Delegated Nursing Skills Training Manual for Unlicensed Assistive Personnel: A Reference for School Nurses (2022)

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Updated to reflect the 2021 School Nurse Roles and Responsibilities Practice Guidelines

Contents

I. Introduction

This manual is designed to assist the school nurse with training and documentation of skill competencies for Unlicensed Assistive Personnel (UAP). The UAP serves a role to assist the school nurse with an ever-increasing workload. Advances in medical technology enable children, who require specialized care, to attend school and receive an equitable education. A UAP may assist the school nurse with the care of one or more students who may require a skilled nursing procedure. Each school district reserves the right to define the position and job duties for the UAP; however, the Registered (school) Nurse (RN) is responsible for training, supervision, and proper documentation of competency for these individuals.

The manual is divided into sections as outlined in the Nursing Tasks matrix of the School Nurse Roles & Responsibilities Practice Guidelines approved by the Arkansas State Board of Nursing, revised September 2021. Each section will give a brief overview of major concepts to include in UAP training followed by the appropriate skills checklist(s) associated with the section. The school nurse may print only the sections necessary for the student-specific teaching.

The RN reserves the right to include or exclude information based on each student's individualized needs. This manual is merely a reference designed specifically for the school nurse.

Scope of Practice: Each nationally certified or licensed [registered] individual is required to practice within certain guidelines. These guidelines are determined by a specific licensing board and will differ from state to state. These positions are, but not limited to, Advanced Practice Nurse (APN), Registered Nurse (RN), Licensed Practical Nurse (LPN), and Licensed Psychiatric Technician Nurse (LPTN).

II. General Guidelines for Training

The training of unlicensed assistive personnel falls under the roles and responsibilities of the school nurse. It is important for a school nurse to understand school district policy regarding who is qualified to serve as a UAP. In addition, it is necessary for a school nurse to consider the diversity of each individual and his/her cultural practices and beliefs.

Training for healthcare-related procedures should occur in a systematic and controlled manner. The nurse should provide general and student-specific training, encouraging student involvement in self-care whenever safely possible. When training is approached in this manner, the results are:

- Safe and effective care for the student
- Increased competence and confidence of care providers
- Family approval of the provision of services

General Training

General training is designed for any person who has contact with a student with a special health care need.

This training creates:

- A positive attitude among teachers, administrators, and classmates
- Increasing inclusion of students with diverse needs
- Opportunity to provide an overview of student-specific health care needs
- Opportunity for school staff, family, and administrators to discuss the social, emotional, and educational impact of attending school with a peer who has a disability or chronic illness
- An emergency plan

The key components of general training include:

The health care plan: The school nurse will collaborate with the parent/guardian to review physician orders and health care plan (HCP). Appropriate information to include in general training may include a brief description of the health condition and health care needs the student may require. The health care plan should NOT be distributed to every teacher. This information is confidential medical information shared on a "need to know" basis.

The emergency plan: An explanation of the student emergency plan should be presented during general training. It is important to include:

- Recognition of emergency situations and appropriate responses
- Clear designation of persons who will provide emergency services and how to contact them
- A review of standard precautions
- Assurances that a procedure is in place
- Known location of copies of the plan

Awareness training: Topics covered as part of such programs include:

- Diversity, equity, and inclusion
- Types of disabilities and health care conditions
- The importance of feeling included
- Sensitivity towards experiencing barriers
- Showing cooperation, curiosity, and respect

Awareness training often includes questions and answers about a student's condition and equipment. For any reason, the student/family always reserves the right to refuse to answer any questions.

Student-Specific Training

Student-specific training is always necessary, even if school personnel are familiar with similar care provided to other students. Anyone providing health care services needs comprehensive training to meet the individual needs of the student.

The key components of student-specific training include:

An overview of the training

- Description of health issues and required procedures
- Standard precautions
- Psychosocial implications including privacy, confidentiality, and dignity
- Maximum involvement of student in self-care
- Attitudes and preferences of the student and family
- Pertinent information from the HCP
- Communication network including school, home, and health care providers

Discussion of health care/medical procedures

- Basic anatomy and body mechanics
- Name and purpose of procedure
- Timing, duration, and demonstration of procedures
- Check list documentation of trainee performance of procedures using a mannequin
- Trainee observation of the parent or trainer performing the procedure
- Location where care will take place
- Confidentiality and student privacy issues
- Hygienic practice
- Equipment and supplies required
- Lifting and positioning of the student
- Level of student involvement in self-care
- Standard precautions
- Signs and symptoms requiring attention
- Documentation of the procedure
- Scheduled supervision and follow up

The emergency plan

- Signs and recognition of potential problems
- Individual responsibilities
- Location of the emergency plan
- List of people to contact in case of an emergency
- Mock emergency drill plan

Student Training

Involving students in their own care results in increased autonomy and independence in the arenas of school and community. Improved self-care skills promote the goal of living independently as an adult.

The key components of student training include:

Increased tolerance for care Students can achieve independence and tolerance of self-care at varying levels depending on cognitive, physical, emotional, social, and cultural factors. Appropriate goals should be developed to increase their tolerance of care.

Direct the care provider Many students with physical disabilities learn to direct the

care provider and assist during aspects of the procedure.

Achieve independence Some students will be able to learn to perform procedures independently. The degree of supervision needed may vary depending on the complexity of the care and the developmental level of the student. Based on the preference of the student and family, procedures can be performed to facilitate inclusion of a peer.

It is important to monitor and evaluate these services to update plans as needed. Revisions may be needed within the areas of student health status, health care plan, and skills training. It is important to use appropriate assessment tools to review the need for changes and to document well.

III. Laws and Practice Guidelines Overview

This section covers the specific legal statutes and codes that govern the scope of the school nurse.

Delegation Ark. Code Ann. § 17-87-102 A licensed Registered Nurse has the authority to delegate skills and tasks which fall within the guidelines of the job descriptions defined by the Arkansas Nurse Practice Act. These definitions can be found in Section IV. Delegation, of this manual.

Family Educational Rights and Privacy Act (FERPA) 20 *U.S.C.* § 1232g; 34 *CFR* Part 99. This federal law protects the student's education record and applies to any institution that receives federal money. To obtain full guidelines please visit http://www.ed.gov/policy/gen/guid/fpco/ferpa/index.html .

Health Insurance Portability and Accountability Act (HIPAA) 45 *CFR* Parts 160, 162, and 164. Established in 1996, this law governs the private health information of every consumer seeking medical assistance. This act allows, "flow of health information needed to provide and promote high quality health care" while ensuring this information is strictly protected. HIPAA is, "designed to be flexible and comprehensive to cover the variety of uses and disclosures that need to be addressed." To obtain full guidelines please visit http://www.hhs.gov/ocr/hipaa

Individualized Healthcare Plans Ark. Code Ann. § 16-18-1005 (a)(6)(A). "Students with special health care needs, including the chronically ill, medically fragile, technology-dependent and students with other health impairments shall have individualized health care plans."

In accordance with the **Nurse Practice Act §17-87-102** and the Arkansas State Board of Nursing Scope of Practice Position statement, school nurses are responsible for health services and nursing care administered by LPNs, LPTNs, and Unlicensed Assistive Personnel.

An RN can assess, diagnose, plan, implement, and evaluate nursing care. An LPN or LPTN may also perform these activities under the direction of a Registered Nurse, Advanced Practice Nurse, physician, or dentist. Unlicensed Assistive Personnel may perform delegated nursing care in accordance with the ASBN rules.

IV. Delegation

Delegation and supervision are separate but equally important professional nursing roles. Delegation is more than the act of merely handing responsibility over to another individual.

To decrease the disparities in terminology and language of *Delegation*, the American Nurses Association (ANA) and the National Council of State Boards of Nursing (NCSBN) combined forces to create a joint statement on delegation.

ANA and NCSBN both define delegation as the process for a nurse to direct another person to perform nursing tasks and activities. NCSBN describes this as the nurse transferring authority while ANA calls this a transfer of responsibility. Both state that a Registered Nurse (RN) may direct an unlicensed individual to perform certain nursing tasks. Position statements from both associations stress that the nurse retains accountability for the delegation.

Supervision does not require the supervisor to be always physically present, however, the supervisor must be available to critically watch and direct the individual to whom the task has been delegated. While nurses may delegate skills, they must never assume they are free from the responsibility of delegation and supervision. The American Nurses Association defines supervision as, "the active process of directing, guiding, and influencing the outcome of an individual's performance of an activity." The amount of supervision required is related to the individual's experience, skills, and ability to perform tasks appropriately for the student(s) being served.

Family members can legally provide nursing care without a nursing license as an allowable exception to the Nurse Practice Act. For example, some parents have been instructed how to give intravenous medication at home. However, ***only the school nurse can determine medically necessary nursing care that can be safely delegated to unlicensed assistive personnel.***

While administrators, teachers, and parents may be helpful resources, they are not legally entitled to delegate direct nursing care. The school nurse may be accountable to the administrator for personnel issues, but ***the nurse is solely responsible for directing nursing care.***

Safe and effective delegation follows five simple principles:

Right Task

Is the task within the scope of practice?
Is the task appropriate to the job description?
Is the task on a shared tasks list?
What is the desired outcome?

Right Circumstances

Is the setting appropriate?
Are there enough resources available?
Are there any other factors to consider?

Right Person

Is this person currently qualified or can they be qualified to do the task?
Does this fit within his/her job description?

Right direction/communication

Clear concise description of task objectives, limits, and expectations

Right Supervisor

Monitoring
Evaluation
Intervention
Feedback

When nurses follow these principles and answer the questions appropriately, delegation will be successful.

V. Activities of Daily Living

Activities of Daily Living-ASBN 1

Skill Sheets for UAP Training:

- Toileting/Diapering (ASBN 1.1)
- Bowel/Bladder Training (ASBN 1.2)
- Bathing/Grooming/Dressing (ASBN 1.3 & 1.4)
- Dental and Oral Hygiene (ASBN 1.5 & 1.6)
- Lifting/Positioning/Transfers (ASBN 1.7)
- Oral Feeding (ASBN 1.8.2)
- Nasogastric Tube Removal (ASBN 1.8.5)
- Gastrostomy Feeding (ASBN 1.8.6)
- Monitoring Gastrostomy Feeding (ASBN 1.8.7)
- Monitoring Gastrojejunal Tube Feeding (ASBN 1.8.10)

Activities of daily living are everyday tasks which allow an individual to function independently. These tasks include feeding, dressing, hygiene, and physical mobility.

Performance of activities of daily living may be impaired by a physical or mental disability. Health care workers play a significant role in teaching these skills to help an individual achieve and maintain the highest level of functioning.

Elimination

Some students may need assistance with toileting, bowel, and bladder training; some will require the use of diapers. Students with elimination difficulties may require psychosocial and physiological support as well. It is important to provide compassionate care to preserve the dignity of the student.

Toileting/Diapering (ASBN 1.1)

Toileting

Providing privacy during toileting activities is respectful and may decrease student anxiety.

Procedure for Toileting:

1. Assist the student to the restroom.
2. Assist the student with removal of necessary clothing.
3. Apply gloves.
4. Assist the student to the toilet—***Proper body mechanics will reduce the risk of back injury.***
5. Provide privacy while remaining close to the

student in case he/she needs assistance.

6. Providing balance or support for the student may be needed.
7. Once finished with elimination, remind the student to use correct methods to clean the perineal area. Girls should use a front-to-back motion for cleansing. The student may require assistance with this procedure.
8. Assist the student with replacing his/her clothing.
9. Wash hands—Caregiver AND student.
10. Assist the student back to the classroom.
11. Notify RN of any changes in elimination or any concerns.
12. **DOCUMENT PROCEDURE**

Documentation is a critical component to any procedure. Occurrences to watch for and document with toileting are:

- Foul smelling urine or difficulty expelling urine
- Complaints of pain or discomfort with elimination
- Change in color of the urine

If any of these occur, notify the RN immediately.

Diapering

Prior to performing a diapering procedure, gather all supplies and set up the area to decrease the amount of time a student will be exposed.

1. Gather needed supplies (diapers, wipes, skin barrier if prescribed) and wash hands.
2. Bring student to changing area and provide privacy.
3. Place student on changing table—***proper body mechanics will reduce the risk of back injury*.** If a second person is needed to assist with lifting, have them present before beginning the procedure.
4. Apply gloves.
5. Remove only enough clothing to gain access to the diaper.
6. Remove soiled diaper.
7. Clean perineal area—remember to use the front-to-back motion with girls. This will decrease risk of infection.
8. If there is an order to use skin barriers such as Desitin™ or Vaseline™, apply the barrier at this time.
9. Apply a clean diaper and replace clothing.

10. Dress student.
11. Dispose of soiled diaper properly.
12. Wash hands.
13. Return student to the classroom.
14. **DOCUMENT PROCEDURE**

Note any changes in skin such as extreme redness, bleeding, or breakage of skin. If any of these occur, notify the RN immediately.

Toileting/Diapering (ASBN 1.1)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y/ N	Date	Date
Diapering			
1. Gather needed supplies (diapers, wipes, skin barrier if prescribed) and wash hands.			
2. Bring student to designated area for changing and provide privacy.			
3. Place student on changing table – *proper body mechanics will reduce the risk of back injury.* If a second person is needed to assist with lifting, have them present before beginning the procedure.			
4. Apply gloves.			
5. Remove only enough clothing to gain access to the diaper.			
6. Remove soiled diaper.			
7. Clean perineal area-remember to use the front-to-back motion with girls. This will decrease risk of infection.			
8. If there is an order to use skin barriers such as Desitin™ or Vaseline™, apply the barrier at this time.			
9. Apply skin cream as prescribed if order is present.			
10. Apply a clean diaper and replace clothing.			
11. Dress student.			
12. Dispose of soiled diaper properly.			
13. Wash hands.			
14. Return student to the classroom.			
15. DOCUMENT PROCEDURE			
Toileting	**Y/N**	**Date**	**Date**
1. Assist student to the restroom.			
2. Assist student with removal of necessary clothing.			
3. Apply gloves.			

4. Assist student to the toilet-*Proper body mechanics will reduce the risk of back injury.*			
5. Provide privacy while remaining close to the student in case he/she needs assistance.			
6. Provide balance or support for the student as needed.			
7. Once finished with elimination, remind the student to use correct methods to clean the perineal area. 8. Girls should use a front-to-back motion for cleansing. 9. Student may require assistance with this procedure.			
10. Assist student with replacing his/her clothing.			
11. Wash hands-Caregiver AND student.			
12. Assist student back to classroom.			
13. Notify RN of any changes in elimination or any concerns.			
14. DOCUMENT PROCEDURE			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Bowel/Bladder Training (ASBN 1.2)

Elimination Impairment

NOTE: Do not place the student on the toilet randomly throughout the day. This may cause a disconnection between the toilet and elimination if no results occur.

A student may have elimination impairment due to structural abnormalities or certain disease processes. It may be possible to regain partial or complete control of elimination through bowel or bladder training. Please refer to the student-specific training guidelines if available. In the event a student does not have a formal written bowel or bladder program, the nurse may use this section as a guideline.

Training programs are designed to correspond with the student's natural urges. Success of the program is more probable when consistency, good nutrition, and timing are observed. To this end, a pattern of normal elimination must be established. Watching and documenting the student's normal elimination pattern over a set period, usually five days is sufficient. Once a pattern has been established, a student-specific plan may be developed.

Special consideration must be taken for students with disabilities. These students may have reduced sensation for the need to empty the bowel or bladder. The goal is to form a habit for toileting.

Key points to remember:

Preparation for toilet training is essential for a successful program. In addition to watching for normal elimination patterns, keep a record of intake and output.
Consistency is critical. Do not start the program until a consistent pattern can be established (i.e., do not begin the program at school in the middle of the week or right before the weekend. Try to begin on a Monday).
Consistency between school training and home training is important. Make sure the parent/guardian is ready to begin the process as well.
Have the child wear clothes that are easy to pull up and down. This will help eliminate accidents related to difficulty in removing clothing.
Coordinate with parent/guardian. Determine the appropriate word that will be used at home such as "potty."
Make a picture schedule using photos of the steps necessary in the toileting procedure. Review the procedure with the student and place the photos in the correct order, then locate the picture schedule in a place clearly visible to the

student.

Eliminate objects in the bathroom that could be a distraction for the student.

Establish a pattern of elimination based upon the information gathered from the earlier studied elimination patterns of the student. Each school day, attempt elimination within 15 minutes of the designated time.

If possible, give the student fluids 20-30 minutes before the scheduled toileting time.

Normal elimination of stool happens within 30 minutes of a meal. If clothes are dry at elimination time, give the student praise. If the student is wet at the first attempt, only give praise for elimination in the toilet. Allow the student to sit on the toilet for approximately 3 minutes.

If the student has eliminated in the toilet, provide positive reinforcement. Remember to provide praise only AFTER the child has finished eliminating. This will prevent frightening the child and causing elimination to stop. If the student does not eliminate DO NOT scold the child. Provide encouragement for the next elimination session.

If a picture schedule was created, review it with the student throughout the process and ask questions such as "What do we do next?"

If necessary, assist the student with hygiene and redressing.

Assist the student with proper hand washing and returning to the classroom.

Bowel / Bladder Training (ASBN 1.2)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y/ N	Date	Date
1. Ensure the student wears non-restrictive clothing.			
2. Create a picture schedule.			
3. Eliminate all distracting items from the bathroom.			
4. Elimination attempts will occur at the following times (remember normal elimination of stool occurs within 30 minutes of a meal) ○ am/pm ○ am/pm ○ am/pm ○ am/pm			
5. Give fluids 20-30 minutes prior to above-mentioned times.			
6. Apply gloves.			
7. Assist student to the restroom and to the toilet. Provide additional support if needed.			
8. Assist with hygiene and redressing if necessary.			
9. Assist with hand washing and returning to the classroom.			
10. **DOCUMENT PROCEDURE**			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Bathing/Grooming and Dressing (ASBN 1.3 and 1.4)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y/ N	Date	Date
1. Personal Care: Dressing (Assist with clothing)			
2. Dressing – being able to make appropriate clothing decisions and physically dress and undress oneself.			
3. Personal Hygiene ○ Oral care ○ Nail care ○ Skin care ○ Bathing ○ Menstrual Hygiene			
4. Apply gloves.			
5. Assist students with undressing if assistance is needed.			
6. Demonstrate proper way to complete personal care by soaping up a washcloth and demonstrating how to use it.			
7. Nurse/UAP will give students his/her privacy to complete the task (if needed, student will signal staff to assist).			
8. Once task is complete, student will complete personal care process by putting on deodorant, lotion, and clean clothes.			
9. Nurse/UAP will provide student privacy to student to complete this task (if needed, student will signal staff to assist)			
10. **DOCUMENT PROCEDURE**			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Dental and Oral Hygiene (ASBN 1.5 & 1.6)

Proper care of teeth and gums is extremely important. Teeth are crucial for chewing food to maintain proper nutrition. Some students are not able to properly care for their own teeth. As primary caregivers in the school setting, it may be necessary to provide dental and oral care for these students. In addition, school-age children will be in the process of losing deciduous "baby teeth."

Procedure:

1. Gather supplies:
   - Toothbrush
   - Toothpaste
   - Cup and water for rinsing
   - Gloves
2. Explain procedure to the student.
3. Apply gloves.
4. Moisten toothbrush and apply toothpaste.
5. Brush teeth, being careful not to apply too much pressure. The gums are extremely sensitive and can easily bleed.
6. Allow the student to spit and rinse his/her mouth.
7. Be careful to only give enough water to rinse the mouth.
8. Note: If a student is not allowed to have liquids by mouth, do not provide water. It would be best only to use oral sponges.
9. **DOCUMENT CARE**

Documentation is a critical component to any procedure. Things to look for when providing oral care:

- Broken or loose teeth
- Mouth sores

Oral Hygiene (ASBN 1.5) Dental Hygiene (ASBN 1.6)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
1. Gather supplies: ○ Toothbrush ○ Toothpaste ○ Cup and Water ○ Gloves			
2. Explain procedure to the student.			
3. Apply gloves.			
4. Moisten toothbrush and apply toothpaste.			
5. Brush teeth, being careful not to apply too much pressure. The gums are extremely sensitive and can easily bleed.			
6. Allow student to spit and rinse his/her mouth.			
7. Provide water to rinse if student is allowed liquids.			
8. **DOCUMENT PROCEDURE**			
Special Considerations for Oral Care: ○ Oral sponges only for students who are at risk for aspiration ○ Students with swallowing difficulty should not be offered water to rinse Things to look for when providing oral care: ○ Broken or loose teeth ○ Mouth sores			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Lifting/Positioning/Transfers (ASBN 1.7)

Body mechanics can be defined as the coordinated effort of the musculoskeletal and nervous systems to maintain balance, posture, and body alignment during lifting, bending, moving and performance of physical activities. If any one of these parts of the body are altered or injured, the result can be loss of or change in the ability to move.

Using proper body mechanics while lifting, transferring, and/or positioning students is extremely important. Preventing injury to the student and/or caregiver is accomplished by utilizing proper body mechanics

Physical disabilities that result in functional impairments can have a variety of causes: central nervous system disorders, deconditioning, and use of specialized equipment is not an exhaustive list.

Guidelines to help ensure proper body mechanics:

1. **Never lift a student who is too heavy**. Seek assistance from another staff member.
2. Explain procedure to the student and have him/her participate as much as possible.
3. Always maintain good alignment.
4. Tighten stomach muscles and tuck the pelvis; this provides balance and protects the back.
5. Provide a broad base of support by placing feet at least twelve inches apart.
6. Bend at the knees while keeping back straight; this helps to maintain a center of gravity and lets the strong muscles of the legs do the lifting.
7. When lifting, keep the weight of the student's body close to the caregiver's body. This action places the weight in the same plane as the lifter and close to the center of gravity for balance.
8. Maintain an erect trunk and bent knees. This will assure that multiple muscle groups work together in a synchronized manner.
9. To lift vertically, the best height is approximately two feet above the ground and close to the lifter's center of gravity.
10. When changing the direction of movement, pivot feet, turn with short steps, and turn the whole body without twisting the upper torso. When lowering a heavy object or student, always bend straight down toward the resting place, NEVER twist to lower the student or object. This will

reduce the risk for twisting sprains and injuries to the back.

Note: Use a verbal 1-2-3 count to coordinate movement with the student and other staff. This will prevent jerking movements that could lead to back strain and injury.

Lifting/Transfers/Positioning (ASBN 1.7)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Lifting and Transfers 1-person ***Never lift a student who is too heavy! Seek assistance from another staff member.***			
1. Explain procedure to student.			
2. Place the wheelchair at a 45° angle to desired end location (changing table, another chair, etc).			
3. Lock wheels in place.			
4. Raise chair, if possible, to height of table or have second person available for lifting, if necessary.			
5. Position self between student's knees bending slightly at the waist.			
6. Position the student in the center of the chair.			
7. Place arms under the student's armpits.			
Use proper body mechanics: o Place feet at least 12 inches apart o Keep weight of student as close to you as possible o Tighten stomach muscles and tuck the pelvis o Bend at knees while keeping back straight o When turning, pivot feet, turn with short steps (turn body without twisting torso o NEVER twist to lower student			
8. Lower student and support, if necessary.			
9. Release brake and move chair out of way.			
10. **DOCUMENT PROCEDURE**			
2-person Lifting and Transfer	**Y/N**	**Date**	**Date**
1. Place wheelchair parallel to table or chair and lock brakes.			
2. Position one person to stand behind student—one person in front of student to one side of student's knees.			
3. One person places arms under the student's armpits while other person grasps student under both knees.			

4. Use a verbal 1-2-3 count to coordinate movement.			
5. Each person bends knees at the same time and pushes straight up, lifting the student onto the table or chair and providing support when necessary.			
6. Release brake and move chair out of way.			
7. **DOCUMENT PROCEDURE**			
Positioning	**Y/N**	**Date**	**Date**
1. Keep student's airway open by ensuring head and neck are in straight alignment.			
2. Maintain equal weight on points of pressure such as buttocks, shoulder blades, elbows, backs of knees and heels.			
3. Assure there is adequate space between back of knee and chair—this will ensure no pressure is placed on the popliteal artery or nerve thus interfering with blood flow and nerve function.			
4. Reposition student as ordered by physician or district policy.			
5. **DOCUMENT PROCEDURE**			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

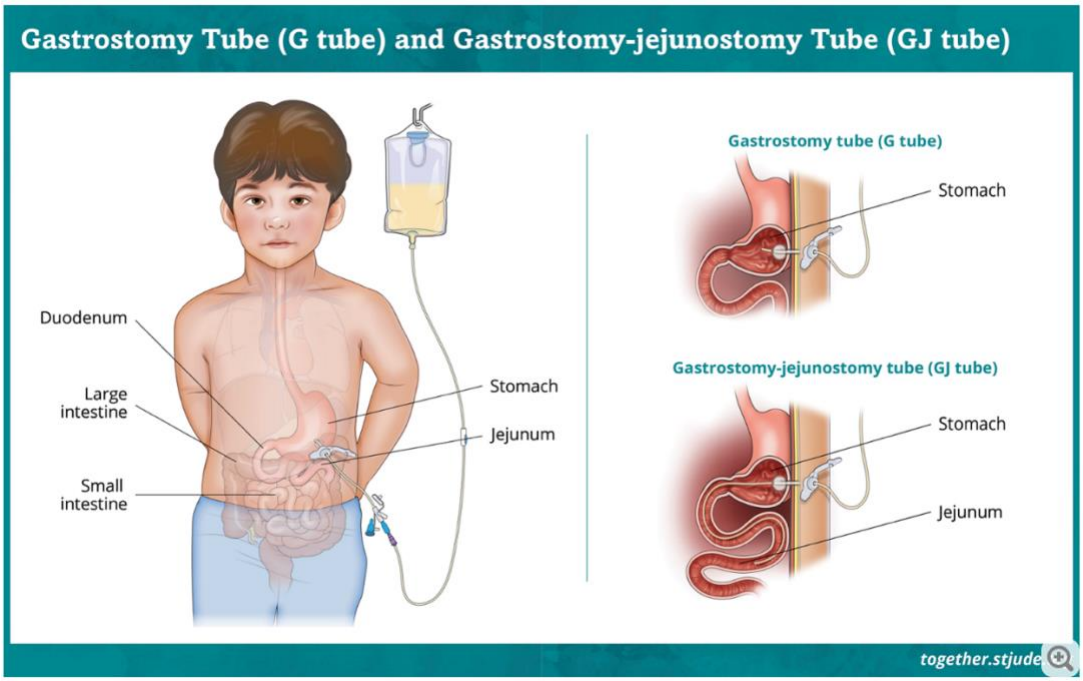
Feeding (ASBN 1.8)

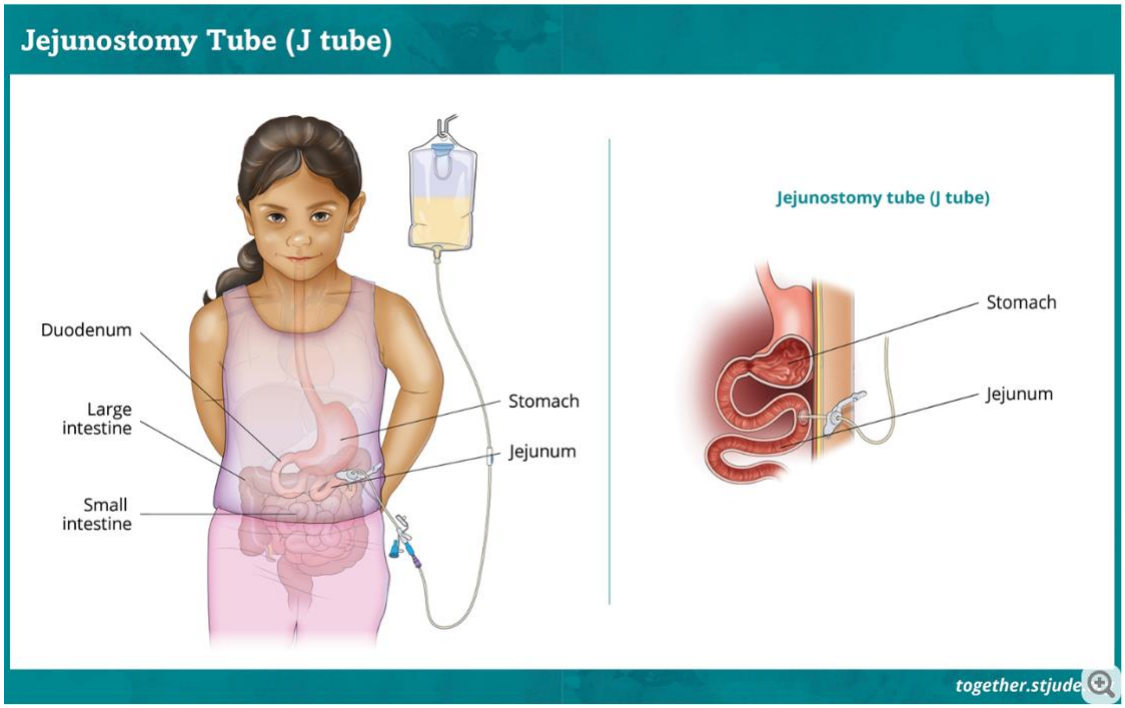
The gastrointestinal system breaks food down into basic nutrients that nourish the body with proteins, vitamins, minerals, water, carbohydrates, and fats. After food is chewed and swallowed, it moves down the esophagus and enters the stomach. Once in the stomach, food is broken down further by powerful stomach acids. From the stomach, the food travels into the small intestine where it is emulsified into nutrients that can enter the bloodstream through tiny hair-like projections. The excess food the body does not need or cannot digest becomes waste and is eliminated from the body.

Students may require assistance with oral or tube feedings. A nasogastric feeding tube (NG tube) is a small, soft tube that goes through the nose, down the throat and into the stomach. Gastrostomy (G-tube) Gastro-jejunostomy (GJ-tube), and Jejunostomy (J tubes) are placed through a small opening called a stoma that is made in the wall of the abdomen. The procedure to create the opening is called an ostomy.

In a school setting, the UAP may assist with the following:

- Administer Gastrostomy feeding
- Monitor Gastrostomy feeding
- Monitor Jejunostomy feeding
- Removal of Nasogastric tube if necessary





Images: [St. Jude's Children's Hospital]

Tube feedings may be used to administer food and fluids directly into the stomach. This method is used to bypass the usual route of feeding by mouth when:

- There is an obstruction of the esophagus
- Swallowing is impaired, and the student is at risk for choking/aspiration
- The student has difficulty taking enough food by mouth to maintain adequate nutrition

A student may receive a tube feeding by either bolus or continuous (slow drip) method. A bolus is a specific amount of feeding given at one time (over 20-30 minutes). A continuous feeding is given slowly over several hours. The G-tube may be used to drain abdominal contents or to release gas when venting is required. Tube feedings can usually occur in any setting where respect for the student's privacy can be observed.

Students requiring venting or drainage procedures should do so in a secluded setting. A stoma is covered by clothing and should not hinder the student's ability to participate in regular school activities; however, the student may require a modification of physical activities.

The school nurse in conjunction with the physician and parent/guardian will perform the health assessment and creation of the Individual Health Care Plan.

Potential problems with tube feedings

Nausea and or cramping: Check rate of feeding—may need to slow it down, check temperature of formula—needs to be room temperature.
Bleeding, drainage, redness, irritation: Check skin around gastrostomy device site daily. Clean stoma site if leakage of fluid, food, or medication encounters skin.

Contact Nurse if the following occur:

Blocked gastrostomy device*:* May be due to inadequate flushing or very thick fluid. Flush with warm water after feeding or medication. problem persists, notify nurse.
Leaking stomach contents: May be due to a problem with the anti-reflux valve. Clean skin and cover with gauze.
Gastrostomy device falls out*:* THIS IS NOT AN EMERGENCY—Save the device in clean gauze or container for reinsertion. In some students, whose tracts may close quickly, the gastrostomy device may need to be reinserted within 1-2 hours. Cover gastrostomy site with bandage or clean dressing.

Stop Feeding Immediately if any of the following occur:

- Gagging
- Vomiting
- Coughing
- Abdominal Distention
- Change in skin color

These signs and symptoms may be due to aspiration of fluid into the lungs. Call the school nurse if he/she is not present.

Cleaning

Refer to student-specific guidelines to determine solution used to clean stoma.

- Rotate device 360 degrees with each cleaning
- Dry stoma
- Leave area open to air to facilitate drying

Nutritional Assessment (ASBN 1.8.1)

DO NOT DELEGATE

According to the Arkansas State Board of Nursing School Nurse Roles & Responsibilities Practice Guidelines, a Registered Nurse MUST perform this task.

Oral Feeding (ASBN 1.8.2)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
1. Wash hands.			
2. Assure the student has the appropriate and correct diet.			
3. Prepare tray: Open cartons, remove lids, cut food.			
4. If the student can eat independently, allow student to feed self.			
5. For the student who cannot eat independently, assist with feeding: a. Sit in a comfortable position. b. Ask the student which food he/she would like to eat first.			
6. Feed student in a manner which promotes chewing and swallowing: give small bites and allow ample time.			
7. Provide liquids as requested.			
8. Talk with the student.			
9. Use this opportunity to talk about good nutrition habits.			
10. Assist with hand washing.			
11. **DOCUMENT PROCEDURE**			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature /date_____

Nasogastric Feeding (ASBN 1.8.3)

DO NOT DELEGATE

According to the Arkansas State Board of Nursing School Nurse Roles & Responsibilities Practice Guidelines, a licensed nurse MUST perform this task.

Monitoring N/G Feeding (ASBN 1.8.4)

DO NOT DELEGATE

According to the Arkansas State Board of Nursing School Nurse Roles & Responsibilities Practice Guidelines, a licensed nurse MUST perform this task.

Nasogastric Tube Removal (ASBN 1.8.5)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y /N	Date	Date
1. Put on gloves.			
2. Remove adhesive from the nose, discontinue suction.			
3. Grasp NG tube at the nose.			
4. Gently pull until the entire tube is removed. *Note: look at the integrity of the tube – is the tube intact or broken?			
5. Notify RN immediately if the NG tube has been emergently removed.			
6. **DOCUMENT PROCEDURE**			
a. Describe environment immediately prior to removal			
b. Explain why the NG tube was removed			
c. Explain actions taken			
d. Note condition of the tube after removal			
Indications for Emergent Removal of the NG tube:	**Y/N**	**Date**	**Date**
Student-specific information to be filled in by RN in conjunction with Physician orders and family wishes.			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Gastrostomy Feeding (ASBN 1.8.6)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	**Y / N**	**Date**	**Date**
Always make feeding feel like a mealtime. Allow student to sit with other students if desired.			
1. Gather supplies: ○ Gloves ○ Formula at room temperature • Determine type and amount to be infused ○ Clamp and plug ○ Water for flushing (if prescribed)			
2. Check health care plan to determine: ○ Infusion type and rate ○ Frequency and timing of administration ○ Amount of water used to flush the tube			
3. Explain procedure to student.			
4. Wash hands.			
5. Place equipment on a clean surface.			
6. To prevent aspiration during the feeding ALWAYS position child with head up at least 30 degrees.			
7. Place towel or washcloth under student's gastrostomy tube.			
8. Put on gloves.			
9. If the following are noticed, do not administer feeding: ○ Abdominal distention ○ Obstruction of G-tube ○ Malposition of G-tube: compare tube length to documented length on file			
10. If residual check is ordered: a. Attach 60ml syringe with plunger to end of tube b. Unclamp tubing and gently draw back c. Document amount withdrawn d. Allow residual to return to stomach passively (do not push syringe, let gravity move the fluid) e. Clamp tubing and remove syringe			
11. Measure prescribed amount of formula.			

12. If the following occur during feeding STOP IMMEDIATELY ○ Gagging ○ Vomiting ○ Coughing ○ Abdominal Distention ○ Change in skin color ○ Difficulty breathing			
For Bolus Feeding (Including Skin-level)	**Y / N**	**Date**	**Date**
a. Pour feeding into syringe until half full.			
b. Open safety plug and attach syringe to G-tube or skin level device.			
c. Elevate feeding above level of the stomach: the higher the syringe is held, the faster the feeding will flow ○ A rapid bolus may cause nausea, vomiting, or diarrhea.			
d. Open G-tube.			
e. Allow feeding to go in slowly over prescribed amount of time.			
For slow or continuous drip feeding:	**Y / N**	**Date**	**Date**
a. Pour feeding into container/bag.			
b. Run feeding through tubing to the tip and clamp tubing closed.			
c. Place tubing into pump and set flow rate.			
d. Open safety plug and insert tubing into G-tube or skin level device.			
e. Program pump to prescribed feeding rate, unclamp tube, and start feeding.			
f. When bag is empty, clamp feeding bag tubing and remove.			
g. After all steps of feeding are complete, wash syringe, feeding bag, and tubing with soap and warm water. Syringe and feeding tubing can be used again for up to 24 hours.			
13. If ordered, vent to relieve gassiness: ○ Lower syringe below level of stomach to facilitate burping ○ Allow gastric contents to passively (gravity) move back to stomach			
14. Flush G-tube: ○ Attach 60cc syringe and flush G-tube with 5cc (or prescribed) amount of water			
15. Disconnect syringe.			
16. Connect cap or plug to G-tube ○ Ensure clamp is not resting on student skin			

17. Keep child in a feeding position (at least 30 degrees) for at least 30 minutes after feeding.			
18. Remove gloves.			
19. Wash hands.			
20. **DOCUMENT PROCEDURE**			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature /date_____

Monitoring Gastrostomy Feeding (ASBN 1.8.7)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Things to watch for with gastrostomy tube feedings			
1. **Changes in skin color, breathing difficulties** **STOP FEEDING IMMEDIATELY**			
2. **Nausea/ vomiting** ○ Check flow rate ○ Check temperature of formula ○ If above items have been checked – STOP FEEDING			
3. **Blocked gastrostomy device** ○ Flush with warm water after feeding or medication administration			
4. **Bleeding, drainage, skin redness and/or irritation** ○ Check skin daily ○ Refer to student emergency plan ○ Rotate device in complete circle (360 degrees) with cleaning ○ Dry stoma well			
5. **Leaking of the stoma** ○ Clean skin and notify RN and family			
6. **Gastrostomy device falls out**—THIS IS **NOT** AN EMERGENCY ○ Save device ○ Contact RN and family			
7. **DOCUMENT PROCEDURE**			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurses signature/date_____

Gastrostomy Tube Reinsertion (ASBN 1.8.8)

DO NOT DELEGATE

According to the Arkansas State Board of Nursing School Nurse Roles & Responsibilities Practice Guidelines, a licensed nurse MUST perform this task.

Gastrojejunostomy Tube Feeding (ASBN 1.8.9)

DO NOT DELEGATE

According to the Arkansas State Board of Nursing School Nurse Roles & Responsibilities Practice Guidelines, a licensed nurse MUST perform this task.

Monitoring Gastrojejunal Tube Feeding (ASBN 1.8.10)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Things to watch for with gastrojejunal tube feedings			
1. **Changes in skin color, breathing difficulties** **STOP FEEDING IMMEDIATELY**			
2. **Nausea/ vomiting** ○ Check flow rate ○ Check temperature of formula ○ If above items have been checked—**STOP FEEDING**			
3. **Blocked gastrostomy device** ○ Flush with warm water after feeding or medication administration			
4. **Bleeding, drainage, skin redness and/or irritation** ○ Check skin daily ○ Refer to student emergency plan ○ Rotate device in complete circle (360 degrees) with cleaning ○ Dry stoma well			
5. **Leaking of the stoma** ○ Clean skin and notify RN and family			
6. **G/J device falls out** —THIS IS **NOT** AN EMERGENCY ○ Save device ○ Contact RN and family			
7. **DOCUMENT PROCEDURE**			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Total Parenteral Feeding (ASBN 1.8.11)

DO NOT DELEGATE

According to the Arkansas State Board of Nursing School Nurse Roles & Responsibilities Practice Guidelines, a licensed nurse MUST perform this task.

Monitoring Parenteral Feeding (ASBN 1.8.12)

DO NOT DELEGATE

According to the Arkansas State Board of Nursing School Nurse Roles & Responsibilities Practice Guidelines, a licensed nurse MUST perform this task.

VI. Urinary Catheterization

Urinary Catheterization-ASBN 2

Skills Sheets for UAP Training:

- Clean Intermittent Catheterization (ASBN 2.1)
- External Catheter Application (ASBN 2.3)
- Indwelling Catheter Care (ASBN 2.4)

The urinary system consists of the kidneys, ureters, bladder, urethra, and the blood vessels that supply them.

The kidneys are two fist-sized organs that filter fluid and eliminate waste from the body in the form of urine. The kidneys also regulate blood pressure, growth, calcium absorption, and red blood cell production.

The blood vessels include renal arteries that carry blood from the main artery to the kidneys and renal veins that transport cleansed blood away from the kidneys. The waste combines with water to form urine. From the kidneys, urine travels down two thin tubes called ureters to the bladder.

The bladder is a reservoir for storing urine until it is ready to leave the body through the urethra. The urethra is a tube leading from the bladder to the outside opening (meatus) of the body. In girls, the meatus is located between the labia, just above the vagina and in boys, at the tip of the penis.

Some students have urinary system impairments due to a disease process or structural abnormality. These students may require a procedure called **clean intermittent catheterization (CIC).** CIC helps prevent urinary tract infections in students who have difficulty emptying their bladder. When the bladder remains full of stagnant urine for extended periods, rapid bacterial growth can occur, and infection may result.

Catheterizing the bladder every few hours eliminates urine before bacteria can multiply and cause an infection. CIC also prevents overflow incontinence, a condition in which urine overflows the bladder and dribbles out the urethra.

CIC is often used when the nerves that stimulate the bladder do not function properly. *Neurogenic bladder* is associated with Spina-Bifida and other conditions in which the nerves from the spinal cord to the bladder are damaged. Nerve damage prevents the bladder from completely emptying, which can lead to an increased risk of infection, kidney damage, and incontinence.

CIC may be performed in a location where the student has privacy. If the unlicensed assistive person is to perform the task, ensure the location is easily accessible and proper body mechanics are utilized.

CIC Procedure Male and Female *(changes to accommodate the female will be italicized)*

1. Wash hands.
2. Gather supplies:
    - Water soluble lubricant
    - Catheter
    - Wet wipes or cotton balls
    - Storage receptacle for catheter
    - Container for urine or toilet
    - Gloves
3. Explain the procedure to the student.
4. Position the student.
5. Wash hands and put on gloves.
6. Show the student, depending on age, the location of the urethral opening.

For a female you can use a mirror to show the opening.

7. Lubricate the tip of the catheter and place it on a clean surface.
8. Cleanse the penis by holding below the glans at a 45° angle from the abdomen (depending on the position of the student or student-specific guidelines) and retract foreskin if not circumcised. Wash the glans with soapy cotton balls or student-specific cleansing supplies. Begin at the urethral opening, and in a circular manner, wash away from the meatus.
9. Repeat twice for a total of three washings. Use clean cotton balls each time.

Female: separate the labia and hold open with fingers. Cleanse in a top to bottom direction from the top of the labia toward the rectum. Wash three times: once down each side and once down the middle.

10. Hold the penis at a 45° angle from the abdomen depending on the position of the student or student-specific guidelines. Insert the catheter gently into the urethral opening. Resistance may be met at the bladder sphincter. Use gentle but firm pressure until the sphincter relaxes. Encouraging the child to relax may be helpful.

Female: locate the urinary meatus (opening). Gently insert the catheter until there is urine.

11. Insert the catheter until there is a good flow of urine. When the flow stops, insert the catheter slightly more and then withdraw a little to make sure all urine is drained. Rotate catheter so catheter openings have reached all areas of the bladder.
12. When the bladder has emptied, pinch the catheter, and withdraw.
13. If the [Male] student is not circumcised, pull the foreskin over the glans when finished.
14. Remove gloves and wash hands.
15. Assist student in dressing.
16. Put on gloves.
17. Measure and record the urine volume if ordered. Dispose of urine, clean equipment, and store in the appropriate container.
18. Wash hands.
19. **DOCUMENT PROCEDURE**

Possible Problems that require Immediate Attention

Bleeding from the urethra: may be due to trauma to the urethra or a urinary tract infection. STOP THE CATHETERIZATION and call the RN.

Inability to pass catheter: may be due to increased sphincter tone caused by anxiety or spasm. Encourage the child to relax.

- *For boys:* reposition the penis and use gentle but firm pressure until the sphincter relaxes. Sometimes it may be helpful to have boys flex at the hips to decrease reflex resistance of the bladder sphincter.
- *For girls*: check catheter placement. The catheter may be in the vagina. If the catheter is in the vagina, do not reinsert; use a clean catheter.
- *If unsuccessful, notify RN for further instructions.*

No urine during catheterization: this may be due to improper placement of catheter, or the bladder may be empty. Check the position of the catheter.

Cloudy urine, mucus, foul odor, color changes, or unusual wetting between catheterizations may be due to a urinary tract infection. Always report to the RN any changes in the student's usual pattern or tolerance of procedure.

Clean Intermittent Catheterization—Male (ASBN 2.1)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Preparation			
1. Identify student ability to participate in procedure.			
2. Review universal precautions.			
3. Procedure will be completed in an area which provides the most privacy for the student.			
4. Position for catheterization.			
5. Identify potential problems and appropriate actions.			
Supplies	**Y / N**	**Date**	**Date**
○ Water soluble lubricant			
○ Type of catheter			
○ Wet wipes or cotton balls			
○ Cleansing supplies			
○ Storage receptacle for catheter			
○ Container for urine			
○ Gloves			
Procedure	**Y / N**	**Date**	**Date**
6. Wash hands.			
7. Gather equipment.			
8. Arrange equipment for procedure (having equipment prepared prior to procedure reduces anxiety of the student).			
9. Wash hands and put on gloves.			
10. Lubricate catheter and place on clean surface.			
Cleaning procedures:	**Y / N**	**Date**	**Date**
11. Prepare cleaning materials.			
12. Retract foreskin if necessary.			
13. Pull penis forward in a straight motion and hold at a 45° angle from the abdomen.			
14. Clean the meatus and glans.			

15. Use each swab only once.			
16. Wipe a minimum of three times.			
Catheterization procedure:	**Y / N**	**Date**	**Date**
17. Grasp catheter about four inches from the tip.			
18. Insert well lubricated catheter into penis with consistent pressure (if muscle spasm occurs, stop momentarily and then again use slow even pressure) NEVER FORCE A CATHETER.			
19.When urine flow stops, insert slightly more, and withdraw slightly.			
20. Rotate catheter so all catheter openings allow for bladder to empty completely.			
21. Allow urine to flow by gravity into the shallow pan or toilet.			
22. If ordered, gently press bladder to help empty.			
23. Pinch catheter and withdraw slowly when urine stops flowing.			
24. If not circumcised, pull foreskin over glans.			
25. Remove gloves and wash hands.			
26. Assist student in dressing.			
27. Put on gloves, measure and record amount of urine collected, clean materials and replace.			
28. Wash hands.			
29. Notify RN of any changes or concerns.			
30. **Document procedure and observations**			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Clean Intermittent Catheterization—Female (ASBN 2.1)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Preparation			
1. Identify student ability to participate in procedure.			
2. Review universal precautions.			
3. Procedure will be completed in an area which provides the most privacy for the student.			
4. Position for catheterization.			
5. Identify potential problems and appropriate actions.			
Supplies			
○ Water soluble lubricant			
○ Type of catheter			
○ Wet wipes or cotton balls			
○ Cleansing supplies			
○ Storage receptacle for catheter			
○ Container for urine			
○ Gloves			
○ Mirror			
Procedure			
6. Wash hands.			
7. Gather equipment.			
8. Arrange equipment for procedure (having equipment prepared prior to procedure reduces anxiety of the student).			
9. Wash hands and put on gloves.			
10. Lubricate catheter and place on clean surface.			
Cleaning procedures			
11. Prepare cleaning materials.			
12. Open labia minora and majora.			
13. Clean from front of folds to back of meatus.			
14. Use swab only once.			
15. Wipe a minimum of three times.			
Catheterization procedure:			

Explanation and Return Demonstration of procedure	Y / N	Date	Date
16. Grasp catheter about three inches from the tip.			
17. Insert well lubricated catheter into the urethra until urine begins to flow NEVER FORCE A CATHETER.			
18. Advance ½ inch more.			
19. Rotate catheter so all catheter openings and allow for complete bladder emptying.			
20. Allow urine to flow by gravity into the shallow pan or toilet.			
21. If ordered, gently press bladder to help empty.			
22. Pinch catheter and withdraw slowly when urine stops flowing.			
23. If urine begins to flow again during removal—Wait until all urine has stopped flowing to remove catheter.			
24. Remove gloves and wash hands.			
25. Assist student in dressing.			
26. Put on gloves, measure and record amount of urine collected, clean materials and replace.			
27. Wash hands.			
28. Notify RN of any changes or concerns.			
29. **Document procedure and observations**			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Sterile Catheterization (ASBN 2.2)

DO NOT DELEGATE

According to the Arkansas State Board of Nursing School Nurse Roles & Responsibilities Practice Guidelines, a Registered Nurse MUST perform this task.

External Catheter Application (ASBN 2.3)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y/ N	Date	Date
Use this form to create a student-specific plan for student with external catheter.			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Indwelling Catheter Care (ASBN 2.4)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y/ N	Date	Date
1. Gather your supplies. You will need: ○ Mild soap, such as Dove® ○ Water ○ 1 Cath-Secure®			
2. Wash your hands with soap and water for at least 20 seconds.			
3. Using mild soap and water, clean the genital area: Male: a) Pull back the foreskin b) Clean the area including the penis c) Return foreskin to the covered position when finished Female: a) Separate the labia b) Clean the area from front to back			
4. Clean the urethra (urinary opening) where the catheter enters the body.			
5. Clean the catheter: a. Start cleaning at the tip of the catheter working away from the tip b. Hold onto catheter close to where it enters body to prevent tension			
6. Rinse the area well and dry it gently.			
7. If you removed the old Cath-Secure, use the new Cath-Secure to attach the catheter to the leg to keep it from moving.			
8. **DOCUMENT PROCEDURE**			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

VII. Medical Support Systems

Medical Support Systems-ASBN 3

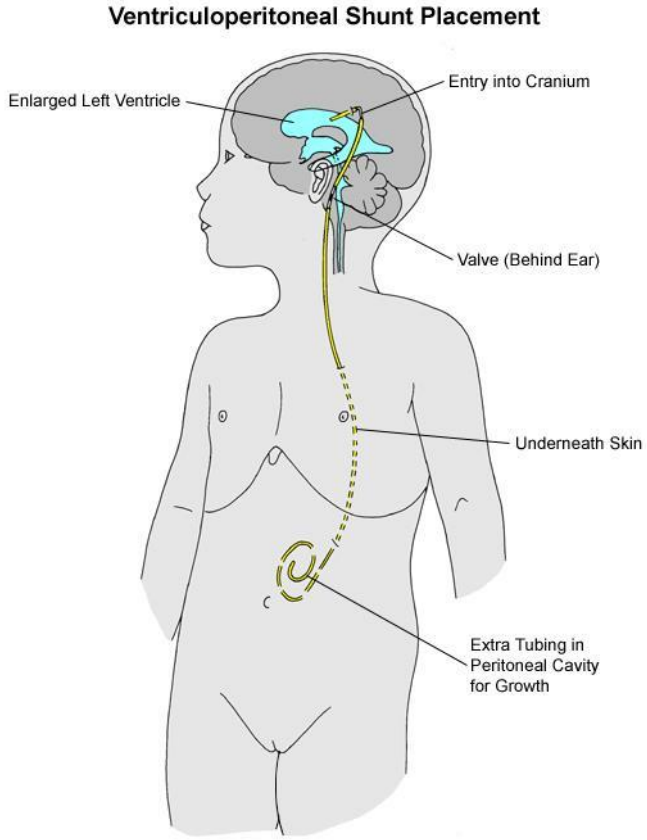
Skill Sheets for UAP Training:

- Ventricular Peritoneal Shunt Monitoring (ASBN 3.1)
- Mechanical Ventilator Monitoring (ASBN 3.2.1)
- Ambu Bag (ASBN 3.2.3)
- Oxygen-Intermittent (ASBN 3.3.1)
- Oxygen-Continuous (ASBN 3.3.2)

Ventricular Peritoneal Shunt

The brain contains hollow spaces, ventricles, which produce cerebrospinal fluid (CSF). This fluid cushions and supplies nutrients to the brain. CSF is normally housed in a compartment around the brain and spinal cord called the subarachnoid space.

A backup of this fluid into the ventricle puts pressure on the brain and results in a hydrocephalus. To remedy this, a shunt system is surgically placed to redirect the flow of CSF to another area of the body where it can be absorbed. When cerebrospinal fluid is redirected from a ventricle to the peritoneal area of the abdominal cavity, it is called a ventriculoperitoneal shunt (VPS).



A VPS is a soft and flexible, but sturdy tube that is well-tolerated by normal body tissues. One end of the catheter is placed within a ventricle in the brain and the other end of the catheter is placed within the peritoneal (abdominal) cavity. A valve located along the catheter regulates and maintains one way flow of CSF. The placement of a VP-shunt is a surgical procedure that is performed by a neurosurgeon. A shunt may be temporary or permanent. Sometimes a shunt may need to be replaced or revised if it is not working properly.

Key elements to watch for when caring for a

student who has a VP-shunt:

- Headache
- Vomiting
- Vision difficulties
- Confusion
- Fever higher than 101.5 orally (check temperature before taking Tylenol)
- Increased redness or discomfort or new or excessive drainage from an incision or wound from a recent shunt placement/revision
- Increased sleepiness

If any of the above-mentioned items occur NOTIFY THE RN IMMEDIATELY.

Ventricular Peritoneal Shunt Monitoring (ASBN 3.1)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
1. Watch for the following symptoms:			
2. If any occur NOTIFY THE RN IMMEDIATELY			
○ Headache			
○ Vomiting			
○ Vision issues			
○ Confusion			
○ Fever greater than 101.5 orally			
○ Increased redness or discomfort or new or excessive drainage from an incision site from a new shunt placement/revision			
○ Increased sleepiness			
3. **DOCUMENT PROCEDURE**			

Checklist reviewed and approved by the school nurse

UAP signature date_____

Nurse signature/date_____

Mechanical Ventilator (ASBN 3.2)

Mechanical ventilation may be necessary for individuals with certain disease processes and respiratory abnormalities. Due to the subject complexity, it is important to gain a thorough understanding of the terminology associated with mechanical ventilation. This knowledge is necessary to recognize problems and know when to notify the RN.

Important terms to understand:

Respiratory rate: The number of times an individual breathes every minute.
Tidal Volume: The amount of air taken into the lungs with each breath (how big the breath is).
Continuous Mandatory Ventilation (CMV): CMV is continuous ventilation by providing the rate of breaths per minute as well as tidal volume.
Synchronized Intermittent Mandatory Ventilation (SIMV): In SIMV mode the machine is set to correlate with spontaneous breathing, so the ventilator and the person do not compete.
Pressure Support Ventilation: PSV mode assists the individual with their own breathing. The person does the work to breathe in and out. The machine only provides pressure to help make the initial breath in easier. With this mode of ventilation, it is important to monitor for periods of apnea (a pause in breathing lasting several seconds) and respiratory fatigue.
Positive end-expiratory pressure (PEEP): PEEP increases oxygenation by providing pressure into the lungs when all air has been expelled from the lungs. This allows more oxygen exchange to occur in the smallest areas of the lungs known as alveoli. With certain conditions, alveoli can collapse due to fluid, mucus, or scar tissue. PEEP helps keep the alveoli from collapsing.
Continuous positive airway pressure (CPAP*):* CPAP is used to keep the airways open during inspiration and expiration. This increases oxygenation just like PEEP.

Monitoring the Ventilator (ASBN 3.2.1)

The ventilator has settings that will alarm if a value is out of an acceptable range. While caring for a student on a ventilator an alarm may sound. It is important to stay calm and troubleshoot. Below are some terms, probable causes and possible solutions.

High pressure alarm

Causes: Coughing, blocked tracheostomy tube, sneezing, talking, laughing, crying, hiccups, holding breath, changes in position or kinked ventilator tubing

Solutions: Suction if needed, reposition student. If these interventions do not correct the alarm, disconnect the patient from the ventilator and use the AMBU bag. If the student is OK then check the ventilator tubing for kinks or water, blocked exhalation valve, or an accidental change in the ventilator setting. Once the problem has been corrected place the student back on the ventilator

Note: A second staff member may need to provide breaths with the Ambu bag while one staff member troubleshoots the ventilator.

Low pressure alarm

Causes: Student has become disconnected from the ventilator or there is a leak in the ventilator tubing.

Solutions: Remove student from ventilator and give breaths with the Ambu bag. If the student is OK then check for disconnected tubing, kinked tubing, punctured tubing, water or a hole in the exhalation valve, loose-fitting heater humidification source, check all ventilator settings. Test the system after a leak is found by occluding the student end of the circuit and wait for the high-pressure alarm to sound.

Note: A second staff member may need to provide breaths with the Ambu bag while one staff member troubleshoots the ventilator.

Power source alarm

Cause: Loss of power from a power source

Solution: Check the AC power; check the internal and external batteries.

If giving breaths with the Ambu bag for longer than 15 minutes, add drops of saline through the tracheostomy tube for humidity or use the passive condenser with the resuscitator bag. ALWAYS FOLLOW THE EMERGENCY PLAN AND NOTIFY THE RN IF AN ALARM OCCURS.

Ambu bag (ASBN 3.2.3)

An Ambu bag is also known as a bag-valve-mask (BVM). This device is used to provide positive pressure ventilation to an individual who is not breathing or not breathing well. The bag has an air chamber that is squeezed to force air into the lungs. When the bag is released, it reinflates, pulling oxygen back into the chamber. The bag can be used by itself or with oxygen depending on the needs of the student.

1. Apply gloves.
2. Ensure the student is free from secretions before using the bag.
3. Connect the bag to the tracheostomy collar connector (these should remain connected in case of an emergency).

4. Connect the oxygen tubing to the bag. Be sure the tubing is connected to the regulator on the oxygen tank, the oxygen tank is turned on, and the regulator is at the flow rate prescribed by the physician.
5. Connect the bag to the tracheostomy tube keeping the bag at a 90° angle. Squeeze the bag in coordination with the student's own breathing.
6. When appropriate remove the bag from the tracheostomy tube.
7. Wash hands.
8. **DOCUMENT PROCEDURE**

Mechanical Ventilator Monitoring (ASBN 3.2.1)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Ventilator Machine and Circuit			
Locate:			
1.The power source:			
○ Internal battery			
○ External battery			
○ Accessible and grounded functioning electrical outlets			
○ Back-up battery			
○ Emergency power supply			
2. Oxygen source (if needed):			
○ Connection to ventilator and spare tubing			
○ Oxygen supply, spare tank, and gauge			
○ Flow (LPM-Liters per minute) and percentage of oxygen			
3. Humidification source:			
○ Passive condenser			
4. Volume			
5. Rate			
6. Patient pressure manometer			
7. Peak inspiratory pressure (PIP)			
8. Positive end expiratory pressure (PEEP)			
9. Ventilator mode			
10. Inspiratory time			
11. Alarms:			
○ High-Pressure			
○ Low-Pressure			
○ Power Source			
12. Describe:			
○ Patient pressure tubing, patient port, exhalation valve PEEP value and additional adaptors			
13. GO BAG Supplies:			

○ Ambu bag with adaptor or mask			
○ Spare tracheostomy tube and supplies			
○ Suctioning supplies			
14. Ventilator Troubleshooting Alarms:			
○ Identify which alarm is sounding			
15. Low-pressure Alarm:			
○ Check student first, then: ○ Remove the student from the ventilator ○ Give breaths with Ambu bag			
16. If the student is OK, then check for:			
○ Leaks			
○ Disconnection of tubing (to student, vent, or along circuit)			
○ Punctured tubing			
○ Water in exhalation valve			
○ Hole in exhalation valve			
○ Loose-fitting heater humidification source?			
○ Check ventilator settings			
○ Test system after leak is found (occlude student end of circuit and wait for high-pressure alarm to sound).			
○ Return student back to ventilator			
17. High Pressure Alarm:			
○ What is the student's body position?			
Is the student:			
○ Coughing?			
○ Sneezing?			
○ Talking?			
○ Crying?			
○ Laughing?			
○ Having hiccups?			
Does the student:			
○ Need suctioning?			
○ Have a blocked tracheostomy tube?			
○ Suction if needed			
○ Realign or change tracheostomy tube if needed			
○ Remove student from ventilator and give breaths with Ambu bag			
If student is OK, then check ventilator for obstructions. Is			

there:			
○ A kink in the tubing?			
○ Water in tubing?			
○ A blocked exhalation valve?			
○ An accidental change in ventilator settings?			
○ After resolving the problem and checking the high-pressure circuit, return student to ventilator.			
18. Power Source Alarm:			
Check student first, then:			
○ AC power			
○ Internal battery			
○ External battery			
19. If all three systems fail:			
○ Remove student from ventilator if all three systems fail and give breaths with Ambu bag			
If use of Ambu bag is required for more than 15 minutes:			
○ Add drops of saline to the tracheostomy for humidity or			
OR			
○ Put passive condenser on resuscitation bag and continue to use Ambu bag.			
20. **FOLLOW THE STUDENT-SPECIFIC EMERGENCY PLAN**			
21. **DOCUMENT PROCEDURE**			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Adjustment of Ventilator (ASBN 3.2.2)

DO NOT DELEGATE

According to the Arkansas State Board of Nursing School Nurse Roles & Responsibilities Practice Guidelines, a Registered Nurse MUST perform this task.

Ambu Bag (ASBN 3.2.3)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Ambu Bag with Tracheostomy			
1. Identify student's ability to participate in the procedure.			
2. Review universal precautions.			
3. Supplies:			
○ Oxygen source with appropriate tubing if needed			
○ Manual resuscitator			
○ Adaptor for tracheostomy tube			
○ Go-Bag items			
4. Wash hands.			
5. Position student and explain procedure.			
6. Check that Ambu bag is functioning properly.			
7. Attach Ambu bag to tracheostomy tube.			
8. Coordinate manual breaths with student breaths, if student breathes independently.			
9. If student is unable to breathe independently, squeeze Ambu bag at regular rate to give prescribed breaths per minute.			
10. Remove Ambu bag from tracheostomy tube when appropriate.			
11. Report any changes to RN Immediately.			
12. **DOCUMENT PROCEDURE**			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Oxygen (ASBN 3.3)

Some students may require oxygen during the school day. Oxygen therapy is used to keep the student from becoming hypoxic. Hypoxia is a condition where not enough oxygen is available in the body to meet the demands of normal metabolism. Therefore, a supplemental oxygen supply must be provided. Certain disease processes require the use of oxygen to correct oxygenation problems.

Guidelines for the use of oxygen:

1. **Oxygen is a medication** and must be administered as prescribed by a physician. Doses may not be changed without a doctor's order.
2. When oxygen is in use a sign stating, "Oxygen in use" MUST be placed on each entry into the classroom.
3. Oxygen must be stored a minimum of ten feet from an open flame.
4. When in use, oxygen cylinders must be kept upright and secured so they do not fall over.
5. Always make sure electrical equipment in the room works properly.
6. Check the level of the portable oxygen tanks before any event that requires the student to be away from a back-up source of oxygen.

Intermittent oxygen therapy (ASBN 3.3.1)

Follow the guidelines stated in the student-specific health care plan.

Continuous Oxygen Monitoring (ASBN 3.3.2)

Things to watch for in the student who is on oxygen therapy:

IF ANY OF THESE SYMPTOMS BELOW OCCUR NOTIFY THE RN IMMEDIATELY AND FOLLOW THE EMERGENCY PROCEDURE

1. Anxiety, apprehension, or behavior change.
2. Increased heart rate.
3. Increased respiratory rate and depth of respirations becomes irregular.
4. Difficulty breathing.
5. Use of accessory muscles for respirations (nasal flaring, rib retractions and tracheal tugging).
6. Dizziness.
7. Changes in color: the student becomes cyanotic (blue or gray looking).

Oxygen—Intermittent (ASBN 3.3.1)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y/N	Date	Date
Use this form to create a student-specific plan for Intermittent Oxygen			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Oxygen—Continuous Monitoring (ASBN 3.3.2)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
1. **NOTIFY RN IF ANY OF THESE SYMPTOMS ARE NOTICED**			
○ Anxiety, apprehension, or behavior change			
○ Increased heart rate			
○ Increased respiratory rate and depth of respirations becomes irregular			
○ Difficulty breathing			
○ Use of accessory muscles for respirations (nasal flaring, rib retractions and tracheal tugging).			
○ Dizziness			
○ Changes in color: the student becomes cyanotic (blue or gray looking)			
2. **DOCUMENT PROCEDURE**			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Central Line Catheter (ASBN 3.4)

DO NOT DELEGATE

According to the Arkansas State Board of Nursing School Nurse Roles & Responsibilities Practice Guidelines, a licensed nurse MUST perform this task.

Peritoneal Dialysis (ASBN 3.5)

DO NOT DELEGATE

According to the Arkansas State Board of Nursing
School Nurse Roles & Responsibilities Practice Guidelines, a licensed nurse MUST perform this task.

VIII. Medication Administration

Medication Administration ASBN 4

Skills Sheets for UAP Training:

- Oral Non-Controlled (ASBN 4.2)
- Over the Counter (ASBN 4.3)
- Injections (ASBN 4.4)
- Epi Pen Allergy Kit (ASBN 4.5)
- Inhalation (ASBN 4.6)
- Eye/Ear Drops (ASBN 4.9)
- Topical (ASBN 4.10)
- Per Gastrostomy (ASBN 4.12)

The licensed school nurse is responsible for the administration of all medications as well as identifying qualified persons to be trained to administer non-controlled medication when a nurse is not present. A provider order and/or written permission from the parent/guardian must be on file for all medication administered "in loco parentis," in the place of the parent.

Administration of oral controlled substances may not be delegated to non-nursing licensed individuals. For an oral controlled substance, in the unavailability of a school nurse, the parent may designate a specific school employee to administer the medication at school (employee MUST agree to the designation).

After training and documentation of UAP competency, administering medications may be delegated as indicated in the nursing task chart and following the Principles of Delegation and the Five Rights of Delegation.

Each school shall have a written policy regarding the administration of medication. The policy should include the following:

A provider order is required for all prescription medications; a label on a prescription bottle may serve as the order, if acceptable to the facility.
Written parental permission must be on file for all OTC medications. Permission slips may be time-limited (school year, semester, month, week) depending on the governing policy.
All medications must be in their original container.
Container must specify storage instructions if appropriate. Unopened insulin can be stored at room temperature.
Prescription labels must include student legal name (on record with the facility), date

prescription was filled, name of ordering provider, name of medication, dose, route, and frequency.
All medications will be given according to label directions on the container. Deviations from label directions will require a written provider order.
Procedure for administering and documenting medications during field trips and extracurricular activities.
Documentation of medication received and administered.
Storage and security of medications.
Access to medications in the absence of the school nurse.
Method of delivery of medications to the school nurse (parent must deliver, student may bring meds, etc.).
Accountability methods for controlled substances.
Counting system for any controlled substance brought to the school: number of doses at the time of delivery must be documented by the parent AND nurse. Both must document the number delivered to the school. A count should be done periodically to verify documentation of medication on hand for student.

Arkansas Department of Health Pharmacy Services rules require controlled substances to be kept under a double lock system
Access to controlled substances is limited to as few personnel as possible. The licensed nurse is to access and administer controlled substances.

In addition, the policy may specify the following:

- A requirement that the initial dose of a new medication must be given by the parent/guardian outside of the facility setting.
- A specific length of time may be required following the initial doses prior to student readmittance to the facility.
- Reports to parents/guardians regarding medication administration.

Parents/guardians are encouraged to administer medication at home whenever possible.

Disposal of unused medications

Thorough documentation is required for unused medications that cannot be returned to the parent/guardian by the end of the school year. Documentation should be kept for no less than 5 years and should include: date, medication name, and quantities disposed of.

A controlled drug surrender form can be found at www.chs-support.weebly.com. Please note that controlled substances should not be transported by school personnel to an Arkansas Take Back

Program location. You may coordinate with your School Resource Officer for the transportation of those medications.

Note: It is not recommended that medications be flushed through the sewer system, nurses may also use "drug deactivation systems" to neutralize medications. Document medication deactivation with nurse and witness signature.

Oral Controlled Substance Prescriptions (ASBN 4.1)

Administration of Oral Controlled substances may not be delegated to non-nursing licensed individuals. When the school nurse is unavailable, the parent/guardian may designate a *specific school employee* to administer the medication at school (employee MUST agree to the Designation).

Oral Non-Controlled Prescriptions (ASBN 4.2)

Procedure:

1. Assemble needed supplies:
    a. Cup
    b. Water
    c. Medication Administration Record
2. Verify a child's ability to take oral medications.
3. Verify accuracy of medication:
    - **Right name**
    - **Right medication**
    - **Right dose**
    - **Right time**
    - **Right route**

4. Prepare the medication.
5. ***Some*** medications may be crushed or broken however, the RN must verify this
6. To mix liquid medication, shake well.
7. Administer the medication to the student:
    a. Ensure the medication has been swallowed by looking into the mouth and under the tongue after the child has taken the medication.
8. **DOCUMENT MEDICATION ADMINISTRATION**.

The following MUST be documented on the Medication Administration Record:

- **Date**
- **Time**
- **Name of medication**
- **Who gave the medication?**

Oral Over-the-Counter Medications (ASBN 4.3)

Follow the procedure listed above. Administer the medication *EXACTLY AS DIRECTED* on the container. There *MUST* be a parent signature on the medication administration record.

Over-the-counter medications *MUST* be in the original packaging. Under NO circumstance will medications be accepted in a plastic bag. Medications in a push-through container must be in the original packing container.

Injectable Medications (4.4)

Glucagon (4.4.1)

DO NOT DELEGATE
See ASBN Insulin and Glucagon Administration training programs
Glucagon_Approved_Training_Programs9.2016.pdf (arkansas.gov)

Insulin (4.4.2 & 4.4.3)

DO NOT DELEGATE
See ASBN Insulin and Glucagon Administration training programs
Insulin_Approved_Training_Programs9.2016.pdf (arkansas.gov)

Epi Pen (4.5)

EpiPen ®Allergy Kit—EpiPen® and EpiPen® Jr

If an EpiPen ® must be used, initiate the Emergency Response by calling 9-1-1

1. Pull off the activation cap.
2. Grasp the injector with a fist around the barrel. ***NEVER place your thumb over the orange or black tip.***
3. Hold orange or black tip near the outer thigh (always apply to the thigh).

4. Swing and jab firmly into the outer thigh until the Auto-Injector mechanism functions.
5. Hold in place and count to three. Remove the EpiPen ®.
6. **DOCUMENT MEDICATION ADMINISTRATION.**

Twinject® 0.3 mg and Twinject® 0.15mg

1. Remove caps labeled "1" and "2"
2. Grasp the injector with a fist around the barrel. ***NEVER place your thumb over the orange or black tip.***
3. Place rounded tip against outer thigh, press down hard until needle penetrates the skin. Hold for 3 seconds, and then remove.
4. **DOCUMENT MEDICATION ADMINISTRATION.**

Second dose administration:

The effects of epinephrine may wear off within several minutes following administration. If severe symptoms return, a second dose will be required.

1. Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.
2. Slide yellow collar off plunger.
3. Put the needle into the thigh through the skin, push the plunger down all the way and remove.
4. Keep the used unit with the student.
5. **DOCUMENT MEDICATION ADMINISTRATION.**

The following MUST be documented on the Medication Administration Record:

- **Date**
- **Time**
- **Name of medication**
- **Who gave the medication?**

Inhalation (4.6)

Metered dose inhalers disperse fine mist into the airway passages. Air exchange takes place deep within the lungs. The deeper portions of the lungs also provide a larger area for medication absorption. When administering inhalation medications, it is important for the student to exhale completely prior to inhaling the medication This can be a challenging skill for children; teaching and demonstration must be provided prior to administration.

Routine/Prophylactic asthma inhaler (ASBN 4.6.1)

This medication is not meant to be used in an emergency, therefore, to decrease confusion, it is best to have the parent administer the medication prior to the student coming to school.

Emergency/Rescue Inhaler (ASBN 4.6.2)

1. Shake the inhaler well prior to administration.
2. If a spacer is used, place the inhaler into the spacer.
3. Tell the student to blow out all the air in his/her lungs and take in a deep breath.
4. Fit the spacer around the student's nose and mouth or have the student place mouth around the tube of the spacer depending on which type the student uses.
5. As the child breathes in, press firmly on the inhaler to activate the medication.
6. Repeat this procedure as often as the prescription states.
7. **DOCUMENT MEDICATION ADMINISTRATION.**

The following MUST be documented on the Medication Administration Record:

- **Date**
- **Time**
- **Name of medication**
- **Who gave the medication?**

Nasal Insulin/Glucagon (4.6.3)

DO NOT DELEGATE
See ASBN Insulin and Glucagon Administration training programs:
Glucagon_Approved_Training_Programs9.2016.pdf (arkansas.gov)
Insulin_Approved_Training_Programs9.2016.pdf (arkansas.gov)

Nasal Controlled Substance (4.6.4)

DO NOT DELEGATE

Naloxone (4.6.5)

DO NOT DELEGATE: See A.C.A § 14-92-101 (16) and www.pharmacyboard.arkansas.gov for Arkansas's Naloxone protocol.

Rectal (4.7)

DO NOT DELEGATE

Bladder (4.8)

DO NOT DELEGATE

Eyes/Ears (ASBN 4.9)

Administering Eye drops:

1. Explain the procedure to the student to decrease anxiety about eye drops.
2. Assist the student to a comfortable position.
3. Apply gloves.
4. Clean the eyelid and the eyelashes with a wet cotton ball. Wipe from the inner eye (closest to the nose) to the outer eye.
5. Have student look up toward the ceiling.
6. Gently pull the lower eyelid down with non-dominant hand.
7. With dominant hand, lightly squeeze drops into the eyelid and release.
8. *Assure the tip of the medication bottle does NOT touch the eye, as this will contaminate the medication*
9. If needed, pat the eyelids with a tissue. DO NOT rub the eye.
10. Wash hands.
11. **DOCUMENT MEDICATION ADMINISTRATION.**

The following MUST be documented on the Medication Administration Record:

- **Date**
- **Time**
- **Name of medication**
- **Who gave the medication?**

Administering ear drops (ASBN 4.9)

1. Explain the procedure to the student.
2. Apply gloves.
3. Assist the student to a comfortable position.
4. Gently pull the ear lobe downward.

5. Squeeze medication into the ear canal.
6. **DOCUMENT MEDICATION ADMINISTRATION.**

The following MUST be documented on the Medication Administration Record:

- **Date**
- **Time**
- **Name of medication**
- **Who gave the medication?**

Topical (4.10)

1. Powder: Sprinkle a thin layer over the skin and cover.
2. Lotions: Use a swab and apply a small amount over the affected area.
3. Aerosol: Hold the can 6-12 inches from skin and spray.
4. Transdermal Patch: Clean and dry skin, remove patch from adhesive, making sure not to touch the medication, place patch on skin.
5. **DOCUMENT MEDICATION ADMINISTRATION**

The following MUST be documented on the Medication Administration Record:

- **Date**
- **Time**
- **Name of medication**
- **Who gave the medication?**

Per Naso-Gastric Tube (ASBN 4.11)

DO NOT DELEGATE

Per Gastrostomy Tube (ASBN 4.12)

1. Dissolve crushed/broken medication in warm water.
2. Open capsules (when allowed) and mix the contents with water.
3. Do not administer solid or undissolved medications through the G-tube.
4. Connect catheter tip syringe to gastrostomy tube.
5. If giving more than one, flush with 3cc of water between medications.
6. When complete, flush with 5 cc of water to clear the tube.
7. **DOCUMENT MEDICATION ADMINISTRATION**.

The following MUST be documented on the Medication Administration Record:

- **Date**
- **Time**
- **Name of medication**
- **Who gave the medication?**

Intravenous (ASBN 4.13)

DO NOT DELEGATE

Under the Arkansas State Board of Nursing
Delegation guidelines, a licensed nurse MUST perform this task

Medication Administration (ASBN 4.0)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Oral—Non-Controlled prescription (4.2)			
1. Assemble supplies.			
2. Verify child's ability to take oral medications.			
3. Verify accuracy of medication. ○ Right Name ○ Right Medication ○ Right Dose ○ Right Time ○ Right Route			
4. Prepare the medication: ○ Only crush or break apart if RN has verified the medication properties allow this.			
5. Shake liquid medication well to mix.			
6. Cover the label of the bottle and pour appropriate dose.			
7. Administer the medication.			
8. **DOCUMENT PROCEDURE**			
Over-the-counter medications (4.3) (Written Parental Consent)	**Y/N**	**Date**	**Date**
1. Follow the procedure listed above.			
2. Administer the medication EXACTLY as directed on the package.			
3. **DOCUMENT PROCEDURE**			
Injections (4.4)	**Y/N**	**Date**	**Date**
DO NOT DELEGATE **See ASBN Insulin and Glucagon training programs**			

EpiPen® Allergy Kit (4.5)			
Initiate Emergency Response—Call 9-1-1			
Administer Epi Pen through student clothing			
1. Pull of gray activation cap.			
2. Grasp the injector with a fist around the barrel.			
3. Hold black tip near outer thigh.			
4. Swing and jab firmly into outer thigh until Auto-injector mechanism functions. Hold in place and count to three.			
5. Remove the EpiPen ®.			
6. **DOCUMENT PROCEDURE**			
Inhalation (4.6)			
Routine Inhalers (4.6.1) should be administered at home.			
Emergency/Rescue inhalers (4.6.2)			
1. Shake the inhaler well.			
2. Place the inhaler into the spacer if used.			
3. Have student exhale completely.			
4. Fit spacer around student's nose and mouth or have the student place mouth around the tube of the spacer.			
5. Instruct student to take a deep breath, press firmly on the inhaler to active the medication.			
6. Repeat this procedure as often as the prescription states to.			
7. **DOCUMENT PROCEDURE**			
Nasal Insulin (4.6.3)			
DO NOT DELEGATE **See ASBN *Insulin* administration training program** Insulin_Approved_Training_Programs9.2016.pdf (arkansas.gov)			
Nasal controlled substance (4.6.4) (Such as, but not limited to Versed)			
DO NOT DELEGATE			
Naloxone (4.6.5)			

DO NOT DELEGATE: See A.C.A § 14-92-101 (16) and ***www.pharmacyboard.arkansas.gov*** for Arkansas's Naloxone protocol.			
Rectal Medications (4.7) Bladder instillation (4.8)	**Y/N**	**Date**	**Date**
DO NOT DELEGATE			
Eye Drops (4.9)	**Y/N**	**Date**	**Date**
1. Explain the procedure to the student.			
2. Assist the student to a comfortable position.			
3. Apply gloves.			
4. Clean the eyelid and eyelashes with a wet cotton ball.			
5. Wipe from the inner eye to the outer eye.			
6. Have the student look up toward the ceiling.			
7. Gently pull the lower eyelid down with the non-dominant hand.			
8. With the dominant hand, put drops into the eyelid and release.			
9. Pat the eyelid with tissue if needed.			
10. Wash hands.			
11. **DOCUMENT PROCEDURE**			
Ear Drops (4.9)	**Y/N**	**Date**	**Date**
3. Explain the procedure to the student.			
4. Apply gloves.			
5. Assist the student to a comfortable position.			
6. Gently pull the ear lobe downward.			
7. Squeeze medication into the ear canal.			
8. Place cotton ball into ear.			
9. **DOCUMENT PROCEDURE**			
Topical (4.10) 4.10.1(Prescription), 4.10.29 (OTC with parental consent)			
1. Powder: sprinkle a thin layer over the skin and cover.			
2. Lotions: use a swab and apply a small amount over the affected area.			
3. Aerosol: hold can 6-12 inches from skin and spray.			
4. Transdermal Patch: clean and dry skin, remove patch from adhesive, making sure not to touch the medication, place patch on skin.			
5. **DOCUMENT PROCEDURE**			

Per Nasogastric Tube (4.11)			
DO NOT DELEGATE			
Per Gastrostomy Tube (4.12)			
○ Do not administer whole or undissolved medications through the G-tube			
○ Dissolve crushed/broken medication in warm water			
○ Open capsules (only when allowed) and mix the contents with water			
1. Connect catheter tip syringe to gastrostomy tube.			
2. Administer medication through G-tube.			
3. If giving several medications, flush with 3 cc of water between Medications.			
4. When complete, flush with 5 cc of water to clear the tube.			
5. **DOCUMENT PROCEDURE**			
Intravenous (4.13)			
DO NOT DELEGATE			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

IX. Ostomies

Ostomy ASBN 5

Skill Sheets for UAP Training:

- Ostomy Care (ASBN 5.1)

An ostomy is a surgical procedure performed to reroute the elimination of waste. Urine or stool will then exit the body through an opening called a stoma. There are different names for ostomies based on location within the digestive system.

Ileostomy: Ostomy created by diverting the contents from the small intestine. The stool has a liquid consistency since it contains stomach acids and will drain freely. A pouch is needed to contain the material.

Colostomy: This ostomy can be in multiple sections of the colon.

Ostomy Care (ASBN 5.1)

It is critical to have the parent/guardian provide instructions for care of an ostomy. A blank skills procedure checklist will be provided so that a student-specific checklist can be created.

Ostomy Care (ASBN 5.1)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y/ N	Date	Date
Use this form to create a student-specific plan for ostomy care.			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Ostomy Irrigation (ASBN 5.2)

DO NOT DELEGATE

Under the Arkansas State Board of Nursing
Delegation guidelines, a licensed nurse MUST perform this task

X. Respiratory

Respiratory ASBN 6

Skill Sheet for UAP Training:

- Pharyngeal Suctioning (ASBN 6.3.1)
- Tracheostomy Suctioning (ASBN 6.3.2)
- Tracheostomy Tube Replacement & Care (ASBN 6.4 & 6.5)

Postural Drainage (ASBN 6.1) and Percussion (ASBN 6.2)

Postural drainage is a procedure that facilitates removal of lung secretions by utilizing gravity. It is used to treat a variety of conditions that cause the build-up of fluid in the lungs. There are several techniques used to accomplish this depending on the individual.

Percussion is a procedure that uses the hand to create a cupping motion sending vibrations throughout the chest wall to loosen secretions.

Chest physiotherapy (CPT) uses percussion and vibration to loosen and force secretions into the larger airways making them easier to expel.

CPT is utilized on specific areas of the chest depending on which part of the lung is affected. This skill is highly student-specific. A blank skills checklist is provided for individualization.

Suctioning (ASBN 6.3)

It may be necessary to suction secretions from the mouth or tracheostomy. Suctioning may be performed with a suction machine or a bulb syringe.

Oral & Pharyngeal (6.3.1) Tracheostomy (6.3.2)

For Tracheostomy suctioning, place the suction catheter or bulb syringe into the tracheostomy tube and proceed with the same steps for the remainder of the procedure.

Procedure for Suctioning:

1. Identify the student's ability to assist in the procedure.
2. Gather supplies:

- Suction machine with tubing
- Catheter
- Cup of tap water or saline
- Bulb syringe
- Gloves
- Plastic bag for disposal

3. Wash hands.
4. Apply gloves.
5. Position student and explain procedure.
6. Turn on the suction machine and check the function.
7. Attach catheter to suction tubing.
8. Insert catheter into nose and advance until student coughs without suction
9. Apply suction. When the student coughs, withdraw the catheter while twirling the catheter.
10. If secretions are thick, place a few drops of normal saline into the nose.
11. Repeat suctioning in this order until secretions are cleared.
12. Suction the mouth by advancing the catheter into the mouth without suction.
13. Apply suction and withdraw the catheter while twirling.
14. Repeat suctioning in this order until all secretions are cleared.
15. Dispose of catheter.
16. Rinse tubing with tap water.
17. Remove gloves and wash hands.
18. Notify RN of any changes in the student's condition or any other concerns
19. **DOCUMENT PROCEDURE**

Note: If resistance is met, DO NOT proceed with the catheter-the nose bleeds easily.

Procedure for Suctioning with a bulb syringe

For Tracheostomy suctioning, place the bulb syringe into the tracheostomy tube and proceed with the same steps for the remainder of the procedure.

Procedure for Suctioning:

1. Identify the student's ability to participate in the procedure.
2. Gather supplies.
   - Bulb syringe
   - Saline
   - Tissues
   - Gloves
3. Wash hands.
4. Apply gloves.

5. Position the student and explain the procedure.
6. Squeeze the bulb syringe and place the tip gently in the nose or mouth and release.
7. Remove the bulb syringe from the nose or mouth.
8. Squeeze the bulb syringe into the tissue, expelling secretions. Repeat steps 6-8 until all secretions have been removed.
9. Clean the bulb syringe and dispose of the tissue.
10. Notify the RN of any changes in the student's condition or any other concerns.
11. **DOCUMENT PROCEDURE**

Tracheostomy Tube Replacement (ASBN 6.4) and Care (ASBN 6.5)

1. Identify the student's ability to participate in the procedure.
2. Gather supplies:
   - Tracheostomy tie or tracheostomy tube holder
   - One-half hydrogen peroxide and one-half normal saline or distilled water mixture
   - Cotton-tipped applicators
   - Pipe cleaners
   - Tracheal gauze or sponges
   - Two clean containers
   - Gloves
3. Wash hands.
4. Apply gloves.
5. Position the student and explain the procedure.
6. Remove old gauze or sponges from the tracheostomy.
7. Clean the stoma with hydrogen peroxide mixture with cotton swabs.
8. If the tracheostomy has an inner cannula, remove the inner cannula.
9. Replace old tracheostomy ties or holders with a new one.
10. Insert tracheostomy sponge under the tracheostomy tube phalanges.
11. Clean the inner cannula with the hydrogen peroxide mixture and the pipe cleaners.
12. Rinse with saline.
13. Replace the inner cannula and lock into place.
14. Discard the cleaning solution.
15. Remove gloves.
16. Report any changes or concerns to the RN.
17. **DOCUMENT PROCEDURE.**

Suctioning (ASBN 6.3.1 and ASBN 6.3.2)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Pharyngeal (6.3.1) and Tracheostomy (6.3.2) Suctioning			
1. Identify the student's ability to assist in the procedure.			
2. Gather supplies.			
3. Wash hands.			
4. Apply gloves.			
5. Position student and explain procedure.			
6. Turn on suction machine and check function.			
7. Attach catheter to suction tubing.			
8. Insert catheter into nose and advance until student coughs without secretions.			
9. For tracheostomy suctioning, place catheter into the tracheostomy and continue			
a. Apply suction. When the student coughs, withdraw catheter while twirling			
b. If secretions are thick, put a few drops of saline into the nose or tracheostomy			
c. Repeat suctioning in this order until secretions are cleared			
10. Suction the mouth by advancing the catheter into the mouth without suction			
a. Apply suction and withdraw the catheter while twirling			
b. Repeat suctioning in this order until all secretions are cleared			
11. Dispose of catheter.			
12. Rinse tubing with tap water.			
13. Remove gloves and wash hands.			

14. Notify RN of any changes or concerns.			
15. **DOCUMENT PROCEDURE**			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Suctioning with a bulb syringe (ASBN 6.3.1 and ASBN 6.3.2)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Suctioning with a bulb syringe (pharyngeal and tracheostomy)			
1. Identify the student's ability to assist in the procedure.			
2. Gather supplies o Bulb syringe o Saline o Tissues o Gloves			
3. Wash hands.			
4. Apply gloves.			
5. Position student and explain procedure.			
a. Squeeze the bulb syringe and place the tip into the nose or mouth and release			
6. For tracheostomy suctioning, place bulb syringe into the tracheostomy and continue			
a. Remove the bulb syringe from the nose or mouth			
b. Squeeze the bulb syringe into the tissue, expelling secretions			
7. If secretions are thick, put a few drops of saline into the nose or tracheostomy.			
8. Repeat suctioning in this order until secretions are cleared.			
9. Clean the bulb syringe and dispose of the tissue.			
10. Remove gloves and wash hands.			
11. Notify RN of any changes or concerns.			
12. **DOCUMENT PROCEDURE**			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Tracheostomy Tube Replacement (ASBN 6.4) and Care (ASBN 6.5)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Tracheostomy tube replacement and care			
1. Identify the student's ability to assist in the procedure.			
2. Gather supplies ○ Tracheostomy tie or tracheostomy tube holder ○ One-half hydrogen peroxide and one-half normal saline (or distilled water mixture) ○ Cotton-tipped applicators ○ Pipe cleaners ○ Tracheal gauze or sponges ○ Two clean containers ○ Gloves			
3. Wash hands.			
4. Apply gloves.			
5. Position student and explain procedure.			
6. Remove old gauze or sponges from the tracheostomy.			
7. Clean the stoma with the hydrogen peroxide mixture with cotton swabs.			
8. If the tracheostomy has an inner cannula, remove the inner cannula.			
9. Replace old tracheostomy ties or holder with a new one.			
10. Insert the inner tracheostomy sponge under the tracheostomy tube phalanges.			
11. Clean the inner cannula with the hydrogen peroxide mixture and pipe cleaners.			
12. Rinse with saline.			
13. Replace the inner cannula and lock into place.			
14. Discard the cleaning solution.			
15. Remove gloves and wash hands.			
16. Notify RN of any changes or concerns.			

17. **DOCUMENT PROCEDURE**			

Checklist reviewed and approved by the school nurse

UAP signature date_____

Nurse signature/date_____

XI. Screenings

Screenings ASBN 7

Skill Sheets for UAP Training:

- Vital Signs (ASBN 7.2)

Growth-Height/Weight (ASBN 7.1)

Please refer to A.C.A § 20-7-135

Vital Signs (ASBN 7.2)

The measuring and recording of vital signs may be delegated. The unlicensed assistive personnel may ONLY *obtain values* and *report* them to the RN. The RN MUST be the one to determine further indications for treatment.

During training, the RN must demonstrate the correct procedures:

- Obtaining a Respiratory Rate (RR)
- Obtaining a Heart Rate (HR)
- Obtaining a Blood Pressure (BP)

Following training and demonstration, the RN MUST observe the unlicensed assistive personnel perform the task. It is up to the RN to determine when successful competency has been reached.

Hearing (ASBN 7.3)

Refer to A.C.A § 6-18-701

Vision (ASBN 7.4)

DO NOT DELEGATE.
Refer to A.C.A § 16-18-1501

Scoliosis (ASBN 7.5)

Refer to ADH Rules & Regulations

Vital Signs (ASBN 7.2)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Heart Rate			
1. Have the student sit in a chair or lie on the health bed.			
2. To check pulse rate place index finger on the radial pulse (thumb side).			
3. Count number of pulsations for one minute (do not press too hard).			
4. Notify RN if pulse is out of normal range.			
5. Notify RN of findings.			
6. **DOCUMENT PROCEDURE**			
Respiratory Rate			
1. Have the student sit in a chair or lie on the health bed.			
2. Place hand in the center of the chest and feel for the rise and fall with each breath.			
Note: It may be necessary to watch the rise and fall of the chest while checking heart rate. When a student is aware a respiratory rate is being counted, they may control the rate leading an inaccurate finding.			
3. Count the number of times the chest rises and falls for one minute.			
4. Notify the RN of findings.			
5. **DOCUMENT PROCEDURE**			
Blood Pressure			
1. Determine the appropriately sized cuff to use.			
2. Wrap the cuff around the student's middle upper arm and make sure the arrow points to the brachial artery.			
3. Place the stethoscope on the brachial artery.			
4. Close the circuit on the bulb and pump until the needle reaches 5. mmHg (millimeters of mercury).			
6. Slowly release the air out of the cuff while listening for the first audible heartbeat.			
7. Record the number.			
8. As you continue to release air from the cuff, listen for the last audible heartbeat and record the number.			
9. Release all the air from the bulb.			
10. Notify RN of findings.			

11. **DOCUMENT PROCEDURE**- blood pressure with the first # on top and the second # on the bottom. (xxx/xx).			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

XII. Specimen Collecting/Testing

Specimen Collection & Testing ASBN 8

Skills Sheets for UAP Training:

- Specimen Collection (ASBN 8.0)
- Blood Glucose Testing (ASBN 8.1)
- Urine Glucose/Ketone Testing (ASBN 8.2)

Blood Glucose Testing (ASBN 8.1)

Blood glucose testing is utilized to monitor glucose metabolism issues like diabetes. Follow the student-specific health care plan for this procedure.

Procedure for Blood glucose testing:

1. Wash hands.
2. Gather supplies:
    - Paper towel
    - Gloves
    - Test strips
    - Lancets
    - Blood glucose meter
    - Alcohol swab
    - Tissue
3. Position student in a chair or on the health bed and have them hang their hand down.
4. Apply gloves.
5. Select a finger to use (try not to use the same finger used during the last test).
6. Wipe the tip or side of the finger with the alcohol swab and allow it to air dry.
7. Turn the glucose meter on.
8. Place the reagent strip into the meter.
9. Use the lancet to puncture the skin and allow a drop of blood to form. Use the reagent strip to obtain the drop of blood for testing.
10. Wait for the results to show and **DOCUMENT** the reading in student glucose monitoring log.

Follow the student-specific Health Care Plan for appropriate actions.

Urine Glucose/Ketones Testing (ASBN 8.2)

It may be necessary to collect and test the urine for glucose or ketones:

If the student is incontinent, save the diaper to sample. Place a catheter tipped syringe against the wall of the diaper while pulling the plunger back. You may have to repeat this process several times to gather an adequate amount of urine for the reagent strip.

1. Wash hands.
2. Gather supplies:
    - Urine cup
    - Urine reagent strips
    - Catheter tipped syringe
    - Paper towel or tissue
3. Apply gloves.
4. Have student void into a cup.
5. Have a reagent strip ready on a paper towel or tissue with the square pads facing up.
6. Use the catheter tipped syringe to obtain a sample of urine.

    OR

    If student is incontinent, use syringe to collect urine from wall of diaper.
7. Place one drop of urine on each section of the reagent test strip.
8. Allow the urine to sit on the test strip according to the directions then turn the reagent strip on its side allowing the urine droplets to fall onto a tissue or towel.
9. Compare the colors on the reagent strip with the color indicators on the side of the reagent strip bottle and
10. **DOCUMENT** findings.

Follow the student-specific Health Care Plan for further directions.

Specimen Collecting (ASBN 8.1 & ASBN 8.2)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Blood Glucose Testing (8.1)			
Follow the student-specific Health Care Plan for appropriate actions			
1. Wash hands.			
2. Gather supplies.			
3. Position student in a chair or health bed and hang hand down.			
4. Apply gloves.			
5. Select finger to use for testing.			
6. Wipe the tip or side of the finger with the alcohol swab and air dry.			
7. Turn on the glucose monitor.			
8. Place the reagent strip into the meter.			
9. Use the lancet to puncture the skin and obtain blood drop with the reagent strip.			
10. Wait for the results.			
11. **DOCUMENT PROCEDURE**			
Urine Glucose/Ketone Testing (8.2)			
Follow the student-specific Health Care Plan for further directions.			
1. Wash hands.			
2. Gather Supplies.			
3. Apply gloves.			
4. Collect urine specimen (voiding into cup or diaper).			
5. Have a reagent strip on a paper towel or tissue with the pads facing up.			
6. Use the catheter tipped syringe to collect urine from cup or diaper and place one drop on the appropriate square pad sections.			
7. Allow the urine to sit on the reagent strip according to the directions.			
8. Compare the colors on the reagent strip with the color indicators on the side of the reagent strip container.			

9. **DOCUMENT PROCEDURE**			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature /date_____

XIII. Other Healthcare Procedures

Other Healthcare Procedures ASBN 9

Skill Sheets for UAP Training:

- Safety Seizure Precautions (ASBN 9.1)
- Vagus Nerve Stimulation (ASBN 9.2)
- Pressure Ulcer Care (ASBN 9.3)
- Dressing Changes (ASBN 9.4 & 9.5)

Seizures (ASBN 9.1)

Epilepsy affects up to 3% of our population making seizures one of the most prevalent nervous system disorders in America today. While epilepsy can develop at any age, the occurrence of new cases is more common in children and in people older than sixty. A seizure is a sudden electrical disruption and can present in a variety of ways depending on which area of the brain that is affected.

Absence seizure

Most common in children
Brief disruption of consciousness
Presents with blank stare
Eyes may roll upward and lack of response
Previously referred to as petit mal seizures

Partial seizures:

Affect one area of the brain in one hemisphere
May or may not experience loss of consciousness
Presents with muscle twitching, repetitive motions, and 'daydreaming'
May transition into a generalized seizure

Generalized seizures

Affect both hemispheres of the brain
Presents with loss of consciousness
Blank stares
Falling to the floor
Sudden jerking movements
Repetitive stiffening and relaxing of muscles

Key points to remember when a child is having a seizure

1. Remain calm.
2. Help the child to the floor.
3. Move objects away from the child.
4. During a seizure, **DO NOT** hold down student or put anything into student's mouth.
5. Once the jerking movements have stopped, turn the child on his/her side.

6. Follow the student-specific Health Care Plan for length of seizure activity before medication administration needs to be considered.
7. Stay with the student until he/she is fully alert.

Seizure Safety Precautions (ASBN 9.1)

Student name/year: _____

Trainee: _____

Nurse: _____

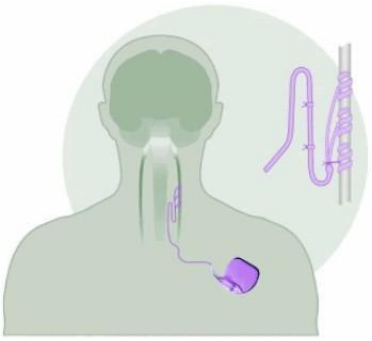
Explanation and Return Demonstration of procedure	Y / N	Date	Date
Seizure Safety Precautions (9.1)			
1. Remain Calm.			
2. Help the child to the floor.			
3. Move objects away from the child.			
4. During a seizure, **DO NOT** hold down student or put anything into student's mouth			
5. Once the jerking movements have stopped, turn the child onto his/her side.			
6. Follow the student-specific Health Care Plan to determine duration of seizure activity before medication administration should be considered.			
7. Stay with the student until he/she is fully alert.			
8. **Document episode including:**			
○ Time of onset ○ Length of episode ○ Loss of consciousness ○ Loss of bowel/bladder continence ○ Return to pre-episode state of alertness			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Vagus Nerve Stimulation (ASBN 9.2)



Vagus nerve stimulation (VNS) is a form of therapy utilized when seizures are poorly controlled by medication. The Food and Drug Administration (FDA) has approved vagus nerve stimulation therapy for children over the age of twelve.

The VNS is a flat battery surgically implanted in the chest wall close to the collarbone. Thin wires send electrical pulses to the vagus nerve, located in the neck. The VNS is programmed to deliver a specific amount of electricity at set intervals. Once the device has been implanted a physician can reprogram the device if needed.

If an individual senses an impending seizure, he/she can pass a magnet over the device to activate the vagus nerve stimulator. This may prevent, terminate, or reduce the duration and intensity of the seizure. The magnet can be clipped to a belt or worn as a watch.

Because the use of a Vagus Nerve Stimulator is extremely student-specific, a blank skills checklist is provided to allow the RN and parent/guardian to create the proper procedure.

Vagus Nerve Stimulation (ASBN 9.2)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Because the use of a Vagus Nerve Stimulator is extremely student-specific a blank skills checklist is provided.			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Pressure Ulcers (ASBN 9.3)

A pressure ulcer is a localized area of tissue destruction that develops when soft tissue is compressed between a bony prominence and an external surface, for a prolonged period.

When blood supply to the skin is diminished, tissue death begins to occur, and an ulcer begins to form. Primary treatment goals include determining the cause to proactively prevent the ulcer before it can form.

Several factors contribute to the formation of ulcers:

- Friction
- Prolonged pressure in one area
- Shearing
- Moisture contact with the skin for extended periods of time

Treatment of a pressure ulcer depends on the severity of tissue involvement. The physician will assess each wound to determine the appropriate course of skin barriers and wound cleansers to be utilized. Once the wound has been assessed, a specific treatment plan will be developed. Due to the student-specific treatment, a blank skills checklist is available so the parent/guardian and the nurse may collaborate to create the proper procedure.

Pressure Ulcer Care (ASBN 9.3)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Pressure Ulcer Care			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Dressing Changes (ASBN 9.4 & 9.5)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Dressing Change—Sterile (ASBN 9.4)			
1. Explain procedure to student.			
2. Expose area with the wound—assure only enough skin is exposed to gain access to the wound.			
3. Wash hands and apply gloves.			
4. Remove soiled dressing and dispose.			
5. Remove gloves and dispose.			
6. Set up sterile field.			
7. Apply sterile gloves.			
8. Open all packages and drop equipment needed onto sterile field.			
9. If ordered, cleanse the wound area with appropriate cleansing agent.			
10. Pat area dry with a towel.			
11. Apply antiseptic ointment as prescribed.			
12. Apply sterile dressing to wound, apply adhesive tape to the dressing to secure dressing in place.			
13. Remove gloves.			
14. Wash hands.			
15. Notify RN of any changes or concerns.			
16. **DOCUMENT PROCEDURE**			
Dressing Change—Non-Sterile (ASBN 9.5)			
1. Explain procedure to student.			
2. Expose area with the wound—assure only enough skin is exposed to gain access to the wound.			
3. Wash hands and apply gloves.			
4. Remove soiled dressing and dispose.			
5. If ordered, cleanse the wound area with appropriate cleansing agent.			
6. Pat area dry with a towel.			
7. Apply antiseptic ointment as prescribed.			

8. Apply clean dressing to the wound and apply adhesive tape to 9. secure dressing in place.			
10. Remove gloves and wash hands.			
11. Notify RN of any changes or concerns.			
12. **DOCUMENT PROCEDURE**			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

XIV. Developing Protocols

Developing Protocols ASBN 10

Healthcare Procedures (ASBN 10.1)

Emergency Protocols (ASBN 10.2)

Individualized Healthcare Plans (ASBN 10.3)

DO NOT DELEGATE

According to the Arkansas State Board of Nursing School Nurse Roles & Responsibilities Practice Guidelines, a Registered Nurse MUST perform this task

XV. Skill Check Off Sheets-Print All

Individualized Check Off Sheet

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature /date_____

Toileting/Diapering (ASBN 1.1)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y/ N	Date	Date
Diapering			
1. Gather needed supplies (diapers, wipes, skin barrier if prescribed) and wash hands.			
2. Bring student to designated area for changing and provide privacy.			
3. Place student on changing table – *proper body mechanics will reduce the risk of back injury.* If a second person is needed to assist with lifting, have them present before beginning the procedure.			
4. Apply gloves.			
5. Remove only enough clothing to gain access to the diaper.			
6. Remove soiled diaper.			
7. Clean perineal area-remember to use the front-to-back motion with girls. This will decrease risk of infection.			
8. If there is an order to use skin barriers such as Desitin™ or Vaseline™, apply the barrier at this time.			
9. Apply skin cream as prescribed if order is present.			
10. Apply a clean diaper and replace clothing.			
11. Dress student.			
12. Dispose of soiled diaper properly.			
13. Wash hands.			
14. Return student to the classroom.			
15. DOCUMENT PROCEDURE			
Toileting	**Y/N**	**Date**	**Date**
1. Assist student to the restroom.			
2. Assist student with removal of necessary clothing.			
3. Apply gloves.			
4. Assist student to the toilet-*Proper body mechanics will reduce the risk of back injury.*			

5. Provide privacy while remaining close to the student in case he/she needs assistance.			
6. Provide balance or support for the student as needed.			
7. Once finished with elimination, remind the student to use correct methods to clean the perineal area. 8. Girls should use a front-to-back motion for cleansing. 9. Student may require assistance with this procedure.			
10. Assist student with replacing his/her clothing.			
11. Wash hands-Caregiver AND student.			
12. Assist student back to classroom.			
13. Notify RN of any changes in elimination or any concerns.			
14. DOCUMENT PROCEDURE			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Bowel / Bladder Training (ASBN 1.2)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y/ N	Date	Date
1. Ensure the student wears non-restrictive clothing.			
2. Create a picture schedule.			
3. Eliminate all distracting items from the bathroom.			
4. Elimination attempts will occur at the following times (remember normal elimination of stool occurs within 30 minutes of a meal) ○ am/pm ○ am/pm ○ am/pm ○ am/pm			
5. Give fluids 20-30 minutes prior to above-mentioned times.			
6. Apply gloves.			
7. Assist student to the restroom and to the toilet. Provide additional support if needed.			
8. Assist with hygiene and redressing if necessary.			
9. Assist with hand washing and returning to the classroom.			
10. **DOCUMENT PROCEDURE**			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Bathing/Grooming/Dressing (ASBN 1.3 and 1.4)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y/ N	Date	Date
1. Personal Care: Dressing (Assist with clothing)			
2. Dressing – being able to make appropriate clothing decisions and physically dress and undress oneself.			
3. Personal Hygiene ○ Oral care ○ Nail care ○ Skin care ○ Bathing ○ Menstrual Hygiene			
4. Apply gloves.			
5. Assist students with undressing if assistance is needed.			
6. Demonstrate proper way to complete personal care by soaping up a washcloth and demonstrating how to use it.			
7. Nurse/UAP will give students his/her privacy to complete the task (if needed, student will signal staff to assist).			
8. Once task is complete, student will complete personal care process by putting on deodorant, lotion, and clean clothes.			
9. Nurse/UAP will provide student privacy to student to complete this task (if needed, student will signal staff to assist)			
10. **DOCUMENT PROCEDURE**			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Oral Hygiene (ASBN 1.5) Dental Hygiene (ASBN 1.6)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
1. Gather supplies: ○ Toothbrush ○ Toothpaste ○ Cup and water ○ Gloves			
2. Explain procedure to the student.			
3. Apply gloves.			
4. Moisten toothbrush and apply toothpaste.			
5. Brush teeth, being careful not to apply too much pressure. The gums are extremely sensitive and can easily bleed.			
6. Allow student to spit and rinse his/her mouth.			
7. Provide water to rinse if student is allowed liquids.			
8. **DOCUMENT PROCEDURE**			
Special Considerations for Oral care: ○ Oral sponges only for students who are at risk for aspiration ○ Students with swallowing difficulty should not be offered water to rinse Things to look for when providing oral care: ○ Broken or loose teeth ○ Mouth sores			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Lifting/Transfers/Positioning (ASBN 1.7)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Lifting and Transfers 1-person ***Never lift a student who is too heavy! Seek assistance from another staff member.***			
1. Explain procedure to student.			
2. Place the wheelchair at a 45° angle to desired end location (changing table, another chair, etc).			
3. Lock wheels in place.			
4. Raise chair, if possible, to height of table or have second person available for lifting, if necessary.			
5. Position self between student's knees bending slightly at the waist.			
6. Position the student in the center of the chair.			
7. Place arms under the student's armpits.			
Use proper body mechanics: ○ Place feet at least 12 inches apart Keep weight of student as close to you as possible ○ Tighten stomach muscles and tuck the pelvis ○ Bend at knees while keeping back straight ○ When turning, pivot feet, turn with short steps (turn body without twisting torso ○ NEVER twist to lower student			
8. Lower student and support, if necessary.			
9. Release brake and move chair out of way.			
10. **DOCUMENT PROCEDURE**			
2-person Lifting and Transfer	**Y/N**	**Date**	**Date**
1. Place wheelchair parallel to table or chair and lock brakes.			
2. Position one person to stand behind student—one person in front of student to side of student's knee.			
3. One person places arms under the student's armpits while other person grasps student under both knees.			

4. Use a verbal 1-2-3 count to coordinate movement.			
5. Each person bends knees at the same time and pushes straight up, lifting the student onto the table or chair and providing support when necessary.			
6. Release brake and move chair out of way.			
7. **DOCUMENT PROCEDURE**			
Positioning	**Y/N**	**Date**	**Date**
1. Keep student airway open by ensuring head and neck are in straight alignment.			
2. Maintain equal weight on points of pressure such as buttocks, shoulder blades, elbows, backs of knees and heels.			
3. Assure there is adequate space between back of knee and chair—this will ensure no pressure is placed on the popliteal artery or nerve thus interfering with blood flow and nerve function.			
4. Reposition student as ordered by physician or district policy.			
5. **DOCUMENT PROCEDURE**			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Oral Feeding (ASBN 1.8.2)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
1. Wash hands.			
2. Assure the student has the appropriate and correct diet.			
3. Prepare tray: Open cartons, remove lids, cut food.			
4. If the student can eat independently, allow student to feed self.			
5. For student who cannot eat independently, assist with feeding:			
a. Sit in a comfortable position			
b. Ask the student which food he/she would like to eat first			
6. Feed student in a manner which promotes chewing and swallowing: give small bites and allow ample time.			
7. Provide liquids as requested			
8. Talk with the student			
9. Use this opportunity to talk about good nutrition habits			
10. Assist with hand washing			
11. **DOCUMENT PROCEDURE**			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Nasogastric Tube Removal (ASBN 1.8.5)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y /N	Date	Date
1. Put on gloves.			
2. Remove adhesive from the nose, discontinue suction.			
3. Grasp NG tube at the nose.			
4. Gently pull until the entire tube is removed. *Note: look at the integrity of the tube – is the tube intact or broken?			
5. Notify RN immediately if the NG tube has been emergently removed.			
6. **DOCUMENT PROCEDURE**			
a. Describe environment immediately prior to removal			
b. Explain why the NG tube was removed			
c. Explain actions taken			
d. Note condition of the tube after removal			
Indications for Emergent Removal of the NG tube:	**Y/N**	**Date**	**Date**
Student-specific information to be filled in by RN in conjunction with Physician orders and family wishes.			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Gastrostomy Feeding (ASBN 1.8.6)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Always make feeding feel like a mealtime. Allow student to sit with other students if desired.			
1. Gather supplies: ○ Gloves ○ Formula at room temperature • Determine type and amount to be infused ○ Clamp and plug ○ Water for flushing (if prescribed)			
2. Check health care plan to determine: ○ Infusion type and rate ○ Frequency and timing of administration ○ Amount of water used to flush the tube			
3. Explain procedure to student.			
4. Wash hands.			
5. Place equipment on a clean surface.			
6. To prevent aspiration during the feeding ALWAYS position child with head up at least 30 degrees.			
7. Place towel or washcloth under student's gastrostomy tube.			
8. Put on gloves.			
9. If the following are noticed, do not administer feeding: ○ Abdominal distention ○ Obstruction of G-tube ○ Malposition of G-tube: compare tube length to documented length on file			
10. If residual check is ordered: a. Attach 60ml syringe with plunger to end of tube b. Unclamp tubing and gently draw back c. Document amount withdrawn d. Allow residual to return to stomach passively (do not push syringe, let gravity move the fluid) e. Clamp tubing and remove syringe			

11. Measure prescribed amount of formula.			
12. If the following occur during feeding STOP IMMEDIATELY ○ Gagging ○ Vomiting ○ Coughing ○ Abdominal Distention ○ Change in skin color ○ Difficulty breathing			
For Bolus Feeding (Including Skin-level)	**Y / N**	**Date**	**Date**
a. Pour feeding into syringe until half full.			
b. Open safety plug and attach syringe to G-tube or skin level device.			
c. Elevate feeding above level of the stomach: the higher the syringe is held, the faster the feeding will flow ○ A rapid bolus may cause nausea, vomiting, or diarrhea.			
d. Open G-tube.			
e. Allow feeding to go in slowly over prescribed amount of time.			
For slow or continuous drip feeding:	**Y / N**	**Date**	**Date**
a. Pour feeding into container/bag.			
b. Run feeding through tubing to the tip and clamp tubing closed.			
c. Place tubing into pump and set flow rate.			
d. Open safety plug and insert tubing into G-tube or skin level device.			
e. Program pump to prescribed feeding rate, unclamp tube, and start feeding.			
f. When bag is empty, clamp feeding bag tubing and remove.			
g. After all steps of feeding are complete, wash syringe, feeding bag, and tubing with soap and warm water. Syringe and feeding tubing can be used again for up to 24 hours.			
13. If ordered, vent to relieve gassiness: ○ Lower syringe below level of stomach to facilitate burping ○ Allow gastric contents to passively (gravity) move back to stomach			
14. Flush G-tube: ○ Attach 60cc syringe and flush G-tube with 5cc (or prescribed) amount of water			
15. Disconnect syringe.			
16. Connect cap or plug to G-tube ○ Ensure clamp is not resting on student skin			

17. Keep child in a feeding position (at least 30 degrees) for at least 30 minutes after feeding.			
18. Remove gloves.			
19. Wash hands.			
20. **DOCUMENT PROCEDURE**			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Monitoring Gastrostomy Feeding (ASBN 1.8.7)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Things to watch for with gastrostomy tube feedings			
1. **Changes in skin color, breathing difficulties** **STOP FEEDING IMMEDIATELY**			
2. **Nausea/ vomiting** ○ Check flow rate ○ Check temperature of formula ○ If above items have been checked – STOP FEEDING			
3. **Blocked gastrostomy device** ○ Flush with warm water after feeding or medication administration			
4. **Bleeding, drainage, skin redness and/or irritation** ○ Check skin daily ○ Refer to student emergency plan ○ Rotate device in complete circle (360 degrees) with cleaning ○ Dry stoma well			
5. **Leaking of the stoma** ○ Clean skin and notify RN and family			
6. **Gastrostomy device falls out**—THIS IS **NOT** AN EMERGENCY ○ Save device ○ Contact RN and family			
7. **DOCUMENT PROCEDURE**			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Monitoring Gastrojejunal Tube Feeding (ASBN 1.8.10)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Things to watch for with gastrojejunal tube feedings			
1. **Changes in skin color, breathing difficulties** **STOP FEEDING IMMEDIATELY**			
2. **Nausea/ vomiting** ○ Check flow rate ○ Check temperature of formula ○ If above items have been checked—**STOP FEEDING**			
3. **Blocked gastrostomy device** ○ Flush with warm water after feeding or medication administration			
4. **Bleeding, drainage, skin redness and/or irritation** ○ Check skin daily ○ Refer to student emergency plan ○ Rotate device in complete circle (360 degrees) with cleaning ○ Dry stoma well			
5. **Leaking of the stoma** ○ Clean skin and notify RN and family			
6. **G/J device falls out** —THIS IS **NOT** AN EMERGENCY ○ Save device ○ Contact RN and family			
7. **DOCUMENT PROCEDURE**			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Clean Intermittent Catheterization—Male (ASBN 2.1)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Preparation			
1. Identify student ability to participate in procedure.			
2. Review universal precautions.			
3. Procedure will be completed in an area which provides the most privacy for the student.			
4. Position for catheterization.			
5. Identify potential problems and appropriate actions.			
Supplies	**Y / N**	**Date**	**Date**
○ Water soluble lubricant			
○ Type of catheter			
○ Wet wipes or cotton balls			
○ Cleansing supplies			
○ Storage receptacle for catheter			
○ Container for urine			
○ Gloves			
Procedure	**Y / N**	**Date**	**Date**
6. Wash hands.			
7. Gather equipment.			
8. Arrange equipment for procedure (having equipment prepared prior to procedure reduces anxiety of the student).			
9. Wash hands and put on gloves.			
10. Lubricate catheter and place on clean surface.			
Cleaning procedures:	**Y / N**	**Date**	**Date**
11. Prepare cleaning materials.			
12. Retract foreskin if necessary.			
13. Pull penis forward in a straight motion and hold at a 45° angle from the abdomen.			
14. Clean the meatus and glans.			

15. Use each swab only once.			
16. Wipe a minimum of three times.			
Catheterization procedure:	**Y / N**	**Date**	**Date**
17. Grasp catheter about four inches from the tip.			
18. Insert well lubricated catheter into penis with consistent pressure (if muscle spasm occurs, stop momentarily and then again use slow even pressure) NEVER FORCE A CATHETER.			
19.When urine flow stops, insert slightly more, and withdraw slightly.			
20. Rotate catheter so all catheter openings allow for bladder to empty completely.			
21. Allow urine to flow by gravity into the shallow pan or toilet.			
22. If ordered, gently press bladder to help empty.			
23. Pinch catheter and withdraw slowly when urine stops flowing.			
24. If not circumcised, pull foreskin over glans.			
25. Remove gloves and wash hands.			
26. Assist student in dressing.			
27. Put on gloves, measure and record amount of urine collected, clean materials and replace.			
28. Wash hands.			
29. Notify RN of any changes or concerns.			
30. **Document procedure and observations**			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Clean Intermittent Catheterization—Female (ASBN 2.1)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Preparation			
1. Identify student ability to participate in procedure.			
2. Review universal precautions.			
3. Procedure will be completed in an area which provides the most privacy for the student.			
4. Position for catheterization.			
5. Identify potential problems and appropriate actions.			
Supplies			
○ Water soluble lubricant			
○ Type of catheter			
○ Wet wipes or cotton balls			
○ Cleansing supplies			
○ Storage receptacle for catheter			
○ Container for urine			
○ Gloves			
○ Mirror			
Procedure			
6. Wash hands.			
7. Gather equipment.			
8. Arrange equipment for procedure (having equipment prepared prior to procedure reduces anxiety of the student).			
9. Wash hands and put on gloves.			
10. Lubricate catheter and place on clean surface.			
Cleaning procedures			
11. Prepare cleaning materials.			
12. Open labia minora and majora.			
13. Clean from front of folds to back of meatus.			
14. Use swab only once.			

15. Wipe a minimum of three times.			
Catheterization procedure:			
Explanation and Return Demonstration of procedure	**Y / N**	**Date**	**Date**
16. Grasp catheter about three inches from the tip.			
17. Insert well lubricated catheter into the urethra until urine begins to flow NEVER FORCE A CATHETER.			
18. Advance ½ inch more.			
19. Rotate catheter so all catheter openings allow for complete bladder emptying.			
20. Allow urine to flow by gravity into the shallow pan or toilet.			
21. If ordered, gently press bladder to help empty.			
22. Pinch catheter and withdraw slowly when urine stops flowing.			
23. If urine begins to flow again during removal—Wait until all urine has stopped flowing to remove catheter.			
24. Remove gloves and wash hands.			
25. Assist student in dressing.			
26. Put on gloves, measure and record amount of urine collected, clean materials and replace.			
27. Wash hands.			
28. Notify RN of any changes or concerns.			
29. **Document procedure and observations**			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

External Catheter Application (ASBN 2.3)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y/ N	Date	Date
Use this form to create a student-specific plan for student with external catheter.			

Checklist has been reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Indwelling Catheter Care (ASBN 2.4)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y/ N	Date	Date
1. Gather your supplies. You will need: ○ Mild soap, such as Dove® ○ Water ○ 1 Cath-Secure®			
2. Wash your hands with soap and water for at least 20 seconds.			
3. Using mild soap and water, clean the genital area: Male: a) Pull back the foreskin b) Clean the area including the penis c) Return foreskin to the covered position when finished Female: a) Separate the labia b) Clean the area from front to back			
4. Clean the urethra (urinary opening) where the catheter enters the body.			
5. Clean the catheter: a) Start cleaning at the tip of the catheter working away from the tip b) Hold onto catheter close to where it enters body to prevent tension			
6. Rinse the area well and dry it gently.			
7. If you removed the old Cath-Secure, use the new Cath-Secure to attach the catheter to the leg to keep it from moving.			
8. **DOCUMENT PROCEDURE**			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Ventricular Peritoneal Shunt Monitoring (ASBN 3.1)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
1. Watch for the following symptoms:			
2. If any occur NOTIFY THE RN IMMEDIATELY			
○ Headache			
○ Vomiting			
○ Vision Issues			
○ Confusion			
○ Fever greater than 101.5 orally			
○ Increased redness or discomfort or new or excessive drainage from an incision site from a new shunt placement/revision.			
○ Increased sleepiness			
3. **DOCUMENT PROCEDURE**			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Mechanical Ventilator Monitoring (ASBN 3.2.1)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Ventilator Machine and Circuit			
Locate:			
1. Power source:			
○ Internal battery			
○ External battery			
○ Accessible and grounded functioning electrical outlets			
○ Back-up battery			
○ Emergency power supply			
2. Oxygen source (if needed)			
○ Connection to ventilator and spare tubing			
○ Oxygen supply, spare tank, and gauge			
○ Flow (LPM-Liters per minute) and percentage of oxygen			
3. Humidification source:			
○ Passive condenser			
4. Volume			
5. Rate			
6. Patient pressure manometer			
7. Peak inspiratory pressure (PIP)			
8. Positive end expiratory pressure (PEEP)			
9. Ventilator mode			
10. Inspiratory time			
11. Alarms			
○ High-Pressure alarm			
○ Low-Pressure alarm			
○ Power Source alarm			
12. Describe:			
○ Patient pressure tubing, patient port, exhalation valve, PEEP value, and additional adaptors			

13. GO BAG Supplies			
○ Ambu bag with adaptor or mask			
○ Spare tracheostomy tube and supplies			
○ Suctioning supplies			
14. Ventilator Troubleshooting Alarms			
○ Identify which alarm is sounding			
15. Low-pressure Alarm:			
○ Check student first, then:			
○ Remove the student from the ventilator			
○ Give breaths with Ambu bag			
16. If the student is OK, then check for:			
○ Leaks			
○ Disconnection of tubing (to student, vent, or along circuit)			
○ Punctured tubing			
○ Water in exhalation valve			
○ Hole in exhalation valve			
○ Loose-fitting heater humidification source			
Check ventilator settings			
Test system after leak is found (occlude student end of circuit and wait for high-pressure alarm to sound).			
Return student back to ventilator			
17. High Pressure Alarm			
○ What is the student's body position?			
Is the student:			
○ Coughing?			
○ Sneezing?			
○ Talking?			
○ Crying?			
○ Laughing?			
○ Having hiccups?			
Does the student:			
○ Needs suctioning?			
○ Have a blocked tracheostomy tube?			
○ Suction if needed			
○ Realign or change tracheostomy tube, if needed			
○ Remove student from ventilator and give breaths with Ambu bag			

If student is OK, then check ventilator for obstructions Is there:			
○ A kink in tubing?			
○ Water in tubing?			
○ A blocked exhalation valve?			
○ An accidental change in ventilator settings			
○ After solving the problem and checking the high-pressure circuit, return student to ventilator.			
18. Power Source Alarm			
Check student then:			
○ AC power			
○ Internal battery			
○ External battery			
19. If all three systems fail:			
○ Remove student from ventilator and give breaths with Ambu bag			
If use of Ambu bag is required for more than 15 minutes:			
○ Add drops of saline to the tracheostomy for humidity.			
OR			
○ Put passive condenser on resuscitation bag and continue to use Ambu bag.			
20. **FOLLOW THE STUDENT-SPECIFIC EMERGENCY PLAN**			
21. **DOCUMENT PROCEDURE**			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Ambu Bag (ASBN 3.2.3)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Ambu Bag with Tracheostomy			
1. Identify student's ability to participate in the procedure.			
2. Review universal precautions.			
3. Supplies:			
○ Oxygen source with appropriate tubing if needed			
○ Manual resuscitator			
○ Adaptor for tracheostomy tube			
○ Go-Bag items			
4. Wash hands.			
5. Position student and explain procedure.			
6. Check that Ambu bag is functioning properly.			
7. Attach Ambu bag to tracheostomy tube.			
8. Coordinate manual breaths with student's own breaths, if student breathes independently.			
9. If student is unable to breathe independently, squeeze Ambu bag at regular rate to give prescribed breaths per minute.			
10. Remove Ambu bag from tracheostomy tube when appropriate.			
11. Report any changes to RN Immediately.			
12. **DOCUMENT PROCEDURE**			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Oxygen—Intermittent (ASBN 3.3.1)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Use this form to create a student-specific plan for Intermittent Oxygen			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Oxygen—Continuous Monitoring (ASBN 3.3.2)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
1. **Monitor and notify RN for the following symptoms**			
○ Anxiety, apprehension, or behavior change			
○ Increased heart rate			
○ Increased respiratory rate and depth of respirations becomes irregular			
○ Difficulty breathing			
○ Use of accessory muscles for respirations (nasal flaring, rib retractions, tracheal tugging)			
○ Dizziness			
○ Changes in color: the student becomes cyanotic (blue or gray looking)			
2. **DOCUMENT PROCEDURE**			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Medication Administration (ASBN 4)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Oral—Non-Controlled prescription (4.2)			
1. Assemble supplies.			
2. Verify child's ability to take oral medications.			
3. Verify accuracy of medication. ○ Right Name ○ Right Medication ○ Right Dose ○ Right Time ○ Right Route			
4. Prepare the medication: ○ Only crush or break apart if RN has verified the medication properties allow this			
5. Shake liquid medication well to mix.			
6. Cover the label of the bottle and pour appropriate dose.			
7. Administer the medication.			
8. **DOCUMENT PROCEDURE**			
Over-the-counter medications (4.3) (Written Parental Consent)	**Y/N**	**Date**	**Date**
1. Follow the procedure listed above.			
2. Administer the medication EXACTLY as directed on the package.			
3. **DOCUMENT PROCEDURE**			
Injections (4.4)	**Y/N**	**Date**	**Date**
DO NOT DELEGATE **See ARSBN Insulin and Glucagon Administration and training programs**			

EpiPen® Allergy Kit (4.5)	Y/N	Date	Date
Initiate Emergency Response—Call 9-1-1			

Administer Epi Pen through student clothing			
1. Pull off gray activation cap.			
2. Grasp the injector with a fist around the barrel.			
3. Hold black tip near outer thigh.			
4. Swing and jab firmly into outer thigh until Auto-injector. mechanism functions. Hold in place and count to three.			
5. Remove the EpiPen ®.			
6. **DOCUMENT PROCEDURE**			
Inhalation (4.6)	**Y/N**	**Date**	**Date**
Routine Inhalers (4.6.1) should be administered by parent/guardian at home.			
Emergency/Rescue inhalers (4.6.2)	**Y/N**	**Date**	**Date**
1. Shake the inhaler well.			
2. Place the inhaler into the spacer.			
3. Have student exhale completely.			
4. Fit spacer around student's nose and mouth, or have the student place mouth around the tube of the spacer.			
5. Instruct child to take a deep breath while press firmly on the inhaler to activate the medication.			
6. Repeat this procedure as often as the prescription states to.			
7. **DOCUMENT PROCEDURE**			
Nasal Insulin (4.6.3)	**Y/N**	**Date**	**Date**
DO NOT DELEGATE See ARSBN Insulin and Glucagon Administration Program			
Nasal controlled substance (4.6.4)	**Y/N**	**Date**	**Date**
DO NOT DELEGATE			
Naloxone (4.6.5)	**Y/N**	**Date**	**Date**
DO NOT DELEGATE			
Rectal Medications (4.7) Bladder instillation (4.8)	**Y/N**	**Date**	**Date**
DO NOT DELEGATE			
Eye Drops (4.9)	**Y/N**	**Date**	**Date**
1. Explain the procedure to the student.			
2. Assist the student to a comfortable position.			

3. Apply gloves.			
4. Clean the eyelid and eyelashes with a wet cotton ball.			
5. Wipe from the inner eye to the outer eye.			
6. Have the student look up toward the ceiling.			
7. Gently pull the lower eyelid down with the non-dominant hand.			
8. With the dominant hand, put drops into the eyelid and release.			
9. Pat the eyelid with tissue if needed.			
10. Wash hands.			
11. **DOCUMENT PROCEDURE**			
Ear Drops (4.9)	**Y/N**	**Date**	**Date**
1. Explain the procedure to the student.			
2. Apply gloves.			
3. Assist the student to a comfortable position.			
4. Gently pull the ear lobe downward.			
5. Squeeze medication into the ear canal.			
6. Place cotton ball into ear.			
7. **DOCUMENT PROCEDURE**			
Topical (4.10) 4.10.1(Prescription), 4.10.29 (OTC with parental consent)	**Y/N**	**Date**	**Date**
1. Powder: Sprinkle a thin layer over the skin and cover.			
2. Lotions: Use a swab and apply a small amount over the affected area.			
3. Aerosol: Hold can 6-12 inches from skin and spray.			
4. Transdermal Patch: Clean and dry skin, remove patch from adhesive, making sure not to touch the medication, place patch on skin.			
5. **DOCUMENT PROCEDURE**			
Per Nasogastric Tube (4.11)	**Y/N**	**Date**	**Date**
DO NOT DELEGATE			
Per Gastrostomy Tube (4.12)	**Y/N**	**Date**	**Date**
○ Do not administer whole or un-dissolved medications through the G-tube.			
○ Dissolve crushed/broken medication in warm water.			

○ Open capsules (only when allowed) and mix the contents with water.			
1. Connect catheter-tip syringe to gastrostomy tube			
2. Administer medication through G-tube.			
3. If giving several medications, flush with 3cc of water between Medications.			
4. When complete, flush with 5cc of water to clear the tube.			
5. **DOCUMENT PROCEDURE**			
Intravenous (4.13)	**Y/N**	**Date**	**Date**
DO NOT DELEGATE			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Ostomy Care (ASBN 5.1)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y/ N	Date	Date
Use this form to create a student-specific plan for ostomy care.			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Suctioning (ASBN 6.3.1 and ASBN 6.3.2)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Pharyngeal (6.3.1) and Tracheostomy (6.3.2) Suctioning			
1. Identify the student's ability to assist in the procedure.			
2. Gather supplies.			
3. Wash hands.			
4. Apply gloves.			
5. Position student and explain procedure.			
6. Turn on suction machine and check function.			
7. Attach catheter to suction tubing.			
8. Insert catheter into nose and advance until student coughs without secretions.			
9. For tracheostomy suctioning, place catheter into the tracheostomy and continue			
a. Apply suction. When the student coughs, withdraw catheter while twirling.			
b. If secretions are thick, put a few drops of saline into the nose or tracheostomy.			
c. Repeat suctioning in this order until secretions are cleared.			
10. Suction the mouth by advancing the catheter into the mouth without suction			
a. Apply suction and withdraw the catheter while twirling.			
b. Repeat suctioning in this order until all secretions are cleared.			
11. Dispose of catheter.			
12. Rinse tubing with tap water.			
13. Remove gloves and wash hands.			

14. Notify RN of any changes or concerns.			
15. **DOCUMENT PROCEDURE**			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Suctioning with a bulb syringe (ASBN 6.3.1 and ASBN 6.3.2)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Suctioning with a bulb syringe (pharyngeal and tracheostomy)			
1. Identify the student's ability to assist in the procedure.			
2. Gather supplies ○ Bulb syringe ○ Saline ○ Tissue ○ Gloves			
3. Wash hands.			
4. Apply gloves.			
5. Position student and explain procedure.			
a. Squeeze the bulb syringe and place the tip into the nose or mouth and release.			
6. For tracheostomy suctioning, place bulb syringe into the tracheostomy and continue			
a. Remove the bulb syringe from the nose or mouth.			
b. Squeeze the bulb syringe into the tissue, expelling secretions.			
7. If secretions are thick, put a few drops of saline into the nose or tracheostomy.			
8. Repeat suctioning in this order until secretions are cleared.			
9. Clean the bulb syringe and dispose of the tissue.			
10. Remove gloves and wash hands.			
11. Notify RN of any changes or concerns.			
12. **DOCUMENT PROCEDURE**			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Tracheostomy Tube Replacement (ASBN 6.4) and Care (ASBN 6.5)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Tracheostomy tube replacement and care			
1. Identify the student's ability to assist in the procedure.			
2. Gather supplies: ○ Tracheostomy tie or tracheostomy tube holder ○ One-half hydrogen peroxide and one-half normal saline (or distilled water mixture) ○ Cotton-tipped applicators ○ Pipe cleaners ○ Tracheal gauze or sponges ○ Two clean containers ○ Gloves			
3. Wash hands.			
4. Apply gloves.			
5. Position student and explain procedure.			
6. Remove old gauze or sponges from the tracheostomy.			
7. Clean the stoma with the hydrogen peroxide mixture with cotton swabs.			
8. If the tracheostomy has an inner cannula, remove the inner cannula.			
9. Replace old tracheostomy ties or holder with a new one.			
10. Insert the inner tracheostomy sponge under the tracheostomy tube phalanges.			
11. Clean the inner cannula with the hydrogen peroxide mixture and pipe cleaners.			
12. Rinse with saline.			
13. Replace the inner cannula and lock into place.			
14. Discard the cleaning solution.			
15. Remove gloves and wash hands.			
16. Notify RN of any changes or concerns.			

17. **DOCUMENT PROCEDURE**			

Checklist reviewed and approved by the school Nurse

UAP signature/date_____

Nurse signature/date_____

Vital Signs (ASBN 7.2)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Heart Rate			
1. Have the student sit in a chair or lie on the health bed.			
2. Place index finger on the radial pulse.			
3. Count number of beats for one minute.			
4. Notify RN if pulse is out of normal range.			
5. Notify RN of findings.			
6. **DOCUMENT PROCEDURE**			
Respiratory Rate	**Y/N**	**Date**	**Date**
1. Have the student sit in a chair or lie on the health bed.			
2. Place hand in the center of the chest and feel for the rise and fall with each breath.			
Note: It may be necessary to watch the rise and fall of the chest while checking heart rate. When a student is aware a respiratory rate is being counted, they may control the rate resulting in an inaccurate finding.			
3. Count the number of times the chest rises for one minute.			
4. Notify RN of findings.			
5. **DOCUMENT PROCEDURE**			
Blood Pressure	**Y/N**	**Date**	**Date**
1. Determine the appropriate size cuff to use.			
2. Wrap the cuff around the student's middle upper arm and make sure the arrow points to the brachial artery.			
3. Place the stethoscope on the brachial artery.			
4. Close the circuit on the bulb and pump until the needle reaches MMHG (millimeters of mercury).			
5. Slowly release the air out of the cuff while listening for the first audible beat.			
6. Record the number.			
7. Listen for the last audible beat and record the number.			

8. Release all the air from the bulb.			
9. Notify RN of findings.			
10. **DOCUMENT PROCEDURE**- blood pressure with the first # on top and the second # on the bottom. (xxx/xx)			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Specimen Collecting (ASBN 8.1. & ASBN 8.2)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Blood Glucose Testing (8.1)			
Use the student-specific Health Care Plan for appropriate actions			
1. Wash hands.			
2. Gather supplies.			
3. Position student in a chair or health bed and hang hand down.			
4. Apply gloves.			
5. Select finger to use for testing.			
6. Wipe the tip or side of the finger with the alcohol swab and air dry.			
7. Turn the glucose monitor on.			
8. Place the reagent strip into the meter.			
9. Use the lancet to puncture the skin and obtain blood drop with the reagent strip.			
10. Wait for the results.			
11. **DOCUMENT PROCEDURE**			
Urine Glucose/Ketone Testing (8.2)			
Follow the student-specific Health Care Plan for further directions.			
1. Wash hands.			
2. Gather Supplies.			
3. Apply gloves.			
4. Collect urine specimen (voiding into cup or diaper).			
5. Have a reagent strip on a paper towel or tissue with the pads facing up.			
6. Use the catheter tipped syringe to collect urine from cup or diaper and place one drop on the appropriate square pad sections.			
7. Allow the urine to sit on the reagent strip according to the directions.			
8. Compare the colors on the reagent strip with the color			

indicators on the side of the reagent strip container.			
9. **DOCUMENT PROCEDURE**			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Seizure Safety Precautions (ASBN 9.1)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Seizure Safety Precautions (9.1)			
1. Remain calm.			
2. Help the child to the floor.			
3. Move objects away from the child.			
4. DO NOT hold down or put anything into the child's mouth			
5. Once the jerking movements have stopped, turn the child onto his/her side.			
6. Follow the student-specific health care plan before medication administration considered.			
7. Stay with the student until he/she is fully alert.			
8. **Document episode including:**			
○ Time of onset ○ Length of episode ○ Loss of consciousness ○ Loss of bowel/bladder ○ Return to pre-episode state of alertness			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Vagus Nerve Stimulation (ASBN 9.2)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Because the use of a Vagus Nerve Stimulator is extremely student-specific, a blank skills checklist is provided to allow the RN and parent/guardian to create the procedure.			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Pressure Ulcer Care (ASBN 9.3)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Pressure Ulcer Care			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

Dressing Changes—Sterile (ASBN 9.4) Non-Sterile (ASBN 9.5)

Student name/year: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Dressing Change—Sterile (ASBN 9.4)			
17. Explain procedure to student.			
18. Expose area with the wound—assure only enough skin is exposed to gain access to the wound.			
19. Wash hands and apply gloves.			
20. Remove soiled dressing and dispose.			
21. Remove gloves and dispose.			
22. Set up sterile field.			
23. Apply sterile gloves.			
24. Open all packages and drop equipment needed onto sterile field.			
25. If ordered, cleanse the wound area with appropriate cleansing agent.			
26. Pat area dry with a towel.			
27. Apply antiseptic ointment as prescribed.			
28. Apply sterile dressing to wound, apply adhesive tape to the dressing to secure dressing in place.			
29. Remove gloves.			
30. Wash hands.			
31. Notify RN of any changes or concerns.			
32. **DOCUMENT PROCEDURE**			
Dressing Change—Non-Sterile (ASBN 9.5)			
13. Explain procedure to student.			
14. Expose area with the wound—assure only enough skin is exposed to gain access to the wound.			
15. Wash hands and apply gloves.			
16. Remove soiled dressing and dispose.			
17. If ordered, cleanse the wound area with appropriate cleansing agent.			
18. Pat area dry with a towel.			

19. Apply antiseptic ointment as prescribed.			
20. Apply clean dressing to the wound and apply adhesive tape to 21. secure dressing in place.			
22. Remove gloves and wash hands.			
23. Notify RN of any changes or concerns.			
24. **DOCUMENT PROCEDURE**			

Checklist reviewed and approved by the school nurse

UAP signature/date_____

Nurse signature/date_____

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