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# Medically Complex

## INTRODUCTION

This section is intended as an informational resource for school and nursing personnel caring for medically complex students in an educational setting. It includes information regarding the most common health procedures seen in medically complex educational settings.

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

Only licensed nurses and non-medical school employees properly trained to perform a specific procedure with/on a specific student should be involved in any health procedure. A Procedure Physician Order form (Attachment L-I) completed and signed by the student's physician must be on file at the school. This form must be updated if there is a change in treatment/procedure and each school year. If a non-medical school employee will be performing a specific procedure, an Authorization for Non-Medical School Employee to Perform Health Procedure form (Attachment L-II) must be completed and signed by the parent. In most cases, the school nurse or parent would be responsible for training designated personnel. Once student specific training has been completed, a Clearance for Non-Medical School Employee to Perform Health Procedure form (Attachment L-III) must be signed by the registered nurse and non-medical school employee. All health procedure skills checklists should be kept in the clinic along with a copy of the Procedure Physician Order form.

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

The following pages contain health procedures that some students may need performed in the educational setting. The procedures vary in the degree to which they require specialized knowledge and skill by persons conducting the procedure. Many are regulated by professional standards of practice. The "Guidelines for the Delineation of Roles and Responsibilities for the Safe Delivery of Specialized Health Care in the Educational Setting," delineates the persons who are qualified to perform each procedure. It should be noted that the term "qualified" assumes that the individual has received appropriate training in the procedure.

These are simply recommendations as to personnel who should be considered with appropriate training, as possible providers of specific health care procedures. It is the responsibility of the school administrator, based on specific Physician's orders and consultation with the registered nurse, to designate personnel to be trained in a health care procedure for a specific student.

## CLEAN INTERMITTENT CATHETERIZATION (C.I.C.) PROCEDURE FEMALE AND MALE

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

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

**EQUIPMENT**:

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

**PHYSICIANS ORDERS:** REQUIRED

**STEPS:**
A bathroom with running water and a toilet is optimal for the purpose of teaching and normalizing the procedure.

1. Gather equipment in a clean, private area:

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

3. Maintain Standard (Universal) Precautions throughout procedure. Wash hands and have student wash hands. Use standard precautions while dealing with body fluids. Use approved hand-washing technique.

4. Explain the procedure and its importance as it is being carried out. Use terms that the student can understand.

5. Position the student, assisting with removal or adjustment of clothing or diaper. Have the **female student** maintain a sitting position on the toilet whenever possible, otherwise position the student on her back with feet flat on cot, knees flexed and apart. Have the **male student** positioned near the toilet whenever possible, otherwise, try to maintain a comfortable sitting position. If the student will be learning self-catheterization, try to use the position that will be used once independent.

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

7. Squeeze lubricant onto tip of catheter; leave in protective wrapper if available, otherwise place on clean paper towel, putting the large end of catheter in a collection container if student is not on toilet. Lubrication prevents trauma.

8. **Female student**: With the thumb and middle finger of the non-dominant hand, gently separate the labia, exposing the urethral meatus. Maintain separation with slight backward and upward tension. Identification of anatomical landmarks should begin now.

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

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

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

10. **Female student**: While continuing to separate the labia with one hand, use the other hand to pick up the catheter approximately 3 inches from the tip; insert the catheter into the meatus, until urine begins to flow; then advance the catheter another one or two inches. Never force the catheter. Hold in place until urine stops flowing.

    Slight resistance as the catheter passes through the urinary sphincters may be met as you advance the catheter into the bladder. If strong resistance is met, do not force the catheter. Remove the catheter and notify the student's parents and/or school nurse immediately.

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

    Slight resistance as the catheter passes through the urinary sphincters may be met as you advance the catheter into the bladder. If strong resistance is met, do not force the catheter. Remove the catheter and notify the student's parents and/or public health nurse immediately.

11. Remove the catheter, pausing if urine begins to flow again. Urine may start and stop with changes in the position of the catheter.

12. Assist the student to redress or to adjust clothing or diaper.

13. If collection container was used, observe urine for signs of abnormality, measure the amount and document, then discard. Observe and document the color, clarity and odor.

14. If reusing the catheter, wash with warm soapy water, rinse and dry. Place in plastic bag or other container. Send home if requested by parent/guardian.

15. Wash collection container with soap and water, rinse and dry. Dispose of wipes or cotton balls.

16. Remove gloves and discard. Discard gloves in covered trash can.

17. Wash hands and have student wash hands.

18. Document procedure and results on flow sheet. Promptly report any abnormality to the parent.

## CLEAN INTERMITTENT CATHETERIZATION (CIC) SKILLS CHECKLIST

### FEMALE

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

Name:_____School: _____

| SKILL | Performs skill in accordance to written guidelines | Requires further instruction & supervision |
|---|---|---|
| | Date | Date |
| 1. Gather equipment in a clean, private area:<br>• Gloves.<br>• Catheter.<br>• Soap, water, and cotton balls or disposable wipes.<br>• Water-soluble lubricant (e.g. K-Y Jelly, **never** Vaseline).<br>• Container to collect urine, if student is unable to use the toilet for positioning.<br>• Towel to place under student, if student is unable to use the toilet for positioning. | | |
| 2. Provide a private area for the student. | | |
| 3. Maintain Standard (Universal) Precautions during procedure. Wash hands and have student wash hands. | | |
| 4. Explain the procedure and its Importance as it is being carried out. | | |
| 5. Position the student, assisting with removal of pertinent clothing. Maintain a sitting position on the toilet whenever possible; otherwise position the student on her back with feet flat on cot, knees flexed and apart. | | |

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

| SKILL | Performs skill in accordance to written guidelines | Requires further instruction & supervision |
|---|---|---|
| | Date | Date |
| 11. Remove the catheter, pausing if urine begins to flow again. | | |
| 12. Assist the student to redress. | | |
| 13. If collection container was used, discard urine after observing for signs of abnormality and measuring the amount of urine. | | |
| 14. If reusing catheter, wash the catheter with warm soapy water, rinse and dry. Place in plastic bag or other container. Send home for parent/guardian to sterilize. | | |
| 15. Wash collection container with soap and water, rinse, and dry. Dispose of wipes or cotton balls. | | |
| 16. Remove gloves and discard. | | |
| 17. Wash hands and have student wash hands. | | |
| 18. Document procedure and results. Promptly report any abnormality to the parent or school nurse. | | |

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

Trainer's Signature_____Initials_____Date_____

Trainee's Signature_____Initials_____Date_____

# CLEAN INTERMITTENT CATHETERIZATION (CIC) SKILLS CHECKLIST MALE

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

Name:_____School: _____

| SKILL | Performs skill in accordance to written guidelines | Requires further instruction & supervision |
|---|---|---|
| | Date | Date |
| 1. Gather equipment in a clean, private area:<br>• Gloves.<br>• Catheter.<br>• Soap, water, and cotton balls or disposable wipes.<br>• Water-soluble lubricant (e.g. K-Y Jelly, **never** Vaseline).<br>• Container to collect urine, if student is unable to use the toilet for positioning.<br>• Towel to place under student, if student is unable to use the toilet for positioning. | | |
| 2. Provide a private area for the student. | | |
| 3. Maintain Standard (Universal) Precautions during the entire procedure. Wash hands and have student wash hands. | | |
| 4. Explain the procedure and its importance as it is being carried out. | | |
| 5. Position the student near the toilet whenever possible assisting with the adjustment of clothing or diaper. | | |
| 6. Put on gloves. | | |

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

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

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

Trainer's Signature_____Initials_____Date_____

Trainee's Signature_____Initials_____Dat _____

# UROSTOMY CATHETERIZATION PROCEDURE

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

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

**EQUIPMENT:**

- Gloves
- Catheter
- Soap and Water
- Cotton balls or physician ordered cleaning solution
- Water-soluble lubricant
- Container to collect urine

**PHYSICIANS ORDERS:** REQUIRED

**STEPS:**

1. Provide a clean, private area for the procedure. Respect student's privacy.
2. Gather the equipment: gloves, catheter, soap, water, cotton balls (or physician ordered cleaning solution), water-soluble lubricant and container to collect urine. If instructing student in catheterization procedure, explain each step.
3. Maintain universal precautions throughout procedure. Wash hands and have student wash hands if assisting. Use universal precautions when handling body fluids. Use approved hand-washing technique.
4. Explain procedure and its importance as it is being carried out. Use terms that the student can understand.
5. Position the student so he/she is comfortable and you are able to easily visualize the stoma. Assist with clothing removal or adjustment. If the student will be learning self-catheterization, try to use the position that he/she will use later on.
6. Prepare catheter supplies. Put on gloves to protect body from body fluids.
7. Clean stoma area starting at stoma and working out several inches in a circular motion using cotton balls saturated with soap and water (or physician ordered cleaning solution). Discard the cotton ball. Repeat 3 times. Cleaning from stoma out prevents contamination of the area.

8. Pick up catheter and apply small amount of lubricant to tip; insert into stoma 2 - 3 inches (never force catheter). Hold in place until urine stops flowing. Re-positioning the catheter may alleviate resistance.

9. Remove catheter. Pause if urine begins to flow again.

10. Assist student in dressing.

11. Measure amount of urine. Assess color, clarity and odor. Know what is “normal” for the particular student. Many urinary diversions will have cloudy urine or excessive mucous.

12. Instruct student in signs/symptoms of urinary infection and importance of reporting to parent/guardian if they occur (unusual odor, color and sedimentation).

13. If re-using the catheter; wash in warm soapy water, rinse, dry and place in storage container. Discard all disposable equipment.

14. Remove gloves and wash hands. Put gloves in trash and follow hand washing procedures.

15. Document procedure and results. Promptly report any abnormality to parents. Chart date, time, color, amount of urine and any unusual results of catheterization.

# UROSTOMY CATHETERIZATION SKILLS CHECKLIST

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

Name:_____School_____

| SKILL | Performs skill in accordance to written guidelines | Requires further instruction & supervision |
|---|---|---|
| | Date | Date |
| 1. Gather equipment in a clean and private area.<br>• Gloves<br>• Catheter<br>• Soap<br>• Water<br>• Cotton balls<br>• Water-soluble lubricant<br>• Container to collect urine | | |
| 2. Maintain universal precautions during procedure. Wash hands and if appropriate have student wash hands. | | |
| 3. Explain the procedure and its importance to the student. | | |
| 4. Position student so he/she is comfortable and you are able to easily visualize the stoma. Assist with removal of clothing or adjustment. If student will be learning self-catheterization, try to use the position that he/she will use later on. | | |
| 5. Prepare catheter supplies. | | |
| 6. Put on gloves. | | |
| 7. Clean stoma areas from center outward in circular motion with cotton balls saturated with soap and water. With new cotton ball, repeat 3 times. | | |

| SKILL | Performs skill in accordance to written guidelines | Requires further instruction & supervision |
|---|---|---|
| | Date | Date |
| 8. Apply lubricant to tip of catheter; insert 2-3 inches into stoma (never use force) and leave in place until urine flow stops. When urine flow stops, remove catheter. | | |
| 9. Assist student to dress. | | |
| 10. Measure amount of urine; assess for color, clarity, and odor. Discard in toilet. | | |
| 11. If reusing catheter wash in warm soapy water, rinse, dry and place in storage container. Discard disposable equipment. | | |
| 12. Remove gloves and wash hands. | | |
| 13. Document procedure and results. Promptly report any abnormality to the parent or school nurse. | | |

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

Trainer's Signature:_____Initials_____Date _____

Trainee's Signature:_____Initials _____Date_____

## Catheterization Log

Student's Name _____ DOB _____ Grade _____

School _____ Physician's Order _____

| Date | Time | Amount | Color/ Consistency | Comments | Initials |
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Signature _____ Date _____ Initials _____

## CHANGING COLOSTOMY/ILEOSTOMY COLLECTION BAG

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

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

**EQUIPMENT:**

- Soap and water
- Skin preparation
- Soft cloth or gauze
- Adhesive
- Tape
- Clean bag and belt, if needed
- Disposable gloves
- Scissors (if needed, to cut skin barrier)

**PHYSICIANS ORDERS:** REQUIRED

**STEPS:**

1. Assemble equipment.

2. Wash hands and apply gloves.

3. Provide private area.

4. Assist student as needed to undress to extent needed for procedure.

5. Empty contents of used bag into toilet.

6. Carefully remove the used bag and skin barrier by pushing the skin away from the bag, instead of pulling the bag off the skin.

7. If a skin barrier is used that requires fitting, measure stoma.

8. Pat actual stoma clean using moistened toilet tissue or facial tissue. Cover the stoma with gauze or cloth and clean the skin around the stoma. **DO NOT SCRUB THE STOMA OR THE SKIN**.

9. Inspect the skin for redness, rash, or blistering. Do not put medication, ointment or adhesive on the damaged skin. Report skin redness, rash, lesions or bleeding promptly to parent/guardian and for:

    - Drops of blood: pat gently with soft cloth/gauze.
    - Moderate bleeding: apply gentle pressure using soft cloth/gauze.
    - Heavy/continued moderate bleeding: apply firm pressure using soft cloth/gauze. Call 9-1-1 if necessary.

10. Pat skin dry with soft cloth/gauze.
11. Place skin barrier on skin around stoma.
12. Peel off backing from adhesive, or apply adhesive to bag if necessary.
13. Center the new bag directly over the stoma.
14. Firmly press the bag to the skin barrier so there are no leaks or wrinkles.
15. Remove gloves and wash hands.
16. Record procedure on flow sheet.
17. Report to the parent/guardian by the end of school day any change in stool pattern.

**DUVAL COUNTY DISTRICT SCHOOLS and DOH-DUVAL SCHOOL HEALTH SERVICES**

# OSTOMY FLOW SHEET

Student's name_____DOB_____Grade _____

School_____Physician's order_____

| Date | Time | Colostomy | Ileostomy | Stool | Flatus | Comments | Initials |
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Signature _____ Date_____ Initials ____

# CHANGING COLOSTOMY/ILEOSTOMY COLLECTION BAG SKILLS CHECKLIST

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

Name:_____School: _____

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

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

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

Trainer's Signature_____ Initials_____ Date_____

Trainee's Signature_____ Initials_____ Date_____

## DIAPERING

**ACTION TO BE PERFORMED BY:** Varies according to location.

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

**EQUIPMENT/SUPPLIES:**
Clean Diaper
Disposable Wipes/clothes
Toilet Paper
Small plastic bag
Disposable gloves
Sanitizing chemical solution (supplied by custodial staff)

**PHYSICIAN ORDERS:** NOT REQUIRED

**STEPS:**

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

14. Wash hands.

15. Return all supplies to designated areas and put clean table paper in place.

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

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

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

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

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

**Frequency of Diaper Changes:**

1. All diapers should be checked every two (2) hours and changed immediately if soiled to prevent skin irritations.

2. There could be circumstances when the changing schedule should be altered due to field trips and other special activities. A reasonable alternative plan should be developed for these occasions.

3. It is suggested that students in diapers have toileting logs kept on the bathroom door or other central location. Logs will be kept by the teacher and discarded at the end of summer school each year.

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

## CARE OF THE MENSTRUATING SPECIAL NEEDS STUDENT

- General Information:

1. The established guidelines for growth and development/health curriculum will be followed in teaching students with special needs.

2. The exceptional student may require additional assistance or monitoring, depending upon her individual limitations, whether mental or physical.

3. The same consideration for privacy and hygiene apply to those reviewed in the discussion on hygiene and diaper changing.

4. Supplying feminine hygiene supplies is the responsibility of the parent. Only pads should be used at school. It remains the responsibility of the school staff to promote good skin care and hygiene while the student is at school. There are feminine hygiene supplies available at school for emergencies and accidents.

5. Procedures for handling bodily fluids should be followed when assisting students with the changing of pads. Proper procedures for disposal of pads, and/or contaminated items should be followed.

Unique considerations:

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

## GASTROSTOMY TUBE FEEDING PROCEDURE

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

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

**EQUIPMENT:**

- Feeding solution at room temperature.
- 20-60 cc syringe with catheter tip.
- Tubing clamp or plug.
- Container of water.

**PHYSICIANS ORDERS:** REQUIRED

**STEPS:**

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

   c. Gently inject air into the feeding port and listen to the stomach for an “air rush” (gurgling or growling sound).

8. If checking residual was ordered, then aspirate all of stomach contents and note amount; then re-instill the entire aspirate. If quantity of residual is greater than noted on physician order, DO NOT FEED. Delay 30 minutes; then repeat aspiration. If residual continues to be greater than ordered contact parent. This is done to evaluate absorption of last feeding,
   a. i.e., whether or not there is undigested feeding solution remaining from previous feeding (residual). If a residual is present, adjust the feeding according to orders.

9. Clamp the tube, remove the syringe, and reattach the syringe (without the plunger) or the feeding bag to the clamped tube or into button. Clamping the tube keeps excess air from entering the stomach, preventing distention.

10. Unclamp the tube; allow air bubbles to escape; fill the syringe with feeding solution or attach prepared feeding bag containing solution (room temperature). Elevate the tube and syringe to about 4-6 inches above the student’s abdomen to start the feeding.

11. Allow the feeding to flow by gravity, adding solution slowly as contents empty, keeping solution in the syringe at all times until feeding is complete. NEVER FORCE solution through the tube. If tube is obstructed, do not feed. Contact parent/guardian. If using feeding bag/gravity, position bag at height slightly above student’s head. Raise or lower the syringe to regulate the rate of the flow. Feeding should take 20-30 minutes. Keeping the syringe partially filled prevents air from entering the stomach. For continuous feeding with pump, place tubing into pump mechanism and set for flow ordered. Stay with the student throughout the feeding.

12. When nearly all the feeding is gone, add prescribed amount of water into syringe or feeding bag (flush). This will clear the solution from the tubing and prevent occlusion.

13. Clamp the tube just above the stoma before the water has completely cleared the tubing. Avoid introducing extra air into the stomach.

14. Remove the syringe, adapter, or bag and tubing. Re-plug tubing.

15. Wash syringe with soap and water; rinse thoroughly, and allow to air dry. This prevents growth of bacteria.

16. Remove gloves. Wash hands.

17. Document procedure.

18. Allow student to remain upright or elevated for 30 minutes after feeding or as indicated on physician’s orders. This helps prevent vomiting and/or aspiration, if student should regurgitate. Observe student for any changes.

## GASTROSTOMY TUBE FEEDING SKILLS CHECKLIST

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

*NOTE: This is a student specific procedure and not all steps may apply.*

Name: School:

| SKILL | Performs skill in accordance to written guidelines | Requires further instruction & supervision |
|---|---|---|
| | Date | Date |
| 1. Assemble equipment:<br>• Feeding solution at room temperature.<br>• 20-60 cc syringe with catheter tip.<br>• Tubing clamp or plug.<br>• Container of water. | | |
| 2. Encourage student to participate as much as possible. | | |
| 3. Position student sitting upright or semi-reclining with head of bed or chair at a 45-degree angle. | | |
| 4. Maintain Standard (Universal) Precautions throughout entire procedure. Wash hands and apply gloves. | | |
| 5. Observe stoma and skin around gastrostomy for bleeding sores or leakage. Further observation of tube placement is dependent on type of tube placed. | | |
| 6. Check for proper tube placement (if ordered).<br>• Draw 5 to 10cc's of air into the syringe.<br>• Place stethoscope on the left side of the abdomen just above the waist.<br>• Attach syringe and/or adapter to the tube or button.<br>• Unclamp the tube.<br>• Gently inject air into the feeding port and listen to the stomach for an "air rush" (gurgling or growling sound). | | |

| SKILL | Performs skill in accordance to written guidelines | Requires further instruction & supervision |
|---|---|---|
| | Date | Date |
| 7. If checking residual was ordered, aspirate all of stomach contents and note amount; then re- instill all of the aspirate. If quantity of residual is greater than physician ordered, DO NOT FEED. Delay for 30 minutes, then repeat aspiration. If residual continues to be greater than ordered, contact school RN if in building, otherwise parent/guardian. | | |
| 8. Clamp the tube, remove the syringe, and re- attach the syringe (without the plunger) to the clamped tube or feeding tube. | | |
| 9. Allow the feeding to flow by gravity, adding solution slowly as contents empty, keeping solution in the syringe at all times until feeding is complete. NEVER FORCE solution through the tube. If tube is obstructed, DO NOT FEED. Contact school RN, if in the building, otherwise parent. *If using feeding bag/gravity, position bag at height slightly above student's head. For continuous feeding with pump, place tubing in pump mechanism and set flow as ordered. | | |
| 10. When nearly all the feeding is gone, add prescribed amount of water into syringe or feeding bag (flush). | | |
| 11. Clamp the tube just above the stoma before the water has completely cleared the tubing. | | |
| 12. Remove the syringe, adapter, or bag and tubing. | | |
| 13. Wash syringe with soap and water; rinse thoroughly and allow to air dry. | | |

| SKILL | Performs skill in accordance to written guidelines | Requires further instruction & supervision |
|---|---|---|
| 14. Remove gloves. Wash hands. | | |
| 15. Document procedure. | | |
| 16. Allow student to remain upright or elevated for 30 minutes after feeding or as directed by physician orders. | | |

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

Trainer's Signature_____Initials_____Date_____

Trainee's Signature_____Initials_____Date_____

## INSTILLATION OF MEDICATION THROUGH FEEDING TUBE

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

**PURPOSE:** Administer medication per physician's orders.

**EQUIPMENT:**

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

**PHYSICIANS ORDERS:** REQUIRED

**STEPS:**

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

**TUBE FEEDING:**
**INSTILLATION OF MEDICATION THROUGH FEEDING TUBE SKILLS CHECKLIST**
*Contact your school RN for a performance check and form completion.

Name:_____School: _____

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

| SKILL | Performs skill in accordance to written guidelines | Requires further instruction & supervision |
|---|---|---|
| | Date | Date |
| 10. Remove gloves and dispose of gloves and any other soiled materials in a plastic bag. | | |
| 11. Wash hands. | | |
| 12. Document on Medication Administration Record. | | |

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

Trainer's Signature_____Initials_____Date_____

Trainee's Signature_____Initials_____Date_____

## TUBE FEEDING
## STORAGE OF NUTRITIONAL FORMULAS

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

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

**EQUIPMENT:**
- The parent will supply all formulas accompanied by an order from physician, APRN or PA.
- Formulas will be administered only with a written physician's order. Non-essential preparations will not be administered during school hours, only prescribed formulas.
- All formula received at the school must be in unopened containers. The label must match the orders received from the provider.
- As formula is received at the school it will be immediately marked with the student's name.

**PHYSICIANS ORDERS:** NOT REQUIRED FOR STORAGE OF FORMULAS

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

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

## Tube Feeding Log

Student's Name _____ DOB_____Grade _____

School_____Formula Type_____

Amount to be administered per feeding_____ Volume of Flush_____

| Date | Time | Amt. formula | Amt. Water | Pump setting | Residual Amount | Comments | Initial |
|---|---|---|---|---|---|---|---|
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Signature _____ Date_____ Initials _____

## TUBE SITE CARE

(Gastrostomy/Jejunostomy)

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

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

**EQUIPMENT:**
- Cotton tipped swabs
- Sterile saline or water
- 2x2 gauze pads
- Disposable gloves

**PHYSICIANS ORDERS: REQUIRED**

**STEPS:**

1. Assemble equipment in a clean work area.
2. Talk to student to minimize surprise and to enhance student's comprehension and communication skills.
3. Position the student on his/her back or right side.
4. Wash hands. Put on gloves.
5. Remove the old dressing and discard in a lined waste container
6. Dampen the tips of the swabs with sterile saline or water.
7. Clean around the tube in circles, moving outward from the opening. All drainage, wet or dried, must be removed.
8. Observe the site for signs of infection such as redness, swelling, heat, tenderness, oozing and report such signs to the parent/guardian.
9. Dry the area well with a 2x2 gauze.
10. Apply sterile gauze around the tube site to absorb leakage if appropriate.
11. Remove gloves and dispose of gloves and other soiled disposable items in a plastic bag or lined waste can.
12. Wash hands
13. Staff will note date and time of tube care; color, amount, consistency and odor of drainage; other pertinent information on Tube Site Care form.

DUVAL COUNTY DISTRICT SCHOOLS and DOH-DUVALSCHOOL HEALTH SERVICES

## Tube Site Care

Students Name_____ DOB: _____ Grade:_____

School: _____Physician's Order:_____

| Date | Time | Drainage (color, amount, consistency, etc.) | Initials |
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Signature _____ Date _____ Initials _____

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

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

Name:_____ School: _____

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

| SKILL | Performs skill in accordance to written guidelines | Requires further instruction & supervision |
|---|---|---|
| | Date | Date |
| 9. Dry the area well with 2x2 gauze | | |
| 10. Apply sterile gauze around the tube site to absorb leakage if appropriate. | | |
| 11. Remove and dispose of gloves and other soiled disposable items in a plastic bag or lined waste can. | | |
| 12. Wash hands | | |
| 13. Staff will note date and time of tube care; color, amount, consistency and odor of drainage; other pertinent information on Tube Site Care form. | | |

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

Trainer's Signature_____ Initials_____ Date_____

Trainee's Signature_____ Initials_____ Date_ _____

## NASAL SUCTIONING

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

**PURPOSE:** To clean nasal passages and prevent complications of mucus remaining in the upper respiratory tract.

**EQUIPMENT:**

- Bulb Syringe
- Normal Saline Solution
- Eye Dropper
- A second person may be needed to help hold the head/hands

**PHYSICIANS ORDERS:** REQUIRED

**STEPS:**

1. Identify Need.

   *Note: sounds of nasal congestion*

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

## NASAL SUCTIONING SKILLS CHECKLIST

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

Name: _____School: _____

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

| SKILL | Performs skill in accordance to written guidelines | Requires further instruction & supervision |
|---|---|---|
| | Date | Date |
| 9. Remove and dispose of gloves. Wash hands. | | |
| 10. Document procedure by charting date, time, type and amount of mucus, and student's response. | | |

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

Trainer's Signature_____Initials_____Date_____

Trainee's Signature_____Initials_____Date_____

## ORAL SUCTIONING

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

**PURPOSE:** To remove sections from the mouth and throat, stimulate the cough reflex, and promote optimal respiratory function.

**EQUIPMENT:**

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

**PHYSICIANS ORDERS:** REQUIRED

**STEPS:**

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

12. Apply suction pressure. Occlude lumen of catheter near the connection to suction tube with ungloved hand during insertion; release to apply suction.
13. Rotate suction catheter around mouth. Alternately apply/release suction pressure.
14. Rinse small “C” Catheter and dip into saline basin intermittently and apply pressure. Rinse frequently.
15. Repeat suctioning until the entire area is cleared of mucus. Stop periodically and observe respiratory effort. Repeat as necessary.
16. Allow student to cough and/or expectorate mucus and repeat as necessary.
17. Clear all tubes and rinse with intermittent suction applied.
18. Turn suction machine off using ungloved hand.
19. Remove glove and discard in covered trash can.
20. Cover end of connection tube and disconnect from suction machine.
21. Wash hands.
22. Document procedure by charting date, time, type and amount of secretions, and student’s response.
23. Plastic suction catheter should be discarded at the end of the day or sooner as necessary.
24. Yankauer suction catheter should be washed in soapy water and rinses well after each use or as indicated by physician’s orders.

## ORAL SUCTIONING SKILLS CHECKLIST

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

Name: _____School: _____

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

| SKILL | Performs skill in accordance to written guidelines | Requires further instruction & supervision |
|---|---|---|
| | Date | Date |
| 10. Moisten tip of catheter by dipping end into saline. | | |
| 11. Put catheter into mouth and pinch tube during insertion | | |
| 12. Apply suction pressure. Occlude lumen of catheter near the connection to suction tube with ungloved hand during insertion; release to apply suction. | | |
| 13. Rotate suction catheter around mouth. Alternately apply/release suction pressure. | | |
| 14. Rinse Catheter and dip into saline basin intermittently and apply pressure. Rinse frequently. | | |
| 15. Repeat suctioning until the entire area is cleared of mucus. Stop periodically and observe respiratory effort. Repeat as necessary. | | |
| 16. Allow student to cough and/or expectorate mucus and repeat as necessary. | | |
| 17. Clear all tubes and rinse with intermittent suction applied. | | |
| 18. Turn suction machine off using ungloved hand. | | |
| 19. Remove glove and discard in covered trash can. | | |

| SKILL | Performs skill in accordance to written guidelines | Requires further instruction & supervision |
|---|---|---|
| | Date | Date |
| 20. Cover end of connection tube and disconnect from suction machine. | | |
| 21. Wash hands. | | |
| 22. Document procedure by charting date, time, type and amount of secretions, and student's response. | | |

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

Trainer's Signature_____Initials_____Date_____

Trainee's Signature_____Initials_____Date_____

**DUVAL COUNTY DISTRICT SCHOOLS and DOH-DUVALSCHOOL HEALTH SERVICES**

## Suctioning Log

Student's Name: _____ DOB: _____

School: _____ Physician's Order: _____

| Date | Time | Amt. | Color | Consistency | Tracheal/ Nasal | Comments | Initial |
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Employee Name (Print) Employee Signature Initials

## OXYGEN ADMINISTRATION

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

**PURPOSE:** To increase oxygen in the lungs and blood stream and reduce the heart's workload.

**EQUIPMENT:**

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

**PHYSICIANS ORDERS:** REQUIRED

**STEPS:**

1. Obtain physician order for oxygen administration. Order needs to include method of delivery (mask, cannula, tracheostomy, etc.), the flow rate, time to be given and if oxygen is to be self-administered.

2. Write a care plan to include responsibilities of parents, school and outside agencies involved, and a plan for failure of the system.

3. In-service staff regarding oxygen administration and designate, in writing, at least two staff members other than the school nurse, who can be responsible for the operation of the equipment and identify empty or nonfunctional apparatus.

4. Notify the risk management office, if requested by school principal, that oxygen will be used on campus. Assist with any safety inspection or measures they feel are necessary.

5. Make necessary arrangements with the Transportation Department who will be transporting the student. In-service this staff as needed.

6. School nurse may request the family bring the student to school for an assessment and planning time.

7. Complete the Oxygen Administration Log.

8. If school is to administer oxygen, the system must be checked every morning upon student's arrival.

## OXYGEN SAFETY PRECAUTIONS

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

**DUVAL COUNTY DISTRICT SCHOOLS and DOH-DUVAL**
**SCHOOL HEALTH SERVICES**

## OXYGEN ADMINISTRATION LOG

Student's Name: _____ DOB: _____

School: _____ Physician's Order: _____

| Date | Time | $O^2$ Sat | Oxygen L/M | Comments | Initials |
|---|---|---|---|---|---|
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Employee Name (Print) Employee Signature Initials

## PULSE OXIMETRY MONITORING

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

**PURPOSE:** Pulse oximetry is a simple non-invasive method of measuring the oxygen level (oxygen saturation) of the blood.

**EQUIPMENT:**

1. Pulse Oximeter
2. Pulse Oximetry Log

**PHYSICIANS ORDERS:** REQUIRED

**STEPS:**

1. Obtain physician order for pulse oximetry. Order needs to include the range for the pulse oximetry reading and action to be taken for low readings.

2. Wash hands.

3. Assemble pulse oximeter and turn on.

4. Instruct student to breathe normally.

5. Attach probe to best site (usually finger). Confirm that the light emitting diode (LED) is placed on top of the nail in opposition to the photodetector. Sensor should be flush with the skin.

6. Watch for pulse-sensing bar on face of oximeter to fluctuate with each pulsation. Environmental conditions that may also result in erroneous readings include: cold fingers/hands, motion, finger nail polish, and acrylic or press-on nails.

7. Read saturation on monitor after it has remained constant for 5 seconds and document results on Pulse Oximetry Log.

8. Refer to physician’s orders for appropriate management.

## PULSE OXIMETRY MONITORING CHECKLIST

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

Name: _____ School: _____

| SKILL | Performs skill in accordance to written guidelines | Requires further instruction & supervision |
|---|---|---|
| | Date | Date |
| 1. Check physician orders. | | |
| 2. Wash hands. | | |
| 3. Assemble pulse oximeter and turn on. | | |
| 4. Instruct student to breathe normally. | | |
| 5. Attach probe to best site. Confirm that the light emitting diode (LED) is placed on top of the nail in opposition to the photodetector. | | |
| 6. Watch for the pulse-sensing bar on face of oximeter to fluctuate with each pulsation. | | |
| 7. Read saturation on monitor after it has remained constant for 5 seconds. | | |
| 8. Refer to physician's order for appropriate management. | | |
| 9. Wash hands and document results on Pulse Oximetry Log. | | |

**DUVAL COUNTY DISTRICT SCHOOLS and DOH-DUVAL**
**SCHOOL HEALTH SERVICES**

**PULSE OXIMETRY LOG**

Student's Name: _____ DOB: _____

School: _____ Physician's Order: _____

| Date | Time | $O^2$ Sat | Comments | Initials |
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_____ _____ _____
Employee Name (Print) Employee Signature Initials

## BLOOD PRESSURE MEASUREMENT (DIGITAL) PROCEDURE

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

**PURPOSE:** To ensure accurate measurement of blood pressure level.

**EQUIPMENT:**

1. Digital blood pressure monitor with appropriate sized cuff
2. Blood Pressure Log

**PHYSICIANS ORDERS:** REQUIRED

**STEPS:**

1. Check physician orders.
2. Wash hands.
3. Assemble digital blood pressure monitor with appropriate sized cuff. A cuff that is too small or too big may give a false reading.
4. Explain procedure to student.
5. Position the student's forearm at the level of the heart with the palm of hand turned up. Make sure the student's legs are not crossed.
6. Make sure the air tube plug is securely inserted into the main blood pressure unit.
7. Place bottom of cuff ½ inch above bend in elbow.
8. Press START/STOP button. The cuff will start to inflate in order to take the measurement.
9. When the measurement is complete, the arm cuff completely deflates. The blood pressure reading is displayed.
10. Record the time and blood pressure reading on the Blood Pressure log.
11. Press START/STOP button to turn off blood pressure monitor.
12. Refer to physician's order for appropriate management.

## PULSE OXIMETRY MONITORING CHECKLIST

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

Name: _____ School: _____

| SKILL | Performs skill in accordance to written guidelines | Requires further instruction & supervision |
|---|---|---|
| | Date | Date |
| 1. Check physician orders. | | |
| 2. Wash hands. | | |
| 3. Assemble digital blood pressure monitor. | | |
| 4. Explain procedure to student. | | |
| 5. Position the student's forearm at the level of the heart with the palm of the hand turned up. | | |
| 6. Make sure the air tube plug is securely inserted into the main blood pressure unit. | | |
| 7. Place bottom of cuff ½ inch above bend in elbow. Press the START/STOP button. | | |
| 8. When the measurement is complete the blood pressure measurement will be displayed. Record the time and blood pressure reading on the Blood Pressure Log. Press START/STOP to turn off machine. | | |
| 9. Refer to physician's orders for appropriate management. | | |

**DUVAL COUNTY DISTRICT SCHOOLS and DOH-DUVAL**
**SCHOOL HEALTH SERVICES**

**BLOOD PRESSURE LOG**

Student's Name: _____ DOB: _____

School: _____ Physician's Order: _____

| Date | Time | Reading | Comments | Initials |
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_____ _____ _____
Employee Name (Print) Employee Signature Initials

## PERCUSSION AND POSTURAL DRAINAGE

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

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

**EQUIPMENT:**

- A wedge, pillow or folded blanket
- Tissues
- Basin for student to spit into
- Suction machine if ordered by physician

**PHYSICIANS ORDERS:** REQUIRED

**STEPS:**

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

# PERCUSSION AND POSTURAL DRAINAGE SKILLS CHECKLIST

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

Name:_____School: _____

| SKILL | Performs skill in accordance to written guidelines | Requires further instruction & supervision |
|---|---|---|
| | Date | Date |
| 1. Identify need. Check physicians order. | | |
| 2. Consider timing in relation to other activities such as eating or therapy. Procedure should not be done immediately after eating. | | |
| 3. Wash hands thoroughly following hand washing procedure, remove all rings. | | |
| 4. Explain procedure to student and use measures to relax him/her. Procedure will be more effective if student is not anxious. | | |
| 5. Position as directed by physician (usually prone, with head down on wedge) with tissue available. Wipe up secretions immediately. The spine should be as straight as possible. Use wedges or pillows to position. | | |
| 6. Observe color and respiratory rate. If indicated, auscultate before and after the procedure. | | |
| 7. Have the student take a few deep breaths. Percuss indicated area. Hand position: cup the hand with fingers close together and wrist loose. Use enough force to make a firm air-cushioned impact (hollow sound) to help dislodge secretions without causing discomfort. A light shirt may be used to make the procedure more comfortable. Do not “slap” the skin. Discontinue if reddening occurs. Vibrate the indicated area for three breaths. Tell the student to cough if able. Do not percuss over the spinal column or soft tissue. Allow for intervals of rest every 2-3 minutes. Vibrate only on exhalation. Helping the student into a sitting position may facilitate coughing. Observe for respiratory status and drainage. Stop the procedure immediately if color changes or respiratory distress is observed. | | |

| SKILL | Performs skill in accordance to written guidelines | Requires further instruction & supervision |
|---|---|---|
| 8. Leave in position for 10-15 minutes. Student should be attended during this time. Provide tissues and basin as necessary. Secretions may be expelled with gravity. | | |
| 9. Suction if ordered and necessary. Refer to suctioning and Physicians orders. | | |
| 10. Assist student slowly to normal position. Do mouth care. Total procedure should be 20-30 minutes. | | |
| 11. Wash hands. | | |
| 12. Document procedure by charting date, time, why done, type and amount of drainage and student's response. | | |

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

Trainer's Signature_____Initials_____Date_____

Trainee's Signature_____Initials_____Date_____

## POSITIONING
(Lifting and Transferring)

**ACTION TO BE PERFORMED BY:** Varies by site.

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

**EQUIPMENT:** Varies by site.

**PHYSICIAN ORDER**: Varies by student.

**STEPS/GUIDELINES**:

- Never attempt to lift a student who is difficult to manage without assistance.
- If two or more adults are moving a student, always discuss and plan the exact movements before beginning.
- The equipment involved must be positioned properly, securely, and as close to the student as possible. When a wheelchair is used, the brakes must be secured and the footrests lifted or removed.
- Avoid quick movements. This may cause the student's spastic muscles to tense and he/she may be frightened.
- Explain the procedure to the student and encourage him/her to assist as much as possible.
- Proper body mechanics are essential as follows:

    1. Bend at the knees, not the waist
    2. Be as close to the student as possible
    3. Keep the back straight
    4. Do not lift higher than the waist
    5. Do not lift quickly or with jerky movements

# SHUNT MONITORING

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

**PURPOSE:**

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

**EQUIPMENT:**

- Penlight
- Protective Helmet, if ordered.

**PHYSICIANS ORDERS:** NOT REQUIRED

**STEPS:**

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

# TRACHEOSTOMY SKIN CARE

**ACTION TO BE PERFORMED BY:** Licensed Nurse

**PURPOSE:** To prevent skin irritation and breakdown, and to remove secretions from the skin.

**EQUIPMENT:**

- Cotton tip applicators
- Cleaning solution as indicated in physician orders
- 4x4 Sponge

**PHYSICIANS ORDERS:** REQUIRED

**STEPS:**

1. Identify need. Check Physician's orders. Observe for skin irritation or breakdown.
2. Wash hands.
3. Obtain equipment and arrange on clean surface.
4. Explain procedure to student using appropriate developmental approach.
5. Put on gloves. Remove old trach dressing. Observe for skin irritation or breakdown. Check with provider if area is irritated.
6. Clean skin around and under tracheostomy tube area, using sterile technique if ordered. Use cotton tip applicator moistened with cleaning solution as indicated in physician orders.
7. Gently pat dry using 2x2's.
8. Insert clean dressing around stoma, under tracheostomy tube using one hand to stabilize tracheostomy tube.
9. Remove and discard gloves. Wash hands.
10. Document procedure charting date, time, reason for procedure, problems, and student's response.

# TRACHEOSTOMY SKIN CARE SKILLS CHECKLIST

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

Name:_____School: _____

| SKILL | Performs skill in accordance to written guidelines | Requires further instruction & supervision |
|---|---|---|
| | Date | Date |
| 1. Identify need. Check Physician's orders. Observe for skin irritation or breakdown. | | |
| 2. Wash hands. | | |
| 3. Obtain equipment and arrange on clean surface. | | |
| 4. Explain procedure to student using appropriate developmental approach. | | |
| 5. Put on gloves. Remove old trach dressing. Observe for skin irritation or breakdown. Check with provider if area is irritated. | | |
| 6. Clean skin around and under tracheostomy tube area, using sterile technique if ordered. Use cotton tip applicator moistened with cleaning solution as indicated in physician orders. | | |
| 7. Gently pat dry using 2x2's | | |
| 8. Insert clean dressing around stoma, under tracheostomy tube using one had to stabilize tracheostomy tube. | | |
| 9. Remove and discard gloves. Wash hands. | | |
| 10. Document procedure charting date, time, reason for procedure, problems, and student's response. | | |

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

Trainer's Signature_____Initials_____Date_____

Trainee's Signature_____Initials_____Date _____

# CHANGING VELCRO TRACHEOSTOMY TIES

**ACTION TO BE PERFORMED BY:** Licensed Nurse

**PURPOSE:** To maintain an open airway. To prevent skin irritation and breakdown.

**EQUIPMENT:**

- Two people must be present
- Clean Velcro trach ties
- Scissors with rounded ends
- Gloves
- Extra trach tube (in the event the child's trach tube becomes dislodged during the procedure)

**PHYSICIANS ORDERS:** REQUIRED

**STEPS:**

1. Identify need. Check Physician's orders.
2. Wash hands. Put on gloves.
3. Obtain equipment and arrange on clean/sterile surface.
4. Explain procedure to student using appropriate developmental approach.
5. Position student and place on back with neck extended or position as ordered/appropriate.
6. First person holds the trach tube in place using tips of finger avoiding occluding the opening.
7. The second person removes the old tie on one side by loosening the Velcro.
8. Check the skin for redness, breakdown, or odor. If any of those signs are present, notify the parent/guardian after the procedure.
9. With the Velcro facing up, slip one side of the tie through the flange on the trach. Repeat steps 6-8 on the other side of the neck. First person should continue to hold the trach tube in place.
10. Secure the ties in the back by overlapping the Velcro. Tighten to allow only one finger between the trach tie and the child's neck.
11. Remove gloves and wash hands.
12. Document procedure by charting date, time, reason for procedure, problems and student's response.

# TRACHEOSTOMY TIES SKILLS CHECKLIST

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

Name: _____School: _____

| SKILL | Performs skill in accordance to written guidelines | Requires further instruction & supervision |
|---|---|---|
| | Date | Date |
| 1. Identify need. Check Physician's orders. | | |
| 2. Wash hands. Put on gloves. | | |
| 3. Obtain equipment and arrange on clean/sterile surface. | | |
| 4. Explain procedure to student using appropriate developmental approach. | | |
| 5. Position student and place on back with neck extended or position as ordered/appropriate. | | |
| 6. First person holds the trach tube in place using tips of finger avoiding occluding the opening. | | |
| 7. The second person removes the old tie on the one side by loosening the Velcro. | | |
| 8. Check the skin for redness, breakdown, or odor. If any of those signs are present, notify the parent/guardian after the procedure. | | |
| 9. Repeat steps for other side. First person should continue to hold tube in place. With the Velcro facing up, slip one side of the tie through the flange on the trach. Repeat steps 6-8 on the other side of the neck. The first person should continue to hold the trach tube in place. | | |

| SKILL | Performs skill in accordance to written guidelines | Requires further instruction & supervision |
|---|---|---|
| | Date | Date |
| 10. Secure the ties in the back by overlapping the Velcro. Tighten to allow only one finger between the trach and the child's neck. | | |
| 11.Remove gloves and wash hands. | | |
| 12. Remove and discard gloves. Wash hands. Document procedure by charting date, time, reason for procedure, problems, and student's response. | | |

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

Trainer's Signature_____ Initials_____ Date_____

Trainee's Signature_____ Initials_____ Date_____

# TRACHEOSTOMY SUCTIONING

**ACTION TO BE PERFORMED BY:** Licensed Nurse

**PURPOSE:** To aspirate retained or excessive sections, maintain an open airway, and aid in the respiratory efforts of the student.

**EQUIPMENT:**

- Portable suction
- Disposable connecting tube
- Sterile disposable catheter (size determined by provider), sterile or clean gloves (per order)
- Sterile saline, preferably in single use packets, at room temperature or a jar of sterile saline with eye dropper dispenser
- Clean rinsing container
- Tissues or paper towels
- Bandage scissors

**PHYSICIANS ORDERS:** REQUIRED

**STEPS:**

1. Identify need and check Physician's orders. Observe for respiratory congestion and cyanosis.
2. Assemble equipment. Use a clean table at a convenient height.
3. Connect machine. Check functioning capacity of machine by turning to "on" position.
4. Explain procedure to student using appropriate developmental approach.
5. Wash hands.
6. Open sterile catheter and glove packet on table.
7. Open and fill rinsing container with sterile normal saline.
8. Open sterile connecting tube already connected to portable suctioning machine.
9. Connect connecting tube to suction outlet.
10. Put sterile glove on dominant hand.
11. This hand will hold the sterile catheter

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

# TRACHEOSTOMY SUCTIONING SKILLS CHECKLIST

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

Name: _____School: _____

| SKILL | Performs skill in accordance to written guidelines | Requires further instruction & supervision |
|---|---|---|
| | Date | Date |
| 1. Identify need and check Physician's orders. Observe for respiratory congestion and cyanosis. *Example:* Agitation, restlessness, hard/fast breathing, bluish color around lips, nail beds, nostrils flaring. | | |
| 2. Assemble equipment. Use a clean table at a convenient height | | |
| 3. Connect machine. Check functioning capacity of machine by turning to "on" position. | | |
| 4. Explain procedure to student using appropriate developmental approach | | |
| 5. Wash hands. | | |
| 6. Open sterile catheter and glove packet on table. Open and fill rinsing container with sterile normal saline. Open sterile connecting tube already connected to portable suctioning machine. Connect connecting tube to suction outlet. | | |
| 7. Put sterile glove on dominant hand. This hand will hold the sterile catheter | | |

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

| SKILL | Performs skill in accordance to written guidelines | Requires further instruction & supervision |
|---|---|---|
| | Date | Date |
| 16. Rinse Catheter. Dip into sterile saline basin, intermittently apply pressure, rinse frequently | | |
| 17. Repeat suctioning Repeat as necessary until desired results are obtained. Allow student to rest 15-20 seconds and catch breath. If catheter becomes blocked rinse with sterile saline. If airway blockage is not relieved call 9-1-1. Suspect a mucus plug if the student continues to be in distress, cut ties and remove trach tube. Reinsert a clean tracheostomy tube according to procedure | | |
| 18. Clear tubes and rinse with intermittent suction applied | | |
| 19. Turn suction machine off using ungloved hand | | |

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

Trainer's Signature_____Initials_____Date_____

Trainee's Signature_____Initials_____Date_____

# EMERGENCY TRACHEOSTOMY TUBE REPLACEMENT

(For Non-Cannulated, Non-Cuffed Tube)

**ACTION TO BE PERFORMED BY**: Licensed Nurse

**PURPOSE:**

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

**EQUIPMENT:**

- Sterile tracheostomy tube of type and size prescribed or clean tube if properly labeled for that particular student. (Extra trach tubes should be on hand at all times)
- Sterile tracheostomy tube of next smaller size. (Extra should be on hand at all times)
- Pair of bandage scissors
- Roll to prop shoulders (optional)
- Trach ties
- Sterile Gloves
- Manual Ventilation Equipment (Bag-valve mask)

**PHYSICIANS ORDERS:** *REQUIRED*

**STEPS:**

1. Identify need. Use when student is unable to provide open airway after three attempts at suctioning; student exhibits signs of respiratory distress, i.e.: anxiety, pale, bluish or dusky color around mouth or lips, flaring nostrils, rapid or labored breathing.
2. Notify principal and have them call 9-1-1.
3. Put roll under student's shoulders, if time permits. Use to visualize the stoma optimally.
4. In an emergency, it is possible to change a tracheostomy in almost any position.
5. Open sterile package. Equipment should be ready to use as needed.
6. Remove old trach ties and gently remove tube. Use an outward and downward motion when removing tube.
7. If new tube will not enter, try to insert trach tube of next smaller size.
8. If smaller tube will not enter, reposition head and try again.
9. During the procedure observe student for distress: cyanosis, anxiety, poor respiratory effort. If necessary, start rescue breathing using manual ventilation (bag-valve mask).

If too much resistance is felt, cover stoma with gauze and use manual ventilation (bag-valve mask). Sometimes, after several breaths, student will relax enough and stoma will open and the tube may be inserted. Resume manual ventilation as need.

10. Remove the sterile tracheostomy from package, holding the tube by flanges, not by the piece which fits into the stoma. Avoid contaminating the tube.
11. Insert the obturator (guide) into the trach tube. The obturator makes insertion easier, but is not left in place after insertion because it blocks the airway. Some brands do not have an obturator.
12. Spreading the stoma open with the index and middle fingers of one hand, gently insert new tube. Tube should be directed back, then down. Remove obturator as soon as tube is in place.
13. Hold the tube in place with slight pressure until a second person can assist in placing new ties. Two people are needed to change tracheostomy ties safely.
14. Suction if necessary. See suctioning procedure
15. Secure the trach ties by overlapping the Velcro. Tighten to allow only one finger between the trach tie and the child's neck.
16. Observe until student's condition is stable and there is no further danger or until paramedics arrive.
17. Remove and discard gloves. Wash hands.
18. Document Procedure. Chart date, time, reason action was indicated, action taken, and student's response.
19. Notify parent/guardian immediately.

# EMERGENCY TRACHEOSTOMY TUBE REPLACEMENT SKILLS CHECKLIST

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

Name: _____ School: _____

| SKILL | Performs skill in accordance to written guidelines | Requires further instruction & supervision |
|---|---|---|
| | Date | Date |
| 1. Identify need. Use when child is unable to provide open airway after three attempts at suctioning; child exhibits signs of respiratory distress, i.e.: anxiety, pale, bluish or dusky color around mouth or lips, flaring nostrils, rapid or labored breathing. | | |
| 2. Notify principal and have them call 9-1-1. | | |
| 3. Put roll under child's shoulders, if time permits. Use to visualize the stoma optimally. In an emergency, it is possible to change a tracheostomy in almost any position. | | |
| 4. Open sterile package. Equipment should be ready to use as needed. | | |
| 5. Remove old trach ties and gently remove tube. Use an outward and downward motion when removing tube. | | |
| 6. Remove the sterile tracheostomy from package, holding the tube by flanges, not by the piece which fits into the stoma. Avoid contaminating the tube. | | |
| 7. Insert the obturator (guide) into the trach tube. The obturator makes insertion easier, but is not left in place after insertion because it blocks the airway. | | |

| SKILL | Performs skill in accordance to written guidelines | Requires further instruction & supervision |
|---|---|---|
| | Date | Date |
| 8. Spreading the stoma open with the index and middle fingers of one hand, gently insert new tube. Tube should be directed back, then down. Remove obturator as soon as tube is in place. | | |
| 9. Hold the tube in place with slight pressure until a second person can assist in placing new ties. Two people are needed to change tracheostomy ties safely. | | |
| 10. Suction if necessary. See suctioning procedure. | | |
| 11. Secure the trach ties by overlapping the Velcro. Tighten to allow only one finger between the trach tie and the child's neck. | | |
| 12. If you are unable to insert the trach tube:<br>a) Reposition the head and try again<br>b) If new tube will not enter, try to insert trach tube of next smaller size<br>c) If smaller tube will not enter, reposition head and try again.<br>d) Observe child for respiratory distress: cyanosis, anxiety, poor respiratory effort. If necessary, start rescue breathing using manual ventilation (bag-valve mask). If too much resistance is felt, cover stoma with gauze use manual ventilation. Sometimes, after several breaths, child will relax enough and stoma will open and the trach tube may be inserted. Resume manual ventilation as needed. | | |

| SKILL | Performs skill in accordance to written guidelines | Requires further instruction & supervision |
|---|---|---|
| | Date | Date |
| 13. Remove and discard gloves. Wash hands. | | |
| 14. Document procedure. Chart date, time, reason action was indicated, action taken, and student's response. | | |
| 15. Notify parent/guardian immediately. | | |

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

Trainer's Signature_____Initials_____Date_____

Trainee's Signature_____Initials_____Date_____

# VAGUS NERVE STIMULATOR (VNS) PROCEDURE

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

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

**EQUIPMENT:**
- VNS magnet

**PHYSICIANS ORDERS:** REQUIRED

**STEPS:**

1. Know the particular signs for impending or occurring seizures as listed in the student's Individualized Healthcare Plan or Seizure Action Plan. Examples include: high-pitched crying, rigid arms and legs. Provide for student's safety. Assist to floor and place on side. Assess airway, breathing, and circulation. Call for assistance.
2. Know location of special magnets. Location(s) will be listed in the student's Individualized Healthcare Plan or Seizure Action Care Plan.
3. At the very beginning of a seizure, look for the VNS special magnet. Look for a bulging area on the left side of the chest wall (implanted generator under the skin). The magnet should be used as soon as possible after onset of seizure or aura or as indicated by physician order.
4. Follow physician orders for the following: number of swipes at onset of seizure, minutes between swipes, and swipes before any emergency medication.
5. Touch the smooth flat side of the magnet to the generator with a swiping motion and the magnet over the generator, then pull it away. You may notice a change in the student's voice, hoarseness, or coughing. This is a normal response. Potential adverse effects include: ataxia, dyspnea, numbness and tingling, spasms of the throat, nausea, and pain.
6. Contact parent/guardian and follow any additional instructions as indicated in the Seizure Action Plan.
7. Return special magnet to its identified location. Keep special magnet at least 10 inches away from credit cards and other magnets. The magnet will damage credit cards. Older microwaves or posted "microwave danger" areas should be avoided. Computer and televisions will not affect the generator.
8. Do not drop the magnet, as this may damage it.
9. Document what time the magnet was swiped over generator, the number of swipes, and the outcome. Documentation of the episode may be done on a seizure observation form.

# VAGUS NERVE STIMULATOR (VNS) PROCEDURE SKILLS CHECKLIST

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

Name: _____ School: _____

| SKILL | Performs skill in accordance to written guidelines | Requires further instruction & supervision |
|---|---|---|
| | Date | Date |
| 1. Know the particular signs for impending or occurring seizures as listed in the student's Individualized Healthcare Plan or Seizure Action Plan. Provide for student's safety. Assist to floor and place on side. Assess airway, breathing, and circulation. Call for assistance. | | |
| 2. Know location of special magnets. Location(s) will be listed in the student's Individualized Healthcare Plan or Seizure Action Care Plan. | | |
| 3. At the very beginning of a seizure, look for the VNS special magnet. Look for a bulging area on the left side of the chest wall (implanted generator under the skin). The magnet should be used as soon as possible after onset of seizure or aura, or as indicated by physician order. | | |
| 4. Follow physician orders for the following: number of swipes at onset of seizure, minutes between swipes, and swipes before any emergency medication. | | |
| 5. Contact parent/guardian and follow any additional instructions as indicated in the Seizure Action Plan. | | |

| SKILL | Performs skill in accordance to written guidelines | Requires further instruction & supervision |
|---|---|---|
| | Date | Date |
| 6. Return special magnet to its identified location. Keep special magnet at least 10 inches away from credit cards and other magnets. The magnet will damage credit cards. Older microwaves or posted "microwave danger" areas should be avoided. Computer and televisions will not affect the generator. | | |
| 7. Document what time magnet was swiped over generator, the number of swipes, and the outcome. Documentation of the episode may be done on a seizure observation form. | | |

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

Trainer's Signature_____Initials_____Date_____

Trainee's Signature_____Initials_____Date_____