Section B.

School Entry & Maintenance

I. Foundations of School Nursing – Refer to the new Delaware School Nurse Manual, Chapter 1, Standards of Practice, and Chapter 4, Leadership

II. Documentation & Recordkeeping

a. Documentation
b. Sharing of Information

~~III.~~ School Entry – Refer to the new Delaware School Nurse Manual, Chapter 3, Community/Public Health

~~a. Immunization~~
~~b. Tuberculosis~~
~~c. Physical examination~~
~~d. Lead~~

~~III.~~ Examinations & Screenings – Refer to the new Delaware School Nurse Manual, Chapter 3, Community/Public Health

~~a. Health Examinations~~
~~b. Vision~~
~~c. Hearing~~
~~d. Postural & Gait~~

~~IV.~~ Medications – Refer to the new Delaware School Nurse Manual, Chapter 2, Care Coordination

~~a. Prescriptions~~
~~b. OTC~~
~~c. Field trips~~

The information in Section B provides guidelines on some fundamentals of school nursing practice in Delaware. A quality documentation system assures easy input and access of information, continuity of care, transfer of records confidentially, and accuracy. School enrollment health requirements also support the health and well-being of the student by providing a current and accurate assessment. Both documentation and data collection help to assure that each student's individual needs are considered when planning for full school participation and academic success. Regulations must be followed as specifically written, but additional protocols and policies may be needed in order to assure safe practice within an individual school setting or for an individual student. For example, the regulation on field trips provides structure for allowing teacher assistance with self-medication; however, in some cases the best management may be to have a school nurse accompany the student. Section B was updated and revised in 2015 with the assistance of Lara Booth, BSN, RN, NCSN; Pat Guilday, MSN, RN, NCSN; and Susan Hoffman, MSN, RN, NCSN.

II. Documentation

Delaware School Health Records

The Department of Education Regulation #817, School Health Record Keeping Requirements (http://regulations.delaware.gov/AdminCode/title14/800/811.shtml**),** describes the requirements for student health records. In general, each student must have an individual, electronic student health record that is a part of the student's cumulative school record but stored separately in the school nurse's office. Hard copies of original documentation, e.g. health assessment form, doctor order and parent permission for medication, must be filed in the student's individual health file and stored securely. The regulation also requires that each student also have a School Health Record Form. In the past, this was maintained as a handwritten, hard copy. Today all of the student's health information must be documented in an electronic health record (EHR) approved by the district/charter. In the event the EHR cannot be sent to the receiving school when a student transfers, the school must send the student's health file and a Delaware School Health Record Form. This Form is created by an EHR report, which minimally contains all of the following:

- Student ID
- Student Name
- Gender, Grade
- Birth Date
- Status
- Counselor
- Medical Alerts
- Growth Exam
- Hearing Exam
- Physical Exam
- Posture/Gait Exam
- Vision Exam
- Other Screenings and Record Reviews
- Issued Medicine
- Office Visits
- Immunizations
- Referrals

All individual student data belongs to the student's record and must transfer with the student when he/she moves to another school. Nursing care provided must meet documentation standards, which minimally include those things identified within the regulation, e.g., a three point date, the person's (student, staff or visitor) first and last name, etc.

Record storage and retention must follow Regulation #252, Required Educational Records and Transfer and Maintenance of Educational Records

(http://archives.delaware.gov/govsvcs/pdfs/General%20Records%20Retention%20Schedules/School%20District%20General%20Records%20Schedule/Student%20Records.pdf).

Health information on students should be accurate and current. The school nurse must continuously update the student's health record. The Emergency Treatment Card provides information that may be new and may require follow-up. For example, a parent may indicate via the Emergency Treatment Card that the child has an allergy. If the allergy is not currently documented in the student's health EHR, it should be entered as Allergy – Parent Report. Further, the school nurse needs to contact the parent to get more information on the reported allergy and to request documentation of a diagnosis from a healthcare provider. The school nurse should periodically collect updated information via the Student Health History Update (refer to next page).

All nursing care, including that which is provided by a substitute school nurse, should be documented in the EHR. Substitute school nurses should be trained in, and have access to, the district/charter EHR. During emergencies, such as when the electronic system is unavailable, nursing care can be documented on a separate form. This form will contact information that needs to be transcribed and entered into the student's EHR. The school nurse should transcribe the handwritten notes with a citation indicating that the documentation was done at a time later than the health office visit and a brief explanation. The nurse might write:

Hand written note of care provided by Anne Example (substitute RN) on 4/3/15 and transcribed by Ima Schoolnurse on 4/4/15.

OR

Nursing notes transcribed by Ima Schoolnurse on 4/15/15 for care provided on 4/14/15 when EHR unavailable.

A sample of a log for maintaining handwritten notes is provided immediately after the Student Health History Update. This log is individual for each student and should be stored in the student's individual file.

Standardized nursing language, such as the Nursing Intervention Code Classification System (NIC), needs to be used as directed by the Delaware Department of Education to document in the student's EHR. A list of Nursing Intervention Codes with abbreviations and definitions follows. Other codes within the EHR are also standardized, such as dispositions, chronic health conditions, and screenings. These are used to ensure uniform reporting of school health data and for data decision-making. The use of abbreviations in nursing documentation is limited to those listed on the following document, "Approved Nursing Documentation Abbreviations".

SAMPLE

This form should only be used when the Electronic Health Record is unavailable

Name: _____ Date of Birth: _____ School:_____

Date	In/Out	Reason (Use Code)	Office Visit Detail Include Referral	Intervention	Rx/TX	Disposition	Initials

NURSING INTERVENTION CLASSIFICATION©

NURSING CARE

Admission Care ADMINCARE – *facilitating entry of student into school (health needs)*
Airway Management AIRMGT– *facilitation of patency of air passages*
Airway Suctioning AIRSUC– *removal of airway secretions by inserting a suction catheter into the patient's oral airway &/or trachea*
Allergy Management ALLERGY– *identification, treatment, & prevention of allergic responses to food, medications, insect bites, contrast material, blood, & other substances*
Artificial Airway Management ARTAIR– *maintenance of endotracheal & tracheostomy tubes and prevention of complications associated with their use*
Aspiration Precautions ASPIR– *prevention/minimization of risk factors in the patient at risk for aspiration*
Asthma Management ASTHMA– *identification, treatment and prevention of reactions to inflammation/constriction of the airway passages*
Bleeding Reduction: Nasal NOSEBL– *limitation of blood loss from the nasal cavity*
Bleeding Reduction: Wound BLEED–*limitation of the blood loss from a wound that may be a result of trauma, incisions, or placement of a tube or catheter*
Bowel Management BWL– *establishment & maintenance of a regular pattern of bowel elimination*
Case Management CASE – *care coordination and patient advocacy to reduce cost, reduce resource use, improve quality of car, and achieve desired outcomes*
Cast Care: Maintenance CAST– *care of a cast after the drying period*
Chest Physiotherapy CHEST– *assisting the patient to move airway secretions from peripheral airways to more central airways for expectoration &/or suctioning*
Contact Lens Care EYECL – *prevention of eye injury & lens damage by proper use of contact lenses*
Diarrhea Management DIARR – *prevention & alleviation of diarrhea*
Emergency Care (illness) ERILL – *providing life-saving measures in life-threatening situations caused by illness*
Emergency Care (injury) ERINJ – *providing life-saving measures in life-threatening situations caused by injury*
Enteral Tube Feeding TUBEFEED – *delivering nutrients & water through a gastrointestinal tube*
Feeding FEED – *feeding of patient with oral motor deficits*
Fever Treatment FVR – *management of a patient with hyperpyrexia caused by non-environmental factors*
First Aid FA or WOUNDFA – *providing initial care for a minor injury*
Health Care Information Exchange (illness) INFOILL – *providing patient care information to other health professionals related to illness*
Health Care Information Exchange (injury) INFOINJ – *providing patient care information to other health professionals related to injury*
Heat/Cold Application (injury) HTCLD – *stimulation of the skin & underlying tissues with heat or cold for the purpose of decreasing pain, muscle spasms, or inflammation*
Heat/Cold Application (non-injury) HTCLDN – *application for non-injury*
Heat Exposure Treatment HEATX – *management of patient overcome by heat due to excessive environmental heat exposure*
Hemorrhage Control HMRR – *reduction or elimination of rapid & excessive blood loss*
High-Risk Pregnancy Care PREG – *identification & management of a high-risk pregnancy to promote healthy outcomes for mother & baby*
Hyperglycemia Management HYPERG – *preventing & treating above-normal blood glucose levels*
Hypoglycemia Management HYPOG – *preventing & treating low blood glucose levels*
Immunization Management IZMGT – *monitoring immunization status and facilitating access to immunization*
Medication Administration MEDADM – *preparing, giving, & evaluating the effectiveness of prescription & nonprescription drugs*
Medication Management MEDMGT– *facilitation of safe/effective use of prescription & over-the-counter drugs*
Multidisciplinary Care Conference (illness) CONFILL – *planning & evaluating patient care with health professionals from other disciplines*
Multidisciplinary Care Conference (injury) CONFINJ – *planning & evaluating patient care with health professionals from other disciplines*
Nausea Management NAUSEA – *prevention and alleviation of nausea*
Neurologic Monitoring NEURO – *collection & analysis of patient data to prevent or minimize neurological complications*
Non-Nursing Intervention NONNURSE – *providing service not requiring nursing skills/expertise*
Nursing Assessment, No Intervention NASS – *providing assessment requiring professional nursing knowledge and skills without related intervention*
Nursing Intervention NURSE – *intervention requiring professional nursing knowledge and skills (not available on current list)*
Nutrition Management NUTMGT – *assisting with providing a balanced dietary intake of foods and fluids*
Nutrition, Special Diet SPDIET – *modification & monitoring of special diet*
Ostomy Care OSTO – *maintenance of elimination through a stoma & care of surrounding tissue*
Pain Management PAIN – *alleviation of pain or a reduction in pain to a level of comfort that is acceptable to the patient*
Positioning POSI – *deliberative placement of the patient or a body part to promote physiological &/or psychological well-being*
Referral Management REFMGT – *arrangement for services by another healthcare provider or agency*
Respiratory Monitoring RESP–*collection & analysis of patient data to ensure airway patency & adequate gas exchange*
Rest REST – *providing environment & supervision to facilitate rest/sleep after nursing evaluation*
Resuscitation RESUS – *administering emergency measures to sustain life*
Seizure Management SZR – *care of a patient during a seizure & the postictal state*
Self-Care Assistance, Nursing SELFNUR – *assisting another to perform activities of daily living*
Self-Care Assistance, Non-Nursing SELFNON – *assisting another to perform activities of daily living*
Skin Care SKIN – *application of topical substances or manipulation of devices to promote skin integrity & minimize skin breakdown*
Surveillance SURV – *purposeful/ongoing acquisition, interpretation, & synthesis of patient data for clinical decision making*
Surveillance: Skin SKINSRV – *collection/analysis of patient data to maintain skin & mucous membrane integrity*
Telephone Consultation TC–*for purpose of updating medical information*

Treatment Administration TXADM – *preparing, giving, & evaluating the effectiveness of prescribed treatments*
Treatment Management TXMGT – *facilitation of safe & effective prescribed treatments*
Tube Care TUBECARE – *management of a patient with an external drainage device exiting the body*
Tube Care, Gastrointestinal TUBECAREGI – *management of a patient with a gastrointestinal tube*
Urinary Catheterization CATH – *insertion of a catheter into the bladder for temporary or permanent drainage of urine*
Vital Signs Monitoring VS – *collection/analysis of cardiovascular, respiratory, & body temperature data to determine/prevent complications*
Wound Care (Ongoing) WOUNDON – *prevention of wound complications & promotion of wound healing*

HEALTH EDUCATION

Anticipatory Guidance (individual) AGUIDE – *preparation of patient for an anticipated developmental &/or situational crisis*
Anticipatory Guidance (group) AGUIDEG – *preparation of a group of patients for an anticipated developmental &/or situational crisis*
Body Mechanics Promotion (individual) BODY – *facilitating a patient in the use of posture & movement in daily activities to prevent fatigue & musculoskeletal strain or injury*
Body Mechanics Promotion (group) BODYG – *facilitating a group of patients in the use of posture & movement in daily activities to prevent fatigue & musculoskeletal strain or injury*
Exercise Promotion (individual) EXER – *facilitation of a patient in regular physical exercise to maintain or advance to a higher level of fitness & health*
Exercise Promotion (group) EXERG – *facilitation of a group of patients in regular physical exercise to maintain or advance to a higher level of fitness & health*
Health Education (individual) HLTHED – *developing & providing individual instruction & learning experiences to facilitate voluntary adaptation of behavior conducive to health in individuals, families, groups, or communities*
Health Education (group) HLTHEDG – *developing & providing group instruction & learning experiences to facilitate voluntary adaptation of behavior conducive to health in individuals, families, groups, or communities*
Smoking Cessation Assistance (individual) SMOKE – *helping the patient to stop smoking through an individual process*
Smoking Cessation Assistance (group) SMOKEG – *helping the patient to stop smoking in a group process*
Substance Use Prevention (individual) SUBAB – *prevention of an alcoholic or drug use life-style through an individual process*
Substance Use Prevention (group) SUBABG – *prevention of an alcoholic or drug use life-style through a group process*
Weight Management WGTMGT – *facilitating maintenance of optimal body weight & percent body fat*

COUNSELING

Counseling (individual) COUNSEL – *use of an interactive helping process focusing on the needs, problems, or feelings of the patient & significant others to enhance or support coping, problem-solving, & interpersonal relationships*
Counseling (group) COUNSELG – *use of an interactive helping process focusing on the needs, problems, or feelings of the group & significant others to enhance or support coping, problem-solving, & interpersonal relationships*

HEALTH PROMOTION/PROTECTION

Abuse Protection Support: Child ABUSE – *identification of high-risk, dependent child relationships & actions to prevent possible or further infliction of physical, sexual, or emotional harm or neglect of basic necessities of life*
Environmental Management ENVMGT – *manipulation of the patient's surroundings for therapeutic benefit, sensory appeal & psychological well-being*
Environmental Management: Safety ENVMGTS– *monitoring & manipulation of the physical environment to promote safety*
Health System Guidance HGUIDE – *facilitating a patient's location & use of appropriate health services*
Infection Protection INFPRO – *prevention & early detection of infection in a patient at risk*
Prevention Care PREVCAR – *prevention of medical condition for an individual at high risk for developing them*
Progressive Muscle Relaxation MURELX – *facilitating the tensing & releasing of successive muscle groups while attending to the resulting differences in sensation*
Seizure Precautions SZRPRE – *prevention or minimization of potential injuries sustained by a patient with a known seizure disorder*
Sports-Injury Prevention: Youth SPORT – *reduce the risk of sports-related injury in young athletes*
Suicide Prevention PRESUI – *reducing risk of self-inflicted harm with intent to end life*
Surveillance: Safety SAFE – *purposeful & ongoing collection & analysis of information about the patient & the environment for use in promoting & maintaining patient safety*
Sustenance Support SUST – *helping a needy individual/family to locate food, clothing, or shelter*

Approved Nursing Documentation Abbreviations

Clear and accurate documentation is essential in any health record, including EHRs in the school setting. School nurses should use accepted nursing nomenclature and abbreviations. eSchool documentation codes are included in the Appendix. Medical abbreviations should be taken from a current edition of Taber's Cyclopedic Medical Dictionary or on-line (http://www.tabers.com/tabersonline/view/Tabers-Dictionary/767492/0/Medical_Abbreviations?q=Medical%20abbreviations&ti=0). There are a number of education acronyms and abbreviations that can also be used and are included in the table below.

adm	administrator	IZ	immunization
adv	advise	LD	learning disability
amt	amount	MDT	multidisciplinary team
AP	apical pulse	nrsg	nursing
appt	appointment	nsg	nursing
asst	assistance	occ	occasionally
BG	blood glucose	OHI	other health impaired
bilat	Bilateral	Para	paraprofessional (educational)
BR	bathroom	PE	Physical Education
CHO	carbohydrate	p/u	pick(ed) up
conf	conference	RTC (or rtc)	return to class
cont	continue	SBHC	School Based Health Center (Wellness Center)
demo	demonstrate	SN	school nurse
drsg	dressing	SW	social worker
EI	Early Intervention	TBRF	Tuberculosis Risk Assessment Form
EPSDT	Early & Periodic Screening and Diagnostic & Treatment Program	TC	telephone call
eval	Evaluation		
FERPA	Family Educational Rights & Privacy Act		
FMLA	Family & Medical Leave Act		
freq	frequency		
F/U	follow-up		
fx	fracture	@	At
GD	growth & development	=	Equals
HA	headache	>	Greater than
HCP	health care provider	<	Less than
HV	home visit	-	Minus
irreg	irregular	#	Number
IHP	Individualized Healthcare Plan	/	Per

Children's Services Cost Recovery Project (CSCRP)

Delaware public schools provide nursing services, which may be eligible for Medicaid reimbursement. Such services must be medically necessary and identified in the student's IEP. The school nurse should work with the CSCRP Specialist assigned to his/her school regarding reimbursement. The following chart describes billable services.

	Children's Services Cost Recovery Project (CSCRP) **EPSDT Nursing Service Description by Medicaid Reporting Number** **Nursing Service Description: Treatment**
1	Care of the Sick
2	Wound Care – First Aid
3	Wound Care – Ongoing
4	Collateral Contacts for Updating Medical Information: Community Agencies, Doctors, Staff, Family
5	Medications – Administration & Monitoring
6	Physician Prescribed Medical Treatments
7	Nursing Evaluation
8	Diabetic Care – Monitoring and/or Medication Administration
9	Cast Care
10	Personal Care, which is Medically Necessary and Requires Nurse Intervention
11	Naso-gastric Feedings – Bolus/Drip
12	Gastrostomy Feedings – Bolus/Drip
13	Change of Gastrostomy Tube
14	Catheterization
15	Feeding of Children with Oral Motor Deficits Speech Pathology/Occupational Therapy
16	Suctioning
17	Tracheal Suctioning
18	Tracheal Care – Decanulation
19	Tracheal Ventilation – Ambu Bag
20	Oxygen Administration
21	Nebulizing/Humidifying
22	Postural Drainage
23	Chest Percussion
24	Special Diet Consideration: Modification & Monitoring
N/A	Child was Medicaid Recipient, But Non-EPSDT Service or Nurse Judged Service not Medically Necessary
Number	**Nursing Service Description: Assessment**
A1	EPSDT Partial Assessment: Health Education
A2	EPSDT Partial Assessment: Immunization
A3	EPSDT Assessment: Hearing
A4	EPSDT Assessment: Vision
A5	EPSDT Partial Assessment: Developmental/Orthopedic
A6	EPSDT Assessment: Dental
Number	**Nursing Service Description: Counseling Therapy**
C1	Individual Counseling Treatment
C2	Group Counseling Treatment
C3	Family Counseling Treatment
C4	Individual Counseling Co-Treatment
C5	Group Counseling Co-Treatment
C6	Family Counseling Co-Treatment
C7	Case Consultation

Document #229

District/Charter Summary of School Health Services

The District/Charter Summary is often referred to as the "Annual Summary" or the "District Summary". It reports Health Services provided in public schools. The document must be received annually by the Department of Education per Regulation #811, School Health Record Keeping Requirements (http://regulations.delaware.gov/AdminCode/title14/800/811.shtml).

Data for this report is derived from documentation of health services provided by the school nurse. The Annual Summary form was changed in 2006 to reflect the fields represented within electronic student medical records used in Delaware public schools. Since that time, DOE has assisted in creating the reports by pulling data from eSchool Plus* (the statewide pupil accountability system that includes medical data). Each August, DOE Technology staff creates an initial Annual Summary for each district and charter. If the district/charter has more than one school, both individual school data and district summative data are created. Schools are asked to review the data for accuracy. When electronic documentation and the new Annual Summary were first introduced, school nurses made significant changes to the drafts as the school nurses were not documenting all activities into the electronic record. Today, the only changes to the report should be the inclusion of information on staff volunteer screenings as these are not included in eSchool. All other information is pulled from the EHR.

* FY16 Two districts (Colonial & Red Clay) use a different medical software program; however, the codes are standardized. DOE Technology does not create an initial Summary for these districts.

School Year____

Due Date: _____

Return electronic version (if not available in eSchool):
Linda C. Wolfe, RN
School Health Services

Justification:

The State Board shall prescribe rules and regulations governing the protection of health, physical welfare and physical inspection of public school children in the State. 14 Del Code 122(b)(2)

School or School District:

I. Clients	**Students**	**Staff**	**Visitors**	**Total**	**% Total Stud Population**	**% Total Staff Population**
B. Nurse Office Visits (minutes out of class)						
1. < 15 min.						
2. 16 - 30 min.						
3. 31 - 45 min.						
4. 46 - 60min.						
5. 60 - 120 min.						
6.> 120 min.						
7. Average time						
8. Total Visits (B1 - B6)						
C. Disposition: % after nurse intervention						
1. Returned to class/activity						
2. Sent to school staff (ex. principal, counselor)						
3. Sent to Wellness Center						
4. Sent home (nurse directed)						
5. Went home (parent directed)						
6. Exclusion for communicable disease						
7. Sent for immediate evaluation/treatment						
8. 911						
9. Not Seen						
10. Other						
D. Contacts/Communication/Notification re: client						
1. Parents/Guardian						
2. School						
3. Community						
II. Nursing Care: Assessment & Intervention	**Students**	**Staff**	**Visitors**	**Total**	**Outcome (Resolution/ Improvement)**	
A. Functional: *Care to promote basic health needs*						
1. Activity/Exercise					n/a	
2. Comfort/Rest					n/a	
3. Growth & Development/Nutrition					n/a	
4. Self-Care					n/a	
B. Physiological: *Care to promote optimal biophysical health*						
1. Physical Health & Well-Being						
a. Special Nursing Procedures					n/a	
b. First Aid/ Emergency Care					n/a	
c. Body Systems Support (ex. cardiac, resp., tissue)					n/a	

2. Pharmacological						
a. Medications						
b. Treatments						
c. Unduplicated Students receiving Rx/Tx						
C. Psychosocial: *Care to promote optimal emotional health and social functioning*						
1. Coping/Emotional Support					n/a	
2. Communication/Relationships					n/a	
3. Knowledge					n/a	
4. Behavior/Self-perception					n/a	
D. Environment: Care *to protect and promote health and safety*						
1. Health Care System					n/a	
2. Risk Management					n/a	
3. Individual Emergency Plan						
4. Individualized Healthcare Plan						
5. IEP/504 Plan						
E. Nursing Assessments/Interventions *unclassified*						
F. Non-Nursing Interventions						
G. TOTAL Interventions						
	Total	**Referred**	**Completed Referral**	**% Completed**		
H. Office Visits						
III. Health Screening	**Total Screened**	**Referred**	**Completed Referral**	**% Completed**	**Number Required***	**# Required Screened**
A. Required (Students)						
1. Hearing						
2. Immunization						
3. Postural/Gait						
4. Normal Exam						
5. Athletic Exam (DIAA)						
6. TB Questionnaire/Reading						
7. Vision						
8. Total Number of Required Screenings						
B. Non-Required (Students)						
1. Blood Pressure						
2. BMI						
3. Dental						
4. Developmental						
5. Pediculosis						
6. Record Review						
7. Other						
8. Total Number of Non-Required Screenings						
C. Total Student Screenings						
D. Staff						
1. BP						
2. TB Questionnaire/Reading						

3. Other						
4. Total Number						
E. Total Screenings (III. C + III. D.4)						

*Reg. 815.2.1.1 Each public school student in kindergarten and in grades 2,4, 7 and grades 9 or 10 shall receive a vision and a hearing screening by January 15th of each school year.

Date: _____ **Signature** _____