

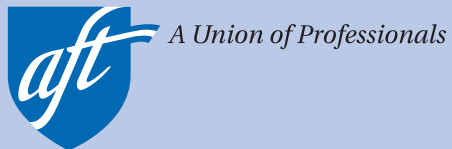


A Union of Professionals

The Medically Fragile Child

Caring for Children with Special Healthcare
Needs in the School Setting





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We must **advocate** for children with special healthcare needs to obtain the **best possible** education.



Foreword

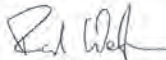
The presence of children with special healthcare needs in schools has broadened the responsibilities of teachers, school nurses, paraprofessionals and other school employees. As members of the education team, we struggle to balance our obligation to students and our concern about duties we may be unprepared or legally not allowed to perform.


In 1989, the AFT heard these concerns from our members and responded by creating the Ad Hoc Committee on Healthcare Responsibilities in Special Education. This committee was a collaborative effort of the AFT's educational issues department (AFT Teachers), the Federation of Nurses and Health Professionals (now AFT Healthcare), and the AFT's paraprofessional and school-related personnel division (AFT PSRP). The work of this committee generated the first edition of a manual titled *The Medically Fragile Child in the School Setting*. The AFT's Task Force on Special Education continued to work on these issues, and its recommendations were incorporated in a second edition of the manual.

The third edition sets out to accomplish three goals: first, to educate our members on their roles and responsibilities in relation to children with special

healthcare needs (sometimes referred to as “medically fragile students”); second, to educate our members on their rights as school employees; and third, to outline possible solutions and protections for local unions to pursue on behalf of their members.

The number of children with special healthcare needs in school settings has increased exponentially since this manual's inception. This trend was one of the catalysts for the community schools proposal that we launched at the most recent AFT convention. The AFT faces multiple challenges related to this trend: We must advocate for an environment that would enable these students to obtain the best possible education, ensure our members have access to information that will support all our students, maintain a safe work environment, and protect members rights. We hope this third edition of the manual will meet these challenges.


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Because **each child is unique**, his or her educational program must be determined on a case-by-case basis.



Chapter 1

Overview:

Children with Special Healthcare Needs

- Are you astounded that teachers and paraprofessionals are expected to provide nursing care to students in addition to teaching them?
- Do you find it hard to believe that districts expect schools to share nurses and that vacant school nurse positions are not being filled, at the same time that increasing numbers of children with serious health conditions are being enrolled?
- Do you know teachers and paraprofessionals who feel legally vulnerable because they are being asked to perform nursing procedures for children with special healthcare needs?
- Do you worry that the education of students might suffer because of the amount of time teachers and paraprofessionals spend on nursing tasks rather than on teaching?
- Do you see the benefits of integrating most children with medical conditions into typical school settings but wish it could be done on a case-by-case basis, with access to essential support services?

These are only a few of the questions, issues and, in some cases, controversies surrounding the education of children with special healthcare needs.

Who Are “Children with Special Healthcare Needs”?

There is no universally accepted definition of “children with special healthcare needs.” The term generally refers to students who require complex health procedures, special therapy or specialized medical equipment/supplies to enhance or sustain their lives during the school day.

Because each child’s condition is unique, his or her educational program must be determined on a case-by-case basis. The same holds true for the development of his or her school-based individualized healthcare plan (IHCP).

Until the 1980s, children with special healthcare needs were most often cared for in hospitals or institutions that saw to their educational, developmental and medical needs. However, the trend toward deinstitutionalization, combined with the pressure for healthcare cost containment, resulted in children being moved into community settings. In addition, advances in healthcare technology have enabled more children to leave hospitals and attend public schools than in previous years.

The Laws Relating to Children with Special Healthcare Needs

The Individuals with Disabilities Education Act (IDEA) and its 1975 precursor, known as the Education for All Handicapped Children Act (EAHCA) or Public Law 94-142, have changed the landscape of education in America, along with the lives of children with special healthcare needs.

IDEA provides children the right to a “free appropriate public education” in the “least restrictive environment” (LRE) appropriate to their needs. “Least restrictive environment” is defined as when: “to the maximum extent appropriate, children with disabilities ... are educated with children who are not disabled, and special classes, separate schooling or other removal of children with disabilities from the regular educational environment occurs only when the nature or severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily.”¹

The initial passage of Public Law 94-142 meant that large populations of children and youth with special healthcare needs—students who previously had been underserved or not served at all by public schools—were now entitled to an education provided by the public school system. The 1990 reauthorization expanded the eligible student population to include preschool students.

Since the inception of IDEA, the number of young people ages 3–21 enrolled in public schools and receiving special education services has increased nearly every year. In 1976–77, some 3.7 million youth (or 8 percent of the total public school population), received services under IDEA. By 2005–06, that number had increased to 6.7 million, or 14 percent of total public school enrollment.²

Who Is Eligible for IDEA?

To be considered IDEA-eligible, a student must be diagnosed with one or more of the disabilities listed in the federal statute, and must require special education instruction and/or related services as a result of that disability. The statute lists 13 basic disabilities, which are listed below. States may choose to add additional categories to this list, and the statutory language may vary somewhat from state to state as well.³

- Autism
- Deaf-Blindness
- Deafness
- Emotional Disturbance
- Hearing Impairment
- Mental Retardation
- Multiple Disabilities
- Orthopedic Impairment
- Other Health Impairment
- Specific Learning Disability
- Speech or Language Impairment
- Traumatic Brain Injury
- Visual Impairment Including Blindness

The Individualized Education Program (IEP) contains, among other things, a statement of the specific special education and related services to be provided to the child, and of the extent to which the child will be able to participate in regular education programs. The IEP is an essential document for the IDEA-eligible child; it is the “road map” for the services that the school district must provide to the child.

Eligibility is determined by a multidisciplinary team, including at least one educator when appropriate. Once the student is declared eligible, an Individualized Education Program (IEP) is developed.

Section 504 of the Rehabilitation Act of 1973

Section 504 of the Rehabilitation Act of 1973 is a federal law that protects the civil rights of persons with disabilities. Under Section 504, no one with disabilities can be denied access to any program or activity that receives federal funds. A student with a disability may be eligible for Section 504 protection if he or she “has a physical or mental impairment that substantially limits one or more major life activities.”⁴

Examples of an “impairment” may include attention problems, severe allergies, cerebral palsy, diabetes or epilepsy. “Substantially limits” means the student is significantly restricted in performing major life activities such as walking, seeing, hearing, speaking, breathing and learning as compared with a peer in the general population.

All IDEA-eligible students also are covered by Section 504, but the reverse is not true. The population of Section 504-eligible students is much larger than the population of IDEA-eligible students. Most students who are only eligible to receive services under Section 504 receive them in a general education setting. Each school is required by law to have a process in place to identify children who may qualify for Section 504 status. Often, there is a coordinator who is part of that process. If a parent or teacher believes that a child may qualify, he or she should find out what the process is in their school district.

The evaluation to determine whether the child qualifies for Section 504 will be conducted by a team made up of individuals who are familiar with the child, most likely including the child’s teacher. The team will compare the student’s performance with that of the average student in the general population to determine whether the effect of the student’s impairment substantially limits a major life activity and whether, without accommodations, he or she would be denied equitable access to educational programs and activities.

Some of the factors the team may take into consideration are whether, as compared with his or her nondisabled peers, a student:

- Consistently requires additional time to complete assignments;
- Routinely needs modified or adapted testing; or
- Frequently displays behavior that significantly interferes with school performance.⁵

Students who meet the eligibility criteria will have a Section 504 plan developed for them that will specify the nature of the impairment, the major life activities affected by the impairment, the accommodations necessary to meet the student’s needs and the person(s) responsible for implementing the plan.

If, at any point in time, an analysis of the data suggests the presence of a disability covered under IDEA, the team will refer the student to an IEP team and the parents will be asked to attend a screening meeting with the IEP team.

The “Least Restrictive Environment”

School districts receiving federal funds must provide a free appropriate public education to each student with disabilities, and must ensure that each student with disabilities is educated with nondisabled students to the maximum extent appropriate to the needs of the student. This concept is known as the “least restrictive environment,” or LRE. For children, this might mean attending school in regular classrooms; resource rooms; self-contained special education classrooms in a regular school; special schools for children with mental or physical disabilities; or, when necessary, hospitals or institutions, depending on the level at which the child is able to function.

A number of state court decisions have given legal weight to the position that children with special healthcare needs should be in regular schools and regular classrooms whenever possible. As a result,

students with severe disabilities are attending public schools in unprecedented numbers—a trend that is likely to increase in part because advances in medical technology have led to higher survival rates for children with chronic illnesses and congenital abnormalities, as well as for victims of trauma.

The placement of children with special healthcare needs in public schools and the responsibilities that accompany these placements have given rise to several areas of concern. These include the need for adequate funding, availability of appropriate facilities, new roles and responsibilities for school personnel, appropriate training, and legal and liability issues.

What About Funding?

IDEA gives public schools the primary responsibility for educating and providing school-related services to children with special healthcare needs. As a result, public schools with already limited funds find that the cost of financing special education—already enormous—is soaring. To carry out this mandate, school districts may need additional funds to hire specialized personnel and school nurses, to provide technical equipment and additional transportation, and, in some instances, to retrofit facilities to accommodate the needs of the children.

When IDEA was passed in 1975, the law included a commitment by the federal government to pay 40 percent of the average per-student cost for every special

The **school nurse** has ultimate responsibility for **deciding** which tasks can be **delegated** and to whom.

education student. According to the most recent available figures, in 2006 the average per-student cost of education was \$7,552, while the average cost per special education student was an additional \$9,369, for a total of \$16,921 per student. That should mean the federal government reimburses school districts \$6,768 for every special education student. Unfortunately, that has yet to happen. If the funding levels approved by Congress during the past 30 years continue at the same rate, IDEA will not reach full funding (that is, 40 percent per student) until fiscal year 2035. School children and school systems cannot wait that long.⁶

Since 1975, the unfunded federal portion of special education spending has cost local schools and taxpayers more than \$300 billion. As a result, school districts are being forced to redirect more and more dollars from their general education budget to cover the federal shortfall, which hurts all students—those in general education and those in special education.

Are Facilities Adequate?

Although the number of children with special healthcare needs in public schools has increased, the facilities and conditions under which health-related procedures must be performed are often woefully inadequate. For example, invasive procedures that may involve injections, anal insertion or suctioning often are performed in facilities lacking privacy, hot water or other proper sanitary conditions. Having to perform health-related procedures in less than optimal conditions may place school personnel in a

position where they could jeopardize the health and safety of their students with special healthcare needs. In addition, due to the decreasing numbers of nurses assigned to public schools, the training, supervision and evaluation of nonmedical personnel asked to perform medical procedures may be inadequate as well.

Who Cares for Children with Special Healthcare Needs?

Most of the healthcare procedures required to be done in public schools must be supervised or performed by state-licensed health personnel such as a registered nurse. These tasks might include suctioning mucous from the airways of children who can't clear their airways themselves, caring for students who have special breathing apparatus, inserting catheters into the bladders of children who are unable to urinate, injecting insulin or medications as required, and inserting feeding tubes for nutrition.

While nonlicensed personnel may be trained to perform some tasks, the school nurse has ultimate responsibility for deciding which tasks can be delegated and to whom, and for ensuring that the procedures are being done correctly.

What's Legal? Who's Liable?

All nursing procedures ultimately are the legal responsibility of the school nurse assigned to the facility. State laws, called nurse practice acts, usually require that nursing procedures be performed only by a person educated and licensed to practice as a registered nurse. Some state nurse practice acts permit the nurse to delegate certain tasks to another person, but only if the nurse trains that person and is confident of that person's ability. Responsibility for the correct performance of the task will remain with the nurse. Not all procedures can be delegated, and each state's board of nursing makes these determinations.

Unfortunately, many school personnel, including administrators, are not aware of this legal framework. Teachers and paraprofessionals may be designated to perform nursing procedures by their school principal or another supervisor, which clearly violates state nurse practice acts. If you have specific questions about delegation, contact your state board of nursing. (A full list of state boards of nursing is included in Appendix C.)

AFT Position on the Education of Children with Special Healthcare Needs

The AFT believes that children with special healthcare needs should be educated in a safe and healthy environment where their health needs are attended to by professionals and trained support personnel. We recommend that the nurse and healthcare aide,

respectively, have the primary responsibility for providing healthcare services to children with special healthcare needs. Teachers, paraprofessionals and other school personnel should not be the primary providers of healthcare services. School districts and state legislatures must ensure that adequate numbers of nurses and support personnel are available to provide health-related services to children who need them. The nursing services described in the IEP must conform to the rules of each state's nurse practice act.

Procedures must be established by state law to ensure that a child with special healthcare needs is placed only in an educational setting where orderly, professionally responsible decisions can be made according to the child's needs; where the proper facilities, equipment and services are available; and where the provision of care will not unduly disrupt the educational progress of the other students.

Endnotes

- ¹ IDEA section 612(a)(5)(A); 20 U.S.C. 1412(a)(5)(A).
- ² www.ideadata.org (see education environment SY06-07).
- ³ LRP Publications offers *Who's Eligible for Section 504? A Quick-Reference Guide for Proper Placement*. www.lrp.com
- ⁴ Office for Civil Rights: Section 504 is enforced by the Department of Education's Office for Civil Rights. www.ed.gov/about/offices/list/ocr/index.html
- ⁵ Office of Special Education and Rehabilitative Services. (2005). *Twenty-seventh Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act*. U.S. Department of Education. Washington, DC: Author.
- ⁶ www.ideadata.org (see education environment SY06-07).

Today, schools **educate** and **care** for children with health needs that require partnerships with **all levels** of school personnel.



Chapter 2

The Role of the School Nurse

Technological advancements in medicine have resulted in children surviving what once would have been fatal illnesses and congenital abnormalities. The Individuals with Disabilities Education Act (IDEA) provides for the public education of children with special healthcare needs in the least restrictive environment appropriate. Today, schools educate and care for children with health needs that are extensive and require sophisticated intervention. These increasing healthcare demands, coupled with shortages of school nurses, require formal partnerships with all levels of school personnel to provide for the care and well-being of children with special healthcare needs.

Responsibilities to Students

The role of the school nurse is to assess the health needs of the child in the school setting and to coordinate with staff, family, physicians and community agencies to provide a comprehensive school health program that facilitates the maximum educational opportunity for that child. This responsibility has increased dramatically during the past three decades with the inclusion of more children with special healthcare needs in public schools.

Each state establishes its own health screening criteria for students, which range from minimal to comprehensive. But no matter what the requirements, the school nurse follows certain standards of care in fulfilling his or her responsibility to the student. *School Nursing: Scope and Standards of Practice*¹ was developed by a task force of organizations, including the National Association of School Nurses (NASN) and the American Nurses Association (ANA). These standards are intended to ensure high-quality, comprehensive care for school children, as well as to guide the school nurse in daily activities and planning. The Standards of Practice, which are comprised of the six steps of the nursing process, include the following:

1. **Assessment**
(The school nurse collects student data.)
2. **Diagnosis**
(The school nurse analyzes the assessment data in determining nursing diagnoses.)
3. **Outcomes Identification**
(The school nurse identifies expected outcomes individualized to the student.)
4. **Planning**
(The school nurse develops a plan of care/action that specifies interventions to attain expected outcomes.)

5. **Implementation**

(The school nurse implements the interventions identified in the plan of care/action.)

6. **Evaluation**

(The school nurse evaluates the student's progress toward attainment of outcomes.)

In addition, school nurses follow well-established Standards of Professional Performance. These standards describe a competent level of behavior in professional activities and include the following items listed in the box below.

The school nurse is responsible for developing individualized healthcare plans (IHCPs) for those students with special healthcare needs. IHCPs detail the healthcare services needed for individual students. In addition to IHCPs, the school nurse also develops emergency care plans (ECPs).

Delegating Responsibilities to Non-Nursing School Personnel

The role of the school nurse in working with non-nursing school personnel is to determine what

Standards of Professional Performance for Nurses

1. Quality of Care (The school nurse systematically evaluates the quality and effectiveness of school nursing practice.)

2. Performance Appraisal (The school nurse evaluates his or her own nursing practice in relation to professional practice standards and relevant statutes, regulations and policies.)

3. Education (The school nurse acquires and maintains current knowledge and competency in school nursing practice.)

4. Collegiality (The school nurse interacts with and contributes to the professional development of peers and school personnel as colleagues.)

5. Ethics (The school nurse's decisions and actions on behalf of students are determined in an ethical manner.)

6. Collaboration (The school nurse collaborates with the student, family, school staff, community and other providers in providing student care.)

7. Research (The school nurse promotes the use of research findings in school nursing practice.)

8. Resource Utilization (The school nurse considers factors related to safety, effectiveness and cost when planning and delivering care.)

9. Communication (The school nurse uses effective written, verbal and nonverbal communication skills.)

10. Program Management (The school nurse manages school health services.)

11. Health Education (The school nurse assists students, families, school staff and the community to achieve optimal levels of wellness through appropriately designed and delivered health education.)

orientation, education and training is necessary to enable them to safely and appropriately help children with special healthcare needs.

As mentioned before, non-nursing school personnel, by and large, have no training in health-related fields. Moreover, most non-nursing personnel never anticipated performing healthcare procedures when they prepared to become teachers or school employees. Many struggle with their anxieties over this additional responsibility, while at the same time working to provide high-quality education for their students. Because these school staff are with the students for the majority of the day and are their primary caretakers, it is imperative that all members of the team—teachers, paraprofessionals, other classified personnel, related service providers, etc.—are trained to participate in appropriate procedures and activities, and know when to contact the school nurse to get emergency assistance.

The school nurse will help team members understand their capabilities as well as their limitations in participating in the healthcare process. All team members should have a basic understanding of the legal issues surrounding the provision of care. Beyond that, the school nurse also will assess student needs, determine how the staff can participate in meeting those needs, develop a training program and resource materials to help staff meet those needs, and finally evaluate and supervise the delivery of care.

In order to ensure that this is accomplished, the school nurse should:

- Develop a procedure or policy manual in cooperation with other appropriate personnel and update it on a regular basis.
- Establish a uniform recording system with standardized forms for use by all staff. These should include, for example, a nurse intake sheet and medical alert sheets.
- Train staff on (appropriate) procedures and routinely assess each individual's competence and ability to perform those procedures safely.
- Keep a documented list of trained staff, when they were trained, periodic re-evaluations, and the school nurse's assessment of their capabilities.
- Develop emergency procedures and evacuation plans, and train and evaluate staff in these areas.
- Arrange for or provide in-service training on basic first aid and CPR.
- Arrange for or provide in-service training on child-specific administration of medication—but only when appropriate.
- Arrange for or provide in-service programs on current health issues.
- Arrange for or provide in-service programs on universal precautions and the appropriate disposal of contaminated waste.²

Many school personnel struggle with **anxiety over performing healthcare**

Legal Considerations for the School Nurse

As the nurse well knows, the nurse practice act in each state governs the scope of nursing practice and limits those nursing tasks that may be delegated to an unlicensed person. When the school nurse has responsibility for several different facilities or is not present at the school site, he or she still maintains responsibility for the care delivered. Ensuring that care is appropriately delegated—within the requirements of both the nurse practice act and school administration policy—is crucial.

It is extremely important that nurses are aware of the extent of their liability in these situations. Unfortunately, this is often difficult because of many state laws' vague language describing what can be delegated and to whom. Experts recommend that the school nurse become as familiar as possible with any existing administration policies on delegating duties, but it is most important to know the law. Prior to delegation, the school nurse must assess the stability of the student's condition based on that condition's predictability, risk of complication and rate of change.

The following four points then can serve as guidelines in helping the nurse determine appropriate delegation.

Safety: Student safety must be the primary concern at all times. Do not delegate if the task is so complex that it should be handled by an individual with advanced skills in order to avoid endangering the student.

Staffing: Don't let short staffing predicate who gets a particular assignment or "fills in" in a pinch. Know the skills level and capabilities of all team members to determine who can best do the job. If no one else is capable, don't delegate.

Schooling: Consider all the educational components in a person's background, including in-service and experience, before asking that person to participate in specific procedures. Make certain you've observed and, if necessary, corrected the person's technique. If not, don't delegate.

Supervision: The keys to safe delegation are adequate supervision by and availability of the school nurse when questions or problems arise. If you can't be sure of either, don't delegate.³

If the school nurse is pressured to delegate inappropriately, or becomes aware that a principal or another administrator is attempting to delegate nursing duties, the nurse should immediately inform the administrator of the specifics of the state's nurse practice act and the liabilities involved in violating it. A letter designed to be used by school personnel who are asked to perform nursing duties, which also could be adapted for use by school nurses, is included in Appendix D. The school nurse also must notify the state board of nursing in writing about the inappropriate delegation.

procedures, while working to provide high-quality education for students.

In addition to state law and school policy, there is another resource designed to help the school nurse and other school personnel determine which individuals can appropriately perform various tasks. The AFT has developed guidelines for the delineation of roles and responsibilities for the safe delivery of specialized healthcare in the educational setting. These guidelines include a matrix that outlines 66 special healthcare procedures that some children will require during the school day and then identifies the appropriate individual(s) to carry out each procedure. The matrix is included in Appendix E. Although not a legally binding document, the guidelines have gained a great deal of recognition for their utility, and many school districts have adopted them as policy.

Endnotes

- ¹ National Association of School Nurses and American Nurses Association, *School Nursing: Scope and Standards of Practice*. 2005.
- ² Schwab, Nadine C. and Mary H.B. Gelfman, *Legal Issues in School Health Services*, Authors Choice Press, 2005.
- ³ *Delegation of School Health Services to Unlicensed Assistive Personnel: A Position Paper of the National Association of School Nurse Consultants*. National School Nurse Consultants. Kent, Ohio. 1995.

The **laws** covering the education of children with disabilities are **complex** and designed to meet their **unique** needs.



Chapter 3

The Legal Framework

for Providing Care to Children with Special Healthcare Needs

The laws covering the education of children with special healthcare needs are complex. In this chapter, we will focus primarily on federal laws, which pertain to all students. For information about state laws, you may want to contact your union, state nursing board, state school nurses association or state department of education.

The Individuals with Disabilities Education Act (IDEA)

The main federal law governing the education of children with special healthcare needs is the **Individuals with Disabilities Education Act**, known as IDEA. IDEA's predecessor, the **Education for All Handicapped Children Act**, was passed in 1975 and was prompted by a congressional finding that one-half of the 8 million children with disabilities in the United States at that time did not receive appropriate educational services. One million of those children had been excluded entirely from the public school system. Accordingly, Congress was clear that "state and local educational agencies have a responsibility to provide education for all handicapped children."¹

The purpose of the current IDEA statute is "to ensure that all children with disabilities have available to them a free appropriate public education (FAPE) that emphasizes special education and related services designed to meet their unique needs and prepare them for further education, employment and independent living."²

What Services Must Schools Provide?

The law is clear that schools are responsible for providing students who have profound health impairments with the "related services" (physical therapy, occupational therapy, health and nursing services, and speech therapy) they need to benefit from their education. The 2004 reauthorization of IDEA specified that school nurse services were part of the "related services" districts must provide.³

At the same time, the school district is not responsible for providing all medical care that the student may require. For example, although IDEA regulations say "medical services" are a "related service" that must be provided, they also narrowly define "medical services" as services provided by a licensed physician for the purpose of determining a child's medically related disability. This limitation on school districts' responsibility for "medical services" has come to be known as the "medical exclusion."

In practice, however, it may be difficult to draw a clear line between “school health and nurse services,” which the school must provide, and “medical services,” which are not the responsibility of the school system. For example, under IDEA, the school is not responsible for replacement of a surgically implanted device the child may need to survive—but it is responsible for making sure that the device is monitored and maintained correctly while the child is being transported to and from school, and while he or she is at school.

What the Courts Say

The first major U.S. Supreme Court case to address the level of services schools are required to provide for children with special healthcare needs involved a student born with spina bifida. She was unable to control her bladder function and required clean intermittent catheterization (CIC) in order to attend school (*Irving Independent School District v. Tatro*⁴). The school district argued that CIC was an excluded “medical service.” But the court—relying first on IDEA regulations that defined medical services as services provided by a licensed physician, and second on evidence presented by the student’s family that CIC could be performed by a nurse or a minimally trained layperson—concluded that CIC was a necessary “related service” and the school was required to provide it.

In 1999, the Supreme Court followed a similar analysis in *Cedar Rapids Community School District v. Garret*.⁵ In that case, the student was paralyzed from the

neck down and required services that included CIC and ventilator assistance. The court again held that if the service could be delivered by someone with less training than a physician, the school district was required to provide it.

Least Restrictive Environment Considerations

Another fundamental principle of IDEA is that the child must be educated in the “least restrictive environment” (LRE). IDEA defines “least restrictive environment” as follows: “To the maximum extent appropriate, children with disabilities ... are educated with children who are not disabled; and special classes, separate schooling or other removal of children with disabilities from the regular educational environment occurs only when the nature or severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily.”⁶

The theory behind LRE is based on several concepts:

- Children with special healthcare needs will be stigmatized if they are removed from the regular classroom and treated differently.
- Keeping children with their nondisabled peers will ensure the same high expectations for both types of students.
- It’s important for students with special healthcare needs to have peer interactions with nondisabled students.

Because each child is different, the issues involved in deciding on an appropriate placement for a student with complex medical needs will vary. It is difficult to generalize about educational placement decisions. IDEA regulations make clear that the placement decision must be based on the child's Individualized Education Plan (IEP)⁷ and that the child should not be removed from age-appropriate regular classrooms solely because of needed modifications in the general education curriculum.⁸

However, in selecting the LRE, it is also important to consider any potentially harmful effect a particular placement might have on the child or on the quality of necessary services.⁹ School authorities sometimes believe they must always try to provide services in the regular classroom first and can only consider alternative placements if that effort fails. In fact, the law requires districts to evaluate whether a student with special healthcare needs can be educated satisfactorily in a regular class with appropriate aids and services. If the answer is no, the regular class is not the least restrictive environment appropriate for that child. The LRE requirement must always be appropriate for the child's needs, so there will be times when a more restrictive placement may be necessary.

It is important that decisions regarding least restrictive environment be made with the input of classroom teachers, paraprofessionals and school nurses, as well as parents. The school nurse's input is especially important in determining where services should be

provided. While a doctor may express an opinion or even write an order saying that a service can be delivered in the classroom, the school nurse has the expertise and knowledge necessary for assessing the situation and determining if it is, in fact, appropriate to provide the necessary services in general classrooms.

Who Cares for the Child with Special Healthcare Needs? The Regulatory Framework for the Practice of Nursing

There are many different categories of nursing personnel, and the scope of practice for each job title is very different. The roles and responsibilities of registered nurses (RNs), licensed practical nurses (LPNs) and certified nurse assistants (CNAs) are defined by state laws that are known as nurse practice acts. Nurse practice acts determine the requirements for obtaining a license to practice nursing, describe the scope of nursing practice for each job title, and establish the framework for oversight of the nursing profession and those who practice nursing.

Nurse practice acts also typically include language that prohibits unlicensed persons, excluding family members and individuals responding to an emergency, from practicing nursing. In most states, practicing nursing without a license is a criminal offense punishable by a fine and/or a jail term.

Scope of Practice:

The Definition of the Practice of Nursing

Licensure authorizes licensed persons, in this case nurses, to perform certain tasks. Unlicensed persons, e.g., school administrators, are not legally permitted to assign those tasks to anyone. Only nurses can delegate activities within the scope of nursing practice; however, the definition of “scope of nursing practice” differs from state to state and is often quite general.

For example, Oregon law defines the practice of nursing as: *... diagnosing and treating human responses to actual or potential health problems through such services as identification thereof, health teaching, health counseling, and providing care supportive to or restorative of life and well-being and including the performance of such additional services requiring education and training which are recognized by the nursing profession as proper to be performed by nurses licensed under [Oregon law] and which are recognized by rules of the Board.*¹⁰

The practical application of this language to school settings is elusive to most unlicensed persons. Often these laws offer little assistance in figuring out who can and cannot perform a particular health-related activity in a school setting. How then do school personnel—administrators, teachers, paraprofessionals and nurses—get clear directions about their proper roles and responsibilities?

The answer usually lies with the state’s board of nursing, either alone or in collaboration with the state’s department of education, the state’s school nurse organization or the department of health. Some state boards of nursing and state departments of education, such as New York’s, have issued joint memoranda explaining the roles and responsibilities of school administrators, school nurses, and other school personnel in providing nursing and health-related services for students in the school setting.

The New York joint memorandum (see Appendix F) lists specifically identified activities that must be performed by registered nurses; activities that, with training and the approval of a registered nurse, sometimes can be performed by unlicensed personnel; and activities that usually can be performed by unlicensed personnel.

In other states, such as Connecticut, Montana and Utah, state departments of education, in collaboration with state boards of nursing, have issued handbooks or guidelines to assist school personnel. In Oregon, the State Board of Nursing issued declaratory rulings in response to complaints or inquiries from school personnel. It is likely that other states may follow this path.

Do I Have to Do This?

Educators, paraprofessionals, and other related staff and support staff are being called upon with more frequency to perform certain duties in the school setting that were traditionally performed by

school nurses or health aides. When told it is their responsibility to carry out these tasks, most do it with trepidation and are left wondering, “Do I have to do this?” The short answer is yes, as an employee of the school district, you are obligated to perform tasks that are assigned. Additional information regarding your rights will be provided in subsequent chapters.

School boards and administrators are often unaware of the legal framework governing the practice of nursing. Nurses, many of whom are without union protection, face difficult challenges in trying to carry out their obligations as nursing professionals when administrators are ignorant of—or even openly hostile to—school nurses’ professional responsibilities and to the laws governing the practice of nursing.

Delegation of Nursing Tasks in the School Setting

The National Council of State Boards of Nursing (NCSBN) defines “delegation” as transferring authority to a competent individual to perform a selected nursing task in a selected situation. Only a nurse can delegate nursing tasks. Even then, accountability and responsibility for correct performance of the task will remain with the nurse.

Rules about delegation vary from state to state. In some states, duties that are within the registered nurse’s scope of practice cannot be delegated to another individual under any circumstance. In other states,

Five Rights of Delegation

To provide for safe care, nurses use the **Five Rights of Delegation** to guide their assessment of whether delegation is appropriate for the student and the situation.

1. The Right Task

- Is the task within the nurse’s scope of practice?
- Is the task reasonably routine with a predictable outcome?
- Is it based on written medical orders?
- Is it one that is repeated frequently?
- Is it performed according to an established sequence of steps, without modification?
- Is the task one that does not involve assessment, interpretation or decision-making?

2. The Right Person

- Who is immediately available to the student, willing and competent to do the task at the required time?

3. The Right Direction

- How much training will be required to perform the task in a safe and appropriate way?
- How many tasks will the person need to learn?
- What other duties does she or he have?

4. The Right Supervision

- How much initial training will the nurse need to provide to the delegatee for the performance of this task?
- What type of ongoing supervision will be needed (on-site, periodic, episodic)?

5. The Right Circumstance

- Is the child particularly vulnerable due to age, developmental level, cognitive abilities, gender or specific health issues?
- Is the environment safe for the person to perform the delegated task as planned?¹¹

Staff are increasingly **being called upon** to perform certain duties **traditionally performed** by school nurses or health aides.

delegation can occur, but ONLY at the direction and supervision of the nurse, who is ultimately responsible for the task being done correctly. The nurse must provide guidance for performing the procedure and must periodically observe the person as the procedure is being performed to be certain it is being done properly.

While the National Council of State Boards of Nursing recognizes health aides and classroom paraprofessionals as persons who may assist with health-related services, instructional paraprofessionals (much like teachers) may, in fact, be poor choices as delegates because their responsibilities to other students allow them little time to attend to the specific health needs of a child with special healthcare needs.

Although parents can collaborate with school personnel in developing a plan of care and preparing other school personnel to serve their child's health needs, the school nurse is responsible for deciding whether delegation is appropriate.

Ideally, school districts should have policies and procedures regarding the delegation of nursing services based on the state's nurse practice act. If guidance is needed, it should be obtained from the state board of nursing. In addition, school nurses, administrators, teachers and paraprofessionals should be involved in developing the policies and procedures pertaining to delegation. These individuals are in the best position to provide information about how delegation will work in their particular school setting.

Complicated Staffing Issues

There are occasions when a student with special healthcare needs may be coming to school with an RN, LPN or even personal care assistant who is employed to accompany the student to school and perform the necessary healthcare services during the school day. Sometimes this may create confusion about who is responsible for the child's care.

The school district always maintains a general duty to the health and safety of all students. In this situation, the school nurse is responsible for coordinating and communicating with the outside agency about the student's care. Usually, the school nurse is not responsible for providing any direct services to the student. If the school staff or school nurse has concerns about the quality or safety of the care being provided by the agency staff, the school nurse must communicate that concern to the case manager from the agency, which is ultimately responsible for the quality of care being delivered by its staff. Usually, the case manager is an RN who is responsible for the planning of care and for delegating that care to LPNs or personal care assistants employed by the agency. In very rare circumstances, the school nurse might intervene in the delivery of care if the student's health and safety were in danger.

A procedure should be established for the school nurse to follow if he or she determines that the private nurse is performing his or her duties in an unsafe manner.

The school nurse also may seek guidance from the state board of nursing and, if necessary, obtain written clarification of his or her responsibilities from the employing school district. In addition, the school nurse should not be placed in the position of substituting for a private nurse when that person is unable to perform his or her duties. It is the parent's or agency's responsibility to locate a substitute if the private nurse is unavailable.

Documentation Standards:

If It Wasn't Written, It Wasn't Done

Documentation is not only important in keeping track of the medical needs of students; it also provides protection against liability for school nurses and assisting personnel. School districts and school personnel may be sued if parents believe that their child has suffered adverse consequences because of neglect or substandard care by school health personnel. School nurses and personnel can protect themselves by clearly and completely documenting their encounters with students, including each step of the nursing process or delegated activity, using an individual, student-specific record. This documentation must be kept up to date—not quickly put together later, when it might appear to be a fabrication or cover-up.

School Health Records

According to the School Nursing Scope and Standards of Practice,¹² school nurses must document each student encounter and each aspect of the nursing process. The standards call for these practices in order to promote:

- consistent and continual care,
- regular evaluation of individualized healthcare plans, and
- subsequent revisions in care.

However, schools are not healthcare institutions, and school administrators may not understand the purpose or requirements of nursing documentation.

While certain laws, such as the Health Information Portability and Accountability Act (HIPAA), treat health information as confidential and prohibit its disclosure, other federal laws, such as the Family Educational Rights and Privacy Act (FERPA), require school districts to give parents the opportunity to review and inspect educational records, and do not make distinctions between records maintained by school health professionals and other types of school records. Clearly, this can create a potential conflict. School nurses bear enormous responsibility for educating school administrators about meeting nursing documentation requirements, establishing appropriate school record-keeping systems, and maneuvering through conflicting legal requirements.

The Family Educational Rights and Privacy Act (FERPA)

The Family Educational Rights and Privacy Act, commonly known as FERPA, requires every school district, annually, to notify parents and eligible students (over 18 years of age) of their right to inspect and review their children’s education records, or their own.¹³ FERPA defines education records as records that are directly related to a particular student and maintained by an educational agency or institution.

Generally, the personal notes of nurses and other professionals are exempt from FERPA rules. However, the record may fall under FERPA disclosure rules if it is created or maintained in response to school district policy or procedure; is discussed with other school personnel at staffing, support or IEP team meetings; or is the basis for a service recommendation.

The Health Information Portability and Accountability Act (HIPAA)

The Health Information Portability and Accountability Act (HIPAA), passed in 1996, establishes privacy standards related to sharing health information.

However, HIPAA regulations specifically exclude from its privacy requirements information considered “education records” under FERPA.

Education records include a student health record or an immunization record. Health records maintained for children eligible under IDEA also are considered education records and are subject to IDEA and FERPA privacy requirements, but are not subject to the HIPAA privacy rules.

Issues for School Health Providers

School nurses are required by the standards of their profession to document information relating to students’ health status—including information about highly sensitive issues such as pregnancy, drug and alcohol abuse, and suspected child abuse—but federal law requires school districts to allow parents access to this information.

Hospitals and physicians may provide schools with voluminous treatment records, believing that the schools will keep the records confidential under HIPAA, but, in fact, schools are not able to honor that expectation.

State laws may protect the confidentiality of communications between students and various professionals, or may require that various kinds of information be treated as confidential, yet federal law may override these protections. Nurses who fail to document sensitive information out of concern for the student’s safety or privacy may, at the same time, place the student at risk and expose themselves to liability.

Recommendations for School Nurses and Other Health Providers

Many states and local school districts have developed school health record policies and procedures that recognize the sensitive legal and professional dilemmas faced by school health personnel. Some states have developed specific guidelines; if you are in a state that has not developed guidelines, you should work with your union to initiate a process that will get you the information you need. Since laws vary, the guidelines in your state and school district will have to address issues that arise under the laws of your state.

The following recommendations, drawn from *Legal Issues in School Health Services: A Resource for School Administrators, School Attorneys, School Nurses*¹⁴ will help you get started:

- Learn about the documentation policies and issues in your state by contacting your state's education department, the state board of nursing, and the state affiliate of the National Association of School Nurses (www.nasn.org).
- Obtain copies of school district policies and procedures regarding student records, and talk with school psychologists, social workers, guidance counselors, teachers and other school professionals about how they handle confidential information.
- Inform school administrators about the documentation standards for the nursing profession and the need for clear district policies and procedures for nursing and healthcare documentation. If your district does not have clear policies and procedures, work with administrators to develop them.
- Obtain legal advice from your state education department, and/or request rulings from your state board of nursing, on how to handle conflicts between state and federal laws regarding confidentiality and disclosure of school health records.
- Examine the kinds of school health records your district maintains, classify them according to the degree of confidentiality required, and make recommendations regarding appropriate record-keeping systems.
- Limit access to student health information to school personnel who need to have the information in order to provide health services, to maintain a safe learning environment for the child or to respond appropriately in case of emergency. School nursing process notes and hospital and physician records should be accorded the maximum protection.
- Record objective information rather than conclusions and, whenever possible, provide an assessment of the student's healthcare needs rather than a medical diagnosis. This is particularly important if the record could be used in legal proceedings (e.g., family court or children's protective services) or is developed for use by nonmedical personnel (e.g., classroom teachers, paraprofessionals, multidisciplinary teams).
- Avoid use of a daily log as the sole record of student visits to the health office. Using a cumulative log limits the ability to track individual student health needs, does not provide accessible information for substitute nurses, and presents difficult issues under FERPA because it contains personally identifiable information about multiple students.

Liability

There are a number of reasons why the practice of school nursing may lead to legal concerns. School nurses do not have the facilities, equipment or clinical support typically available in other healthcare settings. In addition, school nurses usually work independently and are responsible for students with diverse and sometimes complex health and medical needs.

But the good news is that, in spite of all of the potential for litigation, school nurses are not sued very often. When school nurses are sued, usually they are named as additional defendants in lawsuits against school districts. In those cases, the nurse will benefit from state laws and court decisions that narrowly define the duty of school districts and school district employees, that require plaintiffs to prove something more than simple negligence, or that provide immunity for actions undertaken in the course of school district employment. In addition, most states require school districts to defend the school nurse, or reimburse legal fees, when the nurse is sued for actions taken in performing the duties of the job.

Negligence

In order to establish that a nurse or other employee has been negligent, four elements need to be present:

- a legally recognized duty to conform to a certain standard of conduct for the protection of others against unreasonable risks;

- a breach of duty, i.e., a failure on the part of an individual to conform to the standard;
- a reasonably close casual connection between the conduct and the resulting injury (often referred to as “proximate cause”); and
- actual loss or damage to the interests of another.

All four elements—duty, breach of duty, close causal connection, and loss or damage—must be present for liability to be established.

The minimum standard to which an ordinary citizen is held is that of a “reasonable person,” i.e., someone who embodies what the community expects of a prudent, cautious person. Professionals, such as nurses, are held to the standard of what is customary and usual in their profession.

How is that standard defined? The standard of care in the nursing profession may be drawn from a number of sources. On the national level, standards for school nursing practice have been developed by the National Association of School Nurses and the American Nurses Association. On the state level, the state nurse practice act and state’s board of nursing are influential. State education department protocols or guidelines for school nurses also may be referenced in establishing a standard of care. Other resources include nursing textbooks, courses of study and articles in professional publications.

A school nurse can breach the duty of care by carrying out a nursing act that is below the standard of care, or by failing to act in circumstances where a licensed professional would be expected to act.

When someone sues school districts or school employees for acts committed while an employee is doing his or her job, they face several hurdles not present in traditional negligence litigation. Some states require plaintiffs in such cases to prove “gross negligence” or “willful and wanton conduct.” Other states have limited the government’s liability for certain types of claims to situations where the government had been notified of the risk of harm. Yet other states impose obstacles such as “notice of claim” requirements. That is, individuals who are considering suing a school district must let the district know of their intentions very soon after the negligence they are claiming occurs. Requirements like these decrease the chances that school districts and their employees will be sued.

Liability under Section 1983

School personnel who serve students with disabilities can be named in another kind of lawsuit under Section 1983 of the Civil Rights Act of 1871. This Reconstruction-era statute, originally enacted to give freed slaves redress against state and local governments and officials who violated their federal rights, can be used by parents of students with disabilities seeking monetary damages for violation of rights created by the IDEA and Section 504 of the Rehabilitation Act.

Section 1983 is not an independent source of rights. Rather, it allows individuals who believe that their federal rights have been violated to seek money and any damages and other remedies that may not be available under the federal statute or constitutional provision that is the source of their rights.

In cases involving school-age children with disabilities protected by the IDEA, courts usually require parents to exhaust IDEA administrative due process—that is IEP meetings, impartial hearings and state review, if required—before filing a court action.

Do Not Resuscitate Orders

Do Not Resuscitate (DNR) orders direct medical personnel not to use extraordinary lifesaving measures, such as CPR, respirators and cardiac shock, to revive a dying patient. Until recently, Do Not Resuscitate orders generally have applied to terminally ill patients in hospitals and certain other healthcare facilities. However, many states now permit DNR orders to be issued for less serious conditions and for patients outside the hospital setting. School districts may be faced with this issue and may have to address parents’ expectations that the school district will honor physician-issued orders to withhold lifesaving treatment. This is a particularly troubling and difficult issue for school districts and school personnel.

Causes of Liability

Nadine Schwab, co-author of *Legal Issues in School Health Services*, has identified the following as **recurring causes of nursing liability**:¹⁵

- 1. Failure to keep** abreast of nursing knowledge;
- 2. Failure to take** an adequate patient history;
- 3. Failure to function** within established policies;
- 4. Failure to function** within the scope of nursing education and practice;
- 5. Failure to administer** medications and treatments properly;
- 6. Failure to adequately supervise** or monitor patients;
- 7. Failure to observe and report** changes in a patient's condition;
- 8. Failure to document** adequately and promptly: alteration of records;
- 9. Failure to report** incompetent care by others;
- 10. Improper physician orders**—duty to defer execution;
- 11. Failure to use** aseptic technique;
- 12. Use** of defective equipment;
- 13. Abandonment** of patient; and
- 14. Failure to resuscitate** promptly and properly.

Nurses can avoid liability by making sure their practices do not fall into any of these categories, as well as by acquainting themselves with the policies and procedures adopted by their school board and school administration, and, more specifically, by acquainting themselves with their job description. Every school nurse should have a job description and should review it regularly.

Parents of the child with special healthcare needs often are guided by their strong desire to provide their child with a “normal” school experience by being part of a regular classroom. They also want school personnel, students and other parents to respect the very difficult and painful decisions they have made about responding to their own child’s medical emergencies.

Unfortunately, the legal issues surrounding Do Not Resuscitate orders are no less complex than the social and emotional issues surrounding them.

The legal and moral issue at the core of the entire discussion is the so-called right to die. The right to die does not exist as a matter of constitutional law. While the Supreme Court has held that individuals may refuse medical treatment, their right to refuse treatment must be balanced against the state’s interests in preserving and protecting human life.

States may limit the circumstances in which individuals can exercise their “right” to refuse medical treatment. Even more importantly, states may restrict or even refuse to honor DNR requests that are made by family members on behalf of dependent children. States are especially protective of persons who, because of serious mental impairments, cannot participate in or even understand the decisions being made on their behalf.

Addressing the Issue

The legal, moral and ethical questions surrounding this issue are so complex, and the potential outcome so final, that it would be wise for the local union to obtain independent legal advice concerning the obligations and potential liabilities of its members before weighing in on the issue.

In reviewing the issue, legal counsel should, at a minimum, attempt to address the following questions under state law:

- Does state law permit doctors to issue a DNR order when the patient is not terminally ill or in a persistent vegetative state?
- Does state law limit implementation of DNR orders to hospitals or other specific healthcare settings?
- If state law permits nonhospital DNR orders, does it limit the categories of personnel who can implement such orders?
- Does state law permit parents to make “substituted judgments” for minors, and, if so, under what circumstances?
- Does state law impose special conditions on parents who seek to make substituted judgments on behalf of children who are not mentally competent, and, if so, what are those conditions?
- What liability protection, if any, does state law provide for school personnel who, in good faith and compliance with school district policy, carry out decisions not to resuscitate or who, in good faith, refuse to carry out a decision not to resuscitate?

In addition, the union should seek an opinion from the state board of nursing regarding any professional issues that may place school nurses at risk of professional discipline. For example:

- If the district does not have a DNR policy, what is the school nurse’s responsibility when a student’s private physician issues a valid nonhospital DNR order?
- What is the school nurse’s role in implementing a DNR order when a student’s health services are provided by a private (Medicaid or insurance reimbursed) nurse?

School instructional personnel (teachers and paraprofessionals) and non-nursing-related service personnel have other issues to consider. Some members of the school staff may have moral or ethical objections to complying with a DNR order. In some circumstances, the potential emotional trauma to other students and significant disruption to the educational program may mean that, for students with a DNR order, placement in a regular classroom is not appropriate to meet the needs of the student, and placement in a more restrictive setting may be necessary.

If state law allows school district personnel to honor DNR orders, it is the responsibility of the school board to decide how the issue will be addressed in schools. Ideally, the school district should develop its plan before a request is received, so it can study the issue and make recommendations insulated from the passions aroused by a particular situation. The plan

then can be put in place before the question arises. Undoubtedly, the district will receive legal advice before the policy is finalized.

Endnotes

- ¹ 20 U.S.C. 1400
- ² 20 U.S.C. 1400 (d)
- ³ 20 U.S.C. 1401 (26)
- ⁴ 468 U.S. 883 (1984)
- ⁵ 526 U.S. 66 (1999)
- ⁶ 20 U.S.C. 1412 (a)(5)(A). See also 34 C.F.R. 300.114-300.120
- ⁷ 34 C.F.R. 300.116(b)(1)
- ⁸ 34 C.F.R. 300.116(e)
- ⁹ 34 C.F.R. 300.116(d)
- ¹⁰ Oregon State Board of Nursing, *Scope of Practice Decision-Making Guidelines for RN and LPN Practice*. www.oregon.gov/OSBN/pdfs./policies/scope_decision_tree.pdf
- ¹¹ National Association of School Nurses, *Position Statement on Delegation*, adopted June 2006. (www.nasn.org)
- ¹² National Association of School Nurses and American Nurses Association, *School Nursing Scope and Standards of Practice*, 2005.
- ¹³ 20 U.S.C. 1232(g)
- ¹⁴ Nadine Schwab, and Mary H.B. Gelfman, eds., *Legal Issues in School Health Services*, Authors Choice Press, 2005.
- ¹⁵ Ibid

School staff responsible for children with special healthcare needs must work closely with **health professionals**.



Chapter 4

Non-Nursing School Personnel

School personnel in a number of non-nursing roles are responsible for providing educational, transportation and other services to children with special healthcare needs. This chapter is intended to delineate the framework within which those services are delivered.

What Is the Role of the Teacher?

Teachers are responsible for developing and implementing the instructional program in the classroom. This includes using the district's curriculum, incorporating state/district academic standards into classroom practice, providing a safe and orderly classroom environment, serving on IEP teams and participating in a variety of other activities that support instruction. In order to provide high-quality instructional programs to students, teachers may have to consult and collaborate with a variety of specialists, including the school nurse, and may have to coordinate the work of one or more paraprofessionals. However, it is not appropriate for special or regular education teachers to provide nursing services for children with special healthcare needs, and only in very special circumstances should teachers provide personal care services. Nursing services provided by teachers can be dangerous and take precious time away from classroom instruction, as well

as raise legal questions and liability issues. It also may violate a state's nurse practice act. Nursing services must be provided by the school nurse, licensed practical nurse, or well-trained and competent health aide working under the direction of the school nurse.

Nevertheless, it is important for teachers of children with special healthcare needs to work closely with the health professionals to ensure the students' educational programs take into account their health needs.

What Is the Role of the Paraprofessional?

The role of the paraprofessional is to provide support for the students and teacher in the classroom. This includes, for example, small-group instruction, monitoring student activity and tutoring students. Paraprofessionals typically work in either a special education or a regular education classroom. Paraprofessionals in special education classrooms have traditionally been faced with the possibility of providing health services to students. These services include catheterizations, tube feedings and cleaning tracheotomies. Paraprofessionals in regular classrooms

are increasingly exposed to the possibility of providing health services that range from the most basic to extremely complex, invasive procedures, since many school districts are placing special-needs students into regular education classrooms. Many paraprofessionals perform such procedures with inadequate training or no training at all. Paraprofessionals should never provide health services that fall within the scope of nursing practice, unless they have received the appropriate training, which has been documented by a health professional, and unless protocols are in place that define the parameters of delivery. The school administrator cannot legally direct a paraprofessional to provide such services.

What Is the Role of the Health Aide?

The role of the health aide is to assist the school nurse in meeting the healthcare needs of students. Many health aides are paraprofessionals and have the same legal limitations placed on them as other nonmedical school personnel. The health aide works under the supervision of the school principal, but his or her day-to-day work generally is directed by the school nurse. There has been an increasing reliance on health aides because many schools do not have full-time nurses. More and more health aide jobs require LPN or health assistant training. Some school districts use LPNs as health aides to provide healthcare services. Health aides should not be used in place of school nurses.

What Is the Role of the School Secretary?

The school secretary supports the principal in running the school. The secretary is the first point of contact in conducting school business. Smaller schools may have only one secretary, and larger schools may have a team of secretaries. The secretary's numerous duties include administrative details, interacting with staff, scheduling meetings, handling emergencies and communicating with parents. The secretary is central to the flow of verbal and written communication and interaction within the school, between the school and parents, and with other health and social service agencies that provide services to children with special healthcare needs. The secretary's important responsibilities include maintaining and providing access to written communications, such as IEPs, health records and other documentation containing critical information about the student's health, daily interactions, incidents or emergencies. This information could have legal implications for the school district and the student's family.

Many secretaries also provide first aid and dispense medication to students without proper in-service training, procedures or school nurse supervision. This all-too-prevalent practice is dangerous for students and carries serious legal implications for the school secretary and the school district. Providing healthcare services for students is not part of any school secretary's job description. This situation is more common in school districts that do not have a full-time nurse and in rural school districts.

School personnel in **non-nursing roles** are responsible for providing **services** to children with special healthcare needs.

What Is the Role of the School Bus Driver?

School transportation personnel (bus drivers and bus monitors) are charged with providing safe and efficient transportation for students. Transporting children with special needs is more complicated than transporting other students. Some areas of concern include legal requirements, training, emergency procedures, routing, scheduling and equipment needs.

Transportation services for special-needs students are affected by IDEA. Recommendations from a report by the 14th National Conference on School Transportation specifically address:

- Transportation as a related service under IDEA
- Vehicle requirements
- Emergency procedures
- IEPs
- Length of ride
- Pick-up and drop-off
- Parent transportation
- Due process
- Extended school year

The full report is available online at www.ncstonline.org. The 15th conference meets in 2010 to revise the full document. In addition, school districts themselves should develop policies or guidelines to cover suspension of services for behavioral reasons as well as student-restraint procedures.

AFT local unions must be prepared to ensure that their drivers receive proper training. A comprehensive list of training program components is included in Appendix G.

What Is the Role of the School Nutrition Worker?

The school cafeteria worker provides nutritious meals for students through the school lunch and breakfast program, as well as nutrition education to staff and students. The cafeteria manager provides special meals for students who have particular dietary needs or problems such as food allergies. Many children with special healthcare needs have physical problems that require special diets and feeding. Teachers and paraprofessionals should work closely with cafeteria workers so that they can determine and prepare the appropriate foods. Feeding children with special healthcare needs in regular schools may pose a problem for some cafeteria workers who do not have kitchen equipment to prepare special meals because they heat cold lunches from a central kitchen. This issue will have to be addressed by the administration in each school district.

What Is the Role of the Custodian?

The custodian is responsible for providing a clean and well-maintained school environment that is conducive to learning. A well-maintained school gives the perception of being run well; makes a positive impression on parents, staff and visitors; and encourages student learning. Custodians clean for

health. Schools can be breeding grounds for germs and bacteria that can lead to a variety of illnesses and health hazards, including hepatitis C, HIV, toxic mold and E. coli. Because many schools also are used for community activities, a clean school not only helps protect the health of children and school staff, but safeguards the general public's health as well.

However, the school building itself can be “sick.” When a building suffers from bad ventilation, leaky pipes or mold problems that are not corrected, staff and students sometimes become ill and/or develop chronic health problems. Some children with special healthcare needs have respiratory problems that can be exacerbated in such an environment. Chemicals used by custodians to do routine cleaning also may pose health risks or cause problems. Green cleaning, using environmentally friendly cleaning solutions, reduces the chemical risks. Traditional pesticides that are used for pest control also may contribute to children's health problems. Custodians should use integrated pest management to minimize those risks.

Some students need wheelchairs or crutches to move around the school. The custodian must ensure that all ramps, classrooms, doors and other parts of the school that are modified for children with disabilities are in good working order. The custodian would contact the necessary people to fix any problem that might arise.

AFT's Recommendations for Non-Nursing School Staff

The AFT recognizes that teachers, paraprofessionals and school-related personnel have been performing medical procedures for students with special healthcare needs for many years—in some cases, with extensive training, and in many others, with no training at all. Paraprofessionals and health aides provide a valuable service by freeing the teacher to take responsibility for education and allowing the school nurse to handle more serious health needs. This practice should continue where appropriate, but we also believe there are precautions affiliates should take to protect their members.

1. **Negotiate requirements** for appropriate training programs for all school personnel who work with children with special healthcare needs. For examples of appropriate training, see the section on “Training Needs of School Staff” in this chapter.
2. **Educate school staff about the legal limitations** placed on them by the state's nurse practice act.
3. **Educate school staff about the liability issues** they face and the union's ability to protect them.
4. **Develop job descriptions** that clearly define the roles and the responsibilities of the school staff (especially paraprofessionals, to whom the responsibility often falls).

Non-Nursing School Personnel and the IEP

The Individualized Education Plan (IEP) is the legally binding document that commits the school district to provide educational services to a student. The specifics of the IEP are determined by the school's Instructional Support Team (IST) or Educational Management Team (EMT) (team names may vary by state and/or district), which includes the parent. It is important that the IEP designate which specific services and personnel are necessary to provide the student a free and appropriate education in the least restrictive environment. This means, for example, if a student has a designated paraprofessional to assist him or her, this fact should be indicated in the IEP. In addition, any training necessary to enable nonteaching staff to perform their duties should be written into the IEP.

Training Needs of School Staff

New-hire training should be provided for all school personnel. Also, in-service training should be ongoing, systematic and updated as the student population or the requirements of educational programs change. The following areas should be covered in training for school staff on the subject of children with special healthcare needs:

- 1. Individuals with Disabilities Education Act—**
History of the Act, who is covered, how it works.
- 2. Section 504 of the Rehabilitation Act—**
History of the Act, who it covers, how it works.

- 3. Legal issues—**the state's nurse practice act and liability.
- 4. Universal precautions** and exposure to blood-borne pathogens—what this means, how staff can protect themselves, what to do in the event of an exposure.
- 5. Basic first aid,** cardiopulmonary resuscitation (CPR) and automated external defibrillation (AED).
- 6. Emergency procedures for the school—**including emergency response and preparedness; handling pandemic flu; what procedures should be in place; who to call; and where to take students in case of fires, earthquakes or power failures.
- 7. Proper techniques** for lifting and moving students.
- 8. Proper ergonomic equipment** that should be available, proper use of the equipment students might have in school (e.g., wheelchairs, walkers, breathing apparatus).
- 9. Overview** of typical student health problems that may be encountered in the traditional classroom (e.g., asthma, cystic fibrosis) as well as communicable diseases.
- 10. Proper training** on any healthcare procedures delegated to staff by the school health professional, including:
 - What constitutes an emergency.
 - Whether the procedure could be a threat to staff member's own health and safety.
 - Possible side effects to procedures or medications.
 - Possible drug interactions, and legal and liability issues.

The school health professional's responsibility is to certify that non-nursing school personnel have been trained appropriately to provide the health services they have been delegated. It is also his or her responsibility to continually monitor the performance of delegated tasks, and ensure retraining or updated training for school personnel who have been delegated to perform such tasks.

As a further precaution, we also recommend all school personnel who require training verify that their training has been documented and approved by the school nurse or the person who trained them.

A **safe** and **healthful** school is the goal for **children** with special healthcare needs and the **staff** who care for them.



Chapter 5

Creating a Safe Environment: Protecting Staff and Students

When staff members are routinely asked to exceed their physical limits and capacity, their safety—and their students’—is threatened. A safe and healthful school environment is an important and achievable goal for the care and well-being of children with special healthcare needs and the staff who care for them. The physical environment must be adapted for the unique demands of caring for these children. The proper equipment must be available and well-maintained, and staff must be trained on safe techniques for assisting children. When any of these elements is missing, the risk of injury and illness increases for staff and students.

Every school should have a process and policy that will assess the needs of a particular student and identify safety measures for the staff person who will support and assist the child. Such a comprehensive policy also should cite pertinent Occupational Safety and Health Administration (OSHA) standards, and recommendations of both the Centers for Disease Control and Prevention (CDC) guidelines and the National Institute for Occupational Safety and Health (NIOSH). The policy also should evaluate staff training and immunization requirements—especially for high-risk staff, e.g., staff with chronic illnesses such as diabetes and cancer (model policies are available from the AFT).

Below is a review of basic concerns that a school policy should address:

Safe Student Handling: Ergonomics

The research is in: School staff members who physically lift and assist students have a higher rate of back injury and muscle strains and sprains. The National Institute for Occupational Safety and Health reports that it is beyond the capacity of any employee to manually lift a person of more than 50 pounds once a day.¹ Yet, it is not uncommon for some school staff to lift 10-20 times that amount as they assist children with diapering, toileting and transportation. As a result, school staff may experience lower back pain or injury, and the student is more likely to be dropped or injured in a recovery attempt.

Fortunately, ergonomics researchers and designers have developed effective methods for handling and assisting students with special needs. When rooms are designed to accommodate children and their equipment, the risks of injury to either staff or students decrease significantly. For instance, there is an array of lifting equipment (see Appendix H) for whole-body lifts and sit/stand lifts.

Preventing Back Injuries in Classroom Personnel

Here are tips for preventing back injuries in classroom personnel who handle medically fragile children:

Tip #1: Pay attention to chronic/recurring back pain.

People who suffer from chronic back pain are more likely to suffer a serious back injury than people who do not. Remember that most back injuries are an accumulation of daily wear and tear on muscles, disks and ligaments. Consider back pain an alarm not to be ignored. Seek good medical advice before it escalates into major injury.

Tip #2: Never manually lift students by yourself.

Remember that the weight of almost all students far exceeds the lifting strength of most workers; lifting students produces incredible forces or “strains” on the lower back. Unfortunately “lifting techniques” are not useful when handling students; students’ bodies are bulky loads with no “handles,” and a lifter can’t bring that load close enough to the body to reduce strain.

Tip #3: There are ways to manage students in the classroom setting.

Research in the health industry has shown that teamwork is essential when handling patients; this research can be easily applied to a school setting. When transferring students (e.g., for toileting), teams should use lifting devices such as ergonomically designed walking belts that are worn by the student. Walking belts should have handles that allow

staff to get a good grip on the student without hurting the student or risking injury to the staff person. Walking belts may be used when the student is not too heavy (under 150 pounds) and can bear some of his or her weight.

When a student is too heavy and/or cannot provide assistance during a transfer, mechanical devices are essential (see Appendix H).

Tip #4: Every school should have a training and task redesign program to prevent staff or student injuries.

Essential elements of the program should include:

- Assessing and routinely reassessing (every six months) the handling requirements of every child with special healthcare needs (a sample of an assessment chart appears in Appendix I).
- Assessing the physical layout for furniture and equipment. For example, recommendations should be made for change when equipment such as changing tables are too low and force staff to squat or bend excessively.
- Identifying the most stressful tasks.
- Selecting one stressful task at a time to redesign.
- Training all staff on the use of new equipment or techniques that are in the redesign program.
- Maintaining all equipment and assistive devices.

Changing tables that can be adjusted to safely transfer students to and from the table also are available.

The health and well-being of staff is critical for caring for children with special healthcare needs. Therefore, staff members should not ignore back and other muscle/joint pain; the pain can be a sign of cumulative trauma and microtears that will ultimately lead to an injury if neglected.

Emergency Preparedness and Response

School emergency preparedness and response plans often fall short of addressing the issues of children with special healthcare needs. Plans for some types of emergencies may be relatively simple and easy to execute: For example, fire plans may call for students to be taken to a designated room or area where firefighters can evacuate them safely in the event of a fire. However, in other emergency situations, such as bomb threats or natural disasters, evacuation procedures are not so clear. For instance, sometimes children in wheelchairs may be on upper levels of schools—this is particularly true for students in high school who change classes.

The AFT honored two paraprofessionals who physically carried students down three flights of stairs in a high school located near the World Trade Center on Sept. 11. Their efforts were heroic, but they risked injuring the students and themselves. A better solution is to have evacuation chairs or devices that are safe for both students and staff.

Other important considerations for assisting children with special healthcare needs in an emergency include the evacuation site, emergency transportation, and any necessary medical equipment and supplies. All these concerns should be addressed in the school's emergency response and preparedness plan. Every student with special needs should have his or her individual emergency response and preparedness plan easily accessible to staff who will be responsible for their care in the event of emergency.

Ideally, staff members who are directly involved in the care of children with special healthcare needs should be on the school safety committee and should participate in developing emergency response plans for these students.

Infectious and Communicable Diseases

Children with special healthcare needs may be more susceptible to the many infectious disease agents that find their ways into schools. Therefore, school staff should be especially vigilant in monitoring these students for infections and should take precautions not to transmit infections from one student to another or to a staff person. Every year, school staff should receive information and training on infectious disease and also should be advised on immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) for adults in school settings.

In the 26 states where OSHA standards are in place, school employees should receive annual training on preventing work-related exposure to bloodborne pathogens, personal protective equipment such as gloves, and the opportunity to be vaccinated for hepatitis B.²

Preventing exposure and transmission depends on following universal precautions. The first rule of universal precautions is to *assume that everyone is infected*. In addition, all staff should:

- Use barriers between you and a person’s blood/body fluids;
- Wear gloves when coming into contact with blood/body fluids;
- Wash hands after removing gloves;
- When exposure can’t be prevented, wash all exposed skin;
- Use disinfectants to clean all spills; and
- Place used sharps (needles/lancets) in a puncture-proof container.

Hand washing, or “hand sanitation,” as the Centers for Disease Control calls it, is also effective to protect staff and students from infection with microbes. Hand washing is one of the most effective ways to prevent disease transmission.

Frequency (how often hands are washed) is also important. Generally, wash your hands:

- Upon arrival at school;
- Before handling food or feeding children;
- Before and after assisting a child in using the toilet;

- After changing diapers;
- After contact with a runny nose, vomit or saliva;
- After handling pets; and
- After removing gloves.

Some of us don’t have easy access to the restroom to wash our hands at all times. The Centers for Disease Control has recognized another option, when washing our hands isn’t possible or practical. Alcohol gel hand sanitizer that has an alcohol content between 60 percent and 90 percent is effective in killing almost all the germs on a person’s hands.

It’s important for staff not to go overboard with disinfecting surfaces and equipment. Too often, in an attempt to protect everyone, bleach (often in concentrated forms) is applied when routine cleaning and sanitizing may be enough. Bleach is a toxic and highly corrosive chemical that, in high concentrations, not only can irritate and abrade skin, but can cause severe irritation (to the point of burning) to nose, throat, eyes and lungs.

Staff should understand the ABCs of germ control. An all-purpose cleaning product and a microfiber cloth can remove most germs from surfaces. Sanitizing, which by definition has a 99.9 percent kill rate, is generally required for food preparation areas. Disinfectants, as defined by the U.S. Environmental Protection Agency, kill almost all germs on a surface when used as directed. Disinfectants should be used only in high-risk areas, after surfaces have been cleaned. Any residual organic

material (such as feces or dirt) on a surface may deactivate the disinfectant—in other words, make it ineffective.

Chlorine bleach is the highest-risk product and should be used only in situations where there is no alternative. A dilution is only effective for 24 hours, and a jug of bleach has a shelf life, so should not be stored for years until needed.

According to leading authorities, phenols should not be used in school facilities. These are often in aerosol containers of disinfectant. More common these days are quaternary ammonium compounds, or “quats,” used for disinfecting. Benzalkonium chloride, a widely used quat, has been linked with occupational asthma. Therefore, staff should take precautions when using disinfectants with this chemical; adequate ventilation and the proper gloves are imperative when using this product.

The AFT recommends that a green cleaning approach be used universally in schools, but especially in areas used by children with special healthcare needs. Hydrogen peroxide is the basis of many of the environmentally preferable or green products, and is the least toxic on the sanitizing and disinfecting continuum.

Contact the AFT health and safety program for more information on protecting the well-being of staff and students.

Rules of Hand Washing

1. Apply soap.
2. Place your hands under running water with your fingers pointed down.
3. Rub your hands vigorously for about 10 seconds.
4. Dry your hands with a paper towel, then use the towel to turn off the faucets and open the door.

Endnotes

¹ *Musculoskeletal Disorders and Workplace Factors: A critical review of epidemiologic evidence for work-related musculoskeletal disorders of the neck, upper extremity and low back.* NIOSH Publication No. 97 - 141 and *Ergonomic Guidelines for Manual Materials Handling.* NIOSH No. 2007 - 131

² The states with OSHA laws for public sector are: Alaska, Arizona, California, Connecticut, Hawaii, Indiana, Iowa, Kentucky, Maryland, Michigan, Minnesota, Nevada, New Jersey, New Mexico, New York, North Carolina, Oregon, South Carolina, Tennessee, Utah, Vermont, Virginia, Washington, Wyoming plus Puerto Rico and the U.S. Virgin Islands.

Your **union contract** is a **powerful** tool in providing services to students with special healthcare needs.



Chapter 6

Collective Bargaining and Workers' Rights

Many AFT locals have addressed the provision of healthcare services for students using one of their most powerful tools—their union contract. AFT locals have negotiated contract language addressing everything from dispensing medication to student-to-nurse ratios to liability concerns.

Following are some samples of contract language that have been achieved through the collective bargaining process. These are examples of how some locals have addressed various subject areas and should not be viewed as model contract language.

Staffing Ratios for School Nurses

The federal government, professional associations and the AFT agree that the minimum ratio of students to school nurses should be 750 students per school nurse.¹ Most school districts fall far short of that goal.

The AFT also believes that, in addition to ratios, there should be at least one full-time school nurse in every school building. Contract language is one way to ensure the appropriate numbers of school nurses.

- The systemwide ratio of nurses to students shall be 1 to 700. (*Boston Teachers Union, Local 66*)
- The established “students to nurse” ratio (1,500:1) for assignment of a school nurse(s) at a school(s) shall be continued.
Schools having heavy health room needs and utilization by students (both secondary and elementary schools) should continue to have additional nursing services assigned as available. (*Pittsburgh Federation of Teachers, Local 400*)
- Every effort shall be made to provide no more than four (4) school assignments for each nurse. (*Cleveland Teachers Union, Local 279*)
- All high schools will be assigned one (1) individual who shall possess the Registered Nurse designation in addition to regular teacher certification. This individual will not be required to teach classes, but may be used as a resource person in the area of physical health. Requests for classroom appearances should normally be made at least five (5) days before the visitation.
An adult nurse’s aide will be provided from 9 a.m. to 1 p.m. in high schools. The aide shall work under the direction of the nurse.

There shall be a certified, registered school nurse in all high schools and a total of six junior high school nurses. The current staffing level for elementary schools will be maintained while grant funding exists after which the Federation and Board will mutually review and agree to any necessary adjustments. However, a minimum of ten (10) schools nurses shall be employed for elementary schools. (*Toledo Federation of Teachers*)

Right to Refuse

- School nurses shall be assigned only professional and health-related duties in the school(s) to which they are assigned, except in emergencies involving health or safety. (*Pittsburgh Federation of Teachers*)
- School-Related Personnel (SRP) (other than Health Assistants, Senior Child Care Assistants, or LPNs) shall not administer medication or perform routine medical procedures as part of their daily work responsibilities, unless the SRP has volunteered and has been authorized by the worksite or district/program supervisor. The SRP who administers medication or performs routine medical procedures shall receive training by a licensed practical nurse, a registered nurse, a licensed physician or a licensed physician assistant. Such training shall be provided by the Board during the SRP's work hours.

LPNs shall perform invasive medical procedures as part of their daily work responsibilities. Non-medical SRP are prohibited from performing invasive medical procedures.

Personnel other than LPNs shall not be allowed to perform invasive medical services that require special medical knowledge, nursing judgment, and nursing assessment. These procedures (invasive medical services) include, but are not limited to:

1. sterile catheterization
2. nasogastric tube feeding, or
3. cleaning and maintaining a tracheostomy and deep suctioning of a tracheostomy.

SRP (other than Health Assistants, Senior Child Care Assistants, or LPNs) shall not perform health-related services as part of their daily work responsibilities, unless the SRP has volunteered, has been authorized by the worksite or district/program supervisor, and has successfully completed child-specific training by a licensed practical nurse, a registered nurse, a licensed physician, or a licensed physician assistant. All procedures shall be monitored periodically by the nurse. Those procedures include, but are not limited to:

1. cleaning intermittent catheterization,
2. gastrostomy tube feeding,
3. monitoring blood glucose, or
4. administering emergency injectable medication.

For all other invasive medical services not listed above, a licensed practical nurse, a registered nurse, a licensed physician, or a licensed physician assistant

shall determine if non-medical school personnel shall be allowed to perform such service. (*United School Employees of Pasco [Fla.]*)

- Initial hearing and vision screenings and re-evaluations in junior high school will be done by paraprofessional(s). Initial hearing and vision screenings in high school will be done by the school nurse. Re-evaluations are the responsibility of the paraprofessional(s). The Board will provide each high school nurse with an audiometer and maintain and repair the equipment. (*Toledo Federation of Teachers*)

- Non-medical bargaining unit personnel shall not be allowed to perform invasive medical services that require special medical knowledge, nursing judgment, and nursing assessment. The procedures include, but are not limited to:

- (a) Sterile Catheterization,
- (b) Nasogastric tube feeding,
- (c) Cleaning and maintaining a tracheotomy and deep suctioning of a tracheotomy.

Non-medical bargaining unit personnel shall be allowed to perform health-related services upon successful completion of child-specific training by a registered nurse, a licensed practical nurse, a physician licensed pursuant to F.S. 458 or 459, or a physician's assistant certified pursuant to Chapter 458 or 459. All procedures shall be monitored periodically by the nurse. These procedures include, but are not limited to:

- (a) Cleaning intermittent catheterization,
- (b) Gastrostomy tube feeding,
- (c) Monitoring blood glucose,
- (d) Administering emergency injectable medication.

For all other invasive procedures not listed in subsection (1) & (2) above, a registered nurse, a licensed practical nurse, a licensed physician, or a physician's assistant certified pursuant to Chapter 458 or 459 shall determine if properly trained non-medical bargaining unit personnel shall be allowed to perform such service.

Invasive medical training shall be strictly voluntary for non-medical bargaining unit personnel. Any such training shall be provided at no cost to the employee and, if provided at times other than the regular workday, such trainees shall be paid for the time spent at their regular rate of pay.

Non-medical bargaining unit members shall not be assigned the provision of invasive medical service on any basis other than as volunteers. Prior to non-medical bargaining unit members being assigned, the school nurse, where available, shall be called upon first to perform any invasive medical services. (*Bradford Education Association [Fla.]*)

- Teachers shall not be required to provide services which are required by law to be performed exclusively by nurses.

Medically fragile students shall be defined as those with complex health care needs that are extremely disabling or life threatening and which require specific prescribed procedures and/or specialized technological health care procedures for life and/or health support. All teachers will be notified in writing by the administration, or by a nurse employed by the Toledo Public Schools, that a student for whom they are responsible has a Do-Not-Resuscitate

“Teachers are expected to use their **best professional judgment** in rendering... needed **medical assistance** to students.”

(DNR) order on file with the school district. A Case Review will be convened to review the request with all appropriate staff. Teachers of Multidisabled/Medically Fragile students will be provided access to Toledo Public School nurses via portable radios or other communication instruments. Teachers shall not be required to provide services which are required by law to be performed exclusively by nurses. The district will provide training to all teachers, including nurses and therapists, and paraprofessionals who are assigned to provide services to the medically fragile student population, prior to initial assignment and annually, if requested, thereafter. The design and implementation of training shall be cooperatively developed by the Federation and the Board. **Nurse substitutes will be provided an orientation regarding district policies and protocol upon hiring and annually thereafter. The Federation and the Board will jointly develop and implement the orientation.** (*Toledo Federation of Teachers*)

- Teachers (other than school nurses) shall not perform invasive medical services that require special medical knowledge, nursing judgment, and nursing assessment. The procedures include, but are not limited to:

1. sterile catheterization,
2. nasogastric tube feeding, and
3. cleaning and maintaining a tracheostomy and deep suctioning of a tracheostomy.

Teachers (other than school nurses) shall not be required to perform invasive health related services. However, should a teacher volunteer to perform

such services, the district must provide the teacher with child-specific training by a registered nurse, a licensed practical nurse, a licensed physician or a certified physician assistant. All procedures shall be monitored periodically by the school nurse. Those procedures include, but are not limited to:

1. cleaning intermittent catheterization,
2. gastrostomy tube feeding,
3. monitoring blood glucose, and
4. administering emergency injectable medication.

For all invasive medical services not listed above, a registered nurse, a licensed practical nurse, a licensed physician, or a certified physician assistant shall determine if the service could be safely administered by a teacher and approval must be granted by the appropriate district supervisor.

(*United School Employees of Pasco [Fla.]*)

Administering Medications

- No bargaining unit members except school nurses or doctors may be required to dispense medications. (*Cleveland Teachers Union, Local 279*)

- Teachers (other than the school nurse or those authorized by the principal) shall not administer medication or perform routine non-invasive medical procedures as part of their daily work responsibilities while located at the school site.

(*United School Employees of Pasco [Fla.]*)

- In accordance with Article 31.4 no unit member, except public health nurses, shall be required to administer medication or provide other medical services.
- Teachers shall not be required or prevailed upon to administer medication or otherwise provide direct medical assistance to students. This section shall not prohibit any teacher from voluntarily administering medication or providing first aid or other medical assistance for students, nor shall it prohibit the Administration from inquiring as to a teacher's willingness to so volunteer. Teachers are expected to use their best professional judgment in rendering first aid or needed medical assistance to students, or in seeking such assistance for students from other personnel, as circumstances warrant.
- To the fullest extent permitted by law, the Board shall defend, indemnify and hold harmless teachers from and against any and all claims, demands, actions, complaints, suits, or other forms of liability that may arise from the actions of any teacher rendering first aid or other assistance to a student. (*West Northfield Teachers' Association [Ill.]*)

Nurse as part of the IEP planning team

- An individual school's IEP schedule shall be made available to that building's school nurse. At the request of the Principal, or nurse, the nurse shall participate in the IEP conference for individual students. For any student assigned to a school with a medical condition addressed in an IEP or 504 Plan,

the nurse or nurse supervisor shall be a part of, or consulted by, the IEP or 504 Plan Team.
(*Cleveland Teachers Union, Local 279*)

Additional Areas for Bargaining

You may also consider negotiating language in your contract to cover the following:

1. Allowing for volunteer placements to work with children who have special healthcare needs.
2. Having the district provide both general and child-specific training, by qualified and properly prepared healthcare professionals, for staff who volunteer to work with children who have special healthcare needs.
3. Requiring the district provide hepatitis B immunizations for all staff.
4. Having the district provide emergency and CPR training for staff.
5. Having the district and staff develop emergency back-up evacuation and ambulance plans for staff.
6. Having the district provide emergency power provisions (e.g., for suctioning or ventilators).
7. Defending staff from lawsuits when they provide care for medically fragile students.
8. Procedures in the case of Do Not Resuscitate orders.

Endnotes

- ¹ U.S. Department of Health and Human Services, 2000; *National Association of School Nurses Position Paper on Caseload Assignments*, as revised June 2006.

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Appendix A: Resources

American School Health Association | www.ashaweb.org

ASHA is a multidisciplinary organization of administrators, counselors, health educators, physical educators, psychologists, school health coordinators, school nurses, school physicians, and social workers working to promote the health and well-being of students through coordinated school health programs as a foundation for school success.

CDC—Division of Adolescent and School Health (DASH) | www.cdc.gov/nccdphp/dash

Center for Health and Health Care in Schools | www.healthinschools.org

Nonpartisan policy and program resource center located at The George Washington University School of Public Health and Health Services committed to achieving better health outcomes for children and adolescents through school-connected health programs and services.

Council for Exceptional Children | www.cec.sped.org

Dedicated to improving educational outcomes for individuals with exceptionalities, students with disabilities, and/or the gifted.

Council of Educators for Students with Disabilities, Inc. | www.504idea.org/resources.html

Organization of 4,000 members from across the United States dedicated to providing information and training to assist educators in complying with federal laws protecting students with disabilities.

National Association of School Nurses (NASN) | www.nasn.org

The NASN is an excellent resource for the school nurse. NASN has worked in collaboration with the AFT. As the specialty practice group for school nurses, NASN has expertise in identifying and solving many of the problems that confront school nurses daily. For analysis of delegation of care issues, go to: www.nasn.org/Default.aspx?tabid=268.

National Coordinating Committee on School Health and Safety | www.mchb.hrsa.gov/healthystudents

Group of federal and national nongovernmental organizations in support of quality coordinated school health programs in our nation's schools.

National Council of State Boards of Nursing | www.ncsbn.org

In addition to your state board of nursing, the National Council of State Boards of Nursing can assist with practice and policy issues. To see "Working With Others: A Position Paper," go to [https://www.ncsbn.org/Working_with_Others\(1\).pdf](https://www.ncsbn.org/Working_with_Others(1).pdf).

National Dissemination Center for Children with Disabilities | www.nichcy.org

Information on IDEA, including training materials.

National Forum on Education Statistics | nces.ed.gov/forum

- For more information about the overlap of FERPA and HIPAA, go to: nces.ed.gov/pubs2006/2006805.pdf.
- For more information on keeping and protecting student records, go to: nces.ed.gov/pubs2004/privacy/index.asp.

National Resource Center for Paraprofessionals | www.nrcpara.org

National School Boards Association | www.nsba.org/site/index.asp

Serving children under Section 504 and IDEA: www.nsba.org/site/page.asp?TRACKID=&CID=398&DID=8639.

School Nurse | www.schoolnurse.com

Online version of *School Health Alert*.

State Boards of Nursing

Your state board of nursing is a valuable resource that can help you with some of the more specific or difficult questions about your state's Nurse Practice Act. It should also be able to refer you to experts in your field who can answer questions you might have or perhaps conduct workshops for groups of school personnel. Addresses and Web sites for each state's board of nursing are listed in Appendix C.

Appendix B: IDEA Definitions of Covered Disabilities

- 1. Autism** means a developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age 3, which adversely affects educational performance. Characteristics often associated with autism are engaging in repetitive activities and stereotyped movements, resistance to changes in daily routines or the environment, and unusual responses to sensory experiences. The term autism does not apply if the child's educational performance is adversely affected primarily because the child has an emotional disturbance, as defined in 4 below. A child who shows the characteristics of autism after age 3 could be diagnosed as having autism if the criteria above are satisfied.
- 2. Deaf-Blindness** means concomitant (simultaneous) hearing and visual impairments, the combination of which causes such severe communication and other developmental and educational needs that they cannot be accommodated in special education programs solely for children with deafness or children with blindness.
- 3. Deafness** means a hearing impairment so severe that a child is impaired in processing linguistic information through hearing, with or without amplification, which adversely affects a child's educational performance.
- 4. Emotional Disturbance** means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance:
 - (a) An inability to learn that cannot be explained by intellectual, sensory or health factors.
 - (b) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.
 - (c) Inappropriate types of behavior or feelings under normal circumstances.
 - (d) A general pervasive mood of unhappiness or depression.
 - (e) A tendency to develop physical symptoms or fears associated with personal or school problems.The term includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance.

- 5. Hearing Impairment** means an impairment in hearing, whether permanent or fluctuating, that adversely affects a child's educational performance but is not included under the definition of "deafness."
- 6. Mental Retardation** means significantly sub-average general intellectual functioning, existing concurrently (at the same time) with deficits in adaptive behavior and manifested during the developmental period, that adversely affects a child's educational performance.
- 7. Multiple Disabilities** means concomitant (simultaneous) impairments (such as mental retardation-blindness, mental retardation-orthopedic impairment, etc.), the combination of which causes such severe educational needs that they cannot be accommodated in a special education program solely for one of the impairments. The term does not include deaf-blindness.
- 8. Orthopedic Impairment** means a severe orthopedic impairment that adversely affects a child's educational performance. The term includes impairments caused by a congenital anomaly (e.g., clubfoot, absence of some member, etc.), impairments caused by disease (e.g., poliomyelitis, bone tuberculosis, etc.), and impairments from other causes (e.g., cerebral palsy, amputations, and fractures or burns that cause contractures).
- 9. Other Health Impairment** means having limited strength, vitality or alertness, including a heightened alertness to environmental stimuli, that results in limited alertness with respect to the educational environment, that:
- (a) is due to chronic or acute health problems such as asthma, attention-deficit disorder or attention deficit-hyperactivity disorder, diabetes, epilepsy, a heart condition, hemophilia, lead poisoning, leukemia, nephritis, rheumatic fever, sickle cell anemia and Tourette's syndrome; and
 - (b) adversely affects a child's educational performance.
- 10. Specific Learning Disability** means a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, that may manifest itself in an imperfect ability to listen, think, speak, read, write, spell or do mathematical calculations. The term includes such conditions as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia and developmental aphasia. The term does not include learning problems that are primarily the result of visual, hearing or motor disabilities; of mental retardation; of emotional disturbance; or of environmental, cultural or economic disadvantage.
- 11. Speech or Language Impairment** means a communication disorder such as stuttering, impaired articulation, a language impairment, or a voice impairment that adversely affects a child's educational performance.
- 12. Traumatic Brain Injury** means an acquired injury to the brain caused by an external physical force, resulting in total or partial functional disability or psychosocial impairment, or both, that adversely affects a child's educational performance. The term applies to open or closed head injuries resulting in impairments in one or more areas, such as cognition; language; memory; attention; reasoning; abstract thinking; judgment; problem solving; sensory, perceptual and motor abilities; psychosocial behavior; physical functions; information processing; and speech. The term does not include brain injuries that are congenital or degenerative or brain injuries induced by birth trauma.
- 13. Visual Impairment Including Blindness** means an impairment in vision that, even with correction, adversely affects a child's educational performance. The term includes both partial sight and blindness.

Appendix C: State Boards of Nursing Contact Information

ALABAMA

Alabama Board of Nursing
770 Washington Avenue
RSA Plaza, Ste 250
Montgomery, AL 36104

Mailing Address:

PO Box 303900
Montgomery, AL 36130-3900

Phone: 334/242-4060 **FAX:** 334/242-4360

Contact Person:

N. Genell Lee, MSN, JD, RN, Executive Officer

www.abn.state.al.us

ALASKA

Alaska Board of Nursing
550 West Seventh Avenue Suite 1500
Anchorage, AK 99501-3567

Phone: 907/269-8161 **FAX:** 907/269-8196

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Appendix D: Model Letter on Inappropriate Delegation

Administrator
School
Street Address
Address 2
City, State Zip Code

Dear Administrator:

On [date], you informed me that I would be responsible for performing [name of nursing procedure] for a student in our school. You have [asked/directed] me to perform a duty that is not within the scope of my training or responsibilities as a [classroom teacher/paraprofessional]. I am writing because I feel that if I do what you have [asked/directed], I will be doing a disservice to the students and the [district/county name]. In addition, I may be acting in violation of the state Nurse Practice Act and subjecting myself to personal liability if anything should happen to the student.

It is my understanding that, when a student enters the school system with a health problem, [a registered nurse or school nurse] rather than school authorities must perform an assessment, and develop and implement a plan for meeting the student's health needs. [It is my further understanding that the decision as to whether a specific nursing task can be delegated to an unlicensed person, and the specification of training needs if the delegation occurs, must be made by a registered/school nurse.] *(This depends on whether the Nurse Practice Act in your state permits delegation of nursing tasks to unlicensed personnel. In states that do not permit delegation, this sentence should be omitted.)* The state Nurse Practice Act provides that unlicensed persons who perform activities within the scope of nursing practice are subject to [criminal sanctions/administrative penalties in accordance with the state law] for the unauthorized practice of nursing. In addition, if the performance of the procedure by an unlicensed person results in a bad outcome for the student, the district and any of the unlicensed individuals involved in assigning or performing the task could be held liable by the courts.

While I am cognizant of and fully support the rights of our students to receive the medical assistance they need in order to attend school (as affirmed by the U.S. Supreme Court's *Tatro* decision), I believe that students' healthcare needs should be determined and attended to by a school nurse. In the absence of a school district policy that [complies/meets] with [state education department and/or state board of nursing] [requirements/guidelines], I request written assurance from board counsel that my actions will be considered as within the scope of my duty for liability purposes, that the school district will defend my actions in any [criminal/administrative] proceedings that may ensue, and that I will be held harmless from civil liability.

Very truly yours,
Teacher/Paraprofessional Name

cc: Superintendent
Local Union President
School District Attorney
Local Union Attorney
State Board of Nursing

Appendix E: Guidelines for the Delineation of Roles and Responsibilities for the Safe Delivery of Specialized Healthcare 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	Others ³
1.0 Activities of Daily Living							
1.1 Toileting/Diapering		A	A	A	A	A	A
1.2 Bowel/Bladder Training		A	A	A	A	S	S
1.3 Dental Hygiene		A	A	A	A	S	S
1.4 Oral Hygiene		A	A	A	A	S	S
1.5 Lifting/Positioning		A	A	A	A	S	S
1.6 Feeding							
1.6.1 Nutrition Assessment		A	X	X	N	X	X
1.6.2 Oral-Motor Assessment		X	X	X	SP/TH	X	X
1.6.3 Oral Feeding		A	A	A	A	S	S
1.6.4 Naso-Gastric Feeding	*	A	S	X	X	S/HA	X
1.6.5 Monitoring of Naso-Gastric Feeding		A	S	S	S	S	X
1.6.6 Gastronomy Feeding	*	A	S	X	X	S/HA	X
1.6.7 Monitoring of Gastronomy Feeding		A	S	S	S	S	X
1.6.8 Jejunostomy Tube Feeding	*	A	S	X	X	X	X
1.6.9 IV Feeding	*	A	S	X	X	X	X
1.7.0 Monitoring of IV Feeding		A	S	S	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 in-service training
 EM In emergencies if properly trained, and if designated professional not available
 X Should not perform task
 N Nutritionist Only

HA Health Aide Only
 TH Occupational therapist Only
 SP Speech/language pathologist only
 □ Person who should be designated to perform

¹ Related Services include N, TH, and SP.

² Paraprofessionals include teacher aides, health aides, uncertified teaching personnel.

³ Others include secretaries, bus drivers, cafeteria workers, custodians.

***Delineation of responsibilities MUST adhere to each state nurse practice act.**

Procedure	Physician Order Required	Registered Nurse (RN)	Licensed Practical Nurse (LPN)	Certified Teaching Personnel	Related Services Personnel ¹	Para-Professionals ²	Other ³
1.7.1 Naso-Gastric Tube Insertion	*	A	S	X	X	X	X
1.7.2 Naso-Gastric Tube Removal	*	A	S	EM	EM	EM/HA	X
1.7.3 Gastroonomy Tube Reinsertion	*	A	S	X	X	X	X
2.0 Catheterization							
2.1 Clean Intermittent Catheterization	*	A	S	X	X	S/HA	X
2.2 Sterile Catheterization	*	A	S	X	X	X	X
2.3 Crede	*	A	S	S	S	S/HA	S
2.4 External Catheter	*	A	A	S	S	S/HA	X
2.5 Care of Indwelling Catheter (not irrigation)	*	A	S	S	S	S/HA	X
3.0 Medical Support Systems							
3.1 Ventricular Peritoneal Shunt							
3.1.1 Pumping	*	EM	EM	X	X	X	X
3.1.2 Monitoring	*	A	S	S	S	S	X
3.2 Mechanical Ventilator							
3.2.1 Monitoring	*	A	S	EM	EM	S/HA	X
3.2.2 Adjustment of Ventilator	*	X	X	X	X	X	X
3.2.3 Equipment Failure	*	A	S	EM	EM	EM	EM

Procedure	Physician Order Required	Registered Nurse (RN)	Licensed Practical Nurse (LPN)	Certified Teaching Personnel	Related Services Personnel ¹	Para-Professionals ²	Others ³
3.3 Oxygen							
3.3.1 Intermittent	*	A	S	A	EM	EM	X
3.3.2 Continuous (Monitoring)	*	A	S	S	S	S	S
3.4 Hickman/Broviac/IVAC/IMED	*	A	S	X	X	X	X
3.5 Peritoneal Dialysis	*	A	S	X	X	X	X
3.6 Apnea Monitor	*	A	S	S	S	S/HA	X
4.0 Medications *							
4.1 Oral	*	A	S	X	X	S/HA	X
4.2 Injection	*	A	S	X	X	X	X
4.3 Epi-Pen Allergy Kit	*	A	S	EM	EM	EM	EM
4.4 Inhalation	*	A	S	EM	EM	EM/HA	EM
4.5 Rectal	*	A	S	X	X	EM/HA	X
4.6 Bladder Installation	*	A	S	X	X	X	X
4.7 Eye/Ear Drops	*	A	S	X	X	S/HA	X
4.8 Topical	*	A	S	X	X	S/HA	X
4.9 Per Nasogastric Tube	*	A	S	X	X	X	X

* Medications may be given by LPNs and health aides ONLY where the nurse practice act of the individual state allows such practice, and ONLY under the specific guidelines of that nurse practice act.

Procedure	Physician Order Required	Registered Nurse (RN)	Licensed Practical Nurse (LPN)	Certified Teaching Personnel	Related Services Personnel ¹	Para-Professionals ²	Others ³
4.10 Per Gastronomy Tube	*	A	S	X	X	X	X
4.11 Intravenous	*	A	S	X	X	X	X
4.12 Spirometer	*	A	S	X	X	S/HA	X
5.0 Ostomies							
5.1 Ostomy Care	*	A	S	EM	EM	EM	X
5.2 Ostomy Irrigation	*	A	S	X	X	X	X
6.0 Respiratory Assistance							
6.1 Postural Drainage	*	A	S	S	S	S/HA	S
6.2 Percussion	*	A	S	S	TH	S/HA	S
6.3 Suctioning							
6.3.1 Pharyngeal	*	A	S	S	S	S/HA	X
6.3.2 Tracheostomy	*	A	S	S	S	S/HA	X
6.4 Tracheostomy Tube Replacement	*	EM	EM	EM	EM	EM	EM
6.5 Tracheostomy Care (cleaning)	*	A	S	X	X	X	X

Procedure	Physician Order Required	Registered Nurse (RN)	Licensed Practical Nurse (LPN)	Certified Teaching Personnel	Related Services Personnel ¹	Para-Professionals ²	Others ³
7.0 Screenings							
7.1 Growth		A	S	X	X	X	X
7.2 Vital Signs		A	S	X	X	S/HA	X
7.3 Hearing		A	S	X	SP	S/HA	X
7.4 Vision		A	S	X	X	S/HA	X
7.5 Scoliosis		A	S	S	TH	s/HA	X
8.0 Specimen Collection/Testing							
8.1 Blood Glucose	*	A	S	X	X	S/HA	X
8.2 Urine Glucose	*	A	S	X	X	S/HA	X
9.0 Other Healthcare Procedures							
9.1 Seizure Procedures		A	A	A	A	A	A
9.2 Soaks	*	A	S	X	TH	S/HA	X
9.3 Dressings, Sterile	*	A	S	X	X	X	X
10.0 Development of Protocols							
10.1 Healthcare Procedures		A	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
10.4 Nursing Care Plan		A	X	X	X	X	X

Appendix F: Guidance for Staff Roles in Providing Care

1. New York State Department of Education: Guidelines on Health-Related Activities

2. AFT/CEC/NASN/NEA: Guidelines for the Delineation of Roles and Responsibilities for the Safe Delivery of Specialized Health Care in the Educational Setting

New York State Department of Education Guidelines on Health-Related Activities

*Nursing activities that may be performed by registered professional nurses or licensed practical nurses under the direction of a registered nurse and may not be performed by unlicensed persons.**

- Observations and data collection
- Administration of subcutaneous, intramuscular, intravenous, or rectal medications
- Administering oral, topical, and inhalant medication to non-self-directed students according to State Education Department Guidelines
- Problem assessment/intervention-insulin pump
- Gastrostomy feeding (bolus method or with medication)
- Initiation of gastrostomy feeding by drip method (monitoring of the drip feeding can be assigned after initiation by the licensed nurse)
- Nasogastric tube feedings
- Oxygen administration (pm/intermittent) or initiation of continuous oxygen
- Nebulizer with oxygen or medication
- Oropharyngeal suctioning
- Tracheostomy suctioning
- Tracheostomy care
- Respirator/ventilator care
- Respiratory care (postural drainage and cupping, etc.)
- Urinary catheterization
- Reinsertion of an indwelling urinary catheter
- Ostomy care (care of stoma and changing the appliance)
- Cast care
- Warm applications
- Sterile dressings
- Decubitus ulcer care

- Blood glucose monitoring
- Intake and output measurements of gastric and parenteral fluids
- Monitoring of shunt function

*Health-related activities that may be performed by appropriately trained unlicensed persons following assessment and approval by a registered nurse.**

- Measurement and recording of vital signs that can be performed according to standard procedures
- Application of clean dressings when no assessment is necessary
- Ostomy care (emptying bag and observing the integrity of the bag for possible replacement by a licensed nurse)
- Observation to ensure continuous flow of an established drip method gastrostomy feeding that has been initiated by the nurse
- Termination of a drip method gastrostomy feeding after completion of the feeding if flushing is not involved
- Intake and output measurement and recording (except gastric and parenteral fluids)
- Assisting self-directed students with own oral, topical, and inhalant medication according to State Education Department guidelines
- Observing that equipment used to administer continuous flow oxygen is working and that all tubes are in place
- Oral suctioning (mouth only, not pharynx)
- External catheter care
- External care of indwelling catheter
- Nebulizer treatment, if routine and without medication or oxygen
- Transfers
- Aspects of a prescribed exercise and/or range of motion program
- Assistance with braces and prostheses
- Assisted ambulation (crutches, walker, cane)
- Positioning

*Health-related activities that may, under most circumstances, be performed by unlicensed persons without the involvement of a registered nurse.**

- Oral hygiene or nail, hair, and skin care
- Preparing nourishment
- Feeding student orally as long as there are no feeding problems
- Care of an incontinent student
- Assistance with bedpan and urinal
- Non-medical aspects of bowel and bladder training
- Assistance with clothing

**These activities are illustrative only. These lists are not all-inclusive.*

Appendix G: National School Transportation Specifications & Procedures

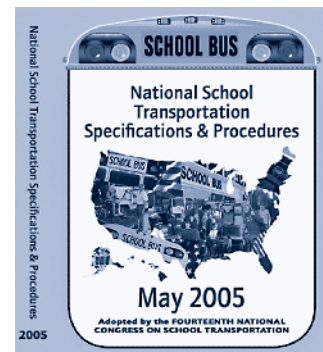
C. Drivers and Attendants


As direct-service providers to student with disabilities, drivers and attendants have a hands-on responsibility to operate special equipment, manage student behavior and provide basic first aid as necessary. Additionally, they must be knowledgeable in passenger positioning, securing adaptive and assistive devices and be familiar with the nature, needs and characteristics of the types of students they transport.

1. Training components

To perform the responsibilities assigned in a safe and effective manner requires a substantial degree of specific training. Some training components that transportation staff must have are:

- A. Introduction to special education**, including characteristics of disabling conditions, the student referral, assessment, IEP process, and confidentiality of student information.
- B. Legal issues**, including federal and state laws, administrative rules, and local policy.
- C. Operational policies and procedures**, including:
 1. Loading/unloading;
 2. Securing the bus;
 3. Pick-up/drop off location;
 4. Evacuation procedures, including the use of emergency equipment such as belt cutter(s), fire blankets, etc.;
 5. Lifting/positioning procedures;
 6. Student accountability and observation, including evidence of neglect or abuse;
 7. Post-trip vehicle interior inspections for students or articles left in the bus prior to parking;
 8. Reporting and record-keeping;
 9. Lines of responsibility relative to role as an educational team member;
 10. Lines of communication, including parents and educational staff;
 11. Route management, including medical emergencies, no adult at home, inclement weather, field trips, etc.;
 12. Behavior management;
 - Techniques for behavior modification and the development of appropriate behavior;
 - Procedures for dealing with inappropriate or unacceptable student behavior that creates emergency conditions, or poses a risk to health and safety;
 - Procedures for documenting and reporting inappropriate or unacceptable student behavior; and
 - Techniques and procedures for response to unacceptable behavior, including possession of weapons, drugs, etc. Awareness of gang activities, harassment/bullying and/or other inappropriate behaviors.
 13. Blood borne pathogens and universal precaution procedures, including use of personal protective equipment; and
 14. Policies and procedures that ensure confidentiality of personal identifying information.



 Download the full text at www.ncstonline.org.

Appendix H: Description of Lifting Equipment

Portable Total Body Lift

Transferring students with limited mobility from one surface to another can be very physically demanding for a paraprofessional or other provider. Those students who can't bear weight, have physical limitations (quadriplegia, amputee) or are very heavy should never be transferred manually. These students should be transferred with a modern portable total body lift.

Portable total body lifts are used to transfer students to and from wheelchairs, toilets, toilet chairs, changing tables, the floor and transportation vehicles. (These devices used to be called "Hoyer" lifts because Hoyer was one of the first companies to make them). A portable total lift supports the entire weight of the student with a sling attached to a stand on wheels that can be freely moved or positioned to allow a transfer to a different surface.

Most modern total body lifts have these features:

- Wide adjustable base
- Extremely strong sling materials
- Steel or aluminum mast and boom
- Electrical motorized lifting mechanisms

Paraprofessionals and students benefit from using a lift. Paraprofessionals who lift students manually must rely on their own physical strength to perform the transfer; when handling the total weight of a student, they often work beyond their physical capabilities. Using a lift can reduce a para's risk of being injured.

Students feel more secure in the sling of a modern lift—they require very little force to push or pull and the slings are designed to reduce the risk of skin tear or abrasion.

There is very little information on important features for use in a school environment. Long-term health care institutions such as nursing homes have found that the following features are critical:

1. **Price**—Expect to pay somewhere between \$3,200 to \$4,900.
2. **Weight capacity**—A weight capacity of at least 400 pounds is recommended to accommodate transferring very heavy students.

3. **Lifting mechanism**—Most new lifts have a hydraulic lifting mechanism that is powered by an electric motor and battery. The electric motor is an important feature since it eliminates the need to pump or crank the lift by hand (an ergonomic hazard in itself!). The motor is controlled by a hand control with buttons for up and down. The electric motor also makes the lifting and lowering of the student a smooth, continuous movement without the jerky or rapid accelerations that are common with older hand crank or pump lifts. Some manufacturers' lifts also come with a two speed-motor, with slow and fast speeds.

4. **Lift height range**—The lift needs to lower far enough to reach a student who is placed on the floor for exercise or who has fallen. Paraprofessionals are at an even greater risk of injury if manually lifting a student in these situations. The lift also should be able to transfer a student to a high diaper changing table.

5. **Various sizes and types of slings**—All students are not built the same and not all sizes of slings will fit all students. Slings must come in a variety of sizes—at a minimum small, medium, large and extra-large. It's also important to have slings for special purposes such as toileting.

6. **Sling position control**—Either a sling can have handles on the outside to help position the student, or the sling bar can have a handle as part of a pivoting frame. This feature is important since the handles or the bar can be used to help position the student in a more upright posture before he or she is lowered into a chair, or to help position the student in a recumbent (lying) posture as he or she is lowered to the floor or changing table.

7. **Battery portability**—Battery portability is a lift feature that allows a dead battery to be quickly exchanged with a fully charged battery. Some manufacturers use a portable battery system as a standard whereas others only offer it as an option. A nonportable system requires the lift to be directly plugged into an outlet to be recharged.

8. **Hand-held control**—A hand-held control is typically a push-button control used to raise or lower the mast. An important feature is the ability to quickly place the control

on the lift during the transfer process. This will free up the paraprofessional's hands to assist or position the student. A control with a magnetic attachment is preferred over a clip since it allows the control to be placed almost anywhere on the lift including the boom.

9. Emergency shut-off control—This control stops the motor in case of an emergency and is a separate control from the hand-held push button that activates the power. This safety feature serves as a back-up to the hand-held control. It could be used in a situation where the student grabs the hand-held control and the para needs to quickly shut off the power to protect the student from harm.

10. Manual override control—In a situation where the battery loses power during the transfer, it will be important that the student can be safely lowered using an override control. This control is usually a manual crank.

11. Boom pressure-sensitive switch—With a pressure-sensitive switch, the lift senses the upward resistance of a person or object underneath the boom and the motor automatically stops. This reduces the risk of a student being injured by coming in contact with the boom.

12. Turnaround for replacement parts/

Country lift made in—It's important to find out the amount of time it takes to repair the lift or get a replacement part. Most manufacturers can provide replacement parts within one or two days. Since most of the manufacturers also service the lifts, they will have a stock of replacement parts on hand. If they don't, the part may have to be ordered from the manufacturer, in which case a U.S. manufacturer can usually provide the parts faster.

13. Base—All lifts have adjustable bases that allow the legs to fit around chairs, commodes, etc. Some bases have legs that are spread in and out by using the hand control and the electric motor. With a manual base, the legs are spread with a bar that's moved by hand or a foot control. If the lift is going to be used in a tight space such as a bathroom stall, make sure that the length of the base (from the mast to the end of the legs) will fit in the bathroom.

Sit-to-Stand Student Devices

What is a sit-to-stand device?

Sit-to-stand devices are used to transfer students between two seated postures such as when transferring a student from a wheelchair to a toilet. A sit-to-stand device is designed to support **only the upper body** of the student and therefore requires the student to be able to bear some weight. The lift is different than a total body lift, which is meant to support the entire weight of the student. A sit-to-stand device is meant to replace the manual stand-and-pivot transfer that caregivers often perform when transferring a weight-bearing student from a seated posture to either a standing posture or a different seated surface.

How is a sit-to-stand device designed to handle a student safely?

Most modern sit-to-stand devices have several common features, including a wide adjustable base, extremely strong sling material, a steel or aluminum mast and boom, and electrical motorized lifting mechanisms. Most newer devices can transfer students up to 300 pounds.

What are the benefits of using a sit-stand device?

The physical demands required to transfer a student using a sit-to-stand device are significantly less than manually performing a stand-and-pivot transfer, even if the paraprofessional is using a **transfer belt**. When using a lift, the para is at much less risk of a back or shoulder overexertion injury, which are two of the most common injuries in paraprofessionals who physically lift students. The less physically demanding the task, the less fatigued the paraprofessional is over the course of the school day, which also means less risk of injury.

Because the sit-to-stand devices are designed to transfer a student quickly between two seated surfaces, the paraprofessional can eliminate two or three manual transfers when toileting the student. For instance, instead of manually transferring a student from the wheelchair to the commode and then from the commode back to the wheelchair, the para can use a sit-to-stand device. Since sit-to-stand devices have a shorter base than total body lift-and-place the student in a standing or nearly standing posture, they can fit a student more easily into tight spaces such as school restrooms.

Not only does the paraprofessional benefit from using a sit-to-stand device, but the student benefits too. Using a sit-to-stand device is much safer for the student, since the device is specifically designed to handle the weight of a student. With a manual stand-and-pivot transfer, the paraprofessionals must rely on their own physical strength to perform the transfer, which often means working beyond their physical capabilities. This, in turn, means greater risk of dropping or mishandling the student during a manual lift. Since sit-to-stand devices are designed to be used when toileting, they also eliminate the manual transfer of the student off the commode, which is often cited by paraprofessionals as the most difficult transfer. In addition, modern sit-to-stand devices are very stable, require very little force to push or pull even with a heavy student in the sling, and are designed with slings that reduce the risk of skin tear or abrasion. Also, with plenty of practice, a sit-to-stand device can be used by one paraprofessional, freeing up additional staff to focus on student care.

Can a sit-to-stand device be used with any student?

No. A sit-to-stand device should only be used with students who can bear some body weight. Depending on how much weight-bearing capacity the student has, the sit-to-stand device can raise the student just high enough for short distance transfers, such as wheelchair to commode. For those students who can bear some body weight, a sit-to-stand device can also be a helpful rehabilitation tool. It can be used to promote increased weight-bearing by controlling the student's position, when such rehabilitation is in the student's IEP or accommodation plan.

Important features of a sit-to-stand device to consider

- **Price**—Expect to pay somewhere between \$3,000-\$4,000 for a new sit-to-stand device.
- **Weight capacity**—A weight capacity of at least 300 pounds is recommended to accommodate transferring very heavy students.
- **Lifting mechanism**—Sit-to-stand devices typically have a hydraulic lifting mechanism that is powered by an electric motor, or an actuator and battery. The electric motor or actuator is an important feature since it eliminates the need to pump or crank the lift by hand. The motor is controlled by a hand control with buttons for up and down. The

electric motor also makes the raising and lowering of the student a smooth, continuous movement without jerky or rapid accelerations that are common with older hand crank or pump lifts. Some manufacturers' lifts also come with a two-speed motor, with slow and fast speeds.

- **Battery portability**—Battery portability is a feature that allows a dead battery to be quickly exchanged with a fully charged battery. Some manufacturers use a portable battery system as a standard, whereas others only offer it as an option. Those that offer a portable battery as an option use a nonportable system as a standard, which requires the lift to be directly plugged into an outlet to be recharged.
- **Hand-held control**—A hand-held control is typically a push-button control used to raise or lower the boom. An important feature is the ability to quickly place the control on the sit-to-stand device during the transfer process. This will free up the caregiver's hands to assist or position the student. For this reason, a control with a magnetic attachment is preferred over a clip, since it allows the control to be placed almost anywhere on the lift, including the boom.
- **Emergency shut-off control**—This control stops the motor in case of an emergency and is a separate control from the hand-held push button that activates the power. This safety feature serves as a back-up to the hand-held control. It could be used in a situation where the student grabs the hand-held control and the paraprofessional needs to shut off the power quickly to protect the student from harm.
- **Manual override control**—In a situation where the battery loses power during the transfer, it will be important that the student can be safely lowered using an override control. These controls are usually a manual crank, although one manufacturer provides a release lever that can be pulled to lower the student automatically. Another manufacturer provides a bit that can be attached to a powered screwdriver that substitutes as the manual crank.
- **Turnaround for replacement parts/Country lift made in**—If the lift requires repair or a part needs to be replaced, how soon will the lift be back in service? Most manufacturers can provide parts within one or two days. Since many of the manufacturers' sales representatives also service the lifts, they will have a stock of replacement parts on hand.

- **Manufacturer’s sales representative**—Most sales representatives also service their lifts, so finding a reliable representative that serves your geographic area is an important consideration.
- **Lift range**—This is the vertical distance the device moves the student from a seated to a standing posture. This may

be very important if the student is being lifted from the floor.

- **Other important features to consider**—Be sure to consider storage space required (especially in overcrowded schools), battery type and replacement costs, sling laundering, and sling material.

Appendix I: Assessment and Care Plan for Safe Student Handling and Movement

1. Student Level of Assistance

- Independent:** student performs task safely with or without assistive devices.
- Partial Assist:** student requires no more help than standing by, cuing or coaxing or no more than 50 percent physical assistance by the para.
- Dependent:** student requires more than 50 percent assistance by para or is unpredictable in the amount of assistance offered.

If the student’s ability to assist varies, perform an assessment before every task or assume the student cannot assist with the transfer/repositioning.

2. Can the student bear weight?

- Yes, full
- Yes, partial
- No

3. Does the student have the upper-extremity strength needed to support his/her weight during transfers?

- Yes
- No

4. Student’s level of cooperation and comprehension:

- Cooperative:** may need prompting; able to follow simple commands
- Unpredictable or varies:** (student whose behavior changes frequently should be considered “unpredictable”) not cooperative, or unable to follow simple commands

5. Student’s weight _____ height _____

6. Check conditions likely to affect transfer/repositioning techniques:

- Bilateral amputation
- Spasms
- History of falls
- Paralysis
- Presence of tubes (feeding etc.)
- Pressure ulcers
- Unstable spine
- Other

7. Care plan

Task	Equipment / Assistive Device	# Staff
Transfer to and from: —chair to toilet —chair to chair		
Transfer to and from: —bus/van to chair		
Transfer to and from: —floor		
Reposition in chair: —wheelchair —dependency chair		

Signature _____ Date _____

Appendix J: Model Safe Student Handling and Movement Policy

1. Purpose: This policy describes ways to ensure that employees use safe student handling and movement techniques at _____ school.

2. Policy: _____ School wants to ensure that its students are cared for safely, while maintaining a safe work environment for school employees. To accomplish this, an Ergonomics Injury Prevention Program for Paraprofessionals, Nurses and Teachers will be implemented to ensure that required infrastructure is in place to comply with components of this safe student handling and movement policy. This infrastructure includes student handling and movement equipment, employee training and a “culture of safety” approach in the school environment. Student care staff should assess high-risk-student handling tasks in advance to determine the safest way to accomplish them. Additionally, mechanical lifting equipment and/or other approved student handling aids should be used to prevent manual lifting and handling of students except when absolutely necessary, such as in a medical emergency.

3. Procedures:

Safe Student Handling and Movement Requirements

Staff shall:

- Avoid hazardous student handling and movement tasks whenever possible. If unavoidable, assess them carefully prior to completion.
- Use mechanical lifting devices and other approved patient handling aids for high-risk-student handling and movement tasks except when absolutely necessary, such as in a medical emergency.
- Use mechanical lifting devices and other approved patient handling aids in accordance with instructions and training.

Training

- Staff will complete and document safe student handling and movement training initially, annually, and as required when new equipment is introduced. Supervisors shall maintain training records for three years.

4. Mechanical lifting devices and other equipment/aids:

- Mechanical lifting devices and other equipment/aids will be accessible to staff; all equipment will be stored conveniently and safely.
- Mechanical lifting devices and other equipment will be maintained regularly and kept in good working order.

5. Ergonomic Injury Prevention Program:

The Ergonomic Injury Prevention Program for Staff will include the following key program elements:

- Ergonomic workplace assessment, including assessment of equipment and academic tools (computers, manipulatives etc.);
- Use of lifting equipment and devices;
- Student assessment criteria and care planning for safe student handling and movement;
- Methods for safe student handling and movement;
- Engineering and administrative solutions for eliminating or preventing ergonomic hazards in schools; and
- Reporting work-related incidents, symptoms and injuries.

6. Reporting of injuries/incidents:

- School staff shall report all incidents/injuries/resulting from student handling to _____.
- Supervisors will maintain incident/accident reports and supplemental injury statistics as required by the school and/or the Occupational Safety and Health Administration (OSHA).

Union representatives shall support policy intent and monitor program effectiveness in partnership with administration.

Definitions

- **High-risk-student handling tasks:** Tasks that have a high risk of musculoskeletal injury for staff performing the tasks. These include but are not limited to transferring tasks, lifting tasks, repositioning tasks, feeding tasks and tasks with long duration.
- **Manual lifting:** Lifting, transferring, repositioning and moving students using a caregiver's body strength without the use of lifting equipment/aids to reduce forces on the caregiver's musculoskeletal structure.
- **Mechanical student lifting equipment:** Equipment used to lift, transfer, reposition or move students. Examples include portable-base, full-body sling lifts, stand-assist lifts and mechanized lateral transfers.
- **Student handling aids:** Equipment used to assist in the lift or transfer process. Examples include gait belts with handles and stand-assist aids.
- **Culture of safety:** Describes the collective and shared commitment by school employees, administrators and students to a safe and healthful environment for employees and students.

Delegation of Authority

Principal or designee should:

- Support the implementation of this policy.
- Support and promote a "culture of safety" within the school.
- Furnish sufficient lifting equipment/aids to allow staff to use them when needed for safe student handling and movement.
- Furnish acceptable storage locations for lifting equipment aids.
- Provide routine maintenance of equipment.
- Provide staffing levels sufficient to comply with this policy.

Supervisors should:

- Ensure high-risk handling tasks are assessed prior to completion and are completed safely.

School staff should:

- Comply with all parameters of this policy.
- Use proper techniques, mechanical lifting devices and other approved equipment/aids during performance of high-risk patient handling tasks.
- Notify supervisor of any injury sustained while performing student handling tasks.
- Notify supervisor of mechanical lifting devices in need of repair.
- Notify supervisor of mechanical devices in need of repair.
- Support a "culture of safety" within the school.

Appendix K: AFT Policy Statements Relating to Care of Children with Special Healthcare Needs

Training and Resources for School Employees Working with Medically Fragile Children

WHEREAS, the number of students in classrooms who can be designated medically fragile has increased by more than 17 percent in the last 10 years, and those numbers will continue to rise as the mandate of the Individuals with Disabilities Education Act are fully implemented in the schools; and

WHEREAS, the facilities that have in the past provided educational services for special-needs students, including those identified as medically fragile children, usually had full-time, on-site, trained health care providers; and

WHEREAS, as special-needs students have been moved into traditional classrooms, these health care providers have frequently been laid off rather than transferred to these settings; and

WHEREAS, this loss of health care personnel has forced more and more untrained school personnel to take on responsibility for providing health/medical services; and

WHEREAS, the provision of health/medical services legally falls within the scope of the school health professional employed by or assigned to a facility, unless he/she has delegated that task to a person he/she has trained to perform the procedure/service:

RESOLVED, that the AFT continue to disseminate information to local and state federations about the legal rights and responsibilities of all school employees with regard to provision of medical services; and

RESOLVED, that AFT locals work to educate policy makers and the general public about the need to increase the numbers of school health personnel so that educational personnel will not be required to perform medical/health procedures: and

RESOLVED, that AFT locals work to guarantee appropriate training for all personnel who may want to take on that responsibility and are delegated the task of providing health/medical services to students; and

RESOLVED, that AFT locals work with state federations to enact legislation that will increase the number of school health professionals, mandate appropriate training standards and provide funding for necessary equipment to ensure a safe and healthy environment for students and employees.
(1992)

Inclusion of Students with Disabilities

WHEREAS, there is no legal mandate or consistent definition for “inclusion,” let it be known that for AFT policy we define inclusion as the placement of all students with disabilities in general education classrooms without regard to the nature or severity of the students’ disabilities, their ability to behave and function appropriately in the classroom, or the educational benefits they can derive; and

WHEREAS, the mission of the public schools and of the AFT is to provide high standards, rich and challenging classroom experiences, and maximum achievement for ALL students, including students with disabilities as well as nondisabled students in general education classes; and

WHEREAS, public schools, particularly in urban areas, already are facing severe burdens because of the inequities in funding that plague them, overcrowding, the persistent social problems that surround them, and demands that they resolve the immense problems that students bring to school, severely reducing the schools’ ability to provide a high-quality educational program for any student; and

WHEREAS, two years before the 20th anniversary of the passage of the Education for All Handicapped Children Act (P.L.94-142), Congress’s continuing cynicism in funding the mandates of the law at under 10 percent of costs instead of the 40 percent promised has compromised schools’ ability to provide appropriate services to students with disabilities and has placed even greater strains on education generally by requiring that higher and higher percentages of funding go to special education; and

WHEREAS, inclusion is being championed as the only placement for all students with disabilities by a movement of some advocacy groups in the face of opposition from the parents of many students with disabilities and many respected advocates for the disabled” when there is no clear evidence that inclusion is appropriate or provides an educational benefit for all students with disabilities, and no clear evidence of its benefit for the other students; and

WHEREAS, there are deep concerns about the high percentage of minority children in some classes for students with disabilities, and inclusion is viewed by some advocates and parents as the only means of getting minority children out of those classes; and

WHEREAS, inclusion is being adopted by a large number of local school boards, state departments of education, legislators, and other policy makers all over the country as a means to save money by placing all students with disabilities in general education classrooms and curtailing special education supports and services; and

WHEREAS, inclusion is being adopted in contradiction to the mandates of P.L.94-142 and the Individuals with Disabilities Education Act (IDEA, the revision of P.L.94-142) that require students to be evaluated and, based on individual needs, assigned to the “least restrictive environment” (LRE) that exists within a continuum, or range, of placements; and

WHEREAS, even when students with disabilities are appropriately placed, general and special education staff who work with them are not receiving the training they need that they are entitled to by law; and

WHEREAS, the federal law and court decisions forbid school districts from removing disruptive students with disabilities from programs for more than 10 days a year, and require that, in the absence of school district and parental consent to an interim placement or a court order, such students “stay put” in the class while their placement is being evaluated and adjudicated; and

WHEREAS, the existing federal legislation limits the ability of teachers to challenge legally inappropriate placements of students with disabilities in general education classrooms; and

WHEREAS, insufficient medical personnel are employed by school districts to care for medically fragile children under existing circumstances, and inclusion would place these students in medical danger and increase the responsibilities of teachers and paraprofessionals; and

WHEREAS, inclusion threatens to overwhelm schools and systems that are already extremely vulnerable “particularly in areas with great poverty and social needs” by placing additional responsibilities on teachers, paraprofessionals and support professionals, thus threatening the ability of schools to meet the educational needs of all students; and

WHEREAS, students with disabilities have frequently been placed in programs that failed to serve their needs to meet high educational standards, fueling the desire of their parents to have their children in general education classrooms even when such placements are not appropriate:

RESOLVED, that the AFT continue to seek high national achievement standards for education, applicable to ALL students, disabled and nondisabled alike; and

RESOLVED, that the AFT oppose inclusion that is, any movement or program that has the goal of placing all students with disabilities in general education classrooms regardless of the nature or severity of their disabilities, their ability to behave or function appropriately in the classroom, or the educational benefits they and their general education peers can derive; and

RESOLVED, that the AFT denounce the appalling administrative practices that have accompanied the inclusion movement. These include, but are not limited to, placing too many students with disabilities in individual general classrooms; placing students with disabilities in general education classrooms without services, professional development or paraprofessional assistance; refusing to assist teachers who are having problems meeting the unique needs of students with disabilities; and changing IEPs en masse so that students with disabilities may be placed in general education classrooms without supports and services and irrespective of the appropriateness of the placement; and

RESOLVED, that the AFT seek alliances with organizations that support the continuum of alternative placements and the educational placement of students with disabilities within the

least restrictive environment appropriate to the individual needs of the students; and

RESOLVED, that the AFT seek with its allies to reopen P.L.94-142 and IDEA, convincing Congress both to recognize in the law the high costs and complex problems of special education and to respond by providing:

1. full funding for all of its mandates;
2. a 5-year reauthorization of the laws for educating students with disabilities—just as every other education act requires—to realize the benefits of new hearings and discussions of problems that arise;
3. the legal right for teachers to attend the IEP meetings of children they teach; the right to appeal inappropriate placements; and the right to be fully represented during due process hearings without reprisal, i.e., intimidation, coercion, or retaliation, for being a child advocate; and the right to be involved in the assessment of delivery of services, staff training, and availability of resources to ensure the effectiveness of the program as intended by Congress;
4. the reauthorization and enforcement of the continuum of placements, which includes mainstreaming as an existing alternative strategy within the range of services for students with disabilities;
5. that criteria for placement in general education require the proximate ability of students to function appropriately both academically and behaviorally when supplementary aids and services are provided by the district;
6. support for districts in maintaining consistent discipline policies for ALL students who disrupt classrooms or engage in dangerous behavior;
7. reauthorization of and insistence on comprehensive professional development;
8. negation of court decisions concerning students with disabilities, which are detrimental to educational programs such as the “stay-put” provision, limitations on the discipline of students with disabilities and decisions that favor inclusion;
9. for limitations on the number of students with disabilities in self-contained and general classrooms;

RESOLVED, that the AFT seek with its allies to address the problem of the high percentages of minority students in special education; and

RESOLVED, that the AFT renew our long-standing commitment to meeting the needs of ALL students for high standards, rich and challenging classroom experiences, and maximum achievement, whatever their educational placements might be.

(1994)

Every Child Needs a School Nurse

WHEREAS, every child must be ready to learn, having their basic needs first met so that they may achieve optimal physical, emotional, social and educational development and be prepared for full participation in society; and

WHEREAS, a professional registered nurse certified by the appropriate state agency provides unique and valuable services to students, parents and school personnel; and

WHEREAS, through public schools, communities can work together in unprecedented ways to eliminate barriers to learning and to provide access to healthcare for children and families; and

WHEREAS, the country’s school nurses are pivotal members of a coordinated school health system, delivering services to children and, thereby, eliminating health disparities and barriers and supporting academic success for all children; and

WHEREAS, school nurses provide vital links between public and private resources and programs, collaboration between schools and health and human service agencies to bring school and community services to schools, and support efforts to connect families to insurance programs to meet the needs of children and families; and

WHEREAS, school nurses create and maintain safe school environments; provide mandatory health education, health screenings and immunizations; deliver early intervention services; design wellness-driven programs; and provide vital medical services to students with chronic and acute illnesses; and

WHEREAS, these essential services require specially educated and experienced professional personnel:

RESOLVED, that the AFT support school nurses as providers of necessary healthcare for children that ensures academic success; and

RESOLVED, that AFT Healthcare, through its program and policy council and school nurse subcommittee, develop and implement a public relations campaign to educate policymakers and the public about the significant role that school nurses play in the lives of our nation's children; and

RESOLVED, that to enhance the educational process for students, the AFT support the services of a professional certified registered nurse in every school; and

RESOLVED, in addition to having at least one full-time school nurse in every school, AFT support the ratio of students for each professional certified registered nurse to be 1:750 or fraction thereof for regular students, 1:225 or fraction thereof for mainstreamed students, or 1:125 or fraction thereof for severely/profoundly handicapped students; and

RESOLVED, that the AFT, its affiliates and locals lobby state legislatures for legislation requiring a school nurse in every school to provide necessary medical services to our children; and

RESOLVED, that AFT locals work to negotiate language in public school contracts calling for the employment of at least one school nurse in every school.

(2002)

The Care of Children with Diabetes

WHEREAS, diabetes is a serious disease in which the body does not produce or properly use insulin, a hormone that is needed to convert sugar, starches and other food into energy needed for daily life; and

WHEREAS, approximately 17 million people in the United States, or 6.2 percent of the population, have diabetes, and approximately 151,000 diabetics are children—that computes to one in every 400 school-aged children; and

WHEREAS, because people with diabetes are at great risk of developing serious health complications over time, including heart disease, blindness and stroke, proper care and management must occur every day throughout the day; and

WHEREAS, children with diabetes face the possibility of two significant challenges every day: hyperglycemia and hypoglycemia—either is serious; and

WHEREAS, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act of 1973 and the Individuals with Disabilities in Education Act (IDEA) provide protection for children with diabetes and require that schools provide necessary accommodations for children with diabetes; and

WHEREAS, school-aged children with diabetes have an ethical and legal right to a quality public education and should be able to participate fully in all life experiences, including school and school-related activities; and

WHEREAS, school nurses who are licensed registered nurses are necessary to provide care to students with diabetes, which includes regular blood glucose monitoring, insulin injections, ensuring the proper type of diet and amount of exercise, and providing the appropriate assessment and response to emergencies when blood sugar levels are elevated or become dangerously low; and

WHEREAS, training non-medical school employees is an inappropriate alternative to hiring the necessary number of school nurses to care for students with medical needs; and

WHEREAS, training non-nurses to inject insulin and/or glucagon or to administer oral diabetes medicine is clearly in violation of state nurse practice acts in several states; and

WHEREAS, there is a danger of cross-contamination when treating children with diabetes if universal precautions are not in place and unlicensed personnel who are required to perform injections are generally unaware of the potential for cross-contamination; and

WHEREAS, AFT supports independent monitoring and treatment by diabetic students who are able to demonstrate to their school nurse their ability, competency and willingness to do so:

RESOLVED, that the AFT work to ensure that all students in our schools are safe and receive the highest quality of necessary health services; and

RESOLVED, that the AFT continue to lobby for at least one full-time licensed registered nurse in every school building; and

RESOLVED, that the AFT lobby against school nurses training non-healthcare school personnel as diabetes personnel; and

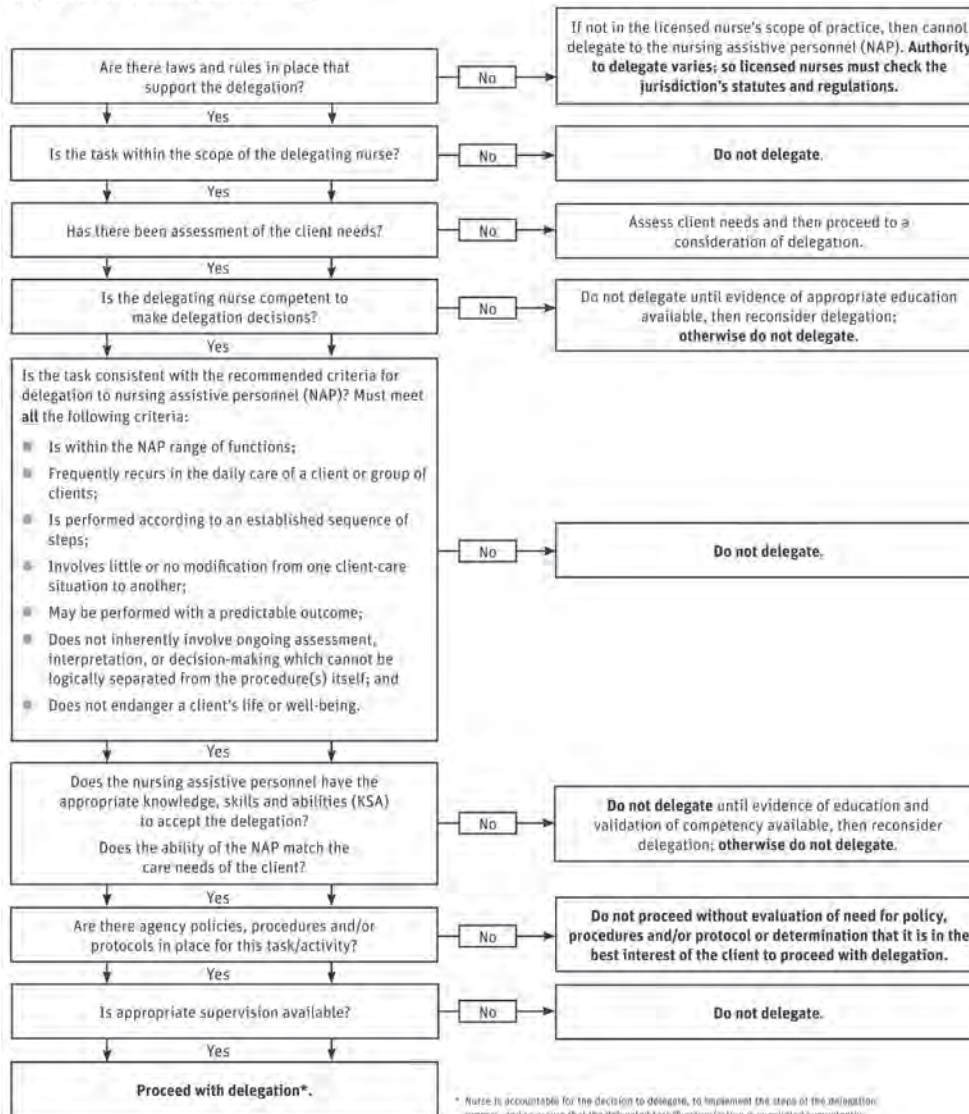
RESOLVED, that the AFT lobby against the use of non-healthcare school personnel trained to administer routine and emergency care to students with diabetes.

(2004)

Appendix L: National Council of State Boards of Nursing Position Paper: Working with Others

Decision Tree – Delegation to Nursing Assistive Personnel

Step One – Assessment and Planning



* Nurse is accountable for the decision to delegate, to implement the steps of the delegation process, and to assure that the delegated task/function/action is completed competently.

Working with Others: A Position Paper

Executive Summary

KEY CONCEPTS

- Boards of Nursing regulate nursing practice.
- State Nurse Practice Acts determine what level of license is required for a task.
- Delegation is a skill requiring clinical judgment and final nursing education should include delegation theory and simulated exercises. However, the application of delegation is a practice setting, where the nurse has clinical experience and the authority to enforce the delegation.
- There is both individual accountability and organizational accountability relates to providing sufficient staff mix, implementation of policies and role description development and creating an environment conducive to patient centered care.
- To delegate is to transfer authority to a competent individual to perform nursing tasks/activities/functions. To assign is to direct a staff member to perform a task within an authorized scope of practice. Assignment (noun) describes each staff member is to accomplish in a given work period.

Download the full text at https://www.ncsbn.org/Working_with_Others.pdf.

Review of Statutes and Rules/Regulations (Spring 2004)

Board	Delegation Definition	RN Scope	(PN/VN) Scope	Delegation Section	Task Lists Can Be Conduct	NA Section	NA Registry	NA Endorsement	Cert of Exp NA	Med Assr	Disruptive Grounds	Other Resources
AL	X											
AK	X	X	X	X		X		X	X		X	X
AS												
AZ	X	X	X			X	X	X				
AR	X	X	X	X							X	
CA-RN	X					X						X
CA-VN												
CO	X			X		X	X	X		X	X	
CT												
DE	X	X		X						X		
DC	X	X		X		X						
FL	X	X	X	X	X	X	X	X	X		X	
GA-PN												
GA-RN												
GU	X	X				X	X	X			X	
HI	X	X		X	X		X					
ID	X			X		X	X	X		X	X	
IL	X	X										
IN	X	X									X	
IA	X	X	X		X						X	
KS	X	X		X		X		X		X	X	
KY	X	X	X	X		X						
LA-PN												X
LA-RN	X	X		X							X	X
ME	X	X		X		X	X	X		X	X	
MD	X	X	X	X			X	X	X	X	X	
MA	X	X	X	X						X		X
MI	X	X		X								
MN		X				X		X		X	X	
MS	X	X										X
MO	X											X
MT	X	X		X	X					X	X	
NE	X	X	X		X			X		X	X	X
NV	X	X	X	X			X	X			X	X
NH	X		X			X	X	X	X	X	X	
NJ				X		X		X	X	X	X	X
NM	X	X						X		X	X	

Summary of Position Statements Regarding Assistive Personnel and Delegation (Fall 2003)

Organization	Delegation/ Decision Making	UAP Role	UAP Titles	UAP Training	Nursing Education	Accountability	Regulation
Academy of Medical-Surgical Nurses	Globalization of market forces and evolving health care reform provide opportunity to analyze nurses' traditional roles and assume responsibility for judicious delegation of nursing tasks to UAP. The RN uses professional judgment to determine what to delegate.	Redesign of traditional nursing roles does not replace RNs with UAP; it gives RNs the opportunity for appropriate support for the delivery of nursing care.	Variety of job classifications	Must be commensurate with the activities that will be delegated. Competency of UAPs should be evaluated annually and provided ongoing education.		RNs are accountable for patient outcomes from nursing care. RNs must participate in decisions regarding UAP job descriptions and UAP job duties within the clinical setting, and be knowledgeable about the competency of each UAP and intervene when needed.	Support the control and monitoring of UAP through the use of existing mechanisms that regulate nursing practice (state board of nursing), including the clarification of the delegation process and what may be delegated and restrictions.
American Association of Spinal Cord Injury Nurses (AASCIN) 1995	Budgetary and resource considerations not valid reasons for wrongful delegation; RN does not have to teach UAP who do not demonstrate the ability to learn and perform care.	RNs asked to increase delegation and use of UAPs; UAP not substitute for RN; UAP should be under direct supervision of RN; UAP role varies by setting.	<ul style="list-style-type: none"> • Nursing aides • Personal care attendants • Family members • Friends • Appointees of the client 	At request of client or client's agent the RN may teach the client's care to UAP. The client or agent then accepts responsibility for the UAP supervision and the type and quality of UAP care; exception when UAP is from an agency		The RN has a legal scope of practice and a legal authority to perform nursing acts; UAPs do not	Employers and RNs who participate in wrongful delegation should be sanctioned
American Federation of Teachers (AFT). 1995	The RN must remain the single authority over delegation of nursing tasks and responsibilities to UAP based on the nurse's evaluation of the training and competencies of the unlicensed person and the nature of the tasks to be performed.	Performance of non-nursing duties such as environmental maintenance; clerical tasks; and directly assisting patients with ADL such as hygiene, feeding and ambulation. Increasingly licensed personnel are being pressured to inappropriately delegate.	Standardized job titles and job description are needed.	Minimum education and training requirements needed at state level		The RN retains responsibility for all tasks he/she delegates	
American Nurses Association (ANA) 1997	Direct patient care activities are delegated by the RN and involve ADL; indirect patient care activities focus on environmental maintenance, such as housekeeping, transporting clerical, and stocking. In delegation the RN uses professional judgment to determine the appropriate activities to delegate.	UAP provide support services to the RN; in virtually all health care settings UAP are inappropriately performing functions within the legal scope of nursing.		The nursing profession should define and supervise the education, training and utilization of UAP		The RN is responsible and accountable for the provision of nursing practice. The RN supervises and determines the appropriate use of UAPs. Therefore, it is responsibility of the nursing profession to establish and the individual RN to implement standards for the practice and utilization of UAPs.	Definitions of nursing in state practice acts.

Appendix M: National Association of School Nurses Position Statement on Delegation

Summary

It is the position of the National Association of School Nurses (NASN) that all children and adolescents deserve safe and effective management of their health care needs (Gelfman & Schwab, 2001). Further, NASN believes delegation is a tool that school nurses may use in implementing interventions outlined in a student's Individualized Healthcare Plan (IHP). The safety and welfare of the individual student and the broader school community, not expediency, delivery of care model, or cost, must be the central focus of all decisions regarding delegation of nursing tasks and functions (National Council of State Boards of Nursing [NCSBN], 1997). The National Association of School Nurses supports appropriate delegation of nursing services in the school setting based on the nursing definition of delegation, requirements of state nurse practice acts, state regulations, guidelines provided by professional nursing organizations and the nursing assessment of the unique needs of the individual student. In many cases, the sound decision may be to not delegate. The practice pervasive functions of assessment, planning, evaluation, and nursing judgment cannot be delegated (NCSBN, 1997, 2005).

History

Delegation is a tool that may be used by the registered professional school nurse to allow unlicensed assistive personnel (UAP) to provide standardized routine health services under the supervision of the nurse, when permitted by the state nurse practice act and supported by the nurse's clinical judgment to be appropriate. There is increased utilization of delegation as a method to meet the health care needs of children in school because of a growing population of children with significant health needs. Advances in health care and technology offer greater opportunities for children with special health care needs to attend school. The incidence of chronic conditions such as asthma, diabetes, severe allergies, and seizure disorders in school-age children is increasing. Complex medical problems that were previously managed at inpatient settings are now being managed in the

school setting. In addition, federal laws set requirements for the provision of health care to children in schools. Laws such as the Individuals with Disabilities Education Act (IDEA), Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act (ADA) of 1990 ensure that children with special health care needs have the right to be educated with their peers in the least restrictive environment (Section 504 Rehabilitation Act, 1973) and to receive support and accommodations for conditions that negatively impact their capacity for learning (Gelfman, 2001).

Delegation has been used effectively in some areas, but unsafe and illegal delegation in school settings can occur. It is important for school districts and school nurses, health care professionals, parents and the public to understand what can be delegated and when delegation is appropriate. Prior to delegation, a student assessment is required. The nurse can then determine what training and supervision is required for safe delegation to occur for this specific student. The legal parameters for nursing delegation are defined by State Nurse Practice Acts, State Board of Nursing guidelines, and Nursing Administrative Rules/Regulations (NCSBN, 2005). Delegation of nursing tasks is not allowed in some states.

Description of Issue

Although delegation is a term used in other fields, it has a unique place and meaning in the practice of nursing. Delegation of nursing care is a legal term and a complex skill requiring sophisticated clinical judgment and final accountability for patients' care (NCSBN, 2005). Effective delegation requires experience as a practicing nurse. Nursing defines delegation as transferring the responsibility of performing a nursing activity to another person while retaining accountability for the outcome (American Nurses Association [ANA], 1994; National Association of State School Nurse Consultants [NASSNC], 2000; NCSBN, 1995). Nurses are accountable to: (1) state laws, rules, and regulations, (2) employer/agency regulations, and (3) standards of professional school nursing practice, including those

pertaining to delegation. The decision to delegate is a serious responsibility and must be determined on a case-by-case basis by the registered nurse. The nurse delegates tasks based on the needs and condition of the student, stability and acuity of the student's condition, potential for harm, complexity of the task, and predictability of the outcome (ANA, 2001).

Nursing tasks commonly performed in the home setting by a student or caregiver take on a more complex dimension in the school setting. Often parents and school administrators are confused about why what appears to be a simple task is held to a much different and higher standard at school (NASN, 2005).

Delegation becomes more complex when applied to settings that do not have organized nursing structures. The registered professional school nurse practices in an environment where health care supports but is secondary to the primary purpose of providing education. Federal mandates and parental expectations that the school is able to manage the health needs of students increase the demands for qualified personnel to ensure the health and safety of students with special health needs. School nurses may be placed in a position where it becomes necessary to decline supervision of an individual who has been designated by an administrator to perform a nursing procedure based on statutes/rules governing education (NCBSN, 2005). The school nurse may be forced to choose between following standards of nursing practice or an administrator's directives.

Rationale

Only a registered nurse can delegate nursing care. Further, delegation is not appropriate for all students, all nursing tasks, or all school settings. The American Nurses Association (2005, p. 3) "does not support delegation of those registered professional nursing services that require assessment and/or emergency care." Key factors guiding determination for delegation include the following: safety issues; state laws, rules, and regulations; and medical needs of students.

- Safety issues unique to providing health services in a school setting, versus in a health care setting or home. (e.g., safety of a fragile student in a large group of other students;

safety of other students and school staff; the stimuli of the school environment distracting attention from safe execution of health tasks by a student; use of unlicensed assistive personnel (UAP) versus assistive personnel with standardized credentials typically used in health care settings).

- State laws, rules and regulations that govern nursing practice, including delegation of care.
- Medical needs of the student, including complexity, stability and acuity of his/her health care status.

To provide for safe care, nurses use the Five Rights of Delegation (ANA, 1997; NCSBN, 2005) to guide their assessment of whether delegation is appropriate for the student and the situation.

1. The Right Task

- Is the task within the nurse's scope of practice?
- Is the task reasonably routine with a predictable outcome?
- Is it based on written medical orders?
- Is it one that is repeated frequently?
- Is it performed according to an established sequence of steps, without modification?
- Is the task one that does not involve assessment, interpretation, or decision-making?

2. The Right Person

- Who is immediately available to the student, willing, and competent to do the task at the required time?

3. The Right Direction

- How much training will be required by the UAP to perform the task in a safe and appropriate way?
- How many tasks will the UAP need to learn?
- What other duties does she/he have?

4. The Right Supervision

- How much initial training will the nurse need to provide to the delegate for the performance of this task?
- What type of ongoing supervision will be needed (on site, periodic, episodic)?

5. The Right Circumstance

- Is the child particularly vulnerable due to age, developmental level, cognitive abilities, gender, or specific health issues?
- Is the environment safe for UAP to perform the delegated task as planned?

When review of the Five Rights of Delegation indicates that delegation is appropriate, the registered professional school nurse must develop an Individualized Healthcare Plan outlining the level of care and health care interventions needed by the student and indicating which tasks can and cannot be delegated. Further, the continuous process of evaluation should be based on outcomes of care, ensuring that the delegated task is completed properly and produces the desired outcome.

Thus, delegation is a complex process that requires thorough attention to safety parameters, student health status, and legal standards. The appropriateness of delegation can only be determined by the registered professional school nurse and is determined through a nursing decision-making process.

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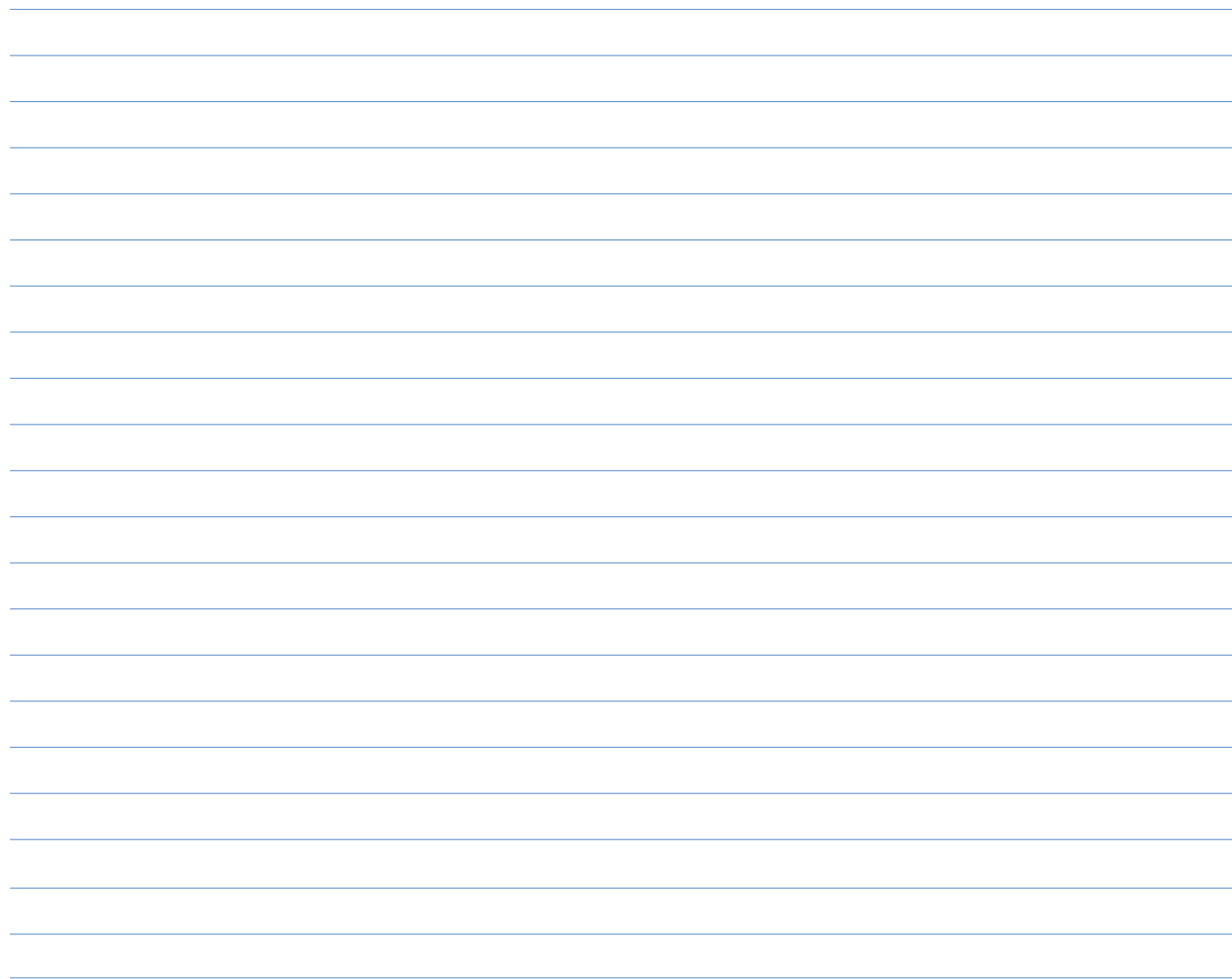
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About the photos

The photos used in this book are of AFT members and were taken by Nijme Rinaldi Nun (Forward), Pat Arnow (Chapters 1 and 5), Karen Sachar (Chapters 2 and 6), Jeffery Grosscup (Chapter 3) and Ernie Leyba (Chapter 4).

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