SOUTHERN WORCESTER COUNTY EDUCATIONAL COLLABORATIVE

HEALTH SERVICES

PROTOCOL AND PROCEDURES MANUAL

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PURPOSE:

The School Health Policies and Procedures Manual is intended to provide guidance to school nurses for school nursing practice. This Manual is designed for school health services to include:

- Current laws, Rules & Regulations
- Policies
- Best practice procedures
- Information and resources to enhance school nurse practice.

This manual and its contents are reviewed annually by the School Nurse Leader to ensure the most current research and evidence is being used. Copies of this manual will be easily accessible in designated administrative offices and the nurse's office at all SWCEC locations.

PHILOSOPHY:

Healthy children learn better. Children must feel well if they are going to be active and successful learners and are more likely to realize their full potential. School-age children are susceptible to increased social, emotional, behavioral and physical problems. It is essential that all health related concerns be recognized early and adequately addressed in order to ensure that children have the ability to reach their full potential.
Children with complex medical conditions or special healthcare needs have the legal right to access health-related services within the school setting. Certified school nurses are essential to meet the increasing needs of students with complex health care needs.

SCHOOL HEALTH PROGRAM GOALS:

As health services are one of the components of coordinated school health programs, it is important to mention the connection with the other components. Health services do not exist in isolation. There is collaboration with health and physical education, physical activity, school counseling, physical and behavioral health services, health promotion and staff wellness, school nutrition and food services, school environment, school climate and youth, parent, family and communities. These make up coordinated school health programs and all are vital links to ensuring student's health and success in schools. School nurses play a role in all these areas and are encouraged to follow this model of health in their schools, as outlined below:

Health Education – A planned, sequential, K-12 curriculum that addresses the physical, mental, emotional, and social dimensions of health.
Physical Education – A planned, sequential, K-12 curriculum that provides cognitive content and learning experiences in a variety of activity areas.
Health Services – Services provided to appraise, protect, and promote student health, facilitate attendance, ensure access and referral to community primary care providers and other youth-serving agencies, foster use of primary care services, prevent and control disease and other health problems, and provide emergency care and educational and counseling opportunities.
Nutrition Services – Access to a variety of nutritious and appealing meals and a nutritional environment that accommodates the health and nutrition needs of all students.
Counseling/Psychological Services – Services provided to improve students' mental, emotional, behavioral, and social health.
Healthy School Environment – Positive physical and aesthetic surroundings, psychosocial climate, and culture for schools.
Parent/Community Involvement – An integrated school, parent, and community approach for enhancing students' health and well-being. School health advisory councils, coalitions, and broad-based constituencies can build support for school health program efforts and gather resources and services to respond effectively to students' health needs.

MGL LEGAL STANDARD: 18.05 (9)
DESE CRITERION NUMBER & TOPIC: 3.2 Health Care Manual

THE SCHOOL HEALTH PROGRAM

M.G.L. c.71, s.53 requires each school committee to appoint one or more school physicians and registered nurses, assign them to public schools within its jurisdiction, and provide all proper facilities for the performance of their duties. The physicians and nurses must be licensed in Massachusetts. School nurses are professional registered nurses issued a license by the Massachusetts Board of Registration in Nursing. M.G.L. c.112, s.80B, the Nurse Practice Act, authorizes the legal practice of nursing in the Commonwealth. The regulations governing nursing practice and nursing education are contained in the Board's regulations at 244 CMR 3.00 – 9.00. The scope of legal nurse practice, including criteria for delegation, is found at 244 CMR 3.00. The statutes and the regulations hold each nurse responsible for his/her own practice. The Accepted Standards of Practice apply in the school setting, just as they would in any other health care arena.

The overseeing consultant Physician for The Collaborative is:

Dr. Jaime Kane
105 Millbury Avenue
Auburn, MA 01501
P: 508-832-9691
F: 508-832-7670

Available to the School Nurse and administration via telephone or face to face meeting (scheduled) as needed Monday - Friday during school hours for consultation regarding school health program, policies, and protocols.

Job Description:

Title: School Physician
Reports to: SWCEC Executive Director
Classification: Independent Contractor

General Responsibilities:

The role of school physician is a position authorized under MGL: Ch.71, Sec 53. The school physician functions as part of a health team addressing the health issues of the students in the school district. The school physician will work closely with the school district's Nurse Supervisor, who is responsible for the daily management of the school health program. The department recommends that the school physician be board certified in a specialty appropriate to school age population (e.g. pediatrics, family practice, adolescent medicine).

The School Physician shall be responsible for the following duties:

- Signing yearly consent form for standing orders for the developmental programs, elementary school and high school.
- Signing prescription yearly for EpiPen and EpiPen Jr at each school site.
- Signing for DPH's medication delegation administration program every year.
- Available for consult throughout the school year during normal school hours and serve as an advisor for school health issues via phone calls and/or emails.
- Signing Department of Public Health's Full delegation medication application annually.

Minimum Qualifications:

- A license to practice medicine in the Commonwealth of Massachusetts (M.G.L. c. 71, s. 53b); and knowledgeable about the health needs of children and adolescents.

Additional Preferred Qualifications:

- The school physician should, in addition, be board certified or board eligible in pediatrics or family practice.

THE SCHOOL HEALTH PROGRAM

The National Association of School Nurses (NASN) adopted the following definition of school nursing:
"School nursing is a specialized practice of professional nursing that advances the well- being, academic success, and life-long achievement of students. To that end, school nurses facilitate positive student responses to normal development; promote health and safety; intervene with actual and potential health problems; provide case management services; and actively collaborate with others to build student and family capacity for adaptation, self-management, self-advocacy and learning."

In Massachusetts, school nursing is one of the most comprehensive and rapidly evolving nursing specialties, moving from an unrecognized component of the health care delivery system to an active partner in the provision of care to the Commonwealth's children and adolescents. While school nurses in Massachusetts actively assume the responsibilities described in the NASN definition, they have also expanded their public health role.

The School Nurse Leader and Massachusetts DESE licensed School Nurse for the Southern Worcester County Educational Collaborative is:

Amanda Silva, RN

The Nurse for The Grow High/Middle School and The Developmental Work Experience Program is:

Ashley Meschke, RN
185 Southbridge Street
Dudley, MA 01571
(508) 764-8500 ext. 1128
Monday-Friday 7:45AM to 2:30PM

The Nurse for the Grow Elementary School is:

Ashley Meschke, RN
121 Ashland Avenue
Southbridge, MA
508-765-8500 ext. 2208
Monday-Friday 7:45AM-2:30PM

The Nurse for The Developmental Program is:

Amanda Silva, RN
185 Southbridge Street
Dudley, MA 01571
(508) 764-8500 ext. 1128
Monday-Friday 7:45AM- 2:30PM

MGL LEGAL STANDARD: 18.05(9)(a) M.G.L c. 71, §§ 53, 53A, and 53B & 18.05(9)(b) M.G.L c. 112 M.G.L. c. 71, §§ 53, 53A, and 53B
DESE CRITERION NUMBER & TOPIC: 16.2 Physician Consultations and 16.3 Nursing

STUDENT HEALTH SERVICES AND REQUIREMENTS

Activities include identification of student health needs, health screening tests (including annual vision screenings, hearing screenings, height/weight/BMI screenings, Postural screenings), communicable disease prevention and control, promotion of the correction of remediable health defects, emergency care of the ill and injured, health counseling, health and safety education, and the maintenance of a healthful school environment.

The Collaborative recognizes that parents have the primary responsibility for the health of their students. The Collaborative will cooperate with appropriate professional organizations associated with maintaining individual and community health and safety. The Collaborative shall provide the services of a medical consultant who shall render medical and administrative consultative services for personnel responsible for school health.

Procedures for Emergencies at School

School personnel shall give emergency care to students who become ill or injured on school property, buses, or while under school supervision. At the start of the school year parent/guardian will complete an emergency information sheet which indicates where the student is to be taken in case of an emergency; the name, address, and accessible phone number(s) for the parent/guardian as well as for of an emergency contact in case the parent/guardian is not available; and any allergies or conditions the student might have. The Collaborative has in place systems for communication throughout the school grounds; including staff calls, walkie-talkie communication to other staff via the front desk administrative specialist, and cell phones during field trips. The collaborative has policies and procedures in place to address situations that require a call to EMS. The Collaborative will ensure school staff receives training regarding how to handle an emergency; to include: CPR (including use & location of AED) which is renewed every 2 years, First Aid which is renewed every 2 years, OSHA which is renewed annually. The School Nurse will also provide trainings, should they be required, as students enter the program requiring supports for EpiPen, Diastat, Vagal Nerve Stimulator etc. These trainings will be conducted at least annually as well as on an as needed basis. The Collaborative will keep records of all trained staff.

Provision for care beyond First Aid; for instances when EMS is required, every effort shall be made to provide the medical unit with the student's emergency information which lists any allergies, current medications and medical conditions the student might have. Provisions shall be made for reporting all accidents, cases of injury, or illness to the School Nurse Leader and the school Principal in a prompt fashion. The Principal will determine if the Executive Director needs to be notified and will be responsible for making said notification.

Student Illness or Injury

In case of illness or injury, the parent or guardian (or emergency contact; provided by the parent/guardian at the start of the school year) will be contacted by a designated Collaborative staff member (Preferably by the School Nurse, or his/her designee in the case he/she is occupied caring for the injured/ill student). Transportation of an ill or injured student is not normally to be provided by the school. If the parent cannot provide transportation and the student is ill or injured, an ambulance may be called. Expense incurred as a result of emergency ambulance use will not be borne by the District. Transportation of a student by school personnel will be done only in an emergency and by the individual so designated by a Collaborative administrator.

First Aid Supplies

The Collaborative Health Office will maintain a secure storage of adequate first aid supplies. The specific supplies, as well as the amount needed will be determined by the School Nurse Leader. School nurses will submit their requests to the School Nurse Leader who will be responsible for submitting the orders for administrative approval. There will be easy access to first aid supplies by all staff; available in the Collaborative Health Office.

MGL LEGAL STANDARD: M.G.L. 71:53;54;54A;54B;55;55A;55B;56;57 and 18.03(10); 18.05(7); 28.09(12) (a, b), and 18.05(5)(c); 18.05(8); 18.05(9)(e, f)(1); 18.05 (9)(j); M.G.L. c. 71, § 32A, and 18.05(9)(e, f)
DESE CRITERION NUMBER & TOPIC: 4.5 Immediate Notifications, 15.5 Parent Consent and Required Notification, 16.4 Emergency First Aid and Medical Treatment

PREVENTATIVE HEALTH CARE/ASSESSMENTS OF STUDENTS

School Entry/Re-Entry/Transfer:

Per Massachusetts General Law; each student must have on file prior to each admission (new student, transferring student, student returning after discharge to an alternate placement) to the Collaborative the following:

1. Physical exam within the year of entry; including TB risk assessment or results of a mantoux test.

2. Up to Date Immunizations (or letter of waiver from Physician that vaccination is medically contraindicated or a letter of waiver from the parent/guardian that vaccination is against their sincere religious beliefs. These letters of waiver are to be renewed annually).

MGL LEGAL STANDARD: MGL c. 71, § 57, M.G.L. c. 76, s.15, 105.CMR 220.000

Physical Exams:

Every student will be carefully examined by a duly licensed physician, nurse practitioner or physician's assistant as follows:

Within one year prior to entrance to school or within 30 days after school entry and at intervals of either three or four years thereafter (typically at entry, Kindergarten, 4th grade, 7th grade, and 10th grade). A student transferring from another school system shall be examined as an entering student. Health records transferred from the student's previous school may be used to determine compliance with this requirement. Student under 16 or over 14 years of age requesting employment certificates must have a valid physical exam on file. Students in the Developmental Programs are asked to provide annual physicals to the nurse to ensure current health needs are being met within the school setting.

The collaborative does not have any MIAA teams; but may have students who participate on MIAA teams for their sending district/program. All participants for a MIAA athletic team will present the signed consent of parent or guardian in order (to both the sending district school Nurse and The Collaborative School Nurse) to participate in competitive athletics and will, with the signed consent of parent or guardian, be examined on an annual basis by a health care provider to determine physical fitness.

A written report stating the fitness of a student to participate, signed by the physician, will be sent to the health office of both the sending district and The Collaborative.

The Collaborative School Nurse Leader will facilitate communications with sending districts school health offices on a quarterly basis regarding MIAA players/participants and proof of physical exam on file.

Dental Exams:

The collaborative Nurse, in cooperation with the student's parent, guardian and/or human service agency which is responsible for payment, shall make provision for each student to receive an annual comprehensive dental examination. The Collaborative will ask for the name of the student's dental provider and date of most recent appointment on the annual student health form. This information will be kept in the student's health record in the Collaborative health office.

Health Screenings:

Collaborative parents/guardians will be informed via written notice, attached to student daily behavior sheet, of when the screenings will be occurring. The School Nurse Leader will be responsible for ensuring that when necessary, appropriate authorization is obtained, prior to any screening being performed. All results of above screenings will be sent home via written notice (sealed in envelope); attached to daily behavior sheets.

PREVENTATIVE HEALTH CARE/ASSESSMENTS OF STUDENTS

- VISION: Per state mandate, every student will be screened for vision in the year of school entry, and annually through grade 5 (or until age 11 in ungraded classrooms,) once in grades 6-8 (or ages 12-14 in ungraded classrooms,) and once in grades 9-12 (or ages 15-18 in ungraded classrooms.). The vision of each student shall be tested by means of the Massachusetts Vision Test or other comparable method approved by the Massachusetts Department of Public Health. Students' who do not meet passing criterion will be re-screened w/in 1 week of the original screen and should he/she not meet passing criterion they will be referred to their PCP and/or other specialist as deemed appropriate by their PCP. This referral will be sent home to the student's parent/guardian with the daily behavior sheet. The referral includes a form to be completed by the evaluating medical professional which should be returned to school. The school nurse will follow up with parent/guardian as needed to encourage a timely follow up.

- HEARING: Per state mandate, every student will be screened for hearing in the year of school entry, and annually through grade 3 (or until age 9 in ungraded classrooms,) once in grades 6-8 (or ages 12-14 in ungraded classrooms,) and once in grades 9-12 (or ages 15-18 in ungraded classrooms.) The hearing of each student shall be tested by means of the Massachusetts Hearing Test or other comparable method approved by the Massachusetts Department of Public Health. Students' who do not meet passing criterion will be rescreened w/in 1 week of the original screen and should he/she not meet passing criterion they will be referred to their PCP and/or other specialist as deemed appropriate by their PCP. This referral will be sent home to the student's parent/guardian with the daily behavior sheet. The referral includes a form to be completed by the evaluating medical professional which should be returned to school. The school nurse will follow up with parent/guardian as needed to encourage a timely follow up.

- HEIGHT/WEIGHT/BMI: Per state regulation, accurate measurement of weight and height and calculation of BMI for students in grades 1, 4, 7, and 10 (or by a student's 7th, 10th, 13th, and 16th birthday) shall be done by trained school personnel approved by MDPH. Per state regulation, parents and legal guardians shall be provided with an opportunity to request, in writing to the School Nurse, that their child not participate in the program. The School Nurse Leader will be responsible for reporting aggregate data to MDPH as required.

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- POSTURE: Every student will have a postural screening annually in grades 5 through 9 (or ages 11-15 in ungraded classrooms). Students' who do not meet passing criterion will be re screened w/in 1 week of the original screen and should he/she not meet passing criterion they will be referred to their PCP and/or other specialist as deemed appropriate. This referral will be sent home to the student's parent/guardian with the daily behavior sheet. The referral includes a form to be completed by the evaluating medical professional which should be returned to school. The school nurse will follow up with parent/guardian as needed to encourage a timely follow up.

Due to the unique nature of our students, Vision and Hearing Screenings are deferred to your child's Primary Care Physician or Specialist for completion. For any Collaborative student who is unable/unwilling to participate in postural, and/or height/weight/BMI screenings at school; the Nurse will send a notice home to the parent/guardian informing them and requesting the student be screened by either their PCP or a Specialist recommended by their PCP. The Nurse will also request documentation of the screening. The Nurse will also inform parent/guardian if their child refuses to participate in the screening process.

The School Nurse Leader, with approval from Collaborative Administration will ensure that all of the equipment being used for screening purposes is approved by MDPH and has been calibrated by a qualified professional as required by manufacturing and state requirements.

MGL LEGAL STANDARD: 18.05(9)(g) M.G.L. c. 71, § 57 M.G.L. c. 111, § 111, 105CMR200.100(B)(1)
105 CMR 200.000; 105 CMR 200.400(B), (C), M.G.L. 71:53; M.G.L. 71: 54; M.G.L. 71:56 603CMR18.05 (9) (g) (1)
DESE CRITERION NUMBER & TOPIC: 16.7 Preventive Health Care

PREVENTATIVE HEALTH CARE/ASSESSMENTS OF STUDENTS

Immunizations:

No child, except as hereinafter provided, shall be admitted to school from Kindergarten through 12th grade, except upon presentation of a physician's certificate that the child has been successfully immunized (as per schedule set by MGL and The Mass DPH) against the following:

- DPT or DTaP (Diphtheria, Pertussis, Tetanus)
  5 doses (4 doses is acceptable if the 4th dose was administered on or after the 4th birthday)

- MMR (Measles, Mumps, Rubella)
  2 doses (1st dose must be given on or after the 1st birthday; 2nd dose administered at least 28 days after)

- Poliomyelitis (Polio)
  4 doses (4th dose must be given on or after the 4th birthday and 6months after the 3rd dose, or a 5th dose is required)

- Varicella (Chicken Pox)
  2 doses (1st dose must be given on or after the 1st birthday; 2nd administered at least 28 days after)
  Laboratory evidence of immunity or Doctor noted verification of disease is also acceptable

- Hepatitis B
  Three doses
  Laboratory evidence of immunity is also acceptable

- Meningococcal (Menactra)
  2 doses (1st to be administered between ages 11-13; 2nd dose to be administered between ages 16-17)

- Tdap (Tetanus booster)
  A single dose of Tdap vaccine will also be required for students attending 7th grade (or 12 years old for ungraded students) if it has been more than five years since the last dose of DTaP, DT or Td.

- Influenza Vaccine (Flu vaccine)
  Annual vaccine required prior to December 31st (new requirement as of 2020/2021)

- Documentation of Lead screening (and result) for those children entering Kindergarten

- TB screening documentation on either immunization report (Mantoux for those born outside of the US) <u>or</u> MD declination (on physical exam) of high/low risk for those students entering Kindergarten or transfers/new admissions to The Collaborative

Please note; these requirements set by the DPH.

** Acceptable forms of "certification of immunization" include: a form or letter signed and dated by a licensed doctor or practitioner which specifies the month, year, and name of vaccine(s) administered to said student, or a copy of the student's immunization certificate from the Massachusetts Immunization Information System (MIIS).

<u>A child shall be admitted to school without complete immunizations only for the following reasons</u>:

- A certification by a physician that he/she has personally examined such child and that, in his/her opinion, the physical condition of the child is such that his/her health would be endangered by such vaccination or by any of such immunizations. Such certification shall be submitted at the beginning of each school year to the Collaborative Nurse.

PREVENTATIVE HEALTH CARE/ASSESSMENTS OF STUDENTS

- Upon written letter from parent/guardian stating that immunization conflicts with the family's sincere religious belief, this written letter stating this shall be submitted at the beginning of each school year. In this case, shall be required to present said physician's certificate in order to be admitted to school.

- Upon written letter from the child's Primary Care Provider that immunization is medically contraindicated and why. This letter stating this shall be submitted at the beginning of each school year.

- Laboratory evidence of Immunity to Varicella or written statement from Physician denoting history of positive Varicella (chicken pox) disease

- Laboratory evidence of immunity to Measles and/or Hepatitis B

- Homelessness (McGinty-Vento act) The Homeless Education Liaison will be notified to assist in obtaining proper immunizations.

**** Unimmunized students who do not meet these requirements shall not be admitted to school. ****

MGL LEGAL STANDARD: M.G.L. c. 76, §15, 105.CMR 220.000, 1983, 1990, 1994, 1998.
DESE CRITERION NUMBER & TOPIC: 16.7 Preventive Health Care

<u>Non consent to treatment</u>:

The Collaborative will not require any student to actively receive and/or participate in medical care/treatment when the parents object thereto on the ground that such treatment conflicts with a religious belief, unless the situation presents itself as an emergency or epidemic disease declared by the Department of Public Health.

The parent/guardian must supply the collaborative nurse with written documentation (a letter) stating requesting that the student be exempt from such treatment as it conflicts with their sincere religious beliefs. The letter will be reviewed and approved by the School Nurse Leader and administration (Principal). The letter will be kept in the student's health record and honored when it does not threaten the health or safety of other students. This letter will be renewed by the parent/guardian annually.

Students, teachers and staff, without proof of immunity from a disease, including those with medical or religious exemptions, are considered susceptible and are subject to exclusion as described in the Isolation and Quarantine Requirements, 105 CMR 3000 and M.G.L. c.111 §.3,6,7,109,111,112

MGL LEGAL STANDARD: 18.05(9)(k)
DESE CRITERION NUMBER & TOPIC: 16.8 Receipt of Medical Treatment – Religious Beliefs

<u>Prevention and control of communicable diseases</u>:

Every school district is required to provide educational services to all school age children who reside within its boundaries. By law, however, admission to school may be denied to any child diagnosed as having a disease whereby attendance could be harmful to the welfare of other students and staff, subject to that sending district's responsibilities to handicapped children under the law.

Neither this policy nor the placement of a student in any particular program shall restrict the administration from taking any temporary actions including removal of a student from the classroom as deemed necessary to protect the health, safety, and welfare of the student, staff, and others.

The Collaborative school board (executive committee) recognizes that communicable diseases which may afflict students range from common childhood diseases, acute and short-term in nature, to chronic, life-threatening diseases. Examples of communicable diseases that may result in a temporary exclusion (MGL c71, 55(a)); <u>include but is not limited to</u>:

PREVENTATIVE HEALTH CARE/ASSESSMENTS OF STUDENTS

Varicella (Chicken Pox or Shingles)	Chlamydia
GAS (Strep Throat, Scarlet Fever)	Conjunctivitis
Herpes (Genital and Simplex)	Pediculosis (Head Lice)
Crabs (Body Lice)	Scabies
Measles	Mumps
Pertussis (Whooping Cough)	Infectious Mononucleosis
Meningitis	Hepatitis B
Hepatitis C	Tuberculosis (TB)
Salmonella	Norovirus

Management of common communicable diseases shall be in accordance with Massachusetts Department of Health guidelines. A student or staff member who exhibits symptoms of a communicable disease may be temporarily excluded from school attendance and if not already reported (by the student's HCP and/or ER); the Collaborative School Nurse Leader will report all reportable communicable disease to the local board of health. The Collaborative School Nurse Leader will require a physician's statement (in writing) authorizing the student/staff return to school prior to his/her return to school.

In all proceedings related to this policy, the Collaborative shall respect the student's and staff's right to privacy. Only those persons with a direct need to know shall be informed of the specific nature of the student's or staff's condition. The determination of those who need to know shall be made by the Collaborative Executive Director and/or Principal and/or Nurse. The Collaborative Nurse will also notify parents/guardian's and referring and sending agencies of any reportable communicable diseases as they present themselves.

The educational placement of a student at the collaborative (by a sending district) who is medically diagnosed as having a life-threatening communicable disease shall be determined (by the Collaborative) on an individual basis in accordance with this policy and accompanying administrative procedures. Decisions about the proper educational placement shall be based on the student's behavior, neurological development, and physical condition; the expected type of interaction with others in school setting; and the susceptibility to other diseases and the likelihood of presenting risks to others. A regular review of the placement decision shall be conducted to assess changes in the student's physical condition, or based on new information or research that may warrant a change in a student's placement. In the event a student with a life-threatening communicable disease qualifies for services as a handicapped child under state and federal law, the procedures for determining the appropriate educational placement in the least restrictive environment shall be used in lieu of the procedures designated above.

MGL LEGAL STANDARD: 18.05(9)(g), M.G.L. c. 71, § 57 c. 71 §55 (a), c. 111, § 111. 105 CMR 300
DESE CRITERION NUMBER & TOPIC: 16.7 Preventive Health Care

Exclusion Policy in relation to communicable diseases (including vaccine preventable):

As potential incubators of communicable diseases, especially those to which children are susceptible, schools have a role to aid in the control of disease and infestations and to protect children and employees from illness. The law requires that each school board adopt a formal policy on this subject for the superintendent to implement. In addition, public health laws require that school physicians and other personnel report to the BOH, Department of Human Services (DHS), certain communicable diseases designated as "notifiable" so that public health measures can be taken to prevent large outbreaks among children and others. (Excerpts from the applicable laws are included in this section; see also section on Immunization). A copy of the rule on notifiable diseases is also included.

The discussion around communicable diseases relates to several distinct situations:

PREVENTATIVE HEALTH CARE/ASSESSMENTS OF STUDENTS

1. Non-reportable communicable conditions, such as the Norovirus
2. Reportable diseases; such as Vaccine-preventable diseases (e.g. Varicella)
3. Reportable diseases; such as “Other-non vaccine preventable” infectious diseases, (e.g. Tuberculosis)

However, the general discussion of the role of the schools, parents, and students are similar in all situations, and are mentioned before the specific situations.

Because of the danger to student and employee health, school boards are required by law to establish policies, consistent with the laws, governing responses to communicable diseases within the public schools. Each school board must adopt a formal policy, to be implemented by the superintendent, to safeguard the health of any student or employee who has contracted or been exposed to a communicable disease.

Exclusion is defined in the respective laws as the responsibility of the superintendent and the MDPH. In essence, MDPH recommends exclusion under specific conditions, and the action is the responsibility of the superintendent. MDPH has broad powers and responsibilities regarding communicable diseases, including quarantining infected persons, investigating cases, establishing reporting requirements, and treating cases. The law specifically allows MDPH to direct that a child who has been exposed to a communicable disease be excluded from school. (There is no distinction made between public and private schools in Title 22.) Under its general authority, it can also close a school, or exclude employees as well.

The only exemption for exclusion of unimmunized students is in the case of homeless children. If a homeless student does not have proper documentation of immunizations, the Homeless Education Liaison must be notified and assist in obtaining proper immunizations.

Excluded will be susceptible close contacts, including students and staff. Susceptible defines as those without a history of disease, those not vaccinated appropriately or those without laboratory evidence of immunity and are subject to exclusion as described in the Isolation and Quarantine Requirements, 105 CMR 3000 and MM.G.L. c.111 §.3, 6, 7,109,111,112.

Examples of exclusion period from school per disease is as follows: (this is list is not comprehensive – see CMR 300.00)

- Measles: day 5 through 21 after exposure
- Mumps: day 12 through 25 after exposure
- Rubella: day 7 through 23 after exposure
- Pertussis: no exclusion, however antibiotics are generally required
- Varicella: day 8 through 21 after exposure (however, if the varicella vaccine is administered during the exclusion period, their exclusion time extends to day 28 post exposure)

Preventative Measures:

The school nurse will be responsible for promoting preventative health, including but not limited to hygiene, healthy living, exercise etc.

Posters demonstrating the proper techniques for hand washing will be posted in restrooms. Information will be provided to students on an as needed as requested basis. Included but not limited to topics such as personal hygiene, hand washing, oral care, and respiratory hygiene can be discussed with any student or classroom as requested by Administration.

The school nurse will assist in providing training courses to staff regarding universal precautions, communicable diseases, infection control guidelines, etc. as required per state mandate and/or as requested by the Administration or deemed necessary by the School Nurse Leader.

Sickness and early dismissal from school due to illness/injury policy:

A student who becomes ill in school will be sent home and/or referred to his/her PCP for evaluation. This law also exempts from liability a Teacher, Principal, Nurse, or other staff who gives emergency First Aid to a student and/or one who provides transportation to a student in the case of an emergency.

If a student presents with any of these problems during the school day, he/she shall be brought to see the school nurse where an assessment will be made whether or not to call the parent/guardian and request that the child picked up from school.

PREVENTATIVE HEALTH CARE/ASSESSMENTS OF STUDENTS

If a student presents with any of the following symptoms, his/her parent or guardian (or emergency contact) will be responsible for making arrangements to have the student picked up from school in a timely manner:

COVID-19 Symptoms: Please refer to the schools re-opening plan. In the event that your child is asked to be dismissed during the 2020/2021 school year, the nurse will provide information on when your child may return to school.

***** The following symptoms are still dismissible but subject to change in when a student can return to school given the severity of the COVID-19 Virus *****

Fever: Temperature >/= 100

Return to school contingent upon being fever free without the use of fever-reducing medications for 24h prior to returning to school.

Vomiting: Witnessed

Return to school contingent upon being free of vomiting for 24h without the aid of medication.

Diarrhea: Explosive watery stool >/= 3 occurrences across the school day and/or any one instance accompanied by vomiting, fever (temperature >/= 100.5) and/or severe abdominal pain.

Return to school contingent upon being free of diarrhea for 24h without the aid of medication.

Severe sore throat/suspected Strep throat:

Children who are diagnosed by a HCP as having strep throat can return to school after having taken 24h of antibiotics and is fever-free (without aid of medication). Parents/guardians should contact the school nurse if his/her child is diagnosed with strep throat so an informational fact sheet can go home with other students in your child's class.

Crusted eyes/suspected Conjunctivitis:

Children who are diagnosed by a HCP as having bacterial Conjunctivitis can return to school when he/she has taken 24h of antibiotics

Head Lice/Nits: Children with suspected and/or visualized head lice will be dismissed at the end of the school day.

Return to school is contingent upon the student receiving proper lice treatment. The child will be checked on the day of return and periodically (to ensure proper treatment), for live lice. If lice is present, the student may be excluded at the nurse's discretion.

Scabies: Scabies is an infestation of the skin by the human itch mite. Persons with crusted scabies are very contagious to other persons and can spread the infestation easily both by direct skin-to-skin contact and by contamination of items such as their clothing, bedding, and furniture.

*Children may return to school when he/she has completed treatment **and** has a note of clearance from a HCP.*

Suspected Impetigo: Impetigo is a bacterial skin infection and is highly contagious. Children with actively oozing or draining sores will need to be dismissed for evaluation by a HCP. Children with suspected impetigo and whose sores are not draining/oozing may stay at school if he/she is able to keep the area covered and/or not touch the area but must be evaluated by a HCP before the next school day (return to school with note documenting visit).

Children with a diagnosis of Impetigo may return to school when he/she has taken 24h of antibiotics.

Inexplicable rashes: Rashes can be from many things ranging from an allergic reaction to an illness. Absence of other symptoms does not indicate the child is well. Children with a suspicious rash (presenting on trunk, face) will be dismissed for evaluation by a HCP.

Children may return to school with note of clearance from the HCP.

The student may return to school when the above symptoms are no longer present for 24 hours without the use of medication (fever, vomiting, diarrhea) and in the case of a bacterial infection after antibiotic treatment has been in place for 24 hours (strep throat, conjunctivitis, impetigo). A doctor's note will be required in certain circumstances (including, but not limited to: scabies and rashes).

PREVENTATIVE HEALTH CARE/ASSESSMENTS OF STUDENTS

Assessment and treatment by the school nurse are provided for minor injuries or illnesses during the school day. It is required that confidential documentation for each episode be documented by the Nurse in the student's electronic health record (SNAP). The nurse will dismiss any child who is too ill to be in school (as per below and/or as per the Nurse's professional judgment), requires further assessment or treatment for an illness or injury, or is considered to be contagious or susceptible to disease.

Parents will be notified via telephone by the school nurse, counselor, or designated administrative staff when medical care other than basic first aid is administered to their child. The school nurse maintains documentation regarding student visits to the nurse's office, concerns and complaints, nurse assessment, and plan of care. The time and date of the visit is recorded and any future visits regarding the same incident. All phone calls and correspondence will be recorded in the student's confidential health record when appropriate.

If a student becomes ill or injured, but the situation is not life-threatening, his/her parent or guardian is notified immediately. If a parent cannot be reached but the student requires further treatment, he/she will be transported via ambulance to the appropriate medical facility. A staff member, if authorized by a member of Administration, will accompany a student to the medical facility until a parent/guardian is reached.

In the event of a serious illness or emergency such as motor vehicle accident, EMS will be called. The victim will be assessed and treated by an appropriately trained staff member while awaiting the arrival of the EMS. If the victim is a student, his/her parent or guardian will be notified immediately. If the victim is a staff member or other, every attempt will be made to notify a family member.

MGL LEGAL STANDARD: c.71 §.55A
DESE CRITERION NUMBER & TOPIC: 16.7 Preventive Health Care

<u>Family Planning Information/Access and Pregnant Students:</u>

Family planning and pregnancy are dealt with on an individual and confidential basis at The Collaborative. The Collaborative Adjustment Counselors will have available literature and referral numbers that will be made available to any student upon request. Students will receive sex education in the context of health class taught by a qualified teaching staff; the Collaborative Nurse will provide recommendations, information, and literature as requested and as needed.

Pregnant students will be permitted to remain in regular classes and participate in extracurricular activities with non-pregnant students throughout their pregnancy and, after giving birth, are permitted to return to the same academic and extracurricular program as before the leave. The student, in cooperation with the school staff, will develop an appropriate educational plan if it is agreed she should no longer attend school regularly.

Every effort will be made to see that the educational program of the student is disrupted as little as possible; that health counseling services as well as instruction are made available and offered to the student. The students return to school after delivery is encouraged; and that every opportunity to complete high school is provided.

The safety of the students comes first, the school nurse and staff will be obligated to report to the authorities any situation which compromises the students of The Collaborative.

MGL LEGAL STANDARD: M.G.L.c 71 §84
DESE CRITERION NUMBER & TOPIC: 16.7 Preventive Health Care

PROTOCOL AND GUIDELINES FOR MANAGEMENT OF SEIZURES

Epilepsy is a medical term covering more than twenty different types of seizure disorders, including:

1. Convulsions or sudden falls
2. Brief but frequent episodes of blank staring
3. Distortions of the child's environment which are invisible to others
4. Dazed, “trance-like” behavior during which the child's consciousness is suspended and his memory does not function.

Although seizures vary, they are all caused by the same thing --a temporary breakdown in the way brain cells control awareness and bodily movements. Many physical injuries or illnesses can cause a single seizure in a child. However, a single seizure is not epilepsy. Epilepsy means recurrent seizures. Thanks to anticonvulsant medications meant to reduce the severity and/or frequency of seizures, many children with epilepsy have these episodes infrequently or not at all and are able to participate fully in school activities. However, seizures may still occur, this policy is meant to address those situations.

Emergency Management:

The average convulsive seizure in a child who has a diagnosis of seizure disorder or epilepsy is not a medical emergency. Seizure related emergencies requiring immediate medical attention (immediate call to EMS via 911, followed by a call to parent/guardian) at The Collaborative include:

1. A first time generalized seizure in an individual not known to have seizures.
2. Consciousness does not return within 30 seconds after the seizure ends (Acceptable response to define consciousness: a response such as pushing the person trying to elicit a response away, vocalization, eye opening, looking in direction of voice of person trying to elicit a response, SIB, aggression).
3. A second generalized seizure within an hour of the first one.
4. A second generalized seizure without eliciting a response from the student immediately following the first one.
5. Prolonged seizure (defined as lasting greater than or equal to 5 minutes, or as defined by Dr in student’s action plan)
6. Administration of Diastat to students with appropriate orders
7. Cessation of breathing for 30 seconds or greater during or following a generalized seizure.
8. Significant injury during/due to a seizure (this would include hitting his/her head if fell during the seizure).

Common Types of Seizures and Their Management:

Epilepsy produces seizures that vary in appearance, effect on the child, and the kind of management they require. The School Nurse has in each student (with known diagnosis of seizure disorder/epilepsy) a seizure action plan from that child’s health care provider. The School Nurse will also conduct annual trainings for teaching staff regarding seizures (care during, effects & SE of medications used to manage seizures, management in the classroom) and refresher trainings as needed.

l. ABSENCE SEIZURES (formerly known as petit mal) produce momentary loss of awareness, sometimes accompanied by movements of the face, blinking, or arm movements. These may be frequent. The child immediately returns to full awareness after one of these episodes.

Management:

a. Teacher will inform School Nurse as soon as possible.

b. School Nurse will inform parent/guardian as soon as possible and via daily log/plan per IEP/504

c. Teacher to make provisions for child to receive access to curricula missed during the seizure

2. SIMPLE PARTIAL SEIZURES are linked to one area of the brain. Consciousness is not lost, though the child may not be able to control body movements. Senses may be distorted during the seizure so that the child sees, hears, smells, or experiences feelings that are not real.

PROTOCOL AND GUIDELINES FOR MANAGEMENT OF SEIZURES

Management:

a. Teacher will inform School Nurse as soon as possible.

b. School Nurse will inform parent/guardian as soon as possible and via daily log/plan per IEP/504

c. Teacher makes provisions for child to receive access to curricula missed during the seizure

3. COMPLEX PARTIAL SEIZURES (also called temporal lobe or psychomotor epilepsy) produce a sequence of automatic behavior in which consciousness is lost or clouded. The child may get up and walk around, be unresponsive to spoken direction or respond inappropriately, may fling off restraints, may mutter, or tap a desk in an aimless, undirected way. He/She may appear to be sleepwalking or drugged. Some children experience fear as part of the seizure and may try to leave the room. This type of seizure usually lasts only a minute or two, but feelings of confusion afterwards may be prolonged. The child will not remember what he did during the seizure. The student's actions while having this type of seizure will not have been under his/her control.

Management:

a. If a child has an episode of this type and appears dazed and oblivious to their surroundings, the teacher can take his/her arm gently (if child is away from their seat), speak to child calmly, and guide him/her carefully back to their seat.

b. Do not grab hold of child or speak loudly. If the child resists, just make sure he/she is not in any jeopardy.

c. If the child is seated, ignore the automatic behavior but have him/her stay in the classroom until full awareness returns.

d. Help reorient the child if he/she seems confused afterwards.

e. Teacher will inform School Nurse as soon as possible.

f. School Nurse will inform parent/guardian as soon as possible and via daily log/plan per IEP/504

g. Teacher makes provisions for child to receive access to curricula missed during the seizure

4. GENERALIZED TONIC-CLONIC SEIZURES (formerly known as grand mal) present suddenly, the body stiffens, and the child may cry out, fall unconscious and then undergo massive jerking movements. Bladder and bowel control may be lost. Typically these type of seizures are self-limiting lasting 1-3 minutes but can last longer (5 minutes or more is considered a prolonged seizure and an emergency in which EMS/911 would be called). Breathing is shallow or even stops briefly, renews as jerking movements end. The child may be confused, weary, and belligerent as consciousness returns

Management:

a. Teacher Call for the School Nurse/Staff

b. Evacuate the classroom of other student to a designated safe place, one teaching staff should stay with the student and start to time the seizure as soon as it starts (or as soon as it is realized the student is having a seizure).

c. Ease child to the floor as/if able

d. Turn child onto his/her side

e. Protect child from injury

f. Move desks/objects away from child

g. Place a pillow/balled up jacket under child's head

h. Do not hold the child or attempt to put anything into their mouth,

i. Stay with the child.

In many cases; the seizure itself triggers mechanisms in the brain to bring it safely to an end. There are no other first aid steps that can hasten that process. Breathing can become shallow during the seizure, and may even have stopped briefly (less than 30 seconds). This can give the child's lips or skin a bluish tinge, which corrects naturally as the seizure ends. <u>In the event that breathing does not resume within 30 seconds, follow emergency guidelines as described above and First Aid/CPR guidelines.</u> Once the seizure has ended (and per Dr orders in action plan), a short period of rest, depending on the child's alertness following the seizure, is usually advised. However, if the child is able to remain in the classroom afterwards, he should be encouraged to do so. Staying in the classroom (or returning to it as soon as possible) allows for a continued participation in the classroom activity and is psychologically less difficult for the child. Of course, if he has lost bladder or bowel control, he should be allowed to go to the rest room first.

The child's parents or guardian should always be notified of a seizure experienced during school and will be notified by the School Nurse. However, if the seizure is an emergency situation, as previously described, the emergency management policy should be followed.

Seizure Management to decrease severity and frequency of seizures:

Treatment typically involves regular use of anti-convulsive medications which have to be taken from one to four times a day. This means that some children with this disorder will have to take medicine during the school day. Some children may have a VNS (Vagal Nerve Stimulator) implanted, be prescribed Diastat or follow a special diet (Ketogenic diet). Specific care needs for these students will be outlined on a seizure action plan, Physician orders, and in their IEP/504 Plans

For students who take anticonvulsant medications; successful management depends on keeping a steady level of medication in the child's blood at all times, so it is important that doses not be missed or given late. It is vitally important that these children remain hydrated, eat meals at regularly schedule times, and be offered the restroom at least three times per day to maintain optimum health and medication levels. The Collaborative has policies in place to ensure that all students are allowed adequate restroom breaks, offered breakfast and lunch and fluids.

The Collaborative has a medication administration at school policy; which will be applied to anticonvulsant medications. This includes pre planning for field trips.

Staff Education:

The Collaborative Nurse will provide training to staff yearly (and as needed for newly diagnosed or upon request) on seizures including what to do for a student having a seizure, types of seizures likely to be seen at The Collaborative, specific student protocols, effects and side-effects of medications.

Parent/Guardian Responsibilities:

- Inform the school of your child’s seizure disorder prior to the start of the school year.
- Complete all related HCP and Parent/Guardian authorization and consent forms by designated date on form.
- Provide the school with current seizure action plans (to be completed annually by a physician).
- Keep the school informed of contact information, emergency contact information
- Inform school of changes to child’s HCP orders related to their seizure disorder. The School Nurse cannot implement any changes until previous orders have been discontinued and new orders received from the prescriber/HCP.
- Provide properly labeled medications in their original sealed containers - delivered to school by parent/guardian or designated responsible adult.
- Work with the school (Teacher and Nurse) to develop a plan that accommodates your child’s needs throughout the school setting (classroom, cafeteria, playground, bus, field trips)

<u>PROTOCOL AND GUIDELINES FOR MANAGEMENT OF FEEDING TUBES</u>

Alternative methods of feeding may be considered if oral nutrition is not possible or is not sufficient to provide adequate calories and nutrients to the student for hydration, growth and development as well as to maintain gastrointestinal function.

A feeding tube provides an opening that allows administration of food, fluids, and medications. Children may require nasogastric (NG tube) or gastrostomy feeding (G or J Tube) for developmental or mechanical reasons, or secondary to other health problems such as:

- ■ Central nervous system dysfunction, e.g., cerebral palsy
- ■ Chronic gagging, vomiting or Gastroesophageal reflux
- ■ Oral hypersensitivity
- ■ Birth defects, such as cleft lip/palate
- ■ Congenital anomalies of the esophagus
- ■ Inability to suck, chew, or swallow
- ■ Muscle and nerve disorders of the face or cranium
- ■ Malfunction or malformation of the stomach or intestines
- ■ Oral motor dysfunction with primitive or abnormal reflexes, such as jaw thrust, lip retractions, tongue retraction, tongue thrust, and tonic bite
- ■ Conditions that entail risk for aspiration or choking

For students with feeding tubes (A surgically inserted tube directly into the stomach <gastrostomy, “G-Tube”>, or tubes that pass through the nose <nasogastric, “NG tube”>, or pass through the mouth (orogastric) to provide hydration, feeding, or administration of medication); there will be HCP orders on hand to:

1. Describe the type of tube and pump used
2. Rationale/Reason for the tube (Diagnosis)
3. Feeds to be administered at school, rate, frequency, brand name of formula
4. Emergent as needed care for the tube and HCP orders for this care (e.g.-the tube becomes partially and/or completely dislodged this will include the procedure to follow to replace a completely dislodged tube, how to replace, who to contact, what to monitor for)

The School Nurse will visualize and assess the tube feed sites prior to and post each feeding/medication administration and will document any abnormal findings into the student’s health record. The School Nurse will <u>not</u> provide routine care for tubes (e.g.-routine tube change).

For students with feeding tubes that may require feedings during the school day, there will be both signed parental/guardian authorization/consent and signed HCP orders on hand to describe the type of formula, the amount, rate of drip, time of day to be delivered. The consent and orders will be renewed annually or any time there is a formula change as per existing guidelines/protocols pursuant to medication administration in school. Parent/Guardian will provide the formula for their child, which will be delivered to school by a responsible adult (parent/guardian or another designated responsible adult) and the School Nurse will document into the student’s health care record what is received. Administration of tube feed will be documented into the student’s health care record after completion; this task may be delegated to a trained staff after being trained. Staff training for delivery/administration of tube feed will be done by the School Nurse per HCP orders/specifications and completed and renewed annually.

For students with feeding tubes that may have medications to be administered during the school day via the tube, there will be both signed parental/guardian authorization/consent and signed HCP orders on hand as per medication administration protocols. The consent and orders will be renewed annually or any time there is a medication change as per existing guidelines/protocols pursuant to medication administration in school. The School Nurse will document into the student’s health care record what is received. Administration of medication via tube will be documented into the student’s health care record after administration; only a Nurse or LPN may administer medications via tube, this cannot be delegated. The feeding tube (if completely dislodged) cannot be replaced by the school nurse if written prescribing Physician orders are not on hand (these orders are to be renewed annually at each school year).

PROTOCOL AND GUIDELINES FOR MANAGEMENT OF FEEDING TUBES

Feeds will not be run during transportation to and from school. HCP orders are also required for any oral feedings that are allowed and/or not allowed (are contraindicated), this must be via a HCP order and documented in the child's confidential folder.

Students with feeding tubes (regardless if they receive tube feeds and/or medications via tube at school) will be monitored for complications related to tube feeds, including:

1. Change in affect, indicators of pain (verbal and non-verbal)
2. Indicators of pain (verbal and non-verbal).
3. Indicators of site infection (redness, warmth, swelling, discharge, elevated body temperature)

If any complication/concern develops during a feed, it will be stopped and the parent and HCP will be notified immediately. The school nurse will document this into the student's health care record.

Due to past trauma or discomfort experienced with dysphasia, the student may develop sensitivities or aversion to touch around the oral motor area or to food stuffs reintroduced orally. School health professionals, i.e., occupational therapists, nutritionists, nurses, and speech pathologists, are trained to work with feeding problems and can be consulted. Management of issues is a team effort. Continuous collaboration and consultation with community counterparts and the primary physician is essential. Documentation of accommodations to the students IEP/504 plan will be in place.

Staff Education:

The Collaborative Nurse in collaboration with OT/SPL will provide training to staff annually (and as needed for newly diagnosed or at request) on tube feeds (including various rationales for tube feeding, positioning during and after feeds, how to review/read HCP orders, complications and what to monitor for). For identified 1:1 staff of a student, the collaborative Nurse will provide further/additional training on how to run feeds (including how to review HCP orders, how to position during/after feeds, how to operate the individual pump). The Nurse will measure/pour the feeds per written HCP orders.

Parent/Guardian Responsibilities:

- Inform the school of your child's feeding tube/button prior to the start of the school year or as soon as possible after feeding tube/button has been placed.
- Complete all related HCP and Parent/Guardian authorization and consent forms by designated date on form.
- Keep the school informed of contact information, emergency contact information
- Inform school of changes to child's HCP orders related to feedings/feeding tube. The School Nurse cannot implement any changes until previous orders have been discontinued and new orders received from the prescriber/HCP.
- Provide replacement and care materials-delivered to school by parent/guardian or designated responsible adult. Supplies may include; but are not limited to: syringes, extension tubing, disposable tubing, clamp for tubing, feeding bags, and containers for water, continuous feeding pump, cleaning materials for supplies, replacement kits.
- Provide properly labeled formulas and medications in their original sealed containers - delivered to school by parent/guardian or designated responsible adult.
- Work with the school (Teacher and Nurse) to develop a plan that accommodates your child's needs throughout the school setting (classroom, cafeteria, playground, bus, field trips)
- Meet with school staff (Teacher and Nurse) prior to beginning of the school year to discuss feeding/medication administration. This ensures care will be performed as prescribed/ordered.

PROTOCOL AND GUIDELINES FOR MANAGEMENT OF FEEDING TUBES

Responsibilities of Collaborative Administration:

- Be knowledgeable and follow applicable federal laws including ADA, IDEA, section 504, and FERPA
- Review health records of students submitted by parents and prescribers/HCP.
- Inform School Nurse of names of relevant school faculty/staff that should participate in an in-service training for student.
- Be able to include student in all school functions, student should not be excluded solely based on a feeding tube/button
- Coordinate with School Nurse to ensure regulations regarding medication storage and formula storage are occurring
- Inform Transportation Department (Collaborative or District) of Feeding tube/button so that appropriate training(s) can be conducted/arranged and transportation can occur.
- Discuss field trips with parent/guardian to plan for feeding tube/button care and /or medication administration.

Responsibilities of School Health Professionals:

- Provide parent/guardian with necessary authorization and consent forms with instructions on how to complete and date due back to the Collaborative Nurse
- Provide copy of ‘Protocol and Guidelines for Management of Feeding Tubes’
- Train appropriate school faculty/staff via in-service on how to care for student with feeding tube/button, what to monitor for, and as/if needed a separate in-service on how to run feeds. Ensure documentation of training is recorded and stored appropriately.
- Provide health information sheet to school faculty/staff on a need-to-know basis
- Be available for questions/concerns, and follow up with trained staff

Responsibilities of Classroom Teacher:

- Review health information sheet, Prescriber/HCP orders, and outlined procedures related to feeding tube/button.
- Participate in in-service training(s) provided by the Collaborative Nurse and/or parent of student that addresses needs specific to student.
- Ensure Para-educators or other school faculty/staff in your classroom attend in-service training if they will be actively involved in the care or feeding of student.
- Leave information in an organized, prominent, and accessible format for substitute teachers and other school faculty/staff in your absence. Ensure a trained faculty/staff member is present in your absence to administer necessary care to student.
- Inform Collaborative Nurse of any complications, concerns, or adverse reactions. If Collaborative Nurse is unavailable, inform parent/guardian and/or EMS in emergencies.

Responsibilities of SWCEC Transportation:

All Collaborative staff transporting students shall be informed that he/she is transporting a child with a feeding tube/button and that the pump should not be running during transition to/from school and designated location.

- Provide functioning emergency communication devices (e.g., cell phones, two-way radios, etc.) on each bus in case of emergency/concern
- Maintain and reinforce policy of feeds not being run during transportation of the student.

PROTOCOL AND GUIDELINES FOR MANAGEMENT OF FEEDING TUBES

<u>Responsibilities for Field Trips:</u>

- Notify Collaborative Nurse two weeks prior to field trip. Please include date, time, and location.
- Ensure needed formulas, and supplies are brought on the field trip.
- Ensure that a functioning cell phone or other communication device is taken on the field trip in case of emergency.
- Provide invitation to parent/guardian of student with feeding tube/button to attend the field trip and accompany their child. The student's attendance on the field trip must not be conditioned on the presence of a parent/guardian. Parent must comply with Collaborative policy regarding background/CORI checks prior to field trip.
- At least one, if not two school faculty/staff should be present on field trip to provide care to student, if parent is not available to attend.
- Collaborative classroom Nurse may contact the HCP should the need for adjustment of feeds be required on the field trip. Feeds cannot be altered / changed due to field trip without parental consent and written HCP order.

REPLACING THE MIC-KEY* TUBE

Must have Physician Orders to do so

When is the Mic-Key Tube replaced?

When the Prescribing Physician states it should be. The School Nurse can change the tube as per prescribing Physician's written orders (should it be completely dislodged from being pulled out/ or it fall's out during the school day). The school nurse will assess the feeding tube site upon the students arrival to school, prior to dismissal and before each feeding. Should the School Nurse note the Mic-Key tube to be (partially or completely) dislodged upon the student's arrival to school; the School Nurse will not replace the tube but rather contact the parent for dismissal. The School Nurse will contact the parent and the prescribing Physician when the tube becomes partially or completely dislodged at school. For a tube that becomes completely dislodged at school, after contacting the parent and prescribing physician; the school nurse will change (as per procedure below with current MD orders on hand) and will then contact the parent and prescribing MD to inform of procedure completion and how student responded.

The Mic-Key tube cannot be replaced by the school Nurse if written prescribing Physician orders are not on hand (these orders are to be renewed annually at each school year).

PROCEDURE FOR REPLACING COMPLETELY DISLODGED MIC-KEY TUBE

STEP	RATIONAL
Wash Hands	To prevent infection
Don Non permeable gloves (vinyl or Nitrile)	Protective barrier, Universal precautions. To prevent infection.
Remove new MIC-KEY feeding tube from package	To have available equipment on hand.
Fill the balloon with 5mL sterile or distilled water	To ensure it is not leaking. To ensure it is functioning properly.
Remove the syringe and observe the balloon.	To ensure it is not leaking and it is symmetrical. To ensure it is functioning properly and decreases risk of injury to child.
Remove the water from the balloon Attach the luer slip syringe to the balloon valve of the MIC-KEY feeding tube Pull back on the plunger until all the water is out of the balloon (5mL).	
Gently remove the (currently in place) MIC-KEY feeding tube from the Child's stomach. (may be helpful to use a small amount of water-soluble lubricant as you remove it) Inspect site for redness, irritation.	To inspect site before replacing (old tube must be removed before new tube is placed!), to facilitate removal (decrease tissue injury)
Lubricate the tip of the new (replacement) MIC-KEY feeding tube with a water-soluble lubricant. DO NOT USE PETOLEUM JELLY or A + D OINTMENT	To facilitate placement. OIL BASED products can occlude the opening.

Gently guide the new tube into the stoma. Insert the tube all the way until it is FLAT against the skin.	To ensure it is placed completely inside the child, for maximal function.
Hold the tube in place. Fill the balloon with 5mL (3-5mL for 12 French sizes) sterile or distilled water. DO NOT USE AIR. CAUTION: Never fill the balloon with more than 10mL of water (never fill the balloon of a 12 French sized tube with more than 5mL water).	Over inflation can injure the child and lead to malfunction of the tube.
Position the balloon against the stomach wall by pulling the MIC-KEY feeding tube UP and AWAY very gently until it stops.	Ensures correct placement of the tube.
Wipe away fluid or water-soluble lubricant from the tube and stoma	To maintain skin integrity, promote comfort and well-being.
Check the tube for correct placement* Insert an extension set into the feeding port Obtain stethoscope and listen for air Aspirate residual stomach contents *Should MD have a different procedure; please indicate this below:	To ensure tube is placed correctly.

PROTOCOL AND GUIDELINES FOR MANAGEMENT OF LIFE-THREATENING ALLERGIES

Allergic food reactions can span a wide range of severity of symptoms. The most severe and potentially life threatening reaction is anaphylaxis. This protocol is to be used for students who are at risk for anaphylaxis and in circumstances where a previously undiagnosed life-threatening allergic response occurs.

Anaphylaxis is a potentially life-threatening medical condition occurring in food allergic individuals after exposure to their specific allergens. Anaphylaxis refers to a collection of symptoms affecting multiple systems in the body, the most dangerous of which are breathing difficulties and a drop in blood pressure or shock, which are potentially fatal. The most common causes of anaphylaxis in children include allergies to:

- Foods (most commonly; dairy products, eggs, fish/shellfish, milk, peanuts/tree nuts, soy, wheat)
- Latex
- Medications
- Stinging insects

Anaphylaxis can occur immediately and/or 2-6 hours following allergen exposure, so it is important to:

- Identify student at risk
- Have appropriate preventative policies
- Be prepared to handle an emergency
- Ensure appropriate medical care and follow-up

The Collaborative cannot guarantee to provide a food allergen-free environment for all students with life threatening allergies, or prevent any harm to students in emergencies. The goal is to minimize the risk or exposure to known/identified food allergens/non-food allergens that pose a threat to those students, educate the community, and maintain and regularly update a system-wide protocol for responding to their needs. A system-wide effort requires the cooperation of all groups of people within the system.

It is the policy of the Collaborative that guidelines shift as children advance through the primary grades and through secondary school and return to their sending district. This plan shall strike a balance between the health, social normalcy and safety needs of the individual students with life threatening allergies and the education, health and safety needs of all students.

<u>Goals include</u>:

To maintain the health and protect the safety of collaborative students who have known & identified life-threatening allergies (food and non-food) in ways that are developmentally appropriate, promote self-advocacy and competence in self-care and provide appropriate educational opportunities.

To ensure that interventions and individual health care plans for students with life-threatening allergies (food and non-food) are based on medically accurate information and evidence-based practices.

To define a formal process for identifying, managing, and ensuring continuity of care for students with life-threatening allergies (food and non-food).

The sections below highlight the major responsibilities of the various groups, but each child's plan will be individualized and therefore not all responsibilities can be spelled out in this protocol. The goal of the Collaborative regarding life-threatening food allergies is to engage in a system-wide effort to:

- Prevent any occurrence of life-threatening food and non-food based allergic reactions
- Prepare for any allergic reactions to food
- Respond appropriately to any allergy emergencies that arise

PROTOCOL AND GUIDELINES FOR MANAGEMENT OF LIFE-THREATENING ALLERGIES

Parent/Guardian Responsibilities:

Each parent of a student with a life-threatening allergy shall have the following responsibilities:

- Inform the school nurse of your child's allergies prior to the opening of school (or as soon as possible after diagnosis).

- Parent(s) must arrange to meet with the school nurse to develop an Individual Health Care Plan for the student and provide medical information from the child's treating physician as needed to write the Plan. Parents must arrange for school health professionals to be able to communicate with student's physician.

- For life-threatening food allergies; parent/guardian may choose to provide the school a list of foods and ingredients to be avoided, and provide a list of safe or acceptable foods that can be served to your child.

- For life-threatening food allergies: Provide the school nurse with enough up-to-date emergency medications (including Epi- pens) so they can be placed in all required locations for the current school year.

- For all life-threatening allergies (food and non-food): Complete and submit all required medication forms

- For life-threatening food allergies: Encourage students to wash hands before and after handling food (for those with life-threatening food allergies.

- Inform the school of any changes in the child’s life-threatening allergy status.

- Provide the school with the licensed provider’s statement of the student no longer has a life-threatening allergy (food or non-food).

- Chaperone field trips and out-of-school activities with your child, whenever possible.

- Sign a release for school personnel to consult with family practitioner/allergist and all medical providers.

- Teach their child to:
    - Recognize the first symptoms of an allergic/anaphylactic reaction.
    - Know where the epinephrine auto-injector is kept and who has access to the epinephrine.
    - Communicate clearly as soon as he/she feels a reaction is starting.
    - Not share snacks, lunches, or drinks (for those with life-threatening food allergies).
    - Understand the importance of hand washing before and after eating
    - Recognize where in the environment allergens may present (Food, Latex and/or stinging insects).
    - Report teasing and/or bullying that may relate to the child's allergy.
    - Take as much responsibility as possible for his/her own safety.

- As children get older, teach them to:
    - Communicate the seriousness of their allergy.
    - Communicate symptoms as they appear.
    - Read labels (for those with food allergies)
    - Where he/she may encounter Latex and/or stinging insects in the environment
    - Administer own epinephrine auto-injector and be able to train others in its use

PROTOCOL AND GUIDELINES FOR MANAGEMENT OF LIFE-THREATENING ALLERGIES

Responsibilities of Students:

Each student with a life-threatening allergy (food or non-food) shall be responsible for the following:

- Take responsibility for avoiding allergens
- For those with food allergies; do not trade or share food
- For those with food allergies; wash hands before and after eating
- Learn to recognize symptoms of an allergic reaction.
- Promptly inform an adult as soon as accidental exposure occurs or symptoms appear.
- Take more responsibility for your allergies as you get older.
- Develop a relationship with the school nurse and/or adjustment counselor in school to assist in identifying issues related to the management of the allergy in school.

Responsibilities of Collaborative Administration:

The Collaborative Executive Director and his/her staff shall be responsible for the following:

- Create a system-wide emergency plan for addressing life-threatening allergic (food and non-food) reactions

- Provide annual in-service training and education on reducing allergy risks, recognizing allergy symptoms, and emergency procedures for staff.

- Training shall include, but not be limited to:
  i. A description/definition of severe allergies and discussion of the most common foods causing allergic reactions.
  ii. The signs and symptoms of anaphylaxis
  iii. The correct use of an Epi-pen
  iv. Specific steps to follow in the event of an emergency

- Adopt a "NO FOOD TRADING/SHARING" and "NO UTENSIL SHARING" procedure in all schools with particular focus at the elementary school level.

- Ensure School health professionals in conjunction with the student's parent(s)/guardian(s) and the primary care provider/allergist prepare an Allergy Action Plan/Individual Health Care Plan for any student with a life-threatening (food & non-food) allergy. The Plans will be reviewed by the school nurse, the student's parent(s)/guardian(s) and primary care provider and/or the student's allergist, and signed off by the child's physician/allergist, indicating that he/she deems it to be adequate. This plan will be available in the school health services office.

- Provide and maintain life-threatening (food) allergy free tables in each school cafeteria as needed by the Individual Health Care Plan. These tables will be designated by a universal symbol. These tables will be cleaned and sanitized as per established protocols set forth by Nutrition Services. All tables in the cafeteria will be cleansed as per established protocols.

- Ensure that SWCEC Transportation and/or sending district transportation department’s school bus drivers are informed of which students in their bus have life-threatening (food & non-food) allergies.

- Ensure Epi-pens (belonging to the school and those prescribed to the students) available in the nurse's office and in other clearly designated locations as specified in the Individual Health Care Plan.

PROTOCOL AND GUIDELINES FOR MANAGEMENT OF LIFE-THREATENING ALLERGIES

- Ensure a contingency plan will be in place and understood by all staff and students in the event the nurse is not in the office or in the building. Staff will call 911 in all instances of any allergic reaction.

Responsibilities of School Health Professionals:

The school nurse is the primary coordinator of each student's plan. Each school nurse will have the following responsibilities:

- Meet with each parent/guardian of a student with a life-threatening allergy and develop an Individual Health Care Plan for the student.
- Maintain updated Individual Health Care Plans in the nurse's office and upon request in the student's homeroom.
- Nurse will assist the principal in providing information about students with life-threatening allergies to staff.
- In conjunction with the principal, provide in-service training and education for staff regarding life-threatening allergies, symptoms, risk reduction procedures and emergency procedures including demonstration on how to use the Epi-pen.
- Familiarize teachers with the Individual Health Care Plan of their students and any other staff member who has contact with student on need-to-know basis.
- The school nurse will be responsible for following Department of Public Health regulations governing the administration of prescription medications. Nurses are also responsible for following the regulations that permit registration of non-licensed personnel to be trained and to administer Epi-pen.
- Discuss with parents the location(s) for storing the Epi-pen and the possibility of receiving more than one Epi-pen as necessary.
- Inform the school principal and parent/guardian if any student experiences an allergic reaction that has not been previously diagnosed.
- Emergency protocol will be in place in the event the nurse is not in the building.

Responsibilities of Teachers:

Each teacher shall have the following responsibilities:

- Review the Individual Health Care Plan, in collaboration with the nurse and parent(s), of any student(s) in your classroom with life-threatening allergies.
- Leave information in an organized, prominent and accessible format for substitute teacher.
- Participate in in-service training for students with life-threatening allergies.
- Teacher, in collaboration with the nurse and input from the parents of the allergic child, will set a classroom protocol regarding the management of food in the classroom.
- Participate in the planning of a student's re-entry into school after an anaphylactic reaction

- Advise parents of any school related activity that requires the use of food in advance of the project or activity (K-5 only).

- Limit use of food for instructional lessons.

- Teacher will collaborate with administration and nurse to send out letters to all parents/guardians of students in a class with an individual with a life-threatening food allergy.

- Whenever reasonable, the teacher will reinforce appropriate hygiene techniques/hand washing before and after eating.

- If an allergic reaction is suspected, call the nurse's office immediately.

Responsibilities of Food Personnel:

The food service department shall have the following responsibilities:

- Supply cleaning materials for washing and sanitizing tables as per district protocol.

- Provide in-service to food service employees regarding safe food handling practices to avoid cross-contamination with potential food allergens.

- Food service employees will wear non-latex gloves.

Responsibilities of SWCEC Transportation:

All school staff providing student transportation shall be informed that he/she is transporting a child with a life-threatening allergy. The school bus drivers shall have the following responsibilities:

- Provide functioning emergency communication devices (e.g., cell phones, two-way radios, etc.) on each bus.

- Maintain and reinforce policy of no food eating on the bus.

The Collaborative Nurse will communicate with sending district school nurses this information so he/she may assist The Collaborative Nurse in disseminating this information. The Collaborative Nurse will also ensure that the Transportation Department (Collaborative and District) are aware of any student(s) on their buses with life-threatening allergies.

Responsibilities during Recess and Physical Education Classes:

During recess and physical education classes (where a child has a life-threatening allergy), the Collaborative shall have the following responsibilities:

- Children will be under the supervision of at least one adult.

- An Epi-pen will be taken outside, if specified in the child's Individual Health Care Plan.

- Develop building-based procedure whereby an emergency communication device (walkie-talkie, cell phone) is accessible and functional.

PROTOCOL AND GUIDELINES FOR MANAGEMENT OF LIFE-THREATENING ALLERGIES

Responsibilities for Field Trips

The Collaborative shall have the following responsibilities when life-threatening food allergy students go on field trips:

- Field trips need to take into consideration the risk for food allergen exposure, and parents must evaluate potential risks when determining whether their child should attend a field trip.
- Lunches should be held in a safe place, so that children cannot access them until the appropriate time.
- Lunches of children with food allergies should be stored separately to minimize cross contamination.
- The teacher and nurse will ensure that a site-specific emergency plan is developed for each field trip.
- The plan should ensure that: an Epi-pen, instructions, and a copy of the child's Individual Health Plan are taken on the trip; the teacher carries a cell phone or other communication device; at least one person on the field trip is trained in the use of an Epi-pen and is in requisite with emergency procedures.

DESE CRITERION NUMBER & TOPIC: 16.7 Preventive Health Care

HEAD INJURY/CONCUSSION POLICY

In 2010, the Massachusetts Department of Public Health's (MDPH) issued the new regulation 105 CMR 201.000 Head Injuries and Concussions in Extracurricular Athletic Activities, mandated by Chapter 166 of the Acts of 2010, An Act Relative to Safety Regulations for School Athletes (See Appendix VII for copy of this statute). This regulation requires all public middle and high schools (serving grades 6 through high school graduation) and those non-public schools that are members of the Massachusetts Interscholastic Athletic Association (MIAA) to have policies and procedures governing the prevention and management of sport-related head injuries. The Collaborative does not have any MIAA teams; but does have student's participating in sending district team MIAA sports and has a policy in place to address those students who report a head injury/concussion to The Collaborative nurse.

The Collaborative seeks to prevent concussion and provide a safe return to activity for all students after injury, particularly after a head injury. In order to effectively and consistently manage these injuries, the Collaborative abides by the following procedures that have been developed in accordance with regulation 105 CMR 201.00 to aid in ensuring that concussed athletes are identified, treated and referred appropriately, receive appropriate follow-up medical care during the school day, including academic assistance, and are fully recovered prior to returning to athletic activity.

Persons Responsible for Implementation of Concussion Policy and Procedure:

The Collaborative has designated its MS/HS principal, who has administrative authority and the nurse to oversee the implementation of these policies and protocols governing the prevention and management of sports-related head injuries. In addition, the Principal will be responsible for:

- Supporting and enforcing the protocols, documentation, training and reporting outlined in this policy.
- Supervising and reviewing that all documentation is in place.
- Reviewing, updating and implementing policy every two years and including updates in annual training and student and parent handbooks.

Annual Training Requirement:

The Commonwealth of Massachusetts requires annual safety training on sports related concussion, including second impact syndrome, for coaches, certified athletic trainers, trainers, volunteers, school nurses, school and team physicians, athletic directors, directors responsible for a school marching band whether employed by a school or school district or serving as a volunteer, parent or legal guardian of a child who participates in an extracurricular athletic activity and student who participates in an extracurricular athletic activity. At The Collaborative, the nurse, and MS/HS principal are required to complete free, on-line training (either the National Federation of High Schools or the CDC's Heads Up Concussion training). Additionally, the nurse will provide the sending district nurse and/or AD, upon request, a copy of participating student's most current physical exam. The Collaborative nurse at the MS/HS will maintain documentation of this contact in each student's individual health record.

- Center for Disease Control and Prevention Heads Up Concussion in Youth Sports On-Line Training Program
  http://www.cdc.gov/concussion/HeadsUp/online_training.html
- National Federation of State High School Associations Concussion in Sports – What you Need to Know
  http://www.nfhslearn.com/electiveDetail.aspx?courseID=15000

Documentation of Physical Exam:

Every student at The Collaborative must be separately and carefully examined by a duly licensed physician, nurse practitioner or physician assistant, prior to a student's participation in competitive athletics, on an annual basis. The completed and signed copy of the medical clearance form should be mailed, faxed or hand delivered to the Collaborative Nurse at the MS/HS and the school nurse or athletic office of the sending district. No student athlete should be allowed to participate in athletic activities until all necessary forms (including annual physical examinations) are signed and submitted. The Nurse and/or AD of the sending district school will ensure that all student athletes that are participating in extracurricular school sports have been medically cleared and will be responsible for ensuring all paperwork is in place and following up with the student regarding his/her participation status prior to the start of the season. The Collaborative Nurse at the MS/HS will facilitate as requested by the parent/guardian and/or sending district to ensure all paperwork is in place.

HEAD INJURY/CONCUSSION POLICY

Pre-Participation Head Injury Reporting Forms, Submissions and Review

Both the law and regulations require student athletes and their parents to provide an accurate history of head injury to the school prior to each athletic season. The Collaborative supports this initiative and will facilitate upon request from the sending district nurse and/or AD, communication with the student and family for completion of any forms by student athletes as needed in order for this requirement to be met. The Collaborative keeps on file a DPH Pre-participation form, should a student/parent require one in order to play. This form can be found at the following web address as well:

- http://www.mass.gov/eohhs/docs/dph/com-health/injury/preparticipation-reporting-form.pdf

Medical/Nursing Review of Pre-Participation Forms:

In order to assure that students who have experienced a concussion/head injury in the past are safe to play, the sending district/school the student athlete is playing for must ensure timely review of all pre-participation forms that indicate a history of head injury by either their school nurse or their school physician. The Collaborative supports this initiative and will facilitate the review process (which will determine how a student's history of head injury/concussion may factor into the decision of whether to allow continued participation in athletics or whether to modify the specific conditions of such participation) upon request as needed.

Medical/ Nursing Review of Reports of Head Injury during the Season:

The Collaborative recognizes that in order to assure that students who experience concussion/head injury are safe to play, that a timely review of all report of head injury forms by either the school nurse or the school physician must take place. The Collaborative Nurse at the MS/HS will facilitate completion of this form as requested by sending district school Nurse and/or AD if the form is not completed at the time of injury. For a student who reports hitting their head and/or having a head injury sustained while playing his/her MIAA sport; The Collaborative Nurse at the MS/HS will assess and evaluate the student, complete a Concussion checklist as well as a head injury in season form. The Parent/Guardian and sending district Nurse will be notified via telephone and a copy of the completed report of head injury in season form will be sent to the parent/guardian and sending district Nurse. For any MS/HS Collaborative student who suffers a head injury at school (during the season) that didn't occur while playing/practicing his/her sport; The Collaborative nurse at the MS/HS will assess and evaluate the student, complete a Concussion checklist as well as a head injury in-season form. The Parent/Guardian and sending district Nurse will be notified via telephone and a copy of the completed report of head injury in-season form will be sent to the parent/guardian and sending district Nurse. Originals of the Concussion checklist and head injury form in-season form will be kept on file in the student's individual health record in the Collaborative health office.

Blank copies of both the Concussion Check List and the Injury in-season form will be kept in the Collaborative health office. The forms can also be located at the following web addresses:

- http://www.mass.gov/eohhs/docs/dph/com-health/injury/in-season-report-form.pdf
- http://www.cdc.gov/concussion/pdf/TBI_schools_checklist_508-a.pdf

Procedure for Reporting Head Injuries:

Because medical evaluation and ongoing monitoring of a student's recovery from concussion is so important for a student's safety, The Collaborative has in place a procedure for facilitating the exchange of information about the status of a student who has sustained a suspected or known head injury or concussion (whether during play or practice or outside of school).

At The Collaborative suspected/actual head injuries and/or suspected concussions (after a bump, blow or jolt to the head or body) sustained during the school day (or reported by the student to the Nurse at the MS/HS as occurring during practice or a game) will be evaluated/assessed and then reported by the end of the school day (2:00pm) to the parent/guardian and the sending district school nurse. The Collaborative supports (and will inform the student athlete that he/she cannot report to practice/play that day as well as the parent/guardian and sending district school Nurse) the ruling that an athlete who experience signs or symptoms of a concussion and/or head injury should not be allowed to return to practice or play until he/she is evaluated/assessed by his/her PCP.

Removing Athletes from Play and Medical Evaluation:

Because continuing athletic activity after sustaining a head injury can be dangerous, resulting in both short and long term consequences up to and including death, removing a student athlete from play who has sustained an actual or suspected head injury is critical. Diagnosis of a head injury on the sidelines is not safe or acceptable practice, nor is returning an athlete to play a few minutes after a blow to the head if symptoms appear to "resolve". The law and the regulations require that players who have symptoms consistent with a suspected head injury must be removed from play, and may not return to play or practice until he/she is evaluated/assessed by his/her PCP.

The regulations state that the responsibility to remove a student athlete from play if a suspected/actual head injury occurs is that of the coach and/or a certified athletic trainer present. If there is any disagreement among responsible personnel regarding whether the student has sustained a head injury or has symptoms suggestive of a concussion, the student should be removed from play, as that is the safest option for the student.

Communication between families, educational personnel (including the school nurse), athletic staff and health care providers following a suspected or actual head injury is critical; this will facilitate a student's healthy return to school and physical activity following a head injury.

The Collaborative expects that the sending district school Nurse or AD will contact The Collaborative MS/HS nurse in the event that a student athlete sustained and actual/suspected head injury and was removed from play or practice by the start of the next school day (8:15am). The Collaborative expects that the coach/athletic trainer followed the standing policy at his/her school, including reporting the head injury (to student athlete's parent/guardian and sending district school nurse) with recommendation for medical assessment and management and for coordination of home instructions and follow-up care.

Should a student athlete who is known to have been removed from play/practice due to concerns of head injury/concussion, complain of/report/exhibit indicators of head injury/concussion The Collaborative nurse will assess/evaluate the student (including completion of a concussion symptom checklist), refer student immediately to their primary care physician or if unavailable, emergency room (this will include contact with parent/guardian) and then inform the sending district school nurse/AD. The Collaborative nurse will send a copy of the concussion symptom checklist with the student for review by medical personnel and, upon request, to the sending school district school nurse/AD. Written orders/instructions from health care provider must return to school with the student. The Collaborative will ensure students follow their primary care physician's written orders concerning return to school and physical activity (which includes physical activity in Physical Education class, recess, sports practice and/or games) when at school. With consent from the parent/guardian the home instructions/discharge care will be forwarded to the sending district school nurse/AD (consent is defined as a signed release of record consent form).

Should a student athlete suffer a fall or other incident during school (unrelated to participation in practice or play) during the school day and there is concern that he/she suffered a head injury/concussion The Collaborative nurse will assess/evaluate the student (including completion of a concussion symptom checklist) and contact parent/guardian. The Collaborative Nurse will also (after informing parent/guardian) inform the sending district school Nurse/AD and will forward the concussion symptom checklist. Should the student athlete begin to exhibit and/or complain of indicators of head injury/concussion; then the Collaborative Nurse will re- asses/evaluate the student (including completion of an additional concussion symptom checklist), refer student immediately to their primary care physician or if unavailable, emergency room (this will include contact with parent/guardian) and then inform the sending district school Nurse/AD. The Collaborative Nurse will send copy of the initial and second concussion symptom checklist with the student for review by medical personnel and upon request to the sending school district school nurse/AD. Written orders/instructions from health care provider must return to school with the student, The Collaborative will ensure students follow their primary care physician's written orders concerning return to school and physical activity (which includes physical activity in Physical Education class, recess, sports practice and/or games) when at school. With consent from the parent/guardian the home instructions/discharge care will be forwarded to the sending district school nurse/AD (consent is defined as a signed release of record consent form).

Return to Play:

The Collaborative expects that an athlete diagnosed (by HCP) with concussion or suspected concussion, will be out of competition until he/she can be cleared for participation by a Physician. No player shall go from being sidelined with a concussion to full play until he/she has followed the recommended stepwise process from the treating physician regarding return to activity. Each student who is removed from practice or competition shall have a written graduated re-entry plan for return to full academic and extracurricular athletic activities. This written plan shall include instructions for students, parent(s) and school personnel addressing physical and cognitive rest, graduated return to academics and athletics, estimated time intervals for resuming activities, assessment frequencies, as appropriate, by the school nurse, physician, team physician, athletic trainer if on staff until full return to academics and athletics is authorized. The plan shall be developed (based on recommendations/discharge instructions and home care instructions provided by the PCP/ER Physician) by the student's teachers, the student's guidance counselor, school nurse, parent, in consultation with the student's primary care provider or the treating physician. The Collaborative nurse will communicate with the sending district school nurse/AD. A plan for communication and coordination shall also be put into place with the above individuals who are managing the student's recovery. The student must be completely symptom free at rest in order to begin graduated re-entry (stepwise program) to activities. Final authority for Return-to-Play shall reside with the student's physician or the physician's designee and documented on a post head-injury clearance form (see link below). The Collaborative nurse expects that the sending district school nurse/AD will forward a copy of this form to The Collaborative Nurse and The Collaborative nurse will forward a copy of completed form to the sending district school Nurse should the original form arrive at The Collaborative.

- http://www.mass.gov/eohhs/docs/dph/com-health/injury/posthead-injury-clearance-form.pdf

Development and Implementation of Post-Concussion Graduated Re-Entry Plans:

Recovery from a concussion requires rest, both physical and cognitive, in order for the brain to heal. This means that during the recovery period, it is as important for a concussed student to refrain from studying, working on a computer or playing video games, as it is for the student to refrain from participating in athletics. A graduated reentry plan, to either academics or sports, should not begin until a student is symptom free at rest. A student should be symptom free at each stage of the plan before graduating to the next phase. The injured student will recover more quickly with rest, not only from physical exertion and athletic activity, but also from the cognitive demands of academic work

The graduated reentry plan for students of The Collaborative will require an approach that includes the student athlete's PCP/treating Physician, as well as among staff of The Collaborative (nurse, teacher, adjustment counselors, the athlete, and his/her parent or guardian) and staff from the sending district school (nurse, coach/AD, student athlete and her/his parent or guardian). This plan will be based on the discharge/home care instructions provided by the treating HCP (PCP/ED Physician) and will include gradual steps from physical and cognitive rest, gradual return to physical and academic activities, estimated time intervals for resumption of activities, frequent assessments, and a communication plan among school staff (The Collaborative and sending district school), parents, and health care providers.

The Collaborative expects that the plan for return to play will involve a stepwise process from complete rest, to light exercise, to aerobic exercise, to no contact training drills, and finally full contact practice and game play. The Collaborative expects that the treating Physician and the sending district school will work together in developing this plan as well as ensuring The Collaborative MS/HS nurse receives a copy of this plan. The Collaborative will ensure that the steps are adhered to in the school setting during the school day. The Collaborative will initiate development and implementation of the academic accommodations/cognitive rest plan; based on instructions/orders from the treating physician and will ensure that the sending district school nurse receives a copy of this plan for the student athlete's record. Both the written graduated re-entry/return to play plan and the academic accommodations re-entry/return to play plan should be kept in The Collaborative school health office (in the student's medical record), in the sending district school health office (in the students medical record), and also the athletic department office of the sending school district.

HEAD INJURY/CONCUSSION POLICY

Providing Information, Forms, and Materials to Parents and Athletes:

Parents/guardians and student athletes who plan to participate in any athletic program from their sending district school must also take a free on-line course about head injury and concussion. It is the expectation of The Collaborative that the sending district school coach/AD is responsible for ensuring that Collaborative student athlete and their parent/guardian are aware of the need to complete this training and that they do participate in the training. Two free on-line courses are available and contain all the information required by the law. Web links are below:

- http://www.nfhslearn.com/electiveDetail.aspx?courseID=15000
- www.cdc.gov/Concussion

Procedure for the School to Notify Parent/Guardian When an Athlete has been Removed from Play for Head Injury or Suspected Concussion:

It is the expectation of The Collaborative that the sending district school be responsible for contacting the parent/guardian when a student athlete has been removed from play for head injury/suspected concussion as per their school policy. Further, The Collaborative has the expectation that the nurse of the sending district school for whom the student athlete plays will contact the MS/HS Collaborative nurse, by 8:15am the next school day, following head injury/suspected concussion. Should a student athlete experience an event causing a head injury/suspected concussion during the school day during the season (unrelated to practice/play); The Collaborative nurse will be responsible for contacting both the student athlete's parent/guardian and the school nurse of the sending district school.

Protocol for Parent/Guardian/Student to Obtain Medical Clearance for Return to Play and Academics after Diagnosed Concussion:

It is the expectation of The Collaborative that the sending district school be responsible for orienting students and parent/guardian on their protocol on obtaining medical clearance for return to play after a diagnosed concussion. The Collaborative Nurse will contact parent/guardian and review with student any time he/she is made aware (by the sending district school Nurse) of a head injury/concussion of the policy of return to play and medical clearance. It is the expectation of the Collaborative that no student athlete will be allowed to return to play athletic activities until the medical clearance form is signed by authorized medical professional, submitted and reviewed by the sending district school nurse and The Collaborative Nurse.

Parent Responsibility for Completion of the Pre-Participation Form or School-Based Equivalent:

It is the expectation of The Collaborative that the sending district school orient parents and students about the requirement to submit the pre-participation form, signed by both student and parent, which provides a comprehensive history with up-to-date information relative to concussion history. At the beginning of every sports season, no student will be allowed to participate in athletic activities until the pre-participation form is signed, submitted by parent and student and reviewed by designated staff annually.

Parent Responsibility for Completion of the Report of a Head Injury Form:

It is the expectation of The Collaborative that the sending district school inform parents and student athletes about the requirement to submit all forms including the Report of Head Injury Form, signed by parent if their child has a head injury related to athletic activities. Further, The Collaborative expects that the sending district school nurse will send to The Collaborative MS/HS nurse copies of the completed head injury forms for the student's confidential health file. The Collaborative expects that that sending district school is responsible for tracking which student athletes are permitted to play or not play based on completion of all necessary pre-season forms.

HEAD INJURY/CONCUSSION POLICY

Inclusion of Sports-Related Head Injury Policy in the Student and Parent Handbook:

The Commonwealth of Massachusetts Executive Office of Health and Human Services require that all high schools subject to the Massachusetts Interscholastic Athletic Association (MIAA) rules adhere to the following law:

Student athletes and their parents, coaches, athletic directors, school nurses, and physicians must learn about the consequences of head injuries and concussions through training programs and written materials. The law requires that athletes and their parents inform their coaches about prior head injuries at the beginning of the season. If a student athlete becomes unconscious, or is suspected of having a concussion, during a game or practice, the law now mandates taking the student out of play or practice, and requires written certification from a licensed medical professional for "return to play."

It is the expectation of The Collaborative that parents and student-athletes attending The Collaborative who plan to participate in any sports program offered by their sending district school will take one free online course about concussions per school year. It is also the expectation of The Collaborative that the sending district school will ensure that this has been completed. The Collaborative MS/HS nurse is available to Collaborative student athletes and parents to answer questions regarding these courses. There are two free online courses available that contain all the information required by the law.

- http://www.nfhslearn.com/electiveDetail.aspx?courseID=15000
- http://www.cdc.gov/concussion/HeadsUp/online_training.html

Communicating with Parents with Limited English Proficiency:

It is the expectation of The Collaborative that sending district schools will communicate with parents/guardians with limited English proficiency their policies on head injury and concussion for student athletes (in both spoken and written format). In the event a Collaborative student athlete display's/indicates symptoms of head injury during the sport season, The Collaborative MS/HS nurse will make every effort to have available an interpreter to assist the MS/HS nurse in contacting the parent.

Outreach to Parents for Form and Training Completion:

It is the expectation of The Collaborative that sending district schools will not permit student athletes to participate in extracurricular sports until both the parent and student have completed and returned the signed Pre-Participation Head Injury/Concussion Reporting Form for Extracurricular Activities forms before the start of every sports season. In the event the school has not received the Pre-Participation Head Injury/Concussion Reporting Form or other required forms, including documentation of an annual physical examination and documentation that both the student athlete and their parent/guardian have completed the required annual training, The Collaborative will provide assistance as needed/requested by sending district schools to contact parents using typical methods of communication (telephone, notes home).

Sharing Concussion Related Health Information:

Generally speaking, a patient's health information is confidential. There are multiple state and federal regulations governing sharing health information in the school setting. There may be times when a school nurse has the legal obligation to disclose health or related information to protect a student's health or safety. Public policy requires the protection of a patient's right to privacy by medical professionals, unless there is an immediate threat or serious harm to the student or others

Informal collaboration occurs on a temporary, as-needed basis for information exchange, as when the school nurse informs (while adhering to protocols for confidentiality) the physical education teacher that a particular student may not participate in athletic activities because of a recent injury. There may be circumstances in which there is a need to share information in the student health record with authorized school personnel; either to enhance the educational progress of the student or protect his/her safety or well-being. This type of disclosure should be made only to those authorized school personnel who work directly with the student in an instructive (academic or athletic), administrative, or diagnostic capacity. Finally, authorized school personnel should be instructed not to re-disclose the information. If there is any question about the sensitivity of the information, the school nurse should seek the permission of the parent/guardian and student, if appropriate, prior to disclosure to authorized school personnel. Federal regulations permit information in the student health record to be seen by authorized school personnel on a need to know basis, and the basis for such sharing seems even more compelling when necessary to protect the well-being or safety of the student.

Requirements that Coaches, Athletic Trainers, and Volunteers Teach Strategies that Minimize Sports-Related Head Injuries and Prohibit Dangerous Play:

It is the expectation of The Collaborative that sending district schools are adhering to these regulations for all student athletes; including those attending The Collaborative.

It is the expectation of The Collaborative that all of its sending district schools take the safety of student athletes seriously and that all members of their respective school staff are expected to follow the policies and protocols to support the health and safety of student athletes. If students or parents have concerns that the policies are being violated, they should follow the sending districts school policy on whom to contact. The Collaborative is available to assist families in determining the sending district schools policy and procedure regarding this.

MGL LEGAL STANDARD: MGL c 111 §222, 105 CMR 201.00, 105 CMR 201.006 (A)(1), 105 CMR 201.006(A)(2), 105 CMR 201.006(A)(3), CMR 201.006(A)(4), 105 CM4 201.006(A)(5), 105 CMR 201.006(A)(6), 105 CMR 201.006(A)(7), 105 CMR 201.006 (A)(8), 105 CMR 201.006(A)(9), 105 CMR 201.011, 105 CMR 201.010(E), 105 CMR 201.006(A)(12), 105 CMR 201.006(A)(13), 105 CMR 201.006(A)(14), 105 CMR 201.006(A)(15), 603 CMR 23.07(4)(h), 603 CMR 23.07(4)(e) 603 CMR 23.07(3), 105 CMR 201.006(A)(16), 105 CMR 201.012(C)(6), 105 CMR 201.013(A)(6) & (7), 105 CMR 201.006(A)(17)
DESE CRITERION NUMBER & TOPIC: 16.7 Preventive Health Care

AIDS (ACQUIRED IMMUNE DEFICIENCY SYNDROME) SCHOOL ATTENDANCE POLICY

HIV screening is a blood test for detecting the presence of antibody to the HIV virus. Antibodies are substances produced by white blood cells that help fight infection caused by viruses or bacteria. Testing for HIV antibody is not recommended for any purposes other than to assist the child's personal physicians in a highly selected set of clinical decisions. Results of HIV antibody tests are confidential and should not be reported to schools.

It is important to note: Blood or any other body fluids including vomit and fecal or urinary incontinence in any child should be treated cautiously. It is recommended that gloves be worn when cleaning up any body fluids.

- These spills should be disinfected with bleach (one part bleach to ten parts water), or another disinfectant, by pouring the solution around the perimeter of the spill.
- All disposable materials, including gloves, should be discarded into a plastic bag. The mop should be disinfected with the bleach solution described in 5A.
- Persons involved in the clean-up should wash their hands afterward.

This policy has been developed from guidelines recommended by the Governor's Task Force on AIDS for implementation in school systems throughout the Commonwealth.

- All children diagnosed as having AIDS or with clinical evidence of infection with the AIDS associated virus, Human Immunodeficiency Virus, (HIV), and receiving medical attention are able to attend regular classes.

- If a child has cutaneous (skin) eruptions or weeping lesions that cannot be covered, he/she should not be in school.

- If the child exhibits inappropriate behavior which increases the likelihood of transmission (i.e. biting or frequent incontinence), he/she should not be in school.

- Children diagnosed with AIDS or with clinical evidence of infection with the AIDS associated virus (HIV), who are too ill to attend school, should have an appropriate alternative education plan.

- Siblings of children diagnosed as having AIDS or with clinical evidence of infection with the AIDS associated virus (HIV) are able to attend school without any further restrictions.

- The child's personal physician is the primary manager of the child diagnosed as having AIDS or with clinical evidence of infection with the AIDS associated virus (HIV). Management includes acting as the "gatekeeper" for the child's attendance at school in accordance with the policy outlined above.

- The child's personal physician, after consultation with the family, is responsible for reporting cases of AIDS to the Massachusetts Department of Public Health's Division of Communicable Disease. The school Superintendent will be notified by the child's personal physician and will provide assistance in identifying those educational or health care agents with an absolute need to know.

- Only persons with an absolute need to know should have medical knowledge of a particular student. In individual situations, the Superintendent might notify one or more of the following:
    - i. Principal
    - ii. School Nurse
    - iii Teacher

- Notification should be by a process that would maximally assist patient confidentiality. Ideally, this process should be direct person to person contact.

- If school authorities believe there is evidence of conditions described in #1 in a child diagnosed as having AIDS or with clinical evidence of infection with the AIDS associated virus (HIV), then the school authorities can dismiss the child from the class and request authorization from the child's personal physician so that class attendance is within compliance with the school policy.

- If school authorities and the child's personal physician are in conflict, then the case should be referred to the Department of Public Health for review by an appointed physician who would determine the permissibility of attendance.

- Since the child diagnosed as having AIDS or with clinical evidence of infection with the Aids associated virus (HIV) has a somewhat greater risk of encountering infections in the school setting, the child should be excluded from school if there is an out-break of a threatening communicable disease such as chicken pox or measles until he/she is properly treated (possibly with hyper-immune gamma globulin) and/or the outbreak has no longer become a threat to the child.

- In-service education of appropriate school personnel should ensure that proper medical and current information about AIDS is available.

These are the guidelines, revised September 1986, from the Massachusetts Department of Public Health.

MEDICATION ADMINISTRATION IN SCHOOL

Under Massachusetts General Law (M.G.L.) Chapter 112, section 80B, a licensed nurse must have a medication order from a physician, dentist, nurse practitioner, or physician's assistant in order to administer any medication during the school day, whether it is a prescription drug or an over-the-counter medication. (Those listed are the only acceptable licensed practitioners who may order medications for administration in the school setting.)

Before medications are dispensed, the following will be implemented:

- No medication will be administered to a student without written consent from a parent/guardian; said consent will be kept on file in the student's health record in the Collaborative Health Office. – Such consent hall be renewed annually.

- No prescription medication shall be administered to a student without the written order of the physician prescribing the medication to that student; which will be kept on file in the student's health record in the Collaborative Health Office.

- Any change of medication, dosage, and/or time must be accompanied by a new order by the prescribing physician. A verbal request from a parent cannot be honored.

- Medications not controlled, monitored, and/or approved through the FDA will be administered in the school setting.

- Short-term prescription medications, i.e. those requiring administration for ten (10) school days or less, the pharmacy labeled container may be used in lieu of a licensed prescriber's order.

- The Collaborative maintains written protocols and procedures regarding administration of (standing order) over-the-counter medications and prescription medications as well as the administration of medication including consent, prepackaging, and staff training.

- For over-the-counter medication i.e. non-prescription medications, the nurse shall follow the Board of Registration in Nursing's Protocol (M.G.L. Chapter 112-Section 80B.)

  The Massachusetts Board of Registration in Nursing issues this Advisory Ruling on Nursing Practice pursuant to Massachusetts General Laws, chapter 30A, section 8 and chapter 112, section 80B.

  Date Issued: June 3, 1992 Date Revised: July 10, 2002

  Scope of Practice: Registered Nurse

  Purpose: To guide the practice of the Registered Nurses who, within their practice as School Nurses, administer Over-the-Counter Medications (OTC).

  Advisory: Registered nurses may administer OTCs to students in Massachusetts schools based on protocols which have been developed in collaboration with the school departments duly authorized prescriber, provided the appropriate school administrative authority allows the use of such protocols.

  Protocols must include the following information:

  - Drug name
  - Dose to be administered
  - Dosage frequency
  - Indications for use
  - Contraindications
  - Potential side-effects
  - Assessment criteria to be gathered prior to administering a particular medication

MEDICATION ADMINISTRATION IN SCHOOL

Registered nurses who, within their practice as school nurses, administer OTCs must have an assessment of the following information:

- The student's current medication profile
- The student's history of allergies
- Parental consent
- Documentation of OTC medication administered according to such protocols must conform to the school department's regulations for documentation of medication administration to students

The duly licensed prescriber, usually the school physician, must sign the protocols "Over-The-Counter" medications that may be administered in school with parental consent, knowledge of the student's current medication profile and history of allergies, and proper documentation of administered medication, included but not limited to date, time, name of medication, dosage and route in which the medication was delivered. Over-the-counter medications should be supplied in the original packaging with a note including the name of the student, the name of the medication, and instructions regarding the dosage and time at which the medication should be given.

- Administration of prescription medication during a field trip or other short term special event include an effort to obtain a nurse to accompany students at special school events. When this is not possible, the school nurse, along with administration, will formulate a plan for safe and appropriate medication administration.

- A parent/guardian or a person designated by the parent/guardian shall deliver all prescription medications to the school nurse or other responsible person designated by the school nurse (i.e. principal, secretary) in a container labeled by physician or pharmacist. At no time may any Collaborative student bring medication to school.

- Collaborative students are not permitted to have (over the counter or prescription) medication on their person during the school day, including those over the age of 18.

- The School Nurse or other responsible person receiving the medication shall document the quantity of the medication delivered into the student's electronic (SNAP) health record.

- A written (electronic or paper MAR) record shall be maintained, in the student's health record in the Collaborative Health Office of the administration of prescription medication to students.

- A written Medication plan shall also be maintained of the administration of prescribed medication to students by a licensed physician, registered nurse, or trained staff. <u>The medication plan shall include information as described in 1-5 CMR-210.005(E):</u>

    - The name, address, and home telephone number of the student.
    - An order, with signature, from a licensed physician who has reviewed medical records and observed the student.
    - The signed authorization of parent, legal guardian or student eighteen years of age or older. This must include home and place of business telephone numbers as well as emergency contact information.
    - Any known allergies to food or medication.
    - The diagnosis, unless the parent, legal guardian or student requests that this information not be documented or it is a violation of confidentiality.
    - The name of the medication.
    - The dose of the medication as well as the frequency and route of administration.

MEDICATION ADMINISTRATION IN SCHOOL

  - Any specific directions for administration should be included as well as procedures to follow for non-compliance. These procedures shall be determined by the school nurse, parent(s) or legal guardian(s) and prescribing licensed physician.

  - Possible side effects, adverse reactions or contraindications that may or may not require medical attention.

- No antipsychotic medication prescription shall be administered for a period longer than is medically necessary.

- State law requires no more than a thirty-day (school day) supply of medication for a student shall be stored at school. Required storage conditions shall be documented.

- Notification of appropriate school personnel involved in monitoring the student on antipsychotic medication. Education and staff training shall be documented.

- A list of other medications taken by the student.

- The location, when appropriate, where the administration of this medication will take place.

- A plan for monitoring the effects of the medication. This shall include the schedule of clinical visits and follow-up with prescribing licensed physician.

- Effects and side effects of medications shall also be available in the student's health record. Any significant side effects experienced by the student will be documented onto the student's health record kept in the Collaborative Health Office.

- The school nurse shall have a current pharmaceutical reference available for his/her use.

All documentation regarding the administration of medication shall be recorded electronically into the SNAP program or in blue or black ball point pen ink and not be altered if administered by a trained delegation staff onto a paper MAR. Documentation will include: the date and time or omission of administration, including the reason for the omission. The Paper MAR will also include the full signature of all nurses and trained delegation staff administering the medication.

<u>Self-administration of prescription medication(s) by a student</u>:

"Self-administration" shall mean that the student is able to consume or apply prescription medication in the manner directed by the licensed prescriber, without additional assistance or direction.

The school nurse will allow the student to take his/her medication after the school nurse has followed the procedures as outline in the procedural manual.

<u>Storage of Medication:</u>

All medicine shall be kept in a locked, secure cabinet and labeled with the student's name, the name of the drug and the directions for its administration. Controlled medications will be stored in a separate secured double-locked cabinet.

This cabinet is kept locked at all times, except when opened to obtain medications.

Access to this cabinet and keys which open it is limited to limited to persons authorized to administer medications.

MEDICATION ADMINISTRATION IN SCHOOL

The Collaborative will keep no more than 30 days of medications on the premises at any one time for each student receiving medication (including but not limited to: oral, G-Tube, nasal, SubQ)

Medications and medical supplies are not to be locked in the same cabinet as other toxic substances. Toxic substances must be labeled with contents and antidote. The phone number for the nearest poison center must is posted clearly in two places in the Collaborative Health office (Medication cabinet and telephone).

<u>Return and/or Disposable of Medications:</u>

The Collaborative shall return to the parent/guardian any unused, discontinued, or expired prescription medication(s); arrangements for pick up by the parent/guardian will be made by the Collaborative Nurse.

If after 30 school days the parent/guardian has not retrieved the medication as planned, The Collaborative nurse will send written notice home (attached to the daily behavior sheet) to the parent/guardian informing them that The Collaborative will dispose of the medication in compliance with current (Massachusetts Department of Health, Division of Food and Drugs) state disposal guidelines should the medication not be retrieved w/in 5 school days (from date correspondence sent).

Parents/guardians may retrieve the prescription medication from the school nurse at any time.

<u>Medications Requiring Refrigeration:</u>

The Collaborative Health Office maintains a separate lock-box in a refrigerator in the case of any medications requiring refrigeration.

<u>Procedure for Medication Refusal by Student:</u>

For any Collaborative student who refuses his/her medication; the school nurse will immediately notify that student's teacher and a plan will be implemented to encourage the student to take his/her prescribed medication. If one hour past time of scheduled delivery has passed, the Collaborative Nurse will document a refusal into the student's health record and medication sign out sheet and then contact that student's parent/guardian to inform. The School Nurse will send a written notice home to the parent/guardian after calling; this note will be attached in a sealed envelope to the student's daily behavior sheet.

<u>Medication Error:</u>
The Collaborative policy and procedures for caring for the student involved, reporting and documentation of medication errors (this includes both prescription and over the counter medications) is as follows:

- Medication error includes any failure to administer medication as prescribed. This includes failure to administer the medication within appropriate time frames, in the correct dosage, in accordance with accepted practice or to the correct student. It also means failure to administer the medication at all.

- In the event of a medication error, the school nurse shall notify the parent or legal guardian immediately. This contact shall be documented. If there is a question of potential harm to the student, the school nurse shall also notify the licensed physician or School Physician Consultant as well as the Nurse Leader.

- The school nurse shall document any medication errors committed on an accident/incident form. These reports shall be retained in the office of the Nurse Leader and copies sent to the Executive Director. They shall be made available to the Department of Public Health upon request.

- All medication errors resulting in serious illness requiring medical care shall be reported to the Department of Public Health-Bureau of Family and Community Health. Any suspected diversion or tampering of drugs shall be reported to the Department of Public Health, Division of Food and Drugs.

- The Nurse Leader and the school nurse shall review reports of medication errors and take necessary steps to ensure appropriate medication administration in the future.

- Procedures for responding to medication emergency situations (any reaction or condition related to the administration of medication that poses an immediate threat to the health or well-being of the student) shall be consistent with the Marshfield School System's policy for handling any medical emergency. Any medical emergency situation requires the activation of the local EMS. system (911).

The Collaborative Administration and teaching staff will incorporate a review of medications administered to student at all case reviews conducted.

MGL LEGAL STANDARD: 18.05 (9) (f, g) (8), 18.05(5)(c); 18.05(8); 18.05(9)(f)(1); 18.05 (9)(j); M.G.L. c. 71, § 32A, 18.05(9)(g) M.G.L. c. 71, § 57 M.G.L. c. 111, § 111, 1-5 CMR-210.005(E).
DESE CRITERION NUMBER & TOPIC: 16.5 Administration of Medication, 15.5 Parent Consent & Required Notification, 16.7 Preventive Health Care

ADMINISTRATION OF ANTIPSYCHOTIC MEDICATIONS IN SCHOOL

The Collaborative shall not administer or arrange for the administration of antipsychotic medication (drugs used in treating psychoses and alleviating psychotic states) except under the following circumstances:

- Antipsychotic medication shall be prescribed by a licensed physician for the diagnosis, treatment and care of the child and only after review of the student's medical record and actual observation of the student.

- The prescribing physician shall submit a written report to the program detailing the necessity for the medication, staff monitoring requirements, potential side effects that may or may not require medical attention, and the next scheduled clinical meeting or series of meetings with the student.

- In accordance with standard medical practice, the medication order shall also contain the following:
    - student's name and date of birth
    - signature of the licensed physician and date
    - place of business and emergency telephone number where the licensed physician can be contacted
    - the name of the medication
    - the route and dosage of the medication
    - the date the medication order goes into effect and the discontinuation date
    - specific directions for administration.

- No antipsychotic prescription shall be administered for a period longer than is medically necessary and students on antipsychotic medication must be carefully monitored by a physician.

- Staff providing care to a student receiving antipsychotic medication shall be instructed regarding the purpose of the medication, potential side effects that may or may not require medical attention and required monitoring or special precautions, if any.

- Except in an emergency, as defined in 18.05 (9)(g), the program nor the school nurse shall neither administer nor arrange for the prescription and administration of antipsychotic medication unless informed written consent is obtained. If a student is in the custody of his/her parent(s), parental consent in writing is required. Parental consent may be revoked at any time unless subject to any court order. If the parent does not consent or is not available to give consent, the referral source shall be notified and judicial approval shall be sought. If a student is in the custody of a person other than the parent, a placement agency or an out-of-state public or private agency, the referral source shall be notified and judicial approval shall be sought.

- In an emergency situation, as defined in 18.05(9) (g), antipsychotic medication may be administered for treatment purposes without parental consent or prior judicial approval if an unforeseen combination of circumstances or the resulting state calls for immediate action and there is no less intrusive alternative to the medication. The treating physician must determine that medication is necessary to prevent the immediate substantial and irreversible deterioration of a serious mental illness. If the treating physician determines that medication should continue, informed consent or judicial approval must be obtained as required by 18.05(9)(e).

- The program shall inform a student twelve years of age and older, consistent with the student's capacity to understand, about the treatment, risks and potential side effects of such medication. The program shall specify and follow procedures if the student refuses to consent to administration of the medication.

- In accordance with standard medical practice, The medication container kept in the school nurse's office must have the correct prescription label attached. This label must contain the name and phone number of the pharmacy, the student's name, the name of the licensed physician, the name and dosage of the medication to be administered.

- The school nurse, in collaboration with parent(s) or legal guardian(s), shall establish a medication plan for each student that receives antipsychotic medication during school hours. Whenever possible, a student who understands the issues of medication administration shall be involved in the decision-making process and his/her preferences respected to the maximum extent possible. The Department of Education guidelines for special education require student consent for the 18-21 age group and student participation in planning after age twelve, if appropriate. The medication administration plan shall be referenced, when appropriate, in any other health or education plan developed pursuant to the Mass. Special Education Law or federal laws.

- Prior to the initial administration of the antipsychotic medication, the school nurse shall assess the student's health status and follow the medication administration plan consistent with the approved medication policy and procedures for The Collaborative (see Administration of Medications in School)

- The Collaborative nurse shall communicate significant observations that relate to medication effectiveness, adverse reactions or other harmful effects to the student's parent(s), legal guardian(s) and licensed physician. A schedule of clinical follow-up is mandated by this policy and included in the medication administration plan.

- The Collaborative Nurse shall document in the medication administration record and the student's health record any significant observations of the medication's effectiveness, as is appropriate, and any adverse reactions or other harmful effects. Any action taken from these observations will also be documented. All documentation will be electronic and/or in blue or black ball point pen ink on the paper MAR and shall not be altered.

MGL LEGAL STANDARD: 18.05(9)(f)(9)
DESE CRITERION NUMBER & TOPIC: 16.6 Administration of Antipsychotic Medication, 15.5 Parent Consent & Required Notification, 16.7 Preventive Health Care

ALCOHOL, TOBACCO, and MARIJUANA USE BY STUDENTS

Smoking, chewing, vaping, or other use of tobacco or marijuana products by staff, students, and members of the public is banned from all Collaborative buildings, classrooms, offices, and meeting spaces. All forms of tobacco and marijuana use is prohibited on all Collaborative property. In addition, tobacco and marijuana use by students is banned at all school-sponsored events, including those events that do not take place on school grounds.

The use of alcohol can endanger the health and safety of the user, and The Collaborative; in recognizing the deleterious effect the use of alcoholic beverages can have on the maintenance of general order and discipline, prohibits the use of, serving of, or consumption of any alcoholic beverage on school property or at any school function. Additionally, any student, regardless of age, who has been drinking alcoholic beverages prior to attendance at, or participation in, a school-sponsored activity, will be barred from that activity and subject to disciplinary action.

LEGAL REF: MGL 71:37H, MGL 272:40A

HEALTH AND WELLNESS POLICY

The Collaborative supports and promotes a healthy teaching and learning community by supporting wellness, sound nutrition, and regular physical activity, presence of school health services and maintenance of healthy and safe facilities as part of the total educational environment. The Collaborative recognizes and supports the relationship between student well-being and student achievement as well as the importance of a comprehensive Collaborative wide wellness program that is based on research-based evidence and best practice. The wellness program will provide developmentally appropriate and sequential nutrition and physical education, as well as opportunities for physical activity. This program will be implemented by The Collaborative Wellness committee via an interdisciplinary approach in nutritional, physical, and emotional wellness that involves students, staff, parents, and the community. The Collaborative is committed to providing a school environment that promotes children's health, well- being and the ability to be ready to learn, by supporting life-long habits of healthy eating and activity. The Collaborative will have established a health and wellness advisory committee comprised of various school personnel from multiple disciplines (including parents and interested community members) who will review and help implement policies addressing school nutrition, nutrition education, physical activity and related issues that affect student health. The Advisory committee will appoint a health and wellness coordinator; who will ensure all elements of the program are being implemented and evaluated.

Program elements include:

Promotion of a healthy school environment; a safe and nurturing climate where all students are known by the staff and encouraged to maintain their overall health and wellbeing as well as move toward optimal physical and mental health; regardless of current health status or abilities/disabilities. The practice of making healthy choices within an enabling environment will reinforce these principles. The interdisciplinary approach will incorporate the following:

Nutritional standards for all foods provided at The Collaborative via the School Nutrition Program:

- Breakfast is considered extremely important and The Collaborative encourages all students to have a healthy breakfast daily. Snacks help ensure that children receive the nutrition they need to learn, play and grow.

- The Collaborative shall provide age-appropriate nutritional education and that is aligned with the standards established by the Massachusetts State Curriculum Frameworks and The USDA's National School Lunch & Breakfast Programs. The goal is that students receive nutrition education that teaches the skills they need to adopt and maintain healthy eating behaviors in school and beyond school.

- The Collaborative Administration, Student support services personnel, teaching staff and food service personnel will work together to promote a consistent, coordinated message about nutrition and healthy eating choices.

- Students will receive consistent and healthy eating messages in the classroom and throughout the entire school from teachers, nurses, administrators and food service staff.

- The Collaborative Child Nutrition Program shall be consistent with State and Federal School Lunch Programs and nutrition guidelines.

- The school shall provide enough space and serving areas to ensure all students have access to school meals with minimum wait time.

- The Collaborative shall provide a clean, safe, enjoyable meal environment for students. Accommodations shall be provided for students with specific food allergies, medical issues, and food intolerances.

HEALTH AND WELLNESS POLICY

- The Collaborative shall make available plain water to all students at no cost. The use of water bottles shall be permitted to drink throughout the day where appropriate. In alignment with state nutritional guidelines, water will be endorsed as the beverage of choice.

- The Collaborative shall ensure students have access to the School Breakfast Program prior to the start of school and 20 minutes for lunch.

- A working snack time shall be made available in all K – 8 classrooms. Teachers shall determine a reasonable time for snack during the course of the day.

- All foods or beverages sold or provided in: (i) à la carte lines in school cafeterias; (ii) school stores; (iii) school snack bars; (iv) vending machines; and (v) any other locations in public schools; shall not include foods sold or provided as part of the School Breakfast Program, the School Lunch Program; provided further, that competitive foods or beverages shall not include non-sweetened carbonated water.

- All competitive foods or beverages sold or provided in The Collaborative shall be limited to foods or beverages that comply with the nutritional standards. Should The Collaborative Executive board elect to apply the nutritional standards beyond this timeframe, to competitive foods or beverages sold on school grounds up to 30 minutes before the beginning of the school day or 30 minutes after the end of the school day, (with the exception of competitive foods or beverages sold through vending machines), to competitive foods or beverages sold during the school day at booster sales, concession stands, and other school-sponsored or school-related fundraisers and events.

Physical Education Program:

The Collaborative shall provide physical education training aligned with the standards established by the Department of Elementary and Secondary Education. The program will provide a variety of developmentally appropriate activities that are reflective of the State standards, benchmarks, and appropriate assessments. Physical education program key components include:

- Physical education instruction will be delivered, whenever possible, by teachers with physical education certification.

- Physical education should be part of the education plan for all students. The amount of time that students spend per week in physical education classes and in recess should be designed to achieve a balance between academic goals and the need for physical activity.

- Modified programs for students with chronic health problems, disabling conditions, or other special physical needs shall be provided.

- The Collaborative will provide a safe environment with functional and necessary protective equipment for all students to participate in physical education classes actively and safely.

- All students are required to complete physical education requirements as set forth by the Collaborative.

- Student-to-teacher ratios in Physical Education classes should strive to be comparable to those in other curricular subjects.

HEALTH AND WELLNESS POLICY

- The Collaborative will work with each sending school district to ensure all Collaborative students and their families are informed about after school organized physical activities (e.g., intramurals, interscholastic sports, community-based programs, and other activities).

- Physical activity will be integrated into the curriculum where appropriate.

- Fundraisers that promote physical activity (e.g. Walk for Hunger, Relay for Life, etc.) are strongly encouraged.

Recess for Elementary Students:

In addition to required Physical Education classes, students at the elementary level should have the opportunity to participate in daily recess and physical activity. Recess shall complement, not substitute for, physical education classes.

- The Collaborative shall provide daily recess period(s) for elementary school students, and currently allocates thirty minutes of time per day for unstructured but supervised active play.

- The withholding of physical activity as a punishment or in lieu of completing other academic work is strongly discouraged. The occasional loss of recess may occur if it is academically beneficial to the student. Repeated loss over time of physical activity is not appropriate.

- To the extent possible, Collaborative physical activity spaces and facilities, especially outdoor facilities shall be available to young people before and during the school day.

- The Collaborative supports all collaborative students who participate in MIAA sports and the benefits gained are increased when they are guided by interscholastic coaches that are certified by the Massachusetts Interscholastic Athletic Association and should have up-to-date training in both First Aid and CPR.

- The Collaborative supports the concept that all Coaches shall demonstrate appropriate and effective motivational skills and provide constructive and descriptive feedback to athletes to foster and promote the student athletes overall health and well-being.

Student services:

The Collaborative offers coordinated programs of counseling and health care, student assistance programs, mentoring, and peer programs.

- The Collaborative shall provide school health services and qualified healthcare providers who will appraise, protect, and support the physical, social, and emotional well-being of students, staff, and families, which will build a healthy school environment.

- The Collaborative shall use an integrated, preventive approach by including community agencies in addressing the needs of students, staff, and families. These services shall promote academic achievement by supporting students' physical, mental, emotional, and social health.

School Health Environment:

The Collaborative will provide a safe, healthy, well-maintained environment. This environment will be tobacco, alcohol, and drug free. There will be a culture which fosters caring, respect, and responsibility.

HEALTH AND WELLNESS POLICY

- The goal of wellness education is to motivate and assist students to maintain and improve their overall health and well-being, disease prevention and avoidance of health risk behaviors.

- The Collaborative Health & Wellness Policy shall strive to raise nutritional awareness, promote healthy eating habits and encourage physical activity among staff employees.

- Encouraging a healthy lifestyle for school employees further supports the overall objective of a healthy school community.

- Healthy lifestyle activities for staff might include community recreation programs and the wellness benefits of the district's health insurance policies.

Programs for adults:

The Collaborative offers professional development for all staff, as well as parent education.

- Ongoing in-service and professional development training opportunities for staff in Physical Education and Health Instruction shall be encouraged

- The Collaborative will offer educational opportunities for staff members and parents regarding healthy food choices and eating behaviors.

- The Collaborative will work will identify educational opportunities for staff, parents, and students regarding healthy physical activity and active lifestyle behaviors. This will include the creation of a wellness information page on the Collaborative website.

MGL LEGAL STANDARD: MGL c. 111, §233, 105 CMR 215.00, 225.100: General Nutrition Standards for Public Schools

DESE CRITERION NUMBER & TOPIC: Wellness Policy

STUDENT NUTRITION

The Commonwealth of Massachusetts Department of Public Health Nutrition Standards for Competitive Foods and Beverages in schools (105 CMR 225.000) defines competitive foods as foods and beverages provided in:

School Cafeterias
School buildings, including classrooms and hallways
School snack bars
School stores
Vending machines
Booster sales
Fundraising activities
School-sponsored or school related events
Any other location on school property

The regulations apply to competitive foods and beverages sold or provided to students thirty minutes before and extend 30 minutes after the regular school day with the exception that student-accessible vending machines must comply at all times.

<u>The School Breakfast/Lunch Programs</u>:

The school food service program provider will follow the MA DPH Nutrition Standards for Competitive Foods and beverages in schools (105 CMR 225.00) when determining items for a la carte and “competitive foods” sales and will make nutrition information available for non-prepackaged competitive foods and beverages served in the cafeteria.

- Only water, milk and 100 percent fruit or vegetable juice may be served or sold at school or school related events.
- Plan, portable water will be made available to students throughout the day free of charge.
- Milk must be 1% or fat free; flavored milk must contain no more than 22 grams of total sugar per 8 ounce serving.
- Juice must be 100% fruit or vegetable juice with no added sugar.
- Foods must contain no more than 200 calories per item.
- No food shall contain more than 35% of its total calories from fat.
- All foods shall be trans-fat- free.
- Exemption of fats; a 1 oz. serving of nuts, nut butters, seeds and reduced fat cheese is allowable.
- Low-fat and fat-free yogurt must contain no more than 30 grams of total sugars per 8 oz. serving.
- Food shall contain no more than 200mg of sodium per item.
- All breads and other grain-based products must be whole grain.
- All items must contain no more than trace amounts of caffeine.
- No food shall contain artificial sweeteners.
- No foods shall be prepared with the use of fryolators.
- Fresh fruit and not-fried vegetables must be offered for sale at any location where food is sold except in non-refrigerated vending machines or beverage only vending machines.

<u>Cafeteria Environment:</u>

Convenient access to hand washing or hand sanitizing facilities before meals will be made available.

<u>Classroom Parties/Group Snacks</u>:

Classroom and school parties and celebrations should emphasize fun activity and socialization rather than food.
Food served at classroom or school celebrations must meet or exceed the MA DPH Nutrition Standards for Competitive Foods and Beverages in schools (105 CMR 225.000).

Only 100% juice, milk or water may be served or sold at school and school related events. Any group snack provided during school or any school activity must meet or exceed the MA DPH Health Nutrition Standards for Competitive Food and Beverages in Schools (105 CMR 225.000). This includes snacks provided by any school staff, the school food service program provider, or any outside agency.

TOILETING PROCEDURE

During the Intake Interview with a prospective student's family, the student's current toileting needs are discussed and documented. Students' toileting plans are written into their IEP. Classroom staff implements IEP goals, and document progress in Quarterly Reports. A new goal may be developed at a future IEP meeting if toileting needs change. Students who are incontinent shall have a written individualized toileting plan incorporating the following:

- Schedule of diapering
- Toilet training plan
- Procedure for handling soiled clothing and diapers
- Personal privacy

<u>Toilet Training Procedures:</u>

- The team develops a specific schedule with individualized procedures.
- Staff model effective communication of the need to toilet
- Staff escorts the student to the bathroom, following a specific set of steps.
- Student toilets to the extent possible independently, while the staff member waits outside the bathroom door or staff assist with each step of the process with the long-range goal to fade physical and verbal prompts.
- Personal items should be kept for each student with a change of clothing if needed.
- Soiled clothing items are placed in plastic bags, tied, and sent home each day.
- Staff instructs and supervises hand washing procedures.
- Students may be rewarded for appropriate attempts at toileting.

<u>Diapering Requirements:</u>

- Based on information given by parents/guardians during the Intake Interview, staff implements a regular diapering schedule for the student.
- All diapering will take place in the designated diapering area/table. .
- Parents/Guardians are responsible for providing all necessary items for diapering including but not limited to: diapers/briefs, wipes.
- Soiled diapers/briefs are bagged in plastic, tied and disposed of in a covered trash container or sent home as appropriate.

<u>Clothing Requirements:</u>

- Parents/Guardians should provide extra clothing for use when a student becomes soiled or wet.
- Soiled items will be bagged in plastic and sent home each day.

DIAPERING PROCEDURE

All diapering for students will be carried out in a sanitary, safe manner to prevent the spread of germs and diseases that can occur during the diaper changing process.

Ensure a proper setting for brief changing by applying the following criteria:

- Changing tables should be sturdy and at a convenient height of 28”-32”.
- Diapering will be changed ONLY on the designated diaper changing area/table.
- Changing table paper and a waterproof pad should be used and placed on a surface that can be cleaned and sanitized. Carpet should not be used.
- The changing of briefs should only be done in a designated, partitioned, private area. Supplies should be stored in an area inaccessible to students.
- Students will not be left alone while receiving a new brief.
- Parents/Guardians are responsible for providing all needed items for diapering; including but not limited to: diapers/briefs, wipes, pads).
- The nurse will maintain a supply of peri-wash and waterproof pads for use.
- The changing table will be disinfected after each student use.
- Food or toys will not be placed on or near the diaper changing area.

<u>Diapering Procedure:</u>

Materials: Fresh plastic bag for soiled clothes (if needed), wipes, cream, disposable gloves, fresh briefs, paper liner.

1. Line table with paper liner so the changing surface extends from student’s shoulders to feet.
2. Disposable non-latex gloves must be worn by staff during diaper changing procedure.
3. Place student on changing table (refer to student specific lifting/transferring procedure and/or SWCEC lift/transfer procedure). Always have one hand on the student for safety.
4. Unfasten brief and clean the peri-area. Remove stool and urine from front to back. Use a fresh wipe for each front to back wipe.
5. Remove soiled diaper and discard in appropriate, covered, receptacle. Place the soiled wipes into the soiled diaper. Fold forward without touching any surface and place into a plastic lined, covered garbage can. Remove gloves and place into the garbage can.
6. Notify the nurse for any sign of skin breakdown. Administer any prescribed ointment if necessary and place fresh brief onto student. Fasten the brief and assist the student in dressing.
7. Using soap and water, assist student as needed to wash his/her hands and return him/her to instructional area.
8. Clean and sanitize the work area. Dispose of paper liner and clean visible soiling from the changing table with soap and water. Then, clean entire surface with designated disinfecting solution; let stand for two minutes. Let air dry for proper sanitation.
9. Wash hands and record elimination in child’s daily log.

LIFTING and TRANSFER POLICY

Students weighing more than 35lbs should be lifted by a minimum of two staff. Students that weigh 45 pounds or more will be lifted with a Hoyer lift or a mechanical lift. Some students, no matter their weight may have specific individual lifting/transfer guidelines because of muscle tone, medical condition, or other concern. PT will assess/ guide classroom staff with these fragile children.

Students should not be transferred or lifted by staff who have not completed a lifting/transfer training from OT/PT. Lifting, if performed poorly, places significant strain on many parts of the body. It is important to plan the lift well and execute the movement with excellent body position.

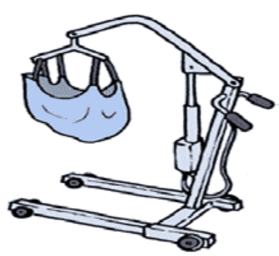
Feet should be comfortably apart, around the load if possible with knees bent and keeping the spine in its natural curves. Position the student as close to the body as possible. Brace abdominal muscles.

Remember that each procedure for transfer and positioning has four main steps:

1. Plan the move and prepare the environment
2. Starting position
3. Lifting Effort
4. Completing the move

Weight cannot be the only determinant for safe patient handling and often is not with students who have neuromuscular conditions where tone is a factor. The Physical Therapist must be the one to determine safe patient handling.

<u>Transfers with Hoyer Lift:</u>



1. Roll the student on his/her side, using proper turning techniques. Center the sling behind him/her, with the bottom of the sling at the knees. Along the length of the sling, roll up half of the sling against the student's back. Roll the student the other way and straighten out the rolled portion. This places the sling under the student without lifting.
2. Raise the Hoyer lift. Spread the lift's legs and roll them under the bed so the lift is over the student.
3. Press the down control button/rotate crank so that the loops reach the sling bars, taking care not to hit the student with the swivel bar. Place the two upper loops onto the lift. "Criss cross" the bottom two loops (the longest loops) before placing them onto the sling. The shorter loops are attached near the shoulders, while the longer loops go to the knees.
4. Raise the lift up enough to tighten the sling. Ensure that the sling is firmly under the student's buttocks so he/she doesn't slip, that his/her arms are inside the sling, and that the head is properly supported. Press the up button/rotate crank, so the student is lifted out of the bed.
5. Pull the Hoyer lift slowly away from the bed. With the other aide guiding the student, move the lift to where it is needed and lock the wheels.
6. Press the down button/rotate crank to lower the student, while the other aide guides the student into his/her designated chair. Ensure that the student's hips are to the back of the chair by using the handle positioned at the back of the sling. After the student is situated, remove the loops from the sling.

7. Reverse the procedure to put the student back into bed, and roll him/her back and forth gently to remove the sling.

MANAGEMENT of the NEEDS of the OXYGEN DEPENDENT STUDENT

Oxygen is considered a medication and as such requires either a physician's order for an individual student. Oxygen does require special notification to the fire department for use in both residential and occupational settings.

As with all medication the decision to delegate can be made only by the licensed professional nurse who is responsible for the administration. The decision to delegate or not to delegate is hers/ his alone. The five rights of delegation (right task, right circumstances, right individual, right direction/communication and right supervision/evaluation) must be met. Only nursing tasks can be delegated, never nursing care (which includes the nursing process of assessment and evaluation). Oxygen may be used in transport and the fire department should be involved. Consult the appropriateness of the delivery system for transport in a motor vehicle. If the student requires oxygen on an as needed basis (p.r.n.), it is the responsibility of the school nurse to determine if a nursing assessment is needed in order to administer the oxygen. If a nursing assessment is not needed for the administration of oxygen, the nurse must assess and document that the student's health care needs are chronic, stable, uncomplicated, routine and predictable. Only in this situation may the administration of the oxygen be delegated to unlicensed personnel. Other factors to be considered in delegating the administration of oxygen are:

1. If the student is able to provide his/her own care with supervision
2. If the environment is conducive to delegation
3. If an unlicensed person is able to perform the delegated nursing task in a safe and competent manner.

Characteristics of Oxygen:

Oxygen composes about a fifth (20.8%) of the air we breathe. As part of air, oxygen supports life and can cause things to burn and rust. During illness, extra oxygen can be therapeutic and is often prescribed for management of diseases such as asthma, cardiac insufficiency, and cystic fibrosis. Because some children who attend school use extra oxygen from one of several types of supplies, it is important for school staff to know about oxygen, oxygen delivery systems, and the risks they present.

A good source of general information on oxygen is the Material Safety Data Sheet (MSDS) for oxygen, available from the oxygen supplier. Information regarding MSDS can be found at http://www.ilpi.com/msds/. Information for specific information on oxygen can be found at http://hazard.com/msds/mf/cards/file/0138.html. Each facility where oxygen is present must have a MSDS for oxygen ready for use or inspection.

Oxygen for therapy is a prescribed drug and must be +99% pure and medical grade as defined by the United States Pharmacopoeia. Therapeutic oxygen is delivered to a patient as a gas, but is stored as a gas or a liquid. As a gas, it is colorless, odorless, and a bit heavier than air, so it will generally sink away from a source and collect in low areas. As a liquid, oxygen is a light blue, water-like substance that is very cold, boiling at -183°C (-297°F) at room temperature. As it boils, the liquid oxygen, or LOX, produces about 860 liters of gaseous oxygen, or GOX, for every liter of liquid. The very cold, or cryogenic, liquid or gas can rapidly freeze skin and materials, causing frostbite in tissue and most materials to become brittle enough to shatter.

The biggest hazard of extra oxygen is the increased risk of fire. Oxygen itself does not burn. Rather, it supports and accelerates combustion. In air many things will burn but need to be ignited by considerable heat. In oxygen-enriched atmospheres, most everything will burn, even some things that will not burn in air, and the amount of heat needed to ignite these materials is considerably less than the amount needed in air.

Team Involvement for Student with Oxygen:

Due to the complex needs of most oxygen dependent students, it is recommended that planning for the needs of these students be done by the pupil/student services team or the Individualized Education Program (IEP) team. The use of oxygen should be appropriately documented on the IEP document and this information should be available to both school and transportation personnel. The team should, as a minimum, consist of the parent/guardian, a school administrator, the school registered nurse, a teacher, a counselor, and a representative from the transportation office (if the student requires transportation by school bus). The parent/guardian may also request that other personnel (a nurse case manager, private duty nurse, respiratory therapist, physical therapist, etc.) attend the team meeting to better explain the needs of the student during the school day. The team will develop a plan addressing the items outlined in this chapter.

MANAGEMENT of the NEEDS of the OXYGEN DEPENDENT STUDENT

Student's Need for Assistance:

- Whether the student's need for nursing services should include a private duty nurse and/or a school nurse on the school bus.
- The need for trained personnel in the school building or staff assigned to the student.
- Any assistance the student may need in managing the oxygen equipment in order to move freely about the classroom.
- Involvement of the student, to the maximum extent possible, in his/her own care.
- The student's ability to request oxygen or assistance as needed.
- The student's ability to assist with the administration and maintenance of the oxygen equipment.
- The type of assistance the student may need to get on and off the school bus and safely secure oxygen on the school bus.
- Emergency plans in the event the student experiences respiratory distress and/or the equipment malfunctions.
- Plans for field trips and other special school-sponsored activities.
- A schedule for providing needed treatments to reduce disruptions and time out of class.

Safe Environment:

- Strategies to maintain the equipment in an upright position to prevent spillage.
- Impact of the equipment on safe movement in the classroom includes emergency evacuation of the student and the equipment.
- Identification of activities that may be hazardous to the oxygen dependent student and/or causes respiratory compromise (e.g., activities which create strong chemical odors, an increase of airborne particulate matter, or require open flames).
- Procedures for ensuring that oxygen is safely stored (e.g., venting for liquid oxygen) in the classroom and/or health suite.
- The need for a modified school day/schedule and/or home and hospital services.
- Plans for delivery and removal of oxygen to and from school.
- The location of signs to alert school staff and students, public safety personnel, and visitors to the use and storage of oxygen.
- Special equipment and/or supplies the student may require (e.g., additional oxygen tubing, tank carrier, etc.) and the provider of the equipment.
- Daily plans to check equipment.
- Back up plans for oxygen in case of equipment failure.

Training:

It is critical that school employees working with oxygen dependent students and their equipment be capable of safely operating these technologies. They must also be knowledgeable of the potential hazards associated with these devices.

Collaborative staff will be trained by the Collaborative Nurse regarding Oxygen therapy. The training will include why oxygen is prescribed/used, characteristics of oxygen delivery systems, inspection and care of the equipment and tanks, safe use and handling of oxygen and oxygen delivery systems, any student specific guidelines/criteria, emergency protocols.

- Nature and type of training required for school staff (i.e., school nurse, school bus driver, school bus attendant, classroom teachers, etc.).

- Proper usage and storage of oxygen delivery system (ODS). (secured properly when in use, how/where to store, proper labeling, and importance to keep ODS away from sources of heat)
- Plan for educating the student's classmates about the student's needs, the equipment, and any safety precautions.
- The school nurse should develop an individualized nursing care plan or emergency protocol for all oxygen dependent students.

MANAGEMENT of the NEEDS of the OXYGEN DEPENDENT STUDENT

Nursing Assessment:

The school nurse is responsible for obtaining the student's medical/health history from the parent/guardians and health care providers. The school nurse is also responsible for obtaining any physician's orders regarding health services required by the student during the school day (oxygen, medications, suctioning, etc.). The assessment and plans developed by the school nurse for the oxygen dependent student should address the following:

- The student's health status, anticipated absences, and the need for a shortened school day due to decreased stamina;
- Whether the student requires oxygen continuously or PRN.
- The type of oxygen the student will use (liquid or gas) and the student's medical supplier (Note: Concentrators are not recommended for classroom usage because they are not portable, require an electrical outlet, and emit a constant motor noise that may be distracting in a classroom setting).
- Whether the student requires other related interventions such as air-conditioned rooms, pulse oximetry readings, etc.
- The ability of the student to determine and communicate his/her need for oxygen, as well as the student's ability to assist in administering and maintaining the oxygen.
- Signs of respiratory distress and steps to take should this occur (an emergency plan)
- The need for a spare or back-up oxygen source.

The school nurse must also collect the following additional information about the oxygen dependent student's day:

- How the student will get to and from school (school bus or personal car) and the duration of the ride.
- The location of the student's classrooms, and whether there is space for the oxygen container in each classroom.
- The presence/absence of air conditioning in the classrooms;
- The characteristics (e.g. age, maturity) of the student's classmates and potential safety concerns they may present.
- The times and locations of physical education classes, recess, and other scheduled activities that may require special consideration.

Emergency Protocols/Plans

All students with special needs, including the use of oxygen, should have up-to-date emergency information available in the school and on the school bus. It is important that this information be filled out by qualified personnel, updated annually, as needed, and kept in a convenient and safe location.

All emergency information should be handled as confidential in accordance with the Family Education Rights Privacy Act (FERPA). It is recommended that the school nurse, in consultation with the family and primary health care provider, develop the child's individual emergency plan. It is recommended that both the parent/guardian and the primary health care provider sign this form and share it with all school staff that has a need to know.

Transportation should be fully informed of this information for emergency evacuation purposes.

Managing the Needs of the Oxygen Dependent Student in the School Building

Consideration must be given to the health and developmental status of the child, training of personnel, safe usage, storage of equipment, and emergency procedures. Additionally, school personnel must be concerned with the impact the presence of oxygen equipment may have on movement in the classroom, limitations it may pose on instructional activities, and the need to share with the other students and staff. Through thorough assessment, planning, communication and training procedures, children with special health care needs can successfully enjoy full and safe access to all educational programs.

MANAGEMENT of the NEEDS of the OXYGEN DEPENDENT STUDENT

Developmental Status of the Child and His/Her Peers:

- Prior to the oxygen dependent student's entry into school, the school nurse should conduct a complete assessment of the student's needs.
- Classroom personnel should receive direct training regarding the student's health care needs, the use of the equipment, and the impact on classroom management and instructional activities.
- With parental/guardian consent, school personnel may also consider providing information regarding the oxygen to the peers of the oxygen dependent student. Depending on the developmental level of the students, it may be appropriate to share information regarding the need for supplemental oxygen and the extra care they must take when moving around the equipment. Such information may reduce the fears and concerns of some students as well as provide an opportunity for them to ask questions.
- The oxygen dependent student and parent/guardian should be involved in planning and presenting these learning opportunities.

Emergency Evacuation Procedures:

It is essential to have a written emergency evacuation plan which takes into consideration the individual needs of students who use oxygen equipment or other special equipment. Evacuation procedures should be well known and rehearsed by teachers and school staff. The daily seating plan in school should always consider evacuation procedures.

- Oxygen dependent students should practice evacuation procedures to the same extent as their non-disabled peers. The manufacturer's guidelines should be followed for the use of oxygen in the school building.
- School administrators should alert their school system's risk managers to the presence of oxygen in the building
- In the event of fire or a fire drill, alert the responding fire department to where oxygen is stored in the building.

Transporting the Oxygen Dependent Student and Related Equipment

Transporting oxygen dependent students require that transportation staff, school bus drivers and school bus attendants be thoroughly informed about the specific needs of each oxygen dependent student. SWCEC transportation with oxygen dependent students will receive training by SWCEC nursing staff. Such training should ensure that transportation personnel are knowledgeable about the mandates that guarantee the right to related service transportation for children with disabilities. They must also understand the characteristics of students with disabilities, and be aware of special considerations that influence services such as the use of oxygen. As is the case with all students, safety must be the first priority when transporting oxygen dependent students. IDEA requires schools to provide transportation for eligible special education students in order to enable them to benefit from special education and related services.

Safe Transport of Oxygen:

The following information should be provided to the school bus driver and attendant before the student starts riding the bus:

- Why the student is using oxygen (included in emergency plan).
- Whether the oxygen is continuous or on an as needed basis (included in emergency plan for emergency medical system- EMS).
- Oxygen setting.
- How to secure the oxygen and how to handle the oxygen in case of a bus evacuation.
- What constitutes an emergency for this student.
- Appropriate emergency phone numbers to be called (usually 911).

- How and what to report in an emergency.
- Basic safety procedures to follow until emergency personnel arrive.
- Training in the safe use of oxygen.

The school bus should be equipped with two-way communications and a sign (or magnetic sticker) conspicuously posted on or near each door that states: CAUTION - OXYGEN ON BOARD: NO SMOKING - NO OPEN FLAMES

MANAGEMENT of the NEEDS of the OXYGEN DEPENDENT STUDENT

- Seats should be assigned considering the student's proximity to heaters and other types of motors.
- The school bus attendant should be able to continuously observe the student.
- All storage, transportation and usage requirements specified by equipment manufacturers must be met.
- Oxygen cylinders/containers must be secured as follows:
    - All respiratory related equipment must be securely mounted or fastened to a wheel chair, bus seat, or bus floor during transit
    - Compressed gas oxygen cylinders should be secured to prevent movement. Specific procedures should be developed by each school district with assistance from the oxygen supplier and manufacturer
    - Liquid oxygen containers should be secured in an upright position to prevent leakage
    - Liquid oxygen containers should be secured to prevent contact with cryogenic material
    - Liquid oxygen containers must be stored in a well-ventilated area
- All oxygen containers should be secured in a location that would allow all passengers free access to or egress from emergency exits.

Need For Assistance on the Bus:

The school nurse, in conjunction with the school team, will determine whether a nurse, parent, or other trained caretaker must accompany the student on the bus. In some situations, it may be determined that the student is stable and can safely ride the bus while using the oxygen. The decision as to whether a licensed nurse is needed during transport to and from school is made using the criteria for delegation outlined in the Nurse Practice Act as well as the nurse's professional judgment. If a nurse is not required, the school nurse will determine the appropriate personnel/staff to whom responsibility for monitoring the oxygen may be delegated.

The school bus driver and attendant should not be responsible for administering oxygen or monitoring oxygen therapy in any case, which requires a nursing assessment of the child's need for oxygen or change in oxygen administration. The school bus driver and attendant must be trained to recognize oxygen equipment malfunctions and the steps to remedy the malfunction.

Special Equipment Handling:

Oxygen is provided by prescription. Rules governing oxygen equipment should be incorporated into the student's IEP. Necessary precautions, as prescribed by the manufacturer, should be followed. Several kinds of equipment may be required while a child is receiving transportation services. Each piece of equipment should be used in accordance with the manufacturers' guidelines. Safety is the primary objective.

Emergency Bus Procedures:

All personnel who transport oxygen should receive training. The individual bus drivers and substitutes should be familiar with the emergency plan developed by the school nurse for each oxygen dependent student.

Evacuation Procedures:

It is essential to have a written emergency evacuation plan, which takes into consideration the individual needs of students who use oxygen or other special equipment. Evacuation procedures should be well known and rehearsed by teachers, school staff, school bus drivers and attendants. The daily seating plan in school and on the bus should always consider evacuation procedures. Oxygen dependent students should practice evacuation procedures to the same extent as their non-disabled peers. The manufacturer's guidelines should be followed for the use and evacuation of oxygen on the school bus and the school building.

Children with "Do Not Resuscitate" or "Comfort Care" Orders in the School Setting

Children with terminal illnesses are attending school in increasing numbers. As the status of a child’s health declines, a family may make the difficult decision not to prolong the child's life and request a "Do Not Resuscitate” order (DNR). A DNR order is executed by a physician, authorized nurse practitioner, or authorized physician assistant, with the consent of the parent or legal guardian, and is issued according to the current standard of care. Special consideration must be given to meeting child and family needs, as well as the needs of the students and staff. The child should be placed only in a school that has a full time school nurse. The local emergency medical services should be informed (with written permission from the parent or guardian) that there is a child in the specific building with a DNR order and Comfort Care/DNR verification form.

If a student has a DNR order, he/she should also have a Comfort Care/DNR Order Verification form for emergency response and ambulance transport use. This form is available through The Department of Public Health’s Office of Emergency Medical Services website, at www.mass.gov/dph/oems. It must be printed out, completed in full and signed by an authorized physician or authorized nurse practitioner, in accordance with instructions on the form. A Comfort Care/DNR form (either the original or a copy) is the only authorized way for EMS/first responders to recognize a patient with a current, valid DNR order. EMS/first responders called to a school will honor a DNR only if the child has a Comfort Care/DNR form. Without a Comfort Care/DNR form, EMS/first responders who are called to a school will provide emergency treatment, including resuscitation, in accordance with standard EMS protocols, and transport to a hospital. The Collaborative Nurse will develop an individualized health care plan with the family in collaboration with the child's physician and the school physician. This plan will include:

- how the student will be moved to the school nursing office (or other designated area) if serious distress or death should occur at another location in the school.
- what comfort measures should be given to the child.
- protocols for notification of the family; if the child has died in school.
- who will do the pronouncement of death (physician, nurse practitioner, or physician assistant).
- how the deceased will be removed from the school.

There are state guidelines that must be adhered to regarding pronouncement of death:

- A nurse practitioner (NP) or physician assistant (PA) pronouncements function as "removal permits" thereby allowing the deceased to be removed from the school grounds by a funeral director.
- The NP or PA who pronounces the death must:
    - Before the pronouncement, try to reach the attending doctor so that the doctor can declare the death and complete the death certificate.
    - After the pronouncement, notify the attending doctor as to where the body has been removed so that the physician can involve planning with the family's designated funeral home. Include such factors as type of vehicle, where it will park, who will clear the corridors, and what kind of stretcher or other method of transport will be used. (NB: by law, EMS providers are not permitted to move the deceased.)

The plan will also address what will happen if the child is in distress, but does not appear to face an imminent risk of death. The response should include immediate consultation with the parents and, consistent with the plan, contact with the local EMS provider. If EMS is called, and the child has a Comfort Care/DNR form, the EMS/first responder can provide comfort care measures and transport to a hospital. The type of care that EMS is able to provide in this situation is spelled out in the Comfort Care Protocol. When a plan is in place, the collaborative nurse will communicate the plan to the appropriate school staff and administrators, answering any questions that they may have.

Whenever a death occurs in the school, the crisis team must be activated immediately to assist the family, staff and students to cope with the loss. Special consideration must be made for any students or staff who witnesses the death. Questions such as, "What if this happens to me?" and "Will they do anything for me?" may need to be addressed.

STUDENT RECORDS

In order to provide students with appropriate instruction and educational services, it is necessary for The Collaborative to maintain extensive and sometimes personal information about them and their families. It is essential that pertinent information in these records be readily available to appropriate school personnel, be accessible to the student's parents/guardian and/or the student in accordance with law, and yet be guarded as confidential information.

The Superintendent will provide for the proper administration of student records in keeping with state and federal requirements, and shall obtain a copy of the state student records regulations (603 CMR 23.00). The temporary record of each student enrolled will be destroyed no later than seven years after the student transfers, graduates or withdraws from the School District. Written notice to the eligible student and his/her parent of the approximate date of destruction of the temporary record and their right to receive the information in whole or in part, shall be made at the time of such transfer, graduation, or withdrawal. The student's transcript may only be destroyed 60 years following his/her graduation, transfer, or withdrawal from the school system.

The Committee wishes to make clear that all individual student records of the school system are confidential. This extends to giving out individual addresses and telephone numbers. SWCEC Student Health Records are considered part of the educational record and will be treated as per above; as well as per FERPA regulations/guidelines. Students and their legal guardian may have access to any part of their health record upon request; it is the right of the SWCEC to allow up to two business days to release the requested information. The student record: shall consist of the transcript and the temporary record, including all information, recording and computer tapes, microfilm, microfiche, or any other materials, regardless of physical form or characteristics concerning a student that is organized on the basis of the student's name or in a way that such student may be individually identified, and that is kept by the public schools of the Commonwealth. The terms as used in 603 CMR 23.00 shall mean all such information and materials regardless of where they are located, except for the information and materials specifically exempted by 603 CMR 23.04.

The temporary record: shall consist of all the information in the student record which is not contained in the transcript. This information clearly shall be of importance to the educational process. Such information may include standardized test results, class rank (when applicable), extracurricular activities, and evaluations by teachers, counselors, and other school staff.

Application of Rights:
603 CMR 23.00 is promulgated to insure parents' and students' rights of confidentiality, inspection, amendment, and destruction of students' records and to assist local school systems in adhering to the law. 603 CMR 23.00 should be liberally construed for these purposes.

(1) These rights shall be the rights of the student upon reaching 14 years of age or upon entering the ninth grade, whichever comes first. If a student is under the age of 14 and has not yet entered the ninth grade, these rights shall belong to the student's parent.

(2) If a student is from 14 through 17 years or has entered the ninth grade, both the student and his/her parent, or either one acting alone, shall exercise these rights.

(3) If a student is 18 years of age or older, he/she alone shall exercise these rights, subject to the following. The parent may continue to exercise the rights until expressly limited by such student. Such student may limit the rights and provisions of 603 CMR 23.00 which extend to his/her parent, except the right to inspect the student record, by making such request in writing to the school Principal or Superintendent of Schools who shall honor such request and retain a copy of it in the student record. Pursuant to M.G.L. c.71, s.34E, the parent of a student may inspect the student record regardless of the student's age.

(4) Notwithstanding 603 CMR 23.01(1) and 23.01(2), nothing shall be construed to mean that a school committee cannot extend the provisions of 603 CMR 23.00 to students under the age of 14 or to students who have not yet entered the ninth grade.

LEGAL REFS: Family Educational Rights and Privacy Act of 1974, P.L. 93-380, Amended
P.L. 103-382, 1994
M.G.L. 66:10 71:34A, B, D, E, H Board of Education Student Record Regulations adopted 2/10/77, June
1995 as amended June 2002. 603 CMR: Dept. Of Education 23.00 through 23:12 also Mass Dept. Of Education publication Student Records; Questions,Answers and Guidelines, Sept. 1995 KDB, Public's Right to Know
CROSS REF: Adopted March 7, 2011 File: JRA

DOCUMENTATION of RECORDS

Documentation is the preparing and assembling of written or electronic records to authenticate health care provided to the individual student and the reasons for providing such care. According to standards of nursing practice, documentation should be accurate, objective, concise, and well organized. When written, it must be legible, written in ink, have the signature of the person writing the entry, and be current with date and time of each entry. It also must be comprehensive, including all relevant statistics, problem statements, observations, assessments, actions, and outcomes. Proper documentation is essential to communication and should demonstrate collaboration, coordination, and continuity of health care, including communication with parents/guardians. It is especially useful when:

- a student enters school;
- a student is promoted or transfers from one school to another;
- a student has a health encounter with the school nurse;
- a student's health status changes; or
- a student receives treatments or medications.

In addition, the nurse should document when:

- making referrals to other health care providers or coordinating care with health care agencies or practices consistent with FERPA and HIPAA regulations;
- conducting personal health counseling or education;
- participating in nurse-parent/guardian or nurse-teacher conferences and team meetings; or
- there are legal issues or concerns.

Documentation organizes material and approaches student health in a systematic and retrievable format that facilitates the application of the scientific process (also called the nursing process). Recognizing the inter-relatedness of problems may help predict and thus prevent problems by highlighting risk factors. Documentation ensures continuity of care, demonstrates accountability, provides a tool for quality assurance, and substantiates the level of care for legal purposes. Recording care demonstrates compliance with professional standards described in the Nurse Practice Act, which is applicable to all settings where nurses are employed. The school nurse may be liable if the care provided is not clearly documented. The old adage, "If it's not documented, it was not done" emphasizes the importance of documentation when legal questions arise. Finally, in addition to the necessary recordkeeping for the individual student, documentation also furnishes useful aggregate data for appropriate evaluation and research, thus promoting evidence-based school nursing practice.

Here at the Southern Worcester County Educational Collaborative we use SNAP Health Center developed by PSNI (Professional Software for Nurses Inc.) as our electronic health record. SNAP Health Center is a comprehensive medical documentation and tracking software that has the capability to manage all aspects of student health related data. All Staff nurses and substitute nurses will have access to the SNAP program. All student encounters as well as communication related to students should be documented appropriately in SNAP. In the event that a nurse is unable to access SNAP for an extended period, the documentation will be completed on paper and entered into SNAP as a "late entry" as soon as reasonably possible.

Confidentiality of Student Health Information

School health records are temporary records governed by the Massachusetts Department of Education's record regulations: Student Records, 603 CMR 23.00. Maintaining and accessing school health records must also adhere to the federal Family Educational Rights and Privacy Act of 1974 (FERPA). In addition, certain transactions may have Health Insurance Portability and Accountability Act (HIPAA) implications.

<u>The Effect of HIPAA on School Health Programs</u>

Many school nurses have expressed concerns about the effect of the Health Insurance Portability and Accountability Act's Privacy Rule (HIPAA) on school health programs. Questions have also been raised regarding the interplay of HIPAA and

FERPA. How HIPAA affects a school health program is dependent on whether the program is administered by an education institution that receives federal funds under any program administered by the U.S. Secretary of Education. If so, the privacy of any health information maintained by the program will not be subject to HIPAA's privacy requirements. Rather, the information will be subject to the requirements of FERPA, and any corresponding state regulations (e.g., 603 CMR 23.000). Thus, for these programs HIPAA does not apply to any health information in the student's health record and in a nurse's personal notes.

However, educational agencies or institutions that do not receive federal funds are not subject to FERPA's requirements. Thus, a school health program at a privately funded educational institution may not be covered by FERPA, and under certain circumstances may have to comply with HIPAA's

THE INDIVIDUALIZED HEALTH CARE PLAN (IHCP)

An individual health care plan (IHCP) is designed to ensure that the child receives the health services he or she needs during the school day (such as health assessments, treatments, or administration of medication). The IHCP should allow for the coordination of needed health care services and emergency planning for the student within the school setting. Like the IEP, an IHCP should be developed to support the child's participation in classroom activities and other school related events such as sports and field trips. For a student who is eligible for special education, the IHCP should be developed in coordination with the IEP. The IHCP should also address any training needs for school staff, so that the plan is understood and implemented appropriately. To the extent possible, the plan should provide for the performance of health care procedures in a manner that minimizes disruption of the educational process both for the individual student and for other students present.

The IHCP is individualized to reflect the child's specific medical, nursing, and educational needs. Review and revision of the IHCP may occur either separately or else as part of the review and revision of an IEP. If elements of the IHCP are incorporated in the IEP, however, a notation can be made in the IEP indicating that the IEP team may not need to reconvene for a change in medication dosage or frequency of a specific treatment, unless those changes substantially impact the student's health care and access to educational services. The development of the Individual Health Care Plan is a collaborative process that should involve the child's family, the child (when appropriate), the school nurse, the school physician (when appropriate), other school staff, community health providers, and medical specialists, where indicated. Because the IHCP becomes the guide for meeting a student's health-related needs, the school nurse is responsible for coordinating and developing the IHCP. The school nurse serves as the link between child/family and other school personnel, as well as between school personnel and community health care providers in primary and tertiary care settings. The IHCP must be developed in compliance with state, federal, and local health laws; state and federal education laws; state and federal confidentiality laws; and standards of practice for nursing and medicine. As with any communication, a child's right to privacy should be protected.

The IHCP Planning Process

The planning process begins prior to the entry into school or, for a student who is already in school, immediately upon the determination of need by the family, the school, and/or the health provider. The team should develop and document strategies for the care and monitoring of each student. Planning should also reflect long-range objectives and desirable outcomes for the child, including emotional, physical, cognitive, and social adaptations to a health condition. It should also include plans for teaching self-care as appropriate.

Assessment

Assessment is a systematic collection and analysis of information about the student's health; it is the function of physicians and registered nurses and can never be delegated to, or assumed by, other personnel. The essential data for assessment typically include physical findings/needs/adaptations, strengths, coping strategies, communication needs, social and emotional relationships, family issues, and what resources are available/needed. A home visit is recommended for children with very complex health needs. This will help the school staff begin to establish a relationship with the family and child, observe the child in his or her natural environment, and determine how care needs have been met prior to school entry. A home visit provides an opportunity to plan for future school attendance, identify required school health services, support family goals for self-care and independence, assess family strengths and needs, establish rapport with individuals who provide a support system for the student, and evaluate the need for community health resources. Home visits should be documented in the student's health record. If a home visit is determined to be unnecessary or is not possible, the school nurse should find an opportunity to meet with the parents/guardians and child, at which time the child's health status can be reviewed. Another component of the health assessment is the review of the physician's or other licensed provider's orders for medical intervention and equipment; it is an opportunity to learn about technology, medications, and procedures used in the specific child's care. The review should include orders and plans from both the primary care provider and the specialty care providers, as appropriate.

Family Participation

Parents/guardians should be actively engaged as planning partners. They see their child in diverse settings and thus best understand how different environments and activities affect the child's health and development. Because family participation is of the utmost importance, convenience for parents/guardians (both time and location) should be a priority when meetings are planned. Information provided by the school about the child's health, school health activities, and resources should be introduced in terms that are understandable to parents/guardians. Parent/guardian participation in training is invaluable to professionals involved in their child's care, offering child-specific techniques and considerations. When English is not the family's primary language, any required communication between the school and the family must

be in the family's primary language. This includes providing appropriate translation services at all meetings and translating applicable written materials. When parents/guardians of a child are deaf or hearing-impaired, an interpreter must be provided. School personnel must always protect the confidentiality of the student and family.

Preparatory Planning Meeting

School personnel may find it useful to convene a preparatory planning meeting with parents/guardians to initiate discussion of the child's needs, map out the planning process, and identify key participants in the process. (This should occur prior to the formal planning meeting and school entry.)

Planning Meeting

The planning meeting is an opportunity for all the key participants, including the family, student (as appropriate), health care provider, school nurse, and other school personnel, to communicate, address important issues, and develop an individualized plan of care prior to school entry or reentry. The meeting should identify the school nurse who will serve as the child's health care coordinator at school, as well as other internal and external contacts who should also be involved in the development of the child's health care plan. The meeting provides the opportunity to organize and seek training for any special care a child will require. The identification of the responsible party for the payment of special services or caregivers may be an issue for the school, parents/guardians, providers, or insurers. Those responsible for the child's care should try to resolve financial details before the child enters school.

Training

Providing appropriate training to care for children with special health care needs is a major challenge for schools. Some elements of training are generic and reflect skills or knowledge necessary or desirable for children with a variety of special health care needs or diagnoses (e.g., the need for development of specific IHCPs or group training on such issues as seizure management). Other training needs address issues related to diseases and conditions with varying levels of severity in a variety of the body's organ systems. Because the school nurse, teachers, other school personnel, and the child's peers need to understand the child's condition and its impact on performance, the school district has a responsibility to provide training for its staff regarding the specific health condition. The IHCP also identifies areas in which training for a specific child's care is needed by those school personnel and/or others who may be involved in the care at school, or in transit to or from school: teachers and administrators, lunchroom personnel, bus drivers and monitors, coaches, and other school staff. Some school staff or transportation providers may require one-on-one training involving more specific procedures identified for care of a child. Community emergency medical service personnel may require training or briefing as well. The school nurse usually has the responsibility for organizing the training to meet a specific child's needs. The child's parents/guardians and a school nurse (familiar with equipment and procedures involved in a child's care) may be the appropriate trainers. Other options, in collaboration with the school nurse, are the child's primary care provider, home nursing personnel, or outside consultants.

NOTE: It is the responsibility of the nurse designated to the specific Collaborative site to complete IHCP's for their respective students when required.

TRACHESOTOMY CARE and SUCTIONING in the SCHOOL SETTING

A tracheotomy is a surgical opening in the neck into the trachea (windpipe), which allows air to go in and out of the lungs. The opening in the neck is called a stoma. A plastic or metal tube called a tracheostomy tube may be inserted through the stoma into the trachea. Some students may not need a tracheostomy tube. There are different types of tracheostomy tubes that are held in place with a tie around the neck. A tracheostomy is performed because of an injury or condition that requires bypassing the normal breathing passages. It may also be due to a neurological, muscular, or other condition which makes it difficult to breathe effectively or to clear secretions from the breathing passages without assistance. Some tracheostomies allow for long-term use of a ventilator or respirator (i.e., breathing machine) and provides an easy way to clear the trachea of mucus. Many students with tracheostomies are able to speak. Most are able to eat and drink by mouth but some may need dietary modifications.

There is no restriction on where a student may receive tracheostomy care. Students with tracheostomies should avoid areas with a lot of dust or other airborne particles (i.e., chalk dust, sand, glitter, etc.). The air the student breathes enters the lungs directly without being filtered, humidified, and warmed by the nose and mouth. Regular tracheostomy care prescribed to maintain the student's health and function should be done at home. In an emergency, care should be given wherever the student is. It is imperative that a complete set of equipment for tracheostomy care be available for the student at all times.

Equipment needed includes: Ambu or resuscitator bag with adapter, Extra tracheostomy tube with ties and obturator, Syringe (3 cc), Saline vials, Portable suction machine (battery operated), Back-up power source for suction machine, Bulb syringe, Suction catheters, Sims Connector, Blunt scissors, Gloves, Tracheal sponges, Supplemental oxygen (if needed).

All tracheostomy care, such as: suctioning, medication administration, oxygen administration, cleaning, and changing (except in cases of an emergency) require a current order from a physician on the Authorization for Health Procedures/Treatment form paying particular attention to the following:
Student's care requirements (e.g. suctioning), Student's ability to request assistance, Student's proneness to emergencies, Accessibility to equipment and back-up equipment, An alternate means of warming and moisturizing the air and preventing mucus from becoming too thick, Signs and symptoms of respiratory distress, Type of tracheostomy tube used (e.g., inner cannula, cuffed), Personnel and equipment needed for transportation (e.g., travel bag), Availability of caregivers, Means of communication used by student (if applicable), Latex allergy alert.

Do not use powders; aerosols (i.e., room deodorizers, etc); small particles, such as sand, glitter, lint, chalk dust, and animal hair; small pieces of food and water; or glue or chemicals with strong fumes near a student with a tracheostomy. Students who may have accidental contact with any of these potential hazards should have a protective covering for the tracheostomy.

A health assessment must be completed by the school nurse.Tracheal care for students, who require care in school, such as suctioning, saline instillation, use of a tracheostomy collar, or other daily care, should be in a school setting where a licensed nurse is present on site. Any staff caring for a student with a tracheostomy must have child specific training including skills checklist provided by a nurse. All staff in contact with students with tracheostomies should have specialized cardiopulmonary resuscitation training. They should be able to recognize signs of breathing difficulty and should know how to activate the emergency management system for their setting.

It is vitally important that this equipment accompany the student at all times, including transport and classroom activities. A backpack or other carrying device could serve as a travel bag. This equipment should be checked daily by the school nurse or other licensed caregiver.

<u>Tracheostomy Terms:</u>

Tracheostomy Tube – A tracheostomy tube is a plastic or metal tube inserted through a hole, (stoma) in the neck and is held in place by ties around the neck. There are various types of tracheostomy tubes but all serve the same purpose. Tracheostomy tubes cause no discomfort to the student.

Obturator– A small plastic device which is used as a guide for insertion of the tracheostomy tube.

TRACHESOTOMY CARE and SUCTIONING in the SCHOOL SETTING

Ambu bag – This is sometimes called a resuscitation bag. It is a device that allows for the manual introduction of air directly into the stoma. An adapter is needed that fits over the tracheostomy tube. It is necessary that the ambu bag be with the student at all times should it become necessary to perform rescue breathing for the student.

Sims Connector– A small plastic tube that fits on the end of the tubing of a portable suction machine. The Sims Connector allows the trach to be suctioned, but prevents the catheter from going too far into the trach. This piece of equipment is essential in the school setting. Only a registered or licensed practical nurse may suction the tracheostomy tube without a Sims Connector.

<u>Possible Problems That Require Immediate Actions:</u> **DO NOT LEAVE THE CHILD ALONE**

- Student shows any of the following signs of respiratory distress:
  - Coughing
  - Color changes
  - Wheezing or noisy breathing
  - Agitation
  - Retraction

  May be due to a plugged tracheostomy tube from mucus, aspiration of foreign matter, accidental decannulation, or dislodged tracheostomy tube. Reassure student. Check air movement from tracheostomy. Check placement of tracheostomy tube.
  Any time there is respiratory distress that cannot be immediately remedied – CALL 911!

- Tracheostomy tube is dislodged
  - Reposition tracheostomy tube, if possible. If unable to reposition tube, insert new (spare) tube.
  - Check air movement. Give breaths with Ambu-bag, if indicated.
  - Administer oxygen if prescribed.
  - Begin CPR, if necessary. Call 911 immediately.
  - Notify family and physician.

- Aspiration of foreign material (e.g., food, sand) into tracheostomy
  - Suction first. Do not give breath with Ambu-bag. This may force aspirate into lungs.
  - Give breaths with Ambu-bag <u>after initial suctioning</u>.
  - Check air movement. If tracheostomy tube remains blocked by foreign material, change tracheostomy tube.
  - Check air movement. Add saline and give breaths with Ambu-bag. Repeat suctioning.
  - Repeat above steps until aspirated secretions are clear or gone.
  - Give breaths with Ambu-bag if indicated.
  - Administer oxygen if prescribed in emergency plan.

  Bronchospasm (wheezing) may also occur. The student may require medication.
  Respiratory distress or arrest can occur with any aspiration. Call 911 immediately. Notify family and physician.

- Increased secretions or thicker than usual mucus
  - May require more frequent suctioning.

  These changes, or yellow or green mucus, may indicate infection.
  This should be documented in on the Student Treatment Record (STR), and the family should be notified.
  Thicker mucus may also be a sign of insufficient humidity.

- Fever
  May be a sign of respiratory infection. Document on STR and notify family.

- Redness or crusting at the stoma.
  May be due to a tracheal infection. The site should be thoroughly cleaned and the problem documented on the STR. Notify the family.

- Bleeding or pain at stoma site
  May be due to infection or trauma.
  Document on the STR and notify family.

- Bloody secretions from tracheostomy.
  May be due to infection or trauma from vigorous suctioning.
  Document on the STR and notify family.

Tracheal Suctioning

<u>Purpose:</u>

Tracheal suctioning is a means of clearing the airway of secretions or mucus. This is accomplished by using a vacuum-type device through the tracheostomy. Tracheal suctioning is performed when a person cannot adequately clear secretions on his or her own. Indications for suctioning include the following:

- Noisy, rattling breath sounds
- Secretions (i.e., mucus) that are visible and filling the opening of the tracheostomy
- Signs of respiratory distress (e.g., difficulty breathing, agitation, paleness, excessive coughing, cyanosis [blueness], nasal flaring, retracting)

<u>Suggested Setting:</u>

Designate a clean area outside the classroom, if possible, for suctioning.
Suctioning can be a noisy procedure and may be distracting and disruptive to the rest of the class. If an electrically powered suction machine is used, the setting must have an accessible, working, grounded electrical outlet.

<u>Suggested Personnel and Training:</u>

A health assessment must be completed by the school nurse. Tracheal suctioning with a Sims connector can be performed by the school nurse, registered nurse, licensed practical nurse. Any person performing tracheal suctioning via Sims connector must be designated by a registered nurse, in collaboration with the school principal, and trained for that specific student. Deep suctioning may only be performed by a registered nurse or a licensed practical nurse designated and trained by a registered nurse.

All equipment for suctioning must be assembled and available for immediate use at all times and checked daily by trained caregiver. If the equipment is not present or not functional, the student should not be at school nor transported on the bus.

<u>Procedure for Tracheal Suctioning with a Sims Connector:</u>

1. Wash hands (or use antiseptic wipes or gel, if water is not available). Assemble needed equipment: □Suction machine, □Saline solution, Sims connector, Gloves, Bulb syringe, □Water to clear tubing.
2. Position student as ordered. When at school, most students are suctioned in an upright position.
3. Explain procedure at student’s level of understanding.
4. Turn on the suction machine and check for function.
5. Encourage student to cough to expel secretions.
6. Attach Sims connector if not already in place.
7. Open saline dosette, if instillation of saline is ordered.
8. Put on gloves.
9. Turn on machine and encourage student to take a deep breath, if possible.
10. Place Sims connector into tracheostomy tube for no more than 5-10 seconds.
11. Repeat, if necessary for 5-10 seconds. Allow student to take a few breaths before repeating suctioning.

12. With the suction machine still running, place the tip of the Sims connector into the water to clear the tubing of secretions.
13. Turn off machine and place Sims connector in wrapping or clean paper towel.
14. Remove gloves and wash hands or use antiseptic wipes or gel.
15. Document color, consistency (e.g., thin, thick) and quantity of secretions on student's log sheet.
16. Report any changes from student's usual pattern to family and/or school nurse.
17. Be sure suction equipment and supplies are restocked and checked daily and are ready for immediate use.

Possible Problems When Suctioning That Require Immediate Action

- Student develops difficulty breathing during suctioning or is not relieved by suctioning
  - **Do not leave student alone**.
  - Reassure student.
  - If tracheostomy tube is blocked, change inner cannula, if present, or replace entire tracheostomy tube.

  Call 911 if you cannot relieve breathing difficulty immediately!

Possible Problems When Suctioning That Are Not Emergencies

- Bleeding occurs during suctioning – The secretions become blood-tinged and the student is not in respiratory distress. Stop suctioning and look at site to check if trauma has occurred to site. Be gentle during suctioning process. Continue to suction to clear airway and report concerns to the school nurse.
- Bronchospasm occurs during suctioning - May be due to excessive suctioning. Allow student to calm self before continuing to suction. If bronchospasm persists, student may require medication. Notify school nurse and/ or family.

Procedure for Tracheal Deep Suctioning:

1. Encourage student to cough to expel secretions.
2. Open suction catheter or kit.
3. Open saline dosette, if instillation of saline is ordered.
4. Put on sterile gloves.
5. Holding the end of the suction catheter in dominant hand, attach it to the suction machine tubing held in non-dominant hand.
6. Turn on machine to appropriate vacuum setting (if machine has a vacuum setting) for student.
7. Encourage student to take a deep breath, if possible. Manually ventilate with resuscitation bag, if prescribed.
8. Hold suction catheter 2-3 inches from tip with dominant hand and insert tip in sterile water. Remove.
9. With thumb off vent hole, gently and quickly insert catheter into tracheostomy to the prescribed depth (Do not insert catheter beyond the distal end of the tracheostomy tube).
10. Cover vent hole with non-dominant thumb while withdrawing catheter. Rotate catheter gently between thumb and index finger while suctioning and withdrawing.

Each insertion and withdrawal of the catheter must be completed within 5-10 seconds. Prolonged suctioning blocks the student's airway and can cause a dangerous drop in the oxygen level.

11. Allow student to breathe or give breaths with resuscitator bag between suctioning passes. Suction sterile water again through catheter to rinse secretions from catheter and tubing.
12. If prescribed, insert several drops of saline into tracheostomy with non-dominant hand. Manually ventilate with resuscitation bag to disperse saline, if ordered.
13. If moist, gurgling noises or whistling sounds are heard, or if mucus is seen at the tracheostomy opening, repeat suctioning procedure (Steps 12 – 17).
14. Suction nose and then back of mouth if indicated after completion of tracheal suctioning. If nose and/or mouth are suctioned, the catheter cannot be reused to suction the tracheostomy.
15. Disconnect catheter from suction tubing. Wrap catheter around gloved hand and pull gloves off inside out.
16. Discard used suction catheter and wash hands.
17. Document color, consistency (e.g., thin, thick) and quantity of secretions on student's log sheet.
18. Report any changes from student's usual pattern to family and/or school nurse.
19. Be sure suction equipment and supplies are restocked and checked daily and are ready for immediate use.

TRACHESOTOMY CARE and SUCTIONING in the SCHOOL SETTING

Possible Problems When Suctioning That Require Immediate Action

- Student develops difficulty breathing during suctioning or is not relieved by suctioning
  - **Do not leave student alone**.
  - Reassure student.
  - If tracheostomy tube is blocked (suction catheter will not pass), change inner cannula, if present, or replace entire tracheostomy tube.

  Call 911 if you cannot relieve breathing difficulty immediately!

- Bleeding occurs during suctioning – A large amount of blood is suctioned from the tracheostomy or the student develops respiratory distress during suctioning.
  - Reassure student.

  Call 911 and the school nurse, if available. Begin Rescue Breathing or CPR, if necessary.

- Tracheostomy tube or inner cannula becomes dislodged
  - Reposition using gentle pressure. If unable to reposition tube, insert new tube.

  Be prepared to initiate emergency plan.

Possible Problems When Suctioning That Are Not Emergencies:

- Bleeding occurs during suctioning – The secretions become blood-tinged and the student is not in respiratory distress
  - Stop suctioning.
  - Check vacuum pressure setting (if applicable) and adjust to lower setting.
  - Continue to suction to clear airway.
  - Use manual resuscitation bag and oxygen, if ordered.
  - Report concerns to the school nurse and/or family.
- Bronchospasm occurs during suctioning - May be due to excessive suctioning.
  - Allow student to calm self before continuing to suction.
  - If unable to remove catheter, disconnect from suction tubing and hold oxygen near end of suction catheter.
  - When bronchospasm relaxes, remove catheter.
  - If bronchospasm persists, student may require medication.
  - Notify school nurse and/ or family.

Tracheostomy Tube Changes

While this procedure is usually done by a registered nurse, in an emergency situation, any school personnel who have been trained may perform this procedure. All staff in contact with students with tracheostomies should have specialized cardiopulmonary resuscitation training. They should be able to recognize signs of breathing difficulty and should know how to activate the emergency plan for their setting. If the trained caregiver(s) and back-up personnel are unavailable on a given school day, the student's parents should be notified to make alternative arrangements. Any school personnel who have regular contact with a student who requires a possible emergency tracheostomy tube change must receive training that covers the student's specific health care needs, potential problems, and how to implement the emergency plan.

All equipment for changing a tracheostomy tube must be assembled and available for immediate use at all times and checked daily by trained caregiver. If the equipment is not present or not functional, the student should not be at school nor transported on the bus. Although only a registered nurse or a licensed practical nurse who is designated and trained

Procedure for Tracheostomy Tube Change in an Emergency by a registered nurse should perform this procedure; it may be performed by any personnel, in an emergency situation, who are trained by a registered nurse.

Procedure should be done by two persons, but can be done by one in an emergency.

1. Wash hands (or use antiseptic wipes or gel, if necessary).

2. Assemble needed equipment: Prescribed type and size of tracheostomy tube for student, Twill tape or other ties, Obturator, if applicable Blunt scissors, Resuscitation bag (Ambu bag), Oxygen, if ordered , Suctioning machine and supplies, Syringe, if trach tube is cuffed. Sterile water-soluble lubricant or sterile saline (never use Vaseline or oil-based lubricant), One size smaller tracheostomy tube, Blanket roll, if needed, Gloves
3. Explain procedure to the student at his or her level of understanding.
4. Position the student as ordered.
5. Open tracheostomy tube package. Keep tube clean. Do not touch curved part of tube.
6. Put on gloves.
7. Put obturator into clean tracheostomy tube, if applicable.
8. Lubricate end of tracheostomy tube with water-soluble lubricant or sterile saline.
9. Have assistant, if available, to hold old trach tube in place while you cut the ties.
10. When the new tube is ready (in hand), have assistant remove the old tube.
11. Insert the new tube at a right angle to the stoma, rotating it downward as it is inserted. If an obturator is present, insert tube straight into stoma. Hold in place.
12. If an obturator is used, immediately remove it after the tube is inserted. Insert inner cannula at this time, if applicable.
13. Have assistant hold the new trach tube in place while you attach the ties (or Velcro holder). Ties should be secure but loose enough to insert one finger between the ties and neck.
14. Listen or feel for air movement through the tracheostomy tube. Watch for chest to fall and rise. Observe student for signs of distress (e.g., restlessness, cyanosis, shortness of breath, agitation).
15. Place gauze around tracheostomy tube, if available.
16. Discard used equipment in an appropriate manner.
17. Remove gloves and wash hands.
18. Document procedure and problems on student log sheet.
19. Notify school principal, school nurse, and/or family.

<u>Possible Problems When Tube Changing That Require Immediate Action:</u>
Tube can be inserted and the student is still having difficulty.

- **Never leave student alone. Call for assistance**.
- Reassure the student. Assess airway and breathing.
- Administer oxygen via the tracheostomy, if ordered.
- Suction the tracheostomy.
- Use bronchodilators, if ordered.
- Use manual resuscitator bag, if indicated.
- If distress persists, initiate emergency plan and begin CPR.

- Tube cannot be reinserted - This may be due to a false passage or bronchospasm.
    - Reassure the student.
    - Encourage the student to take a deep breath – be prepared to insert tube if stoma opens.
    - Administer flow of oxygen directly to the tracheostomy stoma.
    - Attempt to insert the smaller tracheostomy tube or thread a suction catheter through the new tracheostomy tube. Attempt to insert catheter through stoma into trachea as a guide for the tracheostomy tube. Slide tracheostomy tube over catheter into stoma and remove catheter without dislodging tracheostomy tube using the following steps:

      1. Wash hands
      2. Assemble needed equipment: Oxygen source with appropriate tubing, if needed Manual resuscitator (Ambu Bag)
      Adaptor for tracheostomy tube
      3. Explain procedure at student's level of understanding.
      4. Check that resuscitator is functioning properly. Place adaptor, which is connected to the bag, against a gauze pad or tissue in hand. Squeeze bag to be sure it is functioning (if it is functioning, slight resistance will be felt).
      5. Position student per student specific guidelines.

6. Attach resuscitator bag to tracheostomy tube. Hold tracheostomy tube with one hand to prevent accidental dislodgement while attaching adaptor to it.
7. If the student is able to breathe independently, coordinate the manual breaths with his own breaths. Give a breath by squeezing the resuscitation bag as the student begins to inhale i.e., chest begins to rise.
8. 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.
9. If the student is unable to breathe on own, squeeze the resuscitation bag at a regular rate to deliver prescribed breaths per minute. If student has no breathing rate prescribed, a standard range of breaths per minute is: 20-24 for infants; 16-20 for children; 12-16 for adolescents and adults.
10. Remove resuscitation bag from tracheostomy tube. Hold tube with one hand to prevent pulling on or dislodging it.
11. Wash hands and document procedure and any problems on the appropriate form.

- If insertion of tracheostomy tube is not possible and the student has respiratory distress and/or respiratory arrest, Call 911 immediately!
    - Begin CPR with mouth-to-mouth breaths, following universal precautions.
    - Cover trach stoma with your thumb if an air leak is present.
    - Have someone alert the school nurse, principal, and parent immediately.

School Health Special Procedures

SKILLS CHECKLIST – SUCTIONING TRACH
WITH A SIMS CONNECTOR

Student's Name: ________________________ Instructor: _____________________________

Trainee's Name: ____

Demo Date: ________________________

Explanation/Return Demonstration

1. Washes hands or uses antiseptic gel, if water is not available.
2. Assembles needed equipment.
3. Positions student (sitting or lying down).
4. Explains procedure to student, if possible.
5. States two conditions that require suctioning.
6. Turns on suction machine and checks for suction.
7. Attaches Sims Connector, if not in place.
8. Opens saline dosettes, if saline is ordered.
9. Puts on gloves.
10. Turns on machine and encourages student to cough, if possible.
11. Instructs student to take a deep breath, if possible. Places Sims connector into trach tube for 5-10 seconds. Repeats up to two more times allowing student to breathe between suctioning.
12. Places Sims connector tip into water to clear tubing.
13. Turns off machine, places Sims connector in wrapping or paper towel, removes gloves, and washes hands.
14. States two possible problems that require immediate action and what should be done.
15. States one possible problem that is not an emergency and what should be done.

School Health Special Procedures

SKILLS CHECKLIST – DEEP SUCTIONING

Student's Name: _________________________ Instructor: ______________________________

Trainee's Name: ____

Demo Date: ____________________________________

Explanation/Return Demonstration

1. Washes hands.
2. Assembles needed equipment.
3. Positions student (sitting or lying down).
4. Explains procedure to student, if possible.
5. States two conditions that require suctioning.
6. Turns on suction machine and checks for suction.
7. Opens suction catheter kit.
8. Opens saline dosettes, if saline is ordered.
9. Puts on sterile gloves.
10. Holds end of suction catheter in dominant hand and attach it to suction machine tubing (held in non-dominant hand).
11. Turns on machine to appropriate vacuum setting, if required.
12. Encourages student to take a deep breath, if possible.
13. Holds suction catheter 2-3" from tip with dominant hand and inserts tip into sterile water. Removes.
14. With thumb off vent hole, inserts catheter gently and quickly into trach to prescribed depth.
15. Covers vent hole with non-dominant thumb while withdrawing and rotating catheter. Takes 5-10 seconds.
16. Repeats up to two more times allowing student time to take a deep breath between passes.
17. Suctions nose and mouth, if ordered.
18. Disconnects catheter from suction tubing and wraps around glove. Removes gloves and disposes of gloves and catheter in appropriate receptacle.
19. Washes hands and documents procedure on the appropriate form. Reports any changes to school nurse and parents.
20. States two possible problems that require immediate action and what should be done.
21. States one possible problem that is not an emergency and what should be done.

School Health Special Procedures

SKILLS CHECKLIST – CHANGE OF TRACH TUBE

Student's Name: ________________________ Instructor: _____________________________

Trainee's Name: ____

Demo Date: ______________________________

Explanation/Return Demonstration Performed by two people, if possible

1. Washes hands, or uses antiseptic gel.
2. Assembles needed equipment.
3. Explains procedure to student, if possible.
4. Positions student lying down
5. States two conditions that require changing a trach tube.
6. Opens tracheostomy tube package. Avoids touching the curved part of the tube.
7. Puts on gloves.
8. Places obturator into clean trach tube, if applicable.
9. Lubricates end of tube with water-soluble lubricant or sterile saline.
10. Assistant, if available, holds old trach tube in place while ties are cut or undone.
11. Assistant removes old tube while new tube is inserted. Obturator, is used, is removed.
12. Thumb is not placed over the opening of tube.
13. Assistant holds new tube in place while you attach ties. Leave one finger width between ties and neck.
14. Listens for air movement through trach tube.
15. Removes gloves and washes hands. 16. Documents procedure on the appropriate form. Notifies school nurse, school principal, and family.
17. States two possible problems that require immediate action and what should be done.

EMERGENCY MANAGEMENT BASICS AND PLANNING

A health emergency may occur in any school, at any time. Sometimes the risk is predictable, but often it is not. As more children with special health care needs are integrated into community schools, there is increased likelihood that some of these children will need emergency care. However, students with no history of health problems can also become seriously ill or injure themselves in a number of settings, including playgrounds, classrooms, laboratories, or workshops. Students are also at an increased risk for violence-related injuries and/or emotional crises, including depression and suicide attempts. Furthermore, although the natural tendency is to think first of students when considering risk of illness or injury, adults (educators, administrators, support staff, etc.) may also be susceptible. In cases of illness, injury, or other emergency, efficient and effective school procedures are essential.

<u>Categories of Emergency Injuries and Conditions:</u>

Emergencies may be classified into 3 major categories:

- *Life-threatening or potentially disabling*: Because these emergencies can cause death or disability within minutes, they require immediate intervention, medical care, and, usually, hospitalization.
- *Serious or potentially life-threatening or potentially disabling*: Because these may soon result in a life threatening situation or may produce permanent damage, they must be treated as soon as possible.
- *Non-life-threatening*: These are defined as any injury or illness that may affect the general health of a person (e.g., fever, stomachache, headache, seizures, fractures, cuts). The student should be evaluated by a licensed provider as soon as the parents/guardians are notified, or certainly within a few hours.

Note: Anaphylaxis is one of the most serious and life-threatening emergency situations to which school personnel may have to respond.

Emergency plans should be posted with clear instructions on how to activate the local emergency medical services (usually calling 911). In either a life-threatening or potentially disabling situation, it is important to:

- remain with the student and remain calm;
- avoid moving the ill/injured person, unless there is more danger if left in that location;
- assess the emergency at hand;
- activate the emergency plan (referring to the student's individual emergency plan and individual health care plan, if appropriate);
- notify the school nurse;
- notify the EMS;
- notify parent/guardian;
- notify school administration;
- notify student's primary care provider and/or specialist;
- manage crowd control;
- direct EMS to site;
- accompany student to emergency facility, with EMS if appropriate; and
- assist student's re-entry into school.

Note: Many of the above actions are performed concurrently. Also, although the list above refers to students, the same guidelines would apply to situations affecting staff or visitors.

When emergency services are required for life-threatening or potentially disabling situations:

- Direct a responsible person to call 911
- Instruct the person placing the emergency call that he/she MUST stay on the phone until it is certain that EMS has all necessary information. The person placing the call should also:
  - briefly describe the emergency situation (what is wrong);
  - state his/her name as well as the name, exact address, and phone number of the school;
  - give simple, specific directions;
  - specify the exact location within the school of the ill/injured person;
  - tell EMS that he/she will meet them at a specific entrance of the school; and
  - call back for reassessment if necessary (e.g., person has stopped breathing).

EMERGENCY MANAGEMENT BASICS AND PLANNING

Note: There should be no delay in calling 911 in a medical emergency. Unless the nature of the illness/injury is minor, it is prudent to activate the local EMS system. If the injury/illness is later determined by the school nurse or other trained personal to be relatively minor, the EMS response can be canceled or the EMS units can clear the scene after evaluating the situation.

In dealing with life-threatening or potentially disabling injuries/illnesses or serious injuries, school personnel should attempt to notify the parent or legal guardian that the ambulance is transporting or has transported the patient to the nearest hospital. The parents/guardians should be advised to have someone drive them to the hospital with reassurance that trained EMS personnel are caring for their child. Ideally, it is best to:

- have available the child's emergency response information with the phone numbers of parents/guardians;
- have another designated person call the parent/guardian while EMS is being activated; and
- give the emergency information to the EMS Providers

Note: ***School personnel should not delay calling for an ambulance while awaiting the permission or arrival of a parent in cases of potentially life-threatening or disabling or other potentially serious situations.***

The following tables and algorithms, from *Guidelines for the Nurse in the School Setting* (Illinois Emergency Medical Services for Children) show a list of injuries/conditions and the triage categories into which they fall, along with steps to follow for each category. This list is not all-inclusive.
Note: While many situations require a judgment call, it is prudent to call EMS in any serious incident.

TRIAGE CATEGORIES:
The 3 commonly recognized triage categories are *emergent, urgent,* and *non-urgent.* The table below lists triage categories and examples of problems that fall within each category.

Emergent
Student requires immediate medical attention. Condition is acute and has the potential to threaten life, limb, or vision.

- Cardiopulmonary arrest
- Shock
- Severe respiratory distress or failure
- Major burns
- Cervical spine compromise
- Severe medical problems, such as diabetic complications
- Poisoning or overdose
- Emergency childbirth
- Acute seizure states
- Prolonged loss of consciousness
- Caustic chemical spills in the eyes

Urgent
Student requires medical intervention within 2 hours. Condition is acute but not severe or life threatening.

- Deformity suggesting fracture of a long bone without circulatory compromise
- Lacerations in which sutures are required but bleeding is controlled and there is no significant blood loss
- Moderate pain following abdominal trauma
- Head injury with brief loss of consciousness
- Minor burns
- Persistent nausea, vomiting, or diarrhea

Non-urgent
Student may require referral for routine medical care. Minor or non-acute conditions.

- Minor abrasions or bruises
- Muscle sprains and strains
- Mild pain

Source: Illinois Emergency Medical Services for Children, Maywood, IL, 2003. Adapted with permission. INTERVENTIONS, EVALUATION, AND DISPOSITION

SWCEC HEALTH PROGRAM MANDATED TRAININGS

These trainings will be provided to all SWCEC staff and new hires/volunteers during the orientation process.

1. Overview of Health Care staff
2. Overview of Health Care policy and Procedure manual
3. Overview of Universal Precautions
4. Overview of OSHA regulations
5. Overview of OSHA Blood Borne Pathogens
6. Overview of Medical Emergency Preparedness and Triage Assessments

SIGNATURES

Print Name: ____
Signature: ____
School Nurse Leader

Date Reviewed: ____________________________

Print Name: ____
Signature: ____
Director of Special Education

Date Reviewed: ____________________________

Print Name: ____
Signature: ____
Executive Director

Date Reviewed: ____________________________

September, 2005, Revised Aug. ‘12, Aug. ‘13, Dec. ‘14, Jan ’15, Apr. ‘19