



Education
Healthcare
Public Services

Serving the **Medically Fragile Child** in the School Setting





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Our Mission

The AFT is a union of professionals that champions fairness; democracy; economic opportunity; and high-quality public education, healthcare and public services for our students, their families and our communities. We are committed to advancing these principles through community engagement, organizing, collective bargaining and political activism, and especially through the work our members do.

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



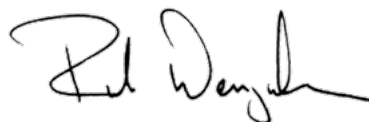
Foreword

Students who require specialized healthcare at school cannot be denied attendance based on their medical condition or disability. Students deserve to have their healthcare needs met in the least restrictive environment. According to the Centers for Disease Control and Prevention (2021), more than 40 percent of school-age children and adolescents in the United States have at least one chronic health condition. The Individuals with Disabilities Education Act (IDEA), the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973 mandate that students have access to education without regard to their disability. The responsibilities of school nurses, paraprofessionals, teachers and other specialized instructional support personnel (SISP), however, have increased along with the number of students requiring services and a shortage of qualified providers. The AFT remains committed to championing the rights of medically fragile children and the inequities they face.

In 1989, the AFT heard these concerns from our members and responded by creating the Ad Hoc Committee on Healthcare Responsibilities in Special Education. This committee was a collaborative effort of the AFT's Educational Issues Department (AFT Teachers), AFT Nurses and Health Professionals (AFT NHP) and AFT's Paraprofessionals and School-Related Personnel Division (AFT PSRP). The work of this committee generated the first edition of a manual titled "The Medically Fragile Child in the School Setting." The AFT's Task Force on Special Education continued to work on these issues, and its recommendations were incorporated in a second edition of the manual. The third edition provided members with a more in-depth review of their roles, responsibilities and rights as related to serving medically fragile children in the school setting.


The fourth edition (2023) sets out to accomplish three goals: (1) to educate our members on their roles and responsibilities in relation to children who are medically fragile; (2) to educate our members on their rights as school employees; and (3) to outline possible solutions and protections for local unions to pursue on behalf of their members.

The number of students receiving services under the IDEA or Section 504 in school settings has increased significantly since this manual's inception. This trend was one of the catalysts for the community schools proposal that we launched at the AFT convention in 2008. In 2022, the AFT reiterated this point via a new resolution at the union's biennial convention and continues to believe in and advance a comprehensive vision for public education that promotes children's well-being. Educators face multiple challenges related to the increase in medically fragile students in the public school setting: We must advocate for an environment that enables medically fragile students to obtain the best possible education, ensures our members have access to high-quality information that will support all students, maintains a safe work environment, and protects members' rights. We hope the fourth edition of the manual will help meet these challenges.



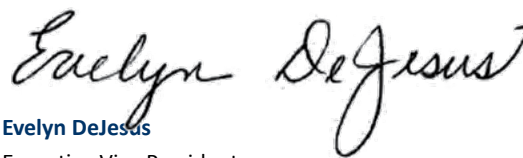
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Because **each child is unique**, their educational program must be determined by their individual needs.



Overview: Medically Fragile Students

Medically Fragile Students

Medically fragile students are children and youth with chronic life-threatening physical health disabilities that require consistent management and monitoring of symptoms. Medically fragile students have either an IEP (individualized education program) to address the impact of the disability on the student's learning with services from a special education teacher, or a Section 504 plan that does not include specialized instruction but does include the necessary accommodations and related services such as nursing and/or occupational therapy, for example.

Chronic medical conditions are health conditions that require greater than six months of monitoring and/or management to control symptoms and to shape the course of the disease and may include life-threatening allergies, asthma, cancer, heart conditions, diabetes, and epilepsy. Other conditions may include ventilator dependence and conditions requiring the suction of lungs and throat, tube feedings and intermittent catheterizations.¹

A school-based individualized healthcare plan (IHCP) is also required for medically fragile students within the IEP or 504 plan and includes the student's medical diagnosis, medical history and description of health problems; type of medical treatment the student is receiving; any physical limitations; medication taken by student (if applicable); an emergency plan; and the possible need for home instruction.

Until the 1980s, children with special healthcare needs were often cared for in hospitals or institutions that saw to their educational development and healthcare needs. Advances in healthcare technology have enabled more children who were not restricted to hospital or homebound services to attend public schools.²

Federal Laws

The Individuals with Disabilities Education Act (IDEA) and its 1975 precursor, known as the Education for All Handicapped Children Act (EAHCA) or Public Law 94-142, have changed the landscape of education in the United States. The initial passage of Public Law 94-142 meant that large populations of medically fragile children and youth—students who previously had been underserved or not served at all by public schools—were now entitled to an education provided by the public school system. The 1990 reauthorization expanded the eligible student population to include preschool students. Congress reauthorized the IDEA in 2004 and amended the IDEA through the Every Student Succeeds Act in 2015.

In law, Congress states:

Disability is a natural part of the human experience and in no way diminishes the right of individuals to participate in or contribute to society. Improving educational results for children with disabilities is an essential element of our national policy of ensuring equality of opportunity, full participation, independent living, and economic self-sufficiency for individuals with disabilities.³

The IDEA governs the education of students with disabilities. Students with disabilities are entitled to a free, appropriate public education (FAPE) that emphasizes special education and related services designed to meet the child's unique needs. The primary vehicle for providing a FAPE is through an appropriately developed individualized education program (IEP) that is based on the individual needs of the child. IEPs must be aligned with state academic content standards for the grade in which a child is enrolled.⁴

Included in the IDEA is the founding principle of the least restrictive environment (LRE):

- To the maximum extent appropriate, children with disabilities, including children in public or private institutions or other care facilities, are educated with children who are nondisabled; and
- Special classes, separate schooling or other removal of children with disabilities from the regular educational environment occurs only if the nature or severity of the disability is such that education in regular (general education) classes with the use of supplementary aids and services cannot be achieved satisfactorily.⁵

The LRE for students depends upon the unique needs of the individual student. The IDEA includes a continuum of services that IEP teams consider when determining the appropriate educational setting for a student with a disability. The continuum includes instruction in:

- Regular (general education) classes
- Special classes
- Special schools
- Home
- Hospital
- Institution

The continuum of services also makes provision for supplementary services (such as resource room or itinerant instruction) to be provided in conjunction with a regular/general education class placement.⁶

The placement of medically fragile students in traditional public schools and the responsibilities that accompany these placements have given rise to several areas of concern. These include the need for adequate funding to hire school nurses, licensed practical nurses (LPNs), the availability of appropriate facilities, new roles and responsibilities for school personnel, appropriate training for healthcare designees and liability concerns.

The individualized education program (IEP) for a medically fragile student varies based on the individual student, however, the foundational IEP requirements include: a statement of the student's current level of performance (academic and functional), social and emotional and/or behavior concerns (if applicable), health concerns, student health plan, annual goals, accommodations/modifications, English language learner accommodations and interventions (if applicable), postsecondary transition plan (federal guidance states transition plan must be in place by age 16; however, some

states' educational codes require the postsecondary plan by age 14), and services to be provided by specialized instructional support personnel (SISP) (e.g., school nurse, social worker, occupational therapist). The IEP also documents the percentage of time the student is removed from the general education setting, if at all, justification for the chosen placement (LRE) and any potentially harmful effects of the placement.⁷ Additionally, while a doctor may express an opinion or even write an order saying that a service can be delivered in the classroom, the school nurse has the expertise and knowledge necessary for assessing the situation and determining if it is, in fact, appropriate to provide the necessary services within the classroom setting.

Since the inception of IDEA, the number of students ages 3–21 enrolled in public schools and receiving special education services has increased nearly every year. In 1976-77, nearly 3.7 million youth (or 8 percent of the total public school population), received services under the IDEA. By 2005-06, that number had increased to 6.7 million, or 14 percent of total public school enrollment. By 2020-21, that number had increased to 7.5 million eligible infants, toddlers, children and youth with disabilities receiving early intervention, special education and related services.⁸

IDEA Disability Categories

To qualify for services under the IDEA, children must have a disability that falls under one of the following categories and as a result of that disability requires special education to make progress in school:⁹

- Autism
- Deaf-blindness
- Deafness
- Developmental delay (Refer to state educational code)
- Emotional disturbance
- Hearing impairment
- Intellectual disability
- Multiple disabilities
- Orthopedic impairment
- Other health impairment
- Specific learning disability
- Speech or language impairment
- Traumatic brain injury
- Visual impairment, including blindness

Child Find

Child Find is a component of the IDEA that requires states to identify, locate and evaluate all children with disabilities, from birth to age 21, who need early intervention or special education services.¹⁰

- All children with disabilities residing in the state, including children with disabilities who are homeless children or are wards of the state, and children with disabilities attending private schools, regardless of the severity of their disability, and who need special education and related services, are identified, located and evaluated;
- A practical method is developed and implemented to determine which children are currently receiving needed special education and related services;
- Children who are suspected of being a child with a disability per IDEA guidance and in need of special education, even though they are advancing from grade to grade; and
- Highly mobile children, including migrant children, are considered.

Some examples of Child Find activities include screenings of infants and toddlers; hearing and vision screenings; ongoing review of general education students; and referrals by teachers and/or caregivers.¹¹

Funding

When the IDEA was passed in 1975, the law included a commitment by the federal government to pay 40 percent of the average per-student cost for every special education student. State and local funding account for the remainder of education funds. Medicaid also serves as a significant funding source.

Federal special education funding is derived primarily from two sources: The Every Student Succeeds Act (ESSA) and the Individuals with Disabilities Education Act. ESSA provides categorical funding to support student achievement in low-income areas. IDEA accounts for the majority of the federal government's ongoing contribution to special education. However, IDEA funding has yet to reach the 40 percent authorized in the act. The actual percentage of funding has resulted in some cuts to both general and special education funding across school districts. State allocation formulas for special education vary and are dependent upon the local district's tax structure. There is a wide disparity in funding across the country. Local funding formulas also vary, and district budgets rely heavily on local revenues. Each federal education law is conditioned on a state's decision to accept

federal funds. The federal law applies only when a state voluntarily chooses to accept federal funds. Any state that does not want to abide by a federal program's requirements can choose not to accept the federal funds associated with that program. Many states and districts accept the requirements and then find that state and federal funding is insufficient to cover local expenses.¹²

Additionally, Medicaid funds may be used for individualized education program implementation, school health services, salaries for service providers, assistive technology equipment, hearing assistance technology, professional development and instructional supplies, materials and software. However, each state has specific requirements for how a local district may use funds, and the local district determines how the funds will reach specialized instructional support personnel (SISP).¹³

Actual annual funding levels vary dramatically across the country, with an average range from \$4,000 to \$10,000 for students without disabilities and, for example, \$10,000 to \$26,000 in California for students with disabilities. New York is the exception, where the current spending amount is \$25,519 per general education student. The federal spending package for fiscal year 2023 (passed December 2022), includes an increase in funding for students with disabilities. Federal spending on special education through IDEA increases from \$13 billion to \$15.5 billion. Current funding is half the allocated amount of 40 percent.¹⁴

Section 504 of the Rehabilitation Act of 1973

The Office for Civil Rights (OCR) is the federal agency that monitors Section 504 compliance. Under Section 504 no student shall, based on race, religion, creed, color, marital status, sex, sexual orientation, national or ethnic origin or disability, be excluded from participation in, or be denied the benefits of, any district educational program or activity. Eligible students are determined to have a physical or mental impairment that substantially limits one or more major life activities, or have a record of such impairment, or be regarded as having such an impairment.¹⁵

Mitigating measures used by a student to manage their impairment or lessen impact of their impairment (medications, cochlear implants, medical devices, assistive technology, behavioral modifications, related aids and services, etc.) should be disregarded when determining whether a student's impairment constitutes a disability.¹⁶

Physical Impairment

The law does not limit a physical impairment to specific diseases or medical conditions. A physical impairment may include, but is not limited to, any physiological disorder or condition, cosmetic disfigurement, anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory, speech organs, cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine.¹⁷

Mental Impairment

Any mental or psychological disorder such as intellectual disability, organic brain syndrome, emotional or mental illness, and specific learning disabilities.¹⁸

A Record of an Impairment or Is Regarded as Having an Impairment

The phrases “has a record of a disability” and “is regarded as disabled” are intended to reach the situation in which a student either does not currently have or never had a disability but is treated by others as such. A student having a “record of” or “is regarded as” disabled is insufficient, in itself, to trigger Section 504 protections that require the provision of FAPE.¹⁹

A Major Life Activity

Major life activities are basic activities that the average person in the general population may perform with minimal or no difficulty. This may include caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, working, standing, lifting, thinking, concentrating, interacting with others, sleeping, bending, communicating, reading and writing.²⁰

What’s Legal? Who’s Liable?

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

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

Additionally, in labor law there’s a general principle known as “obey now, grieve later.” A general rule is that employees are expected to follow directives from management. If an employee believes the directive to be unfair or a violation of the contract, they may file a grievance later. There are limited exceptions to this rule. For example, if the employee does not have the skills or capacity to do what is directed or if they would be putting another person in danger, then obeying may be the wrong thing to do. Throughout this update, we continue to stress the importance of the need for proper training and supervision.²¹

Are Facilities Adequate?

Although the number of medically fragile children and youth in public schools has increased, the facilities and conditions under which health-related procedures (including but not limited to the monitoring of students with diabetes) must be performed are often inadequate. Staff should not be asked to perform procedures in inadequate environments and without the proper equipment. Additionally, students who are not (or struggle to be) potty trained may need to be lifted by school staff onto a changing table to be changed. The lack of hydraulic patient lifts cause school staff to be susceptible to physical harm. Having to perform health-related procedures in less-than-optimal conditions may place school personnel in a position where they could jeopardize the health and safety of their students. Because less than 40 percent of schools in the U.S. employ full-time school nurses, the training, supervision and/or evaluation of healthcare designees asked to perform medical procedures may be inadequate as well.²²

Who Cares for Medically Fragile Students?

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

While non-licensed staff may be trained to perform some tasks, the school nurse has ultimate responsibility for deciding which tasks can be delegated and to whom, and for ensuring that the procedures are being done correctly.²³

AFT Position on the Education of Medically Fragile Students

The AFT believes that medically fragile students should be educated in a safe and healthy environment where their health needs are attended to by professionals and trained support personnel. We recommend that the school nurse, LPN or healthcare aide, respectively, have the primary responsibility for providing healthcare services to medically fragile students. Teachers, paraprofessionals and other school personnel should not be the primary providers of healthcare services. School districts and state legislatures must ensure that adequate numbers of nurses and healthcare personnel are available to provide health-related services to children who need them. The nursing services described in the IEP or Section 504 plan must conform to the rules of each state's nurse practice act.

Procedures must be established by state law to ensure that a medically fragile child is placed only in an educational setting where orderly, professionally responsible decisions can be made according to the child's needs; where the proper facilities, equipment and services are available; and where the provision of care will not unduly disrupt the educational progress of the other students. By failing to follow these procedures, the student is not only being denied FAPE, but the student's well-being and safety are also called into question.

Endnotes

- ¹ www.cps.edu/services-and-supports/health-and-wellness/chronic-conditions/
- ² Lehr, D. and Greene, J. Health Care Needs in Public Schools: The Intersection of Health Care, Education, and the Law. Vol.5, Issue 1. *Journal of Health Care Law and Policy*. 2002.
- ³ About IDEA. <https://sites.ed.gov/idea/about-idea/>
- ⁴ Ibid.
- ⁵ Sec. 300.114. LRE Requirements. U.S. Department of Education. 2017. <https://sites.ed.gov/idea/regs/b/b/300.114>
- ⁶ Sec. 300.115 Continuum of alternative placements. <https://sites.ed.gov/idea/regs/b/b/300.115>
- ⁷ IDEA, [34 CFR 300.320(b) and (c)] [20 U.S.C. 1414 (d)(1)(A)(i) (VIII)]. IDEA Regulations: Individualized Education Program (IEP) Team Meetings and Changes to the IEP. https://sites.ed.gov/idea/files/IEP_Team_and_Changes_to_the_IEP_10-4-06.pdf
- ⁸ National Center for Education Statistics. COE - Students With Disabilities (ed.gov). <https://nces.ed.gov/programs/coe/indicator/cgg/students-with-disabilities>
- ⁹ IDEA, Sec. 300.8 (c). <https://sites.ed.gov/idea/regs/b/a/300.8/c> and Sec. 303.111. <https://sites.ed.gov/idea/regs/c/b/303.111>.
- ¹⁰ Sec. 300.111 Child Find. <https://sites.ed.gov/idea/regs/b/b/300.111>
- ¹¹ Ibid.
- ¹² American Speech-Language-Hearing Association. www.asha.org/advocacy/schoolfundadv/overview-of-funding-for-pre-k-12-education/
- ¹³ Ibid.
- ¹⁴ Politico. <https://subscriber.politicopro.com/article/2022/10/at-25-519-per-pupil-new-yorks-school-spending-nearly-double-national-average-report-finds-00059792>
- ¹⁵ Section 504 of the Rehabilitation Act of 1973. <https://www2.ed.gov/about/offices/list/ocr/disabilityoverview.html>
- ¹⁶ Guidelines and Resources, Section 504. <https://charterselpa.org/wp-content/uploads/2017/10/504-Handbook-2021.pdf>
- ¹⁷ Ibid.
- ¹⁸ Ibid.
- ¹⁹ Ibid.
- ²⁰ Ibid.
- ²¹ United Federation of Teachers. www.uft.org/your-rights/know-your-rights/insubordination
- ²² Willgerodt, M.A., Brock, D. M., & Maughan, E.M. (2018). Public School Nursing Practice in the United States. *Journal of School Nursing*, 34(3), 232-244.
- ²³ Bobo, Nichole. (2018). Principles for Practice: Nursing Delegation to Unlicensed Assistive Personnel in the School Setting. National Association of School Nurses.

Schools **educate** and **care** for children with health needs requiring partnerships with **all levels** of school personnel.



The Role of the School Nurse

Today, schools educate and care for medically fragile children who may require extensive and sophisticated interventions. These increasing healthcare demands, coupled with shortages of school nurses, require formal partnerships with all levels of school personnel to provide for the care and well-being of children with special healthcare needs.

Responsibilities to Students

According to the National Association of School Nurses (NASN, 2022), the role of the school nurse is to assess the health needs of the child in the school setting and to coordinate with staff, family, physicians and community agencies to provide a comprehensive school health program that facilitates the maximum educational opportunity for that child. An example of staff coordination may include a general training or professional learning session on children with asthma, food allergies or diabetes, for example. This should not be confused with specialized individual training of healthcare designees trained in individual student care by the school nurse. This responsibility has increased dramatically during the past four decades with the inclusion of more children with special healthcare needs in public schools. Each state establishes its own health screening criteria for students, which range from minimal to comprehensive. But no matter what the requirements, the school nurse follows certain standards of care in fulfilling their responsibility to the student.

School Nursing: Scope and Standards of Practice¹ was developed by a task force of organizations, including the National Association of School Nurses and the American Nurses Association. These standards are intended to ensure high-quality, comprehensive care for schoolchildren, as well as to guide the school nurse in daily activities and planning. The standards of practice, which are comprised of the six steps of the nursing process, include the following:

1. Assessment

The school nurse collects pertinent student data.

2. Diagnosis (Nursing)

The school nurse analyzes assessment data to describe actual or potential health needs. The nursing diagnosis provides the basis for determining a plan to achieve expected outcomes.

3. Outcomes Identification

The school nurse articulates measurable, realistic and attainable expectations for the student, often expressed as an objective.

4. Planning

The school nurse, in partnership with the family, student and others, formulates a plan of care that specifies strategies for attainment of expected measurable outcomes.

5. Implementation

The school nurse applies the interventions identified in the plan, which includes the components of coordination of care, health teaching and health promotion.

6. Evaluation

The school nurse appraises progress toward attaining measurable outcomes.

In the IEP and Section 504 meetings, the school nurse is an integral member of the respective multidisciplinary team. The team, composed of a student's teacher(s), parent/caregiver, specialized instructional support personnel (SISP) (school nurse, school psychologist, occupational therapist, social worker, speech pathologist, for example) meet to determine the specific health services required for the student to attend classes and participate in educational activities. The school nurse takes the lead in planning related healthcare services to ensure the health and educational success of the student. The school nurse develops individualized healthcare plans, which detail the healthcare services needed for individual students. In addition to these IHCPs, the school nurse develops emergency care plans. The

nurse is also responsible for continuously monitoring and evaluating the health services provided to the student.²

In addition, school nurses follow well-established standards of professional performance, which describe a competent level of behavior in professional activities and include the following items listed in the box below.³

Delegating Responsibilities to Non-Nursing School Personnel

The role of the school nurse in working with non-nursing school personnel is to determine what orientation, education and training are necessary to enable them to safely and appropriately help medically fragile children.

As mentioned before, non-nursing school personnel, by and large, have no training in health-related fields. Moreover, most non-nursing personnel never anticipated performing healthcare procedures when they prepared to become teachers or school employees. Because these school staff are with the students for the majority of the

day and are their primary caretakers, it is imperative that all members of the team—teachers, paraprofessionals, other classified personnel, specialized instructional support personnel (SISP), etc.—are trained to participate in appropriate procedures and activities and know when to contact the school nurse to get emergency assistance.

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

Legal Considerations for the School Nurse

As the nurse well knows, the nurse practice act in each state governs the scope of nursing practice and limits

Standards of Professional Performance for Nurses

- **Ethics**
The school nurse integrates ethics in all aspects of practice.
- **Advocacy**
The school nurse demonstrates advocacy in all roles and settings.
- **Respectful and Equitable Practice**
The school nurse practices with cultural humility and inclusiveness.
- **Communication**
The school nurse effectively conveys information in all areas of practice.
- **Collaboration**
The school nurse collaborates with students, families and key stakeholders.
- **Leadership**
The school nurse leads within their professional practice setting and the profession.
- **Education**
The school nurse seeks knowledge and competence that reflect current nursing practice and promote innovative, anticipatory thinking.
- **Scholarly Inquiry**
The school nurse integrates scholarship, evidence and research findings into practice.
- **Quality of Practice**
The school nurse contributes to high-quality nursing practice.
- **Professional Practice Evaluation**
The school nurse appraises one's own and others' school nursing practice.
- **Resource Stewardship**
The school nurse utilizes appropriate resources to plan, provide and sustain evidence-based nursing services that are safe, effective, financially responsible and used judiciously.
- **Environmental Health**
The school nurse practices in a manner that advances environmental safety, justice and health.⁴

the nursing tasks that may be delegated to an unlicensed person. When the school nurse has responsibility for several different facilities or is not present at the school site, the nurse still maintains responsibility for the care delivered. Ensuring that care is appropriately delegated—within the requirements of both the nurse practice act and school administration policy—is crucial. (Refer to Appendix C, State Boards of Nursing Contact Information.)

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

Many school nurses practice autonomously as the only healthcare provider in the educational environment with limited or no access to a nurse supervisor. Only 36.2 percent of school nurses report being supervised by a registered nurse.⁵ Therefore, many school nurses are supervised and evaluated by non-nursing personnel, such as school administrators, who may have limited understanding of the role of the registered nurse in the school setting.

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

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

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

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

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

If the school nurse is pressured to delegate inappropriately or becomes aware that a principal or another administrator is attempting to delegate nursing duties, the nurse should immediately inform the administrator of the specifics of the state's nurse practice act and the liabilities involved in violating it. If the violation continues, state nurse practice acts may differ on whether RNs have an affirmative obligation to report the violation to their state board of nursing. In some states, if a nurse is aware of a violation of provisions or rules of the state's nurse practice act and does not report the violation, that nurse could be disciplined by the state board of nursing.

In addition to state law and school policy, some states have developed and adopted guidelines to assist the RN in making delegation decisions in the school environment. An example is "Guidelines for the Delivery of Specialized Health Services in the School Setting: An Arizona Resource Guide for Schools." The guidelines are included in Appendix E. While specific only to the state of Arizona, these guidelines may provide a framework for delivery of care by assistive personnel who are operating within the policy and procedures of their state and hiring agencies.

Endnotes

¹ National Association of School Nurses (2022). School Nursing: Scope and Standards of Practice (4th ed.).

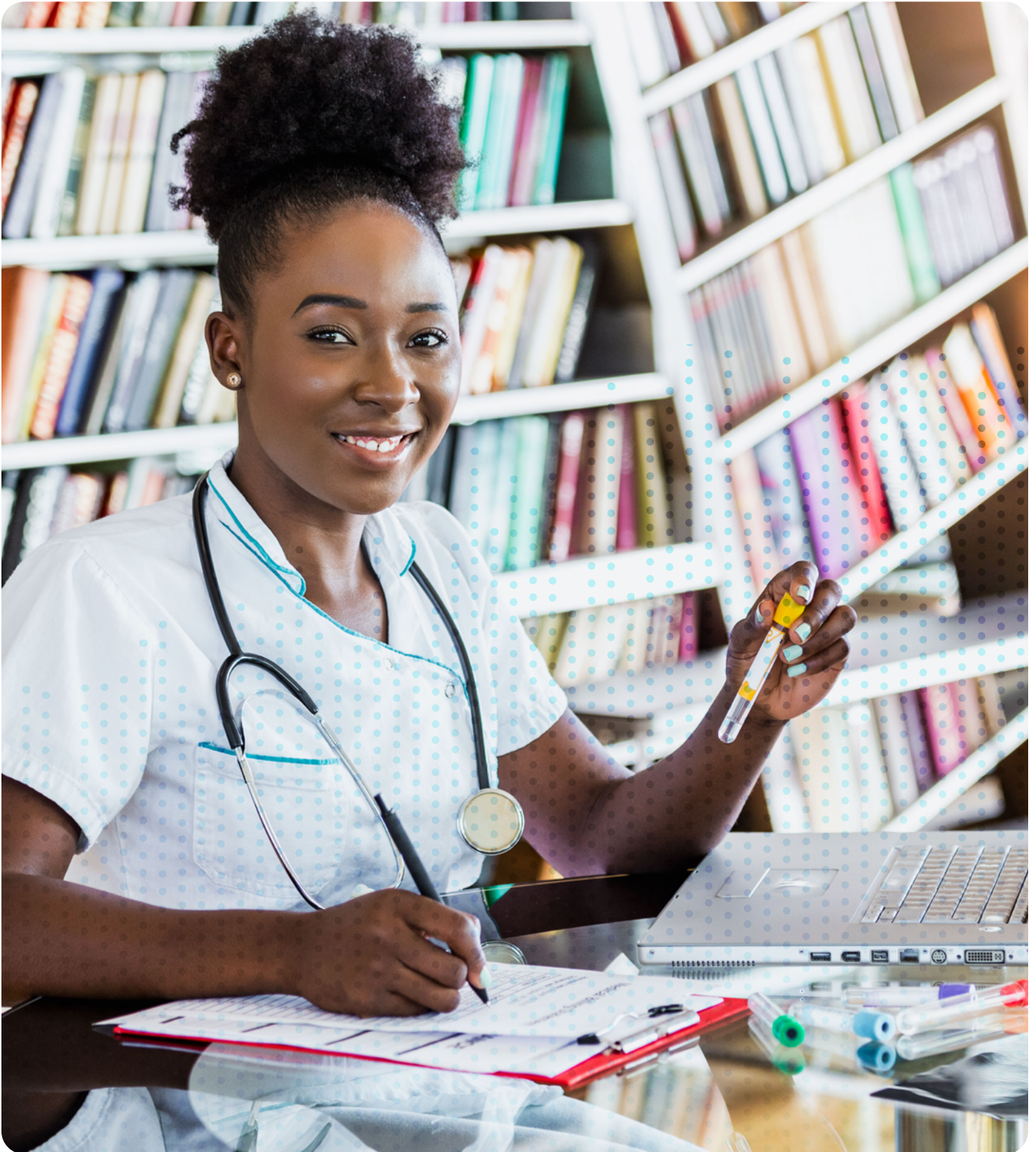
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³ National Association of School Nurses (2022). School Nursing: Scope and Standards of Practice (fourth edition). Cheryl Ann Resha and Kathleen H. Johnson, co-chair.

⁴ National Association of School Nurses (2022). School Nursing: Scope and Standards of Practice (4th ed.).

⁵ The 2015 NASN School Nurse Survey. The 2015 NASN school nurse survey: Developing and providing leadership to advance school nursing practice. A.S. Mangena, E. Maughan - NASN School Nurse, 2015 - journals.sagepub.com

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



The Legal Framework for Providing Care to Medically Fragile Students

What Services Must Schools Provide?

The IDEA is clear that schools are responsible for providing students who have profound health impairments with the “related services” (physical therapy, occupational therapy, health and nursing services, and speech therapy) they need to benefit from their education. The 2004 reauthorization of IDEA specified that school nurse services were part of the “related services” districts must provide.¹

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

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

What the Courts Say

The first major U.S. Supreme Court case to address the level of services schools are required to provide for children with special healthcare needs involved a student born with spina bifida. She was unable to control her bladder function and required clean intermittent catheterization (CIC) to attend school (*Irving Independent School District v. Tatro*).² The school district argued that CIC was an excluded “medical service.” But the court—relying first on IDEA regulations that defined medical services as services provided by a licensed physician, and second on evidence presented by the student’s family that CIC could be performed by a nurse or a minimally trained layperson—concluded that CIC was a necessary “related service,” and the school was required to provide it.

In 1999, the Supreme Court followed a similar analysis in *Cedar Rapids Community School District v. Garret*.³ In that case, the student was paralyzed from the neck down and required services that included CIC and ventilator assistance. The court again held that if the service could be delivered by someone with less training than a physician, the school district was required to provide it.

Who Cares for the Medically Fragile Child?

The Regulatory Framework for the Practice of Nursing

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

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

Scope of Practice

The Definition of the Practice of Nursing

Licensure authorizes licensed persons, in this case nurses, to perform certain tasks. Unlicensed persons, e.g., school administrators, are not legally permitted to assign those tasks to anyone. Only nurses can delegate activities within the scope of nursing practice; however, the definition of “nursing practice” and the scope of practice differs from state to state and is often quite general.⁴

For example, Oregon law defines the practice of nursing as:

“Practice of registered nursing” means the application of knowledge drawn from broad in-depth education in the social and physical sciences in assessing, planning, ordering, giving, delegating, teaching and supervising care that promotes the person’s optimum health and independence.

“Practice of (licensed) practical nursing” means the application of knowledge drawn from basic education in the social and physical sciences in planning and giving nursing care and in assisting persons toward achieving health and well-being.⁵

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

The answer usually lies with the state’s board of nursing, either alone or in collaboration with the state’s department of education, the state’s school nurse organization or the department of health. Some state boards of nursing and state departments of education, such as New York’s, have issued memoranda explaining the roles and responsibilities of school administrators, school nurses, and other school personnel in providing nursing and health-related services for students in the school setting.⁶

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

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

Do I Have to Do This?

Educators, paraprofessionals and other related staff and support staff are being called upon with more frequency to perform certain duties in the school setting that were traditionally performed by school nurses or health aides. When told it is their responsibility to carry out these tasks, most do it with trepidation and are left wondering, “Do I have to do this?” The short answer is yes; as an employee of the school district, you are obligated to perform tasks that are assigned. Once the school nurse has trained the employee and determined that the employee’s knowledge is sufficient to perform the task safely and correctly, the staff member can be designated to perform the task. Additional information regarding your rights will be provided in subsequent chapters.

Five Rights of Delegation

To provide safe and effective care for students, nurses use the five critical components of delegation to guide their decision as to whether delegation of care is appropriate for the student and the situation.

1. Determine the Right Task

Nursing tasks appropriate for delegation are those that:

- Are not complex and without potential for harm;
- Are part of the student's routine plan of care, whether at school or at home; and
- Follow an established sequence of steps:
 - Do not require modification;
 - Have a predictable outcome; and
 - Do not involve assessment, judgment, interpretation of results, or decision-making by unlicensed assistive personnel (UAP).

2. Determine the Right Person

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

3. Determine the Right Direction and Communication

- Training may include general health information, in addition to student-specific training based on the student's plan.
- A skills checklist can help guide the UAP's performance of the required tasks as well as document performance and proficiency.
- Outline a plan for communication, including when and what the UAP should report to the nurse.
- Specify how the UAP should respond in an emergency.
- Instruct the UAP on how to provide required documentation.

4. Determine the Right Supervision and Evaluation

- Document training, competency evaluation and ongoing supervision of the UAP.
- Document student's health outcomes.
- Supervision should include periodic on-site evaluation of the competence of the UAP and their written documentation.
- The amount of time needed for supervision will depend on the abilities of the UAP and the complexity of the nursing task.

5. Determine the Right Circumstance

The student's health status should be stable and the outcome of care predictable. The plan of care should:

- Document who will perform the identified nursing task;
- Specify the unchangeable steps that do not require assessment for performing the task;
- Outline a communication plan to report changes in a student's health status;
- Require a documentation process; and
- Explain how the school nurse will provide ongoing UAP supervision and evaluation as well as evaluation of the student's health outcomes.⁷

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

Delegation of Nursing Tasks in the School Setting

The National Council of State Boards of Nursing (NCSBN) and the American Nurses Association (ANA) Joint Statement (2019) defines "delegation" as transferring a nursing activity, skill or procedure from a licensed nurse to a competent individual who verbally accepts the responsibility to perform a selected nursing task in a selected situation. Only a nurse can delegate nursing tasks. Even then, accountability and responsibility for correct performance of the task will remain with the nurse.⁸

Rules about delegation vary from state to state. In some states, duties that are within the registered nurse's scope of practice cannot be delegated to another individual under any circumstance. In other states, delegation can occur, but *only* at the direction and supervision of the nurse, who is ultimately responsible for the task being done correctly. The nurse must provide guidance for performing the procedure and must periodically observe the person as the procedure is being performed to be certain it is being done properly.

The NCSBN and the ANA recognize health aides and classroom paraprofessionals as people who may assist with the provision of students' health-related services as documented in their respective IEPs or 504 plans. However, paraprofessionals, health aides and teachers require specific training from the school nurse before they are permitted to provide designated healthcare services. Additionally, while the NCSBN recognizes health aides and classroom paraprofessionals as people who may assist with health-related services, delegation of these services should take into account the particular staff member's responsibilities to other students and their time available to attend to the child with specialized healthcare needs.⁹

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

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

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

Complicated Staffing Issues

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

The school district always maintains a general duty to the health and safety of all students. In this situation, the school nurse is responsible for coordinating and communicating with the outside agency about the student's care. Usually, the school nurse is not responsible for providing any direct services to the student. If the school staff or school nurse has concerns about the quality or safety of the care being provided by the agency staff, the school nurse must communicate that concern to the case manager from the agency, which is ultimately responsible for the quality of care being delivered by its staff. Usually, the case manager is an RN who is responsible for the planning of care and for delegating that care to LPNs or personal care assistants employed by the agency. In very rare circumstances, the school nurse might intervene in the delivery of care if the student's health and safety is in danger.¹⁰

A procedure should be established for the school nurse to follow if it is determined that the private nurse is performing their duties in an unsafe manner.

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

Documentation Standards: If It Wasn't Written, It Wasn't Done

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

School Health Records

According to the School Nursing Scope and Standards of Practice,¹¹ school nurses must document each student encounter and each aspect of the nursing process. The standards call for these practices to promote:

- Consistent and continual care;
- Regular evaluation of individualized healthcare plans; and
- Subsequent revisions in care.

It is the position of the National Association of School Nurses (NASN) that all registered professional school

nurses should have access to a software platform for student electronic health records (EHRs) that includes nursing language/medical terminology and complies with standards of confidentiality, security and privacy.¹²

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

While certain laws, such as the Health Insurance Portability and Accountability Act (HIPAA), treat health information as confidential and prohibit its disclosure, other federal laws, such as the Family Educational Rights and Privacy Act (FERPA), require school districts to give parents the opportunity to review and inspect educational records, and do not make distinctions between records maintained by school health professionals and other types of school records.¹³ Clearly, this can create a potential conflict. School nurses bear enormous responsibility for educating school administrators about meeting nursing documentation requirements, establishing appropriate school record-keeping systems, and maneuvering through conflicting legal requirements.

The Family Educational Rights and Privacy Act

The Family Educational Rights and Privacy Act, commonly known as FERPA, requires every school district, annually, to notify parents and eligible students (over age 18) of their right to inspect and review their children's education records, or their own. FERPA defines education records as records that are directly related to a particular student and maintained by an educational agency or institution.¹⁴

Generally, the personal notes of nurses and other professionals, which are intended solely as an extension of memory, are exempt from FERPA rules. However, the record may fall under FERPA disclosure rules if it is created or maintained in response to school district policy or procedure; is discussed with other school personnel at staffing, support, or IEP team meetings; is held within the student's official education record (not in sole possession of the maker of the record); or is the basis for a service recommendation.¹⁵

The Health Insurance Portability and Accountability Act

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

However, HIPAA regulations specifically exclude from the privacy requirements information considered "education records" under FERPA.

Education records include a student health record or an immunization record. Health records maintained for children eligible under IDEA also are considered education records and are subject to IDEA and FERPA privacy requirements, but are not subject to the HIPAA privacy rules.¹⁶

Issues for School Health Providers

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

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

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

Liability

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

But the good news is that, in spite of all of the potential for litigation, school nurses are rarely sued for professional negligence.¹⁸ When school nurses are sued, usually they are named as additional defendants in lawsuits against school districts. In those cases, the nurse will benefit from state laws and court decisions that narrowly define the duty of school districts and school district employees,

that require plaintiffs to prove something more than simple negligence, or that provide immunity for actions undertaken in the course of school district employment. In addition, most states require school districts to defend the school nurse, or reimburse legal fees, when the nurse is sued for actions taken in performing the duties of the job.

Negligence

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

- A legally recognized duty to conform to a certain standard of conduct for the protection of others against unreasonable risks;
- A breach of duty, i.e., a failure on the part of an individual to conform to the standard;
- A reasonably close causal connection between the conduct and the resulting injury (often referred to as “proximate cause”); and
- Actual loss or damage to the interests of another.

Recommendations for School Nurses and Other Health Providers

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

The following recommendations, drawn from *Legal Issues in School Health Services: A Resource for School Administrators, School Attorneys, School Nurses*¹⁷ will help you get started:

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

All four elements—duty, breach of duty, close causal connection, and loss or damage—must be present for liability to be established.¹⁹

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

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

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

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

Liability Under Section 1983

School personnel who serve students with disabilities can be named in another kind of lawsuit under Section 1983 of the Civil Rights Act of 1871.²⁰ This Reconstruction-era statute, originally enacted to give formerly enslaved people redress against state and local governments and officials who violated their federal rights, can be used by parents of students with disabilities seeking monetary damages for

violation of rights created by the IDEA and Section 504 of the Rehabilitation Act.

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

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

Do-Not-Resuscitate Orders

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

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

Unfortunately, the legal issues surrounding DNR orders are no less complex than the social and emotional issues surrounding them.

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

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

Regardless, it is inevitable that school districts will continue to receive physician-issued DNR orders given the increased presence of medically fragile children in our public schools today. School district policies should be established and based on what is best for students, within the confines of state law and with consideration for community resources.²¹

Causes of Liability

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

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

Nurses can avoid liability by making sure their practices do not fall into any of these categories, as well as by acquainting themselves with the policies and procedures adopted by their school board and school administration and, more specifically, by acquainting themselves with their job description. Every school nurse should have a job description and should review it regularly.²²

Addressing the Issue

The legal, moral and ethical questions surrounding do-not-resuscitate orders are so complex, and the potential outcome so final, that it would be wise for the local union to obtain independent legal advice concerning the obligations and potential liabilities of its members before weighing in on the issue.

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

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

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

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

School instructional personnel (teachers and paraprofessionals) and non-nursing-related service personnel have other issues to consider. Some members of the school staff may have moral or ethical objections to complying with a DNR order. It is also important to consider the potential emotional trauma to other students. For some students with a DNR order, placement in a

regular classroom may not be appropriate to meet the needs of the student, and placement in a more restrictive setting may be necessary.

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

Endnotes

¹ 20 U.S.C. 1401 (26)

² 526 U.S. 66 (1999)

³ 468 U.S. 883 (1984)

⁴ Nadine Schwab, and Mary H.B. Gelfman, eds., *Legal Issues in School Health Services*, Authors Choice Press, 2005.

⁵ Oregon State Board of Nursing, Oregon Nurse Practice Act. www.oregonlegislature.gov/bills_laws/ors/ors678.html

⁶ New York State Department of Education: Provision of Nursing Services in School Settings—including One-to-One Nursing Services to Students with Special Needs (2019). <https://p12.nysed.gov/ssd/documents/OnetoOneNSGQAFINAL1.7.19.pdf>

⁷ American Nurses Association/National Council of State Boards of Nursing. (2019). National Guidelines for Nursing Delegation. www.ncsbn.org/public-files/NGND-PosPaper_06.pdf

⁸ Bobo, Nichole. National Association of School Nurses. Principles for Practice: Nursing Delegation to Unlicensed Assistive Personnel in the School Setting (second edition). (2018).

⁹ American Nurses Association/National Council of State Boards of Nursing, op. cit.

¹⁰ Nadine Schwab, and Mary H.B. Gelfman, eds., op. cit.

¹¹ National Association of School Nurses and American Nurses Association, *School Nursing Scope and Standards of Practice*. (fourth edition, 2022).

¹² National Association of School Nurses, Position Statement on Electronic Health Records: An Essential Tool for School Nurses to Keep Students Healthy, adopted January 2019. www.nasn.org/nasn-resources/professional-practice-documents/position-statements/ps-electronic-health-records

¹³ U.S. Department of Education. (2019). Joint Guidance on the Application of the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to Student Health Records. www.hhs.gov/sites/default/files/2019-hipaa-ferpa-joint-guidance.pdf

¹⁴ U.S. Department of Education. (2021). A Parent Guide to the Family Educational Rights and Privacy Act (FERPA). https://studentprivacy.ed.gov/sites/default/files/resource_document/file/A%20parent%20guide%20to%20ferpa_508.pdf

¹⁵ Nadine Schwab, and Mary H.B. Gelfman, eds., op. cit.

¹⁶ U.S. Department of Education. (2019). op. cit.

¹⁷ Nadine Schwab, and Mary H.B. Gelfman, eds., op. cit.

¹⁸ Selekman, J., Shannon, R and Yonkaitis, C. (2019). *School Nursing: A Comprehensive Text* (third edition). Philadelphia: F.A. Davis.

¹⁹ Nadine Schwab, and Mary H.B. Gelfman, eds., op. cit.

²⁰ Ibid.

²¹ Ibid.

²² Ibid.

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



Non-Nursing School Personnel

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

What Is the Role of the Teacher?

Teachers are responsible for developing and implementing the instructional program in the classroom, including the implementation of IEP goals and accommodations/504 plan accommodations for applicable students.¹ This includes using the district's curriculum, incorporating state/district academic standards into classroom practice, providing a safe and orderly classroom environment, serving on IEP and 504 teams, and participating in a variety of other activities that support instruction. To provide high-quality instructional programs to medically fragile students, teachers will have to collaborate with a variety of specialized instructional support personnel (SISP), including the school nurse, and may have to coordinate the work of one or more paraprofessionals. While it is inappropriate for special or general education teachers and paraprofessionals to provide health services to students without the appropriate training from the school nurse, the AFT refers the reader again to the principle of "obey now, grieve later." Once more, if a staff member does not have the skills or capacity to do what is directed or if they would be putting another person in danger, the staff member should notify the administration immediately. Student safety must always be considered.²

Nursing services should be provided by the school nurse, licensed practical nurse, well-trained and competent health aide, or a designee (depending upon the service) working under the direction of the school nurse. In today's schools, it takes a team to best care for these children, including the school nurse, classroom teacher, resource teacher, paraprofessional, school secretary, bus driver, etc.

We all need to support each other, respect each other, communicate effectively and work together to take the best care of our medically fragile children.

It is important for teachers to work closely with the school nurse to ensure the health services in students' IEPs and 504 plans are consistently implemented to avoid a denial of FAPE.

What Is the Role of the Paraprofessional?

The role of the paraprofessional is to provide support for the students and teacher in the classroom. This includes, for example, small-group instruction, monitoring student activity and tutoring students. Paraprofessionals typically work in either a special education or a regular education classroom. Paraprofessionals in self-contained special education classrooms have traditionally been faced with the possibility of providing health services to students. These services may include clean intermittent catheterizations, tube feedings and cleaning tracheotomies. Paraprofessionals in general education classrooms, which include students with IEPs (based on each student's identified LRE) and 504 plans, are increasingly exposed to the possibility of providing health services that range from the most basic to extremely complex, invasive procedures, because many school districts are placing medically fragile students into general education classrooms.³ Many paraprofessionals have informed the AFT that they perform such procedures with inadequate training or no training at all. It is critical to the safety of our students that staff are properly trained to perform delegated healthcare procedures.

School personnel in **non-nursing roles** are responsible for providing **services** to medically fragile students.

What Is the Role of the Health Aide?

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

What Is the Role of the School Administrative Assistant Regarding Medically Fragile Students?

In addition to the numerous responsibilities assigned to a school's administrative assistant, this role is essential to the flow of oral and written communication and interaction within the school, between the school and parents, and with other health and social service agencies that provide services to medically fragile students. The administrative assistant's responsibilities vary by district and may include maintaining and providing access to written communications, fulfilling records requests, maintaining health records and other documentation containing crucial information about the student's health, daily interactions, incidents or emergencies. This information could have legal implications for the school district and the student's family.

Some administrative assistants are named as designees by school principals to administer first aid and dispense medication to students. Staff assigned as designees act under the guidance of the school nurse and require training before providing medication or health

services to students. The nurse also ensures designees maintain individual student medical logs as a means of accountability.

What Is the Role of the School Bus Driver?

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

Transportation services for special-needs students are affected by IDEA. Recommendations from a report by the 16th National Congress on School Transportation specifically address:

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

The full report is available online at www.nasdpts.org/NCST-NSTSP.⁴ The 17th conference will meet in 2025 to revise the full document. In addition, school districts themselves should develop policies or guidelines to cover suspension of services for behavioral reasons as well as student-restraint procedures.

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

What Is the Role of the School Nutrition Worker?

The school cafeteria worker provides nutritious meals for students through the school lunch and breakfast program, as well as nutrition education to staff and students. The cafeteria manager provides special meals for students who have particular dietary needs or problems such as food allergies. Many children with special healthcare needs have physical concerns that require special diets and feeding. Teachers and paraprofessionals should consult with the school nurse and work closely with cafeteria workers so that they can determine and prepare the appropriate foods as documented in a student's IEP or 504 plan. Feeding children with special healthcare needs in regular schools may pose a problem for some cafeteria workers who do not have kitchen equipment to prepare special meals because they heat cold lunches from a central kitchen. This issue will have to be addressed by the administration in each school district.

What Is the Role of the Custodian?

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

The COVID-19 pandemic brought increased attention to the role of school custodians in reducing the spread of viral and bacterial infections within schools, including COVID-19, influenza, staphylococcus aureus, hepatitis B and C, HIV, toxic mold and E. coli. Custodians provide a cleaner and safer environment, which is particularly important for medically fragile children. In addition to performing much of the surface cleaning in schools, custodians are responsible for maintaining ventilation systems. Properly maintained heating, ventilation and air conditioning (HVAC) systems reduce the airborne spread of many infections, reduce the growth of mold, and improve air quality.⁵

Custodians should receive training on when cleaning, sanitizing or disinfecting surfaces is needed per CDC and EPA guidance and the OSHA Hazard Communication standard. However, only roughly half of school employees in the country are covered by OSHA.⁶ In many cases, surface cleaning with detergent and water is sufficient to deactivate or remove viruses and bacteria. Efforts

to sanitize or disinfect all surfaces increase chemical exposures and can exacerbate respiratory illness for students and staff. The CDC provides cleaning guidance for school settings.⁷ Specific guidance on cleaning for infection control in the health suite is available on the CDC's website.⁸ Traditional pesticides that are used for pest control also may contribute to children's health problems. Custodians can use integrated pest management to minimize those risks.⁹ For more information, please see the Healthy Schools Network and its toolkits for green cleaning and healthy products.¹⁰ The AFT participated in the development of these toolkits.

School custodians are also tasked with maintaining heating, air conditioning, plumbing, and the building itself, often without adequate resources. Even new buildings can be plagued with poor ventilation or leaks in the plumbing or roof, but these issues are particularly challenging in older buildings. These problems can result in the growth of mold and/or poor air quality causing "sick building syndrome" for some staff and students and can be dangerous for some medically fragile children. Contact AFT's Health and Safety Program at 4healthandsafety@aft.org for more information on how to address building conditions that contribute to poor health.¹¹

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

AFT's Recommendations for Non-Nursing School Staff

The AFT recognizes that teachers, paraprofessionals and school-related personnel have been performing medical procedures for students with special healthcare needs for many years—in some cases, with extensive training, and in many others, with no training at all. Paraprofessionals and health aides provide a valuable service by freeing the teacher to take responsibility for education and allowing the school nurse to handle more serious health needs.

This practice should continue where appropriate, but we also believe there are precautions affiliates should take to protect their members:

1. **Negotiate requirements** for appropriate training programs for all school personnel who work with children with special healthcare needs. For examples

of appropriate training, see the section on “Training Needs of School Staff” in this chapter.

2. **Educate school staff about the legal limitations** placed on them by the state’s nurse practice act.
3. **Educate school staff about the liability issues** they face and the union’s ability to protect them.
4. **Develop job descriptions** that clearly define the roles and responsibilities of the school staff (especially paraprofessionals, on whom the responsibility often falls).

Non-Nursing School Personnel and the IEP

The individualized education program (IEP) is the legally binding document that commits the school district to provide educational services to a student. The specifics of the IEP are determined by the school’s instructional support team or the educational management team (team names vary by state and/or district), which includes the parent. It is important that the IEP designate which specific services and personnel are necessary to provide the student with a free and appropriate education in the least restrictive environment. This means, for example, if a student has a designated paraprofessional assigned to assist them, this fact must be documented in the IEP. In addition, any training necessary to enable non-teaching staff to perform their duties should be written into the IEP.¹²

Training Needs of School Staff

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

1. **Individuals with Disabilities Education Act**—history of the act, who is covered, how it works.
2. **Section 504 of the Rehabilitation Act**—history of the act, who is covered, how it works.
3. **Legal issues**—the state’s nurse practice act and liability.
4. **Universal precautions** and exposure to blood-borne pathogens—what this means, how staff can protect themselves, what to do in the event of an exposure.
5. **Basic first aid**, cardiopulmonary resuscitation (CPR) and automated external defibrillation (AED).
6. **Emergency** response and preparedness for natural disasters, power failures, and active shooter events, including where to take medically fragile students.

7. **Infectious disease response**, including when to isolate students and stay-at-home policies.
8. **Proper techniques** for lifting and moving students, including training on use and maintenance of lifting and transferring equipment.
9. **Proper** use of the equipment students might have in school (e.g., wheelchairs, walkers, breathing apparatus).
10. **Overview** of typical student health problems that may be encountered in the traditional classroom (e.g., asthma, diabetes, food allergies, cystic fibrosis, seizures) as well as communicable diseases.
11. **Proper training** on any healthcare procedures delegated to staff by the school health professional, including:
 - What constitutes an emergency.
 - Whether the procedure could be a threat to staff member’s own health and safety.
 - Possible side effects of procedures or medications.
 - Possible drug interactions, and legal and liability issues.

The school nurse’s responsibility is to establish that non-nursing school personnel have been trained appropriately to provide the health services they have been delegated. It is also the nurse’s responsibility to continually monitor the performance of delegated tasks, and ensure retraining or updated training for school personnel who have been delegated to perform such tasks. A model email designed to be used by school personnel who are asked to perform nursing duties is included in Appendix D: “Model Email to School Administration Documenting Inappropriate Delegation of Nursing Duties to Teachers or PSRPs.”

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

Endnotes

- ¹ U.S. Department of Education. (2019). A Guide to the Individualized Education Program. <https://www2.ed.gov/parents/needs/speced/iepguide/index.html>
- ² United Federation of Teachers. Insubordination. www.uft.org/your-rights/know-your-rights/insubordination
- ³ National Association of School Nurses. (2022). School Nursing: Scope and Standards of Practice. (fourth edition). Silver Spring, Md.
- ⁴ National Congress on School Transportation. (2015). National School Transportation Specifications and Procedures. www.nasdpts.org/resources/Documents/NCSTFiles/NCST%202015%20Specifications%20and%20Procedures%204.20.18.pdf
- ⁵ Ventilation in Schools and Childcare Programs. www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/ventilation.html
- ⁶ Centers for Disease Control and Prevention. <https://www.cdc.gov/hygiene/cleaning/facility.html> (Nov. 2, 2022)
- ⁷ Ibid.
- ⁸ CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings. <https://www.cdc.gov/infectioncontrol/guidelines/core-practices/index.html> (November 29, 2022)
- ⁹ Healthy Schools Network. www.healthyschools.org/ (2023)
- ¹⁰ Green Cleaning & Healthy Products. www.healthyschools.org/Cleaning-For-Healthy-Schools/ (2023)
- ¹¹ Health and Safety Resource Community. 4healthandsafety@aft.org (2023)
- ¹² The IEP Process. IRIS Center. <https://iris.peabody.vanderbilt.edu/module/iep01/cresource/q2/p03/> (2023)

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



Creating a Safe Environment: Protecting Staff and Students

When staff members are routinely asked to exceed their physical limits and capacity, their safety—and that of their students’—is threatened. A safe and healthy school environment is an important and achievable goal for the care and well-being of children with special healthcare needs and the staff who care for them. Staff members should not be expected to sacrifice their own health and safety to meet their students’ needs.

The AFT feels that the physical environment must be adapted for the unique demands of caring for these children. The proper equipment must be available and well-maintained, and staff should be trained on safe techniques for assisting children. When any of these elements is missing, the risk of injury and illness increases for students and staff.

School staff may deal with student behavior that results in injuries from bites, punches, scratches and kicks. Nonviolent crisis intervention training for school staff is essential for the protection of staff members and students alike. Schools can also implement strategies recommended by the Occupational Safety and Health Administration for reducing the risk of these injuries in healthcare and social assistance settings. This includes tracking these incidents and conducting root cause analysis to identify ways to prevent similar incidents in the future.¹

Every school should have a process and policy that will assess the needs of a particular student and identify safety measures for the staff person who will support and assist the child. Such a comprehensive policy also should cite pertinent OSHA standards, and recommendations of both the Centers for Disease Control and Prevention (CDC) guidelines and the National Institute for Occupational Safety and Health (NIOSH).

The policy also should evaluate staff training requirements and encourage staff to receive recommended vaccinations.² Reducing infectious disease exposures is particularly important for staff with chronic diseases or who are immunocompromised. For more information, contact AFT Health and Safety at 4healthandsafety@aft.org.

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

Safe Student Handling:

Ergonomics

School staff members who physically lift and assist students have a higher rate of back injury and muscle strains and sprains. NIOSH has found that most healthy workers can lift up to 51 pounds with two hands under ideal conditions over the course of a workday without adding increased risk of back pain and injury.³ Yet, it is not uncommon for some school staff to lift that amount 10-20 times as they assist children with diapering, toileting and transportation during the school day. As a result, school staff may experience back pain or injury, and the student is more likely to be dropped or injured in a recovery attempt. An injured staff member cannot contribute fully to the classroom and to student needs. It is beneficial to have healthy staff members who can provide a safe environment for their students.

Fortunately, ergonomics researchers and designers have developed effective methods for handling and assisting medically fragile students. When rooms are designed to accommodate children and their equipment, the risks of injury to either staff or students decrease significantly. For instance, there is an array of lifting equipment for whole-body lifts and sit/stand devices, as well as guidance on

when to use them. (See Appendix H.) Changing tables that can be adjusted to safely transfer students to and from the table are also available.

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

Emergency Preparedness and Response

School emergency preparedness and response plans often fall short of addressing the issues of medically fragile children. Some plans may be clear and relatively easy to

conduct. For example, fire plans may call for students to be taken to a designated room or area where firefighters can evacuate them safely. However, in other emergency situations, such as bomb threats or natural disasters, evacuation procedures may not be clear, especially when there are more students with mobility issues than staff who can safely move them. Students in wheelchairs may be on upper levels of schools—this is particularly true for students in high school who change classes.

The AFT honored two paraprofessionals who carried students down three flights of stairs in a high school located near the World Trade Center on 9/11. Their efforts were heroic, but they risked injuring the students and themselves. A better solution is to have evacuation chairs or devices that are safe for students and staff alike.

Preventing Back Injuries in Classroom Personnel

Back, neck or shoulder injuries caused by lifting or transferring students develop over time and can cause serious pain and even disability, but they are preventable with the proper equipment. Here are prevention tips for classroom personnel who handle medically fragile children (also see Appendix H):

Tip No.1: Pay attention to chronic/recurring back pain.

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

Tip No.2: Never manually lift students by yourself.

Remember that the weight of almost all students far exceeds 51 pounds, the recommended lifting weight determined by NIOSH to be safe. Lifting students produces incredible forces or “strains” on the lower back. Unfortunately, “lifting techniques” are not helpful when handling students; their bodies are bulky loads with no “handles,” and a lifter can’t bring that load close enough to the body to reduce strain.

Tip No.3: There are ways to manage students in the classroom setting.

Research in the healthcare industry has shown that teamwork is essential when handling patients; this research can be

easily applied to a school setting. When transferring students (e.g., for toileting), teams should use lifting devices, such as ergonomically designed sit-to-stand devices or transfer devices. When a student is too heavy and/or does not have the strength to assist during a transfer, mechanical devices are essential (see Appendix H). Gait belts should not be used to lift or catch a falling student, but to steady and assist them while walking. They are contraindicated for students with G-tubes or recent back surgery.

Tip No.4: Every school should have a training and task redesign program to prevent staff or student injuries.

Essential elements of the program should include:

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

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

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

Infectious and Communicable Diseases

The COVID-19 pandemic heightened the need to pay attention to reducing the risk of infection spread within facilities. Medically fragile children may be more susceptible to the many infectious disease agents that find their way into schools, including COVID-19, influenza and measles. School staff should be especially vigilant in monitoring these students for infections and should take precautions not to transmit infections from one student to another or to a staff person. The best practice is for staff to receive yearly training on infectious disease prevention. Staff should also be advised on immunizations recommended by the CDC's Advisory Committee on Immunization Practices for adults in school settings.⁴

During outbreaks of severe or newly emerging infectious diseases (like COVID-19), it is critical for students and staff to have access to personal protective equipment (PPE), specialized clothing or equipment worn by an employee for protection against infectious materials. According to the CDC (2022), the use of PPE drastically reduces the risk of infection from COVID-19 compared with no mask use in healthcare workers. N95 and equivalent respirators provide more protection than surgical masks.⁵ Surgical masks or face masks may also be used as source control to reduce the spread of infection. Some medically fragile children may be unable to wear masks.

Healthy Schools Network and Green Cleaning Products

In the 29 states and territories where OSHA standards are in place, school employees should receive annual training on preventing work-related exposure to bloodborne

Rules of Handwashing

1. Wet your hands with clean, running water (warm or cold); turn off the tap; and apply soap.
2. Lather your hands by rubbing them together with the soap. Lather the backs of your hands, between your fingers and under your nails.
3. Scrub your hands for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song from beginning to end twice.
4. Rinse your hands well under clean, running water.
5. Dry your hands using a clean towel or an air dryer.

www.cdc.gov/handwashing/when-how-handwashing.html

pathogens, PPE and the opportunity to be vaccinated for hepatitis B.⁶

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

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

Hand-washing, or "hand sanitation," as the CDC calls it, is also effective to protect staff and students from infection with microbes. Hand-washing is one of the most effective ways to prevent disease transmission.

Frequency (how often hands are washed) is also important. Wash your hands for 20 seconds:

- Upon arrival at school;
- Before handling food or feeding children;
- Before and after assisting a child in using the toilet;
- After changing diapers;
- After contact with a runny nose, vomit or saliva;
- After handling pets; and
- After removing gloves.

Some school personnel do not have immediate access to the restroom to wash their hands at all times. The Centers for Disease Control and Prevention has recognized another option, when hand-washing isn't possible or practical. Gel hand sanitizer that has an alcohol content between 60 and 90 percent is effective in killing almost all the germs on a person's hands.

It's important for staff not to go overboard with disinfecting surfaces and equipment. Too often, in an attempt to protect everyone, bleach (often in concentrated forms) is applied when routine cleaning and sanitizing may be enough. Bleach is a toxic and highly corrosive chemical that, in high concentrations, not only can irritate and abrade skin, but can cause severe irritation (to the point of burning) to the nose, throat, eyes and lungs. Staff should understand the ABCs of germ control. An all-purpose cleaning product and a microfiber cloth can remove most viruses and bacteria from surfaces. Sanitizing, which by definition has a 99.9 percent kill rate, is generally required for food preparation areas. Disinfectants, as defined by the U.S. Environmental Protection Agency, kill almost all germs on a surface when used as directed. Disinfectants should be used only in high-risk areas, after surfaces have been cleaned.

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

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

Due to the significant side effects associated with phenols, they should not be used in school facilities.⁷ These are often found in aerosol containers of disinfectant. More common these days are quaternary ammonium compounds, or "quats," used for disinfecting. Benzalkonium chloride, a widely used quat, has been linked with occupational asthma. Therefore, staff should take precautions when using disinfectants with this chemical; adequate ventilation and proper gloves are imperative when using this product.

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

It is not uncommon for students to come to school with lice, flea or bedbug infestations. Staff should be trained on district policies and procedures. In some schools, school nurses or paraprofessionals may have access to washing machines and a change of clothes for students, but changing students' clothing may be against district policy in others.

Contact the AFT Health and Safety program at 4healthandsafety@aft.org for more information on protecting the well-being of staff and students.

Endnotes

- ¹ NIOSH (1994, revised 2021). Applications manual for the revised NIOSH lifting equation. By Waters T.R., Ph.D., Putz-Anderson V., Ph.D., Garg A., Ph.D. Cincinnati: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health, DHHS (NIOSH) Publication No. 94-110. www.cdc.gov/niosh/docs/94-110/default.html
- ² Adult Immunization Schedule. Centers for Disease Control and Prevention. <https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html>
- ³ NIOSH [1994, revised 2021]. Applications manual for the revised NIOSH lifting equation. By Waters T.R., Ph.D., Putz-Anderson V., Ph.D., Garg A., Ph.D. Cincinnati: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health, DHHS (NIOSH) Publication No. 94-110. www.cdc.gov/niosh/docs/94-110/default.html
- ⁴ Centers for Disease Control and Prevention. Adult Immunization Schedule.. www.cdc.gov/vaccines/schedules/hcp/imz/adult.html
- ⁵ Centers for Disease Control and Prevention. Occupationally Acquired Infections in Healthcare Settings. www.cdc.gov/hai/prevent/ppe.html
- ⁶ The states with OSHA laws for public sector are: Alaska, Arizona, California, Connecticut, Hawaii, Illinois, Indiana, Iowa, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New Mexico, New York, North Carolina, Oregon, South Carolina, Tennessee, Utah, Vermont, Virginia, Washington, Wyoming plus Puerto Rico and the U.S. Virgin Islands.
- ⁷ Centers for Disease Control and Prevention. Phenol. www.cdc.gov/niosh/topics/phenol/default.html

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



Collective Bargaining and Workers' Rights

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

The following are some samples of contract language that have been achieved through the collective bargaining process. These are examples of how some locals have addressed various subject areas and should not be viewed as model contract language. The scope of bargaining under your state's collective bargaining law may be more limited or more expansive than that of the states in which the following contract language was negotiated. AFT affiliates should consult with local counsel about the types of protections that can be negotiated in their state.

Staffing Ratios for School Nurses

The 2020 National Association of School Nurses "Position Statement on School Nurse Workload: Staffing for Safe Care" recommends:

- Using the nurse-to-student ratio alone is not evidence-based or appropriate.
- Current best practice for staffing involves analyzing complex factors, including number of students, social determinants, acuity levels, other responsibilities, barriers to care, current use of technology, and healthcare to adequately meet the health and safety needs of the children whose care is entrusted to schools.¹

It is also the position of NASN that all students should have access to school nursing care by a registered, professional school nurse (hereinafter referred to as school nurse) all day, every day. "For students who face barriers to accessing healthcare, especially those living in predominantly low-

income, rural and minority communities, a school nurse may serve as their only regular healthcare provider."²

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

- Schools having heavy health room needs and utilization by students (both secondary and elementary schools) should continue to have additional nursing services assigned as available. (*Pittsburgh Federation of Teachers*)
- Every effort shall be made to provide no more than four school assignments for each nurse. (*Cleveland Teachers Union*)
- All high schools will be assigned one individual who shall possess the registered nurse designation in addition to regular teacher certification. This individual will not be required to teach classes, but may be used as a resource person in the area of physical health. Requests for classroom appearances should normally be made at least five days before the visitation.

An adult nurse's aide will be provided from 9 a.m. to 1 p.m. in high schools. The aide shall work under the direction of the nurse.

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

By no later than July 30, 2023, the BOARD [Board of Education of the City of Chicago] will assign at least one full-time nurse to each school in the District.
(*Chicago Teachers Union*)

Right to Refuse

- School nurses shall be assigned only professional and health-related duties in the school(s) to which they are assigned, except in emergencies involving health or safety. (*Pittsburgh Federation of Teachers*)
- School-related personnel (SRP)—other than health assistants, senior child care assistants or LPNs— shall not administer medication or perform routine medical procedures as part of their daily work responsibilities, unless the SRP has volunteered and has been authorized by the work site or district/program supervisor. The SRP who administers medication or performs routine medical procedures shall receive training by a licensed practical nurse, a registered nurse, a licensed physician or a licensed physician assistant. Such training shall be provided by the board during the SRP’s work hours. (See Appendix C)
- LPNs shall perform invasive medical procedures as part of their daily work responsibilities. Non-medical SRP are prohibited from performing invasive medical procedures.
- Personnel other than LPNs shall not be allowed to perform invasive medical services that require special medical knowledge, nursing judgment and nursing assessment. These procedures (invasive medical services) include, but are not limited, to:
 1. Sterile catheterization;
 2. Nasogastric tube feeding; or
 3. Cleaning and maintaining a tracheostomy and deep suctioning of a tracheostomy.
- SRP (other than health assistants, senior child care assistants or LPNs) shall not perform health-related services as part of their daily work responsibilities, unless the SRP has volunteered, has been authorized by the work site or district/program supervisor, and has successfully completed child-specific training by a licensed practical nurse, a registered nurse, a licensed physician or a licensed physician assistant. All procedures shall be monitored periodically by the nurse. Those procedures include, but are not limited to:
 1. Cleaning intermittent catheterization;
 2. Gastrostomy tube feeding;
 3. Monitoring blood glucose; or
 4. Administering emergency injectable medication.
- For all other invasive medical services not listed above, a licensed practical nurse, a registered nurse, a licensed physician or a licensed physician assistant shall determine if non-medical school personnel shall be allowed to perform such service. (*United School Employees of Pasco [Fla.]*)
- Initial hearing and vision screenings and re-evaluations in junior high school will be done by paraprofessional(s). Initial hearing and vision screenings in high school will be done by the school nurse. Re-evaluations are the responsibility of the paraprofessional(s). The board will provide each high school nurse with an audiometer and maintain and repair the equipment. (*Toledo Federation of Teachers*)
- Non-medical bargaining unit personnel shall not be allowed to perform invasive medical services that require special medical knowledge, nursing judgment and nursing assessment. The procedures include, but are not limited to:
 1. Sterile catheterization;
 2. Nasogastric tube feeding;
 3. Cleaning and maintaining a tracheostomy and deep suctioning of a tracheostomy.
- Non-medical bargaining unit personnel shall be allowed to perform health-related services upon successful completion of child-specific training by a registered nurse, a licensed practical nurse, a physician licensed pursuant to F.S. 458 or 459, or a physician assistant certified pursuant to Chapter 458 or 459. All procedures shall be monitored periodically by the nurse. These procedures include, but are not limited to:
 1. Cleaning intermittent catheterization;
 2. Gastrostomy tube feeding;
 3. Monitoring blood glucose; and
 4. Administering emergency injectable medication.
- For all other invasive procedures not listed in sub-sections (1) and (2) above, a registered nurse, a licensed practical nurse, a licensed physician, or a physician assistant certified pursuant to Chapter 458 or 459 shall determine if properly trained non-medical bargaining unit personnel shall be allowed to perform such service.
- Invasive medical training shall be strictly voluntary for non-medical bargaining unit personnel. Any such training shall be provided at no cost to the employee and, if provided at times other than the regular work day, such trainees shall be paid for the time spent at their regular rate of pay.
- Non-medical bargaining unit members shall not be assigned the provision of invasive medical service on any basis other than as volunteers. Prior to non-medical bargaining unit members being assigned, the

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

school nurse, where available, shall be called upon first to perform any invasive medical services. (*Bradford Education Association [Fla.]*)

- Teachers shall not be required to provide services that are required by law to be performed exclusively by nurses.
- Medically fragile students shall be defined as those with complex healthcare needs that are extremely disabling or life threatening, and which require specific prescribed procedures and/or specialized technological healthcare procedures for life and/or health support. All teachers will be notified in writing by the administration, or by a nurse employed by the Toledo Public Schools, that a student for whom they are responsible has a do-not-resuscitate (DNR) order on file with the school district. A case review will be convened to review the request with all appropriate staff. Teachers of students with multiple disabilities/medically fragile students will be provided access to Toledo Public School nurses via portable radios or other communication instruments. Teachers shall not be required to provide services that are required by law to be performed exclusively by nurses. The district will provide training to all teachers, including nurses and therapists, and paraprofessionals who are assigned to provide services to the medically fragile student population, prior to initial assignment and annually, if requested, thereafter. The design and implementation of training shall be cooperatively developed by the federation and the board. **Nurse substitutes will be provided an orientation regarding district policies and protocol upon hiring and annually thereafter. The federation and the board will jointly develop and implement the orientation.** (*Toledo Federation of Teachers*)
- Teachers (other than school nurses) shall not perform invasive medical services that require special medical knowledge, nursing judgment and nursing assessment. The procedures include, but are not limited to:
 1. Sterile catheterization;
 2. Nasogastric tube feeding; and
 3. Cleaning and maintaining a tracheostomy and deep suctioning of a tracheostomy.

- Teachers (other than school nurses) shall not be required to perform invasive health-related services. However, should a teacher volunteer to perform such services, the district must provide the teacher with child-specific training by a registered nurse, a licensed practical nurse, a licensed physician or a certified physician assistant. All procedures shall be monitored periodically by the school nurse. Those procedures include, but are not limited to:
 1. Cleaning intermittent catheterization;
 2. Gastrostomy tube feeding;
 3. Monitoring blood glucose; and
 4. Administering emergency injectable medication.
- For all invasive medical services not listed above, a registered nurse, a licensed practical nurse, a licensed physician or a certified physician assistant shall determine if the service could be safely administered by a teacher and approval must be granted by the appropriate district supervisor. (*United School Employees of Pasco [Fla.]*)

Administering Medications

- No bargaining unit members except school nurses or doctors may be required to dispense medications. (Cleveland Teachers Union)
- Teachers (other than the school nurse or those authorized by the principal) shall not administer medication or perform routine noninvasive medical procedures as part of their daily work responsibilities while located at the school site. (*United School Employees of Pasco [Fla.]*)
- In accordance with Article 31.4 no unit member, except public health nurses, shall be required to administer medication or provide other medical services.
- Teachers shall not be required or prevailed upon to administer medication or otherwise provide direct medical assistance to students. This section shall not prohibit any teacher from voluntarily administering medication or providing first aid or other medical

assistance for students, nor shall it prohibit the administration from inquiring as to a teacher's willingness to so volunteer. Teachers are expected to use their best professional judgment in rendering first aid or needed medical assistance to students, or in seeking such assistance for students from other personnel, as circumstances warrant.

- To the fullest extent permitted by law, the board shall defend, indemnify and hold harmless teachers from and against any and all claims, demands, actions, complaints, suits or other forms of liability that may arise from the actions of any teacher rendering first aid or other assistance to a student. (*West Northfield Teachers' Association [Ill.]*)

Nurses as Members of the IEP and Section 504 Teams

- An individual school's IEP schedule shall be made available to that building's school nurse. At the request of the principal, or nurse, the nurse shall participate in the IEP conference for individual students. For any student assigned to a school with a medical condition addressed in an IEP or 504 plan, the nurse or nurse supervisor shall be a part of, or consulted by, the IEP or 504 plan team. (*Cleveland Teachers Union*)

Additional Areas for Bargaining

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

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

Endnotes

- ¹ National Association of School Nurses. (2020). School Nurse Workload: Staffing for Safe Care. Position Statement. www.nasn.org/nasn-resources/professional-practice-documents/position-statements/ps-workload
- ² National Association of School Nurses. (2022). Student Access to School Nursing Services. Position Statement. www.nasn.org/nasn-resources/professional-practice-documents/position-statements/ps-access-to-services

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Appendix A: Resources

American Nurses Association/National Council of State Boards of Nursing |

www.ncsbn.org/public-files/NGND-PosPaper_06.pdf

National Guidelines for Nursing Delegation.

American School Health Association | www.ashaweb.org

ASHA is a multidisciplinary organization leading efforts to prioritize school-based approaches that promote lifelong health, build a community to support the whole child, and activate champions of school health.

CDC Healthy Schools | www.cdc.gov/healthyschools/health_and_academics/index.htm

Resources for school nurses from the Centers for Disease Control and Prevention on promoting healthy behaviors and managing acute and chronic health conditions in schools.

Center for Health and Health Care in Schools | <https://healthinschools.org>

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

Council for Exceptional Children | <https://exceptionalchildren.org>

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

Council of Educators for Students with Disabilities Inc. | www.504idea.org

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

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

The NASN is an excellent resource for the school nurse. NASN has worked in collaboration with the AFT. As the specialty practice group for school nurses, NASN has expertise in identifying and solving many of the problems that confront school nurses daily, including nursing delegation to unlicensed assistive personnel as well as scope and standards of practice.

- For overall principles for delegation: Bobo, Nichole. (2018). National Association of School Nurses. “Principles for Practice: Nursing Delegation to Unlicensed Assistive Personnel in the School Setting” (second edition).
- For scope and standards of school nursing practice: National Association of School Nurses. (2022). School Nursing: Scope and Standards of Practice. (fourth edition). Silver Spring, Md.

National Coordinating Committee on School Health and Safety |

<https://mchb.hrsa.gov/programs-impact/programs/national-coordinating-committee-school-health-safety>

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

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

In addition to your state board of nursing, the National Council of State Boards of Nursing can assist with practice and policy issues.

National Dissemination Center for Children with Disabilities |

www.fhi360.org/projects/national-dissemination-center-children-disabilities-nichcy

Information on IDEA, including training materials and resources.

National Forum on Education Statistics | <https://nces.ed.gov/forum/>

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

National Resource Center for Paraeducators, Related Service Providers, and Interveners | www.nrcpara.org

National School Boards Association | <https://www.nsba.org>

Serving children under Section 504 and IDEA.

School Nurse | www.schoolnurse.com

Online version of *School Health Alert*.

Schwab, N., & Gelfman, M. (Eds). (2001). *Legal Issues in School Health Services: A resource for school administrators, school attorneys and school nurses*. North Branch, Minn.: Sunrise River Press.

Selekman, J., Shannon, R & Yonkaitis, C. (2019). *School Nursing: A Comprehensive Text* (third edition). Philadelphia: F.A. Davis.

State Boards of Nursing

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

U.S. Department of Health and Human Services. Your Rights Under Section 504 of the Rehabilitation Act. www.hhs.gov/sites/default/files/ocr/civilrights/resources/factsheets/504.pdf

Appendix B: IDEA Definitions of Covered Disabilities

1. **Autism** means a developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age 3, which adversely affects educational performance. Characteristics often associated with autism are engaging in repetitive activities and stereotyped movements, resistance to changes in daily routines or the environment, and unusual responses to sensory experiences. The term “autism” does not apply if the child’s educational performance is adversely affected primarily because the child has an emotional disturbance, as defined in No. 5 below. A child who shows the characteristics of autism after age 3 could be diagnosed as having autism if the criteria above are satisfied.
2. **Deaf-Blindness** means simultaneous hearing and vision impairments, the combination of which causes such severe communication and other developmental and educational needs that they cannot be accommodated in special education programs solely for children with deafness or children with blindness.
3. **Deafness** means a hearing impairment so severe that a child is impaired in processing linguistic information through hearing, with or without amplification, which adversely affects a child’s educational performance.
4. **Developmental Delay** means children ages 3-9 (or any subset of that age range, including ages 3-5), may, subject to the conditions described in §300.111(b), include a child:
 - a. Who is experiencing developmental delays, as defined by the state and as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas: physical development, cognitive development, communication development, social or emotional development, or adaptive development; and
 - b. Who, by reason thereof, needs special education and related services.
5. **Emotional Disturbance** means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child’s educational performance:
 - a. An inability to learn that cannot be explained by intellectual, sensory or health factors;
 - b. An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
 - c. Inappropriate types of behavior or feelings under normal circumstances;
 - d. A general pervasive mood of unhappiness or depression; and
 - e. A tendency to develop physical symptoms or fears associated with personal or school problems. The term includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance.
6. **Hearing Impairment** means an impairment in hearing, whether permanent or fluctuating, that adversely affects a child’s educational performance but is not included under the definition of “deafness.”
7. **Intellectual Disability** means significantly subaverage general intellectual functioning, existing concurrently with deficits in adaptive behavior and manifested during the developmental period, that adversely affects a child’s educational performance.
8. **Multiple Disabilities** means concomitant impairments (such as intellectual disability-blindness, intellectual disability-orthopedic impairment, etc.), the combination of which causes such severe educational needs that they cannot be accommodated in a special education program solely for one of the impairments. The term does not include deaf-blindness.
9. **Orthopedic Impairment** means a severe orthopedic impairment that adversely affects a child’s educational performance. The term includes impairments caused by a congenital anomaly (e.g., clubfoot, absence of some body part, etc.), impairments caused by disease (e.g., poliomyelitis, bone tuberculosis, etc.), and impairments from other causes (e.g., cerebral palsy, amputations and fractures or burns that cause contractures).
10. **Other Health Impairment** means having limited strength, vitality or alertness, including a heightened alertness to environmental stimuli, that results in limited alertness with respect to the educational environment, that:

- a. Is due to chronic or acute health problems such as asthma, attention-deficit disorder or attention-deficit/hyperactivity disorder, diabetes, epilepsy, a heart condition, hemophilia, lead poisoning, leukemia, nephritis, rheumatic fever, sickle cell anemia and Tourette syndrome; and
- b. Adversely affects a child's educational performance.

11. Specific Learning Disability means a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, that may manifest itself in an imperfect ability to listen, think, speak, read, write, spell or do mathematical calculations. The term includes such conditions as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia and developmental aphasia. The term does not include learning problems that are primarily the result of visual, hearing or motor disabilities; of intellectual disability; of emotional disturbance; or of environmental, cultural or economic disadvantage.

12. Speech or Language Impairment means a communication disorder such as stuttering, impaired articulation, a language impairment, or a voice impairment that adversely affects a child's educational performance.

13. Traumatic Brain Injury means an acquired injury to the brain caused by an external physical force, resulting in total or partial functional disability or psychosocial impairment, or both, that adversely affects a child's educational performance. The term applies to open or closed head injuries resulting in impairments in one or more areas, such as cognition; language; memory; attention; reasoning; abstract thinking; judgment; problem-solving; sensory, perceptual and motor abilities; psychosocial behavior; physical functions; information processing; and speech. The term does not include brain injuries that are congenital or degenerative or brain injuries induced by birth trauma.

14. Visual Impairment Including Blindness means an impairment in vision that, even with correction, adversely affects a child's educational performance. The term includes both partial sight and blindness.

Appendix C: State Boards of Nursing Contact Information

ALABAMA

Alabama Board of Nursing
770 Washington Ave.
RSA Plaza, Suite 250
Montgomery, AL 36104
Mailing Address:
P.O. Box 303900
Montgomery, AL 36130-3900
Phone: 334-293-5200 FAX: 334-293-5201
Contact Person:
Peggy Benson, Executive Officer
Alabama Board of Nursing:
www.abn.alabama.gov

ALASKA

Alaska Board of Nursing
550 West Seventh Ave., Suite 1500
Anchorage, AK 99501-3567
Phone: 907-269-8161 FAX: 907-269-8196
Contact Person:
Tessa Walker-Linderman, Executive Administrator
Board of Nursing, Professional Licensing, Division of
Corporations, Business and Professional Licensing
(alaska.gov):
www.commerce.alaska.gov/web/cbpl/ProfessionalLicensing/BoardofNursing.aspx

AMERICAN SAMOA

American Samoa Health Services Regulatory Board
Department of Health
Pago Pago, AS 96799
Phone: 684-633-1222 FAX: 684-633-1869
Contact Person:
Margaret Sesepasara, Executive Secretary

ARIZONA

Arizona State Board of Nursing
1740 West Adams, Suite 2000 Phoenix, AZ 85007
Phone: 602-771-7800 FAX: 602-771-7888
Contact Person:
Joey Ridenour, Executive Director
AZBN | Arizona State Board of Nursing:
www.azbn.gov

ARKANSAS

Arkansas State Board of Nursing
University Tower Building
1123 S. University, Suite 800
Little Rock, AR 72204-1619
Phone: 501-686-2700 FAX: 501-686-2714
Contact Person:
Sue Tedford, Executive Director
Arkansas Department of Health:
www.state.ar.us/nurse

CALIFORNIA—RNs

California Board of Registered Nursing
1625 North Market Blvd.
Suite 150
Sacramento, CA 95834-1924
Phone: 916-322-3350 FAX: 916-574-8637
Contact Person:
Loretta Melby, Executive Officer
California Board of Registered Nursing:
www.rn.ca.gov/

CALIFORNIA—VNs

California Board of Vocational Nurse and Psychiatric
Technician Examiners
2535 Capitol Oaks Drive, Suite 205
Sacramento, CA 95833
Phone: 916-263-7800 FAX: 916-263-7859
Contact Person:
Elaine Yamaguchi, Executive Officer
Board of Vocational Nursing & Psychiatric Technicians:
www.bvnpt.ca.gov

COLORADO

Division of Professions and Occupations
1560 Broadway, Suite 1350
Denver, CO 80202
Phone: 303-894-2430 FAX: 303-894-2821
Contact Person:
Roberta Hills, Program Director
Nursing HOME | Division of Professions and Occupations
(colorado.gov):
<https://dpo.colorado.gov/Nursing>

CONNECTICUT

Connecticut Board of Examiners for Nursing
Department of Public Health
410 Capitol Ave., MS# 13PHO
Hartford, CT 06106

Mailing Address:

P.O. Box 340308 Hartford, CT 06134-0328

Phone: 860-509-7624 **FAX:** 860-509-7553

Contact Person:

Dana M. Dalton, Supervising Nurse Consultant
Board of Examiners for Nursing (ct.gov):

**[https://portal.ct.gov/DPH/Public-Health-Hearing-Office/
Board-of-Examiners-for-Nursing/Board-of-Examiners-for-Nursing](https://portal.ct.gov/DPH/Public-Health-Hearing-Office/Board-of-Examiners-for-Nursing/Board-of-Examiners-for-Nursing)**

DELAWARE

Delaware Board of Nursing

861 Silver Lake Blvd.,
Cannon Building, Suite 203
Dover, DE 19904

Phone: 302-744-4500 **FAX:** 302-739-2711

Contact Person:

Pamela C. Zickafoose, Executive Director
Board of Nursing—Division of Professional Regulation—
State of Delaware:

<https://dpr.delaware.gov/boards/nursing/>

DISTRICT OF COLUMBIA

District of Columbia Board of Nursing
Department of Health
Health Professional Licensing Administration
899 North Capitol St. NE
Washington, DC 20002

Phone: 877-672-2174 **FAX:** 202-727-8471

Contact Person:

Teresa (Terry) Walsh, Executive Director
Health Professionals | doh (dc.gov):

<https://dchealth.dc.gov/service/health-professionals>

FLORIDA

Department of Health
Board of Nursing
4052 Bald Cypress Way Bin C-02
Tallahassee, FL 32399-3252

Phone: 850-245-4125 **FAX:** 850-617-6440

Contact Person:

Joe Baker Jr., Executive Director
Florida Board of Nursing—Licensing, Renewals &
Information (floridasnursing.gov):

<https://floridasnursing.gov>

GEORGIA

Georgia Board of Nursing
237 Coliseum Drive
Macon, GA 31217-3858

Phone: 844-753-7825 **FAX:** 877-371-5712

Contact Person:

Natara Taylor, Executive Director
Georgia Board of Nursing | Georgia Secretary of State (ga.gov):

<https://sos.ga.gov/georgia-board-nursing>

GUAM

Guam Board of Nurse Examiners
194 Hernan Cortez Ave., Suite 213,
Hagatna, GU 96910-5052

Phone: 671-735-7400

Contact Person:

Zennia Pecina, Executive Officer
GBNE Home | HPLO Guam DPHSS (guamhplo.org):

<https://guamhplo.org/gbne>

HAWAII

Hawaii Board of Nursing
King Kalakaua Building, 335 Merchant St.
Third Floor
Honolulu, HI 96813

Mailing Address:

PVLD/DCCA
Attn: Board of Nursing
P.O. Box 3469
Honolulu, HI 96801

Phone: 808-586-3000 **FAX:** 808-586-2689

Contact Person:

Lee Ann Teshima, Executive Officer
Professional & Vocational Licensing Division | Board of
Nursing (hawaii.gov):

<https://cca.hawaii.gov/pvl/boards/nursing/>

IDAHO

Idaho Board of Nursing
11351 W Chinden, Building 6,
Boise, ID 83714

Mailing Address:

P.O. Box 83720
Boise, ID 83720-0061

Phone: 208-577-2476 **FAX:** 208-577-2490

Contact Person:

Nicki Chopski, Executive Director
- Board of Nursing (idaho.gov):

<https://ibn.idaho.gov>

ILLINOIS

Illinois Department of Professional Regulation/Nursing Unit
320 W. Washington St., Third Floor
Springfield, IL 62786
555 W. Monroe, Fifth Floor
Chicago, IL 60661

Scope of Practice: 312-814-2715

Applications and Licensing: 800-560-6420

Contact Person:

Michele Bromberg, Nursing Coordinator
State of Illinois | Department of Financial & Professional
Regulation:

<https://idfpr.illinois.gov>

INDIANA

Indiana State Board of Nursing Indiana Professional
Licensing Agency
402 W. Washington St., Room W072
Indianapolis, IN 46204

Phone: 317-234-2043 **FAX:** 317-233-4236

Contact Person:

Nicholas A. Hart, Executive Director
PLA: Nursing Home:

www.in.gov/pla/professions/nursing-home/

IOWA

Iowa Board of Nursing
RiverPoint Business Park
400 S.W. 8th Street, Suite B
Des Moines, IA 50309-4685

Phone: 515-281-3255 **FAX:** 515-281-4825

Contact Person:

Kathleen Weinberg, Executive Director
Iowa Board of Nursing

<https://nursing.iowa.gov>

KANSAS

Kansas State Board of Nursing
Landon State Office Building
900 S.W. Jackson, Suite 1051
Topeka, KS 66612

Phone: 785-296-4929 **FAX:** 785-296-3929

Contact Person:

Carol Moreland, Executive Administrator
ksbn.kansas.gov | Kansas Nursing Board:

<https://ksbn.kansas.gov>

KENTUCKY

Kentucky Board of Nursing
312 Whittington Parkway, Suite 300
Louisville, KY 40222

Phone: 502-429-3300 **FAX:** 502-429-3311

Contact Person:

Kelly Jenkins, Executive Director
Kentucky Board of Nursing:

<https://kbn.ky.gov/Pages/index.aspx>

LOUISIANA—LPNs

Louisiana State Board of Practical Nurse Examiners
131 Airline Drive
Suite 301
Metairie, LA 70001

Phone: 504-838-5791 **FAX:** 504-838-5279

Contact Person:

Lynn Ansardi, Executive Director
Louisiana State Board of Practical Nurse Examiners:
www.lsbpne.com

LOUISIANA—RNs

Louisiana State Board of Nursing
17373 Perkins Road
Baton Rouge, LA 70810

Phone: 225-755-7500 **FAX:** 225-755-7584

Contact Person:

Karen Lyon, Executive Director
Louisiana State Board of Nursing:
www.lsbns.state.la.us

MAINE

Maine State Board of Nursing
161 Capitol St.
Augusta, ME 04333

Mailing Address:

158 State House Station
Augusta, ME 04333

Phone: 207-287-1133 **FAX:** 207-287-1149

Contact Person:

Kim Esquibel, Executive Director
Maine State Board of Nursing
www.maine.gov/boardofnursing/

MARYLAND

Maryland Board of Nursing

4140 Patterson Avenue

Baltimore, MD 21215

Phone: 410-585-1900 **FAX:** 410-358-3530

Contact Person:

Karen E. B. Evans, Executive Director

maryland.gov):

<https://mbon.maryland.gov/Pages/default.aspx>

MASSACHUSETTS

Massachusetts Board of Registration in Nursing

Commonwealth of Massachusetts

250 Washington St., Third Floor

Boston, MA 02108-4619

Phone: 617-973-0900 **FAX:** 617-973-0984

Contact Person:

Claire MacDonald, Executive Director

Board of Registration in Nursing | Mass.gov

<https://www.mass.gov/orgs/board-of-registration-in-nursing>

MICHIGAN

Michigan Board of Nursing

Department of Licensing and Regulatory Affairs

Bureau of Professional Licensing

611 West Ottawa

Lansing, MI 48933

Mailing address:

P.O. Box 30670

Lansing, MI 48909

Phone: 517-241-0199

Contact Person:

Kerry Ryan Przybylo, Manager, Boards and Committees
Section

Nursing (michigan.gov):

www.michigan.gov/lara/bureau-list/bpl/health/hp-lic-health-prof/nursing

MINNESOTA

Minnesota Board of Nursing

1210 Northland Drive, Suite 120

Mendota Heights, MN 55120

Phone: 612-317-3000 **FAX:** 651-688-1841

Contact Person:

Kimberly Miller, Executive Director

Minnesota Nursing Board / Minnesota Board of Nursing
(mn.gov):

<https://mn.gov/boards/nursing>

MISSISSIPPI

Mississippi Board of Nursing

713 Pear Orchard Road, Third Floor

Ridgeland, MS 39157

Phone: 601-957-6300 **FAX:** 601-957-6301

Contact Person:

Phyllis Polk Johnson, Executive Director

Mississippi Board of Nursing (ms.gov):

www.msbn.ms.gov

MISSOURI

Missouri State Board of Nursing

3605 Missouri Blvd.

P.O. Box 656

Jefferson City, MO 65102-0656

Phone: 573-751-0681 **FAX:** 573-751-0075

Contact Person:

Lori Scheidt, Executive Director

Board of Nursing (mo.gov):

www.pr.mo.gov/nursing.asp

MONTANA

Montana Board of Nursing

301 South Park

P.O. Box 200513

Helena, MT 59620-0513

Phone: 406-841-2300 **FAX:** 406-841-2305

Contact Person:

Missy Poortenga, Executive Officer

Board of Nursing (mt.gov):

<https://boards.bsd.dli.mt.gov/nursing>

NEBRASKA

Office of Nursing and Nursing Support,

DHHS, Division of Public Health, Licensure Unit

301 Centennial Mall South

Lincoln, NE 68509-4986

Phone: 402-471-4376 **FAX:** 402-742-2360

Contact Person:

Ann Oertwich, Executive Director

Nurse Licensing (ne.gov):

<https://dhhs.ne.gov/licensure/Pages/Nurse-Licensing.aspx>

NEVADA

Nevada State Board of Nursing
5011 Meadowood Mall Way, Suite 300
Reno, NV 89502
Phone: 775-687-7700 **FAX:** 775-687-7707

Contact Person:

Cathy Dinauer, Executive Director
Nevada State Board of Nursing –(nevadanursingboard.org):
<https://nevadanursingboard.org>

NEW HAMPSHIRE

New Hampshire Board of Nursing
7 Eagle Square
Concord, NH 03301
Phone: 603-271-2152

Contact Person:

Ashley Czechowicz, Administrator
New Hampshire Board of Nursing | NH Office of
Professional Licensure and Certification:
www.oplc.nh.gov/new-hampshire-board-nursing

NEW JERSEY

New Jersey Board of Nursing
P.O. Box 45010
124 Halsey St., Sixth Floor
Newark, NJ 07101
Phone: 973-504-6430 **FAX:** 973-648-3481

Contact Person:

Donette Walker, Acting Executive Director
New Jersey Board of Nursing
(njconsumeraffairs.gov):
www.njconsumeraffairs.gov/nur/pages/default.aspx

NEW MEXICO

New Mexico Board of Nursing
6301 Indian School Road NE, Suite 710
Albuquerque, NM 87110
Mailing address:
P.O. BOX 3628
Albuquerque, NM 87190
Phone: 505-841-8340 **FAX:** 505-841-8347

Contact Person:

Sheena Ferguson, Executive Director
New Mexico Board of Nursing (sks.com)
<https://nmbon.sks.com>

NEW YORK

New York State Board of Nursing
Education Building
89 Washington Ave., Second Floor West Wing
Albany, NY 12234
Phone: 518-474-3817, ext. 280 **FAX:** 518-474-3706

Contact Person:

Suzanne Sullivan, Executive Secretary
NYS Nursing (nysed.gov)
New York State Board of Nursing
www.op.nysed.gov/registered-professional-nursing/nursing-status

NORTH CAROLINA

North Carolina Board of Nursing
4516 Lake Boone Trail
Raleigh, NC 27607
Phone: 919-782-3211 **FAX:** 919-781-9461
Contact Person:
Crystal Tillman, Chief Executive Officer
North Carolina Board of Nursing: (ncbon.com)
www.ncbon.com

NORTH DAKOTA

North Dakota Board of Nursing
919 South 7th St., Suite 504
Bismarck, ND 58504
Phone: 701-328-9777 **FAX:** 701-328-9785
Contact Person:
Stacey Pfenning, Executive Director
ND Board of Nursing (ndbon.org):
<https://www.ndbon.org>

NORTHERN MARIANAS ISLANDS

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Board of Nursing
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Appendix D: Model Email to School Administration Documenting Inappropriate Delegation of Nursing Duties to Teachers or PSRPs

This email is to inform you that I have been delegated a nursing duty for which I have not been adequately trained. On [date], [name of administrator] informed me that I would be responsible for performing [name of nursing procedure] for a student in our school. Please be aware that this duty is one for which I have not been adequately trained. My primary concern is the safety of the students we all serve and, in my opinion, requiring school personnel to perform nursing duties for which they have not been trained is inappropriate and, at the very least, does a disservice to the student. I am cognizant of and fully support the rights of our students to receive the medical assistance they need in order to attend school, but I believe that students' healthcare needs should be appropriately determined and attended to by a school nurse. If the school administration determines that such assistance should be provided by non-nursing personnel, students and their families should expect that the personnel providing care are properly trained for the task. As the individual who was assigned to perform the nursing duty in this instance, I believe it is important to place you on notice that I have not been properly trained to perform the assigned duty. I fully intend to comply with my assigned duty to the best of my ability; however, should you choose to assign it to a properly trained school employee, I would welcome that, and I believe that a reassignment would be the safest course of action for the student.

Sincerely,

[Name of Teacher or Paraprofessional]

Appendix E: Guidelines for the Delivery of Specialized Health Services in the School Setting: An Arizona Resource Guide for Schools

Rationale

It is best practice that school districts employ licensed registered nurses, as they are the most prepared individuals to provide training and supervision of healthcare tasks to ensure that they:

- Are considered safe and routine for the specific student;
- Pose little potential hazard for the student;
- Can be performed with a predictable outcome; and
- Do not require assessment, interpretation or decision-making while being performed.

Students who require specialized healthcare at school cannot be denied attendance based on their medical condition or disability. Students deserve to have their healthcare needs met in the least restrictive environment. Experts agree that the number of students with chronic medical needs is increasing in school districts around the country. Federal laws, such as the Individuals with Disabilities Education Act (IDEA), the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act mandate that students have access to education without regard to their disability.

Examples of chronic health conditions seen in schools include, but are not limited to: asthma, diabetes, life-threatening allergies, genetic disorders, immunological disorders, cancer, orthopedic disorders, neuromotor disorders, mental health disorders and seizure disorders. Specialized healthcare may include medication administration, gastrostomy feedings, catheterizations, ostomy care, tracheostomy care, ventilator management, central line monitoring and seizure management.

The National Association of School Nurses recommends that delivery of health services in a school environment be supervised by a registered professional nurse (RN), with training in the specialized practice of school nursing. Due to budgetary constraints and a shortage of qualified nursing staff in many schools across Arizona, unlicensed assistive personnel (UAP) are utilized in a variety of settings. Delegation to the UAP is the process whereby the nurse retains accountability (training and documentation) to ensure that delivery of care is implemented safely and effectively to produce positive health outcomes that enhance student learning.

According to the National Association of School Nurses, school nursing is defined as:

“School nursing, a specialized practice of nursing, protects and promotes student health, facilitates optimal development, and advances academic success. School nurses, grounded in ethical and evidence-based practice, are the leaders who bridge healthcare and education, provide care coordination, advocate for quality student-centered care, and collaborate to design systems that allow individuals and communities to develop their full potential.” (NASN, 2017)

The guidelines outlined on the following pages were developed to assist the RN in making delegation decisions in the school environment. It is important to remember a licensed nurse must remain within the state’s Scope of Practice laws at all times. This document is intended to be utilized in conjunction with the Five Rights of Delegation (<https://www.ncbi.nlm.nih.gov/books/NBK519519/>) and may provide a framework for delivery of care by assistive personnel who are operating within the policy and procedures of their hiring agencies. It is recommended that UAP utilize the Emergency Guidelines for Schools in the absence of a nurse. (Arizona Department of Health Services: <https://www.azdhs.gov/index.php>)

Procedure	RN	LPN	UAP	Other
Catheterization				
Clean Intermittent Cath *	Q	S	S	X
External Cath *	Q	S	S	X
Care of Indwelling Catheter *	Q	S	S	X
Ostomy Care *	Q	S	S	X
Skin Care	Q	S	S	X

Definition of symbols:

* Medical provider order required

Q: Qualified to perform task with demonstrated competency

S: Qualified to perform task with training and demonstrated competency

EM: In emergencies with training and demonstrated competency

X: Should not perform task

RN: Registered Nurse

LPN: Licensed Practical Nurse

UAP: (Unlicensed Assistive Personnel): Individuals working in a school health office, teachers, instructional assistants, school secretaries or other school personnel who have daily responsibilities for care of the student

Other: Bus drivers, bus monitors, cafeteria workers or custodians who have routine interaction with the student

Procedure	RN	LPN	UAP	Other
Feeding				
Nutritional Screening	Q	S	X	X
Nutritional Assessment	Q	X	X	X
Oral-Motor Assessment	X	X	X	X
Oral Feeding	Q	Q	S	X
Naso-Gastric Feeding*	Q	S	S	X
Monitoring of Continuous Feed	Q	S	S	X
Gastrostomy Tube Feeding or Venting*	Q	S	S	X
Jejunostomy Feed *	Q	S	S	X
Naso-Gastric Tub Insertion *	Q / EM	S / EM	X	X
Naso-Gastric Tube Removal *	Q / EM	S / EM	EM	X
Gastrostomy Tube Reinsertion * Trained nurses and UAP may re-insert a deflated and clean gastrostomy button to keep the stoma open. Reinflation of the balloon catheter is not an emergency procedure and is not recommended at school. If a nurse or UAP has been trained in balloon re-inflation, documentation of training and provider orders should be detailed.	Q / EM	S / EM	EM	X

Procedure	RN	LPN	UAP	Other
Site Monitoring				
Ventricular Peritoneal Shunt *	Q	S	S	X
Central Intravenous Catheter * (Port, PICC or Broviac)	Q	S	S	S
Ostomies *	Q	S	S	S

Procedure	RN	LPN	UAP	Other
Seizure				
Seizure Precautions	Q	S	S	S
Vagus Nerve Stimulation (VNS)* w/ Magnet	Q	S	S	EM

Procedure	RN	LPN	UAP	Other
Medication				
Oral *	Q	S	S	X
Over The Counter (OTC)	Q	Q	S	X
Injection * (for Insulin see Diabetes)	Q	S	EM	X
Auto-injectable Epinephrine *	Q	S	EM	S / EM
Inhalation *	Q	S	S	S / EM
Oxygen Administration / Monitoring Nasal Cannula / Mask *	Q	S	S	EM
Ear / Eye Drops *	Q	S	S	X
Topical *	Q	S	S	X
Per Nasogastric Tube *	Q	S	S	X
Per Gastrostomy Tube *	Q	S	S	X
Rectal Suppositories *	Q	S	EM	X
Intranasal Med *	Q	S	EM	X
The administration of intranasal medication is a specialized nursing procedure that is not recommended in a school setting				
Oral Chemotherapy *	X	X	X	X
The administration of chemotherapy medications is a specialized nursing procedure that is not recommended in the school setting				
Intravenous Medication Administration *	Q	X	X	X
The administration of IV medications or fluids is a specialized nursing procedure that is not recommended in the				

Procedure	RN	LPN	UAP	Other
Respiratory Assistance				
Postural Drainage *	Q	S	S	X
Percussion *	Q	S	S	X
Suctioning*				
Oral *	Q	S	S	EM
Tracheostomy *	Q	S	S	EM
Trach Change *	Q	S / EM	EM	X
Mechanical Ventilator Care *	Q	S	X	X

Procedure	RN	LPN	UAP	Other
Screenings				
Growth / BMI	Q	S	S	X
Vital Signs	Q	S	S	X
Hearing	Q	S	S	X
Vision	Q	S	S	X
Scoliosis	Q	S	S	X

Procedure	RN	LPN	UAP	Other
Diabetic Procedure *				
Blood Glucose Monitoring	Q	S	S	X
Urine Ketones	Q	S	S	X
Insulin Injection *	Q	S	S	X
Insulin Pump Bolus *	Q	S	S	X
CHO Counting / Dosage Calculation *	Q	S	S	S
Pump Site Change *	Q / EM	S / EM	X	X
Glucagon *	* Please reference ARS 15-344.01 regarding glucagon management			

Procedure	RN	LPN	UAP	Other
Development and Implementation of Individual Healthcare Plan (IHP), IEP, or 504				
Health Care Plan	Q	S	X	X
Emergency Protocols	Q	S	X	S
IEP / 504 Plan	Q	S	X	S

A school district or individual school may develop **Emergency Protocols** in which all school personnel play a role. **It is recommended that the RN or LPN, as the qualified individual**, assist in the identification and incorporation of the individual and group health needs within the Emergency Protocols.

Appendix F: Guidance for Staff Roles in Providing Care

New York State Department of Education: Provision of Nursing Services in School Settings—including One-to-One Nursing Services to Students with Special Needs (2019).

In schools, nursing activities/tasks that may only be performed by registered professional nurses (RNs) or licensed practical nurses (LPNs) under the direction of an RN, physician, nurse practitioner, physician assistant (list is not all-inclusive):

*** May only be performed by a registered professional nurse (RN)**

- Assessment and triage;
- Administration of oral, nasogastric tube, gastrostomy tube, ocular, ear, nose, respiratory, subcutaneous, intramuscular, *intravenous, and rectal or vaginal medications;
- *IV parenteral nutrition;
- *Assessment and care of indwelling lines (e.g. PICC)
- Intake and output measurements of gastric and parenteral fluids
- Feeding students with feeding risks (i.e., aspiration);
- Initiation and cessation of gastrostomy tube feeding by bolus or drip with or without pump;
- Replacement of nasogastric or gastric tube;
- *Replacement of PEG or Mic-Key button;
- Nasogastric tube feeding;
- Oxygen administration (pm/intermittent) or initiation of continuous oxygen;
- Oropharyngeal or tracheostomy suctioning;
- Tracheostomy care, including removal and cleaning of inner cannula;
- *Replacement of tracheostomy outer cannula;
- *Respirator/ventilator care;
- Respiratory care (i.e., postural drainage and cupping);
- Urinary catheterization; reinsertion of an indwelling urinary catheter;
- Ostomy care (care of stoma and changing the appliance) and irrigation;
- Warm applications;
- Sterile dressings, Decubitus ulcer care, cast care;
- Observation of shunt function—LPNs must report changes in student’s baseline to directing practitioner; and
- Venous blood draws (excludes fingerstick).

In schools, health task/activities that may be performed by trained unlicensed school personnel as assessed and approved by the school nurse (RN) or medical director consistent with state laws (list is not all-inclusive):

- Measurement and recording of vital signs that can be performed according to standard procedures;
- Fingerstick blood glucose or ketone tests, using glucometer or blood ketone meter;
- Urine test with urine test strip;
- Administer glucagon or epinephrine auto-injector to students with patient-specific orders in accordance with education law;
- Administer epinephrine auto-injectors on site to any staff or student, or naloxone in accordance with public health laws;
- Assisting supervised students to take their own oral, topical and inhalant medication according to NYSED’s Medication Management Guidelines for Schools;
- Application of small clean dressings (Band-Aids) per health services protocols;
- Ostomy care (emptying bag and observing the integrity of the bag for possible replacement by a licensed nurse);
- Observation to ensure continuous flow of an established drip method gastrostomy tube feeding that has been

initiated by the nurse;

- Termination of a drip method gastrostomy tube feeding after completion of the feeding if flushing is not involved;
- Intake and output measurement and recording (except gastric and parenteral fluids);
- Observing that equipment used to administer continuous flow oxygen is working and that all tubes are in place;
- Oral suctioning (mouth only, not pharynx);
- External catheter care;
- External care of indwelling catheter;
- Transfers and/or positioning;
- Aspects of a prescribed exercise and/or range-of-motion program;
- Assistance with braces and prostheses;
- Assisted ambulation (crutches, walker, cane); and
- Positioning.

In schools, health activities/tasks that may be performed by unlicensed school personnel, generally not requiring involvement of the school nurse or other health professionals (list is not all-inclusive):

- Oral hygiene or nail, hair and skin care;
- Preparing nourishment;
- Feeding student orally if there are no feeding problems;
- Care of an incontinent student, including changing diapers;
- Assistance with bedpan and urinal;
- Nonmedical aspects of bowel and bladder training; and
- Assistance with clothing.

**These activities are illustrative only. These lists are not all-inclusive. www.p12.nysed.gov/sss/documents/OnetoOneNSGQAFINAL1.7.19.pdf*

Appendix G: National School Transportation Specifications and Procedures

C. Drivers and Attendants

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

1. Training components

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

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

Appendix H: Description of Lifting Equipment

For more information and resources on safe lifting and transferring equipment and guidance on assessing students' lifting needs, see:

- Veterans Administration Mobility and Screening and Solutions Tool
<https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-022-08745-1>
- Patient Handling and Mobility Assessments
www.fgiguideelines.org/wp-content/uploads/2019/10/FGI-Patient-Handling-and-Mobility-Assessments_191008.pdf
- Safe Patient Handling and Mobility Design Criteria, U.S. Department of Veteran Affairs
www.cfm.va.gov/til/etc/dcSPHM.pdf

Portable Total Body Lift

Transferring students with limited mobility from one surface to another can be very physically demanding for a paraprofessional or other provider. Students who can't bear weight, have physical limitations (quadriplegia, amputee) or who weigh 50 or more pounds should never be transferred manually. These students should be transferred with a modern portable total body lift.

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

Most modern total body lifts have these features:

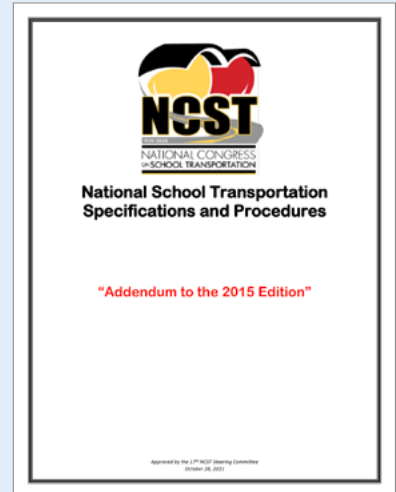
- Wide adjustable base;
- Extremely strong sling materials;
- Steel or aluminum mast and boom; and
- Electrical motorized lifting mechanisms.

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

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

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

1. **Price**—Expect to pay somewhere between \$8,000 and \$10,000.
2. **Weight capacity**—A weight capacity of at least 400 pounds is recommended to accommodate transferring very heavy students.
3. **Lifting mechanism**—Most new lifts have a hydraulic lifting mechanism that is powered by an electric motor and battery. The electric motor is an important feature since it eliminates the need to pump or crank the lift by hand (an ergonomic hazard in itself). The motor is controlled by a hand control with buttons for up and down. The electric motor also makes the lifting and lowering of the student a smooth, continuous movement without the jerky or rapid



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accelerations that are common with older hand crank or pump lifts. Some manufacturers' lifts also come with a two speed-motor, with slow and fast speeds.

4. **Lift height range**—The lift needs to lower far enough to reach a student who is placed on the floor for exercise or who has fallen. Staff members are at an even greater risk of injury if manually lifting a student in these situations. The lift also should be able to transfer a student to a high diaper-changing table.
5. **Various sizes and types of slings**—All students are not built the same, and not all sizes of slings will fit all students. Slings must come in a variety of sizes—at a minimum small, medium, large and extra large. It's also important to have slings for special purposes such as toileting.
6. **Sling position control**—A sling can have handles on the outside to help position the student, or the sling bar can have a handle as part of a pivoting frame. This feature is important because the handles or the bar can be used to help position the student in a more upright posture before the student is lowered into a chair, or to help position the student in a recumbent posture as the student is lowered to the floor or changing table.
7. **Battery portability**—Battery portability is a lift feature that allows a dead battery to be quickly exchanged with a fully charged battery. Some manufacturers use a portable battery system as a standard whereas others only offer it as an option. A nonportable system requires the lift to be directly plugged into an outlet to be recharged.
8. **Hand-held control**—A hand-held control is typically a push-button control used to raise or lower the mast. An important feature is the ability to quickly place the control on the lift during the transfer process. This will free up the caregiver's hands to assist or position the student. A control with a magnetic attachment is preferred over a clip because it allows the control to be placed almost anywhere on the lift, including the boom.
9. **Emergency shut-off control**—This control stops the motor in case of an emergency and is a separate control from the hand-held push button that activates the power. This safety feature serves as a backup to the hand-held control. It could be used in a situation where the student grabs the hand-held control, and the paraprofessional needs to quickly shut off the power to protect the student from harm.
10. **Manual override control**—In a situation where the battery loses power during the transfer, it is important that the student can be safely lowered using an override control. This control is usually a manual crank.
11. **Boom pressure-sensitive switch**—With a pressure-sensitive switch, the lift senses the upward resistance of a person or object underneath the boom and the motor automatically stops. This reduces the risk of a student being injured by coming in contact with the boom.
12. **Turnaround for replacement parts**—It's important to find out the amount of time it takes to repair the lift or get a replacement part. Most manufacturers can provide replacement parts within one or two days. Because most of the manufacturers also service the lifts, they will have a stock of replacement parts on hand. If they don't, the part may have to be ordered from the manufacturer.
13. **Base**—All lifts have adjustable bases that allow the legs to fit around chairs, commodes, etc. Some bases have legs that are spread in and out by using the hand control and the electric motor. With a manual base, the legs are spread with a bar that's moved by hand or a foot control. If the lift is going to be used in a tight space such as a bathroom stall, make sure that the length of the base (from the mast to the end of the legs) will fit in the bathroom.

Sit-to-Stand Student Devices

What is a sit-to-stand device?

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

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

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

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

The physical demands required to transfer a student using a sit-to-stand device are significantly less than manually performing a stand-and-pivot transfer, even if the staff member is using a transfer belt. When using a lift, there is much less risk of a back or shoulder overexertion injury, which are two of the most common injuries to staff members who physically lift students.

The less physically demanding the task, the less fatigued the care provider is over the course of the school day, which also means less risk of injury.

Because the sit-to-stand devices are designed to transfer a student quickly between two seated surfaces, the care provider can eliminate two or three manual transfers when toileting the student. For instance, instead of manually transferring a student from the wheelchair to the commode and then from the commode back to the wheelchair, the care provider can use a sit-to-stand device. Sit-to-stand devices fit a student more easily into tight spaces such as school restrooms.

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

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

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

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

- **Price**—Expect to pay \$3,000-\$4,000 for a new sit-to-stand device.
- **Weight capacity**—A weight capacity of at least 300 pounds is recommended to accommodate transferring very heavy students.
- **Lifting mechanism**—Sit-to-stand devices typically have a hydraulic lifting mechanism that is powered by an electric motor, or an actuator and battery. The electric motor or actuator is an important feature since it eliminates the need to pump or crank the lift by hand. The motor is controlled by a hand control with buttons for up and down. The electric motor also makes the raising and lowering of the student a smooth, continuous movement without jerky or rapid accelerations that are common with older hand crank or pump lifts. Some manufacturers' lifts also come with a two-speed (slow and fast) motor.
- **Battery portability**—Battery portability is a feature that allows a dead battery to be quickly exchanged with a fully charged battery. Some manufacturers use a portable battery system as a standard, whereas others only offer it as an

option. Those that offer a portable battery as an option use a nonportable system as a standard, which requires the lift to be directly plugged into an outlet to be recharged.

- **Hand-held control**—This is typically a push-button control used to raise or lower the boom. An important feature is the ability to quickly place the control on the sit-to-stand device during the transfer process. This will free up the caregiver's hands to assist or position the student. For this reason, a control with a magnetic attachment is preferred over a clip, because it allows the control to be placed almost anywhere on the lift, including the boom.
- **Emergency shut-off control**—This control stops the motor in case of an emergency and is a separate control from the hand-held push button that activates the power. This safety feature serves as a backup to the hand-held control. It could be used in a situation where the student grabs the hand-held control, and the paraprofessional needs to shut off the power quickly to protect the student from harm.
- **Manual override control**—In a situation where the battery loses power during the transfer, it is important that the student can be safely lowered using an override control. These controls are usually a manual crank, although one manufacturer provides a release lever that can be pulled to lower the student automatically. Another manufacturer provides a bit that can be attached to a powered screwdriver that substitutes as the manual crank.
- **Turnaround for replacement parts**—If the lift requires repair or a part needs to be replaced, how soon will the lift be back in service? Most manufacturers can provide parts within one or two days. Many of the manufacturers' sales representatives also service the lifts, so they will have a stock of replacement parts on hand.
- **Manufacturer's sales representative**—Most sales representatives also service their lifts, so finding a reliable representative that serves your geographic area is an important consideration.
- **Lift range**—This is the vertical distance the device moves the student from a seated to a standing posture. This may be very important if the student is being lifted from the floor.
- **Other important features to consider**—Be sure to consider storage space required (especially in overcrowded schools), battery type and replacement costs, sling laundering and sling material.

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

1. Student level of assistance

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

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

2. Can the student bear weight?

- ___ Yes, full
- ___ Yes, partial
- ___ No

3. Does the student have the upper-extremity strength needed to support their own weight during transfers?

- ___ Yes
- ___ No

4. Student's level of cooperation and comprehension:

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

5. Student's weight _____ height _____

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

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

7. Care plan

Task	Equipment / Assistive Device	Number of Personnel Required for Task
Transfer to and from: — chair to toilet — chair to chair		
Transfer to and from: — bus/van to chair		
Transfer to and from: — floor		
Reposition in chair: — wheelchair — dependency chair		

Signature _____ Date _____

Appendix J: Model Safe Student Handling and Movement Policy

1. **Purpose:** This policy describes ways to ensure that employees use safe student handling and movement techniques at [Insert Name] school.
2. **Policy:** [Insert Name] School wants to ensure that its students are cared for safely, while maintaining a safe work environment for school employees. To accomplish this, an Ergonomic Injury Prevention Program for Paraprofessionals, Nurses and Teachers will be implemented to ensure that required infrastructure is in place to comply with components of this safe student handling and movement policy. This infrastructure includes student handling and movement equipment, employee training and a “culture of safety” approach in the school environment. Student care staff should assess high-risk-student handling tasks in advance to determine the safest way to accomplish them. Additionally, mechanical lifting equipment and/or other approved student handling aids should be used to prevent manual lifting and handling of students except when absolutely necessary, such as in a medical emergency.
3. **Procedures:**
Safe Student Handling and Movement Requirements
Staff will:
 - Avoid hazardous student handling and movement tasks whenever possible. If unavoidable, assess them carefully prior to completion.
 - Use mechanical lifting devices and other approved patient handling aids for high-risk-student handling and movement tasks except when absolutely necessary, such as in a medical emergency.
 - Use mechanical lifting devices and other approved patient handling aids in accordance with instructions and training.**Training**
 - Staff will complete and document safe student handling and movement training initially, annually and as required when new equipment is introduced. Supervisors should maintain training records for three years.
4. **Mechanical lifting devices and other equipment/aids:**
 - Mechanical lifting devices and other equipment/aids will be accessible to staff; all equipment will be stored conveniently and safely.
 - Mechanical lifting devices and other equipment will be maintained regularly and kept in good working order.
5. **Ergonomic Injury Prevention Program:**
The Ergonomic Injury Prevention Program for staff will include the following key program elements:
 - Ergonomic workplace assessment, including assessment of equipment and academic tools (computers, manipulatives etc.);
 - Use of lifting equipment and devices;
 - Student assessment criteria and care planning for safe student handling and movement;
 - Methods for safe student handling and movement;
 - Engineering and administrative solutions for eliminating or preventing ergonomic hazards in schools; and
 - Reporting work-related incidents, symptoms and injuries.
6. **Reporting of injuries/incidents:**
 - School staff are required to report all incidents/injuries/resulting from student handling to _____.
 - Supervisors will maintain incident/accident reports and supplemental injury statistics as required by the school and/or the Occupational Safety and Health Administration.

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

Definitions

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

Delegation of Authority

Principal or designee should:

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

Supervisors should:

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

School staff should:

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

Appendix K: Bobo, Nichole. (2018). National Association of School Nurses. Principles for Practice: Nursing Delegation to Unlicensed Assistive Personnel in the School Setting (second edition)

Decision Tree: Nursing Delegation in the School Setting

Does the state's nurse practice act allow delegation?	NO—Cannot delegate YES—Can delegate
Does school policy support training and supervision of the UAP (unlicensed assistive personnel) by the school nurse?	NO—Cannot delegate YES—Can delegate
Has a healthcare provider ordered the healthcare task?	NO—Cannot delegate YES—Can delegate
Does the school nurse have the competence to train the UAP on the nursing task?	NO—Cannot consider delegation YES—Can proceed with delegation
Does the student's individualized healthcare plan—based on the nursing assessment, in combination with the healthcare provider's orders— outline the nursing tasks required to help meet the student's health goals?	NO—Cannot delegate YES—Can delegate
Does the nursing care task meet the criteria of delegation? (Right task) <ul style="list-style-type: none"> • Not complex; • Part of the student's routine plan of care, whether at school or at home; • Follows an established sequence of steps; • Does not require modification; • Has a predictable outcome; and • Does not involve assessments, judgment, interpretation of results, or decision-making by the UAP. 	NO—Cannot delegate YES—Can delegate
Did the nursing assessment of the student's health status and health goals identify any unique needs that may deem delegation inappropriate? (Right circumstance)	NO—Can delegate YES—Cannot delegate
Is an appropriate, competent and willing UAP available? (Right person)	NO—Cannot delegate YES—Can delegate
Is the school nurse able to develop the UAP training, implement the training, provide a written sequence of steps for the nursing task, and evaluate competence? (Right direction and communication)	NO—Cannot delegate YES—Can delegate
Is there a communication plan between the UAP and school nurse in place? (Right direction and communication)	NO—Cannot delegate YES—Can delegate
Can the school nurse provide ongoing supervision of the UAP and evaluation of the student's health outcomes? (Right supervision and evaluation)	NO—Cannot delegate YES—Can delegate
For out-of-state school-sponsored events:	
Are both the home and visiting states members of the Nurse Licensure Compact?*	NO—Cannot delegate YES—Can delegate
Does the visiting state allow delegation to UAP?	NO—Cannot delegate YES—Can delegate

*The Nurse Licensure Compact enables multistate licensure for nurses. For more information, go to <https://www.ncsbn.org/compacts.page>.

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

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

Appendix L: Draft Assignment Despite Objection (ADO) Form

Draft Protest of Assignment or Assignment Despite Objection Form for School Staff

Name of reporting staff person and job title: _____

Date and time of report: _____

School and location within the school or bus route: _____

Statement of concern for the licensed school nurse:

This is to notify the administration of _____ School and the _____ District that I have been directed to delegate _____ to/for a student at _____ School with _____ health condition. Under the Nurse Practice Act of the state of _____, this task must be performed by a licensed nurse. (include citation from Nurse Practice Act) My license is granted by the _____ State Board of Nursing and can be revoked for violations of the Nurse Practice Act.

I will do my best to train the unlicensed staff person(s), but I am concerned that it is potentially unsafe for the student for an unlicensed staff person to perform this duty outside of my direct supervision, which creates a liability risk for the school district.

Signature, printed name and date: _____

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