LABBB Collaborative Nursing Department Policies and Procedures Guide

2018-2019 School Year

Physician Consultation and Nursing

DOE Criterion 16.2 & 16.3
603 CMR 18.05(9)(a)

The LABBB Collaborative has a licensed physician available for consultation with program nurses for matters relating to the health of the school population such as:

1. Policies and procedures

2. Collaborating with nurse, parents, and staff on specific health issues as they relate to the school setting

3. Communicating with the child's primary physician on medical issues pertinent to the school setting, if requested by the school nurse

4. Reviewing the reports of physical examinations performed by the student's primary care physician, if requested by the school nurse

5. Completing the health assessments on such children who do not have this service performed by a primary care provider

6. Examining students referred by the school nurse or other personnel because of health issues identified during screening and/or frequent school absences (if this service is not provided by a primary care provider)

Collaborative Physician Information

The LABBB Collaborative School Physician is:

Dr. Samuel Andonian
16 Clark Street Suite 11
Lexington, MA
781-862-3218

The LABBB Collaborative shall have a Registered Nurse available in order to sufficiently meet the healthcare needs of the student population. The School Nurse or designee will be responsible for contacting the school physician. The School Nurse or designee will contact the school physician for:

1. Renewal of standing orders for staff and students annually such as oxygen, acetaminophen, ibuprofen, Tums, and EpiPen

2. Renewal of Medication Delegation for short-term school events and EpiPen administration and prescription as needed

Hand Washing

Hand washing is the first line of defense against infectious disease and is one of the universal precautions. Numerous studies have shown that unwashed hands are the primary carriers of infection.

POLICY: Staff/students should always wash his or her hands:

1. Before eating or handling food
2. Before and after feeding a student
3. After toileting
4. After handling body secretions (mucus, vomit, diapers, etc.). Use soap and water if available
5. After cleaning
6. Before and after giving/taking medications

PROCEDURE: The five most important concepts to remember about hand washing are:

1. Use running water that drains out, not a stopper sink or container which can spread germs
2. Use antibacterial liquid soap
3. Use friction (rubbing the hands together) to remove the germs
4. Turn off the faucet with a paper towel to prevent recontamination of clean hands by a dirty faucet
5. Dry hands by single-use towels; cloth towels for common use will re-soil clean hands
6. When using alcohol-based hand sanitizer, rub until completely dry

Communicable Disease

POLICY:

In the event that the school nurse either suspects a student may have a communicable disease or if the school has received notification that a student has a communicable disease, including H.I.V. or Hepatitis C, the school nurse will follow the recommendations outlined in the Massachusetts's Department of Public Health's Comprehensive School Health Manual. The nurse shall follow the recommendations in the areas of:

1. Diagnosis
2. Treatment
3. School attendance guidelines
4. Reporting requirements
5. Notification guidelines – state, local, and parent
6. Stop-Spread guidelines

In order to prevent the spread of communicable disease(s) and ensure a rapid recovery with a minimum of after effects, the student(s) cannot return to school until it is felt that the student will not infect others with the disease. Below are listed the most common contagious diseases and their periods of exclusion. The list is not all-inclusive and the school nurse must use good judgment and best practice, if a communicable disease is suspected. She/he should consult with the MA Department of Public Health or the program physician in these cases.

Upon returning to school, the student diagnosed with the communicable disease must report to the school nurse with documentation from a healthcare provider and will be excluded from school until the following treatments or periods of time have elapsed:

Bacterial Conjunctivitis	May return to school after medical treatment has been provided for 24 hours
Chicken Pox	May return to school when lesions are dry and crusted
German measles	May return to school 7 days after the onset of rash
Measles	May return to school 4 days after first appearance of rash
Impetigo	May return to school after all open sores have healed or are small enough that a band-aid will cover the area. May return to school if on medication for 24 hours
Strep Throat	May return after medical treatment has been provided for 24 hours and student is fever free without the use of antipyretics

Ringworm	May return to school the day following initiation of anti-fungal treatment, as detailed by an MD note. Lesions should be covered
HIB Disease	May return after 4 days of treatment with Rifampin or are no longer ill
Mumps	May return 9 days after the onset of swelling or when the swelling has subsided
Whooping Cough	May return 3 weeks after the onset of cough or 5 days after antibiotics start
Rash	At the nurse's discretion; any student with an undiagnosed rash may be excluded from school. The student must have a physician's note to return to school
Molluscum Dermatits	Does not warrant exclusion from school; however students with known diagnosis should avoid swimming in common pools until treatment has been initiated

Gastrointestinal Diseases

POLICY:

1. When students or staff have the following: uncontrolled diarrhea, fever, vomiting, severe or bloody diarrhea, or diarrhea that cannot be contained by diapers (in those students using them), exclude them until fever and diarrhea are gone for 24 hours without the use of antipyretics

2. When students or staff have mild diarrhea but are not sick, take special precautions or exclude on a case-by-case basis using clinical nursing judgment and best practice

3. When students or staff who do not prepare food or feed students are found to have infectious germs in their stool (positive stool cultures) but have no diarrhea or illness symptoms, take special precautions but do not exclude them; however, make sure they have appropriate management. During outbreaks a negative stool culture may be required

4. When staff who normally prepare food or feed students have positive stool cultures, do not permit them to prepare food or feed students until they have one negative stool culture taken 48 hours after medication is completed, if antibiotics are used. During outbreaks, two consecutive negative stool cultures may be required (105 CMR 300.000)

Return to School Guidelines:

Excluded students and staff may come back to school after treatment and when severe diarrhea is gone. During outbreaks, negative stool cultures and documentation from a provider may be required for students and staff to return.

PROCEDURE:

To stop the spread of infectious gastrointestinal diseases:

1. Strictly enforce all hand washing preferably with antibacterial soap and water and cleanliness procedures

2. Give attention to environmental cleaning and sanitation in all settings

3. Keep track of the number of cases of diarrhea

4. If there is an increase in the number of cases expected in the school, call the local board of health and take the following additional precautions:

    a. Remind students and staff not to share food, drink, or eating/drinking utensils
    b. Monitor enforced hand washing for students. Everyone should wash his or her hands upon arrival at school, after using the bathroom, before and after eating or preparing food, or after contact with other body fluids
    c. Staff, including volunteers, should take care to wash hands upon arrival, after using the bathroom themselves or toileting a child, before and after eating or preparing food, before and after feeding a child, or after contact with other body fluids
        i. A hand-washing checklist is available from MDPH for use during outbreaks
    d. Monitor bathrooms daily to ensure an adequate supply of liquid soap, running water, paper towels, and toilet paper. Bathrooms should be thoroughly cleaned and sanitized daily or more often if indicated
        i. A bathroom checklist and hand-washing poster is available from MDPH for use during outbreaks
        ii. Hand-washing posters should be prominently displayed near all sinks

Symptomatic students and non-food handling staff may be required by state or local public health officials to submit a negative stool culture before returning to school

Exclusion from School for Health Reasons

POLICY:

The school nurse or program administrator may exclude a student from school for health reasons if the student:

1. Has returned from a hospital admission within the past 24 hours and does not have appropriate documentation. This does not include routine tests. This **does** include emergency department visits even if admission to an inpatient unit does not occur

2. Has a tympanic temperature of 100 or greater. Temperature must be below 100 degrees Fahrenheit for a full 24 hours without use of antipyretics prior to return to school. The exception is a child with a hypothalamic problem (temperature regulation problem) who is asymptomatic

3. Has strep throat and has not been on antibiotic therapy for 24 hours

4. Has a culture(s) pending, (exceptions can be made at the discretion of the school nurse)

5. Is on respiratory precautions, and/or has a significant change in respiratory status

6. Has chicken pox/shingles, with active rash (rash must be dry, non-weeping), shingles must be covered for student to return

7. With significant seizure activity

8. Has had persistent vomiting and diarrhea; must be symptom free for 24 hours prior to attending school

9. Has a condition that requires immediate intervention (i.e. broken bone)

10. Has a condition that requires ongoing supervision, which cannot be adequately pro-vided in a school setting

11. Is very sleepy to the point where the student cannot access their schedule

12. Experiencing excessive bleeding after a dental visit

13. Poses a significant health risk to others in the normal course of school activities. A significant health risk is when:

    a. Any student is in the infectious stage of an airborne transmitted disease

b. Students are unable to hygienically manage their bowel and bladder functions and they are in the infectious stage of an oral-fecal transmitted disease. Oral-fecal transmitted diseases include, but are not limited:

    i. Hepatitis A

    ii. Gastrointestinal infections such as Giardia, Salmonella, Shigella, and Rotovirus)

    iii. Parasites (such as pinworms)

c. Students have a disease which may be transmitted by body fluids, and have open lesions and whose developmental level or behavior makes it difficult for them to refrain from touching the lesion and, therefore, spreading the underlying infection. These infections include:

    i. Herpes

    ii. Impetigo

    iii. Hepatitis B virus

    iv. Staphylococcus Aureus

    v. Beta Hemolytic Streptococcus

    vi. Conjunctivitis

Standing Orders Protocol

POLICY:

Parents and guardians have the primary responsibility for the health care of their children. The nursing department staff respects this responsibility and will consult with the parent about matters related to the health of their children. The health care provided in school is generally the first aid care of injuries and sudden illness that occur during school hours. The following protocols should be followed in response to non-emergency health concerns and the administration of over-the-counter medications (also see standing orders) should be implemented as needed. Standing orders for over-the-counter medications and parental permission for the nurse to administer are renewed annually, at the beginning of each school year.

Abdominal Pain	Review the history and evaluate. If there is fever, red throat, abdominal tenderness, repeated vomiting, diarrhea, or urinary symptoms, advise dismissal from school and prompt medical attention
Allergy	If an EpiPen is prescribed by the student's physician, follow the student's allergy action plan. Unless prescribed by the student's physician, Benadryl will not be given routinely as it may mask symptoms of anaphylaxis. 911 must be called with every epinephrine administration. Only a nurse may administer a second dose. Only a nurse may administer epinephrine in cases of suspected anaphylaxis without a known allergen
Bee Sting	Review history. If none, remove stinger, apply ice for 15 minutes, observe patient for symptoms of anaphylaxis
Bites	Animal bites - Wash with soap and warm water, cover with sterile dressing. Check records for most recent tetanus shot. Notify parent and advise consult with student's physician. Notify local police/animal control immediately. Contain animal if possible Human bites – Clean with soap and water, provide ice for discomfort. If skin is broken: follow protocol and notify parent/advise consult with student's physician
Burn	Clean with water, apply cool compress for comfort, apply dressing as needed
Elevated Temp	A student with a temperature of 100 degrees Fahrenheit or above should be dismissed from school. Advise parent to consult with family physician. If authorization obtained from parent, administer Acetaminophen or Ibuprofen as prescribed

Headache	Review history and evaluate patient. If severe, have patient lay down in darkened room. Cool compresses applied to the head may be helpful. Notify parent and refer to physician if recurrent or if vision changes are present. Age and/or weight appropriate Acetaminophen or Ibuprofen may be given with parent and physician authorization
Menstrual Cramps	Assess patient. Administer Acetaminophen or Ibuprofen as needed with parent and physician authorization
Open Wounds	Small: clean with soap and water, cover with a sterile dressing. Large: control bleeding, cover with sterile dressing. Notify parent, arrange for transport if necessary
Rash	Wash and apply cool compress. Notify parents and refer if necessary
Irritated Eyes	Gently flush with water; apply cool compresses as needed for comfort. If reddened with or without exudates and conjunctivitis is suspected, call parent/guardian with recommendation to be seen by provider

Students who come to the nurse for care should be advised to return for further assistance if their problem is not relieved or becomes worse.

Receipt of Medical Treatment – Religious Beliefs

POLICY:

In the absence of an emergency or epidemic of disease declared by the Department of Public Health, the LABBB Collaborative will not require any student to receive immunizations or medical treatment when the parents object on the ground that such treatment conflicts with a religious belief. A written statement from the student's physician and parent that details what immunizations/medical treatments conflict with their religious and/or medical beliefs must be on file.

LABBB Collaborative will adhere to the following MDPH guidelines regarding immunization exemptions for religious as well as medical reasons.

MDPH: Immunization Exemptions and Vaccine Preventable Disease Exclusion Guidelines in School Settings

There are two situations in which children who are not appropriately immunized may be admitted to school:

1. A **medical exemption** is allowed if a physician submits documentation that an immunization is medically contraindicated; and
2. A **religious exemption** is allowed if a parent or guardian submits a written statement that immunizations conflict with their sincere religious beliefs.

Law in Massachusetts does not allow philosophical exemptions, even if signed by a physician. Only medical and religious exemptions are acceptable. These exemptions must be kept in the students' files at school (105 CMR 220.000 and M.G.L. c.76, ss. 15 and 15C).

Unimmunized children who do not meet criteria for medical or religious exemption "shall **not** be admitted to school and shall be excluded from school until proof of immunization is obtained."

In situations when one or more cases of disease are present in a school, all susceptible, **including those with medical or religious exemptions**, are subject to exclusion as described in the Reportable Diseases and Isolation and Quarantine Requirements (105 CMR 300.000).

State regulation and law prescribe the reporting and control of diseases identified as posing a risk to the public health. The Isolation and Quarantine Requirements establish isolation and quarantine requirements for cases of certain diseases and their contacts in certain high-risk situations, including the school setting. The following table outlines several of the more common childhood vaccine-preventable diseases identified in the requirements that may occur in schools and the corresponding exclusion requirements.

Guidelines for Select Vaccine Preventable Diseases in a School Setting

Disease	Case	Symptomatic Contact	Asymptomatic Contact
Measles	Student/staff should not return until 4 days after rash onset. (Count the day of rash onset as day zero.)	Same as for a case. Obtain a blood sample for confirmation, drawn $\geq$ 3 days after rash onset. (Count the day of rash onset as day zero).	If one case of measles: Exclude susceptibles[1] from day 5 through 18 after last exposure. If multiple cases: Exclude susceptibles[1] for 14 days after the day of rash onset in the last case.
Mumps	Exclude student/staff until 9 days after onset of glad swelling. (Count the day of swelling onset as day zero.)	Same as for a case. Obtain an acute blood sample for confirmation, drawn as soon as possible after onset of symptoms and a convalescent blood sample drawn 14 days after the acute. (Count the day of swelling onset as day zero).	If one case of mumps: Exclude susceptibles[2] from day 12 through 26 after last exposure. If multiple cases: Exclude susceptibles[2] for 26 days after the onset of the last case.
Rubella	Exclude student/staff for 7 days after rash onset. (Count the day of rash onset as day zero.)	Same as for a case. Obtain a blood sample for confirmation, drawn $\geq$ 3 days after rash onset. (Count the day of rash onset as day zero.)	If one case of rubella: Exclude susceptibles[3] from day 7 through 21 after last exposure. If multiple cases: Exclude susceptibles[3] for 21 days after the date of rash onset on the last case.
Pertussis	Exclude student/staff until 3 weeks after cough onset or after completing 5 days of a 14-day course of appropriate antibiotics.	Same as for a case. Obtain a culture if it is < 2 weeks after the cough onset. Obtain an SLI serology if the patient is $\geq$ 11 years old and it is 2-8 weeks after the cough onset.	Do not exclude after starting appropriate antibiotics. Any susceptible[4] contacts not undergoing antibiotic prophylaxis must be excluded until 21 days after the onset of the last case. In addition to antibiotic prophylaxis,

			contacts that are < 7 years of age who are under-immunized should have immunization initiated or continued depending on their past history.
Varicella	Exclude until all lesions have dried and crusted over, or until no new lesions appear, usually by the 5th day after rash onset. (Count the day of rash onset as day zero.)	Same as for a case.	No restrictions except for neonates and health care workers.

Definition of Susceptibles

[1] **Measles** - Susceptibles include all those born in or after 1957 without documentation of at least two doses of measles-containing vaccine or serologic evidence of immunity. In an outbreak situation, all those with 0 or 1 dose may avoid exclusion if they promptly receive a *new* dose. Those born before 1957 are considered immune.

[2] **Mumps** - Susceptibles include all those born in or after 1957 without written documentation of one dose of mumps-containing vaccine or serologic evidence of immunity. In an outbreak situation, all those with no doses may avoid exclusion if they promptly receive a *first* dose. Those born before 1957 are considered immune.

[3] **Rubella** - Susceptibles include all those born in or after 1957 without written documentation of one dose of rubella-containing vaccine or serologic evidence of immunity. In an outbreak situation, all those with no doses may avoid exclusion if they promptly receive a *first* dose. Those born before 1957 are considered immune.

[4] **Pertussis** - Susceptibles include all those exposed, regardless of their age, immunization status, or past history of disease.

[5] **Varicella** - Susceptibles include those without 1) written documentation of one or two doses of varicella vaccine or 2) a physician-certified reliable history of chickenpox disease or 3) serologic evidence of immunity.

Refer to the MDPH School Health Manual or Division of Epidemiology for more information.

Administration of Medication Orders/Parental Consent

DOE Criterion 16.5
603 CMR 18.05(9)(f)
105 CMR 210.007
105 CMR 210.100
DPH Health Care Manual

Management of the Medication Administration Program

1. The nurse leader shall be the supervisor of the medication administration program in the school district

Medication Orders/Parental Consent

POLICY:

1. The school nurse shall ensure that there is a proper-signed medication order from a licensed prescriber (see *Medication Order form*) that is renewed at the beginning of each academic year and/or as needed.

    a. Only the school nurse can receive a telephone/verbal order.

        i. Any such telephone/verbal order must be followed by a written or faxed order within **three** school days

    b. Whenever possible, the medication order shall be obtained, and the medication administration plan shall be developed before the student enters or reenters school

2. The medication order from a licensed prescriber must contain:

    a. The student's name

    b. The name, signature, and phone number of the licensed prescriber

    c. The name of the medication

    d. The route and dosage of medication

    e. The frequency and time of medication administration

    f. The date of the order and discontinuation date

    g. A diagnosis and any other medical condition(s) requiring medication (if not a violation of confidentiality or if not contrary to the request of a parent, guardian or student to keep confidential)

h. Specific directions for administration

3. Every effort shall be made to obtain from the licensed prescriber the following additional information, if appropriate:

    a. Any special side effects, contraindications, and adverse reactions to be observed

    b. Any other medications being taken by the student

    c. The date of the next scheduled visit, if known

4. Special Medication Situations:

    a. For "Over-the-Counter" Medications, i.e., Tylenol, Advil, Tums a written authorization from the parent/guardian must be obtained. If an OTC medication or dose is not included in the "standing orders" an order must be obtained from the student's physician. Parents may give verbal permission to the nurse for OTC administration, but must return a permission form within three school days

    b. For short-term medications, i.e., those requiring administration for ten school days or fewer, the pharmacy-labeled container may be used in lieu of a licensed prescribers order; if the nurse has a question, she may request a licensed prescribers order or verbal clarification

5. The school nurse shall ensure that parents or guardians authorize medication administration in school. Ideally, written consent would include:

    a. The parent or guardian's printed name, signature and an emergency phone number

    b. A list of all medications the student is currently receiving, (if not a violation of confidentiality or contrary to the request of the parent, guardian or student that such medications not be documented)

    c. Approval to have the school nurse or school personnel designated by the school nurse administer the medication

    d. Persons to be notified in case of a medication emergency, in addition to the parent or guardian and licensed prescriber

    e. However, the parent/guardian's sending of the medication to the school nurses for in-school administration shall constitute authorization in cases where a written consent is not provided.

6. Alternative therapies such as homeopathic, herbal, and nutritional supplements will only be administered when there is a written order from a Massachusetts licensed prescriber who is caring for the student. The school nurse may not administer any type of regimen if it is not approved by the FDA, in accordance with the Nurse Practice Act and 105 CMR 210.000.

7. In the instance that a scheduled medication is to be discontinued at school, an order to discontinue must be obtained from the licensed prescriber.

Medication Administration Plan

PROCEDURE:

1. The school nurse shall assess the child's health status and develop a medication administration plan for scheduled medications administered for longer than ten days (see Medication Administration Plan form) that includes:

    a. The name and date of birth of the student

    b. The name of the licensed prescriber, including business and emergency telephone numbers

    c. Parent/guardian name; home and business telephone numbers if available

    d. Any known allergies to food or medications

    e. The diagnoses (unless a violation of confidentiality)

    f. The name of the medication

    g. The dosage of the medication, frequency of administration, and route of administration

    h. Any specific directions for administration

    i. Any possible side effects, adverse reactions, or contraindications

    j. Special storage instructions, if necessary

    k. The duration of the prescription

    l. The designation of other school personnel, if any, who will administer the medication

    m. Plans, if any, for teaching self administration of the medication

    n. With parental permission, other persons, including teachers, to be notified of medication administration and possible adverse effects of the medication

    o. A list of other medications being taken by the student (if not a violation of confidentiality or contrary to the request of the parent, guardian or student that such medication not be documented)

    p. When appropriate, the location where the administration of the medication will take place

q. A plan for monitoring the effects of the medication

2. The school nurse shall develop a procedure to ensure the positive identification of the student who receives the medication

    a. Nurses and other staff administering medications shall confirm the name and date of birth with the student, if possible, or confirm identification by photo or with other staff member

3. If appropriate, the medication administration plan has been referenced in any other health or educational plan developed pursuant to St. 1972, c. 766 the Massachusetts Special Education Law (Individual Education Plan under chapter 766) or federal laws, such as the Individuals with Disabilities Education Act (IDEA) or Section 504 of the Rehabilitation Act of 1973.

4. The school nurse shall communicate significant observations relating to medication effectiveness and adverse reactions or other harmful effects to the child's parent or guardian and/or licensed prescriber

In accordance with standard nursing practice, the school nurse may refuse to administer any medication, which, based on her/his individual assessment and professional judgment, has potential to be harmful, dangerous, or inappropriate. In these cases, the school nurse will notify the parent/guardian and licensed prescriber immediately and explain the reason for refusal

Self-Administration of Medications

POLICY:

"Self administration" means that the student is able to consume or apply medication in the manner directed by the licensed prescriber, **without additional assistance or direction**. A student may be responsible for taking his/her own medication after the school nurse has determined that the following requirements are met:

1. The student, school nurse, and parent/guardian, where appropriate, enter into an agreement that specifies the conditions under which medication may be self-administered

2. The school nurse, as appropriate, develops a medication administration plan, which contains only those elements necessary to ensure safe self-administration of medication

3. The student's health and abilities have been evaluated by the school nurse, who then deems if self-administration is safe and appropriate. The school nurse shall observe initial self-administration of the medication

4. The school nurse is reasonably assured that the student is able to identify the appropriate medication and knows the frequency and time of day for which the medication is ordered

5. There is written authorization from the student's parent or guardian that the student may self medicate, unless the student has consented to treatment under M.G.L. c. 112, s.12F or other authority permitting the student to consent to medical treatment without parental permission (i.e. if the student is their own legal guardian)

6. If requested by the school nurse, the licensed prescriber provides a written order for self-administration

7. The student follows a procedure for documentation of self administration of medication

8. The school nurse establishes a policy for the safe storage of self-administered medication and, as necessary, consults with teachers, the student, and parent/guardian, if appropriate, to determine a safe place for storing the medication for the individual student while providing for accessibility if the student's health needs require it. This information shall be included in the medication administration plan. In the case of an inhaler or other preventive or emergency medication, whenever possible, a backup supply of the medication shall be kept in the health room or a second readily available location

9. The student's self-administration is monitored based on his/her abilities and health status. Monitoring may include teaching the student the correct way of taking the medication, reminding the student to take the medication, visual observation to ensure

compliance, recording that the medication was taken, and notifying the parent/guardian and licensed prescriber of any side effects, variation from the plan, or the student's refusal or failure to take the medication

With parental/guardian permission, as appropriate, the school nurse may inform appropriate teachers and administrators that the student is self administering a medication.

Administration of Antipsychotic Medication

DOE Criterion 16.6
603 CMR 18.05(9)(f)(9)

POLICY:

Staff of the LABBB Collaborative shall not administer or arrange for the administration of anti-psychotic medications except under the following circumstances. (Anti-psychotic medication shall mean drugs that are used in treating psychosis and alleviating psychotic states.)

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

2. No anti-psychotic prescription will be administered for a period longer than is medically necessary; as determined by the prescribing physician

3. Staff providing care to a student receiving anti-psychotic medication shall be instructed regarding the nature of the medication, potential side effects that may or may not require medical attention, and required monitoring or special precautions as needed

4. Except in an emergency, as defined in 18.05 (9) (g), the school shall neither administer nor arrange for the prescription and administration of anti-psychotic medication unless informed written consent is obtained. For students in custody of the Department of Social Services, an Educational Surrogate Parent shall not have authority to consent to administration of any medication for routine or emergency purposes. For such students, consent shall be obtained consistent with the applicable Department of Social Services requirements. Except for students in the care or custody of the Department of Social Services, informed written consent shall be obtained in the following manner: if a student is in the custody of his/her parent(s), parental consent (in writing or in a witnessed conversation) is required. Parental consent pursuant to this subparagraph 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

The school 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 school shall have procedures to follow if the student refuses to take the medication.

Handling, Storage, and Disposal of Medications

POLICY:

1. A parent, guardian or parent/guardian-designated responsible adult shall deliver all medications to be administered by school personnel or to be taken by self-medicating students, if required by the self administration agreement, to the school nurse or other responsible person designated by the school nurse

    a. The medication must be in a pharmacy or manufacturer labeled container. Container should have expiration date that has not passed

    b. The school nurse or other responsible person receiving the medication shall document the quantity of the medication delivered and person delivering said medication

    c. In extenuating circumstances, as determined by the school nurse, the medication may be delivered by other persons provided that the nurse is notified in advance by the parent or guardian of the arrangement and the quantity of medication being delivered to the school

2. All medications shall be stored in their original pharmacy or manufacturer labeled containers and in such manner as to render them safe and effective. Expiration dates shall be checked monthly

3. All medications to be administered by school personnel shall be kept in a securely locked cabinet used exclusively for medications, which are kept locked except when opened to obtain medications. The cabinet shall be substantially constructed, anchored securely to a solid surface. Medications requiring refrigeration shall be stored in either a locked box in a refrigerator or in a locked refrigerator maintained at temperatures of 32-40 degrees Fahrenheit

4. Access to stored medications shall be limited to persons authorized to administer medications. Access to keys and knowledge of the location of keys shall be restricted to the maximum extent possible. Students who are self-medicating shall not have access to other students medications

5. Parents or guardians may retrieve the medications from the school at any time

6. No more than a thirty (30) school day supply of the medication for a student shall be stored at the school. An exception will be made for students who often do not return refill requests in a timely manner

Where possible, all unused, discontinued, or outdated medications shall be returned to the parent or guardian and the return appropriately documented. However, with parental consent the school nurse, in accordance with applicable policies of the Massachusetts Department of Public

Health's Division of Food and Drugs, can dispose of such medications. All medications should be returned to the parent/guardian at the end of the school year.

Documentation and Record-Keeping

POLICY:

1. For instances when medication is administered by school personnel, each school will maintain a medication administration record for each student who receives medication during school

    a. Such record at a minimum shall include a daily log and a medication administration plan, including the medication order

    b. The daily log shall contain:

        i. The dose or amount of medication administered

        ii. The date and time of administration, or omission of administration, including the reason for omission

        iii. The signature of the nurse or designated unlicensed school personnel administering the medication. The school nurse shall document in the medication administration record significant observations of the medication's effectiveness, as appropriate, and any adverse reactions or other harmful effects, as well as any action taken

    c. All documentation by nurses shall be recorded electronically in the iPass system or by ink on a medication administration record

    d. With the consent of the parent, guardian, or student where appropriate, the completed medication administration record and records pertinent to self-administration shall be filed in the student's cumulative health record. When the parent, guardian, or student, where appropriate, objects, these records shall be regarded as confidential medical notes and shall be kept confidential

2. The school district shall comply with the Department of Public Health's reporting requirements for medication administration in the schools

3. The Department of Public Health may inspect any individual student medication record or record relating to the administration or storage of medications without prior notice to ensure compliance with the Regulations Governing the Administration of Prescription Medications in Public and Private Schools

Reporting and Documenting of Medication Errors

POLICY:

1. A medication error includes any failure to administer medication as prescribed for a particular student, including failure to administer the medication:

    a. Within appropriate time frames (the appropriate time frame should be addressed in the medication administration plan)

    b. In the correct dosage

    c. In accordance with accepted practice

    d. To the correct student

    e. By the correct route

2. In the event of a medication error, the school nurse shall notify the parent or guardian immediately. (The school nurse shall document the effort to reach the parent or guardian.) If there is a question of potential harm to the student, the nurse shall also notify the student's licensed prescriber or school physician.

3. If the student receives the wrong medication or wrong dose of medication, please utilize the *Regional Center for Poison Control and Prevention* as a resource: 800-222-1222. This resource is available 24 hours every day and these trained professionals can assist nurses in determining appropriate interventions depending on the drug that was given in error.

4. The school nurse will document medication errors on the MDPH School Health Medication Error Report form. These reports shall be retained at the LABBB Nursing Office and in the applicable student health record. 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. All suspected diversion or tampering of drugs will be reported to the Department of Public Health, Division of Food and Drugs.

5. The lead nurse shall review reports of medication errors with the administrative team annually and take necessary the steps to ensure appropriate medication administration in the future.

***Note:** Per DPH guidelines, if a medication order has expired, it is the licensed nurse's discretion to use the pharmacy labeled container in lieu of a written order IF the following occur:

1. The medication container must be intact with a completely written and legible label

2. The medication expiration date has not been exceeded

3. Parental consent is obtained

4. The label must contain all the perquisite information necessary prior to administering the medication (i.e. the 5 rights)

Response to Medication Emergencies

PROCEDURE:

In the event of a medication emergency, follow procedures outlined in "Emergency First Aid and Medical Treatment" section of this manual.

Lexington Emergency Numbers:

Fire/EMS: 781-862-0271
Police: 781-862-0270
Poison Control: 800-222-1222
Lahey Clinic: 781-744-5100

Belmont Emergency Numbers:

Fire/EMS: 617-993-2200
Police: 617-993-2500
Poison Control: 800-222-1222
Mt. Auburn Hospital: 781-492-3500

Arlington Emergency Numbers:

Fire/EMS: 781-316-3800
Police: 781-643-1212
Poison Control: 800-222-1222
Mt. Auburn Hospital: 781-492-3500

Burlington Emergency Numbers:

Fire/EMS: 781-272-2211
Police: 781-272-1212
Poison Control: 800-222-1222
Lahey Clinic: 781-744-5100

Bedford Emergency Numbers:

Fire/EMS: 781-275-7262
Police: 781-275-1212
Poison Control: 800-222-1222
Emerson Hospital: 978-369-1400

Dissemination of Information to Parents or Guardians Regarding Administration of Medication

POLICY:

Parents and guardians shall upon the students' admission to the program and once annually receive an outline of medication policies and procedures, including a statement that the entire contents of the Health Care Manual are available for review at the program location.

Procedures for Resolving Questions between the School and Parents/Guardians Regarding Administration of Medications

POLICY:

Parents and students are encouraged to communicate any concerns or questions they may have about the student's health and care with the nurse of the program in which the student is enrolled. They are welcome to communicate their concerns through the use of communication books, email, telephone calls, site visits, and meetings. They are free to express their concerns at any time to staff such as classroom teachers, clinical staff, support personnel, program coordinators, and programs directors, as well as the Executive Director of the LABBB Collaborative. In the event that they do not feel their concerns are being addressed adequately, they are encouraged to use the following Complaint Registration procedural process:

1. Request in writing a conference with the Program Coordinator to make their concerns known

2. Within one week following the conference, the Program Coordinator will follow-up with a response to the student or parents concerns in writing, including any reasons for the decision made. If the decision supports the student or parents concerns, the Program Coordinator will promptly put the decision into effect

3. The Program Coordinator will notify and keep the Program Director informed of the complaint throughout the process. The Program Director may be directly involved in the complaint resolution process at the request of either the Program Coordinator or the parent or at the Program Director's discretion

4. In the event that the student or parent should disagree with any part of the decision made by the Program Coordinator or Program Director, they may in writing appeal the decision to and request a meeting with the Executive Director of the LABBB Collaborative. The Executive Director will follow-up with a response to the student or parents concerns in writing, including any reasons for the decision made. If the decision supports the student or parents concerns, the Program Coordinator will promptly put the decision into effect

5. If a student or parent is still unsatisfied with the decision, it is recommended that they then contact the Director of Special Education of their sending district and express their concerns in writing

6. In the event of an unsatisfactory resolution, the Executive Director of LABBB Collaborative will contact the Director of Special Education of the sending district and inform him/her of the impasse with the student or parent. The Executive Director will work with the Director of Special Education to satisfactorily address the concerns in the best interest of the student

Nothing in this policy is to prevent a parent from exercising his/her right under the Options for Dispute Resolution (Section 28.08) of Massachusetts Special Education regulations.

Delegation of Medication Administration

LABBB Collaborative is registered with the Department of Public Health for the purpose of permitting unlicensed school personnel to administer prescription medication on field trips and other special short term school events.

The school committee (or Board of Trustees) has approved categories of unlicensed school personnel to whom the school nurse may delegate responsibility for medication administration.

1. Individual approved to administer medication meets the following criteria:
    a. Is a high school graduate or its equivalent
    b. Demonstrates sound judgment
    c. Is able to read and write English
    d. Is able to communicate with the student receiving the medication or has ready access to an interpreter when needed
    e. Is able to meet the requirements of 105 CMR 210.000 and follow nursing supervision
    f. Is able to respect and protect the student's confidentiality
    g. Has completed an approved training program pursuant to 105 CMR 210.007

2. Requires a school nurse to be on duty in the school system while medications are being administered by designated unlicensed school personnel, and available by telephone should consultation be required.

3. The delegation of the administration of parenteral medications is not included (with the exception of epinephrine administered in accordance with 105 CMR 210.100).

4. An updated list of unlicensed school personnel who have been trained in the administration of medications shall be maintained. Upon request, a parent shall be provided with a list of school personnel authorized to administer medications.

When a school committee or Board of Trustees has registered with the Department of Public Health and authorized categories of unlicensed school personnel to administer medications, all personnel are under the supervision of the school nurse for the purposes of 105 CMR 210.000.

1. Sufficient school nurses are available to provide proper supervision of unlicensed school personnel.

2. The school nurse shall select, train and supervise the specific individuals, who may administer medications. (When necessary to protect student health and safety, the school nurse is able to rescind such selection.).

3. The number of unlicensed school personnel to whom responsibility for medication administration may be delegated is determined by:
    a. The number, of unlicensed school personnel the school nurse can adequately supervise on a weekly basis, as determined by the school nurse;

b. The number of unlicensed school personnel necessary, in the nurse's judgment, to ensure that the medications are properly administered to each student.

4. The first time that unlicensed school personnel administer medication, the delegating nurse shall provide supervision.

5. The degree of supervision required for each student shall be determined by the school nurse after an evaluation of the appropriate factors involved in protecting the student's health, including but not limited to the following:
    a. Health condition and ability of the student;
    b. The extent of training and capability of the unlicensed school personnel to whom the medication is being delegated;
    c. The type of medication;
    d. The proximity and availability of the school nurse to the unlicensed person who is performing the medication administration.

6. For the individual child, the school nurse shall:
    a. Determine whether or not it is medically safe and appropriate to delegate medication administration
    b. Have a process in place which requires the school nurse to administer the first dose of the medication, if there is reason to believe there is a risk to the child as indicated by the health assessment, or the student has not previously received this medication in a setting;
    c. Establish a process to review the initial orders, possible side effects, adverse reactions and other pertinent information with the person to whom medication administration has been delegated;
    d. Provide ongoing supervision and consultation as needed to ensure that the student is receiving the medication appropriately. Supervision and consultation may include record review, on-site observation and/or assessment;
    e. Review all documentation pertaining to medication administration on a biweekly basis or more often if necessary.

7. For the purposes of 105 CMR 210.000, a Licensed Practical Nurse employed in the school setting functions under the general supervision of the school nurse who has delegating authority.

8. A current pharmaceutical reference is available for the school nurse's use.

<u>The Training of School Personnel Responsible for Administering Medications:</u>

1. All medications are administered only by properly trained and supervised school personnel under the direction of the school nurse.

2. At a minimum, the training program includes both content standards and a test of competency developed and approved by the Department of Public Health in consultation with the Board of Registration in Nursing.

3. Personnel designated to administer medications have been provided with the names and locations of school personnel who have documented certification in cardiopulmonary resuscitation (CPR). (Schools shall make every effort to have a minimum of two school staff members with documented certification in CPR present in each school building throughout the day).

4. The school nurse shall document the training and evidence of competency of unlicensed personnel designated to assume the responsibility for medication administration.

5. The school nurse shall provide a training review and information update at least annually for those school staff authorized to administer medications.

Administration of Prescription Medication by Unlicensed School Personnel in Instances When a Nurse is not Available

LABBB Collaborative is registered with the Department of Public Health for the purpose of permitting unlicensed school personnel to administer prescription medication on field trips and other special short term school events.

POLICY:

1. Every effort shall be made to obtain a nurse to accompany students on field trips, community trips, and vocational sites

2. Every effort shall be made to provide a nurse for overnight trips, whether students with standing or emergency medications are enrolled or not

3. It is up to the discretion of the recreational coordinator if a nurse is required on after school trips. Parents of students with medication shall be notified via the recreational coordinator if a nurse will not be accompanying an after school trip. The recreational coordinator and parents will then make arrangements accordingly

4. In the event that it is not possible for the school nurse to accompany student off campus trips during the school day, the school nurse shall delegate the administration of prescription medication to a responsible adult who has attended and passed the LABBB Medication Delegation presentation and exam

5. Written consent from the student's parent or guardian for the unlicensed personnel to administer the prescription medication shall be obtained

6. Administration of PRN medications/standing order medications by unlicensed personnel is not permitted

7. The school nurse shall instruct the named responsible adult on how to administer the prescription medication to the student. The school nurse shall document the medication instruction on a paper MAR or in the electronic iPass system

8. The named responsible adult shall document the administration of the prescription medication on a paper MAR specific to the student

Administration of Prescription Medication by a Nursing Assistant under direct supervision of a Registered Nurse

LABBB Collaborative employs a CNA who is permitted to work with students in the Health Office under direct supervision and direction of an RN.

POLICY:

1. The CNA will work alongside the RN and assist with activities per the RN's discretion (i.e. ADLs, vital signs, medication administration in accordance to DPH guidelines 105 CMR 210.003-221.007)

2. The CNA will receive continued training, education, and oversight via the RN

3. Any nursing activity that requires assessment will be conducted by the RN

4. The RN will determine whether or not it is medically safe and appropriate for the CNA to assist with said nursing activities

5. The RN will provide supervision and consultation to ensure all nursing activities are being done appropriately. This may include but is not limited to observation, documentation, and clinical review by evidence of competency

Administration of EpiPen (auto injector) by Unlicensed School Personnel

LABBB Collaborative shall be registered with the Department of Public Health for the limited purpose of permitting unlicensed, properly trained school personnel to administer epinephrine by auto injector to students with a diagnosed life threatening allergic reaction, when a school nurse is not immediately available.

POLICY:

1. The school nurse, in consultation with the school physician, manages and has final decision-making authority over this program

2. The school nurse selects the unlicensed personnel authorized to administer epinephrine in a life-threatening situation when he/she is not immediately available. The unlicensed personnel must meet the requirements set forth by 105 CMR 210.004(B)(2)

3. The unlicensed school personnel authorized to administer epinephrine by auto injector are trained by the school nurse and are tested for competency by a written exam and a practical exam in accordance with the standards and curriculum established by the MDPH
    a. The school nurse documents the training and testing of competency
    b. The school nurse provides a training review and update at least one time a year
    c. At a minimum the training shall include:
        i. Procedures for risk reduction
        ii. Recognition of the symptoms of a severe allergic reaction
        iii. The importance of following the medication administration plan
        iv. Proper use of the auto injector
        v. Requirements for proper storage and security
        vi. Notification of appropriate persons following administration
        vii. Record keeping

4. Nurses must maintain an updated list of the unlicensed school personnel in their school that have been trained to administer epinephrine in an emergency

5. Epinephrine shall be administered only in accordance with an Allergy Action Plan that is developed and updated annually by the school nurse, meaning unlicensed personnel may not administer EpiPens to students without Allergy Action Plans. The Allergy Action Plan shall satisfy the applicable requirements of 105 CMR 210.005(E) and 210.009(A)(6), which includes the following:

    a. A diagnosis by a physician that the student is at risk of a life threatening allergic reaction and a medication order containing proper dosage and indications for administration of epinephrine
    b. Written authorization by a parent or legal guardian

c. Home and emergency number for the parents/legal guardians, as well as the names and phone numbers of any other persons to be notified if the parents or guardians are unavailable
d. Identification of place/places where the epinephrine is to be stored, following consideration of the need for storage:
    i. At one or more places where the student may be most at risk
    ii. In such a manner as to allow rapid access by authorized persons, including possession by the student when appropriate
    iii. In a place accessible only to authorized persons. The storage locations should be secure, but not locked during those times when epinephrine is most likely to be administered, as determined by the school nurse
e. A list of the school personnel who would administer the epinephrine to the student in a life-threatening situation when a school nurse is not immediately available
f. An assessment of the student's readiness for self-administration and training, as appropriate
g. The school nurse shall initiate and update annually an Allergy Action Plan. Physician orders written on the Medication Authorization form may be substituted for the medication order section of the Allergy Action Plan. The Medication order form shall be attached to the Allergy Action Plan. A copy of the Allergy Action plan shall be kept with the students EpiPen.

6. The school nurse shall plan and work with the local EMS to assure the fastest possible response to an anaphylactic emergency

7. When epinephrine is administered, there shall be immediate notification of the local emergency medical services system (generally 911) followed by notification of the school nurse, student's parents or, if the parents are not available, any other designated persons, and the student's physician

8. The used epinephrine auto injector shall be safely stored and given to the emergency personnel for transport to the hospital with the student

9. If epinephrine is administered it shall be documented by the person who administered it on the medication record. The medication record shall meet the requirements of 105 CMR 210.009

10. If epinephrine is administered the Massachusetts Department of Public Health Report of EpiPen Administration form shall be completed and mailed to the School Health Unit in Boston

11. Post administration of epinephrine the school nurse will review the events, with all personnel involved and the classroom administrator, to determine the adequacy of response and to consider ways for reducing risks for the particular student

12. The MA Department of Public Health is permitted to inspect any record related to the administration of epinephrine without prior notice, to ensure compliance with 105 CMR 210.100

13. Epinephrine can be administered in accordance with these regulations in before and after school programs offered or provided by a school, such as athletic programs, special school events and school-sponsored programs on weekends, provided that the public school district or non-public school is registered with the Department pursuant to section 210.100 (A) and meets the requirements set forth in section 210.000 (B) and provided the following requirements are met:

    a. The school committee or chief administrative officer in a non-public school has approved in the policy developed in accordance with section 210.100 (A) (1), administration of epinephrine in such programs. The policy has identified the school official(s), along with a school nurse for each school designated by the school nurse leader for determining which before and after school programs and special events are to be covered by the policy.

    b. The designated school nurse approves administration of epinephrine in that program and selects the properly trained person(s) to administer epinephrine.

    c. The school complies with the requirements of 105 CMR 210.100 (A), including immediate notification of emergency medical services following administration of epinephrine.

    d. The program is not licensed by another state agency, in which case the regulations promulgated by that state agency will apply.

    e. In the event the student is accompanied by school personnel from the sending school, such personnel, whenever possible, will assume responsibility for ensuring that the epinephrine is brought, properly stored and administered as necessary, in accordance with the medication administration plan developed by the sending school.

    f. In the event the student is not accompanied by school personnel from the sending school or such personnel are not trained in the administration of epinephrine, the receiving school may, in its discretion, assume responsibility for administering epinephrine, provided that:

    g. The designated school nurse in the receiving school is provided with adequate prior notice of the request, at least one week in advance unless otherwise specified by the designated school nurse

    h. The designated school nurse in the receiving school approves administration of epinephrine for that student

i. The student provides the designated school nurse or the person(s) selected by the designated school nurse to administer epinephrine with the medication to be administered.

j. When the receiving school assumes responsibility for administering epinephrine, whenever possible, the student shall provide the designated school nurse in the receiving school with a copy of the medication administration plan developed in accordance with section 105 CMR 210.005 (E) in timely fashion in accordance with procedures established by the nurse.

k. If no medication administration plan is provided, the student at a minimum shall provide to the designated school nurse in the receiving school:
    i. Written authorization and emergency phone numbers from a parent or guardian
    ii. A copy of a medication order from a licensed provider
    iii. Any specific indications or instructions for the administration

Administration and Disposal of Epi-Pen/Epi-Pen Jr.

Epinephrine is the primary emergency treatment available for an anaphylactic reaction. It must be given as soon as possible to reduce symptoms and buy time to transport a student to an emergency facility for additional care.

PROCEDURE:

1. Identify student by first and last name
2. Check written order and label on medication
3. If TIME PERMITS remove clothing from leg area –if not Epi-Pen CAN BE GIVEN through clothing
4. Remove yellow or green cap from Epi-Pen carrying case
5. Remove Epi-Pen from case
6. Grasp Epi-Pen with black tip pointing downward
7. Pull off grey activation cap
8. Jab black tip firmly into OUTER THIGH and HOLD on thigh for approximately 10 seconds
9. Remove Epi-Pen and massage injection area for 10 seconds
10. Carefully place used Epi-Pen, needle end first, into the storage tube
11. Screw the yellow or green cap of the storage tube on completely— (this automatically bends back the needle and secures the pen so it will not fall out)
12. CALL 911—REQUEST ADVANCED LIFE SUPPORT UNIT. If not already delegated to second adult
13. Send the secured, used Epi-Pen with the student to the Emergency Department

Preventative Health Care

DOE Criterion 16.7
603 CMR 18.05(9)(f&h)

POLICY: Annual Medical Examinations

1. M.G.L. c.71, s.57 and related amendments and regulations (105 CMR 200.000–200.920) requires physical examinations of schoolchildren:
    a. Prior to first school entry and at a minimum every three years after
    b. Annually for students who are participating in competitive sports
    c. Annually for students younger than 16 and older than 14 if they will go to work
    d. Students not meeting regulation shall be excluded from attending school after **three** requests for physical examination documentation have been made by the school nurse to the parent/guardians
    e. A student transferred 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
    f. Students entering who are homeless will **not** be required to submit a physical exam to begin school

2. The school health program should expect that the physical examination and ongoing health assessments will be performed by the families own primary care provider

3. Out of state physical examinations may only be accepted if signed by a **licensed physician**

4. If a child does not have a primary care provider, every effort should be made to link him/her with a primary care provider in the community or the contracted school physician

5. The school physician may be required to provide services such as physical examinations, in hardship cases, for children who do not have access to a private primary care provider (M.G.L. c.71, s.53 and s.57)

6. The program nurse is responsible for obtaining and keeping the records of this documentation

Health Screenings

POLICY:

School nurses will ensure that the results of annual health screenings are maintained and documented in accordance with the MA Department of Public Health guidelines. This should include, but not be limited to, contact with the students, parents/guardians, L.E.A., health care providers, social service agencies, the school physician and any other responsible parties. The Massachusetts D.P.H guidelines for specific screenings are as outlined below:

BMI Screening Procedure: 105 CMR 200.500: (Annual Assessment of Physical Growth and Development**)**

Each school committee shall ensure that school personnel trained in accordance with guidelines of the DPH shall do measurement of Body Mass Index (BMI) and corresponding percentile of each student in grades 1, 4, 7, and 10 (or, in the case of ungraded classrooms, by a student's 7th, 10th, 13th and 16th birthday).

Prior notice of the screening and the benefits of the screening shall be provided to the parent or legal guardian by any reasonable means

1. Equipment: Equipment should include a beam balance scale that has been calibrated with non-detachable weights and a non-stretchable tape attached to a vertical, flat surface such as a wall., and a stadiometer that has a horizontal head piece at least three inches wide

2. Every effort shall be made to respect the privacy of the student during the screening process

3. A report of each student's BMI and percentile, along with easily understood informational and explanatory materials provided or approved by the Department on BMI, healthy eating, and physical activity shall be mailed or otherwise directly communicated in writing to the parent or legal guardian of the student. The materials shall indicate that questions about healthy weight should be discussed with the student's primary care provider

4. Parents or guardians should be encouraged to consult their child's primary care provider if the student's height/weight measurements are below the 5th percentile BMI, above the 85th percentile, or indicate a possible deviation from an expected growth curve for that child. (The school nurse is responsible for referring students via their parents or guardians for follow-up with the child's healthcare provider)

5. The Department of Public Health shall be provided annually with student BMI data, by school or school district, as specified in guidelines of the Department. The DPH shall be notified by **July 15th** each year

6. A copy of the student's BMI shall be maintained in the student's school health record. With the consent of the parent or legal guardian, a copy shall be provided to the student's primary care provider

7. Parent(s) and legal guardian(s) shall be provided with an opportunity to request, in writing, that their child not participate in the program. A rationale for opt-out does not need to be provided

8. More detailed info on BMI screenings as well as resources and formatted letters are available at the following site: http://www.mass.gov/Eeohhs2/docs/dph/mass_in_motion/community_school_screening.pdf

Calculating BMI and Recording Measurements

1. BMI for students is to be calculated and recorded, using proper tools for calculating BMI. Use one of the following:
    a. BMI Table, found online at the following CDC website: http://apps.nccd.cdc.gov/dnpabmi/
    b. BMI Wheel
    c. BMI calculation computer software
    d. BMI Calculator (http://apps.nccd.cdc.gov/dnpabmi/Calculator.aspx)
    e. Children's BMI Tool for Schools (http://www.cdc.gov/healthyweight/assessing/bmi/childrens_bmi/tool_for_schools.html)

2. Plot results in a gender-appropriate BMI-for-Age chart
    a. BMI-for-Age Percentile charts are available on the CDC's website http://www.cdc.gov/growthcharts/clinical_charts.htm

Hearing Screening

105 CMR 200.000

1. In the absence of an exemption on religious grounds, the hearing of every public school child be screened:

    a. In the year of school entry and annually through grade 3 (or by age 9 in the case of ungraded classrooms)

    b. Once in grades 6 through 8 (ages 12 through 14 in the case of ungraded classrooms)

    c. Once in grades 9 through 12 (ages 15 through 18 in the case of ungraded classrooms).

2. The purpose of the hearing-screening program is to identify children with a significant hearing impairment in the educational setting who would otherwise not have been identified

3. Equipment: The hearing of each student shall be tested by means of some form of discrete frequency hearing test such as the Massachusetts Hearing Test or comparable method approved by the Department of Public Health

4. Referral and Follow-up: Appropriate medical and audiological follow-up/referrals are essential to an effective system. Students who fail the initial screening **must be retested** before being considered a candidate for a notice to the parent or guardian. A repeat failure of the screening indicates that there is sufficient deviation from the norm in the results of the screening test to justify parental notification

5. Record Keeping and Documentation: All results of the hearing screening program (passes as well as failures) should be recorded on the child's School Health Record. If the referral confirms a hearing problem, the School Health Record should also indicate the nature of the abnormality as determined by the specialist, and a complete record of any treatment prescribed

    a. The school nurse will make every attempt to follow-up with the family as to whether a determination was made of the apparent hearing problem

6. If needed, classroom teachers should be made aware and educational adjustments should be made

Vision Screening

The purpose of vision screening is to identify children who may have a vision impairment that might prevent them from obtaining maximum benefit from their educational opportunities.

1. In the absence of an exemption on religious grounds, the vision of students in the public schools should be screened:

    a. Upon entering kindergarten or within thirty days after school entry—the parent or guardian of each kindergarten child shall present certification that the student within the previous 12 months has passed a vision screening conducted by personnel approved by the Department (M.G.L,.c. 71, s. 57)

    b. In the year of school entry

    c. Annually through grade 5 (or by age 11 in ungraded classrooms)

    d. Once in grades 6 through 8 (or ages 12 through 14 in ungraded classrooms)

    e. Once in grades 9 through 12 (or ages 15 through 18 in ungraded classrooms)

2. Vision screenings should be done using the official Massachusetts Vision Acuity Test or another comparable method approved by the DPH

3. Massachusetts Vision Test protocol currently prescribes 3 types of vision based on age. The complete protocol may be found on the DPH School Health Unit website at http://www.mass.gov/dph/fch/schoolhealth/

4. Parents of all children who do not perform satisfactorily on a vision screening and subsequent re-test are to be notified in writing by the school nurse. Results must be mailed home

5. For children who fail the screening and for children diagnosed with neurodevelopmental delay, evidence of a comprehensive eye examination meeting the requirements of c. 71, s. 57 shall be provided to the school

6. Record Keeping and Documentation: All results of the vision screening program (passes as well as failures) should be recorded on the child's School Health Record. If the referral confirms a vision problem, the nature of the abnormality as determined by the specialist and a complete record of any treatment prescribed should be noted in the School Health Record

a. The school nurse will make every attempt to follow-up with the family as to whether a determination was made of the apparent vision problem

b. If needed, classroom teachers should be made aware and educational adjustments should be made

Postural and Scoliosis Screening

1. The purpose of postural screening is threefold: (1) to detect early signs of spinal problems that should have further medical evaluation, (2) to provide regular monitoring, and (3) to reduce the need for surgical remedies. Screening must be done annually in grades 5 through 9 (approximately ages 10-15) because people in this age range are in a growth spurt, and they mature at different rates

2. Procedure: The screening program has two components: (1) an initial educational session with each class held by a screener, and (2) the screening itself. An educational session includes information on when, where, and how the screening will be done; what the screener looks for; special clothes to be worn during the screening; a short discussion of postural problems; review of other information; and distribution of the initial letter to parents. The screening itself should include assessments from five different views

    a. Girls and boys are to be screened separately, with an adult screener of the same gender as the student if possible

    b. For optimal viewing of the spine, the student's back should be bare. Therefore, girls are asked to wear halter-tops, sports bra, or other top that allows for an assessment of the back and shorts or a bathing suit (extra tops should be available)

3. Referrals and Follow-up: Children with positive findings should be scheduled for a re-screening. If another person who does the re-screening confirms a positive finding, the school nurse should contact the family by phone and letter

4. Record Keeping and Documentation: (1) The MDPH postural screening worksheet will be used during the screening procedure. It includes positions the student is viewed by the screener, any positive findings, and follow-up/action steps warranted. All observations and recommendations will be documented. (2) The postural screening summary report will be completed on the number of students screened, number of students under treatment, number referred for re-screening, results of physicians' examinations, and comments. A single annual summary postural screening is to be submitted to the School Health Unit of MDPH annually

Immunizations

POLICY:

Massachusetts' immunization regulations specify minimum immunization requirements for enrollment in school (105 CMR 220.000). The law and regulations provide for exclusion of students from school if immunizations are not up to date, but permit exemptions for medical and religious reasons.

All students entering collaborative programs are required to have up-to-date immunization records and will not be admitted without appropriate documentation unless exempt for sincere religious or medical reasons. Signed documentation from the child's primary care provider must be provided to the health office. If the documentation is from out of state, it must be signed by a licensed physician. For students already enrolled in collaborative programs, the following immunization schedule will be followed as recommended by the Massachusetts Department of Public Health.

Whenever possible, the student must obtain the required immunization prior to registration. However, a student subject to 105 CMR 220.700 may be registered without a certificate of immunization, provided that the student supplies a certificate of immunization within 30 days of registration and provided, further, that the secondary school or postsecondary institution has policies and procedures for ascertaining which students have failed to provide the required certification within 30 days and for taking appropriate follow up action to ensure compliance with 105 CMR 220.700.

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
Immunization Requirements for Entry in the 2018-2019 School Year

Immunization	Daycare/Preschool	Kindergarten-Grade 6	Grade 7 – Grade 12	College/Age 18+
Hepatitis B	3 doses	3 doses	3 doses	3 doses
DtaP/DTP	4 doses	5 doses	5 doses	5 doses
Polio (IPV)	3 doses	4 doses	4 doses	-
Hib	1-4 doses	-	-	-
MMR	1 dose measles 1 dose mumps 1 dose rubella	2 doses measles 2 doses mumps 2 doses rubella	2 doses measles 2 doses mumps 2 doses rubella	2 doses measles 2 doses mumps 2 doses rubella
Varicella	1 dose	2 doses	2 doses	2 doses
Tdap	-	-	1 dose	1 dose
Meningococcal	-	-	1 dose	1 dose

LABBB Collaborative provides programs for a number of students ages 18 to 22 years and will follow the same guidelines for students entering college in regard to immunizations

Although not required for entry to school, additional vaccinations may be required for employment at certain vocational worksites (i.e. influenza vaccine)

PROCEDURE:

The school nurses' responsibility is to:

1. Work with student's parents/guardians, sending districts, family physicians, the LABBB Collaborative physician, and the local boards of health in seeing that student's immunizations are up-to-date

2. Maintain Student Health Records to record immunizations as well as other required information

Needlesticks

POLICY:

1. All staff and students experiencing unintended needlesticks shall be seen by the school nurse and their primary care provider or an emergency provider

2. The nurse shall log all needlestick injuries

3. The staff member/student who used the needle before the injury must be tested for bloodborne diseases within 48 hours to allow the affected person time to begin antiretroviral therapies within 72 hours if needed. The results of this testing must be shared with the involved staff member/student and the health office

Emergency First Aid and Medical Treatment

DOE Criterion 16.4
603 CMR 18.05(9)(e)
DPH School Health Manual

First aid is defined as the immediate and temporary care provided to the victim of an injury or illness until the service of a physician can be obtained. This care includes cardiopulmonary resuscitation (CPR), abdominal thrusts (Heimlich maneuver), and other life-saving techniques. Within the school setting, staff members have a duty to provide reasonable assistance to an injured or ill student

POLICY:

Emergency first aid and emergency medical treatment is administered to students who have written authorization from a parent, which is updated annually. It should be noted that school staff that provide first aid in good faith to a student in an emergency are protected from civil liability by the following provision of the M.G.L. c.71, s, 55A:

> *No public school teacher and no collaborative school teacher, no principal, secretary to the principal, nurse or other public school or collaborative school employee who, in good faith, renders emergency first aid or transportation to a student who has become injured or incapacitated in a public school or collaborative school building or on the grounds thereof shall be liable in a suit for damages as a result of his acts or omissions either for such first aid or as a result of providing emergency transportation to a place of safety, nor shall such person be liable to a hospital for its expenses if under such emergency conditions he causes the admission of such injured or incapacitated student, nor shall such person be subject to any disciplinary action by the school committee, or collaborative board of such collaborative for such emergency first aid or transportation.*

Trainings

CPR and First Aid training is required of direct service personnel. Staff members are required to be certified in CPR and First Aid training **every two years**. Staff must also participate in Emergency Procedures training *annually* including seizure and allergy training

Unless they can provide proof of current certification they might have received prior to the date of hire, new staff will be afforded the opportunity to participate in off-site CPR & First Aid training.

Supplies will be stored in an area of easy access to the school nurse. Staff will be informed of the location and will be allowed access for the purposes of administering first aid to students in the absence of the nurse. The first aid supplies are not to be used by staff for routine self-care. Recommended supplies include:

- 4x4 gauze pads
- 2x2 gauze pads
- 4 inch roll gauze bandage
- 2 inch roll gauze bandage
- Triangular muslin bandages
- Sterile eye wash
- 1 inch roll bandage tape
- Scissors
- Safety pins
- Thermometer(s)
- Flashlight with batteries
- Disposable gloves (vinyl)
- Rubber bulb syringe
- Soap
- Small plastic cups
- Paper towels
- Sanitary pads
- Tissues
- Tongue depressors
- Disinfectant (surfaces)
- Cotton swabs
- Record forms

Head Injuries

The following policy was developed in accordance with M.G.L. c. 111, §222.

Advanced concussion training is required and documented annually for the athletic director, athletic coaches, extra-curricular activity coordinators, and school nurses. Students and parents of students participating in school athletic activities are required to complete online training regarding concussions annually. Students may receive a waiver from the health office staff in the event that they are unable to complete and understand the online trainings

Physicals and a concussion screening form will be collected and reviewed each school year in which a student participates in sports or extra-curricular activities with the potential for head injury

Suspected concussions that occur during school activities will be reported to the health office staff and to parents/guardians. Parents/guardians will be responsible for having the student evaluated by a healthcare provider and for returning documentation regarding the evaluation. Head injuries occurring outside of the school day or non-school related athletic activities will be reported to the health office to allow for health and safety assessments as needed

A plan for returning to activity will be developed by the student's care provider, health office staff, athletic director, and coach/activity coordinator

Failure to provide a physical, concussion screening, and post concussion/suspected concussion documentation will result in exclusion from sports and activities

VP Shunt Malfunction

POLICY/PROCEDURE:

If a student has a documented VP shunt and receives a head injury, alert the school nurse if the following symptoms are observed:

1. Behavior (i.e. irritability)
2. Restlessness
3. Crying
4. Lethargy
5. Loss of appetite
6. Decrease in activity
7. Jerkiness
8. Headaches
9. Fever

Notify a physician immediately if the following symptoms are observed:

1. Vomiting
2. Stiff neck
3. Increased head size
4. Abnormal eye movements
5. Seizure activity

Responding to Emergencies

Emergency phone numbers are posted by every telephone. These numbers include, but are not limited to the following:

1.)	Fire department/EMS	911/781-862-0270 from cell phone
2.)	Police department	911/ 781-862-0270 from cell phone
3.)	Poison prevention center	800-222-1222
4.)	Local hospital emergency room	Lahey Clinic Burlington, MA 781-744-5100

A health emergency may occur in any school at any time: children can become seriously ill or injure themselves in a number of settings. It is essential that staff follow procedures learned in their CPR and First Aid and in-service training in assessing whether an emergency has occurred.

Emergencies can be classified in three major categories:

1. Life threatening or potentially disabling: Since they can cause death or disability within minutes, they require immediately intervention, medical care, and usually hospitalization

2. 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

3. Non-life threatening: These are defined as any injury or illness that may affect the general health of a person, for example, fever, stomachache, seizures, broken bones, cuts, etc. The person should be evaluated as soon as possible or within a few hours at maximum

In either a life-threatening or potentially disabling situation, follow these general guidelines during the administration of emergency first aid:

1. Do not leave the ill/injured person alone

2. Do not move the ill/injured person unless in more danger if left in that location

3. Remain calm

4. Notify the school nurse immediately

5. Notify the site administrator immediately

6. Request others leave area quickly and quietly

7. Direct a responsible person to call 911 and activate the local EMS

a. The school secretary should place the call, if available, unless otherwise directed by the school nurse or the site administrator

b. The person placing the call must stay on the phone line until all information is obtained

c. Briefly describe the emergency situation

d. State name of caller, specific school location within the building, and exact address

e. Tell EMS that a staff member will meet them at a specific entrance to the school building or grounds if available

f. Provide EMS with the phone number of the school

g. Make sure the information you provide is simple and specific

h. Make sure EMS has all necessary information before hanging up the phone

i. Call back EMS for reassessment if necessary (e.g., person has stopped breathing; the presence or absence of respirations and/or a pulse is important for a proper EMS response)

The following four major levels of consciousness of a patient is also useful information for the EMS units:

1. Alert/Oriented: Patient converses freely. Knows their name, date, location, time, and what happened. Initiates conversation, asks questions

2. Verbal: Patient responds to questions or commands. Does not initiate conversations or ask questions

3. Pain Response: Responds appropriately to physical stimuli. May be conscious or unconscious at this stage

4. Unresponsive: Does not respond to physical stimuli. Contact EMS immediately

EMS Calls

Unless the nature of the illness/injury is minor, it is prudent to activate the local EMS system to respond to the incident. If the injury/illness is later determined to be relatively minor by the school nurse or other trained personnel, the EMS response can be canceled or the EMS units can clear the scene after they evaluate the situation. It is important to note that it is far easier for a school nurse to cancel a responding ambulance than to wait an additional period of time to summon an ambulance and then await its arrival.

PROCEDURE:

While EMS is being activated, a responsible designee should:

1. Pull the student's emergency information card/sheet

2. Notify the parent or guardian that a serious injury or illness has occurred and their child is being transported by ambulance to the hospital (give name and location of hospital)

3. Prepare list of diagnoses, medications, and last known hospital admission to give to EMS

Upon arrival, give the emergency information card/sheet to EMS workers. It contains information and signatures that may expedite the treatment of the student

One staff person (preferably a person that witnessed the emergency situation) should follow the student to the hospital and be available to medical staff and parents

After seeing to the appropriate care of the student:

1. Complete applicable incident reports

2. In the event of hospitalization:

    a. Notify the sending school district and the Department of Education

The table on the following page displays a list of injuries/conditions requiring treatment, with steps to follow for each category. This list is not all-inclusive. Many situations require nursing judgment but it is prudent to call EMS in any serious incident.

Guidelines for Illness/Injury Requiring Treatment

Category of Injury/Condition	**Problems Requiring This Treatment**	**Emergency Plan – Steps to Follow**
Life-threatening or potentially disabling. Immediate treatment and mobilization of EMS needed.	• Acute airway obstruction • Cardiac or respiratory arrest • Near drowning • Massive hemorrhage (external or Internal) • Severe allergic reaction - anaphylaxis • Choking on food or other objects • Attempted suicide • Poisoning (internal or external) • Severe shock • Penetrating/crushing chest wounds • Uncontrolled convulsion/seizures • Heat stroke • Chemical burns of the eyes • Major burns • Neck or back injury • Spider/snake bites • Bee/wasp/hornet/yellow-jacket stings with anaphylaxis • Internal bleeding • Coronary occlusion • Fractures and dislocations • Burns with blisters • Drug overdose • Severe abdominal pain/acute projectile vomiting • Severe depression or anxiety • Threatened abortion • Penetrating eye injury • Head injury with loss of consciousness • VP shunt malfunction • Puncture wound • Threatened suicide	1. Initiate or direct a responsible person to call Emergency Services/911. 2. School nurse or trained staff person MUST immediately respond to the victim. 3. Have someone notify the nurse if she is not with victim. 4. Have someone notify the administrator.

	• Seizure – cause unknown	
Non-life threatening emergencies. Medical consultation is desirable within an hour.	• Accidental loss of tooth • Lacerations – bleeding controlled • Animal, snake, insect bites and stings • (without anaphylaxis) • Acute emotional state • Moderate reaction to drugs • High fever (above 103F) • Non-penetrating eye injury • Frostbite	1. Contact nurse or, in her absence administrator. 2. Nurse or trained staff person to assess extent of injury. 3. Notify parent. Activate local EMS, if needed.
School nurse, trained staff, parent consultation needed	• Convulsion in known epileptic • Insulin reaction in diabetic – if patient is conscious, alert • Intermittent abdominal pain • Fever 100-103F • Sprains • Fainting	1. Call nurse or trained staff person for assessment. 2. Notify parent and refer to medical facility if necessary.
Minor injuries/illnesses – can be handled by trained staff person following standard procedures	• Abrasions • Minor burns – no blisters • Nose bleeds – minor, less than 10 minutes	1. Refer student to nurse or trained staff person. Child may remain in school.

Anaphylaxis

Anaphylaxis is one of the most serious and life-threatening emergency situations to which school personnel may have to respond. It is an allergic reaction that may be triggered by an insect bite, a drug allergy, or a food allergy. This generalized whole-body allergic reaction requires prompt intervention, proper management, and prompt transportation to an appropriate health care facility. Anaphylaxis is always an emergency in which delayed intervention can be fatal, but prompt reaction and appropriate intervention can result in an effective cure.

POLICY:

A person may exhibit any or all of the following signs and symptoms within a short time (5 minutes), or the reaction may be delayed for several hours. If a person is known to have a severe sensitivity and severe allergic reactions, do not wait for signs and symptoms to become worse, administer the weight appropriate Epi-pen (see standing orders) and call for an ambulance as soon as possible. 911 must be called as soon as possible in the event of anaphylaxis, whether or not an EpiPen is given. Nurses may administer a second dose of weight-appropriate epinephrine if the student becomes unstable before EMS arrival. Signs and symptoms of anaphylaxis may include any or all of the following, and must include two body systems to be considered anaphylaxis:

Skin:	Cold to touch, may be clammy and moist, itching, hives, swelling of lips
Color:	Pale at first, then mottled or bluish
Respiration:	Wheezy, change in voice quality due to swelling of larynx, feeling of fullness in throat, breathing may cease
Pulse:	Rapid, weak
Blood pressure:	Low, progressively lower, or unattainable
Other:	Restlessness, severe headache, nausea, vomiting, diarrhea, loss of consciousness, swelling of eyelids

Protection from Exposure Based on Allergy to Food, Chemical, or Other Material

DESE Criterion 16.11

In the event a student of any LABBB Collaborative program has an allergy to food, chemical, or any other materials as reported by a physician/medical assessment, the school nurse, Program Coordinator, and all other designated staff will make every attempt to remove the allergy causing items from the student's environment. The school nurse should initiate the allergy risk reduction plan if warranted. This may include notifying parents of other students and asking them to comply with implementing an allergy free zone at the program. School nurses and other staff should use vinyl gloves in order to avoid the possibility of exposure to latex for any student that is known to have a latex allergy.

Management of Obstructed Airway

POLICY:

1. Treatment of student with obstructed airway will be instituted immediately

2. All staff will be trained in managing obstructed airway

3. Parent will be notified if Heimlich maneuver is initiated and request that student receive further evaluation by an MD (if 911 is **not** called)

4. At the completion of any obstructed airway incident, an accident report will be completed and a copy forwarded to the administrator

PROCEDURE:

Determine if obstruction is partial or complete

1. *Partial airway obstruction:* Air exchange occurs. Student will be coughing and may be wheezing.

    a. Encourage coughing to dislodge foreign body

    b. Do **not** perform Heimlich maneuver if only partial obstruction is present

2. *Complete airway obstruction:* No or minimal air exchange. Person is unable to speak. May clutch at neck.

    a. Perform Heimlich maneuver

    b. Call ambulance for complete obstruction

    c. If person is conscious they should be standing or sitting

    d. Stand behind person and wrap your arms around the person's waist

    e. Grasp one fist with the other hand and place the thumb side of your fist against the person's abdomen. Landmark: place fist below the ribs and above the navel

    f. Press your fist into the person's abdomen with a quick upward thrust, repeating as many times as necessary to clear the obstruction

    g. In order for the thrust to be effective, make sure your body is up against the person (for an unconscious person or student who is wheelchair bound, lay them on the floor on their back and start CPR)

h. Check for foreign body; remove if visible prior to administering breathes during CPR

Ingestion of Poisons or Foreign Substances

POLICY:

1. Appropriate and immediate treatment will be provided
2. The Poison Control Center should be called for direction and assistance
3. Physician will be called
4. Parents will be notified as soon as possible regarding the incident and intervention
5. Accident reports will be completed. A copy will be provided to the Director

PROCEDURE FOR KNOWN SUBSTANCE:

1. Call Poison Control Center (800-222-1222) and give the following:
    a. Name of substance ingested
    b. Ingredients listed
    c. Approximate amount ingested
    d. Age and weight of student
    e. Known allergies
2. Obtain recommendations for immediate action and follow-up. This may include assistance to vomit
3. Institute actions that can be taken without a physician's order
4. Contact physician, explain circumstances, and convey Poison Control Center recommendations
5. Call ambulance if ordered by the physician or poison control
6. Document the incident

PROCEDURE FOR INGESTION OF UNKNOWN SUBSTANCE:

1. Examine mouth for signs of burns or any residual substance that may identify substance

2. Call ambulance for immediate transport
3. If some of the substance is found, send to the hospital with student
4. Completely document the incident

Management of Seizures

POLICY:

1. During a seizure the student's physical safety will be ensured at all times.

2. For any student whose seizure lasts more than 5 minutes an ambulance will be called. (An exception will be made if a physician specifies otherwise in student-specific seizure plan)

3. Parents will be notified whenever any seizure activity has taken place

4. Two staff members should always be present when a student is seizing, one to maintain the safety of the student and one to make phone calls if necessary

PROCEDURES:

1. As soon as seizure activity is noticed, establish a safe position for the student either in a chair or by carefully lowering the student to the floor

2. Remove any furniture or equipment on which the student might hurt himself

3. Loosen clothing around neck and chest and release body jacket

4. Turn student to the side or tip head slightly forward if in a sitting position

5. Do not place anything in the student's mouth, such as tongue blade

6. Do not try to restrict student's movements

7. Stay with the student until the motor segment of the seizure is over

8. During the seizure observe the characteristics of the activity including the following:

    a. Precipitating factors such as fever, menses, bright lights, loud noises etc.

    b. Time of onset

    c. Aura

    d. Clinical progression of the seizure activity, i.e. from right arm twitching to generalized activity, skin pallor, cyanosis of tongue to circumoral area

    e. Loss of consciousness

f. Duration of motor activities

g. Postictal state (sleepy, lethargic, confusion, crying, vocalizing, headache)

As per policy, inform parents that seizure activity has occurred. Nurses must document all observed seizure activity in the student's record. If a nurse is not present, teaching staff must complete a seizure reporting form for non-licensed personnel.

Students Requiring Diastat

POLICY:

1. Diastat orders and seizure plans shall be renewed annually. If a Diastat order is not to be renewed, written notice of discontinuation from the student's provider is required

2. Students prescribed Diastat shall have access to a nurse during the school day. Every effort will be made to send a nurse when a student with Diastat is traveling off campus during school hours

3. Parents/guardians are responsible for sending unexpired Diastat to school

4. Diastat shall be kept in a locked cabinet, with exception to times when a nurse is travelling off-campus with the student (The nurse shall then carry it on his/her person in a bag)

Fire or Other Emergency

POLICY:

Program administrators are responsible for:

1. Formulating a plan for the protection and evacuation of all persons in the event of a fire. The plan should be formulated with the assistance of the local fire department

2. Ensuring that classroom staff receive proper instructions on fire drill procedure specified for the room or area in which that person carries out his/her duties before assuming such duties

3. Ensuring that every student in all classrooms have been advised of the fire drill procedure or shall take part in a fire drill within three days after entering school

The head of the fire department (or designee) visit the school at least four times each year for the purpose of conducting fire drills and questioning the teachers and staff. The drills are conducted without advance warning to school personnel other than the program administrator or person in charge at the time and are recorded in the Evacuation Drill Log.

Failure to Reach Parent in an Emergency Situation

POLICY:

If staff has been unable to contact parents/guardians or emergency contacts as detailed on the students emergency information sheet, the Program Coordinator or designee will see that a staff person is designated to stay with the student, whether that is at the school, an evacuation location, or a hospital. Staff will continue to make every effort to contact the student's family. If guardians are not contacted in time for emergency medical decisions, school nurse may serve as proxy. In the event a significant period of time has passed without notification and the student is in jeopardy of not joining his/her family during the evening hours, the Program Coordinator or designee may use good judgment in deciding whether to follow Reporting Abuse & Neglect procedures.

Hospitalization

The following is a list of reasons why staff should call an ambulance to transport a student to an acute care facility:

1. Any significant medical emergency that is a concern to the school nurse or clinical staff

2. An extended restraint which lasts for a period of 20 minutes or longer and where the child's response is concerning to school and clinical staff

3. A student is hearing voices, seeing things that don't exist, or is acting in a concerning way that is not consistent with his/her baseline behavior

4. A child is in a state of crisis as determined by clinical and related school staff

5. A child is threatening to kill or seriously harm him/herself and is unable to contract for safety

Staff will follow notification procedures outlined below:

1. Notify the parent and school district by phone and in writing

2. Notify the DPH

3. File all notifications and Incident Reports in Student Record

Return to Program Following Hospitalization-Psychiatric or Medical

Program staff should have ongoing communication with outside service providers for the student in their program. When a student is hospitalized, it is imperative that the staff obtain information regarding their hospitalization, including:

1. Reason for admission

2. Course of treatment

3. Medication regimes and appropriate medication order forms issued by the physician

4. Discharge diagnosis/summary

5. Any recommendations for re-entrance to the program

At the discretion of the Program Director, a re-entry meeting may be required before the student returns to the program to address specific accommodations that may need to be implemented. *Suggested team members: School Nurse, Guidance Counselor, Adjustment Counselor, Administrator, Teacher, and Parent.*

Comfort Care/DNR Protocol

Children with terminal illnesses are attending school in increasing numbers. As the status of the child's health declines a family may make a decision not to prolong the child's life and request a do not resuscitate order (DNR)

1. A DNR order must be executed by a physician, authorized nurse practitioner, or authorized physician assistant, with the consent of the parent or guardian and issued according to the current standard of care

2. If a child has a DNR order, he or she should also have a completed Comfort Care/DNR Order Verification Form for emergency response and ambulance transport. This form can be downloaded at www.mass.gov/dph/oems (If this form is not fully completed and signed, emergency response personnel will be obligated to provide emergency treatment including resuscitation.)

POLICY:

1. A child with a DNR order should only be placed in a school with a full time nurse

2. The local emergency services should be informed (with written parent permission) that there is a student in the specific building with a DNR order and Comfort care/DNR verification form

3. An Individualized Health Care Plan should be developed with the family and in collaboration with the child's physician. The plan should include:

    a. how the child will be moved to the health room or other designated area if serious distress or death should occur at another location in the school
    b. what, if any, comfort measures will be given to the child
    c. protocols for notification of the family
    d. who will do the pronouncement of death if the child should die
    e. how the deceased child will be removed from the school (by law, EMS providers are not allowed to move the deceased)
    f. What will happen if the child is in distress but not in eminent danger of death such as immediate consultation with the parents and, consistent with the plan, contact with EMS. The type of care EMS will administer is spelled out on the following website www.mass.gov/dph/oems

4. When a plan is in place the School Nurse should convey the plan to the appropriate school personnel

If a death occurs, a crisis team must be activated immediately to help students and staff cope with the loss. Special consideration should be given to students and staff that witnessed the death especially if no resuscitative treatment was given.

Nutrition and Diet

POLICY:

1. A physician's diet sheet will be completed and signed by the physician at the beginning of the school year or as changes occur

2. Parent/guardian shall also sign diet sheet. A new sheet will be completed each calendar year or as necessary

Each child's nutritional intake will be monitored to ensure proper nutrition and hydration.

Individualized Health Care Plan

POLICY:

The development of the Individualized Health Care Plan (IHCP) is a collaborative process among 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 for student's with chronic health conditions. The school nurse is responsible for coordinating and/or developing the IHCP. The school nurse, along with other school health personnel, serves as the link between child/family and other school personnel, and between school personnel and community health care providers in primary and tertiary care settings.

1. The IHCP is individualized to reflect the child's specific medical, nursing, and educational needs and it includes a plan for review and revision. For children who have an IEP, the health care plan should be considered in light of the IEP's goals and objectives. The IHCP should be considered an attachment to the IEP to promote coordination of necessary health care services within the school setting

2. An IHCP is designed to ensure that the child receives the health service he or she needs during the school day (such as treatments, health assessments, or administration of medication). The plan should provide for the performance of health care procedures in a manner that minimizes disruption to the educational process to the individual student and other students present

3. The IHCP includes policies and procedures 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

4. School personnel are trained to monitor children with chronic health conditions to ensure that they receive appropriate and timely care as well as to prevent emergencies or intervene should an emergency arise. The preparation and implementation of an IHCP should be considered for students with, but not limited to, the following lists of conditions:
    a. Asthma
    b. Diabetes
    c. Hemophilia
    d. Sickle Cell Anemia
    e. Spina Bifida (Myelodysplasia)
    f. Technology dependent children
    g. Seizure disorders

PROCEDURE:

The team should develop and document strategies for nursing intervention and the care and monitoring of each student. The Individualized Health Care plan should be completed by the school nurse, in collaboration with the family, provider, and other caregivers, for any child or adolescent requiring special health services in the school setting, and comprised of the following:

1. Pertinent information about the child such as names of parents, addresses, and phone numbers. In addition, it provides a summary sheet for the dates of pertinent assessment, interviews, meetings, physician's orders, training, and review of the health care plan

2. Key contacts list which includes all key personnel responsible for the child's care, including both school and primary care providers, and person(s) responsible for the training and supervision of care as well as the dates of the training

3. Background information which contains a brief medical history, home assessment summary, identified special health care needs, child's baseline health status, required medications and diet, and transportation needs

4. Plan for specific procedure which contains directions on how to perform a special clinical procedure including frequency, required equipment (storage and maintenance), child-specific information, and special considerations

5. Parent authorization for specialized care which provides written permission for administering specialized health care to the student

6. Emergency information is a list of the telephone contacts for the parents, key emergency providers, and local hospitals should an emergency occur

7. Emergency plan is a list of potential child-specific emergencies and what to do to ensure that prompt, appropriate action can occur. (Note: The emergency care plan should never substitute for a comprehensive IHCP addressing **all** of the student's relevant needs). The team should design and document each of the student's emergency procedures. These are to be shared with other school personnel, including ancillary staff such as lunchroom workers, custodians, and bus drivers. In addition, a simple set of instructions identifying individuals to notify should be discussed carefully with the student's parents

8. Emergency telephone procedure which provides a detailed guideline for information that may be needed by the emergency medical team respondent: (identifies the school official to be notified)

Animals in School

The LABBB Collaborative recognizes that, for some students, pets serve a therapeutic purpose. There are, however, a number of concerns that need to be addressed when staff or students request permission for pet visits. In order to address these concerns, all pet visits must be approved in advance by the program principal and adherence to the following protocol is required.

POLICY:

1. The principal will consult with the nurse regarding allergies amongst the students
2. Parents/guardians of the children that are expected to be handling the animal will be contacted:
    a. In order to ascertain if there are any known allergies
    b. In order to rule out other concerns they may have for their children
3. Animals will be immunized and licensed as required under state law
4. The length of the visit will be known and approved by the program principal in advance
5. Turtles, parrots, raccoons, bats, or wildlife known to carry rabies or other diseases are prohibited
6. Proper hand washing procedures will be followed after handling any animals
7. All visiting pets will be prohibited from food preparation and dining areas
8. The School Nurse will oversee proper health and safety protocols
9. It will be the Principal's discretion to amend any previous agreements for any pet visit, if it is in her/his opinion:
    a. protocols are not being followed
    b. the visit is interfering with the education of the students
    c. no noticeable benefit is observed

Tobacco Free School Policy

P.L. 103-227, 20 USC 6081
M.G.L. c.71, s. 37H

The programs of the LABBB Collaborative comply fully with the public and private school provisions of the federal Pro-Children Act of 1994 (Section 1041 of the Goals 2000: Educate America Act, P.L. 103-227, 20 USC 6081) which prohibits smoking inside facilities used for preschool, elementary or secondary education or library services to children and on public school grounds.

In addition, the program will comply with M.G.L. c. 71, § 37H, which prohibits smoking by any individual within school buildings; grounds, facilities and buses serving publicly funded students. (Refer also to approval standards 3.2 and 16.12)

Posting
Prohibition of tobacco use signs will be posted in LABBB programs. These postings will be hung in locations such that all students, staff and visitors will be made aware of the policy.

Enforcement
The success and compliance of these regulations depend on the thoughtfulness, consideration, and cooperation of smokers and nonsmokers. All individuals share in the responsibility for adhering to and enforcing this policy. Any individual who observes a violation should report it in accordance with the procedures listed below.

Violation by Students
Any violation of this policy by students shall be referred to the program administrator. Students who violate provisions of this policy shall be subject to building student discipline procedures.

Violations by Staff
Any violation of this policy by staff shall be referred to the program administrator. Any staff violating this policy will be subject to discipline procedures as outlined in the Personnel Policies.

Violations by Visitors
Any violation of this policy by visitors shall be referred to the program administrator. Visitors who are observed using tobacco on school property shall be asked to refrain from smoking. If the individual fails to comply with the request, the program administrator will make a decision on further action that may include a directive to leave school property. Repeated violations may result in a recommendation to prohibit the individual from entering school property for a period of time. If deemed necessary, the program administrator may deem it necessary to contact the local law enforcement agency to assist with the enforcement of this law.

Hazardous Materials

POLICY:

The Program Coordinator and the school nurse or designees are responsible for seeing that any and all hazardous substances and materials remain out of the reach of students. This includes providing a locked, secure cabinet to keep all toxic substances, medications, and sharp objects out of the reach of students.

1. Medications and medical supplies should not be locked in the same cabinet as other toxic substances

2. Toxic substances must be labeled with contents and antidote

The phone number for the nearest poison center must be posted clearly near each phone, medical storage cabinet, and hazardous substance/storage area

Head Lice Protocol

POLICY: If head lice and/or nits are suspected:

1. Abandon the "no-nit policy", allowing children to remain in school when live lice or nits are found

2. Return affected students to class with instruction to avoid head-to-head contact if live lice or nits are found

3. Notify parents at the end of the school day to teach about evidence based treatment options and steps to follow

4. Remove "head lice outbreak letters"

Bed Bug Protocol

POLICY:

If a suspected bed bug is found in the classroom:

1. Every effort should be made to collect a specimen for identification (using a tissue, gauze, or a piece of tape). Try not to crush the bug
2. The specimen should be placed in a sealed plastic sandwich bag with a cotton ball that has rubbing alcohol on it (this will kill the bug)
3. The top of the plastic bag should be folded over about an inch and then sealed with tape
4. If it is caught on clear tape simply affix the specimen to a piece of white paper before bagging it
5. LABBBs pest management company should be called to identify the specimen

If the suspected bed bug is found on a student or their belongings:

1. The student should be discreetly removed from the class so the school nurse can examine the students clothing and other belongings
2. Any bugs that are found should be collected as described above and sent to LABBBs pest management company for identification

If a bedbug is found it could mean that the student has bedbugs at home. However, bedbugs can crawl onto or off of a person or their belongings at any time, so keep in mind that it is also possible that the bed bug was brought to school by someone else.

PROCEDURE:

If LABBB's pest management **positively** identifies a specimen to be a bed bug the following steps should be taken:

1. If the specimen was found on a student or their belongings the nurse or principal will notify the student's parent/guardian to inform them of the presence of a bed bug on their child
2. The Bed Bug Fact Sheet and a Bed Bug Inspection Form should be provided to the family
3. If the specimen was found in a classroom the parent notification letter, *Bed Bugs Found in a Classroom,* should be sent home to all students in the affected classroom
4. The principal will coordinate classroom inspection and treatment as needed with LABBBs pest management company
5. The principal will notify parents and staff if insecticide treatment is necessary

If it is determined that professional extermination procedures must be undertaken, the following steps should be taken by the classroom to prepare:

1. If possible, carpets within affected areas should be loosened at their borders

2. All items attached to the walls should be removed and left in the room

3. Closets and cluttered areas are to be cleaned out and kept in good order going forward

If a student presents with what appears to be bed bug **bites** the following steps should be taken:

1. The school nurse or principal should call the student's family to discuss the possibility of bed bug infestation in the home

2. Bed bug inspection report and educational materials should be sent home

3. Parent should inspect or have pest management professional inspect home and return notification letter to the school

4. If home inspection is positive for bed bugs promote rapid response by parents to treat the infestation using a licensed pest control company—provide guidance and assistance if needed

5. If student lives in an apartment building instruct parents to notify landlord or property manager

6. Student should **NOT** be excluded from school

7. Treatment of bites should be by presenting symptoms (i.e.: antihistamine, steroid or antibiotic ointments/oral preparations)

Note: If a child continues to have repeated episodes of bed bug bites with probable home infestation the board of health in the students town should be contacted for assistance

Student Visit Protocol

PROCEDURE:

1. The Program staff member who is responsible for the intake of student assessments will communicate with Health Office nurses if there is a medical component to the incoming student.

2. The Health Office nurses will communicate with the parent of the incoming student to obtain a brief medical history regarding any scheduled or rescue medications that the student may need during the visit.

3. The parent must complete the "Parent Seizure Questionnaire" form prior to the scheduled visit if there is a known seizure disorder or history.

4. Lexington Health Office must receive and review doctors orders 24 hours PRIOR to scheduled visit. If orders are not received prior, students will fall under "short term medications" for any **emergency medication** that the parent brings in. The pharmacy label will serve as the order for 10 days or less for emergency medications only.

POLICY:

1. Student visits may be accompanied by outside private duty nurses if coordinated by the parent and approved by the Program Coordinator

2. If student requires 1:1 nursing and LABBB/outside services are unable to provide care, parent may be permitted to stay for visit IF visit time is limited to 3 hours or less and is approved by Program Coordinator

Private Duty Nurses

POLICY:

1. The student's home district is obligated to provide private duty nursing services unless the student's parents/guardians already receive private duty nursing services for school hours through their health insurance.

2. The Private Duty Nurse is exclusively responsible for the daily medical and supportive care for the student during school hours and at after-school activities.

3. The Private Duty Nurse must be thoroughly familiar with the student's transportation needs and be prepared to carry out these procedures if requested by the district/parent.

4. The Private Duty Nurse, when hired by the parent/guardian, will present a copy of his/her nursing license and CPR certification to the LABBB Program Director as requested. A CORI check will also be performed, by law.

5. The Private Duty Nurse collaborates with the LABBB nurse and teachers to plan for the safety of the student during brief personal breaks (i.e. bathroom). At all times, the private duty nurse must remain in the school, notify the teachers of his/her location, and be able to respond immediately to the student, if needed.

6. The Private Duty Nurse does not have a duty-free lunch break. Plans for meals will vary according to the needs of the student. The Private Duty Nurse may be permitted to each lunch during a break in the student's nursing care or while the student eats lunch.

7. The Private Duty Nurse notifies the Program Director, teachers, and LABBB nurse of any changes in the student's health status or any medical related issues that may impact the student's attendance, performance, or safety at school.

8. The Private Duty Nurse notifies the Program Director and LABBB nurse of personal illness/emergencies that arise during the course of the school day. The Private Duty Nurse will continue to care for the student until the parent/guardian arrives at the school, if possible.

9. The Private Duty Nurse maintains all equipment and supplies used by the student. The Private Duty Nurse notifies the student's parent/guardian of any concerns related to the student's equipment or supplies.

Responsibilities of the LABBB Nurse

POLICY:

1. The LABBB nurse meets with the private duty nurse on or before the student's first day of school to review the procedure, student's medical/treatment orders, and health paperwork.

2. The LABBB nurse maintains health records on the student including a copy of orders for all treatments and medications to be administered at school, up-to-date physicals and immunizations, copy of the IHCP as well as accessibility to the private duty nurse's documentation of the implementation of orders.

3. The LABBB nurse will make arrangements to obtain a copy of nursing notes for the student health record when a student has a private duty nurse. The Family Educational Rights and Privacy Act (FERPA) require that all student health records maintained by a nurse acting on behalf of the school system be maintained as part of the school record.

4. The LABBB nurse should become familiar with the student's care in the event that he/she is required to assist with the student's care or provide care in an emergency situation.

5. The LABBB nurse informs the parents/guardians and private duty nurse of LABBB and district policies and procedures relevant to the care of the individual student. The LABBB nurse should obtain parent/guardian consent to confer with the student's health care provider as needed.

6. The LABBB team must discuss with the parents/guardians plans for the absence of the private duty nurse.

Medication Administration—Inhaler

PROCEDURE:

1. Check medication and student identification.
2. Explain procedure to student.
3. Position student in an upright position.
4. Check lung sounds and respiratory status.
5. If student is unable to follow directions use an air chamber (spacer) with the inhaler.
6. Have student close mouth tightly around mouthpiece.
7. As student inhales, administer one puff of medication via the inhaler.
8. If using a spacer have student hold in mouth for six or so breaths.
9. If more than one puff of medication is ordered wait 1-2 minutes between puffs.
10. At the end of the procedure recheck student's lung sounds and respiratory status.
11. Chart Medication.

Administering Nebulizer Treatments

POLICY:

1. For each student receiving a nebulizer treatment a physician's written order will be on file. This order will be renewed at the beginning of each school year or as needed

2. Included in the physician's order will be the name and amount of medications, frequency, indications for treatment, possible side effects

3. It will be the responsibility of parents to provide the nebulizer equipment and medication

4. Parents, and if necessary the physician, will be notified of need and result of PRN nebulizer treatment

PROCEDURE:

1. Wash Hands and apply gloves

2. Explain procedure to student

3. Position student in an upright, sitting position

4. Check that machine is clean and ready for use

5. Assess the student's lung sounds and respiratory status

6. Check heart rate

7. Insert medication as ordered by the physician into machine

8. If using mask, apply now

9. If using mouthpiece, have student close mouth tightly around the mouthpiece

10. Plug machine into outlet and turn on

11. Monitor student's respiratory and cardiac status periodically during treatment

12. Continue with treatment until medication is finished

13. Treatment should take 15-20 minutes and may induce coughing

14. Assess student's respiratory status after treatment

15. Document results of treatment

Administering Ear Drops

PROCEDURE:

1. Wash hands and apply gloves
2. Make sure medication is at room temperature
3. Check medication label with order
4. Identify student
5. Position student with affected ear upward
6. Read label again
7. Hold ear upward and backward
8. Instill medication by drops as ordered. Do not touch ear with dropper
9. Instruct student to remain lying down with affected ear up for 15 minutes
10. Insert cotton ball loosely into external canal, if ordered
11. Document administration

Administering Eye Drops

PROCEDURE:

1. Wash Hands and apply gloves

2. Grasp lower eyelid gently below the lashes and pull out to make a pouch

3. Squeeze the indicated amount of medication into the center of the pouch without touching the eye or eyelid with the dropper or bottle tip. If instilling eye ointment, apply a line of ointment along the rim of lower lid

4. Bring the lid up until it touches the eye

5. Close the treated eye slowly and apply gentle pressure over the inner canter to increase drug contact time with tissue and delay drug loss through the tear ducts

6. Wipe excess medication away with a clean tissue

7. When more than one eye medication is prescribed to be administered at the same time, wait five minutes between medications to promote best effect for each medication

8. Wash hands

9. Document administration

Administering Nose Drops

PROCEDURE:

1. Wash hands and apply gloves
2. Check medication and student identification
3. Position student with head lower than shoulders
4. Stand behind student's head
5. Instill number of drops ordered without permitting dropper to touch nose
6. Instruct student to maintain position for at least two minutes
7. Recheck medication and document administration
8. Wash hands

Administering Nasal Sprays

PROCEDURE:

1. Wash hands and apply gloves
2. Check medication and student identification
3. Position student in an upright position, head tilted slightly back
4. Instruct student to inhale while spray is being applied and spray each nare
5. Recheck medication and document administration
6. Wash hands

Administering Subcutaneous Injection

PROCEDURE:

1. Wash hands and apply gloves
2. Prepare medication
3. Withdraw dose of medication and replace needle protector
4. Explain procedure to the student
5. Select site for administration. Preferable sites are the extensor surfaces of the upper arms, the front and lateral aspects of the thigh, and the abdomen
6. Cleanse the skin site with alcohol wipe
7. Remove the needle protector. Expel air from syringe and inject medication by pinching the skin between thumb and forefinger and then firmly and quickly insert needle through all the layers of skin
8. Withdraw needle, apply pressure, massage gently if not contraindicated
9. Dispose of needle in used sharps container
10. Discard all disposable items. Remove gloves
11. Wash hands
12. Document administration

Administering IM Injections

PROCEDURE:

1. Wash hands and apply gloves
2. Prepare medication
3. Withdraw dose of medication and replace needle protector
4. Explain procedure to student
5. Select site for administration. Preferable sites for IM injections are the deltoid muscle in the arm and the outer muscle of the upper thigh
6. Cleanse the skin site with alcohol wipe
7. Remove the needle protector. Expel air from syringe and inject medication by spreading the muscle between thumb and middle finger and then firmly and quickly insert needle through all the layers of skin into the muscle
8. Withdraw needle, apply pressure, and massage gently if not contraindicated
9. Dispose of needle in used needle container
10. Discard all disposable items. Remove gloves
11. Wash hands
12. Document administration

Oral Feeding

POLICY:

1. Wash hands
2. Position child as per feeding information sheet and therapist's evaluation
3. Ensure that all adaptive equipment necessary is being used
4. Encourage as much independence as possible, informing students of type of food and its temperature
5. Follow suggestions from the feeding information sheet to encourage optimum nutrition
6. Document amount and type of intake and any problems with feeding that occurred
7. Consult with occupational therapist/nutritionist/MD/parent as needed

Gastrostomy Feeding

POLICY:

1. For any student with Gastrostomy tube feedings, the physician will complete and sign the diet sheet. It must be completed annually or whenever any change in orders occur

2. Family is responsible for providing all equipment necessary for feedings

3. Family is responsible for providing the particular solution/formula to be used

4. The amount supplied and stored will be decided by the family and facility

5. All supplies and solutions will be stored in a clean dry place

6. Solutions will be refrigerated as necessary

PROCEDURE:

1. Wash hands

2. Assemble Equipment:
    a. Solution/formula at room temperature
    b. Catheter-tipped syringe or other container for feeding
    c. Clamp or cap for end of tube
    d. Water
    e. Rubber bands and safety pins
    f. IV Pole (if needed)

3. Explain the procedure to the student and talk to the student

4. Position student. Student may be sitting or lying on right side. Head should be elevated at 30-degree angle

5. Remove cap or plug from Gastrostomy Tube. Insert syringe

6. Unclamp tubing and draw back on plunger to remove residual left in stomach
    a. Note the amount
    b. Return contents to stomach
    c. Adjust feeding according to physicians orders if residual is present
    d. If residual is greater than recommended, hold feeding thirty minutes and re- check residual

7. Clamp Gastrostomy tube. Disconnect syringe

8. Pour feeding into bag, run feeding through bag and tubing to tip of clamp
9. Hang bag on pole at height required to achieve prescribed flow
10. Insert tip of feeding bag into Gastrostomy tube. Tape securely. Unclamp Gastrostomy tube
11. Open feeding bag clamp. Adjust until flowing at prescribed rate
12. Watch for any unusual changes in student such as nausea, vomiting, cramping or diarrhea. It may indicate feeding too quickly or too cold
13. When feeding is complete clamp feeding tube and Gastrostomy tube
14. Disconnect feeding bag from Gastrostomy tube
15. Unclamp Gastrostomy tube and flush with water if ordered using syringe
16. Vent Gastrostomy tube if indicated by MD
17. Clamp and cap Gastrostomy tube
18. Make sure tubing is secure and tucked inside clothing
19. Wash feeding bag, tubing, and syringe in soapy water and let air dry
20. Wash hands
21. Document feeding and/or medication, residual volume, and feeding tolerance in log

Note: Non medical personnel are allowed to administer tube feedings (i.e milk, formula, water) that are given via gravity.

Gastrostomy Feeding Tube—Bolus Method

PROCEDURE:

1. Wash hands and apply gloves

2. Assemble Equipment
    a. Solution/formula at room temperature
    b. Catheter-tipped syringe or other container for feeding
    c. Clamp or cap for end of tube
    d. Water
    e. Rubber bands and safety pins

3. Explain the procedure to the student and talk to the student

4. Position student-student may be sitting or lying on right side. Head should be elevated at 30-degree angle

5. Remove cap or plug from Gastostomy tube. Insert syringes

6. Unclamp tubing and draw back on plunger to remove residual left in stomach
    a. Note the amount
    b. Return contents to stomach
    c. Adjust feeding according to physician's orders if residual is present
    d. If residual is greater than recommended, hold feeding thirty minutes and recheck residual

7. Clamp tube, disconnect syringe, and remove plunger

8. Reinsert syringe into tubing. Hold syringe six inches above level of stomach

9. Unclamp tubing. Allow air bubbles to escape

10. Pour feeding into syringe and allow to flow in via gravity

11. Continue to pour feeding into syringe as contents empty into stomach

12. Raise or lower syringe or container to adjust flow rate

13. After feeding is completed, flush with the prescribed amount of water

14. Vent Gastrostomy tube if ordered

15. Clamp tubing, remove syringe, and reinsert cap

16. Secure tubing and tuck into clothes. Wash syringe in a closed container with other supplies

17. Wash hands

18. Document feeding/medication residual amount and feeding tolerance on log sheet or in electronic iPass system

Gastrostomy Stoma Care

POLICY:

Gastrostomy tube stoma care will be performed as indicated by an MD to maintain skin health and integrity.

1. Any student-specific orders for Gastrostomy tube stoma care will be followed
2. In the absence of student specific orders, the written procedures for Gastrostomy tube stoma care will be followed

PROCEDURE:

1. Wash hands
2. Explain procedure to student
3. Assume privacy
4. Apply gloves
5. Examine stoma and surrounding skin for breakdown, redness, or drainage
6. Clean skin gently with a solution of hydrogen peroxide and water or plain soap and water
7. Dry gently
8. Apply a small amount of Bacitracin ointment and or dressing if ordered
9. Remove gloves and wash hands
10. Dispose of trash in a plastic bag
11. Wash hands
12. Document the condition of the skin and stoma and care given

Oral Nasopharyngeal Suctioning

POLICY:

1. Licensed nursing staff and respiratory therapists can perform oral and nasopharyngeal suctioning

2. A valid physician's order must be on file

3. The physician's order must be renewed yearly or as changes occur

4. Family will be notified if suctioning has been performed

PROCEDURE:

1. Wash your hands and apply gloves

2. Assess respiratory status

3. Open catheter package and attach connector to suction tubing; leave catheter inside package to prevent contamination

4. Turn on student's suction machine

5. Apply clean gloves and remove catheter from package

6. With vent open, gently insert catheter to desired depth

7. Occlude vent. Rotate catheter while withdrawing catheter. The catheter should be withdrawn from the airway within five seconds

8. Observe for color changes and discontinue suctioning if changes occur

9. Note character of secretions

10. Rinse catheter with saline

11. Alternate if additional suctioning is necessary

12. Provide oxygen as needed before and/or between and after suctioning

13. Suction oral cavity, if necessary

14. Assess respiratory status and reposition patient as needed

15. Clean suction equipment

16. Remove gloves. Wash hands

17. Document procedure and results on progress notes. Describe secretions and effectiveness or adverse response to treatment

Incontinence care

POLICY:

1. Students who are incontinent of urine and/or stool will be cared for with sensitivity privacy, and in a timely manner

2. Diapers/briefs will be changed frequently to prevent skin irritation and infections, even if not soiled

3. Students will be monitored for early detection of urinary tract infections, vaginal infections, and intestinal or other elimination difficulties

PROCEDURE:

1. Wash your hands and apply gloves

2. Move student to an appropriate changing area and bring all supplies to within reach

3. Use privacy screen/curtains at all times

4. Remove the soiled diaper/brief. Wrap it using the tapes to contain contents and place on appropriate surface until care is completed. Never place the diaper/brief on the floor

5. Using wet wipes, wipe the perineum from front to back. When providing care to uncircumcised student, the foreskin should be retracted for proper cleaning and then carefully replace the foreskin to prevent complications

6. Inspect the skin for any redness, rash, or other broken areas. Note characteristics of diaper/brief contents including consistency, color, odor, and volume of stool; amount and concentration of urine; presence of occult blood in either. Then reapply a clean diaper/brief and reposition the student

7. With a male student, the penis should be positioned downward for maximum absorbency to present urine from spilling over the top of the brief. Uncircumcised students should have the foreskin retracted and then carefully extended to prevent complications

8. The soiled diaper/brief and all other disposable supplies and gloves are placed into a plastic bag and are disposed of in an appropriate trash receptacle

9. Wash hands

10. Replace all other items appropriately

11. Document observations and assessments and share findings with parent/guardian

Toileting Procedure

DOE Criterion 14.3
603 CMR 18.03(8)

During the Intake Interview with a prospective student's family, the current toileting needs of the child are discussed and documented. Children who are currently toilet training or incontinent frequently have existing goals written into their IEP at the time of referral to LABBB. Classroom staff implements IEP goals, and document progress in the Quarterly Reports. A new goal may be developed at a future IEP meeting if toileting needs change. The following procedure is followed for students who require staff assistance with toileting needs:

Written Plan: Students who are incontinent shall have a written individualized toileting plan incorporating:

1. Schedule of diapering
2. Toilet training plan
3. Procedure for handling soiled clothing and diapers
4. Personal privacy protection

PROCEDURE:

1. The team develops a specific schedule with individualized procedures
2. Staff models how to effectively communicate the need to toilet, i.e. photo, Mayer-Johnson pictographs that are displayed in the classroom and restrooms, and/or specific verbalization
3. Staff escorts the student to the bathroom, following a set of specific steps, which may be reinforced with a toileting board (set of pictures depicting the steps to be followed)
4. Student toilets independently to the extent possible, while the staff member waits outside the bathroom door. Staff cue for each step in the process with the long-range goal to gradually fade physical and verbal prompts
5. Personal care items are kept for each student with a change of clothing if needed
6. Soiled clothing items are placed in doubled plastic bags, tied, and sent home each day
7. Staff instructs and supervises hand-washing procedures

8. Students are rewarded for appropriate attempts at toileting

9. Individual student plans are documented in files

Diapering Requirements: Based on information given by parents/guardians during the Intake Interview, staff implements a regular diapering schedule for the child.

1. At least three times per day, staff brings a child to the designated changing area and/or bathroom. A changing table is provided in an enclosed area for children who are not able to stand up in a bathroom during toileting. The changing table paper is changed after each use and the surface is disinfected properly. OSHA regulations are followed at all times

2. Families send in diapers/briefs for their children, and the program provides body wipes, gloves, changing table paper, antiseptic surface wipes, and chux

3. Soiled diapers/briefs are double-bagged in plastic, and disposed of in a covered trash barrel. Trash is removed from the building every day. All disposables are similarly bagged and placed in a covered trash container

4. Individual student plans are documented in files

Clothing Requirements

1. An additional set of clothing is provided by families for students who may experience instances when they become soiled or wet

2. Soiled clothing is placed in doubled plastic bags, tied, stored in a waterproof container and sent home each day

Administration of Chest Physiotherapy

POLICY:

1. For any student undergoing chest physiotherapy there must be a valid physician's order on file

2. Chest physiotherapy will only be performed by school nurses, physical therapists, or any other specially trained personnel contracted by the collaborative or sending district

3. Chest physiotherapy should be documented by the nurse on a student-specific MAR or in the electronic iPass system

Adaptive Equipment

POLICY:

1. Adaptive equipment will specifically be designed for each student and ordered by a physician to: prevent contractures, maintain or improve range of motion and positioning, maintain skin integrity, and prevent the development of decubitis or pressure areas

2. Adaptive equipment will be implemented by nursing, PT/OT, or education staff after appropriate staff education has occurred

3. Adaptive equipment is fabricated and/or monitored by PT and OT. A physician's order must be obtained for any adaptive equipment at the start of the school year, or when changes occur

4. Adaptive equipment includes: AFO's (Ankle Foot Orthotic), TLSO's (Thoracic, Lumbar, Sacral Orthotic), and Upper and Lower extremity splints and bivalves

5. LABBB Collaborative purchases adaptive equipment for classrooms and programs in which the equipment benefits multiple children. If adaptive equipment is for one student as prescribed by a physician or warranted by the implementation of the student's IEP, it is the sending districts and/or parents responsibility to supply the equipment. The equipment will be returned to the sending district, if/when the child is discharged from the LABBB program

PROCEDURE:

1. Check adaptive equipment for damage before applying

2. Check skin for any pressure areas or injuries before applying equipment

3. Check for proper fit and tolerance by student every two hours

4. Check skin for marks or pressure areas

5. If redness does not disappear within 15-30 minutes after removal of orthotic, notify the responsible therapist

6. Notify parents with concerns about fit or tolerance

7. Document the use of adaptive equipment applied during school hours

Body Jacket Application

POLICY:

1. Body jacket is to be worn by student as prescribed by their physician

2. A tolerance program is to be prescribed by the primary therapist

3. Body jackets are used to: promote/maintain proper structural alignment and thereby prevent deformity, restrict/immobilize (as in post-surgical instances), and/or to maximize function through increased stability

4. Body jackets are individually fabricated by an Orthopedist to ensure proper fit and are not interchangeable

PROCEDURE:

1. Assemble materials:
    a. Body Jacket
    b. Good fitting shirt or undershirt

2. Lay student on a safe and clean surface while maintaining privacy

3. Inspect skin condition. Examine for reddened or open areas

4. If reddened or open areas are present, do not apply body jacket

5. If reddened or open areas are present, document and notify family and/or physician

6. Place clean, dry undershirt on student

7. Roll student onto his/her side

8. Place back half of body jacket onto student's back

9. Roll student back onto jacket

10. Check placement: waist indentations on student should line up with those on body jacket

11. Place front of body jacket on student. Make sure undershirt is smooth to eliminate wrinkles and prevent skin from being pinched insides of body jacket

12. Secure Velcro straps

13. Check placement: Velcro straps should line up with D-rings and 2-3 fingers should be able to fit between the body jacket and the students' underarm. (Velcro straps are usually labeled with marks to be lined up during application)

14. Place disposable diaper/brief on student as ordered

15. Dress student in appropriate clothing

16. Recheck body jacket position once student is sitting

Lifting and Transfers of Students

POLICY:

1. All students are to be handled in a manner that ensures their safety and comfort while promoting the same for all staff. It is essential that all staff observe proper lifting and safety considerations

2. Upon enrollment, PT and OT will determine the most appropriate transfer for the individual and will communicate this to all staff in writing. This plan will be re-evaluated as needed, but at least once a year

3. All students weighing **more than 50 pounds require a two-person lift**. A student weighing 100 pounds should be transferred at all times using a Hoyer lift

4. For any student under 50 pounds who is compromised orthopedically, medically, or if the staff is uncomfortable with the transfer, a two-person transfer procedure will be used

5. Students should not be carried. Carrying children poses unnecessary safety risks to both the student and the staff person

6. Proper lifting techniques as described below must be followed

7. Wheelchair and equipment are to be pushed one at a time

8. Before attempting a lift, the staff member must be sure they understand the written plan for each student. One should check daily to ensure that no changes have occurred

PROCEDURE FOR STAND AND PIVOT:

1. Explain procedure to the student

2. Position chairs, cot, etc. close to each other in order to ensure pivot will facilitate a smooth transfer

3. Sit student on edge of bed if lying down

4. Stand facing the student

5. Wrap your arms around student's underarms

6. With your knees, legs, and feet brace student's feet and legs

7. On the count of three, assist student to standing position, pivot, and sit student onto transferred area

8. Reposition student and apply seatbelt as needed

PROCEDURE FOR SINGLE PERSON TRANSFER:

With all transfers (single, two-person, or Hoyer lift) always follow the procedure below:

1. Staff will put on lifting belt and secure appropriately
2. Place wheelchair as close as possible to transferring surface and prepare area
3. Lock all brakes
4. Have appropriate number of staff available to perform transfer
5. Talk to the student. Let him/her know he/she is going to be transferred
6. Remove tray and other positioning devices leaving seatbelt for last. Unfasten straps and swing away or remove leg rests to prepare for student transfer
7. Remove seat belt maintaining contact for student safety
8. Lift according to appropriate transfer style for students as indicated by primary therapist

Transfer:

1. Stand to either side of the student, closest to the transferring surface
2. Wrap upper arm around student's upper trunk. Come underneath him/her arms and grasp student's forearm gently and securely
3. Hug student's body close to yours
4. Wrap lower arm underneath student's upper thighs and hold securely
5. Bend your knees and stand with wide base of support
6. Lift student towards you
7. Take the few necessary steps to arrive over the transferring surface
8. Bend your knees with wide base
9. Gently place student onto the surface
10. Position appropriately securing straps as needed

PROCEDURE FOR TWO-PERSON TRANSFER:

1. Top to Bottom

    a. One person is positioned at the head of the wheelchair toward the side nearest the transferring surface. The second person is positioned at the foot of the wheelchair

    b. The top person wraps both arms around the student's upper body and gently yet securely grasps him/her forearm hugging the student close to their body. Certain circumstances may require solely holding their trunk instead of his/her forearms

    c. The bottom person places both hands underneath the student's upper thigh in order to support him/her share of the weight. It may be necessary to support under the buttocks as well, standing in front or to the side of the wheelchair with a wide base and knees bent

2. Side to Side

    a. Position each side of the wheelchair facing the student

    b. Each person's upper arms should wrap under the student's upper arm and then grasp the student's forearm

    c. Each person's lower arm should be underneath the student's upper thigh to support the weight

    d. Student and staff are both ready

    e. Alert student verbally that the transfer is about to begin

    f. Count to three and lift simultaneously

    g. Take the few required steps to arrive over the transferring surface

    h. Gently place and position the student appropriately

Student Positioning

POLICY:

1. The nurse will assess to determine specific therapeutic positions

2. When using adaptive equipment, infection control, safety, therapeutic value, and comfort will be considered

3. When deciding on positioning, staff will consider the activity the student will engage in

4. All equipment will be checked for damage and cleanliness

PROCEDURE:

1. Typical practice involved when positioning a student in a Sidelyer:

    a. Consult with primary therapist/nurse regarding the necessary variations or contraindications to placing the student in a typical Sidelyer position

    b. Place student on side indicated by the therapist/nurse

    c. Position students' back against upward rear wall of the Sidelyer

    d. Move the bottom arm out from underneath the student so the student is not lying on top of it

    e. Place firm pillow under head so the pillow fills all the space between the head and weight bearing shoulder

    f. Bend the elbow of the non-weight bearing (top) arm and place on a pillow that supports the upper arm to the hand

    g. Bend non-weight (top) leg at knee and hip

    h. Place firm pillow between legs

    i. Fasten student to Sidelyer so the chest harness covers hips and torso with enough space between the student and the harness to fit in one finger

    j. Secure chest harness across hips and lower trunk behind back of Sidelyer. It should be secure enough to prevent rolling or hip movement but should allow one finger to be placed between the harness and the body

2. Typical practice involved when positioning a student with a Wedge:

    a. Consult with primary therapist/nurse for necessary variations or contraindications to placing a student in a typical position over a wedge and for determining the most appropriate size, angle, and type of wedge

    b. Place student prone (on stomach) with head turned to the side resting on the higher end of the wedge or place student on back

    c. Wedge straps should be fastened around the student's body so the arms are free with enough space to allow one finger to fit though the wedge straps

    d. If prone, and depending on the nursing recommendations, the arms may be placed so they extend forward over the top end of the wedge and the hands rest on the ground to facilitate upper extremity weight bearing and head control

    e. If prone, and depending on the recommendations from the primary therapist/nurse, the arms may be flexed (bent) outward at the elbows while the forearms rest on the wedge affording the student the opportunity to bear weight on the forearms

    f. If prone, and depending on the recommendations from the team members, the student may be placed on the wedge so the head lies on the angel of decline (lower end) of the wedge to facilitate postural drainage

3. Typical practice involved when positioning a student in a Tumble Form Seat:

    a. Consult with the primary therapist/nurse regarding needed variations or contraindications to place the student in a typical tumble form seat

    b. Adjust tumble form seat from upright to reclined position as indicated by team members to facilitate head control

    c. Place student in tumble form seat so hips are back

    d. Securely fasten shoulder, chest, and hip straps so one finger is able to fit between the straps and the student's body

    e. Pillows or towel rolls may be used as additional support to prevent or limit trunk flexion to right or left

Review and Approval of Contents

I, Dr. Samuel Andonian, have reviewed the LABBB Collaborative Policy and Procedures Guide and have approved its contents. This Policy and Procedure Guide shall be valid for one calendar year from the date below.

_____ _____

Dr. Samuel Andonian Date