

# ***Chapter 8***

## ***Medically Complex***



## INTRODUCTION

This chapter is intended as an informational source for school and nursing personnel dealing with medically complex students in an educational setting and consists of two major sections: Section one includes general information concerning medically complex students and a matrix of recommended responsibilities concerning the delivery of health related services.

Section two includes information concerning the most common medical procedures seen in medically complex educational settings.

This manual is NOT intended to be an instructional instrument from which personnel will “learn” how to perform any medical procedures needed during school hours.

Only personnel specifically designated on physician’s orders and properly trained to perform a specific procedure with/on a specific child should be involved in any health procedure. It is the responsibility of the school administrator and/or health designee to assure that the orders from a child’s doctor are complete, contain information regarding personnel who should be allowed to perform the procedure(s) and note what type of training should take place. In most cases the school nurse or parent would be responsible for training designated personnel.

It is intended that this manual, coupled with appropriate in-service and specific training, will assist personnel in dealing with medically complex students in the school setting.

\*Please note: If a school should register a student with special medical needs that cannot be adequately addressed by the present School Health Manual, the principal should contact their School Nurse, Public Health Nurse or the Clay County School District Exceptional Student Education (ESE) RN.

The following pages contain a “Matrix of Professional Responsibilities” for the delivery of special health care procedures in educational settings. The matrix contains many special health care procedures that some children may need performed in the educational setting. The procedures vary in the degree to which they require specialized knowledge and skill by persons conducting the procedure. Many are regulated by professional standards of practice. The matrix delineates the persons who are qualified to perform each procedure, who should preferably perform, and the circumstances under which these persons would be deemed qualified. It should be noted that the term “qualified” assumes that the individual has received appropriate training in the procedure. The matrix is based on the matrix contained in “Guidelines for the Delineation of Roles and Responsibilities for the Safe Delivery of Specialized Health Care in the Educational Setting” published May 1, 1990 and developed by the Joint Task Force for the Management of Children with Special Health Needs which consists of The National Association of School Nurses and The National Education Association.

These are simply recommendations as to personnel who should be considered, with appropriate training, as possible providers of specific health care procedures. It is the

responsibility of the school administrator, based on specific doctor's orders, to designate personnel to be trained in a health care procedure for a specific child.

## Clay County School Health Services Manual

### GUIDELINES FOR THE DELINEATION OF ROLES AND RESPONSIBILITIES FOR THE SAFE DELIVERY OF SPECIALIZED HEALTH CARE IN THE EDUCATIONAL SETTING

PROCEDURE	PHYSICIAN ORDER REQUIRED	REGISTERED NURSE (RN)	LICENSED PRACTICAL NURSE (LPN)	CERTIFIED TEACHING PERSONNEL	RELATED SERVICES PERSONNEL 1	PARA-PROFESSIONALS 2	HEALTH Assistant	OTHERS 3
<b>1.0 ACTIVITIES OF DAILY LIVING</b>								
1.1 Toileting/Diapering		A	A	A	A	(A) / T	A	A
1.2 Bowel/ Bladder Training (Toilet Training)		A	A	(A)	A	S/T	S	S
1.3 Dental Hygiene		A	A	A	A	S/T	S	S
1.4 Oral Hygiene		A	A	(A)	A	S/T	S	S
1.5 Lifting/Positioning		A	A	(A)	A	S/T	S	S
1.6 Feeding								
1.6.1 Nutritional Assessment		A	X	X	N	X	X	X
1.6.2 Oral-Motor Assessment		X	X	X	(SP/TH)	X	X	X
1.6.3 Oral Feeding		A	A	A	A	(S) / T	S	S
1.6.4 Gastrostomy Feeding	*	(A)	(S)	X	X	S	S	X
1.6.5 Monitoring of Gastrostomy Feeding		A	S	S	S	S	S	X
1.6.6 Jejunostomy Tube Feeding	*	(A)	(S)	X	X	S	S	X

**DEFINITION OF SYMBOLS**

- A** – Qualified to perform task, not in conflict with professional standards
- S**- Qualified to perform task with RN supervision and inservice education
- E** –In emergencies if properly trained and designated professional is unavailable
- X** – Should NOT perform
- T**- Qualified to perform task with teacher supervision and inservice education.
- N** - Nutritionist only
- TH**- Occupational or physical therapist only
- SP** – Speech/language Pathologist only

○ - Person who should be designated to perform task

1. Related Services include N, TH, and SP
2. Paraprofessionals include teacher aids, uncertified teaching personnel.
3. Others include secretaries, bus drivers, cafeteria workers, custodians.
4. Health Assistants include personnel (may be included in the above) who have been properly trained.

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<b>2.0 CATHETERIZATION</b>								
2.1 Clean Intermittent Catheterization	*	(A)	(S)	S	S	S	S	X
2.2 Sterile Catheterization	*	(A)	(S)	X	X	X	X	X
2.3 Crede	*	A	S	S	S	(S)	S	X
2.4 External Catheter	*	(A)	(A)	S	S	(S)	S	X
2.5 Care of Indwelling Catheter (Not Irrigation)	*	(A)	(S)	S	S	(S)	S	X
<b>3.0 MEDICAL SUPPORT SYSTEMS</b>								
<b>3.1 Ventricular Peritoneal Shunt</b>								
3.1.1 Pumping	*	(E)	(E)	X	X	X	X	X
3.1.2 Monitoring	*	(A)	S	S	S	S	S	X

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<b>3.3 OXYGEN</b>								
3.3.1 Intermittent	*	(A)	(S)	E	E	E	E	X
3.3.2 Continuous (Monitoring)	*	A	S	S	S	S	S	S
3.4 Apnea Monitor	*	A	S	S	S	S	S	X
3.5 Cardiac Monitor	*	A	S	S	S	S	S	S
<b>4.0 MEDICATIONS</b>								
4.1 Oral	*	(A)	(S)	S	S	S	S	S
4.2 Injection	*	(A)	(S)	S	S	S	S	X
4.3 Epi-Pen Allergy Kit	*	(A)	(S)	E	E	E	E	E
4.4 Inhalation	*	(A)	(S)	E	E	E	S	S
4.5 Rectal	*	(A)	(S)	E	X	E	S	X
4.6 Bladder Installation	*	(A)	(S)	X	X	X	X	X
4.7 Eye/Ear Drops	*	(A)	(S)	E	X	X	S	S
4.8 Topical	*	(A)	(S)	S	S	S	S	S
4.9 Per Gastrostomy Tube	*	(A)	(S)	X	X	S	S	X

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5.0 OSTOMIES	PROCEDURE	PHYSICIAN ORDER REQUIRED	REGISTERED NURSE (RN)	LICENSED PRACTICAL NURSE (LPN)	CERTIFIED TEACHING PERSONNEL	RELATED SERVICES PERSONNEL 1	PARA-PROFESSIONALS 2	HEALTH Assistant	OTHERS 3
5.1 Ostomy Care		*	(A)	(S)	E	E	E	E	X
5.2 Ostomy Irrigation		*	(A)	(S)	X	X	X	X	X
6.0 RESPIRATORY ASSISTANCE									
6.1 Postural Drainage		*	(A)	(S)	S	S	S	S	S
6.2 Percussion		*	(A)	(S)	S	TH	S	S	S
6.3 Suctioning									
6.3.1 Pharyngeal		*	(A)	(S)	S	S	S	S	X
6.3.2 Tracheostomy		*	(A)	(S)	X	X	X	X	X
6.4 Tracheostomy Tube Replacement		*	(E)	(E)	X	X	X	X	X
6.5 Tracheostomy Care (cleaning)		*	(A)	(S)	X	X	X	X	X
7.0 SCREENINGS									
7.1 Growth			(A)	(S)	S	S	S	S	X
7.2 Vital Signs			(A)	(S)	X	X	S	S	X
7.3 Hearing			(A)	(S)	X	(SP)	S	S	X
7.4 Vision			(A)	(S)	X	X	S	S	X
7.5 Scoliosis			(A)	(S)	X	TH	X	X	X

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<b>8.0 SPECIMEN COLLECTING/TESTING</b>								
8.1 Blood Glucose	*	(A)	(S)	S	X	S	S	A
8.2 Urine Ketones	*	(A)	(S)	S	X	S	S	S
<b>9.0 OTHER HEALTH CARE PROCEDURES</b>								
9.1 Seizure Procedures		A	A	A	A	A	S	A
9.2 Soaks	*	(A)	(S)	X	TH	S	S	X
9.3 Dressings, Sterile	*	(A)	S	X	X	X	X	X
<b>10.0 DEVELOPMENT OF PROTOCOLS</b>								
10.1 Health Care Procedures		(A)	X	X	X	X	X	X
10.2 Emergency Protocols	*	(A)	WITH PHYSICIAN CONSULTATION					
10.3 Individual Education Plan Health Objectives		(A)	X	X	X	X	X	X
10.4 Nursing Care Plan		(A)	X	X	X	X	X	X

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## ***Implementing Special Education: Students with Special Needs***

*Introduction:* The number of children and adolescents with special health care needs in Florida schools has increased over the last 20 years due to legislation requiring education be provided to all children in the least restrictive environment, changing social attitudes that promote inclusion of children with special needs in schools and other community groups, improvements in medical technology, and advances in educational research of special needs populations. Determination of a child's need and eligibility for services at the earliest possible time leads to better education outcomes for the child. School nurse and other school health personnel are involved in identifying and serving students with special needs.

### ***Historical Perspective: Key Federal Legislation***

Listed below are summaries of some key special education federal laws and acronyms of special education.

**Early Education for Handicapped Children Program of 1970.** Congress passed the Early Education for Handicapped Children Program, providing seed money for the development and operation of experimental, demonstration, and outreach preschool and early intervention programs for handicapped children. This was the federal government's first major effort in early intervention.

**Rehabilitation Act of 1973 (Public Law 93-112).** The Rehabilitation Act of 1973 prohibits discrimination on the basis of disability in programs conducted by federal agencies, in programs receiving federal financial assistance, in federal employment, and in the employment practices of federal contractors. The standards for determining employment discrimination under the Rehabilitation Act are the same as those used in Title I of the Americans with Disabilities Act of 1990.

- ◆ **Section 504.** Section 504 of the 1973 Rehabilitation Act is the basic civil rights legislation prohibiting discrimination against persons with "handicapping conditions" in programs that receive federal funds. This includes public schools.
- ◆ **Handicapping Condition.** The definition of "handicapping condition" in Section 504 is: a handicapped student is one who has a physical or mental impairment that substantially limits one or more life activities (such as working, eating, dressing, breathing). The Office of Civil Rights, which oversees enforcement of the statute, has determined that this may include drug and alcohol addiction, attention deficit disorder, AIDS, hospitalization due to depression, and other conditions not typically qualifying under special education. Federal special education funds cannot be used to comply with 504.

**Education Amendments of 1974 (Public Law 93-380).** In 1974, to ensure appropriate education opportunities for children with special needs, Congress passed the Education Amendments of 1974, which guarantees due process and provision of education in the least restrictive environment.

### **Education for All Handicapped Children Act of 1975 (Public Law 94-142).**

In 1975, Congress passed a law called the Education for All Handicapped Children Act (EHA). This law established legal standards and requirements for the education provided to children with disabilities. This law required all states to provide a “Free, appropriate public education” to school-age children with handicaps in the “least restrictive environment.”

- ◆ **Section 619.** Section of the EHA provided incentives to states to serve handicapped children ages 3-5.
- ◆ **Handicapped Children.** Under this law, “handicapped children” were defined as those who are mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, orthopedically impaired, other health impaired, or who have specific learning disabilities, and who by reason of these handicaps require special education and related services. (20 U.S.C. § 1401 [a].)
- ◆ **Related Services.** Under this law, “related services,” which included school health-related services, were among those services that must be provided to sustain these children’s attendance. These services are described in P.L. 94-142 and include, among others, school health services; physical, occupational, and language therapy; modification of classroom schedules; and if necessary, actual physical alterations of the school.
- ◆ **Least Restrictive Environment.** To the extent possible (given the nature and severity of the child’s handicap), the child should be educated in the regular classroom with peers who are not handicapped.

Note: The EHA was to be re-enacted every 4 years, resulting in numerous changes in the Act over the intervening two decades.

**Public Law 98-109 of 1983.** In 1983, believing that it was time to encourage states to expand services to preschool children, infants, and toddlers with handicaps, Congress passed P.L. 98-109. That legislation set aside money for planning, development, and implementation grants dealing with the preschool populations-allowing states to apply for grants to provide services to disabled children age birth through 3 years. In the first quarter of 1985, 20 states received such grants.

**Education of the Handicapped Act Amendments of 1986 (Public Law 99-457).** In 1986, Congress enacted P.L. 99-457, the Education of the Handicapped Act Amendments of 1986. This legislation amended the Education of All Handicapped Children Act (EHA) to, among other things, replace the preschool grants program (Part B, Section 619) and create a new early intervention program for infants and toddlers (Part H). The least restrictive environment concept was continued.

- ◆ **Part B, Section 619.** Replaced the preschool grants program authorized by P.L. 94-142 with a new program (Part B, Section 619) for children with disabilities, ages 3 through 5.
- ◆ **Children with Disabilities.** Under this law, the term “handicapped children” was replaced with “children with disabilities.” This term means mentally retarded, hard of hearing, deaf, speech or language impaired, visually handicapped,

- severely emotionally disturbed, orthopedically impaired, or other health impaired, or children with specific learning disabilities, who by reason thereof require special education and related services. (20 U.S.C. § 1401 [a].)
- ◆ **Infant and Toddlers Program.** Created a new state grant program (Part H) to encourage states to plan, develop, and implement early intervention services to infants and toddlers with developmental delay and their families. States participating in the Part H program were permitted five years (1988-1993) to develop programs to provide appropriate services to eligible children and their families.
  - ◆ **Infants and Toddlers with Disabilities.** Under this law, the term “infants and toddlers with disabilities” is defined as children from birth through age 2 who required early intervention services because they (a) are experiencing developmental delays, as measured by appropriate diagnostic instruments and procedures in one or more of the following areas: cognitive development, physical development, language and speech development, psychosocial development, or self-help skills, or (b) have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay. (20 U.S.C. § 1472.)

**Individuals with Disabilities Education Act of 1990 (Public Law 101-476).** In October 1990, Congress passed P.L. 101-476, which reauthorized the Education for All Handicapped Children Act (EHA), Parts C through G, through fiscal year 1994, changed the name to the Individuals with Disabilities Education Act and made minor changes to Parts B and H. There were some changes in the definition categories for special education and related services, including new categories of traumatic brain injury, developmental delay, and autism. Also, additional services, such as transition and assistive technology, were added.

**Americans with Disabilities Act of 1990.** The Americans with Disabilities Act (ADA) was signed into law on July 26, 1990. The ADA prohibits discrimination on the basis of disability in employment, programs and services provided by state and local governments, goods and services provided by private companies, and in commercial facilities. The ADA protects every person who either has, used to have, or is treated as having a physical or mental disability that substantially limits one or more major life activity. Individuals who have serious contagious and non-contagious diseases—such as HIV/AIDS, cancer, epilepsy or tuberculosis—are also covered under the auspices of ADA. The ADA extends the coverage of Section 504 of the Rehabilitation Act of 1973.

- ◆ **Public Schools.** The ADA affords persons with disabilities meaningful access to programs and facilities of public schools, as well as most business. It requires the employer to make “reasonable accommodations” for disabled persons to perform the job.

**Individuals with Disabilities Education Act Amendments of 1997 (IDEA 1997), (Public Law 105-17).** The Individuals with Disabilities Education Act Amendments of 1997 (IDEA 97) were signed into law on June 4, 1997. (Final implementing regulations released March 12, 1999.) The new law consists of four parts: Part A—General Provisions, Part B—Assistance for Education of All Children with

Disabilities, Part C—Infants and Toddlers with Disabilities (formerly Part H), and Part D—National Activities to Improve Education of Children With Disabilities.

- ◆ **Children with Disabilities.** Under this law, the term “children with disabilities” is defined as those children evaluated in accordance with the federal special education regulations as having mental retardation, hearing impairments (including deafness), speech or language impairments, visual impairments (including blindness), serious emotional disturbance, orthopedic impairments, autism, traumatic brain injury, other health impairments, specific learning disabilities, deaf-blindness, or multiple disabilities, and who, because of those impairments, need special education and related services.
- ◆ **Related Services.** Under this law, “related services” are defined as follows: transportation, and such developmental, corrective, and other supportive services—including speech language pathology and audiology, psychological services, physical and occupational therapy, recreation (including therapeutic recreation and social work services), and medical and counseling services (including rehabilitation counseling), except that such medical services shall be for diagnostic and evaluation purposes only—that may be required to assist a child with a disability to benefit from special education. (IDEA, 20 U.S.C. 1401 [17].) The term also includes school health services, social work services in the schools, and parent counseling and training. (34 C.F.R. 300.1 3[a].)

**Individuals with Disabilities Education Improvement Act of 2004 (IDEA 2004), (Public Law 105-17).** The Individuals with Disabilities Education Act of 2004 (IDEA 2004) is the federal special education law. It gives specific requirements to ensure that students with disabilities receive the services they need to achieve their educational goals.

- ◆ **Other Health Impairment.** The definition of other health impairment in § 300.8(c)(9)(i) has been changed to add “Tourette Syndrome” to the list of chronic or acute health problems..
- ◆ **Related Services.** Related services means transportation and such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education, and includes speech-language pathology and audiology services, interpreting services, psychological services, physical and occupational therapy, recreation, including therapeutic recreation, early identification and assessment of disabilities in children, counseling services, including rehabilitation counseling, orientation and mobility services, and medical services for diagnostic or evaluation purposes. Related services also include school health services and school nurse services, social work services in schools, and parent counseling and training. Related services do not include a medical device that is surgically implanted, the optimization of that device’s functioning (e.g., mapping), maintenance of that device, or the replacement of that device. Nothing in law limits the right of a child with a surgically implanted device (e.g., cochlear implant) to receive related services. This law also limits the responsibility of a public agency to appropriately monitor and maintain medical devices that are needed to maintain the health and safety of the child, including breathing, nutrition, or operation of other bodily functions, while the child is

transported to and from school or is at school; the law also prevents the routine checking of an external component of a surgically implanted device to make sure it is functioning properly. (§300.34(a) and (b)).

**The 2006 Regulations to IDEA 2004.** This law clarified the previous IDEA law and made some corrections to what originally left off.

- ◆ **Related Services.** Section 300.34(b) has been changed to (A) expand the title to read “Exception; services that apply to children with surgically implanted devices, including cochlear implants,” and (B) clarify, in new paragraph (b)(1), that related services do not include a medical device that is surgically implanted, the optimization of that device’s functioning (e.g., mapping), maintenance of that device, or the replacement of that device. (3) A new § 300.34(b)(2) has been added to make clear that nothing in paragraph (b)(1) of § 300.34 (A) limits the right of a child with a surgically implanted device (e.g., a cochlear implant) to receive related services, as listed in § 300.34(a), that are determined by the IEP Team to be necessary for the child to receive FAPE; (B) limits the responsibility of a public agency to appropriately monitor and maintain medical devices that are needed to maintain the health and safety of the child, including breathing, nutrition, or operation of other bodily functions, while the child is transported to and from school or is at school; or (C) prevents the routine checking of an external component of a surgically implanted device to make sure it is functioning properly, as required in § 300.113(b).
- ◆ **School Health Services and School Nurse Services.** The definition of school nurse services in 300.34(c)(13) has been expanded and re-named school health services and school nurse services. The expanded definition clarifies that “school nurse services” are provided by a qualified school nurse, and “school health services” may be provided by a qualified school nurse or other qualified person.



CLAY COUNTY DISTRICT SCHOOLS and  
CLAY COUNTY HEALTH DEPARTMENT  
SCHOOL HEALTH SERVICES



**PROCEDURE PHYSICIAN ORDER FORM**

(To be completed by Physician)

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ School Yr. \_\_\_\_\_

Latex Allergy:  Yes  No Needs Assistance with Procedure:  Yes  No

**PROCEDURE:**

Catheterization:  Clean  Sterile Time of procedure \_\_\_\_\_

Type of Ostomy:  Colostomy  Ileostomy  Urostomy Ostomy Care Frequency \_\_\_\_\_

Gastrostomy/ Jejunostomy Tube  Button  PEG  Other \_\_\_\_\_

**FEEDING:** Pump  Yes  No Type \_\_\_\_\_  Flow rate \_\_\_\_\_ cc/hr

Gravity  Yes  No Syringe  Bag  Check Residual  Yes  No Hold feeding for residual > \_\_\_\_\_ cc

Formula: \_\_\_\_\_  Volume to be given \_\_\_\_\_ cc over \_\_\_\_\_ min.

Volume of water to follow feeding \_\_\_\_\_ cc  Time of feedings \_\_\_\_\_

Positions: During feeding \_\_\_\_\_

After feeding \_\_\_\_\_

Tube Site care  Frequency \_\_\_\_\_

**SUCTIONING:**  Nasal  Oral  Tracheostomy  Frequency \_\_\_\_\_

**OXYGEN ADMINISTRATION:**  Type \_\_\_\_\_  Frequency \_\_\_\_\_

**PERCUSSION AND POSTURAL DRAINAGE:**  Frequency \_\_\_\_\_

**VENTILATOR-** This requires consultation with the Clay County ESE Department- 284-6509.

**OTHER** \_\_\_\_\_

**EQUIPMENT NEEDED** (parent to supply): \_\_\_\_\_

**PRECAUTIONS:** \_\_\_\_\_

**SPECIAL INSTRUCTIONS:** \_\_\_\_\_

**All nursing care is provided by or under the direction/ supervision of a licensed RN or LPN.**

**Authorization for Health Care Provider and School Nurse to Share Information:**

I authorize my child's school nurse to assess my child in regards to his/her special health care needs and to discuss these needs with my child's physician as needed throughout the school year. I understand this is for the purpose of generating a health care plan for my child. I understand I may withdraw this authorization at any time and that this authorization must be renewed annually.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

Notes: \_\_\_\_\_

Signature below indicates that the plan is reviewed and appropriate documentation is complete.

School Nurse Signature \_\_\_\_\_ Date \_\_\_\_\_

**PLACE  
I.D.  
PHOTO  
HERE**



CLAY COUNTY DISTRICT SCHOOLS and  
CLAY COUNTY HEALTH DEPARTMENT  
SCHOOL HEALTH SERVICES



**MEDICAL PROCEDURE AUTHORIZATION**  
**(To be completed by parent)**

I, the undersigned, \_\_\_\_\_ have enrolled my  
child, \_\_\_\_\_ at \_\_\_\_\_.  
(Parent Name) (Child's Name) (School Name)

It is necessary for my child to have a medical procedure performed during school hours.

The procedure is: \_\_\_\_\_  
(Name of Procedure)

***A PHYSICIAN'S ORDER FOR THE PROCEDURE IS ON FILE AT THE SCHOOL: COPY ATTACHED.***

I specifically request that the above procedure be performed by members of the school staff. With the signing of this document I affirm that the individual(s) listed herein have been trained to perform this procedure to my satisfaction and that the procedure used meets with my approval. Therefore, there shall be no liability for civil damages as a result of the administration of the above procedure where the person administering the procedure acts as an ordinarily responsible, prudent person would have acted under the same or similar circumstances.

I also understand that if there is special equipment needed to perform this procedure it will be maintained by me, delivered to the school in working order daily, and that the school personnel will assume **no** responsibility for the proper maintenance or delivery of the special equipment necessary for this procedure.

The following staff member(s) have been trained to my satisfaction and in accordance with a procedure established by the school under the orders of my child's physician.

In the event the trained school board employee(s) cannot complete the above procedure as ordered and all efforts to secure a Clay County School Board substitute nurse have been exhausted:

I, \_\_\_\_\_ (or my designee) will be requested  
(Parent's Name)

to complete the procedure. If I, \_\_\_\_\_ (or my  
(Parent's Name)  
designee) am unavailable, I agree that a substitute nurse will be hired from an approved agency to complete the procedure.

Name(s) of staff members trained:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Parent Signature)

\_\_\_\_\_  
(Date)





**CLAY COUNTY DISTRICT SCHOOLS and  
CLAY COUNTY HEALTH DEPARTMENT  
SCHOOL HEALTH SERVICES**



**CLEARANCE FOR NON-MEDICAL SCHOOL EMPLOYEE  
TO PERFORM HEALTH PROCEDURE**

Part A: Registered Nurse Statement

On \_\_\_\_\_, \_\_\_\_\_ was able to demonstrate  
(Date) (Employee Name)  
competence in \_\_\_\_\_ to my satisfaction.  
(Health Procedure)

He/She exhibited an understanding of actual procedural measures, infection control, appropriate precautions for student safety, and criteria for consultation with a nurse/parent/physician.

Signed: \_\_\_\_\_, RN  
(Registered Nurse)

Date: \_\_\_\_\_

Part B: Employee Statement

On \_\_\_\_\_, I was instructed as to the performance of \_\_\_\_\_.  
(Date) (Health Procedure)

At that time a written procedure was made available to me, and I was given the opportunity to ask pertinent questions. I agree to perform the procedure, if assigned, according to written guidelines and to notify the appropriate medical person(s) or parent if difficulties arise.

Signed: \_\_\_\_\_  
(Employee)

Date: \_\_\_\_\_

## **CLEAN INTERMITTENT CATHETERIZATION (C.I.C.)**

### **PURPOSE:**

Clean intermittent catheterization is the periodic drainage, by catheter, of urine from the bladder. Use of this procedure ensures that the bladder is emptied at regular intervals in order to decrease the morbidity associated with residual urine and to avoid the permanent placement of a catheter in the bladder. The major reason for CIC is the student's kidney function. When the bladder is continually full, pressure forces urine into the ureters (tubes leading from the kidneys to the bladder). This in turn puts damaging pressure on the kidneys. Catheterization helps prevent such damaging pressure by regularly emptying the bladder of urine. Another reason for catheterization is the prevention of urinary tract infections and incontinence which requires the use of diapers or a permanently placed catheter into the bladder.

Under the Education for All Handicapped Children Act (P. L. 94.142), schools are required to provide catheterization to those students needing such services during the hours when they attend school. CIC has been designated as a School Health Services subcategory of related services and is neither a medical service nor a service that requires a physician or a nurse. Students should be assessed for their ability to assist or perform self-catheterization. School personnel designated to assist students in CIC should be trained in the proper procedures by a registered nurse or a physician.

### **PROCEDURE:**

CIC is a procedure for which some students may need assistance while attending school. The person designated to provide assistance does not necessarily have to be licensed. A health room designee, clerk, teacher, etc. trained by a physician or a registered nurse can perform this procedure.

Written parental permission must be obtained prior to assisting with or performing a CIC during school hours. In addition, procedures for CIC must be in accordance with written instructions received from the student's physician. Both the parental permission form and the physician's instructions should be kept in the student's cumulative health record. Doctor's orders must note the frequency with which catheters must be changed.

## CLEAN INTERMITTENT CATHETERIZATION (CIC) PROCEDURE FEMALE AND MALE

**PURPOSE:** To ensure periodic emptying of urine from a student's bladder.

**ACTION TO BE PERFORMED BY:** Person trained by a Registered Nurse.

**DOCTORS ORDERS:** *REQUIRED*

### STEPS:

1. Gather equipment in a clean, private area:

- Gloves.
- Catheter.
- Soap, water, and cotton balls or disposable wipes.
- Water-soluble lubricant (e.g. K-Y Jelly, never Vaseline).
- Container to collect urine, if student is unable to use the toilet for positioning in the case of a female or to be positioned near the toilet in the case of a male.
- Towel to place under student if student is unable to use the toilet for positioning in the case of a female or to be positioned near the toilet in the case of a male.

A bathroom with running water and a toilet is the optimum for purposes of teaching and normalizing the procedure.

2. Provide a private area for the student. Respect privacy.
3. Maintain Standard (Universal) Precautions throughout procedure. Wash hands and have student wash hands. Use standard procedures while dealing with body fluids. Use approved hand-washing technique.
4. Explain the procedure and its importance as it is being carried out. Use terms that the student can understand.
5. Position the student, assisting with removal or adjustment of clothing or diaper. Have the **female student** maintain a sitting position on the toilet whenever possible, otherwise position the student on her back with feet flat on cot, knees flexed and apart. Have the **male student** positioned near the toilet whenever possible, otherwise, try to maintain a comfortable sitting position. If the student will be learning self-catheterization, try to use the position that will be used later on.
6. Put on gloves. Gloves must be used for protection against body fluids.
7. Squeeze lubricant onto tip of catheter; leave in protective wrapper if available, otherwise place on clean paper towel, putting the large end of catheter in a collection container if student is not on toilet. Lubrication prevents trauma.
8. **Female student:** With the thumb and middle finger of the non-dominant hand, gently separate the labia, exposing the urethral meatus. Maintain separation with

slight backward and upward tension. Identification of anatomical landmarks should begin now.

**Male student:** With the non-dominant hand, hold the penis by the shaft and at an angle straight out from the student's body.

9. **Female student:** With the opposite hand, cleanse around the meatus using cotton balls saturated with soap and water, or disposable wipes. Make three single downward strokes, using a clean cotton ball or wipe for each stroke. Front to back cleansing prevents contamination.

**Male student:** With the opposite hand, cleanse around the meatus using cotton balls saturated with soap and water or disposable wipes. If the student is not circumcised, first retract the foreskin. Starting at the urethral meatus, wipe in widening circles around the meatus. Clean three times. Use a clean cotton ball or wipe each time and begin at the meatus each time.

10. **Female student:** While continuing to separate the labia with one hand, use the other hand to pick up the catheter approximately 3 inches from the tip; insert the catheter into the meatus, until urine begins to flow; then advance the catheter another one or two inches. Never force the catheter. Hold in place until urine stops flowing. Slight resistance as the catheter passes through the urinary sphincters may be met as you advance the catheter into the bladder. If strong resistance is met, do not force the catheter. Remove the catheter and notify the student's parents and/or public health nurse immediately.

**Male student:** Use the other hand to pick up the catheter approximately 3 inches from the tip; insert the catheter into the meatus, until urine begins to flow; then advance the catheter another one or two inches. Never force the catheter. Hold in place until urine stops flowing.

11. Remove the catheter, pausing if urine begins to flow again. Urine may start and stop with changes in the position of the catheter.
12. Assist the student to redress or to adjust clothing or diaper.
13. If collection container was used, observe urine for signs of abnormality, measure the amount and document, then discard. Observe and document the color, clarity, and odor.
14. If reusing the catheter, wash with warm soapy water, rinse, and dry. Place in plastic bag or other container. Send home if requested by parent/guardian. Using friction to clean catheter and creating a dry environment for storage will retard growth of germs on catheter.
15. Wash collection container with soap and water, rinse, and dry. Dispose of wipes or cotton balls. Retard growth of bacteria.
16. Remove gloves and discard. Discard glove in covered trash can.
17. Wash hands and have student wash hands.

18. Document procedure and results on flowsheet. Promptly report any abnormality to the parent and public health nurse.

**CLEAN INTERMITTENT CATHETERIZATION (CIC) SKILLS  
CHECKLIST  
FEMALE**

*\*Contact your school RN for a performance check and form completion.*

Name: \_\_\_\_\_ School: \_\_\_\_\_

SKILL	Performs skill in accordance to written guidelines	Requires further instruction & supervision
	Date	Date
1. Gather equipment in a clean, private area: <ul style="list-style-type: none"> <li>• Gloves.</li> <li>• Catheter.</li> <li>• Soap, water, and cotton balls or disposable wipes.</li> <li>• Water-soluble lubricant (e.g. K-Y Jelly, <b>never</b> Vaseline).</li> <li>• Container to collect urine, if student is unable to use the toilet for positioning.</li> <li>• Towel to place under student, if student is unable to use the toilet for positioning.</li> </ul>		
2. Provide a private area for the student.		
3. Maintain Standard (Universal) Precautions during procedure. Wash hands and have student wash hands.		
4. Explain the procedure and its importance as it is being carried out.		
5. Position the student, assisting with removal of pertinent clothing. Maintain a sitting position on the toilet whenever possible; otherwise position the student on her back with feet flat on cot, knees flexed and apart.		

<b>SKILL</b>	<b>Performs skill in accordance to written guidelines</b>	<b>Requires further instruction &amp; supervision</b>
	Date	Date
6. Put on gloves.		
7. Squeeze lubricant onto tip of catheter; leave in protective wrapper if available, otherwise place catheter on clean paper towel, putting large end of catheter in a collection container if student is not on toilet.		
8. With the thumb and middle finger of the non- dominant hand, gently separate the labia, exposing the urethral meatus. Maintain separation with slight backward and upward tension.		
9. With the opposite hand, cleanse around the meatus using cotton balls saturated with soap and water, or disposable wipes. Make three single downward strokes, using a clean cotton ball or wipe for each stroke.		
10. While continuing to separate the labia with one hand, use the other hand to pick up the catheter approximately 3 inches from the tip; insert the catheter into the meatus, until urine begins to flow, then advance the catheter another one or two inches. Never force the catheter. Hold in place until urine stops flowing.		
11. Remove the catheter, pausing if urine begins to flow again.		
12. Assist the student to redress.		

<b>SKILL</b>	<b>Performs skill in accordance to written guidelines</b>	<b>Requires further instruction &amp; supervision</b>
	Date	Date
13. If collection container was used, discard urine after observing for signs of abnormality and measuring the amount of urine.		
14. If reusing catheter, wash the catheter with warm soapy water, rinse, and dry. Place in plastic bag or other container. Send home for parent/guardian to sterilize.		
15. Wash collection container with soap and water, rinse, and dry. Dispose of wipes or cotton balls.		
16. Remove gloves and discard.		
17. Wash hands and have student wash hands		
18. Document procedure and results. Promptly report any abnormality to the parent or school nurse.		

Preceptor's Signature \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_

Preceptee's Signature \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_

*\*Initial and date in space beside each skill indicates procedure has been demonstrated in a competent manner.*



**CLEAN INTERMITTENT CATHETERIZATION (CIC) SKILLS CHECKLIST  
MALE**

*\*Contact your school RN for a performance check and form completion.*

Name: \_\_\_\_\_ School: \_\_\_\_\_

SKILL	Performs skill in accordance to written guidelines	Requires further instruction & supervision
	Date	Date
1. Gather equipment in a clean, private area: <ul style="list-style-type: none"> <li>• Gloves.</li> <li>• Catheter.</li> <li>• Soap, water, and cotton balls or disposable wipes.</li> <li>• Water-soluble lubricant (e.g. K-Y Jelly, <b>never</b> Vaseline).</li> <li>• Container to collect urine, if student is unable to use the toilet for positioning.</li> <li>• Towel to place under student, if student is unable to use the toilet for positioning.</li> </ul>		
2. Provide a private area for the student.		
3. Maintain Standard (Universal) Precautions during entire procedure. Wash hands and have student wash hands.		
4. Explain the procedure and its importance as it is being carried out.		
5. Position the student near the toilet whenever possible, assisting with adjustment of clothing or diaper.		
6. Put on gloves.		

SKILL	Performs skill in accordance to written guidelines	Requires further instruction & supervision
	Date	Date
<p>7. Squeeze lubricant onto tip of catheter; leave in protective wrapper if available, otherwise place catheter on clean paper towel, putting large end of catheter in a collection container if student is not on toilet.</p>		
<p>8. With non- dominant hand, hold the penis by the shaft and at an angle straight out from the students body.</p>		
<p>9. With the opposite hand, cleanse around the meatus using cotton balls saturated with soap and water, or disposable wipes. If the student is not circumcised, first retract the foreskin. Starting at the urethral meatus, wipe in widening circles around the meatus. Clean three times. Use a clean cotton ball or wipe each time and begin at the meatus each time.</p>		
<p>10. Use the other hand to pick up the catheter approximately 3 inches from the tip; insert the catheter into the meatus, until urine begins to flow; then advance the catheter another one or two inches. Never force the catheter. Hold in place until urine stops flowing.</p>		
<p>11. Remove the catheter, pausing if urine begins to flow again.</p>		
<p>12. Assist the student in adjusting clothing or diaper.</p>		

<b>SKILL</b>	<b>Performs skill in accordance to written guidelines</b>	<b>Requires further instruction &amp; supervision</b>
	Date	Date
13. If collection container was used, discard urine after observing for signs of abnormality and measuring the amount of urine.		
14. If reusing catheter, wash the catheter with warm soapy water, rinse, and dry. Place in plastic bag or other container. Send home for parent/guardian to sterilize.		
15. Wash collection container with soap and water, rinse, and dry. Dispose of wipes or cotton balls.		
16. Remove gloves and discard.		
17. Wash hands and have student wash hands.		
18. Document procedure and results. Promptly report any abnormality to the parent or school nurse.		

Preceptor's Signature \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_

Preceptee's signature \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_

*\* Initial and date in space beside each skill indicates procedure has been demonstrated in a competent manner.*

## UROSTOMY CATHETERIZATION PROCEDURE

**PURPOSE:** To drain collected urine from individuals who have had urinary diversion surgery. Intermittent catheterization may be clean or sterile as ordered by the physicians.

**ACTION TO BE PERFORMED BY:** Person trained by a Registered Nurse.

**DOCTORS ORDERS:** *REQUIRED*

### STEPS:

1. Provide a clean, private area for the procedure. Respect student's privacy.
2. Gather the equipment: gloves, catheter, soap, water, cotton balls (or physician ordered cleaning solution), water-soluble lubricant and container to collect urine. If instructing student in catheterization procedure, explain each step.
3. Maintain universal precautions throughout procedure. Wash hands and have student wash hands if assisting. Use universal precautions when handling body fluids. Use approved hand-washing technique
4. Explain procedure and its importance as it is being carried out. Use terms that the student can understand.
5. Position the student so he/she is comfortable and you are able to easily visualize the stoma. Assist with clothing removal or adjustment. If the student will be learning self-catheterization, try to use the position that he/she will use later on.
6. Prepare catheter supplies. Put on gloves to protect body from body fluids.
7. Clean stoma area starting at stoma and working out several inches in a circular motion using cotton balls saturated with soap and water (or physician ordered cleaning solution). Discard the cotton ball. Repeat 3 times. Cleaning from stoma out prevents contamination of the area.
8. Pick up catheter and apply small amount of lubricant to tip; insert into stoma 2-3 inches (never force catheter). Hold in place until urine stops flowing. Re-positioning the catheter may alleviate resistance
9. Remove catheter. Pause if urine begins to flow again.
10. Assist student in dressing.
11. Measure amount of urine. Assess color, clarity, and odor. Know what is "normal" for the particular student. Many urinary diversions will have cloudy urine or excessive mucous.

12. Instruct student in signs/symptoms of urinary infection and importance of reporting to physician if they occur. (Unusual odor, color and sedimentation)
13. If re-using the catheter; wash in warm soapy water, rinse, dry, and place in storage container. Discard all disposable equipment. Retard growth of bacteria.
14. Remove gloves and wash hands. Put gloves in trash and follow hand washing procedures.
15. Document procedure and results. Promptly report any abnormality to parents. Chart date, time, color, amount of urine and any unusual results of Catherization.

## UROSTOMY CATHETERIZATION SKILLS CHECKLIST

*\*Contact your school RN for your performance check and form completion.*

Name: \_\_\_\_\_ School \_\_\_\_\_

SKILL	Performs skill in accordance to written guidelines	Requires further instruction & supervision
	Date	Date
1. Gather equipment in a clean and private area. <ul style="list-style-type: none"> <li>• Gloves</li> <li>• Catheter</li> <li>• Soap</li> <li>• Water</li> <li>• Cotton balls</li> <li>• Water-soluble lubricant</li> <li>• Container to collect urine</li> </ul>		
2. Maintain universal precautions during procedure. Wash hands and if appropriate have student wash hands.		
3. Explain the procedure and its importance to the student.		
4. Position student so he/she is comfortable and you are able to easily visualize the stoma. Assist with removal of clothing or adjustment. If student will be learning self-catherization, try to use the position that he/she will use later on.		
5. Prepare catheter supplies.		
6. Put on gloves.		
7. Clean stoma areas from center outward in circular motion with cotton balls saturated with soap and water. With new cotton ball, repeat cleaning 3 times.		

<b>SKILL</b>	<b>Performs skill in accordance to written guidelines</b>	<b>Requires further instruction &amp; supervision</b>
	Date	Date
8. Apply lubricant to tip of catheter; insert 2-3 inches into stoma (never use force) and leave in place until urine flow stops. When urine flow stops, remove catheter.		
9. Assist student to dress.		
10. Measure amount of urine; assess for color, clarity, and odor. Discard in toilet.		
11. If reusing catheter wash in warm soapy water, rinse, dry and place in storage container. Discard disposable equipment.		
12. Remove gloves and wash hands.		
14. Document procedure and results. Promptly report any abnormality to the parent or school nurse.		

Preceptor's Signature: \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_

Preceptor's Signature: \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_

*\*Initial and date in space beside each skill indicates procedure has been demonstrated in a competent manner.*

**Distribution:** Original in the health room, copy in student health file.





## Ostomy Care

An Ostomy is an opening through the skin of the abdomen into the intestine where stool is formed. The opening may be into the ileum (ileostomy) or the colon (colostomy). The opening is called a stoma. Stool drains through the stoma into a pouch on the abdomen. Ostomy pouches come in many styles. When changing the pouch, check the skin around it. The stoma is a mucus membrane-pink or red and moist-looking. It may bleed when you clean or wipe it. The part of the pouch that sticks to the skin is the skin barrier wafer. This must fit snugly around the stoma to prevent leakage of the stool onto the skin, causing irritation and skin breakdown. If the skin is irritated around the stoma, notify the parent.

Burping the bag, when the bag has filled with gas will help to prevent the bag from coming loose and relieve discomfort caused by the gas.

## CHANGING COLOSTOMY/ILEOSTOMY COLLECTION BAG

**PURPOSE:** To ensure periodic emptying/changing of ostomy appliances for prevention of skin breakdown and appropriate hygiene practices.

**ACTION TO BE PERFORMED BY:** Person trained by a Registered Nurse.

**DOCTORS ORDERS:** *REQUIRED*

### STEPS:

1. Assemble equipment. Stored (location):

---

  - a. Soap and water
  - b. Soft cloth or gauze
  - c. Skin preparation
  - d. Adhesive
  - e. Tape
  - f. Clean bag and belt, if needed
  - g. Disposable gloves
  - h. Scissors (if needed to cut skin barrier)
2. Wash hands and apply gloves.
3. Provide private area.
4. Assist student as needed to undress to extent needed for procedure.
5. Empty contents of used bag into toilet.

6. Carefully remove the used bag and skin barrier by pushing the skin away from the bag, instead of pulling the bag off the skin.
7. If a skin barrier is used that requires fitting, measure stoma.
8. Pat actual stoma clean using moistened toilet tissue or facial tissue. Cover the stoma with gauze or cloth and clean the skin around the stoma. **DO NOT SCRUB THE STOMA OR THE SKIN.**
9. Inspect the skin for redness, rash, or blistering. Do not put medication, ointment or adhesive on the damaged skin. Report skin redness, rash, lesions or bleeding promptly to parent and for:
  - a. Drops of blood: pat gently with soft cloth/gauze.
  - b. Moderate bleeding: apply gentle pressure using soft cloth/gauze.
  - c. Heavy/continued moderate bleeding: apply firm pressure using soft cloth/gauze. Call 9-1-1 if necessary.
10. Pat skin dry with soft cloth/gauze.
11. Place skin barrier on skin around stoma.
12. Peel off backing from adhesive, or apply adhesive to bag if necessary.
13. Center the new bag directly over the stoma.
14. Firmly press the bag to the skin barrier so there are no leaks or wrinkles.
15. Record procedure on flow sheet.
16. Remove gloves and wash hands.
17. Report to the parent by the end of school day any change in stool pattern.



**CHANGING COLOSTOMY/ILEOSTOMY COLLECTION BAG**

*\*Contact your school RN for a performance check and form completion.*

Name: \_\_\_\_\_ School: \_\_\_\_\_

SKILL	Performs skill in accordance to written guidelines	Requires further instruction & supervision
	Date	Date
1. Assemble equipment. a. Soap and water b. Soft cloth or gauze c. Skin preparation d. Adhesive e. Tape f. Clean bag and belt, if needed g. Disposable gloves h. Scissors (if needed to cut skin barrier)		
2. Wash hands and apply gloves.		
3. Provide private area.		
4. Assist student as needed to undress to extent needed for procedure.		
5. Empty contents of used bag into toilet.		
6. Carefully remove the used bag and skin barrier by pushing the skin away from the bag, instead of pulling the bag off the skin.		
7. If a skin barrier is used that requires fitting, measure stoma.		
8. Pat actual stoma clean using moistened toilet tissue or facial tissue. Cover the stoma with gauze or cloth and clean the skin around the stoma. <b>DO NOT SCRUB THE STOMA OR THE SKIN.</b>		

<b>SKILL</b>	<b>Performs skill in accordance to written guidelines</b>	<b>Requires further instruction &amp; supervision</b>
	Date	Date
9. Inspect the skin for redness, rash, or blistering. Do not put medication, ointment or adhesive on the damaged skin. Report skin redness, rash, lesions or bleeding promptly to parent and for: a. Drops of blood: pat gently with soft cloth/gauze. b. Moderate bleeding: apply gentle pressure using soft cloth/gauze. c. Heavy/continued moderate bleeding: apply firm pressure using soft cloth/gauze. Call 9-1-1 if necessary.		
10. Pat skin dry with soft cloth/gauze.		
11. Place skin barrier on skin around stoma.		
12. Peel off backing from adhesive, or apply adhesive to bag if necessary.		
13. Center the new bag directly over the stoma.		
14. Firmly press the bag to the skin barrier so there are no leaks or wrinkles.		
15. Record procedure on flow sheet.		
16. Remove gloves and wash hands.		
17. Report to the parent by the end of school day any change in stool pattern.		

Preceptor's Signature \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_

Preceptee's signature \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_

*\*Initial and date in space beside each skill indicates procedure has been demonstrated in a competent manner.*

## CRÉDÉ MANEUVER PROCEDURE

**PURPOSE:** Application of manual pressure over lower abdomen to promote emptying of bladder.

**ACTION TO BE PERFORMED BY:** Person trained by a Registered Nurse.

**DOCTORS ORDERS: *REQUIRED***

### **PROCEDURE:**

1. Gather equipment in a clean private area.

- Gloves
- Diapers
- Urinal

A bathroom with running water and toilet is the optimum place for purposes of teaching and normalizing the procedure.

2. Explain the procedure to the student. Use terms that the student can understand.

3. Provide a private area for the student. Respect privacy.

4. Maintain Standard (Universal) Precautions during procedure. Wash hands. Use standard procedures while dealing with body fluids. Use approved hand-washing technique.

5. Position student on: toilet, or lying on absorbent material on a changing table.

6. Put on gloves. Gloves must be used for protection against body fluids.

7. Place your hands flat on the student's abdomen just below the umbilicus. Then firmly stroke downward toward the bladder about six times to stimulate the voiding reflex. Identification of anatomical landmarks should begin now. Application of manual pressure over the lower abdomen promotes complete emptying of the bladder.

8. Place one hand on top of the other above the pubic arch. Press firmly inward and downward to compress and expel residual (retained) urine. Continue the procedure as long as urine can be manually expressed.

9. If collection container is used, discard urine after observing for signs of abnormality and measuring the amount of urine. Observe and document the color, clarity, and odor.

10. Remove gloves and discard.
11. Wash Hands.
12. Document procedure and the amount of urine expelled. (If the urine was not measured in a bedpan or urinal, record using the words, small, moderate, large.)

HAND POSITIONING FOR CAREGIVER'S SANITIZER



**CRÉDÉ MANEUVER SKILLS CHECKLIST**

*\*Contact your school RN for a performance check and form completion.*

Name: \_\_\_\_\_ School: \_\_\_\_\_

SKILL	Performs skill in accordance to written guidelines	Requires further instruction & supervision
	Date	Date
1. Gather equipment in a clean private area. <ul style="list-style-type: none"> <li>• Gloves</li> <li>• Diapers</li> <li>• Urinal</li> </ul>		
2. Explain the procedure to the student.		
3. Provide a private area for the student.		
4. Maintain Standard (Universal) Precautions during procedure. Wash hands.		
5. Position student on: toilet, or lying on absorbent material on a changing table.		
6. Put on gloves.		
7. Place your hands flat on the student's abdomen just below the umbilicus. Then firmly stroke downward toward the bladder about six times to stimulate the voiding reflex.		
8. Place one hand on top of the other above the pubic arch. Press firmly inward and downward to compress and expel residual (retained) urine.		
9. If collection container is used, discard urine after observing for signs of abnormality and measuring the amount of urine.		
10. Remove gloves and discard.		
11. Wash Hands.		



<b>SKILL</b>	<b>Performs skill in accordance to written guidelines</b>	<b>Requires further instruction &amp; supervision</b>
	Date	Date
12. Document procedure and the amount of urine expelled. (If the urine was not measured in a bedpan or urinal, record using the words, small, moderate, large.)		

Preceptor's Signature \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_

Preceptee's signature \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_

*\*Initial and date in space beside each skill indicates procedure has been demonstrated in a competent manner.*

## DIAPERING

**PURPOSE:** To maintain the students safety and comfort during diapering while safeguarding against infection.

**NOTE:** Changing diapers in a sanitary way is one of the most important things a school staff member can do to prevent the spread of infectious organisms present in stool. You can help prevent infection and illness among staff, students, and their families by remembering the following guidelines as you diaper students.

**EQUIPMENT:** A. Changing surface-If using an elevated changing table, a restraining strap must be used. Keep students away from the changing surface. Cover it with a smooth, non-porous, moisture resistant, and easily cleanable material. For extra protection, use disposable examining table paper and change it between each use.

B. Hand washing sink and towels-The sink should be in the same room as the changing surface. Soap and towels should be kept at the sink and single-service; disposable towels (i.e. paper towels) should be used.

C. Skin-care items-Keep changing supplies away from students. Keep skin care items nearby. Use cloths and towels only once, and discard. Many disposable diapering cloths are available.

D. Waste container-For disposable diapers use a tightly covered washable container with a foot operated lid. Line the container with a disposable trash bag. Keep it away from students. Remove soiled diapers daily, with double bagging technique.

E. Potty Chairs-Chair frames should be smooth and easily cleanable. The waste container should be removable. Sanitize the chair and frame after each use.

F. Cleaning Supplies-

- 1) Disposable towels/cloths
- 2) Sanitizing chemical solution made from 1 part household bleach per 10 parts tap water. Solution should be prepared daily or stored in air-tight container. Leave the bleach solution on the surface for at least one minute (or for ten minutes at the end of the day or when the surface is soiled with body fluid). Keep solution out of reach of students.

G. Supplies Necessary-

- 1) Clean Diaper
- 2) Disposable wipes
- 3) Toilet paper
- 4) Small plastic bag for disposal of feces

**DOCTORS ORDERS: *NOT REQUIRED***

**STEPS:**

1. Assemble supplies and place clean paper on table or clean surface.
2. Wash hands; put on disposable latex gloves.
3. Assist or take students to changing table/surface.
4. DO NOT leave student unattended.
5. Talk cheerfully to the student during the procedure as some students may be uncomfortable with the height of the table or be embarrassed by the procedure.
6. Remove soiled or wet diaper, fold soiled portion inward, and immediately place in plastic bag or trash can.
7. Do not place wet soiled diaper on table, floor or sink.
8. Remove loose feces from skin with toilet paper or moisturized wipes. Wash the skin gently with moisturized wipes.
9. Dry area well. Apply diaper creams and lotions only with written request by parent.
10. Apply clean diaper and secure outer clothing.
11. Assist student off changing table and return to classroom.
12. Clean and disinfect changing surface.
13. Wash hands.
14. Return all supplies to designated areas and put clean table paper in place.

**Frequency of Diaper Changes:**

- A. All diapers should be checked every two (2) hours and changed immediately if soiled to prevent skin irritations.
- B. There could be circumstances when the changing schedule should be altered due to field trips and other special activities. A reasonable alternative plan should be developed for these occasions.
- C. It is suggested that students in diapers have toileting logs kept on the bathroom door or other central location. Logs will be kept by the teacher and discarded at the end of summer school each year.

## **CARE OF MENSTRUATING SPECIAL NEEDS CHILD**

### A. General Information:

- 1.) The established guidelines for growth and development/health curriculum will be followed in teaching handicapped students.
- 2.) The exceptional child may require additional assistance or monitoring, depending upon her individual limitations, whether mental or physical.
- 3.) The same consideration for privacy and hygiene apply to those reviewed in the discussion on hygiene and diaper changing.
- 4.) Supplying feminine hygiene supplies is the responsibility of the parent. Only pads should be used at school. It remains the responsibility of the school staff to promote good skin care and hygiene while the student is at school. There are feminine hygiene supplies available at school for emergencies and accidents.
- 5.) Procedures for handling bodily fluids should be followed when assisting students with the changing of pads. Proper procedures for disposal of pads, and/or contaminated items should be followed.

### B. Unique considerations:

Additional monitoring and education may be required for students who are mentally handicapped. More repetition of instructions in hygiene is required. Frequent viewing and reviewing of materials on menstruation is necessary.

Identification of girls needing assistance with hygiene while maintaining their right to privacy is difficult. All adult caretakers should be made aware so that they can send the child for changing or remind the student to check herself. The staff at each school should develop a method of identifying these students requiring assistance during menstruation. One method is the use of a log, which easily tracks irregularities, heavy or light flows, or behavior problems. The staff can then anticipate menstrual time. Gloves should be worn when handling soiled hygiene supplies and clothing. Both gloves and soiled items should be placed in a plastic bag and tied before disposal. Soiled clothing should be placed in a plastic bag to be returned home.

## **GASTROSTOMY TUBE FEEDING PROCEDURE**

**PURPOSE:** To provide feedings for the student who is unable to receive adequate nourishment by mouth.

**ACTION TO BE PERFORMED BY:** Person trained by a Registered Nurse.

**DOCTORS ORDERS:** *REQUIRED*

### **STEPS:**

1. Review the physician's treatment order.
2. Assemble equipment:
  - Feeding solution at room temperature.  
Allow feeding solution to sit at room temperature for one hour. Excessive heat coagulates feedings. Excessive cold can reduce the flow of digestive enzymes and cause abdominal cramping.
  - 20-60 cc syringe with catheter tip.
  - Tubing clamp or plug.
  - Container of water.
3. Encourage student to participate as much as possible.
4. Position student sitting upright or semi-reclining with head of bed or chair at a 45-degree angle. These positions enhance the gravitational flow of the feeding and help prevent aspiration into the lungs.
5. Use Standard (Universal) Precautions throughout the entire procedure. Wash hands and apply gloves.
6. Observe stoma and skin around gastrostomy for bleeding sores or leakage. Report any signs of infection, irritation, or leakage. If ordered, clean with prescribed cleaning solution.
7. Check for proper tube placement.
  - Draw 5 to 10cc's of air into a syringe. Place stethoscope on the left side of the abdomen just above the waist. Attach syringe and/or adapter to the tube or button.
  - Unclamp the tube.
  - Gently inject air into the feeding port and listen to the stomach for an "air rush" (gurgling or growling sound).

8. If checking residual was ordered, then aspirate all of stomach contents and note amount; then re-instill the entire aspirate. If quantity of residual is greater than physician ordered, DO NOT FEED. Delay 30 minutes; then repeat aspiration. If residual continues to be greater than ordered contact parent. This is done to evaluate absorption of last feeding, i.e., whether or not there is undigested feeding solution remaining from previous feeding (residual). If a residual is present, adjust the feeding according to orders.
9. Clamp the tube, remove the syringe, and reattach the syringe (without the plunger) or the feeding bag to the clamped tube or into button. Clamping the tube keeps excess air from entering the stomach, preventing distention.
10. Unclamp the tube; allow air bubbles to escape; fill the syringe with feeding solution or attach prepared feeding bag containing solution (room temperature). Elevate the tube and syringe to about 4-6 inches above the student's abdomen to start the feeding.
11. Allow the feeding to flow by gravity, adding solution slowly as contents empty, keeping solution in the syringe\* at all times until feeding is complete. NEVER FORCE solution through the tube. If tube is obstructed, do not feed. Contact parent. If using feeding bag/gravity, position bag at height slightly above student's head. Raise or lower the syringe to regulate the rate of the flow. Feeding should take 20-30 minutes. Keeping the syringe partially filled prevents air from entering the stomach. For continuous feeding with pump, place tubing into pump mechanism and set for flow ordered. Stay with the student throughout the feeding.
12. When nearly all the feeding is gone, add prescribed amount of water into syringe or feeding bag (flush). This will clear the solution from the tubing and prevent occlusion.
13. Clamp the tube just above the stoma before the water has completely cleared the tubing. Avoid introducing extra air into the stomach.
14. Remove the syringe, adapter, or bag and tubing. Re-plug tubing.
15. Wash syringe with soap and water; rinse thoroughly, and allow to air dry. This prevents growth of bacteria.
16. Remove gloves. Wash hands.
17. Document procedure.
18. Allow student to remain upright or elevated for 30 minutes after feeding. This helps prevent vomiting and/or aspiration, if student should regurgitate. Observe student for any changes.

**GASTROSTOMY TUBE FEEDING  
SKILLS CHECKLIST**

*\*Contact the school RN for a performance check and form completion.  
NOTE: This is a student specific procedure and not all steps may apply.*

Name: \_\_\_\_\_ School: \_\_\_\_\_

<b>SKILL</b>	<b>Performs skill in accordance to written guidelines</b>	<b>Requires further instruction &amp; supervision</b>
	Date	Date
1. Assemble equipment: <ul style="list-style-type: none"> <li>• Feeding solution at room temperature.</li> <li>• 20-60 cc syringe with catheter tip.</li> <li>• Tubing clamp or plug.</li> <li>• Container of water.</li> </ul>		
2. Encourage student to participate as much as possible.		
3. Position student sitting upright or semi-reclining with head of bed or chair at a 45-degree angle.		
4. Maintain Standard (Universal) Precautions throughout entire procedure. Wash hands and apply gloves.		
5. Observe stoma and skin around gastrostomy for bleeding sores or leakage. Further observation of tube placement is dependent on type of tube placed.		

SKILL	Performs skill in accordance to written guidelines	Requires further instruction & supervision
	Date	Date
<p>6. Check for proper tube placement.</p> <ul style="list-style-type: none"> <li>• Draw 5 to 10cc's of air into the syringe.</li> <li>• Place stethoscope on the left side of the abdomen just above the waist.</li> <li>• Attach syringe and/or adapter to the tube or button.</li> <li>• Unclamp the tube.</li> <li>• Gently inject air into the feeding port and listen to the stomach for an "air rush" (gurgling or growling sound).</li> </ul>		
<p>7. If checking residual was ordered, aspirate all of stomach contents and note amount; then re-instill all of the aspirate. If quantity of residual is greater than physician ordered, DO NOT FEED. Delay for 30 minutes, then repeat aspiration. If residual continues to be greater than ordered, contact school RN if in building, otherwise parent.</p>		
<p>8. Clamp the tube, remove the syringe, and re-attach the syringe (without the plunger) to the clamped tube or feeding tube.</p>		



<b>SKILL</b>	<b>Performs skill in accordance to written guidelines</b>	<b>Requires further instruction &amp; supervision</b>
	Date	Date
10. Allow the feeding to flow by gravity, adding solution slowly as contents empty, keeping solution in the syringe at all times until feeding is complete. NEVER FORCE solution through the tube. If tube is obstructed, DO NOT FEED. Contact school RN, if in the building, otherwise parent. *If using feeding bag/gravity, position bag at height slightly above student's head. For continuous feeding with pump, place tubing in pump mechanism and set flow as ordered.		
11. When nearly all the feeding is gone, add prescribed amount of water into syringe or feeding bag (flush).		
12. Clamp the tube just above the stoma before the water has completely cleared the tubing.		
13. Remove the syringe, adapter, or bag and tubing.		
14. Wash syringe with soap and water; rinse thoroughly and allow to air dry.		
15. Remove gloves. Wash hands.		
16. Document procedure.		

**Clay County School Health Services Manual**

<b>SKILL</b>	<b>Performs skill in accordance to written guidelines</b>	<b>Requires further instruction &amp; supervision</b>
	Date	Date
17. Allow student to remain upright or elevated for 30 minutes after feeding.		

Preceptor's Signature \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_

Preceptee's signature \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_

*\*Initial and date in space beside each skill indicates procedure has been demonstrated in a competent manner.*

**TUBE FEEDING:  
INSTILLATION OF MEDICATION THROUGH FEEDING TUBE**

**ACTION TO BE PERFORMED BY:** Person trained by a Registered Nurse.

**EQUIPMENT:**

- a) Medication, properly identified according to procedure outlined in the district's School Health Services Manual.
- b) Small container with tap water to follow medication
- c) Catheter tip syringe and tubing (provided by the guardian)
- d) Clamp if needed

**DOCTORS ORDERS:** *REQUIRED*

**STEPS:**

1. Assemble equipment and ensure a clean work area.
2. Wash hands thoroughly with soap and water, put on gloves
3. Prepare medication for administration through feeding tube according to physicians order and if available, manufacturer package insert.
4. Explain the procedure to the student to minimize fear and enhance student comprehension and communication skills.
5. Position the student with head elevated at least 30 degrees.
6. Fill the syringe and catheter with medication.
7. Disconnect the tube from continuous feeding, pinching the tube to keep large amounts of air from entering the stomach or open the safety plug and attach feeding catheter.
8. As soon as the medication has been instilled, and before air is absorbed through the tube, flush with at least 30cc (1 oz) of tap water, or amount specified in doctors order.
9. As the last of the water drains, reconnect or clamp the feeding tube.
10. Remove gloves and dispose of glove and any other soiled materials in a plastic bag
11. Wash hands
12. Document on Medication Administration form.

**TUBE FEEDING:  
INSTILLATION OF MEDICATION THROUGH FEEDING TUBE**

*\*Contact your school RN for a performance check and form completion.*

Name: \_\_\_\_\_ School: \_\_\_\_\_

SKILL	Performs skill in accordance to written guidelines	Requires further instruction & supervision
	Date	Date
1. Assemble equipment and ensure a clean work area.		
2. Wash hands thoroughly with soap and water, put on gloves		
3. Prepare medication for administration through feeding tube according to physicians order and if available, manufacturer package insert.		
4. Explain the procedure to the student to minimize fear and enhance student comprehension and communication skills.		
5. Position the student with head elevated at least 30 degrees		
6. Fill the syringe and catheter with medication		
7. Disconnect the tube from continuous feeding, pinching the tube to keep large amounts of air from entering the stomach or open the safety plug and attach feeding catheter.		
8. As soon as the medication has been instilled, and before air is absorbed through the tube, flush with at least 30cc (1 oz) of tap water, or amount specified in plan.		
9. As the last of the water drains reconnect or clamp the feeding tube		

**Clay County School Health Services Manual**

<b>SKILL</b>	<b>Performs skill in accordance to written guidelines</b>	<b>Requires further instruction &amp; supervision</b>
	Date	Date
10. Remove gloves and dispose of glove and any other soiled materials in a plastic bag		
11. Wash hands		
12. Document on Tube Feeding Documentation form.		

Preceptor's Signature \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_

Preceptee's signature \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_

*\*Initial and date in space beside each skill indicates procedure has been demonstrated in a competent manner.*

## TUBE FEEDING STORAGE OF NUTRITIONAL FORMULAS

**PURPOSE:** To minimize waste of formula while providing safe nutritional support.

**NOTES:**

- A. The parent will supply all formulas.
- B. Formulas will be administered only with a written physicians order.
- C. All formula received at the school must be in unopened containers.
- D. As formula is received at the school it will be immediately marked with the student's name.

**DOCTORS ORDERS:** *NOT REQUIRED*

**STEPS:**

1. Identify the formula by checking the physicians order. Check the expiration date.
2. For liquid or concentrated liquid formulas:
  - a) Wash the top of the can, prior to opening, with tap water, or if obviously soiled, with soap and water.
  - b) Mix and administer according to physicians order and tube feeding procedures.
  - c) Label the can with a marker and/or tape specifying the student's name, the date and time of opening, and the initials of the person opening the can.
  - d) Store the unused formula in a refrigerator, preferably with a cap on the can.
  - e) Never return poured formula to the can. Any portion which has been poured and/or mixed should be discarded.
  - f) Discard unused formula if open over 24 hours.
  - g) When using an already opened can, check the label for the students name and the date and time it was opened. Discard if improperly labeled, opened more than 24 hours, or if anything seems questionable.
3. Powdered Formula:
  - h) If opening for the first time, wash the can lid with tap water or soapy water if soiled.
  - i) Mix and administer according to physicians order and tube feeding procedure.
  - j) Label the can with a marker and/or tape specifying the student's name, date of opening, and initials of person opening the can.
  - k) Store according to package specification in a secured area making certain that the lid has been tightly replaced.
  - l) IF the package specifies a length of time after which the opened powder should be discarded, mark the projected discard date clearly on the label.



## TUBE SITE CARE

(Gastrostomy/Jejunostomy)

### PURPOSE:

To prevent skin breakdown and infection around tube insertion site and to keep tube from becoming clogged.

### TERMS:

**G Tube**= Gastrostomy Tube; a tube inserted through a surgical opening in the abdominal wall into the stomach.

**J Tube**= Jejunostomy Tube; a tube inserted through a surgical opening in the abdominal wall directly into the jejunum.

**NOTES:** Students with jejunostomy/gastrostomy tubes will receive tube care at the discretion of the nurse. Routine tube care should be scheduled outside of school hours.

### EQUIPMENT:

- a) Cotton tipped swabs
- b) Sterile saline or water
- c) 2x2 gauze pads

### DOCTORS ORDERS: *REQUIRED*

### STEPS:

1. Assemble equipment in a clean work area.
2. Talk to student to minimize surprise and to enhance student's comprehension and communication skills.
3. Position the student on his/her back or right side.
4. Wash hands. Put on gloves.
5. Remove the old dressing and discard in a lined waste container
6. Dampen the tips of the swabs with sterile saline or water.
7. Clean around the tube in circles, moving outward from the opening. All drainage, wet or dried, must be removed.
8. Observe the site for signs of infection such as redness, swelling, heat, tenderness, oozing and report such signs to the parent.
9. Dry the area well with a 2x2 gauze.
10. Apply sterile gauze around the tube site to absorb leakage if appropriate.



11. Remove gloves and dispose of gloves and other soiled disposable items in a plastic bag or lined waste can.
12. Wash hands
13. Staff will note date and time of tube care; color, amount, consistency and odor of drainage; other pertinent information on Tube Site Care form.



**TUBE SITE CARE**  
(Gastrostomy/Jejunostomy)

*\*Contact your school RN for a performance check and form completion.*

Name: \_\_\_\_\_ School: \_\_\_\_\_

<b>SKILL</b>	<b>Performs skill in accordance to written guidelines</b>	<b>Requires further instruction &amp; supervision</b>
	Date	Date
1. Assemble equipment in a clean work area.		
2. Talk to student to minimize surprise and to enhance student's comprehension and communication skills		
3. Position the student on his/her back or right side.		
4. Wash hands. Put on gloves		
5. Remove the old dressing and discard in a lined waste container		
6. Dampen the tips of the swabs with sterile saline or water.		
7. Clean around the tube in circles, moving outward from the opening. All drainage, wet or dried, must be removed.		
8. Observe the site for signs of infection such as redness, swelling, heat, tenderness, oozing and report such signs to the guardian.		
9. Dry the area well with 2x2 gauze		
10. Apply sterile gauze around the tube site to absorb leakage if appropriate.		

<b>SKILL</b>	<b>Performs skill in accordance to written guidelines</b>	<b>Requires further instruction &amp; supervision</b>
	Date	Date
11. Remove gloves and dispose of gloves and other soiled disposable items in a plastic bag or lined waste can.		
12. Wash hands		
13. Staff will note date and time of tube care; color, amount, consistency and odor of drainage; other pertinent information on Tube Site Care form.		

Preceptor's Signature \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_

Preceptee's signature \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_

*\*Initial and date in space beside each skill indicates procedure has been demonstrated in a competent manner.*

## NASAL SUCTIONING

**ACTION TO BE PERFORMED BY:** Person trained by a Registered Nurse.

1. To clean the nasal passages of mucus and discharge
2. To prevent complications of mucus remaining in the upper respiratory tract

**EQUIPMENT:**

1. Bulb Syringe
2. Normal Saline Solution
3. Eye Dropper
4. A second person may be needed to help hold the head/hands

**DOCTORS ORDERS:** *REQUIRED*

**STEPS:**

1. Identify Need.  
*Note: sounds of nasal congestion*
2. Wash hands following hand washing procedure.
3. Obtain equipment and arrange on clean surface.
4. Explain procedure to child using appropriate developmental approach.
5. Insert 1-2 drops of saline into one nostril. Prepare to suction saline and mucus once the saline causes some thinning of mucus.
6. Depress syringe bulb with thumb and insert into nostril, release to suction. Do not place suction tip directly against wall of nasal passages after bulb is depressed.
7. Repeat steps 5 & 6 on other nostril. Continue to suction alternate nostrils until nasal passages sound clear.
8. Evacuate bulb syringe and clean. Wash bulb syringe in warm soapy water and place in an open area to dry.
9. Wash hands following hand washing procedures.
10. Document procedure by charting date, time, type and amount of mucus, and child's response

## NASAL SUCTIONING

*\*Contact your school RN for a performance check and form completion.*

Name: \_\_\_\_\_ School: \_\_\_\_\_

SKILL	Performs skill in accordance to written guidelines	Requires further instruction & supervision
	Date	Date
1. Identify Need. i. <i>Note: sounds of nasal congestion</i>		
2. Wash hands following hand washing procedure		
3. Obtain equipment and arrange on clean surface.		
4. Explain procedure to child using appropriate developmental approach.		
5. Insert 1-2 drops of saline into one nostril. Prepare to suction saline and mucus once the saline causes some thinning of mucus.		
6. Depress syringe bulb with thumb and insert into nostril, release to suction. Do not place suction tip directly against wall of nasal passages after bulb is depressed.		
7. Repeat steps 5 & 6 on other nostril. Continue to suction alternate nostrils until nasal passages sound clear.		
8. Evacuate bulb syringe and clean. Wash bulb syringe in warm soapy water and place in an open area to dry.		
9. Wash hands following hand washing procedures.		

<b>SKILL</b>	<b>Performs skill in accordance to written guidelines</b>	<b>Requires further instruction &amp; supervision</b>
	Date	Date
10. Document procedure by charting date, time, type and amount of mucus, and child's response		

Preceptor's Signature \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_

Preceptee's signature \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_

*\*Initial and date in space beside each skill indicates procedure has been demonstrated in a competent manner.*

## ORAL SUCTIONING

**ACTION TO BE PERFORMED BY:** Person trained by a Registered Nurse.

1. To remove secretions from the mouth and throat
2. To stimulate the cough reflex
3. To promote optimal respiratory function

**EQUIPMENT:**

1. Suctioning unit
2. Disposable connecting tube
3. Disposable catheter and glove or clean YanKauer Catheter
4. Bottle of Saline
5. Clean rinsing container
6. Tissues
7. Paper bag
8. A second person may be needed to help hold the head/hands

**DOCTORS ORDERS:** *REQUIRED*

**STEPS:**

1. Identify Need. Check MD orders, observe for respiratory congestion.
2. Obtain equipment. Use a clean table at a convenient height.
3. Connect machine. Put adapter into wall outlet if vacuum type is used.  
Check functioning of machine by turning to “on” position
4. Wash hands by following Follow hand washing procedure
5. Explain procedure to student by using appropriate developmental approach.
6. Arrange equipment. Open Catheter and have gloves ready. Open and fill rinsing container with normal saline. Open connecting tube to suction outlet. Place end that will be connected to catheter to avoid contamination.
7. Place glove on dominant hand. This hand will hold the catheter.
8. Attach suction tube to catheter. Hold catheter in gloved hand, pick up suction tube with ungloved hand and attach it by pushing/twisting gently.
9. Turn on suction machine using gloved hand.



10. Moisten tip of catheter by dipping end into saline.
11. Put catheter into mouth and pinch tube during insertion.
12. Apply suction pressure. Occlude lumen of catheter near the connection to suction tube with ungloved hand during insertion; release to apply suction.
13. Rotate suction catheter around mouth. Alternately apply/release suction pressure.
14. Rinse small "C" Catheter and dip into saline basin intermittently and apply pressure. Rinse frequently.
15. Repeat suctioning until the entire area is cleared of mucus. Stop periodically and observe respiratory effort. Repeat as necessary.
16. Allow student to cough and/or expectorate mucus and repeat as necessary.
17. Clear all tubes and rinse with intermittent suction applied.
18. Turn suction machine off using ungloved hand.
19. Remove glove and discard in covered trash can.
20. Cover end of connection tube and disconnect from suction machine.
21. Wash hands using hand washing procedure.
22. Document procedure by charting date, time, type and amount of secretions, and child's response.

**METHODS OF CARE:**

- Disposable plastic suction catheter for oral use: discard at the end of the day or sooner as necessary
- Yankauer Suction Catheter: wash in soapy water daily; every 2 days, after washing in soapy water, soak in 50% vinegar solution for 20 minutes and rinse well.

## ORAL SUCTIONING

*\*Contact your school RN for a performance check and form completion.*

Name: \_\_\_\_\_ School: \_\_\_\_\_

SKILL	Performs skill in accordance to written guidelines	Requires further instruction & supervision
	Date	Date
1. Identify Need. Check MD orders, observe for respiratory congestion		
2. Obtain equipment. Use a clean table at a convenient height		
3. Connect machine. Put adapter into wall outlet if vacuum type is used. Check functioning of machine by turning to "on" position		
4. Wash hands by following Follow hand washing procedure.		
5. Explain procedure to student by using appropriate developmental approach.		
6. Arrange equipment. Open Catheter and have gloves ready. Open and fill rinsing container with normal saline. Open connecting tube to suction outlet. Place end that will be connected to catheter to avoid contamination.		
7. Place glove on dominant hand. This hand will hold the catheter.		
8. Attach suction tube to catheter. Hold catheter in gloved hand, pick up suction tube with ungloved hand and attach it by pushing/twisting gently.		
9. Turn on suction machine using gloved hand.		

SKILL	Performs skill in accordance to written guidelines	Requires further instruction & supervision
	Date	Date
10. Moisten tip of catheter by dipping end into saline.		
11. Put catheter into mouth and pinch tube during insertion		
11. Apply suction pressure. Occlude lumen of catheter near the connection to suction tube with ungloved hand during insertion; release to apply suction.		
12. Rotate suction catheter around mouth. Alternately apply/release suction pressure.		
13. Rinse Catheter and dip into saline basin intermittently and apply pressure. Rinse frequently.		
14. Repeat suctioning until the entire area is cleared of mucus. Stop periodically and observe respiratory effort. Repeat as necessary.		
15. Allow student to cough and/or expectorate mucus and repeat as necessary.		
16. Clear all tubes and rinse with intermittent suction applied.		
17. Turn suction machine off using ungloved hand.		
18. Remove glove and discard in covered trash can.		

<b>SKILL</b>	<b>Performs skill in accordance to written guidelines</b>	<b>Requires further instruction &amp; supervision</b>
	Date	Date
19. Cover end of connection tube and disconnect from suction machine.		
20. Wash hands using hand washing procedure.		
21. Document procedure by charting date, time, type and amount of secretions, and child's response.		

Preceptor's Signature \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_

Preceptee's signature \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_

*\*Initial and date in space beside each skill indicates procedure has been demonstrated in a competent manner.*



## OXYGEN ADMINISTRATION

**ACTION TO BE PERFORMED BY:** Person trained by a Registered Nurse.

**EQUIPMENT:**

1. Oxygen tank and delivery system
2. Back up oxygen tank and delivery system, if ordered by physician

**DOCTORS ORDERS:** *REQUIRED*

**STEPS:**

A. Prior to student's arrival:

1. Obtain physician order for oxygen administration. Order needs to include method of delivery (mask, cannula, tracheostomy, etc.), the flow rate, time to be given and if oxygen is to be self administered.
2. Write a care plan to include responsibilities of parents, school and outside agencies involved, and a plan for failure of the system.
3. In-service staff regarding oxygen administration and designate, in writing, at least two staff members other than the school nurse, who can be responsible for the operation of the equipment and identify empty or nonfunctional apparatus.
4. Notify the risk management office, if requested by school principal, that oxygen will be used on campus. Assist with any safety inspection or measures they feel are necessary.
5. Make necessary arrangements with the Transportation Department who will be transporting the student. In-service this staff as needed.
6. School nurse can request a home visit by the Health Public Health Nurse or request the family bring the child to school for an assessment and planning time.

B. When student arrives at school:

1. Complete the oxygen administration log.
2. If school is to administer oxygen, the system must be checked every morning upon student's arrival.
3. Obtain new physician's order every three (3) months and contact family and physician as needed.

## **OXYGEN SAFETY PRECAUTIONS**

- Do not smoke or allow open flames, heaters, or radiators near oxygen
- Never permit oil, grease or any highly flammable material to come in contact with oxygen cylinders, liquid oxygen, valves, regulators or fittings. Do not lubricate with oil or other flammable substances. Do not handle equipment with greasy hands or rags.
- Never put anything over gas cylinder.
- Know who the home oxygen supply company contact person is and have phone number posted in an obvious place.
- Return any defective equipment to the authorized company for replacement.
- Have spare oxygen readily accessible, based on the student's needs. This should be stored safely in a secure place.
- Extra tubing and tank equipment (wrenches, etc.) must be kept in an easily accessible place.
- If using oxygen gas be sure that the tank is securely placed in its stand and cannot fall or be knocked over.
- Be careful that the oxygen tubing does not become kinked, blocked or disconnected.
- Use only the flow meter setting prescribed by the child's doctor.
- The local fire department should be notified that oxygen is in use in the school.





## PERCUSSION AND POSTURAL DRAINAGE

**PURPOSE:** To prevent respiratory complications by loosening bronchial secretions for easier and more effective deep breathing, coughing, and expectoration.

**CONTRAINDICATIONS:** Percussion and postural drainage can be done at the discretion of the R.N. There are many contraindications to this procedure. A physicians order is always needed for this procedure.

### EQUIPMENT:

1. A wedge, pillow or folded blanket
2. Tissues
3. Basin for child to spit into
4. Suction machine if ordered by physician

**DOCTORS ORDERS:** *REQUIRED*

### PROCEDURE:

1. Identify need.
2. Consider timing in relation to other activities such as eating or therapy. Procedure should not be done immediately after eating.
3. Wash hands thoroughly following hand washing procedure, remove all rings.
4. Explain procedure to child and use measures to relax him/her. Procedure will be more effective if child is not anxious.
5. Position as directed by physician (usually prone, with head down on wedge) with tissue available. Wipe up secretions immediately. The spine should be as straight as possible. Use wedges or pillows to position.
6. Observe color and respiratory rate. If indicated, auscultate before and after the procedure.
7. Have the child take a few deep breaths. Percuss indicated area. Hand position: cup the hand with fingers close together and wrist loose. Use enough force to make a firm air-cushioned impact (hollow sound) to help dislodge secretions without causing discomfort. A light shirt may be used to make the procedure more comfortable. Do not "slap" the skin. Discontinue if reddening occurs. Vibrate the indicated area for three breaths. Tell the child to cough if able.
8. Leave in position for 10-15 minutes. Child should be attended during this time.
9. Suction if ordered and necessary.
10. Assist child slowly to normal position. Do mouth care.

11. Wash hands thoroughly using hand washing procedure.
12. Stop the procedure immediately if color changes or respiratory distress is observed.
13. Document procedure by charting date, time, why done, type and amount of drainage and child's response

## PERCUSSION AND POSTURAL DRAINAGE

*\*Contact your school RN for a performance check and form completion.*

Name: \_\_\_\_\_ School: \_\_\_\_\_

SKILL	Performs skill in accordance to written guidelines	Requires further instruction & supervision
	Date	Date
1. Identify need. Check physicians order.		
2. Consider timing in relation to other activities such as eating or therapy. Procedure should not be done immediately after eating.		
3. Wash hands thoroughly following hand washing procedure, remove all rings.		
4. Explain procedure to child and use measures to relax him/her. Procedure will be more effective if child is not anxious.		
5. Position as directed by physician (usually prone, with head down on wedge) with tissue available. Wipe up secretions immediately. The spine should be as straight as possible. Use wedges or pillows to position.		
6. Observe color and respiratory rate. If indicated, auscultate before and after the procedure.		
7. Have the child take a few deep breaths. Percuss indicated area. Hand position: cup the hand with fingers close together and wrist loose. Use enough force to make a firm air-cushioned impact (hollow sound) to help dislodge secretions without causing discomfort. A light shirt may be used to make the		

**Clay County School Health Services Manual**

<p>procedure more comfortable. Do not “slap” the skin. Discontinue if reddening occurs. Vibrate the indicated are for three breaths. Tell the child to cough if able. Do not percuss over the spinal column or soft tissue. Allow for intervals of rest every 2-3 minutes. Vibrate only on exhalation. Helping the child into a sitting position may facilitate coughing. Observe for respiratory status and drainage.</p>		
<p>8. Leave in position for 10-15 minutes. Child should be attended during this time. Provide tissues and basin as necessary. Secretions may be expelled with gravity.</p>		
<p>9. Suction if ordered and necessary. Refer to suctioning and doctors orders.</p>		
<p>10. Assist child slowly to normal position. Do mouth care. Total procedure should be 20-30 minutes.</p>		
<p>11. Wash hands thoroughly using hand washing procedure.</p>		
<p>12. Stop the procedure immediately if color changes or respiratory distress is observed. Document procedure by charting date, time, why done, type and amount of drainage and child’s response</p>		

Preceptor’s Signature \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_

Preceptee's signature \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_

*\*Initial and date in space beside each skill indicates procedure has been demonstrated in a competent manner.*

## POSITIONING

(Lifting and Transferring)

**PURPOSE:** To acquaint school personnel with basic techniques to follow when changing the position of a student who is unable to sit, stand, or walk without the assistance of an adult. Before lifting, carrying or transferring a disabled student, it is recommended that the personnel involved participate in a practice session where a professional, such as a physical therapist, demonstrates the correct technique and procedure.

### NOTES:

- A) Never attempt to lift a student who is difficult to manage without assistance.
- B) If two or more adults are moving a student, always discuss and plan the exact movements before beginning.
- C) The equipment involved must be positioned properly, securely, and as close to the student as possible. When a wheelchair is used, the brakes must be secured and the footrests lifted or removed.
- D) Avoid quick movements. This may cause the students spastic muscles to tense and he/she may be frightened.
- E) Explain the procedure to the student and encourage him/her to assist as much as possible.
- F) Proper body mechanics are essential as follows:
  - Bend at the knees, not the waist
  - Be as close to the student as possible
  - Keep the back straight
  - Do not lift higher than the waist
  - Do not lift quickly or with jerky movements

## SHUNT MANAGEMENT

### PURPOSE:

- 1) To maintain shunting of cerebral spinal fluid from the ventricles to the peritoneum and atrium.
- 2) To prevent infection
- 3) To prevent obstruction of the shunt.

### EQUIPMENT:

- 2) Penlight
- 3) Measuring Tape
- 4) Protective Helmet, if ordered.

### DOCTORS ORDERS: *NOT REQUIRED*

### PROCEDURE:

- 1) Identify students with V-P or V-A shunts if possible. This should be listed on the student Emergency Information card. Initiate a Nursing Care Plan.
- 2) Observe for signs of shunt obstruction. Signs can include vomiting, nausea, headache, lethargy, irritability, increased head circumference, vision problems, unequal or non-reactive pupils.
- 3) Observe for signs of shunt infection. Signs can include fever, irritability, restlessness, lethargy, poor feeding, redness or swelling along shunting system and seizures.
- 4) If signs of obstruction or infection are observed, notify student's parents and doctor.
- 5) Assist in protection of the students shunt by encouraging the use of protective helmet, if ordered; Advise the physical education teacher to exclude the student from contact sports (only if indicated by the students physician). Advise teachers to keep the student from napping on the shunted side.

## TRACHEOSTOMY SKIN CARE

### **PURPOSE:**

1. To prevent skin irritation and breakdown
2. To remove secretions from skin

### **EQUIPMENT:**

1. Cotton tip applicators
2. Normal saline
3. 4x4 Sponge

### **DOCTORS ORDERS: *REQUIRED***

### **PROCEDURE:**

1. Identify need. Check doctor's orders. Observe for skin irritation or breakdown.
2. Wash hands using hand washing procedure.
3. Obtain equipment and arrange on clean surface.
4. Explain procedure to child using appropriate developmental approach.
5. Remove old trach dressing. Observe for skin irritation or breakdown. Check with MD if area is irritated.
6. Clean skin around and under tracheostomy tube area, using sterile technique if ordered. Use cotton tip applicator moistened with normal saline or half strength hydrogen peroxide.
7. Gently pat dry using 2x2's.
8. Insert clean dressing around stoma, under tracheostomy tube using one hand to stabilize tracheostomy tube.
9. Wash hands using hand washing procedures
10. Document procedure charting date, time, reason for procedure, problems, and child's response.

**TRACHEOSTOMY SKIN CARE**

*\*Contact your school RN for a performance check and form completion.*

Name: \_\_\_\_\_ School: \_\_\_\_\_

SKILL	Performs skill in accordance to written guidelines	Requires further instruction & supervision
	Date	Date
1. Identify need. Check doctor's orders. Observe for skin irritation or breakdown.		
2. Wash hands using hand washing procedure		
3. Obtain equipment and arrange on clean surface.		
4. Explain procedure to child using appropriate developmental approach.		
5. Remove old trach dressing. Observe for skin irritation or breakdown. Check with MD if area is irritated.		
6. Clean skin around and under tracheostomy tube area, using sterile technique if ordered. Use cotton tip applicator moistened with normal saline or half strength hydrogen peroxide.		
7. Gently pat dry using 2x2's		
8. Insert clean dressing around stoma, under tracheostomy tube using one hand to stabilize tracheostomy tube.		
9. Wash hands using hand washing procedures		
10. Document procedure charting date, time, reason for procedure, problems, and child's response.		

Preceptor's Signature \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_

Preceptee's signature \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_

*\*Initial and date in space beside each skill indicates procedure has been demonstrated in a competent manner.*



## CHANGING TRACHEOSTOMY TIES

### PURPOSE:

1. To maintain an open airway
2. To prevent skin irritation and breakdown

### EQUIPMENT:

1. Two people must be present
2. Twill tape or bias seam tape
3. Bandage scissors
4. Gloves
5. Thermostat

### DOCTORS ORDERS: *REQUIRED*

### PROCEDURE:

1. Identify need. Check doctor's orders. Observe for skin irritation or breakdown
2. Wash hands (following hand washing procedures)/Put on gloves
3. Obtain equipment and arrange on clean/sterile surface.
4. Explain procedure to child using appropriate developmental approach.
5. Position child and place on back with neck extended or position as ordered/appropriate.
6. First person holds the trach tube in place using tips of finger avoiding occluding the opening.
7. Second person cuts and removes ties carefully using scissors.
8. Use ties prepared as described:
  - a) Make cut  $\frac{1}{2}$ " from the end of the tie
  - b) Use the hemostat to pull through, from bottom to topSecond person follows listed steps to put on new ties
  - a) fold the end of the tie and cut a small slit
  - b) Thread the tie through the flange hole
  - c) Pull the other end of the tie through the slit
9. Repeat steps for other side. First person should continue to hold tube in place.
10. First person bends the child's head forward while holding the tube in place. This technique tightens the tie.

11. Second person ties a knot in the tie on the side of the child's neck. The tie should be tight enough to get only one small finger between the tie and the child's neck.
12. Remove gloves and wash hands following hand washing procedures.
13. Document procedure by charting date, time, reason for procedure, problems and child's response.

**CHANGING TRACHEOSTOMY TIES**

*\*Contact your school RN for a performance check and form completion.*

Name: \_\_\_\_\_ School: \_\_\_\_\_

SKILL	Performs skill in accordance to written guidelines	Requires further instruction & supervision
	Date	Date
1. Identify need. Check doctor's orders. Observe for skin irritation or breakdown.		
2. Wash hands (following hand washing procedures). Put on gloves.		
3. Obtain equipment and arrange on clean/sterile surface.		
4. Explain procedure to child using appropriate developmental approach.		
5. Position child and place on back with neck extended or position as ordered/appropriate.		
6. First person holds the trach tube in place using tips of finger avoiding occluding the opening.		
7. Second person cuts and removes ties carefully using scissors.		
8. Use ties prepared as described: a) Make cut ½" from the end of the tie b) Use the hemostat to pull through, from bottom to top i. Second person follows listed steps to put on new ties c) fold the end of the tie and cut a small slit e) Thread the tie through the flange hole f) Pull the other end of the tie through the slit		

<b>SKILL</b>	<b>Performs skill in accordance to written guidelines</b>	<b>Requires further instruction &amp; supervision</b>
	Date	Date
9. Repeat steps for other side. First person should continue to hold tube in place.		
10. First person bends the child's head forward while holding the tube in place. This technique tightens the tie.		
11. Second person ties a knot in the tie on the side of the child's neck. The tie should be tight enough to get only one small finger between the tie and the child's neck.		
12. Remove gloves and wash hands following hand washing procedures.		
13. Document procedure by charting date, time, reason for procedure, problems and child's response.		

Preceptor's Signature \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_

Preceptee's signature \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_

*\* Initial and date in space beside each skill indicates procedure has been demonstrated in a competent manner.*

## TRACHEOSTOMY SUCTIONING

### PURPOSE:

1. To aspirate retained or excessive secretions
2. To maintain open airway
3. To aid in the respiratory efforts of the student

### EQUIPMENT:

1. Portable suction
2. Disposable connecting tube
3. Sterile disposable catheter (size determined by M.D.), sterile or clean gloves (bases on M.D. order)
4. Sterile saline, preferably in single use packets, at room temperature or a jar of sterile saline with eye dropper dispenser
5. Clean rinsing container
6. Tissues or paper towels
7. Bandage scissors

### DOCTORS ORDERS: *REQUIRED*

### PROCEDURE:

1. Identify need and check doctor's orders. Observe for respiratory congestion and cyanosis.  
*Example:* Agitation, restlessness, hard/fast breathing, bluish color around lips, nail beds, nostrils flaring.
2. Assemble equipment. Use a clean table at a convenient height
3. Connect machine. Check functioning capacity of machine by turning to "on" position.
4. Explain procedure to child using appropriate developmental approach
5. Wash hands following hand washing procedure (use disposable wipes if water is not available.)
6. Arrange equipment for use. Open sterile catheter and glove packet on table. Open and fill rinsing container with sterile normal saline. Open sterile connecting tube already connected to portable suctioning machine. Connect connecting tube to suction outlet.
7. Put sterile glove on dominant hand. This hand will hold the sterile catheter
8. Attach suction tube to sterile catheter. Hold catheter in gloved hand, pick up suction tube with ungloved hand and attach it by pushing and twisting gently.
9. Turn on suction machine. Use ungloved hand

10. Tell the child to take several deep breaths. This increases oxygen reserve
11. Moisten tip of catheter. Dip end of catheter in sterile saline
12. If secretions are thick, place 2-3 drops of saline directly into tracheostomy. Allow saline to dilute mucus to facilitate removal.
13. Insert catheter into trach being careful not to cover catheter vent opening. Leave inner cannula in place. Insert to depth of 3 inches (7.5 cm) to cleanse cannula or until resistance is met. DO NOT insert further than needed to stimulate coughing
14. Apply suction pressure. Occlude catheter vent opening with ungloved thumb
15. Slowly pull catheter out with a rotating action, alternating on and off suction pressure. Intervals of continuous suction should not last longer than 5 seconds. Use suction only when removing catheter to prevent damage to mucus membrane
16. Rinse catheter. Dip into sterile saline basin, intermittently apply pressure, rinse frequently
17. Repeat suctioning as necessary until desired results are obtained. Allow student to rest 15-20 seconds and catch breath. If catheter becomes blocked, rinse with sterile saline. If airway blockage is not relieved contact RN or dial 911. Suspect a mucus plug if the student continues to be in distress, cut ties and remove trach tube. Reinsert a clean tracheostomy tube according to procedure
18. Clear tubes rinse with intermittent suction applied
19. Turn suction machine off using ungloved hand
20. Discard disposable equipment using covered trash receptacle
21. Clean rinsing container and return equipment to proper place. Store in assigned area
22. Wash hands following hand washing procedure
23. Document procedure by charting date, time, why done, type and amount of secretions and child's response

**TRACHEOSTOMY SUCTIONING**

*\*Contact your school RN for a performance check and form completion.*

Name: \_\_\_\_\_ School: \_\_\_\_\_

SKILL	Performs skill in accordance to written guidelines	Requires further instruction & supervision
	Date	Date
1. Identify need and check doctor's orders. Observe for respiratory congestion and cyanosis. <i>Example:</i> Agitation, restlessness, hard/fast breathing, bluish color around lips, nail beds, nostrils flaring.		
2. Assemble equipment. Use a clean table at a convenient height		
3. Connect machine. Check functioning capacity of machine by turning to "on" position.		
4. Explain procedure to child using appropriate developmental approach		
5. Wash hands following hand washing procedure (use disposable wipes if water is not available.)		
6. Arrange equipment for use. Open sterile catheter and glove packet on table. Open and fill rinsing container with sterile normal saline. Open sterile connecting tube already connected to portable suctioning machine. Connect connecting tube to suction outlet.		

<p>7. Put sterile glove on dominant hand. This hand will hold the sterile catheter</p>		
<p><b>SKILL</b></p>	<p><b>Performs skill in accordance to written guidelines</b></p>	<p><b>Requires further instruction &amp; supervision</b></p>
	<p>Date</p>	<p>Date</p>
<p>8. Attach suction tube to sterile catheter. Hold catheter in gloved hand, pick up suction tube with ungloved hand and attach it by pushing and twisting gently.</p>		
<p>9. Turn on suction machine. Use ungloved hand</p>		
<p>10. Tell the child to take several deep breaths. This increases oxygen reserve</p>		
<p>11. Moisten tip of catheter. Dip end of catheter in sterile saline</p>		
<p>12. If secretions are thick, place 2-3 drops of saline directly into tracheostomy. Allow saline to dilute mucus to facilitate removal.</p>		
<p>13. Insert catheter into trach being careful not to cover catheter vent opening. Leave inner cannula in place. Insert to depth of 3 inches (7.5 cm) to cleanse cannula or until resistance is met. DO NOT insert further than needed to stimulate coughing</p>		
<p>14. Apply suction pressure. Occlude catheter vent opening with ungloved thumb</p>		
<p>15. Slowly pull catheter out with a rotating action, alternating on and off suction pressure. Intervals of continuous suction should not last longer than 5 seconds. Use suction</p>		



only when removing catheter to prevent damage to mucus membrane		
<b>SKILL</b>	<b>Performs skill in accordance to written guidelines</b>	<b>Requires further instruction &amp; supervision</b>
	Date	Date
16. Rinse Catheter. Dip into sterile saline basin, intermittently apply pressure, rinse frequently		
17. Repeat suctioning Repeat as necessary until desired results are obtained. Allow student to rest 15-20 seconds and catch breath. If catheter becomes blocked rinse with sterile saline. If airway blockage is not relieved contact RN or dial 911. Suspect a mucus plug if the student continues to be in distress, cut ties and remove trach tube. Reinsert a clean tracheostomy tube according to procedure		
18. Clear tubes Rinse with intermittent suction applied		
19. Turn suction machine off using ungloved hand		

Preceptor's Signature \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_

Preceptee's signature \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_

*\* Initial and date in space beside each skill indicates procedure has been demonstrated in a competent manner.*

## **EMERGENCY TRACHEOSTOMY TUBE REPLACEMENT**

(For Non-Cannulated, Non-Cuffed Tube)

### **PURPOSE:**

To replace the tracheostomy tube which provides an open airway. This is an EMERGENCY procedure and should never be done at school unless suction is unsuccessful after at least three attempts.

### **EQUIPMENT:**

1. Sterile tracheostomy tube of type and size prescribed or clean tube if properly labeled for that particular child. (Extra trach tubes should be on hand at all times)
2. Sterile tracheostomy tube of next smaller size. (Extra should be on hand at all times)
3. Pair of bandage scissors
4. Roll to prop shoulders (optional)
5. Trach ties (twill tape)
6. Sterile Gloves

### **DOCTORS ORDERS: *REQUIRED***

### **PROCEDURE:**

1. Identify need. Use when child is unable to provide open airway after three attempts at suctioning; child exhibits signs of respiratory distress, i.e.: anxiety, pale, bluish or dusky color around mouth or lips, flaring nostrils, rapid or labored breathing.
2. Put roll under child's shoulders, if time permits. Use to visualize the stoma optimally. In an emergency, it is possible to change a tracheostomy in almost any position.
3. Open sterile package. Equipment should be ready to use as needed.
4. Cut old ties and gently remove tube. Use an outward and downward motion when removing tube.
5. Remove the sterile tracheostomy from package, holding the tube by phalanges, not by the piece which fits into the stoma. Avoid contaminating the tube.
6. Insert the obturator (guide) into the trach tube. The obturator makes insertion easier, but is not left in place after insertion because it blocks the airway. Some brands do not have an obturator.

7. Spreading the stoma open with the index and middle fingers of one hand, gently insert new tube. Tube should be directed back, then down. Remove obturator as soon as tube is in place.
8. Hold the tube in place with slight pressure until a second person can assist in placing new ties. Two people are needed to change tracheostomy ties safely.
9. Suction if necessary. See suctioning procedure
10. Tie the ties on the side of the neck using a square knot (R over L, L over R). It should be loose enough to permit one finger to be placed between knot and neck
11. If you are unable to insert the trach tube:
  - a) Reposition the head and try again
  - b) If new tube will not enter, try to insert trach tube of next smaller size
  - c) If smaller tube will not enter, reposition head and try again. If still not successful, CALL 9-1-1
  - d) Observe child for respiratory distress: cyanosis, anxiety, poor respiratory effort. If necessary, start rescue breathing using mouth to stoma technique. If too much resistance is felt, cover stoma with gauze and do mouth to mouth. Sometimes, after several breaths, child will relax enough and stoma will open and the trach tube may be inserted and mouth to stoma rescue breathing can resume.
12. Observe until child's condition is stable and there is no further danger or until paramedics arrive.
13. Wash hands. Follow hand washing procedure
14. Document Procedure. Chart date, time, reason action was indicated, action taken, and child's response.
15. Notify parents and physician immediately.

## EMERGENCY TRACHEOSTOMY TUBE REPLACEMENT

*\*Contact your school RN for a performance check and form completion.*

Name: \_\_\_\_\_ School: \_\_\_\_\_

SKILL	Performs skill in accordance to written guidelines	Requires further instruction & supervision
	Date	Date
1. Identify need. Use when child is unable to provide open airway after three attempts at suctioning; child exhibits signs of respiratory distress, i.e.: anxiety, pale, bluish or dusky color around mouth or lips, flaring nostrils, rapid or labored breathing		
2. Put roll under child's shoulders, if time permits. Use to visualize the stoma optimally. In an emergency, it is possible to change a tracheostomy in almost any position.		
3. Open sterile package. Equipment should be ready to use as needed		
4. Cut old ties and gently remove tube. Use an outward and downward motion when removing tube		
5. Remove the sterile tracheostomy from package, holding the tube by phalanges, not by the piece which fits into the stoma. Avoid contaminating the tube		
6. Insert the obturator (guide) into the trach tube. The obturator makes insertion easier, but is not left in place after insertion because it blocks the airway. Some brands do not have an obturator		

<p>7. Spreading the stoma open with the index and middle fingers of one hand, gently insert new tube. Tube should be directed back, then down. Remove obturator as soon as tube is in place.</p>		
<p><b>SKILL</b></p>	<p><b>Performs skill in accordance to written guidelines</b></p>	<p><b>Requires further instruction &amp; supervision</b></p>
	<p>Date</p>	<p>Date</p>
<p>8. Hold the tube in place with slight pressure until a second person can assist in placing new ties. Two people are needed to change tracheostomy ties safely</p>		
<p>9. Suction if necessary. See suctioning procedure</p>		
<p>10. Tie the ties on the side of the neck using a square knot (R over L, L over R). Knot should be loose enough to permit one finger to be placed between knot and neck.</p>		
<p>11. If you are unable to insert the trach tube:</p> <ul style="list-style-type: none"> <li>a) Reposition the head and try again</li> <li>b) If new tube will not enter, try to insert trach tube of next smaller size</li> <li>c) If smaller tube will not enter, reposition head and try again. If still not successful, CALL 911</li> <li>d) Observe child for respiratory distress: cyanosis, anxiety, poor respiratory effort. If necessary, start rescue breathing using mouth to stoma technique. If too much resistance is felt, cover stoma with gauze and do mouth to mouth. Sometimes, after several breaths, child will relax enough and stoma will open and the trach tube</li> </ul>		

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may be inserted and mouth to stoma rescue breathing can resume.		
<b>SKILL</b>	<b>Performs skill in accordance to written guidelines</b>	<b>Requires further instruction &amp; supervision</b>
	Date	Date
12. Observe until child's condition is stable and there is no further danger or until paramedics arrive.		
13. Wash hands. Follow hand washing procedure		
14. Document Procedure. Chart date, time, reason action was indicated, action taken, and child's response		
15. Notify parents and physician immediately.		

Preceptor's Signature \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_

Preceptee's signature \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_

*\*Initial and date in space beside each skill indicates procedure has been demonstrated in a competent manner.*

## VAGUS NERVE STIMULATION THERAPY

Vagus nerve stimulation therapy is another form of treatment that may be tried when medications fail to stop seizures. It is currently approved for use in adults and children over the age of 12. The therapy prevents seizures by sending regular small pulses of electrical energy to the brain via the vagal nerve, in the neck. The energy is delivered by a flat, round battery, about the size of a silver dollar, which is surgically implanted in the left chest wall (opposite of a pacemaker). These wires (electrodes) are threaded under the skin and around the vagal nerve in the neck. The battery is programmed by the health team to send a few seconds of electrical energy to the vagal nerve every few minutes. If the person with the system feels a seizure coming on, he or she can activate the discharge by passing a small magnet over the battery. In some people, this has the effect of stopping the seizure. It is also possible to turn the device off by holding the magnet over it. In the event that a student needs assistance in using this device, a doctor's order will need to be provided by parent/guardian and kept in Medication record. Parent permission to apply this intervention will be required. Parent and school nurse may train non-nursing staff to apply this procedure if needed. Written record of this training will be kept on file in student's record.

## VAGUS NERVE STIMULATOR (VNS) PROCEDURE

**PURPOSE:** To prevent or stop a seizure

**ACTION TO BE PERFORMED BY:** Person trained by a Registered Nurse.

**DOCTORS ORDERS:** *REQUIRED*

### STEPS:

1. Know the particular signs for impending or occurring seizures as listed in the student. Individualized healthcare plan Examples: High-pitched crying, rigid arms and legs. Provide for students safety. Assist to floor and place on side, pad area to prevent injury. Assess airway, breathing, and circulation. Call for assistance.
2. Know location of special magnets. Location(s) will be listed in the student Individualized healthcare plan.
3. At the very beginning of a seizure look for VNS special magnet usually worn on wrist or clipped to a belt like a pager. Look for bulging area on the left side of the chest wall (implanted generator under skin). The magnet should be used as soon as possible after onset of seizure or aura.
4. Touch the smooth flat side of the magnet to the generator with a swiping motion and pass the magnet over the generator, then pull it away. You may notice a change in the child's voice, hoarseness or coughing this is a normal response. Potential adverse affects include ataxia, dyspnea, numbness and tingling, spasms of throat, nausea, and pain.
5. Call school registered nurse to assess the student immediately. (Have someone else call RN if possible). RN will take over care of student.
6. Return special magnet to belt or wrist. Keep special magnet at least 10 inches away from credit cards, computer disks, and other magnets. The magnet will damage credit cards. Computer and televisions will not affect the simulator. Older microwaves or posted microwave danger areas should be avoided.
7. Do not drop magnet as this may damage it.
8. Document what time magnet was swiped over generator and the outcome. Documentation of episode may be done on seizure observation form.



## VAGUS NERVE STIMULATOR SKILLS CHECKLIST

*\*Contact your school RN for your performance check and form completion.*

Name: \_\_\_\_\_ School: \_\_\_\_\_

SKILL	Performs skill in accordance to written guidelines	Requires further instruction & supervision
	Date	Date
1. Know the particular signs for impending or occurring seizures as listed in the Seizure Care Plan for the student. Examples: High-pitched crying, rigid arms and legs.		
2. Know location of special magnets. Location(s) will be listed in Individual Health Care plan.		
3. At the very beginning of a seizure look for VNS special magnet usually worn on wrist or clipped to a belt like a pager. Look for bulging area on the left side of the chest wall (implanted generator under skin).		
4. Touch the smooth flat side of the magnet to the generator with a swiping motion and pass the magnet over the generator, then pull it away.		
5. Call school registered nurse to assess the student immediately. (Have someone else call RN if possible).		
6. Return special magnet to belt or wrist. Keep special magnet at least 10 inches away from credit cards, televisions, computer disks, microwave ovens and other magnets.		
7. Do not drop magnet.		
8. Document what time magnet was swiped over generator and the outcome.		

Preceptor's Signature: \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_

Preceptor's Signature: \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_

*\*Initial and date in space beside each skill indicates procedure has been demonstrated in a competent manner.*