs.
- ❑ A list and brief description of professional development opportunities provided for WV Pre-k classroom staff.
- ❑ Number of WV Pre-k classroom staff that participated in professional development opportunities.
- ❑ Number of children who transitioned from WV Pre-k classrooms into kindergarten.

TITLE 126
PROCEDURAL RULE
BOARD OF EDUCATION

SERIES 94
PROCEDURES FOR THE COLLECTION, MAINTENANCE AND DISCLOSURE OF STUDENT DATA (4350)

§126-94-1. General.

1.1. Scope. – These procedures are applicable to all education agencies and institutions that are under the general supervision of the West Virginia Board of Education.

1.2. Authority. – W. Va. Constitution, Article XII, Section 2, W. Va. Code §18-2-5, Public Law 105-244, the Family Educational Rights and Privacy Act (as amended); Public Law 105-17, the Individuals with Disabilities Education Act Amendments of 1997 (hereinafter IDEA); Public Law 107-110, the No Child Left Behind Act of 2001; Public Law 107-107, the National Defense Authorization Act for the Fiscal Year 2002, and their respective regulations.

1.3. Filing Date. – August 19, 2003.

1.4. Effective Date. – September 18, 2003.

1.5. Repeal of Former Rule. - This procedural rule revises W. Va. 126CSR94, West Virginia Board of Education Policy 4350, "Procedures for the Collection, Maintenance and Disclosure of Student Data", filed October 22, 2002 and effective November 21, 2002.

§126-94-2. Purpose.

2.1. The purpose of these procedures is to set forth the conditions governing the protection of privacy and access of parents and students as it relates to the collection, maintenance, disclosure and destruction of education records by agencies and institutions under the general supervision of the West Virginia Board of Education.

§126-94-3. Definitions.

3.1. As used in these procedures:

3.1.1. "Attendance" at an agency or institution includes, but is not limited to: (a) attendance in person and having homebound instruction, and (b) the period during which a person is working under a work-study program.

3.1.2. "Consent" means that (a) the parent has been fully informed of the information set out in this document in his or her native language or other mode of communication, unless it clearly is not feasible to do so; (b) the parent understands and agrees in writing to the carrying out of the activity for which consent is sought, and the consent sets forth that activity and lists the records (if any) which will be released and to whom; and (c) the parent understands that the granting of consent is voluntary on the part of the parent.

3.1.3. "Destruction" means physical destruction or removal of personal identifiers so that the information is no longer personally identifiable.

3.1.4. "Directory information" includes a student's name, address, telephone listing, date, and place of birth, major field of study, participation in officially recognized activities and sports, weight and height of members of athletic teams, dates of attendance, degrees and awards received, and the most recent previous educational agency or institution attended by the student.

3.1.5. "Disciplinary action or proceeding" means the investigation, adjudication, or imposition of sanctions by an educational agency

or institution with respect to an infraction or violation of the internal rules of conduct applicable to students of the agency or institution.

3.1.6. "Disclosure" means permitting access or the release, transfer, or other communication of education records of the student or the personally identifiable information contained therein, orally or in writing, or by electronic means, or by any other means to any party.

3.1.7. "Educational institution" or "educational agency or institution" means any public or private agency or institution under the general supervision of the West Virginia Board of Education.

3.1.8. "Education records" means those records that are directly related to a student and are collected, maintained or disclosed by an educational agency or institution or by a party acting for the agency or institution. The term does not include:

a. Records of instructional, supervisory, and administrative personnel and educational personnel ancillary to those persons that are kept in the sole possession of the maker of the record and are not accessible or revealed to any other individual except a temporary substitute.

b. Records of the law enforcement unit of an educational agency or institution, subject to the provisions of Section §126-94-7.

c. Records relating to an individual who is employed by an educational agency or institution that are made and maintained in the normal course of business; relate exclusively to the individual in that individual's capacity as an employee, and are not available for use for any other purpose. However, records relating to an individual in attendance at the agency or institution who is employed as a result of his or her status as a student are education records and are not excepted.

d. Records relating to an eligible student that are:

A. Created or maintained by a physician, psychiatrist, psychologist, or other recognized professional or paraprofessional acting in his or her professional or assisting in a paraprofessional capacity;

B. Created, maintained, or used only in connection with the provision of treatment to the student; and

C. Disclosed only to individuals providing the treatment (provided that the records can be personally reviewed by a physician or other appropriate professional of the student's choice). For the purpose of this definition, "treatment" does not include remedial educational activities or activities that are a part of the program of instruction at the educational agency or institution.

e. Records of an educational agency or institution that contain only information related to a person after that person is no longer a student at the educational agency or institution. (An example would be information collected by an educational agency or institution pertaining to the accomplishments of its alumni).

3.1.9. "Eligible student" means a student who has attained eighteen years of age, or is attending an institution of post-secondary education.

3.1.10. "Exceptional student" means a student having been determined to have an exceptionality in accordance with eligibility criteria under W. Va. 126CSR16, West Virginia Board of Education Policy 2419, "Regulations for the Education of Exceptional Students,"(hereinafter, Policy 2419) who receives services under an Individualized Education Program (IEP).

3.1.11. "Financial Aid" means a payment of funds provided to an individual (or a payment in kind of tangible or intangible property to the

individual) that is conditioned on the individual's attendance at an educational agency or institution.

3.1.12. "Institution of post-secondary education" means an institution that provides education to students beyond the secondary school level; "secondary school level" means the educational level (not beyond grade 12) at which secondary education is provided, as determined under state law.

3.1.13. "Parent" includes a parent, guardian, or an individual acting as a parent of a student in the absence of a parent or guardian.

3.1.14. "Party" means an individual, agency, institution or organization.

3.1.15. "Personally identifiable" means that the data or information includes, but is not limited to, (a) the name of a student, the student's parent, or other family member, (b) the address of the student or student's family, (c) a personal identifier such as the student's social security number, or student number, (d) a list of personal characteristics that would make the student's identity easily traceable, or (e) other information that would make the student's identity easily traceable.

3.1.16. "Record" means any information or data recorded in any medium including, but not limited to: handwriting, print, video or audio tape, film, microfilm, microfiche, and computer media.

3.1.17. "Secretary" means the Secretary of the U.S. Department of Education or an official or employee of the U.S. Department of Education acting for the Secretary under a delegation of authority.

3.1.18. "Student" includes any individual who is or has been in attendance at an educational agency or institution, and regarding whom the educational agency or institution collects, maintains, or discloses educational records.

§126-94-4. Parent Rights.

4.1. An educational agency or institution shall give full rights to either parent unless the agency or institution has been provided with evidence that there is a court order, state statute, or legally binding document relating to such matters as divorce, separation or custody, that specifically revokes those rights.

§126-94-5. Student Rights.

5.1. For the purpose of this part, whenever a student has attained eighteen years of age, or is attending an institution of post-secondary education, the rights accorded to and the consent required of the parents transfer to the student.

5.2. This policy does not prevent educational agencies or institutions from giving students rights in addition to those given to parents.

5.3. If an individual is or has been in attendance at one component of an educational agency or institution, that attendance does not give the individual rights as a student in other components of the agency or institution to which the individual has applied for admission, but has never been in attendance.

§126-94-6. Annual Notification of Rights.

6.1. Each educational agency or institution shall annually notify parents of students currently in attendance, or eligible students currently in attendance, of their rights under this policy.

6.2. The notice must inform parents or eligible students that they have the right to:

6.2.1. Inspect and review the student's education records;

6.2.2. Seek amendment of the student's education records that the parent or eligible student believes to be inaccurate, misleading, or otherwise in violation of the student's privacy rights;

6.2.3. Consent to disclosures of personally identifiable information contained in

the student's education records, except to the extent that Section §126-94-16 authorizes disclosure without consent; and

6.2.4. File with the U.S. Department of Education a complaint as described in Section §126-94-27 concerning alleged failures by the educational agency or institution to comply with the requirements of this policy.

6.3. The notice must include all of the following:

6.3.1. The procedure for exercising the right to inspect and review education records;

6.3.2. The procedure for requesting amendment of records under Section §126-94-12;

6.3.3. A specification of criteria for determining who constitutes a school official and what constitutes a legitimate educational interest;

6.3.4. Types of information designated as directory information and procedures in Section §126-94-23 for refusing to allow information to be so designated; and

6.3.5. The procedure for disclosure of education records without consent to officials of another school district in which the student seeks to enroll.

6.4. An educational agency or institution may provide this notice by any means that are reasonably likely to inform the parents or eligible students of their rights.

6.4.1. An educational agency or institution shall effectively notify parents or eligible students who are disabled.

6.4.2. An agency or institution of elementary or secondary education shall effectively notify parents who have a primary or home language other than English.

6.5. Parents of exceptional students, and eligible students who are exceptional, shall receive notice of rights under IDEA, included in the procedural safeguards notice.

§126-94-7. Law Enforcement Units.

7.1. Law enforcement unit means any individual, office, department, division, or other component of an educational agency or institution, such as a unit of commissioned police officers or non-commissioned security guards, that is officially authorized or designated by that agency or institution to:

7.1.1. Enforce any local, state, or federal law, or refer to appropriate authorities a matter for enforcement of any local, state, or federal law against any individual or organization other than the agency or institution itself; or

7.1.2. Maintain the physical security and safety of the agency or institution.

7.2. A component of an education agency or institution does not lose its status as a law enforcement unit if it also performs other, non-law enforcement functions for the agency or institution, including investigation of incidents or conduct that constitutes or leads to a disciplinary action or proceedings against the student.

7.3. Records of a law enforcement unit means those records, files, documents, and other materials that are:

7.3.1. Created by a law enforcement unit;

7.3.2. Created for a law enforcement purpose; and

7.3.3. Maintained by the law enforcement unit.

7.4. Records of a law enforcement unit does not mean:

7.4.1. Records created by a law enforcement unit for a law enforcement purpose that are maintained by a component of the educational agency or institution other than the

law enforcement unit; or

7.4.2. Records created and maintained by a law enforcement unit exclusively for a non-law enforcement purpose, such as a disciplinary action or proceeding conducted by the educational agency or institution.

7.5. Nothing in this policy prohibits an educational agency or institution from contacting its law enforcement unit, orally or in writing, for the purpose of asking that unit to investigate a possible violation of, or to enforce, any local, state, or federal law.

7.5.1. Education records, and personally identifiable information contained in education records, do not lose their status as education records and remain subject to this policy including the disclosure provisions of Section §126-94-15 while in the possession of the law enforcement unit.

7.5.2. Disclosure by an educational agency or institution of its law enforcement unit records is neither required nor prohibited by this policy.

§126-94-8. Right to Inspect and Review Education Records.

8.1. Each educational agency or institution or state educational agency (hereinafter SEA) and its components shall permit the parent or an eligible student to inspect and review the education records of the student.

8.2. The educational agency or institution, or SEA or its component, shall comply with a request for access to records within a reasonable period of time, but not more than 45 days after it has received the request.

8.3. The educational agency or institution, or SEA or its component, shall respond to reasonable requests for explanations and interpretations of the records.

8.4. When a request is being made regarding records of an exceptional student:

8.4.1. The agency shall comply with Section §126-94-8.2 and before any meeting regarding an IEP or any hearing relating to the identification, evaluation, or educational placement of the student, or the provision of free appropriate public education to the student;

8.4.2. The right to inspect and review education records of an exceptional student includes the right to have a representative of the parent inspect and review the records; and

8.4.3. The participating agency shall provide parents, upon request, a list of the types and locations of education records collected, maintained, or used by the agency.

8.5. If circumstances effectively prevent the parent or eligible student from exercising the right to inspect and review the student's education records, the educational agency or institution, or SEA or its component, shall:

8.5.1. Provide the parent or eligible student with a copy of the records requested; or

8.5.2. Make other arrangements for the parent or eligible student to inspect and review the requested records.

8.6. The educational agency or institution, or SEA or its component, shall not destroy any education records if there is an outstanding request to inspect and review the records under this section.

8.7. While an educational agency or institution is not required to give an eligible student access to treatment records as defined in Section §126-94-3.1.8.d., the student may have those records reviewed by a physician or other appropriate professional of the student's choice.

§126-94-9. Fees.

9.1. An educational agency or institution may charge a fee for copies of educational records,

which are made for the parent or eligible student, provided that the fee does not effectively prevent the parent and/or eligible student from exercising the right to inspect and review those records.

9.2. An educational agency or institution may not charge a fee to search for or retrieve the education records of a student.

§126-94-10. Limitations on Right to Inspect and Review Education Records.

10.1. If the education records of a student contain information on more than one student, the parent of the student or the eligible student may inspect and review or be informed of only the specific information about that student.

10.2. A post-secondary institution does not have to permit a student to inspect and review education records that are:

10.2.1. Financial records, including any information those records contain, of his or her parents;

10.2.2. Confidential letters and confidential statements of recommendation placed in the education records of the student before January 1, 1975, as long as the statements are used only for the purposes for which they were specifically intended; and

10.2.3. Confidential letters and confidential statements of recommendation placed in the student's education records after January 1, 1975, if the student has waived his or her right to inspect and review these letters and statements and the letters and statements are related to the student's admission to an educational institution, application for employment or receipt of an honor or honorary recognition. Provided that a waiver is valid only if:

a. The educational agency or institution does not require the waiver as a condition for admission to or receipt of a service or benefit from the agency or institution; and

b. The waiver is made in writing and signed by the student, regardless of age.

10.2.4. If a student has waived his or her rights under this section, the educational institution shall:

a. Give the student, on request, the names of the individuals who provided the letters and statements of recommendation; and

b. Use the letters and statements of recommendation only for the purpose for which they were intended.

10.2.5. A waiver under this section may be revoked in writing with respect to any actions occurring after the revocation.

§126-94-11. Maintenance and Destruction of Education Records.

11.1. An educational agency or institution is not precluded from destroying education records, subject to the following exceptions:

11.1.1. The agency or institution may not destroy any education records if there is an outstanding request to inspect and review them under §Section 126-94-8;

11.1.2. Explanations placed in the education record under Section §126-94-13, shall be maintained as long as the record or the contested portion is maintained;

11.1.3. The record of access required under Section §126-94-18 shall be maintained for as long as the education record to which it pertains is maintained; and

11.1.4. For records collected for exceptional students under Policy 2419, a. the public agency shall inform parents when personally identifiable information collected, maintained, or used is no longer needed to provide educational services to the child; b. the information must be destroyed at the request of the parents; c. however, a permanent record of a

student's name, address, and phone number, his or her grades, attendance record, classes attended, grade level completed, and year completed may be maintained without time limitation.

11.2. The following shall apply to the length of time and special consideration for maintaining student records:

11.2.1. Directory information may be maintained in perpetuity;

11.2.2. Academic grades and attendance records may be maintained in perpetuity;

11.2.3. Records to verify implementation of federally funded programs and services and to demonstrate compliance with program requirements must be maintained for five years after the activity is completed;

11.2.4. Other personally identifiable data which is no longer needed to provide education services may be destroyed;

11.2.5. Parents and eligible students must be informed through public notice of any timelines established by the educational agency or institution for maintenance and destruction of student records; and

11.2.6. Files must be maintained in a secured location. Electronic files must be protected through the use of individual user identification and/or passwords. When user identification and/or passwords have been established, an individual is permitted to use only his or her designated identification and password to gain access to education records.

§126-94-12. Request to Amend Education Records.

12.1. The parent of a student or an eligible student who believes that information contained in the education records of the student is inaccurate, misleading or violates the privacy rights of the student may request the educational agency or institution to amend the record.

12.2. The educational agency or institution shall decide whether to amend the educational records of the student in accordance with the request within a reasonable period of time after it receives the request.

12.3. If the educational agency or institution decides not to amend the record as requested, it shall inform the parent of the student or the eligible student of the refusal and of the right to a hearing under Section §126-94-13.

§126-94-13. Right to a Hearing.

13.1. An educational agency or institution shall give a parent or eligible student, on request, an opportunity for a hearing to challenge the content of a student's education records on the grounds that information contained in the education records of the student is inaccurate, misleading or otherwise in violation of the privacy rights of the student.

13.2. If, as a result of the hearing, the educational agency or institution decides that the information is inaccurate, misleading or otherwise in violation of the privacy rights of the student, it shall amend the education records of the student accordingly and so inform the parents of the student or the eligible student in writing.

13.3. If, as a result of the hearing, the educational agency or institution decides that the information is not inaccurate, misleading or otherwise in violation of the privacy rights of the student, it shall inform the parent or eligible student of the right to place in the education records of the student a statement commenting on the contested information in the record and/or stating why he or she disagrees with the decision of the agency or institution.

13.4. Any explanation placed in the education records of the student under Section §126-94-13.3 shall:

13.4.1. Be maintained by the educational agency or institution as part of the education records of the student as long as the record or

contested portion thereof is maintained by the agency or institution; and

13.4.2. Be disclosed if the education records of the student or the contested portion thereof is disclosed by the educational agency or institution to any party.

§126-94-14. Conduct of the Hearing.

14.1. The hearing required to be held by Section §126-94-13.1 shall be conducted according to procedures that shall include at least the following elements:

14.1.1. The hearing shall be held within a reasonable period of time after the educational agency or institution has received the request;

14.1.2. The parent of the student or the eligible student shall be given notice of the date, place, and time reasonably in advance of the hearing;

14.1.3. The hearing may be conducted by any individual, including an official of the educational agency or institution, who does not have a direct interest in the outcome of the hearing;

14.1.4. The parent of the student or the eligible student shall be afforded a full and fair opportunity to present evidence relevant to the issues raised under Section §126-94-12, and may be assisted or represented by individuals of his or her choice at his or her own expense, including an attorney;

14.1.5. The educational agency or institution shall make its decision in writing within a reasonable period of time after the conclusion of the hearing; and

14.1.6. The decision of the educational agency or institution shall be based solely upon the evidence presented at the hearing and shall include a summary of the evidence and the reasons for the decision.

§126-94-15. Prior Consent for Disclosure Required.

15.1. An educational agency or institution shall obtain written consent of the parent of a student or the eligible student before disclosing personally identifiable information from the education records of a student, other than directory information, except as provided in Section §126-94-16.

15.2. Whenever written consent is required, an educational agency or institution may presume that the parent of the student or the eligible student giving consent has the authority to do so unless the agency or institution has been provided with evidence that there is a legally binding instrument or a court order governing such matters as divorce, separation or custody, which provides to the contrary.

15.3. The written consent required by Section §126-94-15.1 must be signed and dated by the parent of the student or the eligible student giving the consent and shall include:

15.3.1. A specification of the records to be disclosed;

15.3.2. The purpose of the disclosure; and

15.3.3. The party or class of parties to whom the disclosure may be made.

15.4. If a parent or eligible student so requests, the educational agency or institution shall provide a copy of the records disclosed.

15.5. If the parent of a student who is not an eligible student so requests, the educational agency or institution shall provide the student with a copy of the records disclosed.

§126-94-16. Prior Consent for Disclosure Not Required.

16.1. An educational agency or institution may disclose personally identifiable information

from the education records of a student without the written consent of the parent of the student or the eligible student if the disclosure is:

16.1.1. To other school officials, including teachers, within the educational agency or institution who have been determined by the agency or institution to have legitimate educational interest; and

16.1.2. To officials of another school or school system, or institution of post-secondary education, in which the student seeks or intends to enroll, subject to the requirements of Section §126-94-20.

16.1.3. Subject to the conditions set forth in Section §126-94-21, to authorized representatives of:

a. The Comptroller General of the United States;

b. The Secretary of the U.S. Department of Education (hereinafter, Secretary) or

c. State and local educational authorities.

16.1.4. In connection with financial aid for which a student has applied or which a student has received; provided, that personally identifiable information from the education records of the student may be disclosed only as may be necessary for such purposes as:

a. to determine the eligibility of the student for financial aid;

b. to determine the amount of the financial aid;

c. to determine the conditions which will be imposed regarding the financial aid; and

d. to enforce the terms or conditions of the financial aid.

16.1.5. To state and local officials or authorities to whom this information is specifically:

a. Allowed to be reported or disclosed pursuant to state statute adopted before November 19, 1974, if the allowed reporting or disclosure concerns the juvenile justice system and the system's ability to effectively serve the student whose records are released; or

b. Allowed to be reported or disclosed pursuant to state statute adopted after November 19, 1974, subject to the requirements of Section §126-94-24.

16.1.6. To organizations conducting studies for, or on behalf of, educational agencies or institutions for the purpose of (a) developing, validating, or administering predictive tests; (b) administering student aid programs, or improving instruction; provided, that the studies are conducted in a manner that will not permit the personal identification of students and their parents by individuals other than representatives of the organization and the information will be destroyed when no longer needed for the purposes for which the study was conducted; the term "organizations" includes, but is not limited to federal, state, and local agencies, and independent organizations.

16.1.7. To accrediting organizations in order to carry out their accrediting functions.

16.1.8. To parents of a dependent student.

16.1.9. To comply with a judicial order or lawfully issued subpoena; provided, that the educational agency or institution makes a reasonable effort to notify the parent of the student or the eligible student of the order or subpoena in advance of compliance, so that the parent or eligible student may seek protective action; unless the disclosure is in compliance with:

a. A federal grand jury subpoena and

the court has ordered that the existence or the contents of the subpoena or the information furnished in response to the subpoena not be disclosed; or

b. Any other subpoena issued for a law enforcement purpose and the court or other issuing agency has ordered that the existence or the contents of the subpoena or the information furnished in response to the subpoena not be disclosed.

c. If the educational agency or institution initiates legal action against a parent or student and has complied with Section §126-94-16.1.9, it may disclose education records that are relevant to the action to the court without a court order or subpoena.

16.1.10. To appropriate parties in health or safety emergency subject to the conditions set forth in Section §126-94-22.

16.1.11. The disclosure is information the educational agency or institution has designated as "directory information".

16.1.12. The disclosure is to the parent of a student who is not an eligible student or to the student.

16.1.13. The disclosure is to an alleged victim of any crime of violence, as that term is defined in 18 U.S.C. § 16, of the results of any disciplinary proceeding conducted by an institution of post-secondary education against the alleged perpetrator of that crime with respect to that crime.

16.2. This section does not forbid an educational agency or institution to disclose, nor does it require an educational agency or institution to disclose, personally identifiable information from the education records of a student to any parties under this section, with the exception that parents of a student who is not an eligible student and the student must have access.

16.3. For records of special education students, each participating agency shall maintain, for public inspection, a current listing of the names and positions of those employees within the agency who may access personally identifiable information.

§126-94-17. Disciplinary Information.

17.1. If a student transfers to another school in the state, the principal of the school from which the student transfers shall provide a written record of any disciplinary action taken against the student to the principal of the school to which the student transfers, (W. Va. Code §18A-5-1a) subject to requirements of Section §126-94-20.

17.2. The educational agency includes in the records of a student with a disability under Policy 2419 a statement of any current or previous disciplinary action that has been taken against the student and transmits the statement to the same extent that the disciplinary information is included in, and transmitted with, the student records of non-disabled students.

17.2.1. The statement may include a description of any behavior engaged in by the student that required disciplinary action, a description of the disciplinary action taken, and any other information related to the safety of the student and other individuals involved with the student.

17.2.2. If the student transfers from one school to another, the transmission of any of the student's records must include both the student's current Individualized Education Program (IEP) and any statement of current or previous disciplinary action that has been taken against the student.

17.3. A public agency reporting a crime committed by a student with a disability under Policy 2419 shall ensure that copies of the special education and disciplinary records of the student are transmitted for consideration by the appropriate authorities to whom it reports the crime, but only to the extent permitted by this policy's provisions regarding disclosure of

education records.

§126-94-18. Record of Disclosure Required to be Maintained.

18.1. An educational agency or institution shall for each request for access to and each disclosure of personally identifiable information from the education records of a student maintain a record kept with the education records of the student that indicates:

18.1.1. The parties who have requested or obtained personally identifiable information from the education records of the student;

18.1.2. The date access was given; and

18.1.3. The legitimate interest these parties had in requesting or obtaining the information.

18.2. If an educational agency or institution discloses information with the understanding that the party receiving the information may make further disclosures, the record of disclosure must include the names of the additional parties to which the receiving party may disclose the information on behalf of the educational agency or institution and the legitimate educational interests each of the additional parties has in requesting the information.

18.3. Section §126-94-18.1 does not apply to disclosures to a parent of a student or an eligible student, disclosures pursuant to the written consent of a parent of a student or an eligible student when the consent is specific with respect to the party or parties to whom the disclosure is to be made, disclosures to school officials, or to disclosures of directory information, or to a party seeking or receiving the records as directed by a federal grand jury or other law enforcement subpoena and the issuing court or other issuing agency has ordered that the existence or the contents of the subpoena or the information furnished in response to the subpoena not be disclosed.

18.4. The record of disclosures may be inspected:

18.4.1. By the parent of the student or the eligible student;

18.4.2. By the school official and his or her assistants who are responsible for the custody of the records; and

18.4.3. For the purpose of auditing the record keeping procedures of the educational agency or institution by the parties authorized in and under the conditions set forth in Section §126-94-16.1.1 and Section §126-94-16.1.3.

§126-94-19. Limitation on Redisclosure.

19.1. An educational agency or institution may disclose personally identifiable information from the education records of a student only on the condition that the party to whom the information is disclosed will not disclose the information to any other party without the prior written consent of the parent of the student or the eligible student, except that:

19.1.1. The personally identifiable information which is disclosed to an institution, agency or organization may be used by its officers, employees and agents, but only for the purposes for which the disclosure was made.

19.1.2. An educational agency or institution may disclose personally identifiable information with the understanding that the party receiving the information may make further disclosures of the information on behalf of the educational agency or institution if the parties meet the requirements of Section §126-94-16 and required records of disclosure under Section §126-94-18.

19.2. Section §126-94-19.1 does not apply to disclosures made pursuant to court orders or lawfully issued subpoenas, to disclosures of directory information or to disclosures to a parent or student. Except for these disclosures, an educational agency or institution shall inform a

party to whom disclosure is made of the requirements of this section.

19.3. If the Family Policy Compliance Office determines that a third party improperly rediscloses personally identifiable information from education records, the educational agency or institution may not allow that third party access to personally identifiable information from education records for at least five years.

§126-94-20. Conditions for Disclosure to Officials of Other Schools and School Systems.

20.1. An educational agency or institution transferring the education records of a student to officials of another school, school system or institution of post-secondary education where the student seeks to enroll shall:

20.1.1. Make a reasonable attempt to notify the parent of the student or the eligible student of the transfer of the records at last known address of the parent or eligible student, unless:

a. The transfer of records is initiated by the parent or eligible student at the sending agency or institution, or

b. The agency or institution includes in its annual notice that it forwards education records on request to other agencies or institutions in which a student seeks or intends to enroll;

20.1.2. Provide the parent of the student or the eligible student, upon request, a copy of the record that was transferred; and

20.1.3. Provide the parent of the student or the eligible student, upon request, an opportunity for a hearing under these procedures.

20.2. If a student is enrolled in more than one school, or receives services from more than one school, the schools may disclose information from the education records of the student to each other without obtaining the written consent of the parent of the student or the eligible student; provided, that the disclosure meets the requirements of Section §126-94-20.1.

§126-94-21. Disclosure to Certain Federal and State Officials for Federal Program Purposes.

21.1. The Comptroller General, Secretary or state and local educational authorities may have access to education records in connection with the audit or evaluation of federal or state supported education programs, or for the enforcement of or compliance with federal legal requirements which relate to these programs.

21.2. Except when written consent of the parent of a student or an eligible student has been obtained for disclosure, or when the collection of personally identifiable information is specifically authorized by federal or state law, any information collected under Section §126-94-21.1 shall be protected in a manner that does not permit the personal identification of students and their parents by other than those officials, and personally identifiable data shall be destroyed when no longer needed for such audits, evaluation, or enforcement of or compliance with federal and state legal requirements.

§126-94-22. Conditions for Disclosure in Health and Safety Emergencies.

22.1. An educational agency or institution may disclose personally identifiable information from the education records of a student to appropriate parties in connection with an emergency if knowledge of the information is necessary to protect the health or safety of the student or other individuals.

22.2. The factors to be taken into account in determining whether personally identifiable information from the education records of a student may be disclosed under this section shall include the following:

22.2.1. The seriousness of the threat to the health or safety of the student or other individuals;

22.2.2. The need for the information to

meet the emergency;

22.2.3. Whether the parties to whom the information is disclosed are in a position to deal with the emergency; and

22.2.4. The extent to which time is of the essence in dealing with the emergency.

22.3. Nothing in this Act or this part shall prevent an educational agency or institution from:

22.3.1. Including in the educational records of a student appropriate information concerning disciplinary action taken against the student for conduct that posed a significant risk to the safety or well-being of that student, other students, or other members of the school community;

22.3.2. Disclosing appropriate information maintained under Section §126-94-22.3.1 to teachers and school officials within the agency or institution who the agency or institution has determined have legitimate educational interests in the behavior of the student; or

22.3.3. Disclosing appropriate information maintained under Section §126-94-22.3.1 to teachers and school officials in other schools who have been determined to have legitimate educational interests in behavior of the student.

22.4. Sections §§126-94-22.1 and 126-94-22.3 shall be strictly construed.

§126-94-23. Conditions for Disclosure of Directory Information.

23.1. An educational agency or institution may disclose personally identifiable information from the education records of a student who is in attendance at the institution or agency if it has given notice that information has been designated as directory information.

23.2. An educational agency or institution may disclose directory information from the educational records of an individual who is no longer in attendance at the agency or institution without following the procedures under Section §126-94-23.3.

23.3. In order to designate directory information, an educational agency or institution shall give public notice of the following:

23.3.1. The categories of personally identifiable information the institution has designated as directory information;

23.3.2. The right of the parent of the student or the eligible student to refuse to permit the designation of any or all of the categories of personally identifiable information with respect to that student as directory information, including the right of the parent to refuse to permit the designation of names, addresses, and telephone listings of their children as directory information for purposes of providing the information to military recruiters as set forth in Section §126-94-30; and

23.3.3. The period of time within which the parent of the student or the eligible student must inform the agency or institution in writing that such personally identifiable information is not to be designated as directory information with respect to that student.

23.4. All county boards of education shall, at a minimum, establish that the names, addresses, and telephone listings of secondary school students are designated as directory information for the purposes of providing the information to military recruiters as set forth in Section §126-94-30.

23.5. Once the county board of education establishes directory information, it shall provide access to established directory information to any person or group which makes students aware of educational, occupational, and career opportunities available in the armed services.

23.6. The county board of education may provide access to established directory

information to other persons or groups as determined by board action.

§126-94-24. Juvenile Justice System.

24.1. If reporting or disclosure allowed by state statute concerns the juvenile justice system and the system's ability to effectively serve, prior to adjudication, the student whose records are released, an educational agency or institution may disclose education records under Section §126-94-16.1.5.

24.2. The officials and authorities to whom the records are disclosed shall certify in writing to the educational agency or institution that the information will not be disclosed to any other party, except as provided under state law, without the prior written consent of the parent of the student.

§126-94-25. Safeguards for Exceptional Students, Information Collected under Policy 2419.

25.1. Each participating agency shall protect the confidentiality of personally identifiable information at collection, storage, disclosure and destruction stages.

25.2. One official at each participating agency shall assume responsibility for ensuring the confidentiality of any personally identifiable information collected under Policy 2419 and IDEA.

25.3. All persons collecting or using personally identifiable information must receive training or instruction regarding the state's policies and procedures under this policy and Policy 2419.

25.4. Each participating agency shall maintain for public inspection, a current listing of the names and positions of those employees within the agency who may have access to personally identifiable information of identified special education students.

25.5. A complaint may be filed with the West Virginia Department of Education, Office of Special Education, if it is alleged that the confidentiality of personally identifiable information regarding an exceptional student in accordance with the requirements of this policy and Policy 2419 has been violated. This is in addition to the right to file a complaint with the U.S. Department of Education, as described in Section §126-94-26.

§126-94-26. Enforcement Authority.

26.1. For the purpose of this part, "Office" means the Family Policy Compliance Office, U.S. Department of Education. The Secretary designates the Office to:

26.1.1. Investigate, process, and review complaints and violations under the Family Educational Rights and Privacy Act, and this part; and

26.1.2. Provide technical assistance to ensure compliance with the Act and this part.

26.2. The Secretary designates the Office of Administrative Law Judges to act as the Review Board required under the Act to enforce the Act with respect to all applicable programs. The term "applicable program" is defined in Section 400 of the General Education Provisions Act.

26.3. If an education agency or institution determines that it cannot comply with the Act or this part due to a conflict with state or local law, it shall notify the Office within 45 days, giving the text and citation of the conflicting law.

26.4. The Office may require an educational agency or institution to submit reports containing information necessary to resolve complaints under the Act and the regulations in this part.

§126-94-27. Complaint Procedure.

27.1. A parent or eligible student may file a written complaint with the Office regarding an alleged violation under the Act and this part. The

Office's address is, Family Policy Compliance Office, U.S. Department of Education, Washington, D.C. 20202-4605.

27.2. A complaint must contain specific allegations of fact giving reasonable cause to believe that a violation of the Act or this part has occurred.

27.3. The Office investigates each timely complaint to determine whether the educational agency or institution has failed to comply with the provisions of the Act or this part.

27.4. A timely complaint is defined as an allegation of a violation of the Act that is submitted to the Office within 180 days of the date of the alleged violation or of the date that the complainant knew or reasonably should have known of the alleged violation.

27.5. The Office extends the time limit in this section if the complainant shows that he or she was prevented by circumstances beyond the complainant's control from submitting the matter within the time limit, or for other reasons considered sufficient by the Office.

27.6. The Office notifies the complainant and the educational agency or institution in writing if it initiates an investigation of a complaint. The notice to the educational agency or institution:

27.6.1. Includes the substance of the alleged violation; and

27.6.2. Asks the agency or institution to submit a written response to the complaint.

27.7. The Office notifies the complainant if it does not initiate an investigation of a complaint because the complaint fails to meet the requirements of Section §126-94-27.2.

27.8. The Office reviews the complaint and response and may permit the parties to submit further written or oral arguments or information.

27.9. Following its investigation, the Office provides to the complainant and the educational agency or institution written notice of its findings and the basis for its findings.

27.10. If the Office finds that the educational agency or institution has not complied with the Act or this part, the notice under Section §126-94-27.9:

27.10.1. Includes a statement of the specific steps that the agency or institution must take to comply; and

27.10.2. Provides a reasonable period of time, given all of the circumstances of the case, during which the educational agency or institution may comply voluntarily.

§126-94-28. Enforcement Procedures.

28.1. If the educational agency or institution does not comply during the period of time set under Section §126-94-27.10.2, the Secretary may, in accordance with part E of the General Education Provisions Act:

28.1.1. Withhold further payments under any applicable program;

28.1.2. Issue a complaint to compel compliance through a cease and desist order; or

28.1.3. Terminate eligibility to receive funding under any applicable program.

28.2. If, after an investigation, the Secretary finds that an educational agency or institution has complied voluntarily with the Act or this part, the Secretary provides the complainant and the agency or institution written notice of the decision and the basis for the decision.

§126-94-29. Collection and Use of Student Social Security Numbers.

29.1. A social security number is personally identifiable information and must, therefore, be used in compliance with the other provisions of this policy, the Family Educational Rights and

Privacy Act, and the provisions of W. Va. Code §18-2-5e.

29.1.1. No public or private elementary or secondary school shall display any student's social security number for identification purposes on class rosters or other lists provided to teachers, on student identification cards, in student directories or other listings, on public postings or listings of grades, or for any other public identification purpose unless specifically authorized or required by law.

a. Compliance will be required of Exemption A schools for county board of education approval.

29.1.2. The student social security number may be used for internal record keeping purposes or studies.

29.1.3. The student social security number or alternative number is required for enrollment or attendance in public schools.

a. Effective July 1, 2003, the county board of education must request from the parent, guardian, or responsible person the social security number of each child who is currently enrolled in the county school system.

b. Effective July 1, 2003, prior to admittance to a public school in the state, the county board of education must request from the parent, guardian, or responsible person the social security number of each child who is to be enrolled.

c. The county board of education must inform the parent, guardian, or other responsible person that, if he or she declines to provide the student social security number, the county board of education will assign the student an alternate nine digit number as designated by the West Virginia Board of Education.

29.1.4. For any student who is attending a public school and for whom a social security number has not been provided, the county board shall make a request annually to the parent, guardian, or other responsible person to furnish the social security number.

§126-94-30. Release of List of High School Students to Military Recruiters.

30.1. Pursuant to Section 9528 of the Elementary and Secondary Education Act (ESEA) of 1965 (20 U.S.C. 7908), as amended by the No Child Left Behind Act of 2001 (P.L. 107-110), and 10 U.S.C. 503, as amended by Section 544, the National Defense Authorization Act for the Fiscal Year 2002 (P.L. 107-107),all county boards of education are required to provide military recruiters, upon request, with the names addresses and telephone listings of secondary school students unless the parents/guardians have advised the county board of education that they do not want their students' information disclosed without prior written consent as set forth in Section §126-94-23.

30.2. Each county board of education shall provide military recruiters the same access to secondary school students as is provided generally to post-secondary educational institutions or to prospective employers of those students.

§126-94-31. Severability.

31.1. If any provision of this rule or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of this rule.

TITLE 126
LEGISLATIVE RULE
BOARD OF EDUCATION

SERIES 99
STUDENT CODE OF CONDUCT (4373)

§126-99-1. General.

1.1. Scope. – This rule sets the requirements for the conduct of students in West Virginia schools in order to assure a nurturing and orderly, safe, drug-free, violence- and harassment-free learning environment that supports student academic achievement and personal-social development.

1.2. Authority. – W. Va. Constitution, Article XII, §2, and W. Va. Code §§16-9A-4,16-9A-9, 17A-1-1, 18-2-5, 18-2-5a, 18-2-7b, 18-2-9, 18-2-33, 18-2C-1 et seq., 18-5-1, 18-5-13, 18-16-1, 18A-1-1, 18A-5-1, 18A-5-1a, 60A-1-101,60A-7-11a, 61-2-15, 61-7-2,
and 61-7-11a.

1.3. Filing Date. – December 16, 2002.

1.4. Effective Date. – July 1, 2003.

1.5. Repeal of Former Rule. – This legislative rule revises W. Va. §126CSR99, "Student Code of Conduct" (Policy 4373) filed June 7, 2002 and effective July 7, 2002. This policy is to be read in conjunction with W. Va. §126CSR18, "Racial, Sexual, Religious/Ethnic Harassment and Violence Policy" (Policy 2421), and W. Va. §126CSR98, "Student Handbook - Student Rights and Responsibilities" (Policy 4372).

§126-99-2. Purpose.

2.1. The West Virginia Board of Education recognizes the need for students, teachers, administrators, and other school personnel to have a nurturing and orderly, safe, and stimulating educational environment. The purpose of these regulations is to provide West Virginia school districts with a policy of student conduct that will ensure an orderly and safe environment that is conducive to learning. These regulations also require that West Virginia's public schools respond immediately and consistently to incidents of harassment, intimidation, bullying, substance abuse and/or violence or other Student Code of Conduct violations in a manner that effectively deters future incidents and affirms respect for individuals. These regulations require county boards to design and implement prevention and response programs, to outline investigatory and reporting procedures, and to delineate penalties for violations of this policy. The West Virginia Board of Education believes further that public schools should undertake proactive, preventive approaches to ensure a nurturing and orderly and safe school environment that fosters learning and personal-social development. Public schools must create, encourage, and maintain a safe, drug-free, and fear-free school environment in the classroom, on the playground, and at school-sponsored activities. Assuring such an educational environment requires a comprehensive program supported by everyone in the school organization, as well as parents/guardians, and the community. Any form of harassment, intimidation, bullying, substance abuse, violence, or other policy violation is unacceptable in West Virginia schools.

§126-99-3. Student Code of Conduct.

3.1. All students enrolled in West Virginia public schools shall behave in a manner that promotes a school environment that is nurturing, orderly, safe and conducive to learning and personal-social development.

3.1.1. Students will help create an atmosphere free from bullying, intimidation and

harassment.

3.1.2. Students will demonstrate honesty and trustworthiness.

3.1.3. Students will treat others with respect, deal peacefully with anger, use good manners and be considerate of the feelings of others.

3.1.4. Students will demonstrate responsibility, use self-control and be self-disciplined.

3.1.5. Students will demonstrate fairness, play by the rules, and will not take advantage of others.

3.1.6. Students will demonstrate compassion and caring.

3.1.7. Students will demonstrate good citizenship by obeying laws and rules, respecting authority, and by cooperating with others.

§126-99-4. Application.

4.1. These regulations apply to all students attending public schools in West Virginia during any education-sponsored event, whether in a classroom, elsewhere on school premises, on a school bus or other vehicle used for a school related event, or at a school-sponsored activity or event, whether or not it is held on school premises, in a building or other property used or operated by a county board of education, Regional Education Service Agency (RESA) or West Virginia Department of Education, or in another facility being used by any of those agencies.

4.1.1. Students who do not behave in a manner that promotes a nurturing, orderly, safe environment conducive to learning will be subject to the responses to violations as outlined in §126-99-7.

4.1.2. This policy does not supercede any rights granted to special education students by federal or state law or other West Virginia Board of Education policy.

§126-99-5. Planning by County Boards of Education.

5.1. County boards of education shall develop a plan for the implementation of this policy. This plan shall reflect the particular needs of students and staff members to study, learn and work in an environment free from Student Code of Conduct violations. To the maximum extent possible, these plans shall be developed collaboratively with state and local agencies that share the purposes of this policy.

5.2. By July 1, 2003, each county board of education shall develop or revise its existing policies to address all forms of Student Code of Conduct violations. This document represents the minimum components needed in a Student Code of Conduct. Counties may add components to reflect county school system policy and procedures.

5.3. To ensure understanding of the Student Code of Conduct, each county board of education must develop and implement an education program for each grade level, as well as a program for all faculty and staff. The programs, at a minimum, must: raise awareness of the different types of Student Code of Conduct violations, how they are manifested, their devastating emotional and educational consequences, and their potential legal consequences. In addition, multicultural education programs must be developed and implemented for faculty, staff and students to foster an attitude of understanding and acceptance of all individuals.

§126-99-6. Attendance Policy.

6.1. The West Virginia Board of Education emphasizes the value of regular attendance in enabling students to benefit from the school's education programs. W. Va. §126CSR81, West Virginia Board of Education Policy 4110, Attendance, places responsibility on students to attend school on a daily basis, and on each parent or guardian to send his/her child(ren) to school on

a daily basis.

6.2. Recognizing that frequent absences and tardiness, for any reason, are certain to adversely affect the student's schoolwork, each county school system will implement an attendance policy that includes the policy components outlined in W. Va. §126CSR81, West Virginia Board of Education Policy 4110, Attendance, in order to communicate the expectation that students will be in school every day except when illness, injury, or some providential condition beyond the student's control prevents attendance.

6.3. Absences resulting from the mandatory suspension/expulsion of a student due to a violation of W. Va. Code §18A-5-1a (battery on a school employee, possession of a firearm or deadly weapon, or sale of a narcotic drug) shall not be calculated in the school's/county's attendance rate.

§126-99-7. Violations of the Student Code of Conduct.

7.1. This policy classifies student violations of the Student Code of Conduct in four levels. County policies may reclassify specific violations as Level I, II, or III, depending on the severity or repetition of the violations and provided this reclassification assures that the treatment of the violations is consistent with W. Va. Code. W. Va. Code requires that the principal shall suspend a student who commits a violation classified as a Level IV in this policy. Level III and IV violations are to be referred directly to the appropriate administrator because of the serious and/or unlawful nature of the misconduct. County/school policies should identify responses and/or interventions that include, but are not limited to, examples provided in this policy to address Level I and II violations. Each county and/or school shall identify the individual who will receive complaints of violations of the Student Code of Conduct, and develop a procedure for acting upon those complaints. The specific procedures to be followed when any staff member observes any violations outlined in this policy should be outlined in county/school policies.

7.1.1. Level I Violations.

a. Anti-Social Conduct. A student will not orally, in writing, electronically, or with photographs or drawings, direct profanity or insulting, obscene gestures toward another student that causes embarrassment, discomfort, or a reluctance to participate in school activities.

b. Cheating/Academic Misconduct. A student will not plagiarize, cheat, gain unauthorized access to, or tamper with educational materials. The response to violations under this section may include academic sanctions in addition to other discipline.

c. Disorderly Conduct. A student will not harass another student or other person or misbehave in a manner that causes disruption or obstruction to the education process. Disruption caused by talking, making noises, throwing objects, or otherwise distracting another person, constitutes disorderly conduct. Behavior is considered disorderly if a teacher is prevented from starting an activity or lesson, or has to stop instruction to address the disruption.

d. Improper Operation of a Motor Vehicle. A student will not engage in improper parking of a motor vehicle on school property.

e. Inappropriate Displays of Affection. Students will not engage in inappropriate displays of affection, such as kissing or embraces of an intimate nature.

f. Inappropriate Dress and Grooming. A student will not dress or groom in a manner that disrupts the educational process or is detrimental to the health, safety or welfare of others. A student will not dress in a manner that is distractive or indecent, to the extent that it interferes with the teaching and learning process, including wearing any apparel that displays or promotes any drug-, alcohol- or tobacco-related product that is prohibited in school buildings, on school grounds, in school-leased or owned

vehicles, and at all school-affiliated functions.

g. Leaving School Without Permission. A student will not leave the school building, classroom, cafeteria, assigned area, or campus without permission from authorized school personnel.

h. Possession of Inappropriate Personal Property. A student will not possess personal property that is prohibited by school rules or that is disruptive to teaching and learning.

i. Tardiness. A student will not fail to be in his/her place of instruction at the assigned time without a valid excuse.

j. Technology Abuse. A student will not violate the terms of W. Va. §126CSR41, West Virginia Board of Education Policy 2460, Safety and Acceptable Use of the Internet by Students and Educators.

k. Tobacco. In accordance with W. Va. §126CSR66, West Virginia Board of Education Policy 2422.5A, Tobacco-Free Schools, a student will not smoke, use tobacco, or possess any substance containing tobacco in any building/area under the control of a county school system, including all activities or events sponsored by the county school district.

l. Trespassing. A student will not enter upon the premises of the county school system property, other than to the location to which the student is assigned, without authorization from proper school authorities. If removed, suspended, or expelled from school, a student will not return to the school premises without permission of the proper school authorities.

m. Truancy. In accordance with W. Va. §126CSR81, West Virginia Board of Education Policy 4110, Attendance, a student will not fail to report to the school's assigned class or activity without prior permission, knowledge or excuse by the school or by the parent/guardian.

7.1.2. School Responses to Level I Violations.

a. School administrators and staff may use appropriate intervention strategies, as determined by local policies, including, but not limited to, staff and student/parent conferences, auxiliary staff intervention and counseling programs, student programs for conflict resolution and peer mediation, and programs for anger management and violence prevention.

b. Any of the following intervention strategies and disciplinary actions may be used as appropriate in response to the violation:

A. Administrator/student conference or reprimand,

B. Administrator and teacher-parent/guardian conference,

C. Referrals and conference to support staff or agencies,

D. Referral to a tobacco cessation program,

E. Daily/weekly progress reports,

F. Behavioral contracts,

G. Change in the student's class schedule,

H. School service assignment,

I. Confiscation of inappropriate item,

J. Restitution/restoration,

K. Before and/or after-school detention,

L. Denial of participation in class and/or school activities,

M. Immediate exclusion by

teacher from one class period of the school day,

N. Weekend detention,

O. In-school suspension,

P. Out-of-school suspension for up to three days, or

Q. Law enforcement notification.

7.1.3. Level II Violations.

a. Bullying/Harassment/Intimidation. A student will not bully/intimidate/harass another student. According to W. Va. Code §18-2C-2, "harassment, intimidation or bullying" means any intentional gesture, or any intentional written, verbal or physical act or threat that: (a) a reasonable person under the circumstances should know will have the effect of : (1) harming a student; (2) damaging a student's property; (3) placing a student in reasonable fear of harm to his or her person; or (4) placing a student in reasonable fear of damage to his or her property; or (b) is sufficiently severe, persistent, or pervasive that it creates an intimidating, threatening or abusive educational environment for a student.

b. Failure to Serve Assigned Detention. A student will not fail to serve an assigned detention of which students and/or parents/guardian have been notified.

c. False Identification. A student will not use another person's identification or give false identification to any school official with intent to deceive school personnel or falsely obtain money or property.

d. Forgery. A student will not sign the name of another person for the purpose of defrauding school personnel or the county board of education.

e. Fraud. A student will not deceive another or cause another to be deceived by false or misleading information in order to obtain anything of value.

f.. Gambling. A student will not engage in any game of chance or contest wherein money or other items of monetary value are awarded to the winner, except for those games and contests authorized as official school functions.

g. Gang Activity. A student will not, by use of violence, force, coercion, threat of violence, or gang activity, cause disruption or obstruction to the educational process. Gangs are defined as organized groups of students and/or adults who engage in activities that threaten the safety of the general populace, compromise the general community order, and/or interfere with the school district's education mission.

A. Gang activity includes:

(a) Wearing or displaying any clothing, jewelry, colors, or insignia that intentionally identifies the student as a member of a gang, or otherwise symbolizes support of a gang.

(b) Using any word, phrase, written symbol, or gesture that intentionally identifies a student as a member of gang, or otherwise symbolizes support of a gang.

(c) Gathering of two or more persons for purposes of engaging in activities or discussions promoting gangs.

(d) Recruiting student(s) for gangs.

h. Insubordination/Unruly Conduct. A student will not ignore or refuse to comply with directions or instructions given by school authorities. Refusing to open a book, complete an assignment, work with another student, work in a group, take a test or do any other class- or school-related activity not listed herein, refusing to leave a hallway when requested by a school staff member, or running away from school staff when told to stop, all constitute insubordination/unruly conduct.

i. Loitering. A student will not remain or linger on school property without a legitimate purpose and/or proper authority.

j. Theft or Possession of Stolen Property. A student will not, without permission of the owner or custodian of the property, take property or have in his or her possession property valued less than $100.00 which does not belong to the student.

7.1.4. School Responses to Level II Violations. The county school system may modify this list in accordance with alternatives available to the district, such as conflict resolution or peer mediation programs. Intervention strategies may include, but are not limited to, the following intervention strategies and disciplinary actions:

a. Any Level I response.

b. Out-of-school suspension for up to ten (10) days.

7.1.5. Level III Violations. Violations in the Level III category are consistent with those addressed in W. Va. Code §18A-5-1a(b) and (c) and shall be reported immediately to the principal of the school in which the student is enrolled. The principal will address the violation following the procedures outlined in W. Va. Code §18A-5-1a, subsections (b) through (h).

a. Alcohol. A student will not possess, distribute or be under the influence of alcohol in an educational facility, on school grounds, a school bus or at any school-sponsored function.

b. Defacing School Property. A student will not willfully cause defacement of, or damage to, property of the school or others. Actions such as writing in school textbooks or library books, writing on desks or walls, carving into woodwork, desks, or tables, and spray painting surfaces are acts of defacement. Examples of damage to school property include, but are not limited to, ruining bulletin boards, intentionally clogging the plumbing system, breaking light bulbs or fixtures, and damaging school equipment to the point where repair is necessary.

c. Disobeying a Teacher in a Willful Manner. A student will not willfully disobey a teacher.

d. Hazing. A student will not haze or conspire to engage in the hazing of another person. "Hazing" means to cause any action or situation which recklessly or intentionally endangers the mental or physical health or safety of another person or persons to destroy or remove public or private property for the purpose of initiation or admission into or affiliation with, or as a condition for continued membership in, any activity or organization, including both co-curricular and extra-curricular activities.

e. Improper or Negligent Operation of a Motor Vehicle. A student will not intentionally or recklessly operate a motor vehicle, on the grounds of any educational facility, parking lot, or at any school-sponsored activity, so as to endanger the safety, health or welfare of others.

f. Marijuana (Simple Possession). A student will not possess or be under the influence of marijuana in an educational facility, on school grounds, a school bus or at any school-sponsored function.

g. Physical Altercation. A student will not participate in a physical altercation with another person while under the authority of school personnel.

h. Profane Language. A student will not use profane language directed at a school employee or a student. Using profane language may include, but is not limited to, verbally, in writing, electronically, or with photographs or drawings, direct profanity or insulting, obscene gestures toward any school employee or student.

i. Theft. A student will not, without

permission of the owner or custodian of the property, take property or have in his or her possession, property valued at between $100 and $999.

j. Threat of Injury or Injury. A student will not threaten to injure another student, a teacher, administrator or other school personnel. [This includes assault on a school employee defined in W. Va. Code 61-2-15(a)].

k.. Violation of School Rules or Policies. A student will not habitually, as defined by the county, violate school rules or policies.

7.1.6. School Responses to Level III Violations.

a. A principal may suspend a student from school, or transportation to or from the school on any school bus, if the student, in the determination of the principal, after an informal hearing pursuant to W. Va. Code §18A-5-1(d), has committed any Level III Violations.

b. If a student has been suspended pursuant to W. Va. Code §18A-5-1a(b) or (c), the principal may request that the superintendent recommend to the county board that the student be expelled following the provisions in subsections (b) through (l) of W. Va. Code §18A-5-1a.

c. Any school responses to Level I and II Violations.

d. Agency notification, such as the West Virginia Department of Health and Human Resources.

7.1.7. Level IV Violations. Violations in the Level IV category are consistent with those addressed in W. Va. Code §18A-5-1a(a) and (b). Level IV violations in this policy are aligned with definitions in W. Va. Code §§61-6-17, 61-6-24, and 18A-5-1, and in the Gun-Free Schools Act of 1994 (the reauthorization of the Elementary and Secondary Education Act of 1965 (ESEA), Public Law 103-382, and require that the principal of the school in which the student is enrolled shall address the violation following the procedures outlined in W. Va. Code §18A-5-1a(a) and (b).

a. Battery on a School Employee. A student will not commit a battery by unlawfully and intentionally making physical contact of an insulting or provoking nature with the person of a school employee as outlined in W. Va. Code §61-2-15(b).

b. Felony. A student will not commit an act or engage in conduct that would constitute a felony under the laws of this state if committed by an adult as outlined in W. Va. Code §18A-5-1a(b)(i). Such acts that would constitute a felony include, but are not limited to, arson (W. Va. Code §61-3-1), malicious wounding and unlawful wounding (W. Va. Code §61-2-9), bomb threat (W. Va. Code §61-6-17), sexual assault (W. Va. Code §61-8B-3), terrorist act or false information about a terrorist act, hoax terrorist act (W. Va. Code §61-6-24), burglary (W. Va. Code §61-3-11), robbery (W. Va. Code §61-2-12), and grand larceny (W. Va. Code §61-3-13).

c. Possession of a Controlled Substance. According to W. Va. Code §18A-5-1a(b)(ii), a student will not possess, distribute, or be under the influence of a controlled substance governed by the Uniform Controlled Substances Act as described in W. Va. Code §60A-1-101, et seq., on the premises of an educational facility, at a school-sponsored function or on a school bus.

d. Possession of a Firearm or Deadly Weapon. According to W. Va. Code §18A-5-1a(a), a student will not possess a firearm or deadly weapon as defined in W. Va. Code §61-7-2, on any school bus as defined in W. Va. Code §17A-1-1, or in or on any public or private primary or secondary education building, structure, facility or grounds thereof, including any vocational education building, structure, facility or grounds thereof, or at any school-sponsored function as defined in W. Va. Code §61-7-11a.

A. As defined in W. Va. Code

§61-7-2, a "dangerous weapon" means any device intended to cause injury or bodily harm, any device used in a threatening manner that could cause injury or bodily harm, or any device that is primarily used for self-protection. Dangerous weapons include, but are not limited to, blackjack, gravity knife, knife, switchblade knife, nunchuka, metallic or false knuckles, pistol, or revolver. A dangerous weapon may also include the use of a legitimate tool, instrument, or equipment as a weapon including, but not limited to, pens, pencils, compasses, or combs, with the intent to harm another. A pocket knife with a blade of three and one-half inches or less shall not be included in the definition of knife as defined in W. Va. Code §61-7-2 unless such knife is knowingly used or intended to be used to produce serious bodily injury or death.

e. Sale of a Narcotic Drug. According to W. Va. Code §18A-5-1a, a student will not sell a narcotic drug, as defined in W. Va. Code §60A-1-101, on the premises of an educational facility, at a school-sponsored function or on a school bus.

7.1.8. School/County Responses to Level IV Violations. Level IV Violations in this policy are those violations addressed in W. Va. Code §18A-5-1a that require the mandatory suspension of the student by the principal from school, or from transportation to or from the school on any school bus, after an informal hearing pursuant to subsection (d) of W. Va. Code §18A-5-1a.

a. Pursuant to W. Va. Code §18A-5-1a(b), if a student has been suspended for committing an act or engaging in conduct that would constitute a felony under the laws of this state if committed by an adult; or unlawfully possessing a controlled substance governed by the Uniform Controlled Substances Act as described in W. Va. Code §§60A-1-101 et seq., on the premises of an educational facility, at a school-sponsored function, or on a school bus, the principal may request that the superintendent recommend to the county board that the student be expelled.

b. If a student has been suspended for battery on a school employee, possession of a firearm or deadly weapon, or sale of a narcotic drug pursuant to W. Va. Code §18A-5-1a, the principal shall, within twenty-four hours, request that the county superintendent recommend to the county board that the student be expelled.

c. Upon such request of the superintendent by a principal, the county superintendent shall recommend to the county board that the student be expelled.

d. Upon such recommendation to the county board by the superintendent, the county board shall conduct a hearing in accordance with W. Va. Code §18A-5-1a subsections (e), (f), and (g), to determine if the student committed the alleged violation. If the county board finds that the student did commit the alleged violation, the county board shall expel the student.

e. Students may be expelled pursuant to W. Va. Code §18A-5-1a for a period not to exceed one school year, provided that a county superintendent may lessen the mandatory one-year period of expulsion if the circumstances of the pupil's case demonstrably warrant such a reduction following the guidelines provided in W. Va. Code §18A-5-1a (i).

f.. A county board of education that expels a student, may attempt to establish the student as a "dangerous student" as defined in W. Va. Code §18A-5-1a, at a hearing to determine the expulsion of the student. In a notice to the parent/guardian, the county board shall state clearly whether the board will attempt to establish the student as a "dangerous student" and will include any evidence to support its claim in this notice of the hearing date and time.

g.. W. Va. Code §18A-5-1a defines a "dangerous student" as a student who is substantially likely to cause serious bodily injury to himself, herself or another individual within that student's educational environment, which may include any alternative education environment as W. Va. §126CSR20, West

Virginia Board of Education Policy 2418, Alternative Education Programs for Disruptive Students, as evidenced by a pattern or series of violent behavior exhibited by the student, and documented in writing by the school, with the documentation provided to the student and parent or guardian at the time of any offense.

h. A county board that expels a student, and finds that the student is a dangerous student, may refuse to provide alternative education pursuant to the conditions outlined in W. Va. Code §18A-5-1a but must re-evaluate this decision at least every three months.

i. With regard to students with disabilities, nothing in this policy may be construed to be in conflict with the federal provisions of the Individuals with Disabilities Education Act (IDEA) Amendments of 1997 (Public Law 105-17), or with W. Va. §126CSR16, West Virginia Board of Education Policy 2419, Regulations for the Education of Exceptional Students.

§126-99-8. Guidelines for Suspension and Expulsion.

8.1. Suspension is considered a temporary solution to a violation of the Student Code of Conduct until the problem that caused the suspension is corrected. The length of a suspension should be short, usually one (1) to three (3) school days, but may extend to ten (10) school days. A student is entitled to an informal hearing when faced with a suspension of ten (10) days or less. At this hearing, the principal must explain why the student is being suspended, and the student must be given the opportunity to present reasons why s/he should not be suspended. However, a student whose conduct is detrimental to the progress and general conduct of the school may be suspended immediately and a hearing held as soon as practical after the suspension. A student may not participate in any school-sponsored activities, or be permitted on school grounds during the period of suspension without permission of school officials. Other procedures the school must follow when dealing with suspensions are outlined in W. Va. Code §18A-5-1 and §18A-5-1a.

8.2. A suspension of more than ten (ten) days requires a formal hearing before the county board of education. Procedures the school and county must follow when dealing with suspensions of more than ten (10) days are outlined in W. Va. Code §18A-5-1 and §18A-5-1a.

8.3. The county superintendent, upon recommendation by the principal, may recommend that a county board of education expel a student from school if the student's conduct is judged to be detrimental to the progress and general conduct of the school. In all cases involving expulsion, the student is entitled to formal due process procedures if the county board of education agrees to act upon recommendations to expel a student from school. These procedures are outlined in W. Va. Code §18A-5-1 and §18A-5-1a.

8.4. W. Va. Code §18A-5-1 and §18A-5-1a require mandatory suspension by the principal and mandatory expulsion for a period of not less than twelve (12) consecutive months by the county board of education for: possession of a deadly weapon, battery of a school employee, or sale of a narcotic drug. Procedures that must be followed when dealing with an expulsion are outlined in W. Va. Code §18A-5-1 and §18A-5-1a.

8.5. According to W. Va. Code §18A-5-1, a teacher or bus driver may exclude from a classroom or bus any student who: is guilty of disorderly conduct; interferes with an orderly education process; threatens, abuses, intimidates or attempts to intimidate a school employee or student; willfully disobeys a school employee; or uses profane or abusive language toward a school employee. Once a student is excluded from the classroom or bus, the student must be referred to the appropriate administrator who will take disciplinary action, notify the parent/guardian in writing of the disciplinary action taken, and provide a copy to the teacher or bus driver before the student is readmitted to class or to the bus.

§126-99-9. Complaint Procedures.

9.1. All violations of the Student Code of Conduct observed by school employees or by students must be reported to the appropriate personnel for appropriate action to be taken as specified in this policy. Each county/school policy shall designate the individual(s) who will receive complaints about violations of the Student Code of Conduct as indicated in §126-99-7, above. Employee failure to report a violation is addressed in W. Va. Code §126CSR142, West Virginia Board of Education Policy 5310, Performance Evaluation of School Personnel.

9.2. County boards of education shall develop procedures to assure that any person who believes he or she has been the victim of a Student Code of Conduct violation or any person with knowledge or belief of conduct which may constitute a violation of the Student Code of Conduct has an identified mechanism to report the alleged acts immediately to an appropriate official designated by the county's policy. Nothing in this policy shall prevent any person from reporting violations directly to the county superintendent, as appropriate, or to the West Virginia Human Rights Commission, or to a law enforcement agency.

9.3. County Boards of Education shall develop appropriate procedures for investigating, reporting, responding, and devising consequences for the failure of the employee to appropriately respond to violations of W. Va. §126CSR99, West Virginia Board of Education Policy 4373, Student Code of Conduct, in accordance with W. Va. §126CSR142, West Virginia Board of Education Policy 5310, Performance Evaluation of School Personnel, in a manner that promotes understanding and respect.

§126-99-10. Investigation Procedures.

10.1. The individual(s) designated by the school to investigate, shall upon receipt of a report or complaint immediately undertake or authorize an investigation. The investigation may be conducted by school/school system officials, or by a third party designated by the school system, in accordance with this policy and the procedures developed pursuant to §126-99-9, above.

10.2. The investigation must, at a minimum, consist of personal interviews with the complainant, the individual(s) against whom the complaint is filed, and others who may have knowledge of the alleged incident(s) or circumstances giving rise to the complaint. The investigation may also consist of any other methods and review of circumstances deemed pertinent by the investigator. When any student is to be interviewed in connection with an investigation pursuant to a Level IV violation, a reasonable effort shall be made to contact the student's parent, custodian, or guardian and invite them to be present during such interview, provided such parental notification does not compromise overall school/student safety. Parental notification is encouraged at Levels II and III and is discretionary at Level I.

10.3. The principal shall immediately take such reasonable steps as necessary, to protect the complainant, students, teachers, administrators or other personnel pending completion of an investigation of an alleged policy violation.

10.4. The principal shall determine whether the alleged conduct constitutes a violation of this policy or W. Va. Code §18A-5-1a.

10.5. In determining the appropriate response and/or punishment for a Level I, II, or III violation, the principal, superintendent or local board of education should consider the surrounding circumstances, the nature of the behavior, past incidents or continuing patterns of behavior, the relationships between the parties involved and the context in which the alleged incidents occurred. Whether a particular action or incident constitutes a violation of this policy requires a determination based on all the facts and surrounding circumstances.

10.6. The investigation will be completed as soon as practicable but no later than ten school days following the reported violation, unless

permission has been requested and granted by the West Virginia Department of Education to extend the investigation period. The investigator shall make a report to the principal upon completion of the investigation. The report shall include a determination of whether the allegations have been substantiated as factual and whether they appear to be violations of this policy. County procedures must be developed for the recording and filing of these reports at the local level.

10.7. The result of the investigation of each complaint filed under these procedures will be reported in writing to the complainant or his/her legal guardian by the principal or his/her designee.

10.8. Confidentiality of the filing of complaints, the identity of subjects and witnesses of any complaint and of any action taken as a result of such complaint is essential to the effectiveness of this policy. Only those individuals necessary for the investigation and resolution of the complaint shall be given information about it. Therefore, the right of confidentiality of complainants, subjects, witnesses, and investigators will be vigorously protected and violations of such confidentiality may itself be grounds for disciplinary action.

§126-99-11. County Board of Education Action and Reporting.

11.1. Upon receipt of a report substantiated by staff observation or by the investigation, the principal, superintendent or local board of education will take appropriate action against those found to have violated §126-99-6 pursuant to W. Va. Code §18A-1-1 and §18A-5-1a.

11.2. The principal or superintendent shall also initiate such other action as is appropriate to ease tensions and to affirm the values of respect and understanding, in accordance with the county's plan developed pursuant to §126-99-5, above.

11.3. The principal, superintendent or designee shall promptly enter the required disciplinary data into the West Virginia Education Information System (WVEIS) in order to file the required information with the West Virginia Department of Education of all substantiated reports of all violations of the Student Code of Conduct.

§126-99-12. Reprisal.

12.1. The county board of education will develop discipline procedures to take appropriate action against any student who retaliates against any person who reports alleged violations or any person who testifies, assists or participates in an investigation, or who testifies, assists or participates in a proceeding or hearing relating to such violations. Retaliation includes, but is not limited to, any form of intimidation, reprisal or harassment. The county board of education will develop a discipline process to take appropriate action against any student, administrator or other school personnel who falsely reports violations of this policy.

§126-99-13. Right to Alternative Complaint Procedures.

13.1. These procedures do not deny the right of any individual to pursue other avenues of recourse which may include filing charges with the West Virginia Human Rights Commission, initiating civil action or seeking redress under the state criminal statutes and/or federal law.

§126-99-14. Dissemination of Policy and Training.

14.1. This policy or a summary shall be conspicuously posted throughout each county's/school's facilities in areas accessible to students and staff members.

14.2. This policy, or a summary, shall appear in the student handbook and if no handbook is available, a copy will be distributed to all students, faculty, staff and parents.

14.3. When a student enters middle/junior high/high school for the first time, the student and his/her parent/guardian will be requested to sign

and return a contract agreeing to abide by the stipulations in the policy and consequences associated with violations.

14.4. The county board of education will develop and implement training for students and staff on these regulations and on means for effectively promoting the goals of this policy. The county shall review their policy at least bi-annually for compliance with state and federal law and West Virginia Board of Education policy.

§126-99-15. Assessment of Effectiveness.

15.1. The West Virginia Department of Education will prepare an annual report to the West Virginia Board of Education to include: reported and substantiated incidents of Student Code of Conduct violations; action taken in response to incidents; and training and staff development offered by the counties and other agencies.

§126-99-16. Identification of and Classification as a Persistently Dangerous School.

16.1. As required by H.R. 1, Title IX, Part E, Subpart 2 (9531) (No Child Left Behind), West Virginia will use the criteria set forth in section 16.2 of this policy to determine whether a school will be classified as a Persistently Dangerous School. Beginning with the 2002-2003 school year, and in each subsequent year, data indicating the number of substantiated violations at each school as set forth in section 16.2 of this policy will be collected using the West Virginia Education Information System (WVEIS) in order to identify and classify a school as persistently dangerous.

16.2. A West Virginia public school will be classified as a Persistently Dangerous School on or before July 1, beginning in 2003, and in each subsequent year, if the school has, for two consecutive years, substantiated violations of the following offenses that exceed five percent (5%) of the total number of students enrolled in the school based on the school's second month enrollment:

a. Battery on a school employee [W. Va. Code §61-2-15(b)].

b. Commission of an act or conduct that would constitute a felony under the laws of the state.

c. Possession of a firearm or deadly weapon as defined in W. Va. Code §61-7-2 on any school bus as defined in W. Va. Code §17A-1-1, or in any public or private primary or secondary education building, structure, facility or grounds thereof, or at any school-sponsored function as defined in W. Va. Code §61-7-11a.

d. Sale of a narcotic drug as defined in W. Va. Code §60A-1-101 on the premises of an educational facility, at a school sponsored function or on a school bus.

16.3. Beginning with the 2003-2004 school year, county school systems must provide targeted technical assistance to any school that has, for two consecutive years, substantiated violations of the offenses set forth in section 16.2 of this policy that exceed three percent (3%) of the total number of students enrolled in the school, based on the school's second month enrollment.

16.4. Beginning with the 2003-2004 school year, the West Virginia Department of Education must provide targeted technical assistance to any school that has, for two consecutive years, substantiated violations of the offenses set forth in section 16.2 of this policy that exceed three and seventy-five one hundredths percent (3.75%) of the total number of students enrolled in the school, based on the school's second month enrollment.

16.5. Beginning with the 2003-2004 school year, a student attending a Persistently Dangerous School, as defined by the state, or who becomes a victim of a violent criminal offense, as determined by State law, while in or on the grounds of a public school that the student attends, shall be allowed to attend an alternate safe public school within the Local Education Agency (LEA).]

16.6. Beginning with the 2003-2004 school year, a LEA that has one or more schools identified as persistently dangerous must, in a timely manner, notify parents of each student attending the school that the state has identified the school as persistently dangerous; offer students the opportunity to transfer to a safe public school within the LEA; and, for those students who accept the offer, complete the transfer.

16.7. A LEA that has one or more schools identified as persistently dangerous must also develop a corrective action plan, submit it to the West Virginia Department of Education, and implement that plan in a timely manner.

§126-99-17. Prevention and Intervention Training.

17.1. The West Virginia Department of Education, RESAs, and LEAs shall provide training, technical assistance in research-based, effective models for violence prevention education (including the prevention of bullying, harassment, and intimidation), substance abuse prevention, as well as other programs and initiatives that include, but are not limited to, conflict resolution, peer mediation, responsible students program, and character education. Training, technical assistance and support shall also be provided in the effective use of student assistance teams to identify students who are at risk and to develop interventions to assure school success for these students.

§126-99-18. Severability.

18.1. If any provision of this rule or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of this rule.

FORM HD 201
(10-66)

FISCAL NOTE WORKSHEET
(Submit 4 Copies)

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

SUBJECT **Policy 2422.7 Standards for Basic and Specialized Health Care Procedures.** FUND N/A

SOURCE OF REVENUE: ☐ GENERAL FUND ☐ SPECIAL ☐ OTHER (SPECIFY) N/A

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

INCOME ESTIMATE BASED ON: ☐ AN ORIGINAL ESTIMATE ☐ BUDGET BILL ☐ OTHER (SPECIFY) N/A

SHOW OVER-ALL EFFECT IN ITEMS 1 AND 2 & 3 GIVE EXPLANATION OF BREAKDOWN BY FISCAL YEAR INCLUDING LONG-RANGE EFFECT

EFFECT OF PROPOSAL	ANNUAL INCREASE	ANNUAL DECREASE	FISCAL YEAR CURRENT	FISCAL YEAR NEXT	FISCAL YEAR THEREAFTER
1. ESTIMATED TOTAL COST	$ 6,660.00	$0.00	$ 6,660.00	$ 0.00	$ 0.00
PERSONAL SERVICES CURRENT EXPENSES REPAIRS/ALTERATIONS EQUIPMENT OTHER	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
2. ESTIMATED TOTAL REVENUES	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00

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

Graphics
Printing
Paper Supplies

Expenses for 400 books @16.65/each = $6,660.00

DATE AGENCY AUTHORIZED REPRESENTATIVE

POLICY 2422.7 STANDARDS FOR BASIC AND SPECIALIZED HEALTH CARE PROCEDURES (2422.7)
COMMENT LOG
July19-August 18, 2004

Action
: No Response
NA: Not Accepted
A: Accepted

Type
- Negative
+ Positive
o Neutral

Date	Individual/Organization	Comments	Action/ Type	Rationale
		§126-25A-1. General.		
8/9/04	**Jane Ishman– jishman1@earthlink.net** School Nurse County: Berkeley County	I am still having problems with the insulin pump procedure. One last time, let me make sure I understand it correctly. If a student is on a pump and knows he has had x number of carbs and therefore his scale says x number of units of insulin. If the student dials this up, non-licensed person cannot verify this, I realize the student must administer the bolus (if ordered that way). If verification is required, the school nurse or other licensed personnel must be present. I guess I am looking at the verification as a safety issue or double check. I am also concerned about driving all over my end of the county every time a student wants a snack. It could take up to 15 minutes to get there. I realize at lunch I will have to be there unless the MD writes the order that student may self-administer. I guess I like the idea of someone verifying the student's BS reading. Please forgive my confusion on this issue. Another question. If school nurses are certified as K-12, will an additional certification be needed for Pre-K? I realize we already serve the Pre-K handicapped, but this issue of certification has never come up or been addressed	NA	Any aspect of insulin that is delegated will hold the RN responsible for any errors. So, if a simple double check turns into an overdose that leaves a child with irreversible brain damage or even death then the RN will be held responsible for delegating a duty that could jeopardize a child's life. Look at the Delegation/Assignment Decision Model within the Scope of practice by The West Virginia Board of Examiner's for Registered Professional Nurses (was the purple book). This may also be found in Appendix A of the Basic and Specialized Health Care Procedure Manual. Read pages 11-13. "TASKS DELEGATED SHOULD NOT HAVE POTENTIAL FOR JEOPARDIZING CLIENT WELFARE AND SHOULD NOT REQUIRE NURSING JUDGMENT. EXCEPT AS SPECIFICALLY PROVIDED IN LAW (WV Code 16-50-1n et seq.). Although we function in a unique environment that allows school personnel to do nursing skills, we must have Board of Nursing approval for anything that is not compliant with the

				scope of practice or decision model. Please refer all certification questions to the Certicfication Office at WVDE and/or Policy 5202.
8/18/04	**From:** Margaret McFarland [mailto:mmcfarla@access.k12.wv.us]	1. The size - it has become extremely thick. While I agree with and like having copies of W. Va. Codes and WVDE Policies that directly effect our practices as school nurses I feel perhaps what has been added is in excess of what we need . This is a procedure manual, which establishes the standard of care and protocols to be used when performing those procedures listed. Why for example do we need "West Virginia's Universal Access to Early education System Policy # 2525? It is twenty -five pages if you include the forms that monitor enrollment. Same for the "STARS" information about competency levels required for people who work with young children, when you add that you are up to 41 pages of information that has little to do with nursing procedures. If there is some important section in these policies that directly impacts nurses like section 18.4 of 126CSR28 that talks about the required health screenings for pre-k children's programs then could we just have that section quoted?	NA	Policy 2525 refers to the health and safety requirements for a Pre-school child. This is in §126-20-18 of Policy 2525. The addition of certain sections of policy would be confusing to the reader. The entirety of a policy provides clarity and prevents confusion.
		2. The thing I find most disconcerting is that you have changed the substance of what text appears in the formatted heading, **PURPOSE,** for each procedure. For example take the procedure TRACHEOSTOMY CARE on page S-87 - under **Purpose:** It is written "To provide training and supervision guidelines for etc. etc. **It used to say - 1. To maintain an open airway by keeping inner cannula open and free of secretion and exudate. 2. To prevent infection etc. etc.**	NA	The purpose of the procedure development is to provide training and supervision for a specific health care task. The guidelines of the procedure defines the significance of performing the health care task. This change has made the procedure language consistent and definable.
		Looking at the procedure for PHRENIC NERVE STIMULATOR on page S-50 , under Purpose it says - To provide training and supervision guidelines for the care of etc. etc. It never really tells you what the phrenic stimulator is supposed to do - how does it help the patient	A	This will be added under guidelines of this procedure to properly define the reason a student would have an implanted phrenic nerve stimulator.

		Look at OXYGEN ADMINISRATION on page S-78, again the Purpose as stated is to provide training and supervision guidelines etc. I t used to say - To prevent and or treat hypoxia while reducing labored breathing.	NA	This is stated under Guidelines of the procedure. The Guidelines of the procedure defines the significance of performing the health care task. This change has made the procedure language consistent and definable.
		The purpose for doing a nursing procedure should be stated to reflect the expected outcome, the reason for performing the procedure. The purpose for this manual is "To provide training and supervision guidelines, to promote a safe standard of care and that is fairly well stated on page ii in the beginning. It really disturbs me that the format has been changed like this. When I am teaching a procedure to unlicensed assistive personnel I make copies of the procedure and give them each a copy and tell them that this is the standard of care against which they will be judged if there is ever a problem or perceived problem with the care they give and they end up in court over it. I want the purpose for performing the procedure to be stated clearly in terms that tell why we do this, what does this procedure accomplish. I certainly hope this is changed back. What was the rationale for changing it?	NA	The purpose of the procedure development is to provide training and supervision for a specific health care task. The guidelines of the procedure defines the significance of performing the health care task. This change has made the procedure language consistent and definable.
8/18/04	CatherineSlemp, Acting State Health Officer Bureau for Public Health 505 Capitol Street, Suite 200 Charleston, WV 25301	1.Recommended edits/additional information to consider adding to Introductions: Diabetes is a disease in which the body does not make or properly use insulin, a hormone needed to convert sugar, starches, and other food into energy. People with diabetes have increased blood glucose (sugar levels because they lack insulin, have insufficient insulin, or are resistant to insulin's effects. Diabetes can lead to serious health problems. Effective diabetes management is to control blood glucose levels by keeping them within a target range that is determined for each child. Optimal blood glucose control helps promote normal growth and development and allows for optimal learning. Generally, food raises blood sugar while exercise and insulin or diabetes pills will lower blood sugar.	A	The input of the BPH is greatly appreciated and will be incorporated into the BSHCP Manual

		Balancing all of these factors may be difficult while maintaining good glucose control. It is important to recognize when the student needs assistance. 2. Additional information to consider adding under "Keypoints/Precautions" and subsequent sections. Page S-30 Essential Steps A – History should include the student's usual signs and symptoms of abnormal blood sugars, student's ability to recognize the symptoms and how to treat.. Page S-30 – C - An overview of the mealtimes and activity times can help identify possible times of blood glucose fluctuations. Page S-31 – D.2.b – Hyperglycemia or high blood glucose may be caused by too little insulin, too much food, or decreased exercise or activity, illness, infection, injury, stress or emotional upset. Blood glucose can rapidly rise if insulin has not been received by syringe/insulin pump or if the student is experiencing physical or emotional stress which can cause the insulin not to work effectively. Page S-32 – B.I. Guidelines – This will give important information regarding their current health status and if an intervention is required to return the child's blood glucose to euglycemia (near normal blood glucose). Page S-35 – I.4. – When mixing insulin, withdraw clear insulin first and then withdraw cloudy insulin.		
		§126-25A-2. Purpose.		
		§126-25A-3. Definitions.		
August 5, 2004	Sandra Haller – School Nurse Rt.1, Box 219-B Philippi, WV 26416	Unlicensed Personnel needs defined. This term is used under personnel section of the procedures: Insulin administered by injection and Administration of insulin by pump. Point to consider – Is a teacher licensed personnel?	A	A definition of unlicensed school personnel will be added to provide clarity to the term.
8/18/04	Ann Sammons, RN, BSN, MS School Nurse Coordinator 122 Dexter Avenue Beckley, WV 25801	Need to include a definition for contracted provider. This definition is found in the medication policy.	A	A definition for contracted licensed health care, contracted school nurse and licensed health care provider will be added to this policy to maintain consistency in policies and ensure clarity.

		§126-25A-4. State Administrative Procedures.		
		§126-25A-5. Organization and Management.		
8/18/04	Ann Sammons, RN, BSN, MS School Nurse Coordinator 122 Dexter Avenue Beckley, WV 25801	Please add: 5.2.f – contracted provider approved by a certified school nurse!	A	A contracted licensed health care provider and contracted school nurse will be added as a provider of training for basic and specialized health care procedures.
		§126-25A-6. System for School Admission and Care		
		§126-25A-7. Health Care Plan.		
		§126-25A-8. Quality Assurance.		
		§126-25A-9. School Health Records.		
		§126-25A-10. Staffing Requirements.		
8/18/04	Ann Sammons, RN, BSN, MS School Nurse Coordinator 122 Dexter Avenue Beckley, WV 25801	10.2 Please add the certified school nurse must have a minimum of 3 years direct patient care experience. NASN states "because school nurses practice in a setting with few or no other health professionals, present, they should have sufficient experience to work independently.	NA	This should be a change in policy implemented through Policy 5202-Minimum Requirements for the Licensure of Professional/Paraprofessional Personnel and Advance Salary Classifications (126CSR136). This policy is currently on-line for comment and directly addresses current requirements and standards of employment.
		§126-25A-11. Student Rights.		

		§126-25A-12. Penalties.		
		§126-25A-13. Administrative Due Process.		
		§126-25A-14. Severability.		
8/18/04	Ann Sammons, RN, BSN, MS School Nurse Coordinator 122 Dexter Avenue Beckley, WV 25801	* Additional comment: I do not agree that oral suctioning can be delegated to unlicensed school personnel.	NA	The procedure Oral Suctioning on page S-75 of the Basic and Specialized Health Care Procedure Manual refers to oral cavities only. This is performed by bulb suction or machine. The procedure does not allow for nasal, tonsil, endotracheal or any invasive suctioning thus making it safe to delegate to unlicensed school personnel.

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Bob Wise
Governor

Paul L. Nusbaum
Secretary

August 18, 2004

Dr. David Stewart
Superintendent of Schools
West Virginia Department of Education
Capitol Complex
Building 6, Room 358
Charleston, West Virginia 25305

Dear Dr. Stewart:

Attached are the collected comments and recommendations of the Bureau for Public Health regarding the latest (2004) updates of the *Basic Specialized Health Care Procedure Manual for Public Schools*. We were happy to review this from the public health perspective. We support your approach of working closely with the child physician to assure appropriate, child-specific clinical care.

In order to gain a multi-disciplinary perspective several offices within the bureau reviewed the manual, including programs in Surveillance and Disease Control; Maternal, Child, and Family Health; and Health Promotion. Conclusions: (1) From the public health perspective, the Council of School Nurses did an outstanding job in updating the manual to reflect current policy and practice; (2) As always, we are pleased by the long standing cooperation that exists between the Bureau for Public Health and the Department of Education in promoting a healthier generation of young West Virginians.

Sincerely,

Catherine C Slemp

Catherine Slemp, MD, MPH
Acting State Health Officer

CS:pc

cc: Chris Curtis
Jim Cook

BUREAU FOR PUBLIC HEALTH
505 Capitol Street, Suite 200
Charleston, West Virginia 25301
Telephone: (304) 558-1218 Fax: (304) 558-0464

Endocrine: A. General Guidelines for Diabetic Management
Recommended edits from Diabetes Program, WVBPH

1. Recommended edits / additional information to consider adding to Introduction:

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

2. Additional suggested edits / additional information to consider adding under "Keypoints/Precautions" and subsequent sections.

Page	Essential Steps	Edit Reference # (noted on copy of document)	Recommended Edit / additional info
S-30	A	1	History should include the student's usual signs and symptoms of abnormal blood sugars, student's ability to recognize the symptoms and how to treat.
S-30	C	2	An overview of the mealtimes and activity times can help identify possible times of blood glucose fluctuations.
S-31	D. 2.b.	3	Hyperglycemia or high blood glucose may be caused by too little insulin, too much food, or decreased exercise or activity, illness, infection, injury, stress or emotional upset. Blood glucose can rapidly rise if insulin has not been received by syringe/ insulin pump or if the student is experiencing physical or emotional stress which can cause the insulin not to work effectively.
S-32	B.I. Guidelines	4	This will give important information regarding their current health status and if an intervention is required to return the child's blood glucose to euglycemia (near normal blood glucose).
S-35	I. 4.	5	When mixing insulin , withdraw clear insulin first and then withdraw cloudy insulin.
S-37	II.G.6.	6	there is no information.

Reviewed by Peggy Adams

1. Information received by the School Nurses belonging to their Association is included "Helping the Student with Diabetes Succeed:
2. Website, www.diabetes.org, go to search, enter Powerpoint then GO. "Diabetes Care Tasks at School: What Key Personnel Need to … the slides are great.

Rebecca King

From: Margaret McFarland [mmcfarla@access.k12.wv.us]
Sent: Wednesday, August 18, 2004 4:37 PM
To: Rebecca King
Subject: Draft of Policy 2422.7 "Standards of Basic and Specialized HealthCare Procedures

I want to make some comments on the new manual.

1. The size - it has become extremely thick. While I agree with and like having copies of W. Va. Codes and WVDE Policies that directly effect our practices as school nurses I feel perhaps what has been added is in excess of what we need . This is a procedure manual which establishes the standard of care and protocols to be used when performing those procedures listed. Why for example do we need "West Virginia's Universal Access to Early education System Policy # 2525? It is twenty -five pages if you include the forms that monitor enrollment . Same for the "STARS" information about competency levels required for people who work with young children, when you add that you are up to 41 pages of information that has little to do with nursing procedures, If there is some important section in these policies that directly impacts nurses like section 18.4 of 126CSR28 that talks about the required health screenings for pre-k childrens programs then could we just have that section quoted?

2. The thing I find most disconcerting is that you have change the substance of what text appears in the formatted heading, **PURPOSE,** for each procedure. For example take the procedure TRACHEOSTOMY CARE on page S-87 - under **Purpose:** It is written "To provide training and supervision guidelines for etc. etc. **It used to say - 1. To maintain an open airway by keeping inner cannula open and free of secretion and exudate. 2. To prevent infection etc. etc.**

Looking at the procedure for PHRENIC NERVE STIMULATOR on page S-50 , under Purpose it says - To provide training and supervision guidlines for the care of etc. etc. It never really tells you what the phrenic stimulator is supposed to do - how does it help the patient

Look at OXYGEN ADMINISRATION on page S-78 , again the Purpose as stated is to provide training and supervision guidelines etc. I t used to say - To prevent and or treat hypoxia while reducing labored breathing.

The purpose for doing a nursing procedure should be stated to reflect the expected outcome, the reason for performing the procedure.
The purpose for this manual is "To provide training and supervision guidelines , to promote a safe standard of care and that is fairly well stated on page ii in the beginning.

It really disturbs me that the format has been changed like this. When I am teaching a procedure to unlicensed assistive personnel I make copies of the procedure and give them each a copy and tell them that this is the standard of care against which they will be judged if there is ever a problem or perceived problem with the care they give and they end up in court. over it. I want the purpose for performing the procedure to be stated clearly in terms that tell why we do this, what does this procedure accomplish . I certainly hope this is changed back. What was the rationale for changing it?

Policy 2422.7: Standards For Basic And Specialized Health Care Procedures (2422.7)
Series 25A

Comment Period Ends:

Please use this form when commenting on proposed Policy 2422.7. You may attach additional sheets if necessary.

Individual/Organization: Ann Sammons RN BSN MS
Title: School Nurse Coordinator
Street Address: 122 Dexter Avenue City/State/Zip Beckley, WV 25801

§126-25A-1. General.

§126-25A-2. Purpose.

§126-25A-3. Definitions.

* Need to include a definition for contracted provider. This definition is found in the medication policy.

§126-25A-4. State Administrative Procedures.

§126-25A-5. Organization and Management.

* Please add: 5.2. f - contracted provider approved by a certified school nurse.

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

§126-25A-7. Health Care Plan.

§126-25A-8. Quality Assurance.

§126-25A-9. School Health Records.

§126-25A-10. Staffing Requirements.

10.2 Please add the Certified school nurse must have a minimum of 3 years direct patient care experience. NASN states, "Because school nurses practice in a setting with few or no other health professionals present, they should have sufficient experience to work independently.

§126-25A-11. Student Rights.

§126-25A-12. Penalties.

§126-25A-13. Administrative Due Process.

§126-25A-14. Severability.

* Additional comment: I do not agree that oral suctioning can be delegated to unlicensed school personnel.

Return comments by August 18, 2004 to:

Rebecca King
Coordinator
West Virginia Department of Education
Building 6, Room 309
1900 Kanawha Boulevard, East
Charleston, WV 25305-0330
E-mail: riking@access.k12.wv.us
FAX: (304) 558-3787

Policy 2422.7: Standards For Basic And Specialized Health Care Procedures (2422.7) Series 25A

Comment Period Ends: August 18, 2004

Please use this form when commenting on proposed Policy 2422.7. You may attach additional sheets if necessary.

Individual/Organization: SANDRA Haller

Title: School Nurse

Street Address: Rt. 1 Box 219-B City/State/Zip Philippi, WV 26416

§126-25A-1. General.

§126-25A-2. Purpose.

§126-25A-3. Definitions.

Unlicensed Personnel needs defined.
This term is used under personnel Section of the Procedures: Insulin administered by injection and Administration of insulin by Pump.
Point to consider - Is A teacher licensed personnel?

§126-25A-4. State Administrative Procedures.

§126-25A-5. Organization and Management.

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

§126-25A-7. Health Care Plan.

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Return comments by August 18, 2004 to:

Rebecca King
Coordinator
West Virginia Department of Education
Building 6, Room 309
1900 Kanawha Boulevard, East
Charleston, WV 25305-0330
E-mail: rjking@access.k12.wv.us
FAX: (304) 558-3787

Linda Payne

From: Rebecca King [rjking@access.k12.wv.us]
Sent: Monday, August 09, 2004 10:04 AM
To: Linda Payne
Subject: FW: updated manual

Please add to the comment log on policy 2422.7.

Thanks,

Becky
-----Original Message-----
From: Jane Ishman [mailto:jishman1@earthlink.net]
Sent: Sunday, August 08, 2004 2:48 PM
To: rjking@access.k12.wv.us
Subject: updated manual

Rebecca:

Looks like alot of work for the manual. A couple of comments. When the manual is printed, I would suggest combining pages that only have one or two lines on the next page. I.E., S 55, 63, and 74. You may already have done this, but it would probably save on postage and people may not see things on the next page, unless continued is printed on the previous page. If that can be done, then one line could most likely be added.

For SS 18-5-15d: Is the HIV training for employees required every year or every so many years?

I appreciated the opportunity to review the manual. Our lead nurse is Marsha Spickler. I will forward this to her on Monday. I do feel it is VERY difficult to get a true response from nurses when they are currently not under contract and vacationing, etc over the summer. I realize you want this completed before school starts, but feel many will not have sufficient opportunity to comment or discuss until it is already in place, making for some hard feelings. I am not blaming, just expressing what you may encounter.

You will find I speak my mind, however, only want what is best in the long run.

I am still having problems with the insulin pump procedure. One last time, let me make sure I understand it correctly. If a student is on a pump and knows he has had X number of carbs and therefore his scale says X number of units of insulin. If the student dials this up, a non-licensed person canNOT verify this, I realize the student must administer the bolus (if ordered that way). If verification is required the school nurse or other licensed personnel must be present. I guess I am looking at the verification as a safety issue or double check. I am also concerned about driving all over my end of the county every time a student wants a snack. It could take up to 15 minutes to get there. I realize at lunch I will have to be there unless the MD writes the order that student may self-administer. I guess I like the idea of someone verifying the student's BS reading. Please forgive

my con! fusion on this issue.

I think its great that the manual has so much included. Will school nurses be doing budgets, etc for the pre-school population? and assessment of programs?

Another question. If school nurses are certified as K-12, will an additional certification be needed for Pre-K? I realize we already serve the Pre-K handicapped, but this issue of certification has never come up or been addressed.

I did not receive the School Nurse Institute brochure until a week after the seminar.

I'll stop rambling. Thank you for your support of school nurses. As things continue to become more complicated, we really need a voice in Charleston!

Jane Ishman, RN, MS, CHES
Berkeley County