

CDC NURSING PROCEDURES

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(A) ERC NURSING STAFF DRESS CODE

Properly fitting Scrub top and bottom of any color. Clothing should be neat and clean.

No inappropriate slogans or messages printed on scrubs. A long sleeve top may be worn under the scrub top.

Tattoos depicting inappropriate messages are not to be visible.

Hairstyles should be moderate and long hair worn up off the shoulders.

Make up should be moderate. No jewelry that can be pulled from the body or potentially scratch a child during care is to be worn.

Fingernails are to be short/clean.

Perfumes/colognes should be avoided due to the potential to trigger reactions in children with asthma/allergies.

Shoes: flats with enclosed toes are required.

Name tag with identification of licensure is required.

Site Directors will use their discretion to determine if clothing/tattoos are inappropriate.

(B) PROCEDURE TITLE: STAFF EDUCATION/SKILL TRAINING

PURPOSE: To ensure all ERC staff providing direct care or observation of students, receive education/training regarding the medical conditions and needs of the students standard: all ERC staff are provided information regarding student medical needs to ensure quality care.

Nursing staff are provided resources for education/information including consultation with the RN, written medical care plans, and in-service education provided by the RN on topics pertinent to student care.

The American Academy of Pediatrics guidelines are utilized for pediatric care procedures.

Staff education will be conducted only after RN approval of the information used for education. Parent/guardian education will be performed using the preapproved communicable disease teaching

sheets, approved information from the nursing procedures, information provided or reviewed and approved by the RN, or information provided by the student's physician.

PROCESS: the student's individual health plan/medical care plan is reviewed with ERC staff. The nursing staff are available to answer specific questions, provide detailed information under the direction of the RN. The medical care plan is placed in the classroom information book and copies given to classroom staff for review. The care plans are updated as needed and the updated care plans are provided to classroom staff. Medical care plans are accessible on Therap, the nursing MAR book and classroom information book. Nursing staff provide training/education to ERC staff on general medical topics as deemed necessary or as requested by service coordinators, certified teachers, site director, or director of children's services.

New staff will receive education about health and safety issues from nursing staff as part of the new employee orientation non-licensed ERC staff will be trained to perform nursing tasks in accordance with the Arkansas State Board of Nursing guidelines for school nurses. This training is performed and documented by the registered nurse. The documentation is maintained in a labeled section in the back of the nursing MAR book.

(C) Procedure Title: Delegation of Nursing Care Duties

Purpose: To provide a reference as to the organization of the nursing department and responsibilities within the department for the delegation of nursing care duties.

Standard: The organization will employ on a full-time, part-time, or consultant basis appropriate staff necessary to carry out nursing duties.

Professional staff will be licensed, certified, or registered in accordance with applicable state laws. The Registered nurse will make clinical decisions and monitor clinical services provided by LPN and CNA nursing staff.

Nursing duties carried out by non-licensed staff will be limited to those tasks for which the staff member has been fully trained by the registered nurse and the training documented. Delegation of tasks will follow Arkansas State Board of Nursing School Nurse Guidelines.

Process: The following information outlines specific duties/responsibilities of ERC nursing staff:

The RN will be available to the Preschool nursing staff "on site or on call" and provide clinical direction to the nursing staff:

- Any time emergency services are accessed for a student

- Any time EMS is activated (911) or a student is taken to the Emergency Room by a parent/even if he/she is not admitted to the hospital
- Any significant change in a student's medical or physical condition that requires closer monitoring; elevated temperature, persistent nausea/vomiting, seizure activity, allergic reactions, significant change in behavior (completion of a GER/T-log designated as MEDIUM or HIGH notification automatically alerts the RN to review the GER/T-log)
- To discuss clinical issues and obtain input for clinical decision
- Upcoming admission of a new student/discharge of students
- Changes in medication/treatment
- Medication or procedure errors or suspected errors
- Diagnosed or suspected communicable disease diagnosis
- Groupings of similar illnesses/suspected clusters of possible communicable conditions
- Any GER not completed by the end of the day requires RN notification
- Questions regarding nursing Procedures
- Review of documentation of assessment of medical/physical findings when reporting suspected abuse/neglect to DHS

RN RESPONSIBILITIES:

- Assess medical information of all students/Review all MHI forms
- Provide medical care plans for students with special health care needs; complete the Individualized Health Care Plan (IHP).
- Update the IHP/Medical care plans as needed in regard to changes in medication, treatment, or medical condition of the student.
- Research and provide information to nursing staff and other ERC staff regarding diagnosis and care of students.
- Provide instruction/education for nursing staff, class room staff and other staff as needed, to assure appropriate student medical care/health and safety. Instruct nursing staff/designated classroom staff regarding monitoring symptoms/treatment/procedures/medications/diagnosis.
- Provide supervision of all facility nursing staff. Review and approve all nursing staff Therap documentation. Provide feedback and direction for any documentation requiring improvement or lacking appropriate assessment information. Ensure that all documentation is concise, descriptive, and contains necessary nursing assessment information.
- Report any trends or unusual events identified through review of documentation to the Site Coordinator and/or the Director of Children's Services.
- Conduct periodic quality improvement surveys. Review on site documentation: Physician orders, consent forms, MAR documentation, Seizure plans, Allergy plans, Daily Schedule, Medication refrigerator temperature log, OTC lot # log sheets, Immunization log, well child exam log, and any documentation not completed in Therap.
- Conduct periodic quality improvement surveys.
- Review hard charts for appropriate documentation and provide feedback to nursing and The Director of Children's services, regarding improvement opportunities. Monitor/observe on site

performance of nursing staff. Provide feedback for performance improvement to nursing staff, Site Coordinator and Director of Children's services.

- Create and revise as necessary, Procedures for nursing staff and/or classroom staff. Procedures will meet DHS, CARF, and Arkansas State Board of Nursing guidelines for school nurses, and all other governing body guidelines.

DUTIES: Licensed Practical Nurse/Certified Nursing Assistant

- Follow all Nursing Procedures; communicate directly with the RN regarding any clinical or Procedure questions/issues. Report changes in medical conditions to the RN promptly. UPDATE THE DAILY ACTIVITY SHEET IMMEDIATELY WHEN MEDICATIONS OR PROCEDURES ADDED OR CHANGED.
- Provide direct medical care to students and maintenance of necessary paperwork to complete that care to include:
 - Obtain medical information from family/guardian on new students and send information to the RN via secure email (Therap) Obtain necessary consent and release of information form signatures.
 - Obtain physician orders for any medication or medical procedures to be performed by the school nurse
 - Upon request by ERC staff or as nursing staff deems necessary by observation; assess child for signs/symptoms of illness, provide treatment as needed (physician ordered or minor first aid), and notify parent/guardian. Notify RN of medical symptoms other than minor first aid.
 - Document student medical conditions (T-log), accident injuries (GER), and parent/guardian notification (T-log). Contact parent/guardian to share information on child's condition/pick up child if appropriate,
 - Arrange medical transport if appropriate, or direct classroom staff to monitor child and report changes in condition to the nurse as appropriate. All documentation to be completed the day of and ASAP after the event/assessment/treatment occurred.
- Complete medication administration forms (MAR) update monthly as well as maintain current physician orders for all medications and procedures.
- Administer medications to students per physician orders and document on medication administration form (MAR). Follow all ERC medication procedures every time medication is administered. Document medications/procedures at the time they are given/completed.
- Document and report to RN any medication side effects or suspected side effects, medication adverse reactions or medication errors or suspected errors.
- Manage all handling, storage of medications and/or medical equipment
- Performance and documentation of medical procedures for which education/training has been completed (within the guidelines designated by the Arkansas State Board of Nursing)
- Participate in classroom staff education regarding medical conditions of students by providing a copy of the IHP/Medical care plan to staff. IHP/Medical care plans will be placed in classroom information books and copies given to staff for review. Maintain familiarity with Classroom

health procedures (written copy in classroom information book). Provide re-education to classroom staff regarding health procedures upon request of RN and/or site coordinator.

ADDITIONAL NURSING STAFF CNA/DUTIES (other than Fayetteville CDC)

- Complete all USDA paperwork regarding meal/snack service on the day of service.
- Serve and document snacks and lunches that meet all the USDA requirements for components and serving sizes. The daily production sheet and infant production sheets will be completed daily using the forms located on the K-drive. K-drive – USDA forms – name of the center- USDA Attendance form to be completed daily; USDA meal count form to be completed daily. Refer to the USDA manual and specific instructions for completion of all documentation.
- Monthly review of Lunch menu received from the senior center; review and update daily snack menu; inventory all snack foods; order snack foods; baby food products; ancillary food service equipment:

LUNCH AND SNACK MENUS WILL BE SENT HOME TO PARENTS AT THE BEGINNING OF EACH MONTH

(D) Procedure Title: NURSING STAFF REQUIRED NOTIFICATION OF REGISTERED NURSE

RN notification is **required** any time there is a significant change in a child's medical/physical condition (due to illness or injury), when EMS is activated (even if the child is not transported), when a child is sent to the hospital (even if parents transport), when a Medical Emergency is called in the facility any time medication or procedure errors occur or are suspected to have occurred, and situations where suspicion of abuse/neglect of a child is observed.

Examples of significant change to a child's medical/physical condition include: seizure activity, allergic reactions, administration of PRN medication (prescription and OTC), continued vomiting (not from a known chronic medical condition), diarrhea (not from a known chronic medical condition), elevated temperature, Rash (other than diaper rash), diagnosed/suspected contagious medical conditions.

The RN is automatically notified by Therap of GER's that are designated as HIGH or MEDIUM notifications at the time they are submitted. In addition to that notification a phone call or text should be used to notify the RN of any emergent conditions, serious medical symptoms, EMS activation, Medication/treatment errors. The GER completion is not sufficient notification for any serious medical conditions/potentially serious conditions/errors. If nursing staff have GER's or T-logs not completed by the end of the day they are **required** to be reported to the RN via phone call as well.

Other RN notifications include: Expected admission of new students, changes in medications, diagnosis or allergies of current students. Any medical information requiring updating of the medical care plan portion of the IHP. Clinical concerns, questions, and requests for medical resource information.

The RN contact information is available in the staff telephone listing information. All nursing staff are provided the RN's cell phone number and all contact information.

(E) Procedure Title: REPORTING SUSPECTED ABUSE/NEGLECT

Mandated child abuse reporters include nursing staff, as well as all staff in a child care facility. All ERC preschool staff are required to report to DHS any suspected Abuse/neglect. This reporting is of conditions that are "suspicious" to the reporter and DHS uses that information to determine if an investigation necessary.

The reporter is not "accusing" the parent/guardian of abuse/neglect, but reporting observations that "could" be connected to abuse/neglect.

Nursing staff will notify the site director and the RN of any suspected abuse/neglect. Documentation (GER) will be completed. DHS hotline will be called and information reported. No parent/guardian contact will be made until the report to DHS is complete and at that time DHS instructions are to be followed regarding parent/guardian contact and any disposition of the child.

It is appropriate for Nursing staff to complete an assessment on a child if any ERC preschool staff member reports suspected abuse/neglect. If the Nursing staff also suspect abuse/neglect based on their assessment; the documentation and the verbal report by nursing staff will accompany the report of the ERC staff member initiating the report. If the assessment of the child/situation does not provide the nursing staff with information that requires DHS reporting (based on their nursing judgment and consultation with the RN); this information will be provided to the site coordinator. The ERC preschool staff member will initiate the DHS hotline call to report the suspected abuse/neglect. The site Director and/or Nursing staff will assist the staff member as needed and the GER report will be provided to DHS as requested. Each staff member is responsible for reporting suspected abuse/neglect and Nursing staff do not give instruction to staff to "report" or "not report"; they may give their professional nursing opinion based on assessment of the child and situation.

Refer to the Elizabeth Richardson Center Procedure Guidelines for Reporting of Suspected Abuse or Neglect. The ERC Procedure contains necessary information for reporting. Your immediate supervisor and/or Registered nurse can also assist with this information.

Detailed information regarding reporting of suspected child abuse can be accessed at the official website. www.arkansas.gov/reportARchildabuse The DHS Hotline number for reporting suspected abuse/neglect is listed at each preschool site and can be obtained from the site director, CT, or the Director of Children's Services.

(F) PROCEDURE TITLE: MEDICAL EMERGENCY PROCEDURE

When ERC staff determine a need for immediate assistance with a serious medical condition/Injury. A MEDICAL EMERGENCY will be announced either through an overhead paging system or verbal notification of staff. MEDICAL EMERGENCY in (name the location)".

GENERAL MEDICAL EMERGENCY GUIDELINES

Nursing staff will immediately report to the area where the medical emergency is located. Assess the medical situation and request assistance as needed. Available staff (site coordinator, certified teacher, receptionist, service coordinator) will report to the area and offer assistance based on the individualized plan for the center or the nursing staff specific request. ERC staff will vacate hallways, Move children from the hallways to the nearest appropriate area. Keep children in classrooms, therapy rooms, or on the playground when the Medical Emergency is called and remain in place with children until MEDICAL EMERGENCY ALL CLEAR is reported. Staff in the medical emergency area will remove other students to adjoining classroom if necessary to make room and/or decrease stimulus. If nursing staff and/or receptionist are relieving classroom staff for breaks; the classroom staff should return immediately to the area where their children are located (classroom/playground) and resume care since the nursing staff and receptionist will need to go to the medical emergency location. Nursing staff will immediately proceed to the area of the medical emergency. The receptionist should await return of classroom staff for ratio compliance.

ERC staff should avoid crowding the area of the emergency. Assess the need to assist with relocating students and/or maintaining child/staff ratio. Follow any request by the nursing staff or site coordinator for assistance.

In the absence of nursing staff, 911 should be accessed and reasonable first-aid measures employed

THE NURSING STAFF AND SITE COORDINATOR AT EACH CENTER WILL DEVELOP A SITE SPECIFIC MEDICAL EMERGENCY PLAN. The RN will provide assistance with the development and review of the plan. The Medical Emergency Plan will delegate duties and give instructions specific to that preschool. The Medical Emergency Plan will be written and posted in the receptionist area and nursing office. All ERC staff will be educated regarding the specific Medical Emergency Plan. Quarterly Medical Emergency Drills will be conducted and documented by nursing staff according to the Emergency Drill Calendar. Tasks to be assigned during a medical emergency include: calling 911, calling the parent, calling the RN, moving children out of the medical emergency area, obtaining needed equipment/medication, obtaining documents needed prior to transport of a child via EMS, monitoring for arrival of EMS and directing them to the site of the medical emergency.

(G) PROCEDURE TITLE: MEDICATION ADMINISTRATION

STANDARD: To establish procedures for the safe and accurate administration of medication to students in accordance with Nursing Rules and Regulations of the Arkansas State Board of Nursing, Arkansas State Board of Nursing School Nurse Guidelines, and all other regulatory agencies involved in the oversight of ERC preschool centers.

PROCESS: Medications will be administered only by ERC staff licensed to administer medication or ERC staff with specialized training in medication administration (performed and documented by the RN/per Arkansas State Board School nursing guidelines) (OTC diaper rash creams/ointments and sunscreen lotion are not considered medications. These may be administered by the ERC staff in the classrooms after documented education by the Nursing Staff). Documentation for non-licensed staff trained for medication administration will be located in the MAR book.

Medications will be administered according to physician direction/label direction.

The Six Rights of Medication Administration will be observed at all times

- Right student
- Right medication
- Right dose
- Right time
- Right route
- Right documentation

STEPS FOR SAFE MEDICATION ADMINISTRATION

These steps will be followed by all Nursing staff/medication trained ERC staff every time medication is administered

1. Read order on MAR check expiration dates of prescription/physician order and Parent/guardian consent form (do not administer medication without current physician order and parent/guardian consent)
2. Remove drug from medication storage area and compare label information on medication container to order written on MAR; ensuring child's name, medication name, dose, route, time are correct. (Do not administer medication if information is not accurate or you are unsure about any aspect of the medication administration).
3. Check expiration date of medication (do not administer expired medication)
4. Double check the medication label against the MAR documentation and prepare the dose for administration
5. Make proper identification of the student prior to medication administration with the following steps:
 - Confirm the identity of the child by stating the child's first and last name to classroom staff and requesting they verbalize the child's first and last name back to you; confirming the identification of the child.

- Call the child by name (if age appropriate) - If further verification is necessary refer to the Site Coordinator or CT for accurate identification of a student prior to medication administration. Medications and/or treatments may be given up to one hour before or one hour after the scheduled time and remain within procedure; but should be given as close to the prescribed time as possible.

PARENT/GUARDIANS ARE ENCOURAGED TO ADMINISTER MEDICATION AT HOME WHENEVER POSSIBLE

THE FIRST DOSE OF A NEW MEDICATION SHOULD BE ADMINISTERED AT HOME WHENEVER POSSIBLE.

ANY MEDICATION ORDER/INSTRUCTION THAT APPEARS INAPPROPRIATE CONSIDERING THE STUDENT'S AGE, CONDITION, DIAGNOSIS, OR KNOWN ALLERGIES SHOULD NOT BE GIVEN UNTIL VERIFIED WITH THE STUDENT'S PHYSICIAN: CONTACT THE RN FOR REVIEW OF ANY QUESTIONABLE ORDERS/INSTRUCTIONS.

MEDICATION ALLERGIES: Nursing staff will obtain medication allergy and food allergy information from the parent/guardian and document this information on the (MHI) Medical history/information form. Allergy stickers will be placed on the outside of the hard chart covers and allergy information listed. Medication allergies and food allergies will be listed if applicable and NKDA/NKFA will be listed to designate no known drug allergies/no known food allergies when applicable.

All medication allergies will be listed on the MAR form
All severe food allergies will be listed on the MAR form

MEDICATION ADMINISTRATION PROCEDURE

Nursing staff will obtain a list of current medications taken by the child.

Medications to be administered at school will require:

1. A Physician order
2. Parent/guardian signed permission form for medication (consent form)
3. MAR form
4. Medication side effect information (refer to Drugs.com for needed medication information and/or contact RN if medication information is needed).

A Physician order for prescription medication may consist of:

1. Prescriptions/legible copies of prescriptions (may be obtained from pharmacy)
2. Written physician orders/legible copies of written physician orders
3. Verbal orders received by the school nurse and sent for physician signature/REVIEW ANY VERBAL ORDERS RECEIVED WITH THE RN PRIOR TO ADMINISTRATION
4. A legible copy of the medication label/prescription information Medication orders must contain the following information:
 - Student's name
 - Date of the order
 - Name of the medication

- Dosage of medication including strength or concentration
- Route of administration
- Times/frequency of administration

PRN orders should include criteria for administration of medication
Medication orders will be placed in the hard chart and a copy placed in the MAR book.

PERMISSION FORM FOR PRESCRIPTION MEDICATION/PROCEDURE

The Permission Form containing the names of all medications and signed by the student's parent/guardian will be placed in the hard chart and a copy placed in the MAR book.

New medication orders will require completion of a new Permission form.

A Medication Administration Record (MAR) form will be completed with medication information. All medication order information will be listed on the MAR form. The MAR forms will be stored on the K-drive to allow for access.

Monthly updates of the MAR will include confirmation of the MAR information compared to the Physician's order and checking expiration dates of medication, consents, and prescriptions. Check all information before printing copies of MAR for a new month.

Sign the new MAR forms as soon as they are printed to document your review of the information contained on the MAR. Highlight expiration dates that are within 30 days of expiration.

The MAR form will include the following information:

- Student Name
- Month/Year
- Medication allergies
- Severe food allergies
- Medication name/dose/route/Time or Frequency
- Nursing staff/trained ERC staff signature and initials

Expiration dates listed on the MAR will include:

- Medication expiration date
- Prescription expiration date
- Parent/guardian consent form expiration date

All medication administration will be documented on the MAR sheet at the time of administration. The nursing staff/trained ERC staff administering the medication will initial under the date the medication is given. PRN (as needed) prescription medication will be documented on the MAR with the time placed under the appropriate date and under the time; the initials of the administering nursing staff/trained ERC staff.

The following letters will be used to document on the MAR the corresponding events:

A=Absent

R=Refused

U=Unavailable (no medication at school for administration)

C=School closed (other than normal weekend closure i.e. snow day, holiday)

H=Held (medication was held; document reason in T-log)

P=Given at home by parent (medication normally administered at school was given at home)

The MAR form documentation is completed on the paper format MAR in the MAR book.

No other documentation is required for prescription/routinely ordered medication unless medical symptoms are observed requiring a health note T-log or communication with parent/guardian, RN, physician, pharmacist, dietician, etc. regarding medication requiring a nurses note or parent notification T-log.

NUTRITIONAL SUPPLEMENTS: Nutritional supplements ordered by a physician and administered by or added to formulas by nursing staff may be listed on the MAR and administration documented by the nurse/trained ERC staff. Each nutritional supplement need will be reviewed and a care plan created by the RN. The need for MAR documentation will be determined at that time by the RN. Store supplements according to label directions. Check expiration dates as with medications. Additives sent to school premixed in formulas will not require MAR documentation by Nursing staff. Additives for the purpose of thickening will be included in the MEDICAL CARE PLAN but will not require MAR documentation. Nutritional supplements sent by parents as part of a student's daily diet (not physician ordered) will be reviewed by nursing staff and instructions for use provided to the class room staff

DISCONTINUED MEDICATION will be documented on the MAR by writing D/C under the date of discontinuation and placing initials under the D/C; then drawing a line through the remainder of the dates. Discontinued medications will also be documented with a T-log note containing any pertinent information.

MEDICATION CHANGES will be documented on the MAR by discontinuing the old medication order (follow instructions for discontinued medication) The change will be written on the MAR form with a line drawn through the dates prior to the medication change.

Copies of new physician orders/parent/guardian permission form/will be placed in the MAR book and the hard chart. New expiration date information will be added to the MAR.

Each month new MAR forms will be completed by nursing staff and placed in the MAR book. The expiration dates will be checked at this time. Initiation of obtaining new medications/prescriptions/Parent/guardian permission forms will begin prior to expiration.

T-log Parent/guardian Notification requesting medication/information/pharmacy contact to acquire updated prescription information/Physician office contact for updated order information will be

utilized to maintain current medication information.

Completed MAR forms are filed in the hard chart MEDICATION DROPPED onto an unclean surface will be discarded and another dose used. Document the wasted dose in a T-log parent/guardian notification form. Notify the RN if each dose must be accounted for such as controlled substances, ask the site coordinator or CT to witness discarding of the contaminated drug dose and document/sign Controlled substance flow sheet.

RECEIVING MEDICATION: medications may be brought to the ERC nursing staff by the parent/guardian. If medication is transported it must be in the original container or inside a container that includes a copy of the original prescription information.

NEVER ADMINISTER MEDICATION FROM AN UNLABELED CONTAINER.

RETURN OF MEDICATION: unused medications and expired medications will be returned to the parent/guardian. If the parent/guardian declines to retrieve the medication or if there is no response to requests for medication to be picked up; after 30 days the nurse will dispose of the medication. Disposal of medication that is controlled will require the witness and cosign signature of the RN or the site Director.

DISPOSAL OF MEDICATION – UNUSED, DISCONTINUED, EXPIRED MEDICATIONS WILL BE RETURNED TO THE PARENT/GUARDIAN FOR DISPOSAL

In the event that medications must be disposed of in the preschool setting (disposal of expired multi dose OTC medications will be performed by nursing staff) the FDA guidelines for safe disposal of medication will be followed. For instructions for disposal of specific medications; check medication labels and follow instructions for safe disposal, Refer to the FDA CDC Complete Nursing Procedures (4-2014) 17 medication disposal information in this Procedure, contact the dispensing pharmacy for instructions, and/or contact the RN.

When medications are expired or no longer needed it's important to dispose of them properly to avoid harm to others.

Disposal of medications in trash container.

You can follow these simple steps to dispose of most medicines in the trash

- Mix medicines (do NOT crush tablets or capsules) with an unpalatable substance such as used coffee grounds;
- Place the mixture in a container such as a sealed plastic bag; and
- Throw the container in the trash. (Trash container must have a lid and be located away from child care areas.
- Before throwing out a medicine container, such as a pill bottle, remember to mark out all information on the prescription label to make it unreadable (use a sharpie pen)

Medicines Recommended for Disposal by Flushing

This list from FDA tells you what expired, unwanted, or unused medicines you should flush down the sink or toilet. Flushing these medicines will get rid of them right away.

Medicine Active Ingredient

Abstral (PDF - 1M)6, tablets (sublingual) Fentanyl

Actiq (PDF - 251KB)7, oral transmucosal lozenge * Fentanyl Citrate

Avinza (PDF - 51KB)8, capsules (extended release) Morphine Sulfate

Daytrana (PDF - 281KB)9, transdermal patch system Methylphenidate

Demerol, tablets * Meperidine Hydrochloride

Demerol, oral solution * Meperidine Hydrochloride

Diastat/Diastat AcuDial10, rectal gel [for disposal instructions: click on link, then go to "Label information" and view current label] Diazepam **Dilaudid**, tablets * Hydromorphone Hydrochloride

Dilaudid, oral liquid * Hydromorphone Hydrochloride

Dolophine Hydrochloride (PDF - 48KB)11, tablets * Methadone Hydrochloride

Duragesic (PDF - 179KB)12, patch (extended release) *Fentanyl

Embeda (PDF - 39KB)13, capsules (extended release) Morphine Sulfate; Naltrexone Hydrochloride

Exalgo (PDF - 83KB)14, tablets (extended release) Hydromorphone Hydrochloride

Fentora (PDF - 338KB)15, tablets (buccal) Fentanyl Citrate

Kadian (PDF - 135KB)16, capsules (extended release) Morphine Sulfate **Methadone Hydrochloride**, oral solution * Methadone Hydrochloride **Methadose**, tablets * Methadone Hydrochloride **Morphine Sulfate**, tablets (immediate release) * Morphine Sulfate

Morphine Sulfate (PDF - 282KB)17, oral solution * Morphine Sulfate

MS Contin (PDF - 433KB)18, tablets (extended release) * Morphine Sulfate

Nucynta ER (PDF - 38KB)19, tablets Tapentadol CDC Complete Nursing Procedures (4-2014) 19 (extended release)

Onsolis (PDF - 297KB)20, soluble film (buccal) Fentanyl Citrate **Opana**, tablets (immediate release) Oxycodone Hydrochloride

Opana ER (PDF - 56KB)21, tablets (extended release) Oxycodone Hydrochloride **Oxecta**, tablets (immediate release) Oxycodone Hydrochloride **Oxycodone Hydrochloride**, capsules Oxycodone Hydrochloride

Oxycodone Hydrochloride (PDF -100KB)22, oral solution Oxycodone Hydrochloride

Oxycontin (PDF - 417KB)23, tablets (extended release) * Oxycodone Hydrochloride **Percocet**, tablets * Acetaminophen; Oxycodone Hydrochloride **Percodan**, tablets * Aspirin; Oxycodone Hydrochloride

Xyrem (PDF - 185KB)24, oral solution Sodium Oxybate

*These medicines have generic versions available or are only available in generic formulations

MEDICATION LABELING

All medication must be accurately labeled. Multi-dose OTC medications must remain in the original container with attached label. Prescription medications should remain in the original prescription container with attached label. If the prescription medication original container is not available obtain a copy of the current prescription label from the pharmacy, parent or physician's office. Attach label information to medication or place medication in a plastic bag with the prescription information. ONLY

LABEL MEDICATIONS WITH VERIFIED CONTENT (medication given to you from a labeled container, medication in a labeled container with medication change requiring label update) medication you have removed from the original container, such as an inhaler removed from the labeled box; should be labeled with the child's name and the original box retained; or a copy of the label on the box.

MEDICATION STORAGE

Nursing staff are responsible for the proper storage of medications. All medications will be stored in a specifically designated, locked area. Only the administrative staff and the nursing staff will have access to the medication.

Medication requiring refrigeration will be stored in a medication only refrigerator in the nursing office that can be locked when it contains medication. Keys to all medication cabinets and the medication refrigerator will be maintained by the nurse during school hours and maintained/stored in designated locked area in administrator's office or receptionist area after hours. Medication requiring protection from light during storage will remain in the locked medication cabinet and removed only during administration.

Any medications requiring other special storage or treatment will be reviewed with the RN and/or Pharmacist and all storage and handling instructions followed.

MEDICATION REFRIGERATION

Medications requiring cold storage must be refrigerated. Only medications/special formula or formula additives/ may be stored in this refrigerator. Medication refrigerator temperatures will be monitored and recorded each business day by the nursing staff. Temperature readings are recorded on the temperature Log sheet posted on refrigerator. Temperature should be maintained between 36 and 46 degrees Fahrenheit. Temperature readings outside these parameters should be reported to maintenance. Medication may be placed in a labeled container and stored temporarily in another secure refrigerated location in an emergency situation until medication refrigerator is repaired or replaced.

PARENT/GUARDIAN NOTIFICATION: The student's parent/guardian will be notified (by phone or note sent home) of any deviation in routinely ordered medications or procedures such as: PRN MEDICATION ADMINISTERED, MEDICATION HELD, MEDICATION REFUSED, MEDICATION WASTED, ALLERGIC REACTION, SUSPECTED ALLERGIC REACTION, and MEDICATION ERROR.

DOCUMENTATION/COUNT OF CONTROLLED SUBSTANCES

MEDICATIONS CONSIDERED AS CONTROLLED SUBSTANCES SHOULD IDEALLY BE ADMINISTERED AT HOME AND NOT IN THE SCHOOL SETTING.

Any questions regarding classification of drugs should be referred to the RN and/or the Pharmacist Medications designated as controlled substances by the FDA will be counted and monitored with the completion of the CONTROLLED SUBSTANCE FLOW SHEET.

Fill out the CONTROLLED SUBSTANCE FLOW SHEET, adding the amount of medication received sign the form along with PARENT/GUARDIAN cosigner after you have both confirmed the amount of medication received. A daily count of the medication by nursing staff will be documented on the flow sheet.

Controlled substances must be delivered to ERC nursing staff by parent/guardian or other family member and documentation of receipt signed by the adult bringing the medication to the preschool. Any discrepancies in controlled substance count/administration/receipt must be reported to the RN and the Director of Children's Services immediately.

MEDICATION ERRORS: a *medication error* is defined as an inappropriate or incorrect medication prescribed for, dispensed for, or given to a student. It is also an omission of a vital medication due to a prescribing, dispensing or administering error.

Medication Administration Errors Include:

- Medication omissions
- Incorrect drug
- Incorrect rate or dose
- Incorrect route
- Incorrect timing
- Incorrect labeling
- Incorrect identification of child

ADVERSE MEDICATION REACTION

An *adverse medication reaction* is defined as an unintentional or unintended harmful effect, occurring as a result of a medication administration, such as an allergic reaction in a patient with no documented history of allergy to the medication.

ALLERGIC REACTION

An *allergic reaction* is defined as an unexpected immunologic response to a drug or other substance; can produce a variety of symptoms ranging from a singular hive, to diarrhea, to cardiopulmonary arrest. (Anaphylactic). Allergic reaction may occur from medication administration even when the medication has been tolerated in the past.

In the event of an adverse medication reaction/allergic reaction, EMERGENCY MEDICAL CARE AND EMS ACTIVATION (911) WILL BE INITIATED.

Action should be taken as necessary to protect the student's safety and welfare. Attending physician, RN, and parent/guardian will be notified immediately. The nursing staff responsible for the error or identification of the error/adverse reaction will document the error/reaction and all subsequent actions taken to include:

- The factual specifics of the error/adverse reaction (GER)
- Name of physician and time of notification if applicable (GER)
- Notification of parent/guardian and time (T-log and GER)

- ☑ Notification of RN (GER)
- ☑ Physician subsequent orders
- ☑ Actions taken
- ☑ Student's condition/response to any treatment

The nurse will document the medication error in Therap (GER)
 All medication errors will be reviewed by the RN and the Director of Children's Services.

PROCEDURE TITLE: ORAL AND NASAL INHALATION ADMINISTRATION

STANDARD: Oral and nasal inhalants should be administered by a licensed nursing staff/specially trained ERC staff, per physician order.

PROCESS: Follow procedures as with all other medication administration
 CDC Complete Nursing Procedures (4-2014) 23

Shake inhaler well prior to administration

If student age/compression allow, instruct student to exhale. May observe for exhalation in younger children. Spacer and other inhalation assistive devices may be required for young children.

Place mouthpiece or assistive inhalation device in/over mouth and/or nose. Depress medication canister on inhalation. If age appropriate, instruct student to hold breath briefly to enhance medication absorption. If more than one inhalation is ordered, wait a short period of time, then repeat
 Clean inhaler and/or assistive device by wiping with tissue, unless specific instructions accompany device.

Specific use and/or cleaning instructions for inhalation assistive devices will be kept in the MAR book in the nurse's office.

PROCEDURE TITLE: ADMINISTRATION OF OVER THE COUNTER (PRN) MEDICATION

STANDARD: To establish procedures for safe and accurate administration of Over the Counter (OTC) medication. Students with parent/guardian consent for OTC medication administration may be treated with approved OTC medications for minor medical symptoms.

PROCESS: Medication will be administered by ERC staff licensed to administer medication or ERC staff with specialized training in medication administration (Performed and documented by RN)

SKIN PROTECTANT OINTMENT APPLICATION

Nursing staff will provide education regarding appropriate use of diaper rash ointment. Classroom staff will sign the OVER THE COUNTER DIAPER RASH OINTMENT INSERVICE/SKILL CHECK form. The form will be signed by nursing staff and sent to RI to be added to the employee education file. Nursing staff will maintain a list in each classroom book of students who **do not** have consent for diaper rash ointment (this information will be placed on the whiteboard in the classroom for easy access of information by classroom staff and/or written on the IHP list on the back cover of the classroom information book.

OTC DIAPER RASH OINTMENTS WILL BE STORED IN THE CLASSROOM OUT OF THE REACH OF CHILDREN.
 A&D ointment will be kept in the classroom for use by staff.

DESITIN OINTMENT (zinc oxide) will be used only upon instruction from the nursing staff. After assessment of skin; nursing staff may instruct classroom staff to apply Desitin ointment to diaper area for a designated length of time. (IF THE PARENT HAS SIGNED OTC CONSENT FOR DESITIN) The Desitin will be placed in a plastic bag and labeled by nursing staff with the child's name. The Desitin ointment may be kept in the classroom after it is labeled, for the duration of use, then returned to the nursing staff. NURSING STAFF WILL NOTIFY PARENT/GUARDIAN OF SKIN CONDITION AND USE OF DESITIN, AND DOCUMENT ON THE OTC MAR. NURSING STAFF WILL RE-ASSESS CHILD'S CONDITION AND INSTRUCT STAFF/NOTIFY PARENT GUARDIAN REGARDING CONTINUED/DISCONTINUED USE OF DESITIN.

PRESCRIPTION OINTMENTS will require a physician's order and will be applied by nursing staff or ERC staff specially trained in the application of the ointment. Documentation of the staff training may be performed by nursing staff and will be documented in a nurse's note.

A&D ointment may be applied by classroom staff for MINOR skin dryness, chaffing, or for protection from irritation (children in diapers).

SUNSCREEN APPLICATION

New employee orientation includes information about appropriate use and application of sunscreen. Classroom staff will sign the APPLICATION OF SUNSCREEN INSERVICE/SKILL CHECK FORM during new employee training. The form is sent to administration and placed in the employee file. Parent/guardian consent is required for application of sunscreen. Nursing staff will maintain a list in each classroom book of students with current consent for sunscreen application.

SUNSCREEN WILL BE STORED IN THE CLASSROOM OUT OF THE REACH OF CHILDREN

NO AEROSOL SPRAY SUNSCREEN; TOPICAL ONLY

Refer to the classroom health instructions for details about sunscreen application.

Parent/guardian may send sunscreen for their child. Sunscreen sent from home will be labeled with child's name.

Sunscreen will be applied to students (with current consent) by classroom staff prior to exposure to sun. Students without parent/guardian consent will not play in areas with sun exposure.

The **PERMISSION FORM FOR OTC MEDICATION** will be completed and signed by the parent/guardian. The nurse will review and cosign the form.

Parent/guardian must initial beside each medication for which they give consent. Parent/guardians who do not wish their child to receive OTC medications will initial the statement declining consent on the form and sign the form. The original form will be placed the student's chart and a copy maintained in the Nursing MAR book

The OTC side effect information sheet will be given to the parent/guardian when signature on OTC consent form is obtained. Only medications listed on the OTC form may be given without a physicians order. OTC medication will only be given to children of the appropriate age for label dosage instructions.

FOLLOW ALL LABEL INSTRUCTIONS FOR ADMINISTRATION OF OTC MEDICATION

Prior to administration of any OTC medication;

1. Check child's age against label instructions for medication
2. Check child's allergies
3. Check the chart to confirm parent/guardian consent.
4. Before administration of oral OTC medication (Acetaminophen/Ibuprofen) Contact the parent/guardian to inform them of child's symptoms and to confirm if any OTC medication was given prior to school.

(If the student has been at school the appropriate length of time required between medication doses; medication administration may be completed without parent/guardian contact, if consent form is current).

Medications will be administered according to label instructions.

The six rights of Medication Administration will be observed

- ☑ Right student
- ☑ Right medication
- ☑ Right dose
- ☑ Right time
- ☑ Right route
- ☑ Right documentation

FOLLOW STEPS FOR SAFE MEDICATION ADMINISTRATION

These steps will be followed by all Nursing staff/medication trained ERC staff every time medication is administered:

- A. Remove drug from medication storage area check expiration date of medication (do not administer expired medication)
- B. Double check the medication label instructions against the child's information (medication, age, appropriate dose)
- C. Make proper identification of the student prior to medication administration with the following steps:
- D. Confirm the identity of the child by stating the child's first and last name to classroom staff and requesting they verbalize the child's first and last name.
- E. Call the child by name (if age appropriate)
- F. If further confirmation of identity is required refer to the site coordinator to obtain identification

FOLLOW UP ASSESSMENT WILL BE COMPLETED AND DOCUMENTED AFTER ADMINISTRATION OF PRN MEDICATION, INCLUDING PRN OTC MEDICATION TO DETERMINE EFFECTIVENESS OF MEDICATION AND ASSESS CONDITION OF CHILD.

DOCUMENTATION OF OTC MEDICATION

OTC/ MAR documentation will be completed at the time of medication administration. The OTC/MAR form will be used to document all OTC medications. The time of administration will be written under the date of administration and the initials of the staff administering the medication will be written underneath the time. Sign and initial the OTC MAR form.

Sunscreen application does not require MAR documentation

A&D ointment application does not require MAR documentation

Desitin ointment requires nursing staff documentation by initial placed under the date. No times are required, as the ointment may be applied several times by classroom staff. Nursing staff initial under the date the application was initiated and on all following days of use.

Nursing staff will document symptoms observed and OTC medication administered in Health note T-log in Therap. Document follow up information on the same T-log. If the student leaves school before time allows for follow up, document it on the T-log.

T-log PARENT/GUARDIAN NOTIFICATION will be completed by nursing staff and a copy sent home to child's parent/guardian. (communications in person and by phone with parent/guardian will be documented in a T-log and a copy of the T-log documentation sent home; the T-log may be sent home the following day if the communication happened at the end of the school day without time to send the T-log home)

The school nurse will notify the student's parent/guardian of administration of any OTC/PRN medications and the student's symptoms; with the exception of preventative skin ointment (A&D) and sunscreen application.

ADMINISTRATION OF OTC MEDICATION FROM MULTIDOSE CONTAINER

complete an OTC lot# form for each multi-dose container the form should include name of medication, the lot number and the expiration date of the medication, when OTC medications are administered document the students name on the corresponding OTC sheet with date of administration.

after the multi-dose bottle of medication is discarded place completed forms in nursing office file.

complete a new sheet for each new multi-dose bottle of medication

check these forms monthly and order needed OTC medications via site coordinator before medications expire then discard medications when they expire

(H) PROCEDURE TITLE: SPECIALIZED HEALTH CARE PROCEDURES

Standard: performance of specialized health care / medical

Procedures according to physician orders

Process: identify students who require specialized health care procedures to be performed while they are attending school.

the parent/guardian will provide information to the nursing staff regarding the procedure during the conference meeting. This information will be documented on the MHI form and scanned to the RN via secure email (Therap). The parent/guardian will sign the parent consent for medication/treatment form. Physician orders/instructions for the procedure will be placed in the hard chart and a copy will be placed in the mar book procedures will be documented on a MAR sheet additional information may be documented on health note t-log or nurses note t-log

The specialized healthcare procedure will be included in the student's IHP/medical care plan and all ERC staff with direct contact with the student will be educated about the procedure.

Example of specialized health care include: GI feedings, catheterizations, CBG checks

(I) PROCEDURE TITLE: CONTAGIOUS / COMMUNICABLE CONDITIONS

Key Criteria for exclusion of children who are ill: when a child becomes ill but does not require immediate medical help, a determination must be made regarding whether the child should be sent home. (excluded from preschool) Most illnesses do not require exclusion. The nursing staff will make the determination and may use information from the classroom staff, assessment of the child, communication with parent, consultation with RN, to make the determination. Key factors:

1. Does the illness prevent the child from participating in activities?
2. Does the child's illness result in a need for care that is greater than the staff can provide?
3. Does the child's illness pose a risk of spread of *harmful* disease to others?

Excluding children with mild illnesses is unlikely to reduce the spread of most infectious agents (germs) caused by bacteria, viruses, parasites, and fungi. MOST INFECTIONS ARE SPREAD BY CHILDREN WHO DO NOT HAVE SYMPTOMS. They spread the infectious agent (germs) before or after their illnesses and without evidence of symptoms. Exposure to frequent mild infections helps the child's immune system develop in a healthy way. As a child gets older s/he develops immunity to common infectious agents and will become ill less often. Since exclusion is unlikely to reduce the spread of disease, the most important reason for exclusion is the ability of the child to participate in activities and the staff to care for the child. The terms contagious, infectious, and communicable have similar meanings. A fully immunized child with a contagious, infectious, or communicable condition will likely not have an illness that is harmful to the child or others. Children attending preschool frequently carry contagious organisms that do not limit their activity nor pose a threat to their contacts. Hand and personal hygiene is most important in the prevention of spreading of the organisms (germs).

TEMPERATURE: Remember when taking a child's temperature; The amount of temperature elevation varies at different body sites and varies depending on the type of instrument used to check the temperature.

The height of fever does not indicate a more or less severe illness.

STANDARD

ANY CHILD WHO BECOMES ILL AND UNABLE TO PARTICIPATE in daily activities shall be separated from other students; supervised, and parents shall be called to pick up the child as determined by assessment of the nursing staff.

process: the child will be separated from the other children/physical contact with other children will be discouraged by classroom staff. children with suspected mild contagious illnesses or exhibiting mild/moderate symptoms of illness will be maintained in the classroom with monitoring by classroom staff and nursing staff. children with severe symptoms may require 1:1 monitoring by the nurse or designated staff in the nursing office or designated area. The determination will be made by the nurse based upon assessment of symptoms and condition. parent/guardian will be contacted by nursing staff and symptoms, changes, abnormalities in the child's condition, will be discussed with the parent. if the symptoms/illness are mild and the child is able to participate in school and therapy activities the parent may choose to allow the child to remain at school. if the symptoms are more severe and/or the child is unable to participate in activities nursing staff may request the parent/guardian pick up the child to allow rest at home or nursing staff may recommend the child should be evaluated by a physician.

Nursing staff may require a physician note for return of student to school if the symptoms are highly suspicious of a vaccine preventable contagious condition or the symptoms are severe and confirmation that physician assessment has occurred is necessary. Nursing staff may request that student remain fever free for 24 hours prior to return to school if the symptoms are highly suspicious of influenza (during the influenza season) The RN should be consulted regarding questions of appropriate disposition/recommendations of students. The RN will utilize the a American Academy of Pediatric guidelines, national health and safety performance standards guidelines for early care and education programs, DHS guidelines, and the local health department recommendations regarding communicable disease and school attendance when determining school attendance requirements

THIS PROCEDURE CONTAINS INFORMATION ABOUT CONTAGIOUS DISEASES AND ILLNESSES. IT IS A GENERAL GUIDELINE. Physician orders/notes, health department recommendations, specific disposition of children will be decided individually. Vaccine preventable contagious diseases are of immediate concern and the RN and parent should be notified. Any child with a suspected Vaccine preventable illness will be removed from the classroom and monitored in a separate area until pick up by parents for physician assessment. The nursing staff will determine if the illness appears to pose a risk of the spread of **Harmful diseases.**

For common minor contagious illnesses such as Respiratory and GI viruses the nursing staff will determine if the illness prevents the child from participating comfortably in activities or results in a greater need for care than the child care staff can provide.

Nursing staff will temporarily exclude children from school when they have:

Lethargy, complete lack of participation that is not normal for that child. Unexplained irritability and/or persistent crying that is determined by nursing staff to be related or likely related to illness rather than behavioral or environmental causes.

Difficulty breathing will be assessed by nursing staff and treated; referred to parent for assessment by physician or EMS activated dependent upon assessment findings.

A **quick spreading rash** will be assessed by nursing staff and parent contacted for physician assessment or EMS activated; dependent upon assessment findings.

Fever of 101f or greater **who also have pain, behavior changes indicating illness, or other symptoms of illness.** (not explained by a chronic illness or a known (diagnosed) acute illness currently under treatment by physician)

Fever in an infant younger than two (2) months will require assessment by a physician within an hour

Fever in an infant younger than 6 months will require assessment by a physician

Diarrhea: defined as watery/runny stool, if more than two (2) **above normal for that child** (not explained by chronic condition or known (diagnosed) acute illness currently under treatment by physician) not related to dietary change or medication.

Nursing staff will observe child's stool to determine diarrhea (watery/runny stool) vs loose or soft formed stools.

Blood or mucus in stool will be assessed by nursing staff to determine likely cause by hard stool/constipation or acute illness requiring physician assessment.

Vomiting: two or more occasions (observed by staff or reported by parent/guardian) within past 24 hours (not explained by a chronic illness or known (diagnosed) acute illness currently under treatment by physician) Nursing staff will observe emesis to differentiate between possible reflux (spitting up a small amount of regurgitated stomach content usually occurring children under age 2 and/or children with GERD) Vomiting undigested or partially digested food (possible motion sickness if upon arrival via transport; possible viral illness; possible food aversion. Vomiting mucus or undigested/partially digested food containing a large percentage of mucus (possible drainage related vomiting, usually accompanied by runny nose and/or nasal/upper airway congestion)

Abdominal pain will be assessed by nursing staff to determine need for physician assessment or monitoring.

Rash: (not fast spreading) with fever or behavioral changes indicating physical/medical symptoms.

Mouth sores with drooling

Sore throat: if associated with fever or swollen glands in neck. possible strep throat; a bacterial infection which is contagious before the symptoms appear. requires antibiotic treatment. child may return to school after 24 hours of antibiotic treatment.

Scarlet fever (scarlatina): a child with strep throat may develop scarlet fever. fever 101-104 f. red, slightly raised rash lasting 3-5 days may result in skin peeling after rash subsides. requires antibiotics to treat the primary strep bacterial infection. may return to school after 24 hours of antibiotic treatment.

Severe coughing: episodes of coughing which may lead to repeated gagging, vomiting or difficulty breathing (not explained by a chronic illness or an acute illness currently being treated) whooping cough (pertussis) is an uncommon contagious condition caused by a bacteria. a severe cough is the dominant symptom. child may have cold symptoms for 1-2 weeks then cough worsens. requires antibiotic treatment. child may return to school after 24 hours of antibiotic treatment.

PINK EYE: laymen's term for pink or red eye discoloration; the medical condition/diagnosis is conjunctivitis: indicated by pink or red conjunctiva (outer layer of the eyeball) there may be white, yellow or green eye mucus/ drainage and matted eyelids after sleep. This is a self-limiting infection and does not require exclusion from school; Parent/guardian should be contacted with recommendation to consult their physician (many physicians do not feel it is necessary to examine or treat primary conjunctivitis) Treatment may be provided by physician but is not required the infection is self-limiting.

Exception: if two unrelated children in the same class have symptoms, the organism causing the conjunctivitis may have a higher risk for transmission and the RN should be consulted regarding exclusion.

Exclude if the child has fever; eye pain (not itching but pain) or there is severe swelling and redness to the tissue/skin surrounding the eyes. (indicates possible cellulitis, the parent should be notified and instructed to contact the child's physician).

RING WORM: a fungal infection of the scalp or skin. Usually appears first as a red scaly patch that may develop into round or oval areas with smooth centers and scaly borders. Scalp ring worm contagious through sharing combs, brushes, hats, barrettes, bike helmets. Ring worm on body parts other than scalp may be of a type spread by cats and dogs. cover the area with band aid if other than scalp treated with antifungal (may return to school after evaluation and under treatment as instructed by physician) cover area with band aid while at school. Contact parent/guardian and report suspected ringworm recommend they contact physician. Note that red circular dry patches of skin occur with Eczema and may look similar to ringworm; check with parent regarding Eczema diagnosis.

IMPETIGO: a contagious bacterial skin infection. red sores on the face usually around the mouth and nose. impetigo usually clears up on its own in 2-3 weeks, but since it is contagious and the child could develop complications it is usually treated with antibiotics. child may return after 24 hours of antibiotic treatment or a physician note to return to school.

SCABIES: a parasite of the skin. red rash of small elevations in the skin that often appear to form lines. The parasite leaves a trail of allergic reaction to excreted fecal matter. may return after treatment (topical)

HEAD LICE: Exclusion for treatment of an active lice infestation may be delayed until the end of the day. Contact parent/guardian and report infestation/suspected infestation. Child may return to school after treatment.

No follow up exam by nursing staff is required; only verification from parent that the child was treated. The presence of nits or suspected nits is not considered an infestation and requires no action other than parent notification of observation. New treatments for head lice do not require removal of nits therefore the presence of nits does not indicate that treatment was not provided or effective.

HAND, FOOT, MOUTH DISEASE: Multiple sores inside mouth with drooling: after treatment by physician: unless health care provider determines the condition is non-infectious (note from physician) hand, foot, and mouth disease is a contagious viral condition. Children are contagious 3-7 days before symptoms begin. fever, sore throat, HA, decreased appetite, red rash on hands and soles of feet (usually no itching), sores/blisters in mouth including tongue and gums. Child will require **physician note** for return to school.

RSV: (respiratory syncytial virus) common contagious respiratory illness. spread by secretions or airborne droplets. can lead to pneumonia or bronchiolitis. Common outbreaks in winter and early spring. child is contagious for 2-4 days. will require **physician note** for return to school.

MEASLES: rare but contagious condition demonstrates high fever and rash. contagious 4 days prior to rash and 4 days after start of rash. diagnosis would require **physician note** for return to school and/or health department consult.

RUBELLA: (German measles): rare but contagious. Usually presents with low grade fever and a pink rash that varies but generally begins on the face then moves down the body, disappearing from the face as it moves downward. Swollen glands at back of the neck and/or behind the ears. Child diagnosed would need to remain out of school 7 days from the date of rash appearance. **Physician's note** required

ROSEOLA: common contagious illness usually in children less than 2 years of age. begins with fever 102-105 f. for 3-7 days followed by rash (spotty raised rash on trunk/arms lasting only 24 hours) rash begins after fever resolves. may exhibit mild diarrhea, slight cough, runny nose, irritability, eyelids may swell. if diagnosed by physician will require **fever free for 24** hours before return to school **or a note from the physician** indicating the child may return to school.

CHICKEN POX: common contagious illness. children are contagious 1-2 days before blisters appear. raised red papules, itchy. May return to school in 5-7 daysafter all blisters have crusted over. the condition is contagious 24 hours after the last new blister. parent/guardians will be notified of any possible exposure to a

contagious illness as soon as possible. a letter informing the parent/guardian of an exposure or possible exposure to a potentially contagious illness will be sent home with general information regarding symptoms of the condition, and instructions to contact the student's pediatrician for further information, or if symptoms appear. refer to the exposure notification letter located on the k-drive under nursing forms potentially contagious conditions include but are not limited to:
fifth disease /certain types of conjunctivitis (pink eye) / Influenza / whooping cough / roseola / rubella / chicken pox / strep throat / ringworm scarlet fever / impetigo / mumps / RSV / measles

(J) Procedure title: Reportable/communicable diseases

Standard: identified communicable diseases in students will be reported appropriately

Process: identification of suspected communicable diseases should be reported to the student's parent/guardian by the nursing staff, with instructions to contact the student's physician reportable communicable diseases are reported by the physician's office. In the event the school nurse is requested by the physician to report a communicable disease; access 1-800-482-8888 the toll free reporting system **children with medical exemptions from immunization or under the age appropriate for vaccination may need exclusion from school if a possible exposure to a vaccine preventable disease occurs.**

immediate notification is recommended for the following.

notify the RN of diagnosis

- Hepatitis
- measles/rubella
- Whooping cough (pertussis)
- Meningitis
- Mumps
- Tuberculosis
- Salmonella
- e-coli

Clusters of communicable diseases may be identified in the preschool setting and reported by the preschool nurse. Diagnosed children may have various physicians and cities of residence making the common factor the preschool setting. The school nurse should utilize all resources when dealing with suspected communicable diseases. Consultation with supervising RN, contact with the local health department for current information, the treating physician when appropriate. Report all suspected communicable disease exposures to the RN.

Report any apparent clusters of communicable disease or similarity of symptoms to the RN. All suspected clusters, suspicious illnesses, will be reported to the local health department by the RN. The RN will communicate with the local health department regarding questions of communicable disease.

Procedure title: Parent notification of possible communicable disease exposure

Standard: follow department of human services licensure guidelines to ensure that all suspected exposures are reported to parent/guardians.

Process: Nursing staff will send letters home to parent/guardians along with information sheets regarding possible exposures. When a child is diagnosed with a communicable disease (refer to communicable disease procedure) a letter will be sent home with student's to notify the parent/guardian of the possible exposure. Letters will be sent home with all students. A diagnosis of communicable disease may come from the physician/office or the parent may relay that diagnosis to the ERC nursing staff. Certain potentially communicable conditions will not require physician diagnosis. ERC nursing staff may identify suspected; head lice, scabies, ringworm, or other conditions that require notification. ERC nursing staff will consult with the RN regarding questions of diagnosis or notification.

DOCUMENTATION:

PURPOSE: To ensure communication of pertinent information between the school nurse and the student's parent/guardian

STANDARD: The student's parent/guardian will receive notification from the nursing staff regarding possible exposures to contagious conditions.

PROCESS: Write a T-log in Therap for the student diagnosed or showing symptoms of a possible communicable illness. In the summary section name the document COMMUNICABLE ILLNESS LEVEL 1, 2 or 3 AND NAME THE DIAGNOSED OR SUSPECTED ILLNESS. Example: Communicable illness/level 2/strep throat (Refer to the communicable levels list below to determine if the illness is Level one, two, or three. If the illness is not listed; contact the RN for level determination)

Document the method by which the information was obtained; diagnosed by physician, symptoms reported by parent or symptoms observed by ERC nursing staff. At the end of the T-log write:

EXPOSURE NOTIFICATION SENT to document that you are sending letters and information forms home.

At the bottom of the form select FOLLOW UP as the type of form. The

document will be printed and placed in the EXPOSURE NOTIFICATION file folder in the nursing office.

CLASSIFICATION SYSTEM FOR COMMUNICABLE DISEASE

LEVEL 1 – EMERGENT COMMUNICABLE CONDITIONS REPORTABLE TO STATE HEALTH DEPARTMENT

HEPATITIS A

E-COLI

MEASLES/RUBELLA

SALMONELLA

WHOOPING COUGH (PERTUSIS)

TUBERCULOSIS

MENINGITIS

MUMPS

INCLUDING COMMUNICABLE DISEASES EVALUATED AS LEVEL ONE BY REGISTERED NURSE

IMMEDIATE NOTIFICATION/HEALTH DEPARTMENT IS REQUIRED FOR THESE DIAGNOSIS

LEVEL 2 –COMMUNICABLE DISEASES WITH HIGH RISK OF TRANSMISSION/HARM IN THE PRESCHOOL SETTING

INFLUENZA

FIFTH'S DISEASE

STREP THROAT

ROSEOLA

CHICKEN POX

MRSA INFECTIONS

RSV

INCLUDING COMMUNICABLE DISEASES EVALUTATED AS LEVEL TWO BY REGISTERED NURSE

LEVEL 3 – COMMUNICABLE DISEASES WITH LOW RISK OF TRANSMISSION AND/OR LOW RISK OF HARM

SCABIES

IMPETIGO

PINWORMS (All types of tapeworm infestations)

CONJUNCTIVITIS (if diagnosed by physician as contagious conjunctivitis; or more than one child in the same room with symptoms of conjunctivitis)

RINGWORM

HAND, FOOT, MOUTH DISEASE

INCLUDING COMMUNICABLE DISEASES EVALUATED AS LEVEL THREE BY THE REGISTERED NURSE

(K) PROCEDURE TITLE: PARENT/GUARDIAN NOTIFICATION

Purpose: To ensure communication of pertinent information between nursing staff and the student's parent/guardian

Standard: The student's parent/guardian will receive notification from the Nursing staff regarding health/medical issues

Process: The nursing staff will notify the student's parent/guardian by phone and/or by written notification of any health/medical issues addressed by the nurse during school hours. The T-log will be utilized. In the summary section name the document PARENT/GUARDIAN NOTIFICATION.

At the bottom of the form select CONTACT as the type of form. The document will be printed and sent to parent/guardian and the electronic document will be retained for the student's records.

The nursing staff will attempt to notify the student's parent/guardian by phone for health issues other than very minor symptoms/injuries or if the symptom/treatment is ongoing/frequent and the parent is aware. Phone contact with parent/guardians will be documented in a T-log in Therap. If nursing staff are unable to make contact with the parent/guardian; questions regarding treatment will be directed to the RN. If symptoms/injury are severe/emergent and immediate medical treatment is required; initiate care through the emergency medical service system.

(L) PROCEDURE TITLE: NURSING STAFF DOCUMENTATION GER/T-LOG

PURPOSE: Establish guidelines for the documentation of General Event Report Forms (GER), Nurses Notes, Parent Notification notes, and all required documentation procedures.

STANDARD: Nursing staff will document using the Therap electronic system.

Reported or observed information regarding accidents, Injuries, medical symptoms, as well as assessments will be documented on the day of the event. All communications with parent/guardian, physician, dietician, and other health care professionals will be documented on the day of occurrence.

PROCESS: GER (General Event Report) will be used to document reported or observed accidents/injuries and the assessments completed post accident/injury. The T-Log (named according to the symptom; vomiting, fever etc.) will be used to document reported or observed medical symptoms and the completed assessments of those symptoms. The T-log will be used to document Parent/Guardian notification/communication. The T-log will be used to document Nursing/medical information, communications not related to direct assessment of a child.

WHEN AN INJURY/ACCIDENT INVOLVING A CHILD IS REPORTED, A **GER** WILL BE COMPLETED AND A T-LOG PARENT NOTIFICATION SENT HOME TELLING THE PARENT ABOUT THE INJURY/ACCIDENT WHEN NURSING STAFF COMMUNICATE WITH A PARENT REGARDING THEIR CHILD (In person or by phone) THAT CONVERSATION IS DOCUMENTED IN A **T-LOG NURSES NOTE OR PARENT NOTIFICATION DEPENDING ON THE CONTENT OF THE CONVERSATION** WHEN NURSING STAFF COMMUNICATE WITH OTHER HEALTH CARE PROVIDERS REGARDING A STUDENT (PHYSICIAN, PHYSICIAN'S NURSE, NUTRITIONIST, PHARMACY, HEALTH DEPT, REGISTERED NURSE, ETC) A **T-LOG NURSES NOTE** IS COMPLETED DOCUMENTING THE CONVERSATION.

WHEN NURSING STAFF PERFORM AN ASSESSMENT OF OBSERVED OR REPORTED MEDICAL SYMPTOMS A **T-LOG HEALTH ASSESSMENT** WILL BE COMPLETED

ACCIDENT/INJURY

Assessment/treatment of the child will be completed; then the documentation process will be completed as follows:

Classroom staff will report accidents/injuries/medical symptoms to the Nursing staff. If the event is an accident/injury the classroom staff will complete an Injury Report form and provide this form to nursing staff. The report will be reviewed by nursing staff for completeness of information. If further information/clarification is needed, nursing staff will request classroom staff to provide additional written information on the Injury Report form. The information from the Injury Report form will be used by nursing staff when completing the GER on the accident/injury. The GER documentation will be marked *Injury* and the narrative description will begin with the information reported on the Injury

Report form. I.e. *classroom staff (name may be inserted) report that the child was running on the playground and fell on his knees, scraping them.* The narrative will continue with nursing staff assessment/treatment. I.e. *minor nickel size abrasions to knees with redness, no bleeding. No other injuries observed. child tearful initially, states he fell on the playground and says he was running. Abrasions cleaned with saline, band aids applied. Child cooperative, quickly stops crying and returns to play without limitations.* The Injury Report form completed by classroom staff is filed in a labeled folder (nursing office) and kept on file for one month then shredded.

MEDICAL SYMPTOM

Classroom staff will report observation of or suspected medical symptoms to the nursing staff. After assessment /treatment of child, nursing staff will document the information in a T-log. The T-log will be named according to the medical symptoms/condition (vomiting, rash, fever, cough, etc.) A narrative documentation will be completed based on the classroom staff report and the assessment completed by nursing staff. Quotes from staff may be included if pertinent i.e. child has not been participating, has c/o of pain or physical symptoms to the classroom staff, was observed by classroom staff while symptom occurring such as vomiting, diarrhea, holding/pulling at ears, ex. Classroom staff reports that child has been tearful and pulling at left ear. This will be followed by documentation of the assessment ex. Child alert/active, admits to pain in left ear, temperature is 100.4F temporal, no drainage or external abnormalities to either ear. Lung sounds clear bilaterally, no nasal drainage, no other symptoms observed. Classroom staff report intake normal and decreased participation in classroom activities.

GENERAL EVENT REPORT (GER)

The GER (General Event Report form in Therap electronic documentation program) will be completed by the nursing staff upon the report or observation of accident/injury/medical symptom. Documentation should be concise and complete, including description of symptoms, assessments, treatment, and outcomes when appropriate. All completed GER s will be reviewed by the Registered Nurse. GER's will be completed on the day of the event. Completed documentation on the GER will be maintained in the electronic student record.

Classification of GER. The notification level of GER may be low, medium or high, based upon the severity of the event. Medical symptoms or accident/injuries requiring assessment with no treatment would be classified as low notification level.

Medical symptoms or accident/injuries requiring minor medical treatment, the student sent home from school and/or recommended physician visit, the use of PRN medication with stable condition, would be medium notification level.

Medical symptoms or accident/injuries emergency treatment/EMS activation, immediate transport by parent/guardian to physician's office, use of a newly obtained PRN order to treat new onset medical symptoms, prolonged monitoring of student condition post medical symptom/injury, would be high notification level or an incident with no major medical treatment required, but potentially life threatening i.e. choking, seizure, or an accident that had potential to cause serious injury.

GENERAL EVENT REPORT (GER) DETAILED PROCEDURE

To complete a GER; sign on to Therap and the Dashboard will be your initial page – click INDIVIDUAL from the selections on the left side of page – then General Event Report (GER) will be listed on the screen with a choice of new/search....search allows you to look for GER's by child, staff, or date of completion. New – allows you to create a GER. Click new and the next CDC Complete Nursing Procedures (4-2014) 41 screen presents preschools listed by name, select the correct preschool by clicking on the name (in blue) on the left side. A student list will be presented and you may select a student from the list by clicking on the student name. (click on a letter from the letter bar and the student names will be displayed alphabetically by last name) Once the student is chosen the blank GER opens.

GER FORM

Students name will appear as well as the location; at the top of the form. The report date will auto fill to the current date. The Event date auto fills (all GER's should be reported on the date of the occurrence). (The event date can be changed if necessary under instruction by the RN. IF NOT AT RESPONSIBLE PROGRAM - only required if the event occurred in a location other than the school – home, transport van/bus.

DESCRIBE WHAT HAPPENED BEFORE EVENT - section available for narrative report on activity prior to event. Usually not necessary, this information should be included in the narrative section of injury report.

Under Location Address – click SAME AS PROGRAM and address of school will auto fill

ADD EVENT – choose event type INJURY OTHER MEDICATION ERROR

Choose INJURY for documenting accident/injury information and assessment

A new window will open - select injury type, injury cause, time of injury, injury severity, body part.....from drop down boxes. Select observed or discovered.

INJURY SUMMARY is where the narrative description of the reported event and the nursing assessment are documented. Type in the information in narrative format.

Click ADD at the bottom of the page and this information is added to the GER form; you may return to the data by clicking edit and make additions or changes if needed.

Choose OTHER for documenting medical symptoms non accident/injury related; such as cough, vomiting, diarrhea, etc.

A new window will open and you will select CHANGE IN CONDITION from the drop down box under event type. Choose time, observed or discovered and the event summary will include the narrative description of the symptom, assessment, and treatment if indicated; as well as any follow up documentation regarding the medical symptom. *i.e. follow up assessment at 10:30AM; classroom staff report child with no further coughing, RR 28 and unlabored, lung sounds clear bilaterally, temp 98.5F temporal, child is awake, active, playing with peers.*

Click ADD at the bottom of the page and this information is added to the GER form, you may return to the data by clicking edit and make additions or changes if needed.

Choose MEDICATION ERROR if appropriate and fill in information regarding error. RN will give specific instructions for documentation of Medication/Treatment errors.

ALL MEDICATION ERRORS OR SUSPECTED ERRORS MUST BE REPORTED TO THE RN AT THE TIME OF OCCURRENCE OR DISCOVERY.

The next section of the GER form is GENERAL INFORMATION – answer yes/no to abuse suspected, neglect suspected, IF THE ANSWER IS YES AND ABUSE OR NEGLECT IS SUSPECTED THE PRESCHOOL COORDINATOR AND THE RN MUST BE NOTIFIED IMMEDIATELY AND ASSISTANCE WILL BE OFFERED IN COMPLETION OF THE DOCUMENTATION.

INTERNAL REPORT ONLY Yes/No.....YES this is created as an internal report but the guardian may request copies of any or all GER completed on their child. Answer NO if the assessment is about a condition that is reported to DHS; because it is created as an external report to be shared with DHS.

NOTIFICATION LEVEL – select HIGH, MEDIUM, LOW – refer to previous section regarding selection of notification levels.

Your name will auto fill as the person completing the report – Reporters relationship to the individual – select STAFF from drop box.

NOTIFICATION section. Click ADD NOTIFICATION and enter the name of the person notified, select description from drop box that describes the person notified. Enter time of notification. Choose type of notification from drop CDC Complete Nursing Procedures (4-2014) 43 box; direct (in person), by phone, or choose other and type in note sent home at the box to the right.

THE SITE COORDINATOR MUST BE NOTIFIED OF ALL GERs AND SHOULD BE ON THE NOTIFICATION LIST NOTIFICATIONS OF THE RN, PHYSICIAN, DHS, etc. are added to the notification list when appropriate ACTIONS TAKEN OR PLANNED section

CORRECTIVE ACTIONS TAKEN – This may simply state – assessment completed or child sent home with parent or EMS Activated or PRN medication administered. It is a simple description of the action taken.

PLAN OF FUTURE CORRECTIVE ACTION – This may simply state – treatment provided or parents taking child for physician assessment or classroom staff will continue to monitor and report any changes in condition to the nurse or will complete follow up assessment upon child’s return to school.

Upon completion of the GER clicking SUBMIT at the bottom of the form will send the report for RN review after approval by the RN the GER will be saved as part of the student’s electronic record. Proofread your documentation prior to submitting. All GER’s will be reviewed by the RN and returned with feedback if changes/clarifications are required. The GER will be listed in your work list under the TO DO section on the Dashboard. Check this section frequently and respond promptly to request from the RN for editing/information.

The GER may be saved for proofreading later and/or for the addition of follow up information. Click SAVE and the GER will be added to your work list under the TO DO section on the Dashboard. You may then add/edit information later in the shift. The RN has access to the information while it is saved. It is designated as In Progress to identify that you have not completed the documentation.

PARENT/GUARDIAN NOTIFICATION/T-LOG

To ensure communication of pertinent information between the school Nursing staff and the student’s parent/guardian, nursing staff will notify the student’s parent/guardian in person, by phone, or by written notification of any health/ medical issues addressed by nursing staff during school hours.

The nursing staff will create the parent/guardian notification in the T-log. To create a T-log note, sign on Therap and the Dashboard will be your initial page. From the left side column select INDIVIDUAL T-log will be listed on the screen with choices new/search - select NEW – The screen will then list the preschool choices; select a preschool by clicking the name of the preschool (in blue) on left. Select a student from the list (you may click on a letter from the letter board and the students will be listed alphabetically by last name) click on the students name and a T-log opens. The child’s name is on the form and you will fill in the SUMMARY – type PARENT/GUARDIAN NOTIFICATION and in the body of the form type your information. Request to contact the nurse, recommendation to follow up with the student’s physician, instructions to provide a note from physician before child returns to school, Instructions to await resolution of symptoms before child returns to school, requests for medication refills, notification of symptom treated with PRN medication; are types of information that may be included in the Parent/Guardian Notification. Information should be brief, concise, and professional. Avoid medical terminology. *Ex. Dear parent (you may insert name) your child was seen today by the nursing staff for: falling while running on the playground I observed a small scraped area on his left knee and cleaned it off and put on a band aid. He returned to play. Please follow up with your Physician if any problems develop. Feel free to contact me..... (provide contact information)*

At the bottom of the note select CONTACT. This document will then be filed under contact. When the form is complete and has been proofread, click submit at the bottom of the page. Choose view this T-log

from the next screen and click PDF at the bottom of the T-log – print the form and send home to the parent/guardian.

NURSES NOTE/T-LOG

The nursing staff will document nurse's notes in the T-log section of Therap. In the summary section type in Nurses Note as the title of the note. At the bottom of the note select NOTES. These forms will be utilized by the nurse for documentation of information not contained in GER/PARENT/GUARDIAN NOTIFICATION T-LOG OR HEALTH NOTE T-LOG. Parent or physician reported diagnosis, changes in treatments, medications, or medication doses;

Information pertinent to the medical condition of the child; but not related to an assessment of an injury or medical symptoms of the child (these would be documented in GER/HEALTH NOTE T-LOG) The Nurses Note will be maintained as part of the student's electronic record.

NURSING STAFF DOCUMENTATION MAR BOOK

The Medication administration records will be maintained in the MAR book along with copies of all pertinent information.

Nursing staff are responsible for maintaining the MAR book and all required contents. Each preschool MAR book will use the same format and forms, allowing consistency and accuracy of care by any member of the nursing staff.

Information in the MAR book will include these forms in this order and presentation.

The DAILY SCHEDULE –MAINTAINED ON COMPUTER K-DRIVE AND PAPER FORM IN MAR BOOK. This form provides a time detailed list of all tasks to be completed by nursing staff; including medication administration, treatments, medical equipment to be checked, students requiring daily observations, and any other pertinent information. Names of classroom staff that are trained and authorized to perform these tasks (documented/signed by RN) will be listed on the form. The paper form may be updated in pencil for temporary changes (such as antibiotic administration for a few days) as well as to document changes immediately until the electronic copy of the schedule can be updated UPDATE ALL CHANGES IMMEDIATELY; THIS FORM PROVIDES INSTRUCTIONS FOR NURSING STAFF TO COMPLETE NEEDED TASKS AND MUST ALWAYS BE ACCURATE.

The electronic version of the form is located on the K-Drive (go to the center site and then nursing) and will be updated by nursing staff as changes occur.

DETAILED INFORMATION –the 2nd page of the Daily Schedule includes further details regarding the tasks listed on the DAILY SCHEDULE. List each task for which there is specific information and provide details. Special needs/requirements, location and type of equipment used, details of the task such as medication is mixed with pudding, the medication is located in the refrigerator, etc. This information allows tasks to

be completed efficiently by other nursing staff and should include all the necessary information and be updated as changes occur. This document is part of the DAILY SCHEDULE and is located on the K-drive with the Daily Schedule.

MONTHLY NURSING SCHEDULE: tasks to be completed each month will be designated for completion week 1, 2, 3, or 4 of the month.

DETAILED INFORMATION The 2nd page of the Monthly nursing schedule provides details of how to perform the listed tasks. Information specific to the task and to the center.

CLASSROOM DIAGRAM – a diagram of the building with classrooms labeled by name.

CLASSROOM LIST – A list of each student and their current classroom

INDIVIDUAL DIVIDERS LABELED WITH THE NAME OF EACH CHILD, PLACED ALPHABETICALLY BEHIND LETTER DIVIDERS

The information for each child will be placed after their individual divider.

Original forms are filed in the student's hard chart. Copies of the information are maintained in the MAR book. The forms will be placed in the following order:

INDIVIDUAL DATA/INFORMATION FORM – This form has parent/guardian contact information and should be updated as needed. Nursing staff will add pertinent information regarding parent contact, such as language information.

(All students)

MAR FORM for routine or PRN medications/treatments (if applicable)

DIVIDERS WITH RED TABS MARKED MAR WILL BE INSERTED TO IDENTIFY LOCATION OF MAR FORMS (if applicable) COPIES OF PRESCRIPTIONS/PHYSICIAN ORDERS/MEDICATION LABEL

COPIES/DIETICIAN INSTRUCTIONS FOR FEEDINGS/SPECIAL PROCEDURE

ORDERS/TRAFFIC LIGHT ORDERS/ALLERGY PLAN/EPIPEN CONSENT

FORM/SEIZURE PLAN/IHP MEDICAL CAREPLAN (if applicable) DIVIDERS WITH YELLOW TABS MARKED IHP WILL BE INSERTED TO IDENTIFY LOCATION OF IHP/MEDICAL CAREPLANS

COPY OF PARENT CONSENT FOR PRESCRIPTION MEDICATION/TREATMENT

FORM (all students)

COPY OF PARENT CONSENT FOR OTC MEDICATION FORM (all students)

Two sections are included in the back of the MAR book. A section labeled OTC lot#, which will include the current lot # forms for multi-dose OTC medications. (refer to medication Procedure for details) and a section labeled Non-licensed staff Authorization, which will include copies of the non-licensed education & authorization forms for medication administration and/or treatments. These forms document the authorization of classroom staff to perform nursing tasks. These forms are completed and signed by the RN and maintained in the MAR book.

THE FOLLOWING FOLDERS/DOCUMENTS WILL BE MAINTAINED IN THE NURSING OFFICE:

EXPOSURE NOTIFICATION DOCUMENTATION – T-logs documenting exposure notifications sent. These will be maintained in the nursing office for one year and then relocated to permanent filing.

ACCIDENT/INJURY FORMS COMPLETED –Reports received from classroom staff will be maintained in this file for reference for six months then shredded

OTC LOT# FORMS – When a multi-dose container of OTC medication is completed or expires, this form will be placed in the file; then shredded after one year.

LIST OF MHI FORMS REQUIRING RN SIGNATURE (the MHI has been reviewed by the RN electronically and after the form is complete the hard copy requires RN signature)

REFERRAL MHI FORMS/Copies of MHI forms completed at Referral conference awaiting the Programming conference

THE FOLLOWING BLANK FORMS WILL BE PLACED IN LABELED FILES:

(*the forms used in conferences may be placed in separate folders or grouped together based on conference requirements)

MHI (medical history information) FORM

NURSING LETTER TO PARENT

PARENT CONSENT/MEDICATION AND TREATMENT

PARENT CONSENT/OTC MEDICATION

OTC SIDE EFFECT SHEET

USDA FORMS

VISION/HEARING SCREENING FORMS

EPSDT (well child physician form)

UPDATE/REVIEW MHI FORM

THE FOLLOWING BLANK FORMS WILL BE PLACED IN LABELED FILES:

OTC LOT # FORMS

OTC MAR

PRESCRIPTION MAR

DAILY ACTIVITY FORM

PARENT NOTIFICATION ACCIDENT/INJURY (for use if Therap is unavailable)

NURSES NOTE (for use if Therap is unavailable)

(M)PROCEDURE TITLE: STUDENT IMMUNIZATION STATUS/RECORDS

STANDARD: ENSURE IMMUNIZATION RECORDS ARE CURRENT AND ACCURATELY REFLECT THE IMMUNIZATION STATUS OF STUDENTS PROCESS

The ERC policy requires all students to have current immunizations with one exception, a medical exemption from the state of Arkansas. We require the documentation/records be received and reviewed by the immunization nurse before a student begins school. The letter given to parents by the SC when preparing for the referral conference lists immunization records as one of the documents the parent/guardian should bring to the referral conference. If the parent/guardian does not bring the immunization records to the referral conference they should be informed that until the records are received and reviewed to verify immunization status the programming conference cannot be scheduled. The script for services and the immunization records must be obtained prior to scheduling the programming conference. The process requires the nursing staff to send the immunization records to the nurse monitoring immunizations (Huntsville). The records must be obtained and reviewed/approved. The nurse will need ample time to review the records since she receives requests from all CDC. *Please do not tell parent/guardians that we can look up their child's records if they do not have them. The Arkansas immunization website is a resource we can use for verification but frequently does not list all immunizations received and should not be the initial source of our records until all other options have attempted.* A copy of the immunization record should be obtained from the physician office. The will request a copy of the immunization records from the PCP when they request the treatment Script for Day Hab, after the referral conference is completed. The responsibility is with the parent/guardian but we want to be helpful. At the referral conference if the parent/guardian does not have the records but reports they have them or will obtain them; explain to them the records are needed within 48hours of the referral conference to allow time for review.

1. Service Coordinators will make sure the parent understands the need to bring the immunization records to the referral conference (no immunization *confirmation*, no programming conference scheduled) Nursing staff will inform SC when the immunization status is confirmed as current. Only medical exemptions from the State of Arkansas are accepted (refer questions to the RN)
2. Nursing staff: After the referral conference send the immunization information to Linda Malloy in Huntsville. Linda will review the records and send you an email letting you know if the child is current or if they need vaccinations. If the child's vaccinations are current; nursing should report this information to the SC so they can continue with scheduling. Give a copy of the E-mail regarding the child's immunization status to the SC. If the child needs additional vaccinations the SC will contact the parent/guardian to let them know what vaccinations are required before the child can be scheduled for a programming conference.
3. When the child's immunization status is confirmed as current add the child's name and date of birth to the immunization flow sheet ; type PENDING beside their name. When the child starts school, remove PENDING notation from beside their name on the immunization flow sheet and notify Linda Malloy (as well as notifying the RN) that the child is starting school. Linda M can

then add immunization information to the flow sheet as to when the next vaccinations are due etc. If it is determined the child is not going to start school ; remove their name from the flow sheet and let us know so we can remove that child from our records

(Linda M immunizations/Linda R medical history information form/ file)

4. IMMUNIZATIONS UP TO DATE: NURSING STAFF REMEMBER YOU MUST CHECK THE FLOWSHEET AT LEAST MONTHLY AND THE FIRST NOTIFICATION OF THE NEED FOR A VACCINATION IS SENT THREE (3) MONTHS PRIOR TO THE VACCINATION DUE DATE. This gives the parent/guardian time to get the appointment scheduled. Document the immunization appointment on the flow sheet.

No student without current immunization documentation will be allowed to attend preschool. Refer to the Arkansas department of Health website for the current school year list of required vaccinations for preschool children.

Obtain copies of the child's vaccination record from the parent/guardian or the Arkansas Immunization website; verify current status (immunization information should be sent to Huntsville preschool for review and verification by the immunization nursing staff.

IMMUNIZATION EXEMPTIONS: Only Medical immunization exemptions are accepted. Parent/Guardian of a Student with a Medical immunization exemptions from the Arkansas Department of Health will need to provide a copy of the official exemption letter from the state. Parent/Guardians requesting immunization exemptions may contact Arkansas Department of Health 485 West Markham-Mail slot 48 Little Rock, AR 72205 501-661-2169

Nursing staff will send letters of notification to parents with information about upcoming required immunizations. The first notification letter of upcoming immunization requirement will be sent three (3) months prior to immunization due date; this letter will request notification of the appointment date for the vaccination. A second letter will be sent if no appointment date has been received. The second letter will be sent thirty (30) days or more prior to immunization due date.

Immunization roster will be checked monthly by nursing staff for upcoming Immunization requirements. Immunization letters sent to parent/guardians will be documented on the roster by nursing staff. Add the date the letter was sent home under the notification column of the immunization flowsheet located on the K-drive and indicate if this was the first notification letter or the second notification letter by adding #1 or #2 after the date. If no appointment date is received and the child is within thirty (30) days of requiring the vaccination; contact the RN for follow up.

SUSPENSION OF STUDENTS LACKING CURRENT IMMUNIZATIONS:

Students thirty (30) days overdue for a vaccination will be suspended from school. If documentation of required vaccinations is not received within 14 days of suspension, the student will be discharged from school.

The following is an example of the first letter to remind parent/guardian of the upcoming immunization requirement.

Dear Parent/Guardian

Our records and the Arkansas Immunization Website show that your child will be due for vaccination very soon. If the vaccination has been completed, please provide us with the information; a copy of the vaccination record or the name of the clinic or health department where the vaccination was given and the date the child was vaccinated. If the vaccination has not been given yet; please schedule an appointment and provide us with the appointment information. We need to document that the vaccination has been scheduled in your child's school health record.

We are required to keep records of all student immunization information; we follow the Arkansas State Immunization guidelines about when vaccinations (shots) must be given. Students overdue for vaccinations are subject to suspension and dismissal from school. Please contact the nursing staff regarding this information, you can call or send a note with the information: The place and date of the appointment for your child to receive their vaccination.

Thank You

The following is an example of the second letter to parent/guardian regarding immunization records and requesting appointment information.

Dear Parent/Guardian

Our information shows that your child will soon be due for vaccinations (shots). Our records may not include all of your child's information. If these vaccinations have been completed, please provide us with the information. A copy of the vaccination record or the name of the clinic or health department where the vaccination was given.

If the vaccination has not been given, please schedule an appointment for your child to receive their vaccination and provide us with the appointment information. We must document that the vaccination has been scheduled.

We are required to keep records of all student immunization information and cannot allow children without documentation proving current immunization to attend school. We must follow the Arkansas State Immunization Guidelines about when immunizations (shots) must be given

Please contact the nursing staff regarding this information, you can call or send a note with the information: The place and date of the appointment for your child to receive their vaccination.

(N) NEW STUDENTS ENROLLMENT

Notify the RN of new students and the date they will begin school via Scomm email in Therap. Provide any new health/medical information obtained since the MHI was completed and scanned to the RN. Medical information will be reviewed by the RN and any needed careplans will be written and sent to the nursing staff at the center

ADD NEW STUDENTS TO THE THERAP SYSTEM BEFORE THEY START SCHOOL. Nursing staff are responsible for adding new students to the Therap system. Students should be placed in the Therap system before they start school if possible. Students who require careplans will need to be placed in Therap to allow the RN to complete the carplan in the system.

INSTRUCTIONS FOR ADDING STUDENTS TO THERAP

ADMIN TAB

INDIVIDUAL INTAKE CLICK - NEW-----you will be on individual entry page put in info including ID#(C+ last 4 digits of the students SS#)

ADD INFO THEN CLICK – SAVE – you will get a message saying successfully saved then choose edit **program enrollment** from the list on that page.....
If the last 4 numbers of student’s SS are the same as another student the computer will pop up a list and you will know.....in that case you change the ID# to C and the last 4 digits of the student home phone #.
CLICK BACK TO CHANGE THE INFORMATION.

CLICK EDIT ENROLLMENT THEN CLICK ENROLL

PICK CENTER AND CLICK ENROLL

X OUT OF ENROLL AND CLICK SAVE

YOU SHOULD HAVE THE DATA SHEET ON YOUR SCREEN - SCROLL TO THE BOTTOM AND CLICK ADMIT

THEN ADMIT DATE SCREEN WILL COME UP COMPLETE THAT THEN CLICK DONE

YOU SHOULD GET A SCREEN THAT SAYS SUCESSFULLY ADMITTED

SO CLICK BACK AND IT WILL TAKE YOU BACK TO THE DATA FORM

SCROLL TO THE BOTTOM AND CLICK EDIT INDIVIDUAL DATA

THEN ADD INFORMATION AND WHEN DONE CLICK SAVE AT THE BOTTOM OF THE DATA FORM

DISCHARGING STUDENTS: NOTIFY THE RN OF STUDENTS LEAVING THE PRESCHOOL/NOTIFY THE IMMUNIZATION NURSE IN HUNTSVILLE. NURSING SERVICE ARE RESPONSIBLE FOR REMOVING STUDENTS FROM THE THERAPY SYSTEM. THIS SHOULD BE DONE PROMPTLY

INSTRUCTIONS Discharge students from Therapy

1. Click on Administration from the list on the left side of the screen
2. Then choose Individual
3. Click by program
4. Click on the name of the preschool the child was attending
5. Click on the name of the child from the list of students
6. The data form will pop up; scroll to the bottom of the form and click discharge

(O) CONFERENCES: Nursing staff participate in conferences to obtain medical/health information and obtain consents. The conferences nursing participates in are:
Referral conference; the initial meeting with parent/guardian about a possible new student
Programming conference; the 2nd meeting with parent/guardian. The child has qualified and paperwork is finalized for the student to start Preschool.

Annual conference; The student is attending preschool and all paperwork is reviewed and updated annually.

3-5 Referral; The student is attending preschool but will be moving into the 3-5 year old program. This program is considered a separate program from the 0-3 age program and all paperwork will be updated. This is the 1st conference for that process.

3-5 Programming; The 2nd conference in the process of switching a current student from the 0-3 program into the 3-5 program.

Referral Conference: the initial conference with parent/guardian.

FORMS NEEDED: 1. VISION/HEARING SCREENING

2. MHI FORM

3. EPSDT (well child screening)

1. Complete the vision/hearing screening form, which is a very basic check of the child's visual and hearing ability. Sign the form after completion and give the original form to the SC (service coordinator)
2. Obtain medical/health information and document it on the MHI form (medical history/information form) Do not date, sign, or obtain signature from parent/guardian on the MHI form at this time since the information will be reviewed at the Programming conference. Ask all the questions on the form and if a

medical issue is identified add the appropriate additional MHI form to document further information (Respiratory, Neurological, GI, etc.)

Upon completion of the conference make a copy of the MHI form, give the original to the SC. Scan the MHI form and send to the RN via Scomm email/Therap. File the copy in the nursing office files. If the RN has questions/needs more information, you will receive an Scomm/Therap email with specific questions/information that will need to be obtained at the programming conference. Print the email and attach it to the copy of the MHI form filed in the nurse's office.

3. EPSDT (well child screening form) will be sent to the child's physician by the SC (service coordinator). Refer to the MHI form information for questions on the form that have been answered and documented on the MHI form. Ask the additional questions.....Has your child been to the dentist in the past 12 months; Do you have any concerns about your child's health and specifically ask about development delays, speech delays. Many of the children will have developmental delays and speech delays or concerns regarding these areas and this should be documented on this form.

The completed form is signed by the parent and given to the SC.

4. Obtain the Immunization information from the parent/guardian and fax it/email it to the LPN at the Huntsville Preschool. Add the students name and DOB to the Immunization flowsheet on the K-drive and write PENDING beside to name to indicate the child is pending immunization approval before the programming conference can be scheduled.

Programming conference: The 2nd conference with the parent/guardian.

FORMS NEEDED: 1. The copy of the MHI from at the Referral conference

2. Original MHI (will be obtained from SC at conference)
3. Medication consent form
4. OTC medication consent form
5. OTC side effect sheet
6. Personal data form (SC will bring to conference)
7. USDA forms
8. Allergy sticker for the hard chart

1. Review the MHI copy and any attached information; obtain the original MHI form from the SC at the conference; review information with parent/guardian and obtain information as requested by the RN or as needed. Obtain the signature of the Parent/guardian on original when complete. **(scan and send any new/updated information to the RN via Scomm email)**

2. Complete the Medication consent form. The parent will initial the section at the top and sign at the bottom if the child takes no medication. If the child will need medication administered at school, the name of the medication will be added to the form (no doses or times) and the parent/guardian will sign and date at the bottom of the form only. If a child takes medication at home but could potentially require that medication to be given at school, add the medication to the consent form. **Any medication to be given must be listed on a current consent form. New medications will require a new consent**

form be completed and signed by parent/guardian. Phone consent may be taken and documented on the form. Obtain signature ASAP. Send a copy home for signature if necessary.

Procedures will be listed in the second section of the form and the parent will sign consent for the procedure such as G-tube feeding, catheterization, suctioning, etc. (refer to the RN for questions regarding designation of a procedure)

Make a copy of the consent form after the conference; the original goes to the SC and a copy goes in the MAR book.

3. Give the parent/guardian the OTC side effect sheet and remind them that all medications have potential side effects.
4. Review the OTC consent form with the parent/guardian and obtain initials next to OTC medication which the parent/guardian gives consent. Obtain signature and date at the bottom of the form. Make a copy of the consent form after the conference; the original goes to the SC and a copy to the MAR book.

NOTE THAT SUNSCREEN AND A&D OINTMENT ARE LISTED ON THE OTC CONSENT FORM. IF A STUDENT CANNOT HAVE A&D AND/OR SUNSCREEN OINTMENT THE CLASSROOM WILL NEED THIS INFORMATION LISTED ON THE CLASSROOM WHITEBOARD AND/OR THE BACK COVER SHEET OF THE CLASSROOM INFORMATION BOOK.

TELL THE PARENT THAT CHILDREN MUST HAVE SUNSCREEN PRIOR TO OUTDOOR PLAY AND THE PARENT MAY PROVIDE THEIR OWN SUNSCREEN IF THERE IS A SKIN SENSITIVITY ISSUE.

5. Complete the sunscreen/Tylenol section of the Personal data form. If the parent just signed OTC consent for sunscreen and Tylenol then check the ok to give sections and have parent/guardian sign. If they did not give consent; check the *don't give* section and have parent/guardian sign. There is another section of the Personal data form that nursing staff will complete either during the conference or immediately after the conference. The Pertinent medical information section: complete this section using the data you collected during the MHI completion.

6. Page one of the USDA form informs the parent/guardian of our food services. Review the snack and meal information with the parent/guardian. We serve AM snack, Lunch (provided by outside source) and PM snack. List any food allergies, special dietary needs of the child and obtain parent/guardian signature at the bottom of the form. Page two requires the parent/guardian to list all the children who live in the household and list a total of the child/children's income (if any) then in the bottom section they list all the adults that live in the home and the monthly income of each adult. The parent/guardian must list the last 4 numbers of their social security number and at the bottom they print then sign their name. There is a USDA information sheet and you will give that to the parent. The USDA paperwork form will be completed by the nursing staff following the USDA income guidelines in the USDA book located in the nursing office (Fayetteville nursing will give the original paperwork to Dietary for completion) After the form is completed and the Free/Reduced/Paid information filled out and signed, scan the form to Patti Jones and make a copy for the SC (service coordinator) Place the original forms in the USDA book in the nursing office and add the student to the USDA roster list in the book and the USDA attendance sheet on the K-drive.

7. Letter to the parent. Review the letter to the parent information and give the letter the parent.
8. Discuss any food/medication allergies and/or medications the child takes with the SC to assure that the nursing documentation and the Service Coordinator documentation are the same and accurate. The Service Coordinator will list allergies/diagnosis/medications on the Individual Face Sheet. The nursing staff will complete the Allergy Sticker to be placed on the hard chart. List any medication allergies and/or food allergies. List NKDA if no known drug allergies. List NKFA if no known food allergies.

Annual conference: COMPLETE THE VISION/HEARING SCREENING PRIOR TO THE DUE DATE LISTED ON THE SC ANNUAL SCHEDULE. Give the completed form to the SC.

The child is attending preschool and information will be reviewed; new consent forms obtained.

FORMS NEEDED: 1. Vision/Hearing screening form

2. A copy of the MHI form
3. MHI Update/Review form
4. Medication consent form
5. OTC medication consent form
6. OTC side effect sheet
7. USDA forms
8. Letter to parent

Complete the Vision/Hearing screening form (this should be completed prior to the conference if possible; complete when you are notified that the conference is scheduled) Give original to Service Coordinator.

Review the MHI information and if there are no changes or changes are minimal, complete the MHI Update/Review form, obtain signature, and attach the form to the copy of the MHI form. (complete new MHI forms if changes have occurred that require detailed documentation). Scan and send to the RN via Therap/Scomm email MHI Update/Review form and any additional MHI forms containing medical/health information. Place copies of the new consent forms in the MAR book.

3-5 Referral and Programming conferences will follow the above instructions with the exception that the MHI will be reviewed and if there are no changes or the changes are minimal; this will be documented on the MHI Update/Review form which will be attached to a copy of the MHI form. (complete new MHI forms if changes have occurred that require detailed documentation)The child receives a new chart when moved to the 3-5 program, so any information from the old chart must be copied and given to the SC to be included in the new chart. The MHI will be copied/reviewed/attached to the MHI Update/Review form and a copy of immunization record will be copied. If the child has medication/treatment prescriptions or information any IHP medical care plans or medical information the nursing staff want to include in the new chart make copies and give to the SC.

(P) STUDENTS WITH SPECIAL DIETARY NEEDS

(copies of all physician orders and/or IHP/Medical care plans regarding dietary issues will be provided to the dietary staff in the Fayetteville preschool)

STANDARD: Some children require special diets due to medical conditions, food intolerances, food allergies, oral aversions, the need for increased nutrition, or parent food preferences.

PROCESS: Information regarding the child's dietary needs is obtained by nursing staff and documented on the MHI form.

Parent/guardian will be informed of dietary limitations of the preschool setting. Children with complicated dietary needs such as gluten free/soy free diets will require parents to provide food to the preschool. We do not prepare meals in the facility and cannot meet all special dietary needs.

FOOD ALLERGIES:

CHILDREN WITH SEVERE FOOD ALLERGIES REQUIRING MEDICATION/MEDICAL INTERVENTION WILL BE INCLUDED ON THE EMERGENCY INFORMATION LIST POSTED ON THE MEDICATION CABINET DOOR IN THE NURSING OFFICE.

ERC IS A PEANUT FREE FACILITY DUE TO THE HIGH INCIDENT OF PEANUT ALLERGY IN PRESCHOOL CHILDREN

Students who are known to have a severe allergic reaction to food or other substances in the environment that may result in anaphylaxis and require specific medication/medical intervention will have an Emergency Allergy Plan.

An Emergency allergy action plan will reduce the risk of accidental exposure to food/environmental allergens and provide appropriate intervention in the case of exposure. The Emergency Allergy Plan will be written by the RN and sent to the physician for review and signature, then placed in the student's chart with a copy placed in the MAR book in the nursing office. Nursing staff will place a copy of the Emergency Allergy Plan in the classroom information book and review information with classroom staff. ANAPHYLAXIS is a life threatening emergency that requires specific and immediate action. Causes can be from exposure to certain food, medications, insect sting, latex, or chemicals or other substances in the environment.

Student's with orders for use of adrenalin (Epi Pen) at school will have instructions for use included in their ALLERGY PLAN/IHP/medical care plan.

If **Epi-Pen** is ordered parent/guardian must sign **Epi Pen consent form**. If Benadryl or other medication are included in the Allergy Plan, parent/guardian must sign medication consent form.

The Allergy Plan is signed by the physician and all instructions contained in the plan are physician's orders. Benadryl, Epi Pen orders included.

If Benadryl orders are included in the Allergy Plan:

ERC or parent/guardian will provide Benadryl. Nursing staff will label and maintain the medication. All ERC staff who may need to administer adrenalin (Epi Pen) will have specific training on Epi Pen administration technique.

ANAPHYLAXIS SYMPTOMS generally occur within 15 minutes of exposure to allergen. Symptoms may include:

- Feelings of apprehension, sweating, weakness
- Feeling of fullness in throat, swelling of lips, tongue, eyelids or nose
- Respiratory difficulty
- Change in quality of voice
- Tingling sensation around mouth or face, nasal congestion, itching, wheezing.
- Low blood pressure with weak rapid pulse
- Loss of consciousness, shock, coma
- May be accompanied by hives

CLOSURE OF THE VOCAL CHORDS BLOCKING AIR INTAKE CAN OCCUR AS PART OF ANAPHYLAXIS OR BY ITSELF WITHOUT ANY OF THE ABOVE SYMPTOMS. IT REQUIRES IMMEDIATE ESTABLISHMENT OF AN AIRWAY.

CALL 911

In the event that a student has an allergic reaction: Follow the Allergy Plan:
Administer Epi pen per instructions/if ordered and activate the EMS system (call 911)

Stay with student until EMS arrives/Notify parent and student's physician as soon as possible

(Q) PROCEDURE TITLE: SEIZURES

CHILDREN WITH SEIZURES WILL BE LISTED ON THE EMERGENCY INFORMATION LIST POSTED ON THE MEDICATION CABINET DOOR IN THE NURSING OFFICE

STANDARD: Seizure activity should be responded to appropriately for prevention of injury to the student and to maintain an open airway.

PROCESS: Prior to admission to preschool the student's medical history, related to seizure activity, will be obtained from parent/guardian and documented on the MHI form. A seizure management care plan will be written by the RN. If specific medication/medical intervention is required; an Emergency Seizure plan will be written by the RN and sent to the physician for review and signature, then placed on the student's chart. A copy will be kept with the MAR book.

Seizure activity in a student without a diagnosed seizure disorder requires EMS intervention, notification to parent/guardian, physician, and RN.

Document seizure activity on T-log Health note and T-log Parent/guardian notification.

For students with a diagnosed seizure disorder. Specific/descriptive information regarding a student's seizure activity/type will be included on the seizure plan if known and actions to be taken including administration of any emergency medications and when to activate EMS.

RECTAL DIASTAT IS NOT ACCEPTED FOR USE IN THE PRESCHOOLS IF A CHILD HAS A PHYSICIAN ORDER FOR RECTAL DIASTAT USE TO TREAT SEIZURE ACTIVITY THE PARENT/GUARDIAN SHOULD BE INFORMED THAT A PHYSICIAN REQUEST TO CHANGE THE MEDICATION WILL BE INITIATED BY THE RN.

CLONAZEPAM (dissolving) IS APPROPRIATE TREATMENT IN THE PRESCHOOL SETTING (only licensed nurses are allowed to administer Diastat rectal per Arkansas State Board of Nursing School Nurse Guidelines; therefore staff available to administer emergency medication would be limited and not effective for an emergency plan of treatment)

SEIZURE SAFETY CARE:

DO NOT ATTEMPT TO HOLD STUDENT DOWN

DO NOT ATTEMPT TO PLACE ANYTHING IN THE STUDENT'S MOUTH

Provide safety care to prevent injury

Do not move the child unless environment exposes student to imminent danger/remove; hazardous items from area, if ambulatory assist to floor ,place on side if possible, place padding under/around head if available, maintain airway/loosen clothing, reposition head if needed to maintain airway/breathing, provide supervision during seizure, until student is awake and alert

SEIZURES DOCUMENTATION

Nursing staff will document the following on a health note T-log

Duration of seizure/observed or reported by staff/onset, vital signs/if applicable, description of seizure activity, loss of bowel/bladder control/ if age appropriate, neurological assessment appropriate for age and baseline functioning of child.

Document Physician orders, notifications of physician, parent/guardian, RN

(R) POLICY TITLE: CARE OF DIABETIC STUDENTS

DIABETIC STUDENTS WITH SPECIFIC MEDICATION/MEDICAL INTERVENTIONS WILL BE LISTED ON THE EMERGENCY INFORMATION LIST POSTED ON THE MEDICATION CABINET DOOR IN THE NURSES OFFICE.

Standard: Monitoring of diet, blood glucose testing, will be performed as ordered by physician.

Process: Information pertaining to the student's diabetes i.e. Copies of physician orders, student's usual diet, history of signs/symptoms will be obtained. The diabetic care will be included in the student's IHP/Medical care plan. A diabetic care plan will be completed by the RN. A copy will be kept in the MAR book. Education of ERC staff involved in student's care will be performed by the nursing staff. Copies of the student diabetic plan will be provided to the classroom. Information on specific hypo/hyperglycemia symptoms for monitoring and dietary restrictions will be provided to classroom staff (and dietary staff in Fayetteville center)

Glucose monitoring will be performed by the nursing staff per physician orders. The student's personal glucose monitoring equipment will be used by the nursing staff. Parent/guardian will be instructed to send glucose monitoring equipment with student. Glucose readings will be recorded with the equipment for parent/guardian review. If the student uses a cbg log the glucose readings will be recorded in the student's cbg log by the nurse, per parent/guardian or documentation of readings sent to parent. All glucose readings obtained by the nurse will be documented on the MAR.

Physician and parent/guardian notification of cbg readings will follow physician notification parameter orders. The nursing staff will work in conjunction with the child's dietician regarding special diabetic dietary needs.

Calibration and control solution testing should be performed by the parent/guardian in the student's home. In the event a new bottle of test strips are opened at school, the nursing will follow the manufacturer's instructions for calibration of the cbg machine.

(S) PROCEDURE TITLE: INDIVIDUAL HEALTHCARE PLANS

STANDARD: Statutes in the Education Chapter of the Arkansas Code require the school to provide individual healthcare plans (IHP) for students with healthcare needs. The development of the IHP inherently requires assessment, diagnosis, and planning. The RN has these skills within his/her professional scope of practice.

Nursing staff at each preschool will obtain medical information on all potential incoming students and document the information on the MHI form. The nursing staff will scan the MHI form and send to the RN via Secure communication (Scomm/Therap) The information will be reviewed by the RN and further data collection initiated if necessary. The RN will notify nursing staff via secure email (Scomm) of any further information required and the nursing staff will print the email and include it with a copy of the MHI form filed in the nursing office. If the student has health care needs; the Individual Health Care Plan/Medical care plan will be created by the RN and provided to the preschool nursing staff prior to or at the time of the student's admission to the preschool. (nursing staff will notify RN when new students are to begin school) THE IHP/MEDICAL CAREPLAN WILL BE PROVIDED TO THE CLASSROOM STAFF PRIOR TO THE CHILD STARTING SCHOOL WHENEVER POSSIBLE. THE IHP/MEDICAL CAREPLAN/S WILL BE PLACED IN THE STUDENTS CHART/THE MAR BOOK/CLASSROOM INFORMATION BOOK/ AND A COPY

WILL BE GIVEN TO CLASSROOM STAFF TO REVIEW; CLASSROOM STAFF WILL SIGN AND DATE THE SIGNATURE FORM IN THE CLASSROOM BOOK UPON RECEIPT OF MEDICAL CAREPLAN. UPDATED IHP/MEDICAL CAREPLANS WILL BE PROVIDED WHEN NEEDED AND THE SAME PROCEDURE FOLLOWED FOR EACH UPDATE.

(T) PROCEDURE TITLE: CLEANING FOOD AREAS IN THE CLASSROOM

PURPOSE: Cleaning and sanitizing reduces the spread of infectious disease in general. In the food service areas, appropriate cleaning and sanitizing provides clean surfaces for food consumption and prevents students with food allergies from physical contact with food product (allergen).

STANDARD: All surfaces in the dining area will be cleaned and sanitized before and food service and cleaned after food service use. ALL

CLEANING/SANITIZING/DISINFECTING PRODUCTS MUST BE USED ACCORDING TO THE MANUFACTURERS DIRECTIONS.

“CLEAN “means removing all visible soil. Wet cloths/paper towels may be used for this purpose.

“SANITIZE” means using a product to reduce germs on inanimate surfaces to levels considered safe by public health codes or regulations. Special cleaners that reduce germs may be used to sanitize food service areas such as tables and high chair trays. Use the appropriate product and follow all directions. Product must be dispensed from a labeled container and stored out of the reach of children. The “Quat stat” sanitizer (SANIBET spray cleaner) is appropriate for sanitizing.

“DISINFECT” means using stronger products to kill most germs/bacteria from a surface. Disinfectants are appropriate for cleaning diapering areas, toys and other items that may be contaminated with urine, fecal matter, or blood. When disinfectant cleaners are used the product must be allowed to remain on the surface and dry (usually 10 minutes) to maximize benefit.

The item or area may be wiped with a wet cloth after cleaning with disinfectant is dry time is not available. The full effect of the disinfectant will not be realized, but the area or item will be sanitized. (The disposable disinfectant wipes require dry time or rinse and wipe prior to contact with skin) Sponges should not be used for cleaning and sanitizing. They harbor bacteria and are difficult to clean and sanitize between cleaning surfaces.

Disposable paper towels may be used and discarded. Washable cloths may be used if used one time only, then stored in a container out of the reach of children until washed.

PROCESS: Prior to serving snacks or meals all surfaces of tables will be cleaned and sanitized.

Before food is served and when food service is finished, table tops, chairs, high chairs, and any surface coming in contact with food product will be cleaned and sanitized.

Children's hands and faces should be cleaned and all food residues removed.

Food spills on clothing may be wiped off if the amount is small or clothing changed if the food spill is large.

COMMENT: IF A CHILD IN THE CLASSROOM HAS A FOOD ALLERGY SPECIAL ATTENTION SHOULD BE GIVEN TO PREVENTION OF POSSIBLE EXPOSURE. FOOD SPILLS ON CLOTHING CONTAINING THE ALLERGIN WILL REQUIRE THE CLOTHING TO BE CHANGED. HANDS AND CLOTHING CAN COME IN CONTACT WITH OTHER CHILDREN DURING PLAY AND POSE AN EXPOSURE RISK. REFER TO THE CHILD'S MEDICAL CAREPLAN IN THE CLASSROOM INFORMATION BOOK AND REFER TO THE NURSE FOR ANY SPECIFIC QUESTIONS.

PROCEDURE TITLE: CLEANING STUDENT TO STUDENT EQUIPMENT

STANDARD: To prevent the spread of illness/infection all equipment should be cleaned between student to student use. All cleaning products must be used according to the manufacturer's directions

PROCESS: after use of equipment, any gross contamination should be removed with soap and water or saline per equipment instructions/tolerance. Then wipe Equipment thoroughly with *antibacterial* cloths or spray with Quat stat cleaner and allow to air dry or wipe dry with a paper towel.

DISINFECTING EQUIPMENT – If blood/fecal soiling of equipment or exposure to known infectious waste occurs; equipment may be disinfected using approved *disinfectant chemical*. (Quat stat spray cleaner will disinfect if sprayed and allowed to air dry for 10 minutes) If disinfectant wipes are used, thoroughly clean the item with disinfectant and allow to air dry for 10 minutes. Dispose of all cleaning materials in a safe manner in trash container with lids.

Antibacterial aerosol sprays may be used for cleaning fabric and fabric containing equipment such as ice pack covers, cloth toys, chairs, etc. Spray equipment in a well ventilated area and allow to air dry before use. For equipment requiring special cleaning care all manufacturer's instructions should be followed. (Quat stat spray may be used to sanitize by spraying and allowing to 10 seconds before wiping the item; to disinfect all materials with Quat stat; spray the item and allowing the item to air dry for 10 minutes)

Washable items should be laundered after use

The following are examples of nursing staff items with student to student use and require cleaning after use. Alcohol may be used to wipe equipment between uses for sanitizing.

Thermometer

Stethoscope

Otosopes

Nebulizer machine

O2 monitor

Any items in the nursing service area used by children with known or suspected contagious illnesses should be disinfected after use.

PROCEDURE TITLE: DISINFECTION OF SUCTION EQUIPMENT

Standard: To prevent the spread of infection suction equipment should be cleaned after use and stored in a sealed bag.

Process: After use of suction equipment, soak canister with soapy water until secretions rinse off. Wash the inside and outside of equipment. Store catheters and necessary supplies with the canister.

ALL CLEANING/SANITIZING/DISINFECTION PRODUCTS MUST BE USED ACCORDING TO THE MANUFACTURERS DIRECTIONS

Student's suction equipment sent to school from home will be cleaned use by the nurse after use; prior to returning the equipment home

(U) PROCEDURE TITLE: STUDENTS REQUIRING MEDICAL EQUIPMENT

STANDARD: To provide care/monitoring of medical equipment required by students during school hours Students may require the use of medical equipment while attending school. Medical equipment including (but not limited to) oxygen equipment (refer to oxygen administration Procedure), feeding tubing/pumps/CBG machines/suctioning equipment

Information/instructions for use and cleaning of special medical equipment will be obtained by the nurse and the information will be placed in students chart as well as a copy in the MAR book. Education for school staff will be provided by the school nurse. All medical equipment (sent with student from home or ERC equipment) will be checked by the school nurse prior to use and checked and cleaned as instructions or physician orders indicate.

Any equipment without specific cleaning instructions will be cleaned with antibacterial wipes. (refer to student to student equipment cleaning Procedure)

Students may have implanted special medical equipment that require monitoring and/or scheduled checks by the school staff. Information regarding the student's particular needs will be included in the IHP (Individual health care plan). Monitoring will be performed according to physician instructions and/or equipment directions. Required daily checks or other procedures related to the equipment will be documentation on the MAR (Medicine administration record) by the school nurse.

Example: Daily checks of cochlear implants performed by teaching or nursing staff daily and recorded on the MAR. Unusual observation, identified problems, questions regarding condition or function will be reported to the student's parent/guardian and if deemed necessary by the school nurse; to the student's physician.

(V) PROCEDURE TITLE: TRACHEOSTOMY CARE

STANDARD: Tracheostomy care/suctioning is to be performed by licensed nursing staff/specially trained ERC staff, following all physician order. Care of the tracheotomy is important to maintain an open airway.

PROCESS: Physicians orders regarding tracheotomy care and/or suctioning will be placed in the student's chart. A copy will be kept in the MAR book in the nursing office. Parent/guardian consent for medication/treatment form will be obtained prior to performing any procedure. A copy will be placed in the student's chart and a copy will be kept in the MAR book.

Any special instructions regarding tracheostomy care and/or equipment will be placed in the student's chart. A copy will be kept in the MAR book in the nurse's office.

Aseptic technique is used during endotracheal suctioning and cleaning of reusable tracheotomy tubes. Information regarding the procedure for changing tracheotomy tube, required equipment for tracheotomy care and general information is provided in the Nursing Procedure Manual. Always refer to physician orders for specific care instructions. Contact the RN for review of procedure prior to initial performance of specialized treatment.

Tracheostomy equipment should remain with student at all times during school. Student's equipment used by nurse, should be cleaned and returned to student's bag/belongings

(W) PROCEDURE TITLE: CATHETERIZATION

STANDARD: Catheterization will be performed by licensed nursing staff/specially trained ERC staff per physical orders to relieve the retention of urine in the bladder.

PROCESS: Review catheterization order. A copy will be placed in the student's chart and the MAR book Review parent/guardian consent form for medication/treatments. A copy will be placed in the chart. A copy will be kept in the MAR book in the nurse's office.

Refer to procedure for clean intermittent catheterization for instructions

Provide private area with adequate workspace for procedure

Explain procedure to student based on age and comprehension level.

Obtain assistance from other ERC staff for stand by assist as needed

Document procedure on MAR. Follow physician instructions regarding need for documentation of amounts of urine obtained.

Any deviations from normal should be documented in GER and parent/guardian notification documented by T-log.

RN notification required of any abnormalities

(X) PROCEDURE TITLE: OXYGEN ADMINISTRATION

STANDARD: Oxygen administration continuously or intermittently is required for the treatment of certain diseases or conditions and should be administered under the orders of a physician.

PROCESS: Oxygen administration is considered a medication administration and should be managed by the nurse. Oxygen canisters/supplies will be sent with student from home and returned home with student at the end of the school day. Copies of physician orders will be obtained and placed in student's chart, with a copy placed in the MAR book in the nurse's office.

A copy of the emergency plan from the student's IHP will be placed in the MAR book. All ERC staff caring for student will be trained regarding use of supplemental oxygen. All ERC staff will be in serviced regarding oxygen safety. RN training of Oxygen care by classroom staff will be documented and maintained in the MAR book in the nursing office. Specific instructions for the oxygen equipment used by the student will be obtained from the parent/guardian, physician and/or the medical supply company. Instructions for equipment use will be placed in the MAR book in the nurse's office. All ERC staff caring for student will be in serviced in specific equipment functions.

Notify parent of signs of yellowing/deterioration are present in tubing sent from home.

(Y) PROCEDURE TITLE: FEEDING TUBES/FEEDINGS AND MEDICATION ADMINISTRATION

Standard: To provide liquid nourishment, and/or medication, through a Gastronomy tube into the alimentary tract. Either through bolus feedings or continuous feeding via a pump. Refer the child's IHP/Medical care plan for instructions on G-tube feedings. The physician order or IHP/Medical care plan should specify whether bolus (gravity) or pump administration is used. The type of G-tube button (most common is Mickey button).

Medications will be provided through a G-tube by licensed nursing staff/specially trained ERC staff; following physician orders and/or RN instructions/medical care plan. FOLLOW ALL GUIDELINES FOR MEDICATION ADMINISTRATION.

Process: Review physician order for medications. Review parent/guardian consent form for medications. Review physician order and/or RN instructions/care plan for feedings.

Follow specific manufacturer instructions for use of a pump. Any needed instructions for specific pump use will be kept in the MAR book in the nurse's office and/or the classroom information book. Bolus feedings are performed with a syringe and tubing, post feeding flush of 5cc will be given unless instructions from parent/guardian or specific physician orders instruct otherwise.

Flush with water prior to and following medication administration. 5cc unless otherwise specified in physician orders. Administer medications with syringe. After use rinse, dry, and store syringe in plastic bag labeled with student information. Return equipment to student's storage for transport home if appropriate. If equipment is kept at the preschool, it may be placed inside the medication refrigerator (to decrease bacterial/fungal growth) Plastic tubing/syringes should be replaced if yellowing or cracking occurs. Notify parent/guardian if tubing needs to be replaced.

REMOVAL OF FOREIGN BODIES (FB)

FB such as splinters, insect stingers, ticks etc. may be removed by the nursing staff, if they are not deeply embedded. Contact the parent/guardian and describe the FB and the need for removal and obtain verbal consent. If unable to contact the parent; contact the RN for consultation and proceed with removal of FB if directed by the RN. If the child is uncooperative the nursing staff may not be able to attempt removal; inform the parent/guardian by phone if possible. T-log note home describing the location and type of FB. If unable to make phone contact.

TICKS: Prompt and complete removal of ticks can help prevent illness. If nursing staff are unable to safely remove a tick contact the parent/guardian and give them the option to come to the school and remove the tick. First attempt to remove the tick with an alcohol pad; place the pad over the tick and hold in place for 30 seconds or more. Then hold downward pressure while wiping in the direction of the ticks body (from the head of the tick toward the body)

If the tick is too firmly imbedded in the skin; contact the parent/guardian by phone for verbal consent to remove the tick with tweezers. Use tweezers to grasp the tick as near to the mouthparts (and as close to the skin) as possible. Use gentle, steady, straight force to pull the tick out. The site should then be thoroughly cleaned and disinfected with alcohol or another disinfectant. The tick should be killed by flushing down the toilet (it should not be crushed or squeezed). **Hands should be washed afterwards.** .

INSECT BITES AND STINGS

- Insect bites and stings can cause an immediate skin reaction. The bite from fire ants and the sting from bees, wasps, and hornets are usually painful. Bites caused by mosquitoes, fleas, and mites are more likely to cause itching than pain. General steps for most bites and stings: Move to a safe area to avoid more bites or stings.
- If needed, remove the stinger. (wasps, hornets, bees may leave a stinger)

- Wash the area with soap and water or a saline wipe
- Apply a cool compress. Use a cloth dampened with cold water or filled with ice. This helps reduce pain and swelling. Leave on for no more than 10 minutes.
- Apply OTC hydrocortisone ointment if the bite leaves redness, swelling
- OTC pain reliever, such as acetaminophen (Tylenol) or ibuprofen (Motrin) may be given if child displays pain and parent/guardian give consent.
- Remove the stinger by scraping a straight-edged object across the stinger. **You can use a plastic disposable spoon** Do not use tweezers -- these may squeeze the venom sac and increase the amount of venom released.

REMEMBER INSECT BITES HAVE THE POTENTIAL TO CAUSE ALLERGIC REACTIONS CHILDREN SHOULD BE MONITORED FOR SYMPTOMS OF SYSTEMIC REACTION:

Call 911 if the injured person experiences:

- Difficulty breathing
- Swelling of the lips, eyelids or throat
- Dizziness, faintness or confusion
- Rapid heartbeat
- Hives
- Nausea, cramps or vomiting

SPLINTERS

Most wood splinters and small objects like a sliver of glass can be removed with tweezers if a section is protruding (sticking out) from the skin enough to grasp it with the tip of the tweezers.

Clean the tweezers with alcohol before and after use

Wash your hands and the affected area with soap and water and clean the area with soap and water or a saline wipe

Reassure the child as best you can. If possible, seat him on your lap while you work on the splinter, or have another staff hold and comfort him while you remove it.

Grasp it gently at the base (where it emerges from the skin) with the tweezers and pull it straight out, tugging in the same direction it's pointed.

If it doesn't slide right out, don't pick at it – you don't want to break a piece off and leave the rest embedded.

If a very small splinter is protruding you may be able to remove it by:

Pressing a piece of strong sticky tape to the site and then lifting up. This sometimes works for fragile splinters

If neither of those methods works, or if the splinter is embedded in the skin with little or no piece sticking out for you to grab; let the parent/guardian know that it requires more aggressive/invasive method of removal than can be performed at school, refer them to contact the physician

When the splinter's out:

Wash the whole area thoroughly with soap and warm water.

Cover the spot with a thin film of antibiotic ointment (if OTC consent) and a Band-Aid