National Association of School Nurses

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Revised January 2018

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The School Nurse's Role in Behavioral Health of Students

Position Statement

National Association of School Nurses

SUMMARY

It is the position of the National Association of School Nurses (NASN) that registered, professional school nurses (hereinafter referred to as school nurses) serve a vital role in promoting positive behavioral health outcomes in students through evidence-based programs and curricula in schools and communities. Behavioral health is as critical to academic success as physical well-being. As members of interdisciplinary teams, school nurses collaborate with school personnel, community healthcare professionals, students, and families in the assessment, identification, intervention, referral, and follow-up of children in need of behavioral health services. School nurses, because of their regular access to students, are uniquely qualified to identify students with potential behavioral health concerns. School nurses can serve as advocates, facilitators, and counselors of behavioral health services within the school environment and in the community.

BACKGROUND

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines behavioral health as "mental/emotional well-being and/or actions that affect wellness" (SAMHSA, 2017a). SAMHSA also states that behavioral health includes the "service systems that encompass prevention and promotion of emotional health; prevention of mental and substance use disorders, substance use, and related problems; treatments and services for mental and substance use disorders; and recovery support" (SAMHSA, 2017a). Behavioral health and wellness occur across a continuum. Schools and school nurses have an essential role in addressing behavioral health disorders, promoting mental wellness and social-emotional competencies, enhancing protective factors, and referring to and collaborating with behavioral health support networks when appropriate.

Behavioral health disorders that school-age children commonly experience include, but are not limited to, attention deficit hyperactivity disorders, mood disorders, depression, bipolar disorders, conduct disorders, anxiety disorders, panic disorders, eating disorders, psychotic disorders, and substance use disorders. Behavioral health disorders affect a significant number of America's school-age children. According to the Centers for Disease Control and Prevention (CDC), 13% to 20% of children living in the United States experience a mental disorder in a given year, and surveillance from 1994 to 2011 indicated increasing prevalence over time (CDC, 2013). In 2014, approximately 5% of adolescents ages 12-17 in the U.S. had a substance use disorder (SAMHSA, 2017b).

The (CDC) 2015 Youth Risk Behavior Survey found that 17.7% of high-school students had seriously considered attempting suicide in the past twelve months; 14.6% had made plans to do so; and 8.6% had made one or more attempts to do so (Kahn et al., 2016). Suicide is the second leading cause of death in adolescents (Banspach et al., 2016). Data from the Youth Risk Behavior Survey also indicates that 21.7% of students were offered, sold, or given an illegal drug on school property in the past year; and 17.7% of students consumed five or more servings of alcohol in a row in the past 30 days (CDC, 2015). In addition, adverse childhood experiences (ACEs), including physical, emotional and sexual abuse and other potentially traumatic experiences, are common among youth and are related to increased risk for lasting negative effects on physical and mental health (CDC, 2015). The CDC Behavioral Risk Factor Surveillance System Survey ACE Data, 2009-2014, indicates that approximately 66% of adults surveyed report experiencing at least one ACE; and more than 20% reported experiencing three or more ACEs. An

increased risk for long term health and mental health problems was noted as the total number of ACEs experienced increased (CDC, 2015).

Behavioral health disorders result in significant psychosocial and economic costs not only for the young people who experience them but also for their families, schools, and communities (Mental Health America, 2016). Childhood mental health and substance use disorders not only result in poorer school outcomes but also often persist into adulthood. These disorders are associated with multiple risk factors throughout one's lifespan such as reduced employment opportunities, adverse health conditions, earlier mortality, and financial burden (Bitsko et al., 2016).

The American Academy of Pediatrics estimates that only 10% to 40% of students needing behavioral health services receive them (AAP, 2016; SAMHSA, 2012). Barriers to treatment include the stigma associated with mental illness, families not recognizing the signs of mental illness, and families not knowing where to go to seek help (Bowers, Manion, Papadopoulos, & Gauvreau, 2012). Additional barriers include inadequate funding at the state and federal level, lack of insurance or limited coverage for behavioral healthcare services, and a shortage of child behavioral health providers, which lead to long wait times for treatment and/or families having to travel long distances for care (AAP, 2017).

The AAP Council on School Health (2013) recommends screening for mental health disorders and early intervention of at-risk students and families. The AAP (2013) noted that meeting the child's needs for mental health services and nurturing positive coping strategies early are critical for normal development and can significantly influence the child's ability to become socially adept and academically successful.

RATIONALE

School nurses are in a unique position to play an active role in mental wellness promotion, mental health screening, and early intervention programs and to assist in managing the ongoing treatment of mental health and substance use disorders in the school setting. The CDC notes that schools are one of the most efficient systems for reaching children and youth to provide health services and programs, as approximately 95% of U.S. children and youth attend school (CDC, 2014). School nurses are educated to identify somatic complaints and co-occurring behavioral health concerns (Shannon, Bergren & Matthews, 2010). Thus, school nurses are often a student's first point of entry into behavioral health services. School nurses are also part of the normal school experience and are easily accessible to students seeking assistance with behavioral health issues. Visiting the school nurse may be viewed as less stigmatizing for students than seeking a school behavioral health provider (Pryjmachuk, Graham, Haddad, & Tyler, 2011). It has been reported that school nurses spend approximately one third of their time providing mental health services (Bobo & Shubert, 2013).

As integral members of school behavioral health service teams, school nurses:

- Work on the front lines and are familiar with and educated to recognize warning signs such as changes in school performance, mood changes, complaints of illness before or during the school day, problems at home, self-harm, and suicidality (Zupp, 2013; American School Counselor Association [ASCA], 2015).
- Adhere to appropriate guidelines regarding confidentiality (ASCA, 2015).
- Promote student success by developing and implementing Section 504 plans, the health portion of the Special Education Individual Education Program (IEP), and the Individualized Healthcare Plan (IHP). Using these tools, the school nurse can assist in the re-entry of students into the school environment following

homebound instruction or hospitalization and serve as a care coordinator among community behavioral health and primary care providers, the family, and school personnel.

- Provide behavioral health screening and basic behavioral health skills that include education about mental health and substance use disorders, psychotropic medication information, and cognitive behavioral skills.

- Recognize care coordination as a critical component of comprehensive behavioral health services, and regularly make referrals and connect parents and children with school and community behavioral health resources (NASN, 2015). School nurses' regular contact with students allows them to provide ongoing assessment, monitor treatment compliance, and provide timely feedback to families, physicians and mental health professionals regarding a student's response to treatment, thus allowing for better medical management of behavioral health conditions and health outcomes (AAP, 2016; Bobo & Shubert, 2013).

- Regularly provide educational programming to teachers, administrators, parents and guardians, and students about behavioral health concerns, and assist with crisis intervention planning.

CONCLUSION

School nurses recognize that positive behavioral health is essential for academic success. School nurses are critical to the school mental health team in that they can help address and reduce the stigma of a behavioral health diagnosis, decrease fragmentation of care, and remove barriers to behavioral health services. School nurses, because of their regular access to students and their experience with care coordination, are also uniquely equipped to assist school and community-based behavioral health professionals in providing services including prevention, assessment, early identification/intervention, and treatment of mental illness and substance use disorders.

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Bullying Prevention in Schools

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (hereinafter referred to as school nurse) is a crucial member of the team participating in the prevention of bullying in schools. School nurses are the experts in pediatric health in schools and, therefore, can have an impact on the health and safety of all students including students who bully; students who are bullied; or students who both bully and are bullied by others (Centers for Disease Control and Prevention [CDC], 2011a, 2011b). The school nurse role includes the prevention of bullying and the identification of students who are bullied, bully others, or both. The school nurse has a significant leadership role in the implementation of bullying prevention policies and strategies.

BACKGROUND

Bullying is identified by the Centers of Disease Control and Prevention as a form of youth violence (CDC, 2011b). The 2011 Youth Risk Behavior Surveillance System indicates that nationwide 20% of students in grades 9-12 experienced bullying (CDC, 2011b). Bullying is most often defined as an attack with an intended purpose of causing physical, verbal, or emotional harm. It includes an imbalance of power between the bully and the victim and involves repeated acts over time (CDC, 2011a, 2011b; Dressler-Hawkes & Whitehead, 2009; Liu & Graves, 2011). Liu and Graves (2011) describe bullying as aggressive behavior, not a diagnosis. Children with physical, developmental, intellectual, emotional, and sensory disabilities are more likely to be bullied than their peers (U.S. Department of Health and Human Services [USDHHS], 2013). Any number of factors including physical vulnerability, social skill challenges, gender identification, or intolerant environments may increase a student's risk to be bullied at school. Research suggests that some children with disabilities may bully others as well (USDHHS, 2013).

Bullying is the most common type of aggression and victimization experienced by school-age children (O'Brennan, Bradshaw, & Sawyer, 2009). Bullying occurs at all age levels but starts to increase in late elementary school, peaks in middle school, and generally decreases in high school. Bullying affects both boys and girls. Boys are more often involved in physical aggression (Liu & Graves, 2011). Gendron, Williams, and Guerra (2010) found girls were more often involved with social distancing or indirect forms of bullying including false rumors, insults, and exclusion. The increase in psychological bullying using technology has involved both boys and girls (CDC, 2011b).

Cyberbullying involves the use of electronic devices including instant messaging, e-mail, chats, websites, online games, social networking, and text messages (Kowalski & Limber, 2013). Kowalski and Limber (2013) note that there are similarities and differences between traditional bullying and cyberbullying; however, the differences are significant enough to define cyberbullying as a unique form of bullying. Some students may perpetuate or be the subject of both traditional bullying and cyberbullying. For some students cyberbullying may provide a venue for bullying that they would never say or do in person.

Bullying is a persistent public health concern that has a significant impact in the school setting (USDHHS, 2013). However, until the past decade, bullying was often dismissed as normative and without long-term effects (Gendron et al., 2010). Research has led to a better understanding of the serious, often long-term, consequences of bullying. Society's shifting perspectives on bullying have been driven by high-profile cases that have resulted in accidental death or suicide. With the growing concern in the U.S. and throughout the world regarding school violence, researchers, educators, and healthcare providers have found that bullying affects students' social-emotional health and has implications for school safety. Therefore, schools and public health officials are looking to understand why children bully and are seeking to develop effective strategies to reduce or eliminate risk factors (CDC, 2011a, 2011b).

Bullying can have serious and often long-term consequences for both the student who bullies and the student who is bullied including increased school absenteeism, diminished educational achievement, behavior issues, low self-esteem, sleep deprivation, depression, anxiety, and self-harm (Dressler-Hawkes & Whitehead, 2009). Bullied students are also at risk for physical symptoms including stomach pain, sleep disturbances, headaches, tension, bedwetting, fatigue, and decreased appetite (Kowalski & Limber, 2013). The consequences of bullying can continue into adulthood (Copeland, Wolke, Angold, & Costello, 2013). Boys who are frequently bullied have been found to suffer more often from anxiety disorders, agoraphobia, and panic disorders in adulthood (Copeland et al., 2013).

Any student can be bullied at school, particularly students with disabilities (USDHH, 2013) and other vulnerable populations such as students with academic difficulties, and speech impairments (Redmond, 2011). Students may be bullied based on their physical appearance such as glasses, hair color, and weight (Perron, 2013). Lesbian, gay, bisexual and transgender (LGBT) students are more likely to be subjected to all types of bullying (Wang & Iannotti, 2012). School nurses can advocate for students with disabilities in school by educating students and staff, advocating for student support, promoting equal access to education in the least restrictive environment, and advocating for student support in IEP and Section 504 plans (CDC, 2011b). At present, no federal law directly addresses bullying. In some cases bullying overlaps with discriminatory harassment when it is based on race, national origin, color, sex, age, disability, or religion. When bullying and harassment overlap, federally funded schools have an obligation to resolve the harassment. When the situation is not adequately resolved, the U.S. Department of Education's Office for Civil Rights and the U.S. Department of Justice's Civil Rights Division may be able to help (USDHHS, 2013).

Students who bully are also at risk for both health and academic problems (Kowalski & Limber, 2013). In an analysis of Youth Risk Behavior Survey data, the CDC found that middle school students who bully were more likely to report recent use of alcohol and drugs (CDC, 2011a). Students who reported that they participated in bullying also reported higher incidents of violent family encounters.

Students who both bully and are bullied were at the highest risk for negative outcomes (CDC, 2011a, 2011b). Students in middle and high school who both bully and are bullied reported the highest frequency for considering suicide, being physically hurt by a family member, harming themselves, witnessing family violence, feeling sad or hopeless, and needing to talk to someone other than a family member about feelings or problems (CDC, 2011a).

RATIONALE

Bullying can have serious health, physical, and psychological effects on the student who bullies; the student who is bullied; or the student who both bullies and is bullied. Bullying is not an isolated incident but occurs repeatedly over time. Therefore, the school nurse should:

- Be knowledgeable about bullying, aggression and victimization;
- Be aware of the importance of not labeling their students as "bullies" or "victims";
- Be knowledgeable about the long-term consequences to the student who bullies, the student who is bullied, and the student who both bullies and is bullied;
- Provide leadership to bring together students, school personnel and families to implement bullying prevention strategies in the school environment and in the community;
- Participate as a key member of the school team that identifies students who bully, students who are bullied, and students who both bully and are bullied;
- Share information and observations and alert the team to signals that may identify students at risk;
- Facilitate access to school health services for students with nonspecific or somatic complaints;
- Assess students with frequent unexplained somatic complaints explicitly for bullying and stress;
- Identify concerns and work with the school team to intervene and mitigate a bullying situation;

- Create a safe space in the school health office where students can verbalize concerns about all health issues including bullying and other incidents of violence (Selekman, Pelt, Garnier & Baker, 2013);
- Foster school connectedness and personal connections with students during health encounters (Dressler-Hawke & Whitehead, 2009);
- Promote school activities that would foster home and community connectedness to reduce bullying (Haeseler, 2010);
- Educate parents, staff, and community members about the dangers of violence and aggressive behavior in children (Liu & Graves, 2011); and
- Influence policy at the local, state, and national level to advocate for students (Dressler-Hawkes & Whitehead, 2009).

CONCLUSION

Bullying can have severe short- and long-term negative social and emotional effects on the student who bullys; the student who is bullied; and the student who both bullies and is bullied. Therefore, it is important for school nurses, as the experts in pediatric health, to be knowledgeable about the impact of bullying. The school nurse can support evidence-based interventions to prevent and mitigate bullying in the school. The school nurse is a key leader to promote and enhance student safety, wellness, engagement, and learning.

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Care of Victims of Child Maltreatment:
The School Nurse's Role

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that prevention, early recognition, intervention and treatment of child maltreatment are critical to the physical well-being and academic success of students. Registered professional school nurses (hereinafter referred to as school nurses) serve a vital role in the recognition of early signs of child maltreatment, assessment, identification, intervention, reporting, referral and follow-up of children in need. School nurses are uniquely qualified to participate as members of interdisciplinary teams to collaborate with school personnel, community healthcare professionals, students and families.

BACKGROUND

The Child Abuse and Prevention and Treatment Act (CAPTA), originally passed in 1974 and amended by the CAPTA Reauthorization Act of 2010, defines child maltreatment as the following:

> "Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm" (CAPTA, 2010, p. 6).

A *child* is defined as a person who has yet to reach the age of 18 years and who is not an emancipated minor. It is important to understand that there are many exceptions and varying definitions made by individual state laws (Child Welfare Information Gateway, n.d.). All 50 states, the District of Columbia, and the U.S. territories have mandatory child maltreatment reporting laws that require certain professionals and institutions to report suspected maltreatment to a Child Protective Services agency (United States Department of Health and Human Services [USDHHS], 2010).

School nurses, teachers, and other school staff are legally required to report suspected child maltreatment (Child Welfare Information Gateway, 2012).

In 2010, Child Protective Services received approximately 3.3 million reports of suspected child maltreatment, and it was estimated that 1560 children died as the result of child maltreatment (CDC, 2012). CAPTA identified the incidence of four types of child abuse:

- 78% of cases involved neglect;
- 18% involved physical abuse;
- 9% involved sexual abuse; and
- 8% of victims suffered emotional abuse.

The psychological and academic impact of child maltreatment can be devastating and create life-long challenges. Children who have been victims of maltreatment exhibit high levels of risk taking and have impaired decision-making skills (Weller & Fisher, 2013). Children who suffered maltreatment were found to have significantly lower cognitive abilities and academic achievement (DeBellis, Wolley, & Hooper, 2013).

The lifetime economic burden of child maltreatment based on the substantiated non-fatal child maltreatment cases and the fatal cases of child maltreatment is estimated to be 124 billion dollars that includes significant costs

for health and medical care, productivity losses, child welfare, criminal justice, and special education services (Fang, Brown, Florence, & Mercy, 2012).

RATIONALE

School personnel are often the first to become aware that a child may be a victim of maltreatment and is struggling because of adverse events occurring in his or her life. The Adverse Childhood Experiences Study (ACE) identified 17 long-term health issues that were the result of childhood abuse or neglect. These health issues were clustered by the number of adverse experiences a person identified. There is a direct correlation between the number of adverse events experienced by a victim of child maltreatment and the number of long term health issues they experience (CDC, 2010). Child maltreatment increases the childhood risk of diabetes, obesity, grade repetition, and engagement in risk-taking behaviors (USDHHS, 2010). The effect of violence alone on a child increased the risk of appetite problems by 28%, headaches by 57%, sleep problems by 94%, and stomachaches by 174% (Shannon, Bergren, & Matthews, 2010). Childhood maltreatment has been linked to long-term risk for depression (Nanni, Uher, & Danese, 2011), chronic fatigue syndrome (Fuller-Thomsen, Sulman, Grennenstuhl, & Merchant, 2011), higher rates of mental health problems (Burke, Hellman, Scott, Weems, & Carrion, 2011) increased tendencies toward youth violence and intimate partner violence (USDHHS, 2010) and increased risk of psychiatric disorders (Chen et al., 2010). These long-term effects of child maltreatment influence individual health, academic achievement and the healthcare system as a whole (DeBellis et al., 2013).

Early identification and intervention is crucial in promoting recovery and preventing further victimization. Therefore, it is vital that school personnel receive training to recognize the signs of maltreatment and report accordingly. The school nurse is a leader in educating school personnel about recognition of child maltreatment. Signs that indicate child maltreatment may include child reports of maltreatment, sudden behavior changes, lack of medical referral follow-through, learning problems that have no known etiology, child responses that are consistently guarded and/or overly compliant, and child's avoidance of home or certain individuals. Child maltreatment may present in a variety of ways (Child Welfare Information Gateway, 2013):

- Physical Abuse – non-accidental physical injury whose presentation and explanation are inconsistent with assessment data;
- Neglect – failure to provide for child's physical, medical, educational or emotional basic needs, abandonment;
- Sexual Abuse – children who have sexual knowledge that is not commensurate with their age, sexualized behavior not developmentally appropriate for child's age;
- Emotional Abuse – witness to maltreatment of other individuals, actions that are persistently demeaning of a child's self-esteem; and
- Substance Abuse – prenatal exposure to illicit substances, young children who have access to and/or speak the language of illegal drugs or alcohol, children exposed to the toxic and extremely dangerous process of methamphetamine manufacture.

School nurses are involved in prevention, early identification, reporting, and treatment related to child maltreatment because of their opportunity to interact with children on a daily basis. The role of the school nurse is to report suspicion of abuse; the role of Child Protective Services is to investigate the suspicion. School nurses are accountable and responsible to do the following:

- Know local laws, regulations, policies and procedures for the process of reporting child maltreatment;
- Provide for personal body safety education to students and advocate for school health education policies that include personal body safety;
- Educate and support staff regarding the signs and symptoms of child maltreatment;
- Identify students with frequent somatic complaints which may be indicators of maltreatment;
- Support the victims of child maltreatment;
- Link victims and families to community resources, including a medical home (Health Resources and

Services Administration [HRSA], 2013); and

- Collaborate with community organizations to raise awareness and reduce incidence.

CONCLUSION

School nurses are uniquely positioned to advance the academic achievement of students by protecting their health and safety. Prevention, early recognition, and treatment of child maltreatment are critical to the physical/emotional well-being of students and, therefore, their academic success. Additionally, school nurses serve as a resource to faculty and staff in the recognition and reporting of child maltreatment.

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Child Mortality in the School Setting

Position Statement

NASN
National Association of School Nurses

SUMMARY

It is the position of the National Association of School Nurses (NASN) that data on children's deaths in school should be recorded, analyzed and reported at the local, state and national levels. The systematic review of data on child mortality is necessary to drive interventions and policies that will decrease mortality from injuries, violence, acute illness and chronic disease in the school setting (Bergren, 2010; Christian & Sege, 2010).

BACKGROUND

Schools are not immune from the threat of fatal injury or death of school-age children. Schools today provide care for an increasing number of chronically and acutely ill children. Medically fragile children in schools require ventilators, tube feedings, medication, and other complex nursing care procedures (Allen, Henselman, Laird, Quinones, & Reutzel, 2012; Bergren, 2011; Centers for Disease Control and Prevention [CDC], 2015; National Association of State Chronic Disease Directors [NACDD], 2016; Perrin, Anderson, & VanCleave, 2014). Chronic conditions may put students at higher risk for unexpected death. In 2015, 8.4% of children were identified as having had asthma (CDC, 2016a). Diabetes is one of the most common chronic diseases in children and adolescents, affecting 167,000 children in 2009 (CDC, 2016b). Ten percent of children over 6 years of age are allergic to peanuts, potentially at risk for life threatening anaphylaxis (Liu et al., 2010). Epilepsy primarily affects children who also bear the burden of its most catastrophic forms (Institute of Medicine [IOM], 2012). Overall, 15% to 18% of children and adolescents have a chronic health condition (Perrin, Bloom, & Gortmaker, 2007). School children are at risk of injuries in classrooms, gyms, playgrounds and playing fields. Drug and alcohol overdoses, suicide, violence and homicide can also occur at school (American Academy of Child and Adolescent Psychology [AACAP], 2013).

There is a dearth of data surrounding the health of the 50.4 million students who attend school every day (Kena et al., 2016). While voluminous amounts of data on children are reported in various national health data bases in hospitals, clinics and primary care offices, data is not collected or analyzed on a national level about the intensity or quality of health care that is delivered in school every day (Patrick et al., 2014).

The lack of data on students' health also extends to a corresponding lack of data on students' deaths. In the United States, deaths of employees that occur at work are monitored and investigated by the Occupational Health and Safety Administration (OSHA). OSHA can specify that exactly 4,836 United States workers died on the job in 2015 (Bureau of Labor Statistics, 2016). However, the number of children who die at school or who die following an adverse event at school is often known only from anecdotal or newspaper accounts limiting the ability to understand causes or identify preventative measures (Malone & Bergren, 2010). Only half of all states review child death from all causes (Christian & Sege, 2010). Forty-three states participate in the National Center for Fatality Data Review and Prevention (NCFRP, 2016); but, despite asking if school was the location of the death, not all data elements are submitted by all states A few states, including North Carolina and Massachusetts, collect and publish public data on chronic and acute health conditions of students in public schools (Massachusetts Department of Public Health, 2013; North Carolina Healthy Schools, 2016; Selekman, Wolfe, & Cole,

2016). However, many states do not collect that data, and no national repository exists on child deaths at school nor on whether they are accidental or due to disease or violence.

RATIONALE

Preventable child mortality is classified as a "never event" (Agency for Health Research and Quality [AHRQ], 2013). A never event is a rare, devastating, preventable adverse event (National Quality Forum [NQF], 2011). While there are widespread initiatives to eliminate devastating "never events" in healthcare settings, there is not a similar broad effort to address dire outcomes in the school setting. The systematic review of child mortality in schools would drive population level data analysis and interventions for a safer school environment for all children. The increasing number and complexity of students with serious health conditions require vigilance to prevent those conditions from exacerbating and to reduce preventable child fatalities. Registered professional school nurses need to advocate for the collection and analysis of student health data at the local level and for the reporting and aggregation of student health data at the state and national level in order to inform and advise health and education policy makers (Bergren et al., 2016; Christian & Sege, 2010; Johnson, Bergren, & Westbrook, 2012).

CONCLUSION

Just as there are federal laws to monitor deaths in the workplace, there needs to be a parallel federal system for child deaths at school. Registered professional school nurses should accept opportunities to serve on state and national child fatality review committees to provide input into policies that protect children at school and in the community.

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Students with Chronic Health Conditions: The Role of the School Nurse

National Association of School Nurses

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that to optimize student health, safety, and learning, a professional registered school nurse (hereinafter referred to as school nurse) be present all day, every day. The American Academy of Pediatrics' Council on School Health (2016) highlights the important role school nurses play across a child's continuum of care and recommends that every school should have at least one nurse. The Every Student Succeeds Act (2015) identifies school nurses as leaders of student chronic disease management in schools. Utilizing the nursing process, the school nurse manages chronic health conditions in the school setting by providing direct care, providing case management, and advocating for students and families to help them access needed resources and support to achieve academic success (CDC, 2017b).

BACKGROUND

Chronic health conditions include acquired, incurable diseases and other illnesses lasting more than 12 months (U.S. Department of Health and Human Services, 2011). These conditions include long-term physical, emotional, behavioral, functional and developmental disorders that occur along a continuum from mild to severely disabling (McClanahan & Weismuller, 2015). It is estimated that one in four students in United States schools may have a chronic health condition (Jackson, Vann, Kotch, Pahel, & Lee, 2011; Van Cleave, Gortmaker, & Perrin, 2010). Approximately 6% of those students have multiple chronic conditions leading to challenges with treatment adherence, disease acceptance, lifestyle modification, care coordination, increased exposure to chronic condition risk factors, and difficulties transitioning to adult healthcare settings (Anderson, 2010; Rezaee & Pollock, 2015). Children with chronic conditions are at risk for high absentee rates, low student engagement, dropping-out of school, exposure to bullying, disruptive behaviors, poor grades, and below-average performance on standardized achievement tests (Forrest, Bevans, Riley, Crespo, & Louis, 2011; Bethell et al., 2012). As life expectancy for students with chronic conditions increases, the complexity of the healthcare and educational service needs of students also increases (Martin & Osterman, 2013).

School nurses are responsible for informing educational communities about the impact of the chronic health condition(s) on students' abilities to engage in their education. These students' rights of participation and access to school healthcare services are protected by the Rehabilitation Act, Section 504 (1973) and the Individuals with Disabilities Education Improvement Act [IDEIA](2004). It is the responsibility of local school districts to educate students with chronic conditions in the least restrictive environment. The school nurse collaborates with education staff to promote a safe and accommodating school environment for children with chronic health conditions (American Nurses Association & National Association of School Nurses [NASN], 2017; Brook, Hiltz, Kopplin, & Lindeke, 2015).

RATIONALE

The special needs of students with chronic health conditions are complex and continuous. The school nurse has a pivotal role in:

- interpreting a student's health status;
- explaining the health impairment to the school team;
- translating the healthcare provider orders into the school setting by developing Individualized Healthcare Plans;
- providing assessment, direct care, coordination and evaluation of care;
- providing nursing delegation that aligns with state nurse practice acts, rules and regulations; and
- advocating for appropriate accommodations in the educational setting (Leroy, Wallin, & Lee, 2017; McClanahan & Weismuller, 2015; NASN, 2015; Zirkel, Granthom, & Lovato, 2012).

The services of a school nurse support readiness to learn, classroom participation, and academic progress (ANA & NASN, 2017; Bethell et al., 2012; NASN, 2015). Bethell et al., 2012; NASN, 2015). The Whole School, Whole Community, Whole Child Model (WSCC) (ASCD and Centers for Disease Control and Prevention [CDC], 2014) reminds schools and communities that the child, at the center of educational systems, must be healthy, safe, engaged, supported and challenged. The school nurse works to support the constructs of WSCC by coordinating intervention and evaluation services, identifying previously unrecognized symptom patterns and student responses to those patterns, and referring students to the appropriate resources (CDC, 2017a). By assisting students with the management of their chronic conditions, the school nurse contributes to risk reduction, increased classroom seat time, decreased student absenteeism, improved academic success, and cost savings to families and educational and healthcare systems (Forbes, 2014; NASN, 2015; Wang et al., 2014, Michael, Merlo, Basch, Wentzel, & Wechsler, 2015). School nurses decrease chronic absenteeism by assisting families to access health care; by providing condition-related education to parents, students and staff; and by coordinating care between school, family and medical home (Jacobsen, Meeder, & Voskuil, 2016).

School nursing services result in improved health outcomes for students with chronic health conditions (Leroy et al., 2017). The school nurse, working within the constructs of the Framework for 21st Century School Nursing Practice (NASN, 2015) plays a decisive role in mitigating the long-term impact of chronic health conditions on children by coordinating the interests of families, education, healthcare systems, public health, insurance, and community agencies (McClanahan & Weismuller, 2015; Wolfe, 2013). Healthcare providers can utilize the power of school nurses to maintain the health of students who have chronic conditions at the highest level; decrease healthcare costs, unnecessary use of emergency rooms, and hospitalizations; and increase quality of care (Wang et al., 2014). The school nurse collaborates with transition planning teams to facilitate seamless movement of the student through the educational and healthcare settings (Bargeron, Contri, Gibbons, Ruch-Ross, & Sanabria, 2015; NASN, 2014). School nurse care coordination between "schools, parents and health-care providers assists students with chronic health conditions...to optimize health and learning" (Miller, Coffield, Leroy & Wallin, 2016, p. 362). Considering the positive impact school nurses have on health and academic outcomes of students with chronic conditions, school systems should develop processes to include school nurses at the outset of student enrollment and in special education individual education planning.

CONCLUSION

It is the position of NASN that to optimize student health, safety, and learning, a school nurse be present all day, every day. The school nurse is part of a comprehensive healthcare and education system. The school nurse is well positioned to support the health and academic success of students with chronic health conditions by providing

direct care and facilitating the many practice components of care coordination (Bargeron et al., 2015; Brook et al., 2015; NASN 2015). School nurse advocacy helps students and families to access needed resources in support of academic achievement (CDC, 2017). School nurses are leaders who provide care coordination, health education and promotion, quality improvement, and critical thinking skills that benefit schools, families, the healthcare system, and most importantly children with chronic health conditions.

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Concussions – The Role of the School Nurse

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (hereinafter referred to as school nurse) is an essential member of the school health team to address student concussions. The school nurse has the knowledge and skills to provide concussion prevention education to parents/guardians, students, and school staff; identify suspected concussions; and help guide the student's post-concussion graduated academic and activity re-entry process.

BACKGROUND

Concussions are considered a type of traumatic brain injury (TBI). The potential for the occurrence of concussions in children is greatest during activities where collisions can occur, such as during physical education class, playground time, or school-sponsored sports activities (Centers for Disease Control and Prevention [CDC], 2015a).

In 2010, TBI related injuries, either alone or in combination with other injuries, resulted in about 2.5 million emergency department (ED) visits, hospital visits, or deaths in the United States (CDC, 2015b). In 2009, an estimated 248,418 children (age 19 or younger) were treated in U.S. EDs for sports and recreation-related injuries that included a diagnosis of concussion or TBI (CDC, 2011). From 2001 to 2009, the rate of ED visits for sports-related injuries rose 57% among children (age 19 or younger) (CDC, 2015b) While falls are the most common cause of concussions in children, between 2001-2009 emergency room visits for sports-related TBI diagnosis increased by 57% in school-age children (CDC, 2011). The actual incidence of concussions may be higher than is currently reported due to underreporting (Register-Mihalik et al., 2013a). In one study, researchers indicated that over 50% of concussions in high school football players go unreported with the two most common reasons being players do not consider their injury as serious enough and they do not want to be removed from the play (Register-Mihalik et al., 2013b.)

Recognition of a concussion and immediate assessment is critical in preventing further injury and for post-concussion management. Any force or blow to the head and/or symptoms of a concussion in a student or athlete should be immediately evaluated by either the school nurse or designated trained school personnel. Several concussion management guidelines are available; CDC's *Heads Up Campaign for Concussion Prevention and Management* (2015c) and the Rocky Mountain Hospital for Children *REAP Concussion Management Program* (Rocky Mountain Hospital, n.d.) are examples of evidence-based resources available for the school nurse.

Research has demonstrated that recovery for the school-age student generally occurs within three weeks from the injury, but school adjustments during this recovery period may be necessary (Halstead et al., 2013). However, for some, symptoms may last for months or longer and can lead to short- and long- term problems affecting how a young person thinks, acts, learns, and feels (CDC, 2015d). Although a concussion can have obvious direct effects on learning, there is also increasing evidence that using a concussed brain to learn may worsen concussion symptoms and perhaps even prolong recovery (Halstead et al., 2013).

During this recovery phase, the student may have an array of physical, mental, and emotional symptoms, which can affect the student in the school setting. Children with diagnosed concussions require cognitive rest and a graduated re-entry plan to pre-concussion activities, as determined by the healthcare provider (Brown et al., 2014). In addition, students are at a risk for increased emotional symptoms following a concussion, especially if concussion was associated with assault or bullying incident (Halstead et al., 2013). Recognizing the potential for

these emotional symptoms in recovering students, the school nurse can provide encouragement and information for the students, parents, and school staff.

RATIONALE

It is imperative that appropriate preventative guidelines and post-concussion accommodations are followed at school. The school nurse advocates for the prevention of concussions by educating families and school staff about the risks for concussion, adverse outcomes when a concussion occurs, and the importance of creating a safe school environment. According to the National Council of State Legislatures (NCSL), since 2007, all 50 states have enacted legislation to address youth sports-related concussions (NCIL, 2015). School nurses are identified as key stakeholders in policy development and implementation because of their unique position to be a liaison between the health and education communities (CDC, 2015b; Braine, 2013).

It is essential that school nurses are made aware when a student sustains a concussion (Weber, Parsons, & McLeon, 2015). Educating parents, teachers, coaches, and students about concussion is key as not all concussions are reported. If a student is not acting normally, referral should be made to the school nurse. Proper management of a student with a suspected concussion includes assessment for symptoms, notification to parents/guardians, referral to a healthcare professional if symptoms are noted, and -- if no symptoms are present -- instructions to parents/guardians and school staff for continued observation (CDC, 2015b).

As a student returns to school after a concussion, the school nurse works in collaboration with the healthcare provider, athletic trainer, and other school staff to support the return-to-learn process (Weber, Parsons, & McLeon, 2015; Hossler, McAvoy, Rossen, Schoessler, & Thompson, 2014). The school nurse can provide on-going monitoring of post-concussion symptoms and act as a liaison with the student's healthcare team. For students who have persistent symptoms, the school nurse develops an individualized healthcare plan based on healthcare provider orders. If it is determined Section 504 plan is needed, the school nurse contributes to the development of plan to provide accommodations such as allowing rest during the school day, postponing testing until symptom-free, pacing (or modifying) homework or assignments, limiting screen time including use of electronics (smart boards, chrome books, etc.) in classrooms, and/or limiting physical school activities (Halstead et al., 2013).

CONCLUSION

The school nurse is in a pivotal position to implement evidence-based concussion prevention and management protocols at school. The school nurse identifies students with possible concussion, makes appropriate referrals, and assists students and families through the school and activity re-entry process. The school nurse collaborates with the team of stakeholders including healthcare providers, school staff, athletic trainers, parents and students to ensure that the physical and psychosocial needs of the students are met. School nurses provide support for the prevention of concussions by advocating for safe environments and education of students, parents/guardians and staff on concussions.

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Nursing Delegation to

Unlicensed Assistive Personnel in the School Setting

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that the delegation of nursing tasks in the school setting can be a valuable tool for the registered professional school nurse (hereinafter referred to as school nurse), when based on the nursing definition of delegation (American Nurses Association [ANA], 2012) and in compliance with state nursing laws and/or regulations and guidance. Delegation *may* occur when the school nurse determines it is appropriate, but such delegation *may not* be appropriate for all students or all school nurse practice settings. The legal parameters for nursing delegation are defined by state laws that regulate nursing, State Board of Nursing guidelines, and Nursing Administrative Rules/Regulations (ANA, 2012; American Academy of Pediatrics [AAP], 2009).

BACKGROUND

Advances in healthcare and technology enable children with increasingly complex medical needs to be a part of the general school population. The incidence of chronic conditions such as asthma, diabetes, severe allergies, and seizure disorders in school-age children is increasing; and complex medical conditions that were previously handled in acute care settings are now being managed in the school setting, requiring school nurses to make care decisions that may include delegation where appropriate (Van Cleave, Gortmaker, & Perrin, 2010; Federal Interagency Forum on Child and Family Statistics, 2013).

Federal laws set requirements for the provision of healthcare to children in schools. For example, the Individuals with Disabilities Education Act (IDEA), Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act (ADA) of 1990, include requirements to ensure that children with special healthcare needs have the right to be educated with their peers in the least restrictive environment (U.S. Department of Health and Human Services [USDHHS], 2006) and to receive support and accommodations for conditions that adversely affect their capacities for learning (Gelfman, 2005). School nurses use their expert assessment skills to appropriately delegate health-related tasks and address the specific healthcare needs of students, enabling access to a free appropriate public education (Resha, 2010).

The ANA defines nursing delegation as *transferring the responsibility of performing a nursing activity to another person while retaining accountability for the outcome* (ANA & the National Council of State Boards of Nursing [NCSBN], 2006). Nurses are accountable to: (1) state laws, rules, and regulations; (2) employer policies and procedures/agency regulations, and (3) standards of professional school nursing practice, including those pertaining to delegation. The decision to delegate is a serious responsibility that the school nurse determines on a case-by-case basis based on the needs and condition of the student, stability and acuity of the student's condition, potential for harm, complexity of the task, and predictability of the outcome (ANA, 2012). Prior to delegation, the school nurse is required to perform an assessment of the student to guide the school nurse in determining the level of training and supervision required for safe delegation for this specific student. The safety and well-being of the individual student and the broader school community must be the central focus of all decisions regarding the

delegation of nursing tasks (ANA & NCSBN, 2006). Delegation is used effectively in some areas, however unsafe and inappropriate delegation in school settings can occur. It is important for school districts, school nurses, healthcare professionals, parents/guardians and the public to understand what activities can be delegated and when delegation is appropriate. Due to the complexity of delegation in the school setting, school nurses should be provided educational opportunities to review current delegation practices, case studies, situational reviews, or simulations (Weydt, 2010).

Delegation in school nursing is a complex process in which the authority to perform a selected nursing task is transferred from the school nurse to a competent unlicensed individual, also known as unlicensed assistive personnel (UAP), in a specific situation. The decision to delegate and the supervision of those delegated to perform nursing tasks in the school setting rests solely with the school nurse. The school nurse makes the determination to delegate based on the nursing assessment and in compliance with applicable laws and/or regulations and guidance provided by professional nursing associations (ANA & NCSBN, 2006; *Mitts vs. Hillsboro Union High School*, 1987). In some states, delegation in the school setting is the responsibility of the building administrator, however the actual delegation of nursing tasks can only be designated by the school nurse. In other states, delegation of nursing tasks is not permitted. This underscores the importance of school nurses being knowledgeable of the delegation laws in the states where they practice, as nurse practice acts vary from state to state (Gordon & Barry, 2009).

Nursing tasks commonly performed in the home setting by a parent/guardian or caregiver take on a more complex dimension in the school setting. Often parents/guardians and school administrators are confused about why what appears to be a simple task is held to a much different and higher standard at school (Resha, 2010). One of the challenges to delegation in the school setting is that parents/guardians and school administrators may not recognize that there is a requirement for medical orders for any health-related procedures in the school setting and that nurses are held to a higher protocol standard than a parent/guardian would be when delivering the same procedure at home (Resha, 2010). The school nurse practices in the educational setting where nurses support the primary purpose of providing education and must comply with state and federal mandates, nursing licensure standards and meet the expectations of parents/guardians, while working to ensure the health and safety of all students.

Supervision of delegated nursing tasks means the delegating registered nurse must supervise or periodically monitor and assess the capabilities and competencies of the UAP to safely perform delegated tasks. Unless otherwise guided by state law, the registered nurse determines how closely to supervise and how often to reassess an unlicensed individual. If an individual, who has been assigned by a school administrator, is not competent to complete the task, whether due to lack of education, attentiveness, availability or proximity, the registered nurse must work with administration to identify a more qualified individual. Until that person can assume the responsibility of delegation, the school nurse may need to directly provide the care needed by the student. The registered nurse adheres to state laws regulating nursing and standards of nursing practice, even if it is conflicts with an administrator's directives.

School districts must have a clear, concise, all-inclusive policy in place to address the use of delegation within the school setting, and it should be reviewed periodically. This policy should be consistent with federal and state laws, nursing practice standards, and established safe practices in accordance with evidence-based information and include the development of a developmentally appropriate Individualized Healthcare Plan (IHP) and Emergency Care Plan (ECP).

RATIONALE

The term delegation is used in other fields, but holds a unique place and meaning in the practice of nursing.

To provide for safe care, school nurses should utilize the Five Rights of Delegation (ANA & NCSBN, 2006) to guide their assessment of whether delegation is appropriate for the student and the situation.

1. The Right task
2. The Right circumstances
3. The Right person
4. The Right directions and communication
5. The Right supervision and evaluation

When a review of the Five Rights of Delegation indicates that delegation is appropriate, the school nurse must develop an individualized healthcare plan (IHP), based on the medical orders, outlining the level of care and healthcare needs of the student and indicating which nursing tasks can and cannot be delegated. Further, the continuous process of evaluation should be based on outcomes of care, ensuring that the delegated task is completed properly and produces the desired outcome.

Delegation is not appropriate for all students, all nursing tasks, or in all school nurse practice settings. Neither the American Nurses Association nor the National Council of State Boards of Nursing support delegating steps in the nursing process, including nursing assessment or the use of nursing judgment (ANA & NCBSN, 2006). Key factors guiding determination for delegation include the following: state laws, rules, and regulations; the five rights of delegation; safety issues; healthcare needs of students; school practice characteristics; and UAP competence.

CONCLUSION

NASN supports, in states where laws and regulations allow, delegation in the school setting. By law, the appropriate professional to delegate nursing tasks in the school setting is the school nurse. Delegation is a complex skill requiring professional clinical judgment, critical thinking, and final accountability for care of the client (ANA, 2012). Delegation is a strategy the school nurse can use when planning for care. It requires both knowledge and practice to become comfortable and competent in delegation. Effective delegation in school nursing practice requires a school nurse who has the requisite skill, expertise and authority to practice in the state in which the delegation occurs. Delegation is a valuable tool for meeting the healthcare needs of students in a challenging healthcare environment and in assuring that resources are managed both safely and effectively.

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Diabetes Management in the School Setting

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (hereinafter referred to as school nurse) is the school staff member who has the knowledge, skills, and statutory authority to fully meet the healthcare needs of students with diabetes in the school setting. Diabetes management in children and adolescents requires complex daily management skills (American Association of Diabetes Educators [AADE], 2016). Health services must be provided to students with diabetes to ensure their healthcare needs are met; requirements of relevant federal and state laws are met; and they can fully participate in school and school-sponsored events (AADE, 2016).

BACKGROUND

Diabetes is the third most common chronic health disease affecting an estimated 2.22/1,000 children and adolescents according to The Search for Diabetes in Youth (SEARCH) Study (Pettitt et al., 2014). Children and adolescents are defined as youth under the age of 20 years. In 2009, approximately 191,986 or one in 433 youth with diabetes lived in the U.S. From these, 87% have type 1 diabetes and 11% have type 2 diabetes (Pettitt et al., 2014). In the year 2008 to 2009, 18,436 youth were newly diagnosed with type 1 diabetes and 5,089 youth were newly diagnosed with type 2 diabetes (Centers for Disease Control and Prevention [CDC], 2014).

Advances in diabetes technology continue to enhance the students' ability to manage diabetes at school, thus improving their quality of life. Children and adolescents monitor blood glucose levels several times a day via blood glucose meters and continuous glucose monitors, conduct carbohydrate calculations, and inject insulin via syringe, pen and pump to attain blood glucose control (Brown, 2016). Intensive resources and consistent evidenced-based interventions will achieve the long-term health benefits of optimal diabetes control, according to the landmark study from the Diabetes Control and Complications Trial Research Group (DCCT, 1993).

Each student with diabetes is unique in his or her disease process, developmental and intellectual abilities, and levels of assistance required for disease management. An individualized Diabetes Medical Management Plan (DMMP) is completed by the healthcare provider and includes the medical orders to manage the student's diabetes needs during the school day and at school-sponsored activities (Jackson et al., 2015). The school nurse develops an individualized healthcare plan (IHP) in partnership with the student and his or her family, based on the medical orders in the DMMP and the nurse's assessment. (American Nurses Association/National Association of School Nurses [ANA/NASN], 2011). The IHP outlines the student's diabetes management strategies and personnel needed to meet the student's health goals in school (National Diabetes Education Program [NDEP], 2016). The school nurse also prepares an emergency care plan (ECP), based on the DMMP medical orders, that summarizes how to recognize and treat hypoglycemia and hyperglycemia and directs action to take in an emergency. Copies of the ECP should be distributed to all school personnel who have responsibilities for the student during the school day and during school-sponsored activities (NDEP, 2016).

Throughout childhood and adolescence, the student who has diabetes continuously moves through transitions toward increasing levels of independence and self-management (American Diabetes Association [ADA], 2016), requiring various levels of supervision or assistance to perform diabetes care tasks in school. Students who lack diabetes management experience or cognitive and developmental skills must have assistance with their diabetes management during the school day, as determined by nursing assessment and as outlined in the IHP (Wyckoff, Hanchon, & Gregg, 2015).

Hypoglycemia (low blood glucose) is the greatest immediate danger to the student with diabetes. During hypoglycemic incidents, the student may not be able to self-manage due to impaired cognitive and motor function. A student experiencing hypoglycemia should never be left alone, sent anywhere alone, or escorted by another student. Communication systems and trained school staff should be in place to assist the student. Hypoglycemia can occur suddenly and requires immediate treatment (NDEP, 2016).

Another complication of diabetes, hyperglycemia (high blood glucose), can develop over several hours or days (NDEP, 2016). If untreated, hyperglycemia can lead to the life-threatening condition, diabetic ketoacidosis (DKA) (Wyckoff et al., 2015). For students using insulin infusion pumps, lack of rapid-acting insulin increases their risks of developing DKA more rapidly (Brown, 2016). School nurses may utilize one or more of the model NDEP three levels of staff training to facilitate prompt, safe, and appropriate care for students with diabetes (NDEP, 2016).

Students with disabilities, which include students who have special healthcare needs such as diabetes, must be given an equal opportunity to participate in academic, nonacademic, and extracurricular activities. Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act prohibit recipients of federal financial assistance from discriminating against people on the basis of disability (NDEP, 2016). These laws are enforced by the Office for Civil Rights (OCR) in the U.S. Department of Education. Schools are required to identify all students with disabilities and to provide them with a free appropriate public education (FAPE) (NDEP, 2016).

Advances in science, technology, and evidence-based practices related to diabetes management require school nurses to attain and maintain current knowledge and competence in the delivery and coordination of the care for the student with diabetes (NDEP, 2016, Pansier & Schultz, 2015).

RATIONALE

Children and adolescents with diabetes are confronted with many challenges and potential educational barriers in school. Some of the main barriers include lack of informed and trained staff, absence of a school nurse who is on site daily, and lack of diabetes management policies (Pansier & Schultz, 2015). School-based diabetes interventions led by school nurses are essential to improve health and academic outcomes and ensure a safe school environment for children and adolescents with diabetes.

The increasing prevalence of health-related disabilities, including type 1 and type 2 diabetes, has compounded the need for coordination of care between the school, the student's healthcare team, the family, and service providing agencies (McClanahan & Weismuller, 2015). Recent studies show that care coordination in the school setting improves quality of life, diabetes glucose control, ability to self-manage, readiness to learn, classroom participation, and academic performance (Pansier & Schultz, 2015). Care coordination, a core professional school nursing principle, and its related practice components involve developing and maintaining competence in creating, updating, and implementing care plans that comprehensively create an environment where students will maintain optimal health in the school setting so that they can succeed academically (NASN, 2016).

School nurses implement the DMMP, develop IHPs and ECPs, and train school personnel (McClanahan & Weismuller, 2015). When nursing delegation of diabetes care tasks is deemed appropriate, the school nurse provides ongoing supervision and evaluation of student health outcomes (Wyckoff et al., 2015). School nurses are accountable for addressing the students' ongoing healthcare needs, encourage independence and self-care within the student's ability, and promote a healthy, safe school environment that is conducive to learning (NDEP, 2016).

Ineffective management of diabetes in school may lead to absenteeism, depression, stress, poor academic performance, and poor quality of life (Pansier & Schulz, 2015). Managing diabetes at school is most effective when there is a partnership among students, parents/guardians, school nurses, healthcare providers, and other school personnel (e.g., teachers, counselors, coaches, transportation, food service employees, and administrators). The school nurse provides the health expertise and coordination needed to ensure cooperation from all partners in assisting the student toward self-management of diabetes. Poorly controlled diabetes not only affects academic

performance but can lead to long-term complications such as retinopathy, cardiovascular disease, and nephropathy. Maintaining blood glucose levels within a target range can prevent, reduce, and reverse long-term complications of diabetes (DCCT, 1993).

CONCLUSION

Diabetes is listed as the third most common chronic health condition that impacts approximately one in 433 children and adolescents in the United States (Pettitt et al., 2014). The school nurse is the most appropriate staff member in the school to fully meet the healthcare needs of students and should be the key coordinator and care provider for the student who has diabetes (ADA, 2016). The school nurse's competence in the practice components of the principle of Care Coordination (e.g., case management, collaborative communication, providing and/or coordinating the provision of direct care, training of non-medical personnel) is essential to promoting the health, safety, and academic success of students who have diabetes within the school setting (AADE, 2016; McClanahan, 2015; NASN, 2016).

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Do Not Attempt Resuscitation (DNAR) – The Role of the School Nurse

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that each student with a Do Not Attempt Resuscitation (DNAR) order have an Individualized Healthcare Plan (IHP) and an Emergency Care Plan (ECP) developed by the registered professional school nurse (hereinafter referred to as school nurse) with input from parents or guardians, the student's healthcare provider, the palliative care team, administrators, teachers, local emergency medical services, local funeral director and, when appropriate, the student in order to support the student's access to education and palliative health care. Furthermore, a DNAR order for a student should be evaluated individually at the district level with input from the school district's legal counsel for consideration of state and local laws.

BACKGROUND

Families today face many issues but none more sensitive and emotionally challenging than an order for DNAR. A DNAR order is not abandonment of medical treatment and does not rescind any obligation to provide quality care; rather it is part of the management plan. This plan is reviewed by the healthcare provider with the family to communicate the difficult decision to refrain from life sustaining treatment that is determined by the healthcare provider and family to be ineffective or that the risks would outweigh the benefits. A DNAR medical order for the school should be implemented in the context of palliative care, including comfort measures as well as addressing emotional and spiritual needs (AAP, 2010).

In a 1974 statement, the American Heart Association declared that cardiopulmonary resuscitation (CPR) was not indicated for all patients. Individuals with terminal, irreversible illnesses where death is the expected outcome do not necessarily merit CPR. In 1994 the American Academy of Pediatrics (AAP) and the National Education Association (NEA) issued guidelines on foregoing life-sustaining CPR for children and adolescents (AAP, 2010). Originally, the medical order was referred to as a Do Not Resuscitate order (DNR), which evolved to Do Not Attempt Resuscitation (DNAR), and sometimes Allow Natural Death (AND) (Selekman, Bochenek & Lukens, 2013). Currently, the order to provide comfort care is part of a much broader palliative care plan, which may include Medical Orders for Life Sustaining Treatment (MOLST) (APA, 2010). In the case of ABC School v. Mr. and Mrs. M, in Massachusetts, the court ordered the school to honor the DNAR order for a medically fragile child. In addition, the court refused to allow the school to shield staff from liability should they choose not to honor the DNAR order (Adelman, 2010).

Chronic health conditions that involve special healthcare needs affect an estimated 19.2% (14.2 million) school-age children (Bethell et al., 2011). The AAP (2010) estimates that, on any given day, there are 2,500 adolescents and 1,400 preadolescents who are within 6 months of dying from their chronic condition, such as end-stage heart, liver, kidney disease and cancer (Adleman, 2010). According to a Centers for Disease Control and Prevention survey, the percentage of schools where health services staff reported the need to follow a DNAR order increased from 29.7% in 2000 to 46.2% in 2006 (AAP, 2010).

Growing populations of students with chronic health conditions -- including terminal and irreversible illnesses, congenital defects, injuries, and malignancies, where death may be the expected outcome -- are now routinely attending school (Klick & Hauer, 2010; Adelman, 2010). Children with special healthcare needs are entitled to a free and appropriate education in the least restrictive environment (U.S. Dept. of Justice, 2005). Whenever possible, students with chronic or terminal conditions belong in school in order to access their education. Students

benefit from the psychosocial and emotional benefits of interacting with peers and maintaining their daily routine (Klick & Hauer, 2010). Because state and local laws and regulations vary regarding DNAR orders for students, each palliative care request must be reviewed by the school team with leadership from the school nurse in order to provide the best care possible in the school setting for the student (AAP, 2010). The school nurse and staff should focus on what can be provided for comfort rather than on what is not being provided. In addition, it was found in a recent NASN discussion list inquiry that deaths of students with DNAR orders often did not occur at school. (Zacharski et al., 2013).

RATIONALE

Development and implementation of the IHP are the responsibility of the school nurse and are supported by the AAP (AAP, 2008). The development of the IHP requires the school nurse to do the following:

- Be knowledgeable about state and local laws and regulations regarding DNAR orders.
- Work collaboratively with the school team (the family, school psychologist, the school guidance counselor, administrators, teacher, and members of school crisis teams).
- Coordinate plan with local EMS, funeral director, hospice providers and other local agencies where applicable.
- Communicate and coordinate the development of the school plan with all members of the student's healthcare team that may include the family, pediatrician, social worker, child life specialist and palliative care team members (Klick & Hauer, 2010).
- Participate as an essential member of team in the development of the Section 504 plan or the IEP plan, communicating the plan and the IHP to school staff while maintaining student confidentiality to the extent requested by the student/family. This plan should minimally be reviewed annually or sooner if required.
- Coordinate emotional support for staff utilizing school district and community resources, including bereavement services for the school community in collaboration with the palliative care team, school team and community mental health resources (Klick & Hauer, 2010).
- Provide support for school staff to address attitudes and cultural beliefs concerning death and dying in order for the student to have the optimum experience while at school.
- Provide clear, evidence-based information to school staff regarding the student's condition in terms school staff can comprehend.
- Recognize the importance of self-care during this process (Morgan, 2009).
- Support nursing research to develop evidence-based care for students in need of palliative care and a DNAR in school (Morgan, 2009).

Components of the IHP include but are not limited to:

- A written DNAR request from the parent(s) as well as the healthcare provider's written DNAR order that is acceptable per state regulations. A court order may be required (Selekman, Bochenek, & Lukens, 2013);
- DNAR information;
    - Acceptance of DNAR orders vary according to state regulations.
    - The DNAR request should have a clearly delineated date (some orders are rescinded while in hospital or otherwise. Many DNARs need to be reordered as deemed by the medical facility or state regulations). Some DNAR orders are issued for short periods of time and need to be renewed within a few weeks.
    - An original DNAR order or a copy of the order on the appropriate state EMS Palliative Care/DNAR order form may be required.
    - A state authorized *Out of Hospital Do Not Resuscitate* bracelet or necklace may also be accepted by Emergency Medical Services.
    - The DNAR order may be revoked at any time verbally or in writing by the parent/guardian (Zacharski et al., 2013).

- Notification of EMS and medical examiner of DNAR orders for student in school;
- Specific actions that may and may not be performed by staff clarifying end-of-life issues versus acute episodes that may require treatment/ management vs. comfort care measures;
- Comfort measures which may include holding, positioning, oxygen administration, pain and bleeding control (Selekman, Bochenek, & Lukens, 2013);
- Determination of which staff members should be informed of and educated about the IHP and the DNAR order;
- Contacts in case of emergency (the parent, primary physician, and prearranged notification with the EMS provider);
- Development of a code to which all staff will know how to respond;
- Where to move the student to provide student/family privacy;
- Who will do the pronouncement of death (physician, nurse practitioner or physician assistant)? In some states, pronouncement of death becomes a concern in the school setting; i.e. the local EMS may not be able to remove the body if death has already occurred. If this happens, arrangements must be made as to who will arrive promptly to pronounce death so that the body can be removed from the school as soon as possible;
- Transportation and mortuary arrangements; and
- Plans for training and supporting staff and student's peers.

CONCLUSION

School nurses play a pivotal role with respect to DNAR orders as well as the delivery of health care (AAP, 2010; Klick & Hauer, 2010). In addition, the school nurse is the school health professional with the knowledge, experience and skills to coordinate the care for a student with a DNAR order, linking the school with the medical and community services needed by the student, while advocating for the student and family to ensure access to a free and appropriate education (Selekman, Bochenek, & Lukens, 2013).

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Education, Licensure, and Certification of School Nurses

NASN
National Association of School Nurses

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that every school-age child should have access to a registered professional school nurse (hereinafter referred to as the school nurse), who has a *minimum of* a baccalaureate degree in nursing from an accredited college or university and is licensed as a registered nurse through a board of nursing. These requirements constitute minimal preparation needed to practice at the entry level of school nursing (American Nurses Association [ANA] & NASN, 2011). Additionally, NASN supports state school nurse certification and endorses national certification of school nurses through the National Board for Certification of School Nurses (NBCSN) (NASN, 2016a).

BACKGROUND

School nursing is a subspecialty of public health nursing, which is incorporated in the curriculum for baccalaureate nursing programs. Baccalaureate nursing education develops competencies in leadership, critical thinking, quality improvement, and systems thinking. It provides graduates with nursing theory and clinical experience and cultivates their ability to translate research into evidence-based nursing practice. Baccalaureate prepared nurses also address and analyze current and emerging healthcare issues, including the need for health policy and healthcare financing (National Advisory Council on Nurse Education and Practice, 2014; Institute of Medicine [IOM], 2010).

To practice as a professional registered nurse, graduates must pass the National Council Licensure Examination for the Registered Nurse (NCLEX-RN) in their state, territory, or country in which the exam is offered. In addition to nursing licensure by a board of nursing, post-baccalaureate education and or certification approved by departments of education may be required to practice school nursing. Licensure protects the public by indicating that a nurse successfully completed an examination that demonstrated a minimal level of competency to practice professional nursing. Certification documents a higher level of competence and expertise in a focused area of practice. Requirements for state certification and the certifying bodies vary by individual state, territory, or county in which a school nurse practices.

In the 1980s, NASN developed a national certification examination and then established the National Board for Certification of School Nurses (NBCSN), which became an independent incorporation in 1991. The purpose was twofold: to promote and recognize quality practice in school nursing and to assure that certification criteria and examinations in school nursing are determined by experts in the specialty practice (NBCSN, 2015).

RATIONALE

"School nursing, a specialized practice of public health nursing, protects and promotes student health, facilitates normal development, and advances academic success. School nurses, grounded in ethical and evidence-based practice, are the leaders that bridge health care and education, provide care coordination, advocate for quality student-centered care, and collaborate to design systems that allow individuals and communities to develop their full potentials" (NASN, 2016b). The ANA (2013) takes the position that the minimum preparation for beginning professional nursing practice in public health be a baccalaureate degree. The IOM (2010) recommends that nurses attain advanced education to be able to react to the increasing demands of nursing practice. School nursing requires advanced skills included in a baccalaureate program, which consists of the ability to practice

autonomously, supervise others, and delegate care in a community, rather than a hospital or clinic setting if allowed by state laws (ANA & NASN, 2011).

NASN's Framework for 21st Century School Nursing Practice™ provides structure and focus for current, evidence-based school nursing practice. School nurses use these skills outlined in the practice components of each principle (NASN, 2016c). School nurses work with a vulnerable pediatric community population to achieve improved health outcomes (Kulbok, Thatcher, Park, & Meszaros, 2012). Williams and Counts (2013) found that the public benefits from the certification of nurses by way of improved client safety, increased nurse knowledge and skills, and focused nurse professional development throughout their career. "Certification for school nurses benefits the public by recognizing those nurses that have competence beyond the novice level" (Selekman & Wolfe, 2010, Preface).

CONCLUSION

Licensed registered nurses who work in the specialty practice of school nursing require advanced skills to address the complex health needs of students within a school community setting (ANA/NASN, 2011). These skills are attained through a minimum of a baccalaureate degree in nursing and validated by specialized certification in school nursing (IOM, 2011).

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School Nurse Role in Electronic School Health Records

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that Electronic Health Records (EHRs) are essential for the registered professional school nurse (hereinafter referred to as school nurse) to provide efficient and effective care in the school and monitor the health of the entire student population. It is also the position of NASN that it is the school nurse's role to collaborate with school administrators to ensure that EHRs use meets the highest quality standards for the safety and protection of student, family and staff information. The meaningful use of EHRs in the school setting has the potential to maximize quality, decrease cost, and prevent errors, as well as promote the interoperability of school health records with providers in other care settings (Johnson & Bergren, 2011). Additionally, EHRs in the school setting provide a means of integrating health and educational data in a way that addresses the needs of children at risk for poor health or academic outcomes. EHRs also facilitate the sharing of data into a national database of student health data.

BACKGROUND

Documentation of health information is an expectation of professional school nursing practice according to the Scope and Standard of School Nursing Practice (American Nurses Association & National Association of School Nurses [ANA & NASN], 2011) and may be required by state health statutes. School nurses work with a variety of health information including immunization records, screening records, progress notes, physician orders, physical examination records, medication and treatment logs, reports of serious injury (Centers for Disease Control and Prevention [CDC],2013), individualized healthcare plans, emergency healthcare plans, third party medical records, consent forms, the management of students' chronic health conditions (NASN, 2012), Medicaid, and other insurance billing forms, and flow charts. Health information in any form must be confidential, secure, accessible only by authorized staff, and protected from loss, alteration, or destruction. As an educational record, school health records must be transferrable to new school sites when a student progresses to other buildings within a district or moves outside of the district.

Society and the United States healthcare system is transitioning from paper to electronic technology. The Centers for Medicare and Medicaid Services (CMS) actively promotes EHRs with a goal of improving health care; school nurses share this same goal. EHRs improve the efficiency and the use of school health data such as absenteeism (CDC, 2013) to determine appropriate interventions (Johnson & Guthrie, 2012). EHRs support the ability to make the right information available to the right provider at the right time to benefit student care (Johnson & Guthrie, 2012). A central component of healthcare reform is the use of electronic health records with a focus on the "meaningful use" (MU) of the data in those records to achieve the triple aim – reduced cost, improved satisfaction and improved quality (Blumenthal, 2009; Policy Researchers and Implementers, n.d.).

In 2011, 74% of school nurses reported using EHRs (NASN, 2011). Therefore, it is important for school districts to have policies and procedures in place regarding the types, maintenance, protection, access, retention, destruction, and confidentiality of student health records. Information technology professionals with school districts may require expert assistance in addressing the requirements for health documentation standards; thus school nurses should participate in the selection of documentation systems as well as the development of appropriate policies and procedures.

RATIONALE

School health records provide the mechanism for a school nurse to communicate information to students, families, the school multidisciplinary team, emergency personnel, other healthcare providers, and school nurse substitutes. Data from school health records can show evidence of student health problems that should be addressed. Data are also used for evaluation of school health programs, quality assurance, disease surveillance (Calman, Hauser, Lurio, Wu, & Pichardo, 2012) and evaluation of program outcomes.

The large caseloads and volumes of longitudinal student information collected by school nurses result in a quantity of data that is not readily managed by paper processes. Electronic documentation systems allow for efficient data management processes including the documentation, reporting, and analysis of student health data. Electronic data management systems also allow for the aggregation of data from multiple sources if the data elements are standardized across systems. The ability to build a database requires the EHRs to be able to speak the same language. Data in systems that use standardized languages and are interoperable across a variety of settings will allow the expansion of evidence to determine nursing interventions that support student academic success

Using aggregate data from standardized school nurse documentation would support the development of a national school health database that could be used to describe the student healthcare needs, best outcome based interventions, and academic success (Johnson, Bergren, & Westbrook, 2012). The Office of the National Coordinator for Health Information Technology (ONC) predicted that the MU of EHRs will strengthen the communication of information, improve care coordination, and enhance the quality of care (Blumenthal, 2009). Aggregate data and EHRs also will assist school nurses to function within their broader role as public health nurses by providing the opportunity to improve links between other healthcare providers and public health departments (CDC, 2012).

Reports from EHR systems will allow school nurses to (Johnson & Guthrie, 2012, p. 28):

- Efficiently describe health service activity,
- Develop evidence for practice,
- Describe nursing sensitive student outcomes,
- Analyze population health,
- Evaluate the effectiveness of care delivery, and
- Manage appropriate resource allocation.

Documentation of the nursing interventions provided to students with chronic disease who need more complex care and management at schools is crucial for efficient disease management and collaboration with all of the student's team members. The Robert Wood Johnson report (2010), *Unlocking the Potential of School Nursing: Keeping Children Healthy, In School and Ready to Learn* describes school nursing's role, the "hidden system" of care, in management of chronic disease, costs and the impact on learning depend on school nurses who can expertly collaborate with the student's family and medical home. EHRs are a crucial piece of communication and management of students with chronic disease.

School nurses can best advocate for quality EHRs by considering the following:

- The five rights of electronic documentation systems include right data, right presentation, right decisions, right work processes, and right outcomes (Amatayakul, 2009).
- Confidentiality assurance by following laws governing school health records include the Federal Family Education Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA) as well as individual state laws (United States Department of Health and Human Services & United States Department of Education [USDHH & USDE], 2008).
- School nurses should address security by being involved on the school district technology team to provide input on the need for privacy and meet health documentation requirements. Special provisions must be established to protect EHRs and student privacy in the school district. The use of secure passwords,

programs to thwart hackers, and screen savers -- as well as several areas of access for the student health data base and a policy of never leaving the computer unattended when student health data are accessible or viewable -- is necessary for security. Computer software should have over-write protection and an appropriate level of role-dependent secure access if multiple health office employees will be entering data.

- Federal and state laws and regulations need to be considered when determining EHR policies and procedures.
- Complete lists of EHR system requirements can be accessed in several resources (Bergren, 2005; Johnson & Guthrie, 2012).

Having a standardized electronic data system in the school setting is a reality for many schools in the U.S. In Delaware, all public school nurses use an EHR that is within the educational pupil accounting electronic records and uses standardized languages and coding of all health information and school nurse interventions (L. C. Wolfe, personal communication, September 2013). This facilitates a means for health data to be linked to student demographics and educational needs. Further, it provides an avenue for research into the relationships between school nursing activities and student outcomes.

CONCLUSION

EHRs are required for school nurses to use the aggregate data to build a standardized school health database that identifies student health trends, determines evidenced-based interventions, supports effective student healthcare models, and documents improved student academic success. Aggregated school health data allows for population-based disease surveillance (Baer, Rodriguez, &Duchin, 2011) and holds the potential for analysis by community and demographic groups, of the most effective strategies for school-based health promotion and illness prevention activities. In addressing EHR use, school nurses should, receive training on the use of the system, evaluate school district policies and procedures, initiate changes if indicated, and educate staff, students, and parents on the value of EHRs. Additionally, school nurses should be able to describe the security measures taken by the school district to protect student confidentiality. Without EHRs, the contributions of school nursing services to a child's health and academic success cannot be fully examined or appreciated.

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Emergency Preparedness and Response in the School Setting

– The Role of the School Nurse

National Association of School Nurses

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (hereinafter referred to as school nurse) provides leadership in all phases of emergency preparedness and response. School nurses are a vital part of the school team responsible for developing emergency response procedures for the school setting using an all-hazards approach.

The school nurse is often the first health professional who responds to an emergency. The school nurse has the education and knowledge to identify emergent situations, manage the emergency until relieved by emergency medical services (EMS) personnel, communicate the assessment and interventions to EMS personnel, and follow up with the health care provider.

BACKGROUND

Each school day, families entrust our nation's schools to provide safe and healthy learning environments for approximately 55 million elementary and secondary school students in public and nonpublic schools (U. S. Department of Education [USDE], 2012). Families and communities expect that schools will keep children safe from threats (e.g., human-caused emergencies such as crime and violence) and hazards (e.g., natural disasters, disease outbreaks, and accidents) (USDE, 2013). There is a fundamental link between day-to-day emergency readiness and disaster preparedness. Schools that are well prepared for an individual emergency involving a student or staff member are more likely to be prepared for complex events such as community disasters (AAP, 2008).

School nurses respond to emergencies and disasters that can range from one student or adult injured to the mass illness situations observed with the H1N1 influenza pandemic (Pappas, 2011). An emergency is a dangerous event normally managed at the local level (Doyle, 2011). Disasters are distinguished from emergencies by the greater level of response required. A disaster is a dangerous event that causes a significant human and economic loss, and demands a crisis response beyond the scope of local and state resources (Federal Emergency Management Agency [FEMA], 2011; Doyle, 2013). Whether for an emergency or disaster, preparedness is essential to ensure an effective response (Doyle, 2011). Planning for health-related emergencies involves developing emergency plans for students with known health-related conditions, and utilizing first aid skills to assess and respond to other unanticipated medical emergencies.

The types of emergency events for which the school nurse must be prepared to respond include:

- Student, staff and visitor health-related emergencies, due to injury or illness.
- Large numbers of individuals in casualty incidents, such as the collapse of bleachers, exposure to toxic gas, or a school shooting (Doyle, 2013).
- Weather-related emergencies (e.g. hurricanes, tornadoes, tsunamis and flooding, snow and ice storms).
- Hazards such as explosions and fires, physical plant, technological hazards, or nuclear meltdowns that may cause damage in the school and result in physical injuries, or loss of life.

For larger scale emergencies and disasters, the National Response Framework (NRF) offers guiding principles that enable all response partners to prepare for and provide a unified national response to disasters and emergencies –

from the smallest incident to the largest catastrophe (FEMA, 2013). The term “response” as defined by NRF includes taking immediate action to save lives, protect property and the environment, and meet basic human needs. Response also includes the execution of emergency plans and actions to support short-term recovery. The NRF also describes how agencies, such as schools, can work together with communities, tribes, states, the federal government, and private partners (Doyle, 2011).

Two national response models serve as the framework for local policy and response plans. The National Incident Management System (NIMS) is a comprehensive national design for approaching incident management. NIMS provides the template for management of the incident, while the NRF provides the structure and mechanisms for national-level policy for incident management (FEMA, 2011). One component of the NIMS is the Incident Command system (ICS), which provides a standardized approach for incident management, regardless of cause, size, location, or complexity. By using ICS during an incident, schools will be able to more effectively work with the responders in their communities (USDE, 2013).

To maximize success, effective management of school emergencies requires training, preparation and planning for best practices (RWJ, 2012).

RATIONALE

Schools should be responsible for anticipating and preparing to respond to a variety of emergencies (Doyle, 2013). School nurses, by virtue of their education, are experts in the nursing process, which includes assessment, planning, implementation and evaluation (Doyle, 2011). During emergencies, these steps closely parallel the phases of emergency management, which include prevention/mitigation, preparedness, response, and recovery. The school nurse, as a leader, is in the unique position to provide continuous integration, coordination, and training of all school and community members within the framework of the school’s emergency management plan. The role of the school nurse within the four identified phases of emergency management planning includes the following:

Prevention/ Mitigation: School nurses should participate in an ongoing assessment to identify hazards from all possible sources and to reduce the potential for an emergency to occur. Examples include educating students and staff about recognizing and reporting suspicious behaviors and persons, implementing and maintaining an effective immunization program for students and staff, improving security measures to control access to school facilities and using metal detectors at entry points if appropriate (Doyle, 2011).

Preparedness: School nurse participation on community-wide planning groups is helpful in the facilitation of a rapid, coordinated, effective emergency response within the framework of the ICS. This includes establishing standard emergency response plans and practicing skills, drills and other exercises to evaluate the response capabilities of a school, as well as the effectiveness of the plan (e.g., medical emergency, evacuation, shelter-in-place, lock down, and intruder). Specifically, the school nurse can be instrumental in identifying unique emergency preparedness needs for children with special health care needs, as well as specific equipment and supplies needed to respond, and to assess for and provide first aid.

Response: The school nurse is knowledgeable about her or his role in responding to an emergency, which may include triage, training of first aid response teams, and direct physical and mental health care for all victims of an emergency, including linking them to medical and public health resources. The school nurse also serves a vital role in reuniting families during and after a crisis (RWJ, 2012). NASN’s School Emergency Triage Training (SETT) program, (NASN, 2012) provides school nurses with the knowledge, skills and resources to perform as leaders of First-Aid teams in response to mass casualty events occurring in the school setting.

Recovery: After a disaster, the school nurse assists students, parents, and school personnel, providing direct support and serving as the liaison between community resources and those in need. This includes

both short and long-term recovery, and may include maintenance of student and staff health status, as well as mental health issues and psychological response.

Children with Special Health Needs

Schools are responsible for the emergency management planning and response efforts to assist students with special health care needs. This includes conducting an evaluation, providing housing, and caring for these students during an emergency event (Robert Wood Johnson [RWJ], 2012). If students are required to be sheltered in school for extended periods, the school nurse plans and prepares to support and care for children with chronic health conditions, including diabetes, asthma, and allergies/anaphylaxis. These plans may include:

- Healthcare provider orders for 72-hour lockdown or disaster.
- A system for retrieving and transporting medications to areas of lockdown or evacuation.
- Provision of necessary supplies and food in the classroom or carried with the child or teacher in an evacuation or a 3-day supply in case of a lock down.
- Education of all staff members/substitutes responsible for the child with a special health needs during an emergency.
- An alarm system for students with auditory and/or visual needs.
- Back-up power source for specialized equipment.
- Emergency evacuation plan for students with physical, mental or communication limitations (e.g. visually and/or hearing impaired, students with autism, and "English as a second language" students).

Emergency Equipment

A primary role of the school nurse is to ensure a system is in place to provide triage and immediate first aid care to ill and injured students, staff and community volunteers. This is accomplished by the school nurse, or through his/her direction of others (Doyle, 2011). The availability of essential emergency supplies is an integral component of being able to render appropriate on-site care and manage the emergency condition (Doyle, 2013). The type of equipment is primarily contingent on portability for use as a first-aid kit or for use by the school nurse in the health office (Illinois Emergency Medical Services for Children, 2010). NASN's *Emergency Resources, Equipment and Supplies – With/Without A School Nurse* (NASN, 2014) provides emergency equipment recommendations as a resource to schools and school nurses.

CONCLUSION

The school nurse is a leader and integral partner in developing plans for first aid, facilitating an evacuation, caring for special needs students, performing triage responsibilities, educating and training staff, providing surveillance, and reporting. The school nurse is an effective communicator and educator, responsible for sharing information about health risks and connecting students and families to providers who can offer immediate crisis care and support, and refer to appropriate mental health services for long-term support. He/she provides a unique and critical perspective in the evaluation and revision of school emergency plans. The school nurse is the primary connection to the medical/public health community (Doyle, 2013). In order to optimize positive outcomes in all phases of emergency management, it is of the utmost importance that the school team include a school nurse for emergency preparedness and response planning.

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Environmental Health in the School Setting:
The Role of the School Nurse

Position Statement

SUMMARY

Environmental health is a branch of public health that is concerned with all aspects of the natural and built environment. The World Health Organization (WHO) defines environmental health as those aspects of human health and diseases that are determined by factors in the environment. It also refers to the theory and practice of assessing and controlling factors in the environment that can potentially affect health (WHO, 2011).

It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (hereinafter referred to as school nurse) is the health expert in the school setting. With a public health focus, the school nurse has the educational and clinical background required to understand the issues of environmental health in the school setting and is in a prime position to advocate for a sustainable healthy school environment.

BACKGROUND

In the school setting, environmental health is affected by the complex interaction of factors inherent in the school's location, its occupants and school activities. Some include, but are not limited to, building materials (insulation and carpets), materials used in art, music and science classrooms, computer labs, health rooms, playground equipment, food preparation areas, waste management supplies and equipment, cleaning products, pest management equipment, fragrances, heating, cooling, and ventilation equipment, gymnasium areas, sports fields, outside parking including recreation areas and custodial and maintenance supplies and equipment.

The WHO recognizes that clean air in schools, homes, offices and other public buildings where people spend a large part of their time is a basic requirement of life and an essential determinant of health and well-being (WHO, 2011, Foreword, p. xv). The Institute of Medicine (IOM) states that asthma, cancer, cardiovascular failure, and developmental defects and delays are known ill-health effects from substandard environmental conditions (IOM, 2011). More than 50 million children attend public school every day for 6-8 hours, making schools the places for prevention – but also mitigation – of chronic health conditions (Department of Education, National Center for Education Statistics – cited in Environmental Protection Agency [EPA], 2012a, p. 2; Duff, 2013). During these hours, children may be exposed to the various contaminants in their building (Paulson & Barnett, 2010, NASN, 2011).

Children have developing organ systems that are highly susceptible to environmental stressors and are at a higher risk of exposure to toxic environmental substances; they breathe more air and drink more water than adults, are physically closer to – and spend more time on - the ground, and engage in more hand-to-mouth contact than adults. As a result, they are more vulnerable to the effects of air and water pollution, pesticides, and other toxins (EPA, 2012b; Paulsen & Barnett, 2010). Children also experience higher exposure rates to environmental pollutants than adults, increasing their vulnerability to potentially harmful chemicals. All these issues contribute to children receiving less than optimal learning experiences and higher absenteeism rates (IOM, 2011).

RATIONALE

A child's environment plays a role in many chronic conditions faced by children today: premature birth, lead poisoning, asthma, some childhood cancers, and some birth defects (Children's Environmental Health Network [CEHN], 2012). For children asthma specifically has many potential causes and triggers that are found in schools: dust mites, cockroaches, rodents, mold, tobacco smoke and outdoor pollution, all with potential for triggering asthma episodes in children (CEHN, 2012). With a training and clinical background that incorporates public health,

the school nurse is ideally placed to assess the learning environment for risk factors, educate the community on the impact of environmental exposure, and advocate for the need to address environmental pollution issues. As the first responder, the school nurse is able to identify trends and abnormal illnesses that may be the result of environmental toxin exposure. The school nurse has the credibility to provide scientifically sound information about environmental issues and toxin exposures to school and community leaders and is well placed to serve on committees that affect safe environmental practice (Agency for Toxic Substances and Disease Registry [ATSDR], 2012).

CONCLUSION

"Environmental preferability, sustainability, 'green', reducing your environmental footprint…these terms have become part of our everyday lexicon as schools, businesses, households, and the public sector have increasingly focused on strategies and tactics designed to reduce their negative impacts on the environment and human health" (Balek, 2012, p. 16). Poor environmental quality results in children suffering ill health and lost academic instruction during their school years.The long-range burden of this will often continue into their adult lives, resulting in adults with chronic health conditions, and may affect their opportunity to excel in a chosen career.

The school nurse is witness to the daily consequences to school children when they arrive at the health room or are absent from school, but the associated costs resulting from doctor visits, hospitalization, and loss of working days for parents affect the greater community. These repercussions may result in financial hardship on the family and subsequently an economic strain on the nation's economy. By advocating for a healthy school environment, the school nurse will provide children with a greater chance for a healthy future, with reduction of chronic disease. The school nurse promotes a healthy future for children by providing them education about their illness and teaching them to also advocate for themselves regarding environmental factors contributing to their illness.

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Head Lice Management in the School Setting

NASN
National Association of School Nurses

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that the management of head lice (Pediculus humanus capitis) in the school setting should not disrupt the educational process. Leadership provided by the registered professional school nurse (hereinafter referred to as the school nurse) can impact reduction of the stigma associated with head lice by providing accurate health education including anticipatory guidance to the school community and implementing evidence-based strategies for the management of head lice in schools. Evidence-based strategies include abandoning “no-nit” school policies, allowing children to remain in class and participate in school-sponsored activities when live lice or nits (the eggs of head lice) are found on their heads, notifying parents/caregivers at the end of the school day when findings indicate the presence of a head lice infestation, and educating parents/caregivers about evidence-based treatment options.

BACKGROUND

In the United States, head lice infestations are most common among preschool and elementary school-age children and their household members regardless of socioeconomic status and hygienic living conditions (Centers for Disease Control and Prevention [CDC], 2013a). According to research head lice infestations predominantly affect the age group of 3-11 years (Frankoswski & Bocchini, 2010), with an estimated 6 million to 12 million cases annually (CDC, 2013a). A 2004 study estimated annual direct and indirect costs associated with head lice infestations and recent treatment costs at $1 billion (Hansen & O’Hayer, 2004). “No-nit” policies that require a child to be free of nits before he or she can return to school lack evidence of being effective, result in unnecessary absenteeism, and may violate affected children’s civil liberties (Pontius, 2014; CDC, 2013a). Unnecessary absenteeism leads to missed learning opportunities for the student and potentially lost family wages due to loss of parent/guardian workdays (Pontius, 2014).

Head lice are not known to cause disease; however, secondary bacterial infection of the skin resulting from contaminated scratching and related lesions can occur. Research has shown that the survival of head lice when not on the head is usually less than one day, and the eggs can only hatch when incubated by body heat found near the scalp (Devore et al., 2015; CDC, 2013c). Transmission occurs primarily through head-to-head contact and infrequently through indirect contact with shared personal belongings.

Even with this knowledge, the presence of head lice can negatively affect families and schools. For the student and family there can be significant social stigma and caregiver strain (Gordon, 2007). For the school, when evidence-based policies and intervention strategies are not in place, head lice can significantly disrupt the education process (CDC, 2013c; Pontius, 2014).

In the past, many schools with “no nit” policies expended innumerable hours and resources in attempts to eradicate head lice infestations. Studies have shown that control measures such as, mass screenings for nits ,have not been shown to have a significant effect on the incidence of head lice in a school community, nor have they shown to be cost-effective (Devore et al., 2015; Meinking & Taplin, 2011; CDC, 2013a). Communication between school personnel and parents/caregivers highlighting cases of head lice (e.g., “head lice outbreak letters”) has been shown to increase community anxiety, increase social stigma causing embarrassment of affected infested students, and puts students’ rights to confidentiality at risk (Gordon, 2007; Pontius, 2014).

Head lice treatment success is variable, adding to confusion and frustration among students, families, and members of the school community. Some children develop persistent head lice, which requires concentrated efforts to address treatment as well as the stress experienced by the child and family (Gordon, 2007). Head lice in some communities have developed resistance to common over-the-counter treatments, resulting in the need for a more individualized approach to management by a healthcare provider (Yoon et al., 2014; Meinking et al., 2002;

Devore et al., 2015). Treatment failures can also result from initial misdiagnosis, non-adherence to a treatment protocol, a new infestation acquired after treatment, or the lack of use of an ovicidal product (Devore et al., 2015; Pontius; 2014; Pollack, Kiszewski, & Spielman, 2000; CDC, 2013b).

RATIONALE

Evidence-based strategies for the management of head lice in the school setting can reduce the incidence of infestations, the social stigma and caregiver strain experienced by students and families, and the negative impact on students' education. The school nurse can provide leadership within the school community to effectively manage head lice by:

- Attaining knowledge and competency that reflect current evidence-based school nursing practice related to the management of head lice (American Nurses Association & National Association of School Nurses [ANA & NASN], 2011).
- Providing accurate health education to the school community focused on dispelling common myths about head lice (e.g., incidence, life cycle of the head louse, mode of transmission, importance of regular surveillance at home, recommended evidence-based treatment options, care of the environment) (ANA & NASN, 2011 Pontius, 2014).
- Advocating and providing rationale for the elimination of mass school screenings for head lice (Devore et al., 2015; CDC, 2013a).
- Educating families about how to assess their children for suspected head lice (Devore et al., 2015).
- Providing privacy when conducting student health assessment for suspected or reported cases of head lice (ANA & NASN, 2011).
- Returning affected students to class or other school sponsored activities with instruction to avoid head-to-head contact (Pontius, 2014). If live lice or nits are found,
    - Eliminating classroom-wide or school-wide family head lice notification.
    - Notifying parents/caregivers at the end of the school day to teach about evidence-based treatment options and steps to follow.
- Advocating for and providing rationale for the abandonment of "no-nit" school policies that require a child to be free of nits before he or she can return to school (Devore et al., 2015; Pontius, 2014).
- Educating parents/caregivers about the chosen evidence-based treatment option, the importance of adherence with the treatment protocol, and the importance of reassessment for recurrence (Devore et al., 2015; Pontius, 2014).

CONCLUSION

The school nurse is the health professional who provides leadership for the school community to implement evidence-based strategies for the management of head lice in the school setting. The role of the school nurse includes the following (Pontius, 2014; Devore et al., 2015; CDC, 2013a):

- Provide accurate health education to the school community about the etiology, transmission, assessment, and treatment of head lice;
- Advocate for school policy that is more caring and less exclusionary (i.e., elimination of the "no-nit" school policies);
- Implement intervention strategies that are student-centered;
- Support the current treatment recommendation of the American Academy of Pediatrics and CDC; and
- Participate in research that evaluates the effectiveness of head lice policies and educational programs.

It is unlikely that all head lice infestations can be prevented. Parents/caregivers will benefit from receiving support from the school nurse about the importance of regular surveillance at home, choosing and adhering to the protocols of evidence-based treatment recommendations, and educating to dispel head lice myths. The education mission of schools will be supported by implementing evidence-based policies and strategies under the guidance of the school nurse. The burden of unnecessary absenteeism to the students, families, and communities far outweighs the perceived risks associated with head lice.

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Healthy Communities -The Role of the School Nurse

NASN
National Association of School Nurses

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (hereinafter referred to as school nurse) should work across sectors, professions, and disciplines to build a culture of health and improve student and community health outcomes by providing leadership, advocacy, care coordination, critical thinking, and mitigation of barriers to health.

BACKGROUND

A healthy community as described by the U.S. Department of Health and Human Services (USDHHS) *Healthy People 2010* report is "one that continuously creates and improves both its physical and social environments, helping people to support one another in aspects of daily life and to develop to their fullest potential" (Centers for Disease Control and Prevention [CDC], 2014a, para. 1). The Healthy Communities concept began within the 19th century public health movement. In 1986 at a World Health Organization (WHO) conference in Toronto, the attendees drafted the Ottawa Charter called the "Constitution of Healthy Cities/Healthy Communities" (CDC, 2017). The concepts covered in this charter started a movement that still exists today. For example, one of the aims of the National Quality Strategy, which was required by the Patient Protection and Affordable Care Act (2010), is "to improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher-quality care "(USDHHS/ Agency for Healthcare Research and Quality, 2013, para. 4).

The Healthy Communities Movement continues to envision a community that provides basic sanitation and hygiene needs, promotes healthier eating, increases physical activity, encourages active transportation (i.e., walking, biking), develops a sense of belonging, and accelerates economic equality (BC Healthy Communities, n.d.). To combat school health concerns such as obesity, diabetes, asthma, and anxiety in a more global and holistic way, school nurses are encouraged to partner with stakeholders, pledge support and advocate for policy, system, and environmental change to facilitate a healthier community.

RATIONALE

According to the Association for Community Health Improvement (2017, para. 4), "Only 20% of health outcomes are attributable to clinical care. Health behaviors, socioeconomic factors and the physical environment account for 80% of health." Health is vitally linked to where people live, learn, work, and play (Brand, 2016). Schools are key, trusted institutions in the community that can bring stakeholders together to address local needs and improve health (Butler & Diaz, 2016). School nurses are community leaders who bring knowledge of social environments and health systems to mitigate, prepare, and respond to student and community needs and to promote better health outcomes (Brand, 2016). Utilizing the nursing process and the NASN's *Framework for 21st Century School Nursing*™ (NASN, 2017), school nurses can serve their communities by assessing physical, psychological, cultural, and environmental information. School nurses are the critical link to address environmental and socioeconomic problems, understand political landscapes, and develop strong relationships with individuals, families, and communities to create a working plan with measurable goals. School nurses intervene by teaching health and wellness and resolving knowledge deficits. As leaders, school nurses work as change agents as they

identify current and emerging issues, look at outcomes, evaluate where changes are needed, and advocate for that change (Gerber, 2012; NASN, 2017).

The Healthy Cities/Healthy Communities framework is the standard way in which the WHO addresses community health. According to this framework, the health of a community is affected by the social determinants of health and development–the factors that influence individual and community development. Each community is different, and addressing the needs or barriers is a unique process best evaluated at a local level. The barriers or prerequisites for health in communities include

- *Peace.* This can be interpreted to cover both freedom from warfare and freedom for fear of physical and/or emotional harm.
- *Shelter.* Shelter adequate to the climate, to the needs of the occupants, and to the extremes of weather
- *Education.* Education for children (and often adults as well, as in the case of adult literacy) that is free, adequate to equip them for a productive and comfortable life in their society, and available and accessible to all
- *Food*. Not just food, but enough of it, and of adequate nutritional value, to assure continued health and vigor for adults, and proper development for children
- *Income.* Employment that provides an income adequate for a reasonable quality of life and public support for those who are unable to work or find jobs
- *A stable ecosystem*. Clean air, clean water, and protection of the natural environment
- *Sustainable resources*. These might include water, farmland, minerals, industrial resources, power sources (sun, wind, water, and biomass), plants, animals, etc.
- *Social justice*. Where there is social justice, no one is mistreated or exploited by those more powerful. No one is discriminated against. No one suffers needlessly because she's poor or ill or disabled. All are treated equally and fairly under the law, and everyone has a voice in how the community and the society are run.
- *Equity*. Equity is not exactly the same thing as equality. It doesn't mean that everyone gets the same things but that everyone gets, or has access to, what he needs.

(CDC, 2017, para. 5)

The idea of healthy communities fosters a broad definition of health and community and creates a shared vision of improving the quality of life for everyone in the community. This vision is driven and owned by the community members who use collaborative problem-solving to create systems change (Ashby & Pharr, 2012). As members of the community, school nurses can use their knowledge, critical thinking, nursing interventions, and relationships with individuals to promote healthy living and improve health outcomes (McCollum, Kovner, Ojemeni, Brewer, & Cohen, 2017).

The school nurse supports student health and academic success by contributing to a healthy community (NASN, 2017). Utilizing the NASN's *Framework for 21st Century School Nursing*™ (NASN, 2017), school nurses can inform, educate, and empower their community about health issues (CDC, 2014b) by planning and executing campaigns geared to improve community health. School nurses can mobilize community partnerships to help identify and solve problems (CDC, 2014b) by participating in Campaigns for Action or serving on a community board. School nurses can link students and their families to needed personal and preventative health services and work to mitigate barriers to attaining optimal health.

CONCLUSION

A healthy community continually builds and improves the environment by expanding resources (Ashby & Pharr, 2012). School nurses are uniquely positioned to collaboratively assess needs in the community, collect data to formulate a plan, advocate for better health, and evaluate outcomes. School nurses can expand their scope of influence by working across sectors, professions, and disciplines to build a culture of health and improve health outcomes in their communities. School nurses can do this by providing leadership, advocacy, care coordination, critical thinking, and mitigating the barriers to health.

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IDEIA and Section 504 Teams - The School Nurse as an Essential Team Member

National Association of School Nurses

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (hereinafter referred to as school nurse) is an essential member of multidisciplinary educational teams participating in the identification, evaluation, and monitoring of students who may be eligible for services through the Individuals with Disabilities Education Improvement Act (IDEIA) (2004) and Section 504 of the Rehabilitation Act of 1973, as amended through the Americans with Disabilities Amendment Act (ADAA) in 2008. Evaluations must be comprehensive, multifactorial, and nondiscriminatory; and they must be conducted by qualified professionals (Heward, 2015; Yonkaitis & Shannon, 2017). In the school setting, the school nurse is the professional qualified to conduct a comprehensive health evaluation. The school nurse identifies needed health accommodations, outlines plans of care, provides nursing services, and evaluates the effectiveness of the health services provided to students. School nurses should be consulted regarding any information needed in the areas of health (Minchella & Brubaker, 2017; Yonkaitis & Shannon, 2017).

BACKGROUND

The Education for All Handicapped Children Act has been reauthorized over the past forty years. The latest 2004 reauthorization, titled the Individuals with Disabilities Education Improvement Act, is often referred to as IDEIA or IDEA 2004 (Yonkaitis & Shannon, 2017). IDEIA provides specific provisions for identifying and evaluating students who may need special education services. It also outlines the components for Individualized Education Programs (IEPs) as well as procedural safeguards (Yonkaitis & Shannon, 2017).

School districts are mandated to identify, locate, and evaluate all children with disabilities, regardless of severity, to determine if they qualify for special education services, including the related service of school nursing or health services (I34 C.F.R. §104.32). This is referred to as Child Find and includes all children from birth to age 21. Some of the children identified through Child Find are eligible for services other than special education.

Additionally, IDEIA mandates that individuals with appropriate expertise in the area of concern should conduct the evaluation and determine additional data needed (Yonkaitis & Shannon, 2017). As a licensed healthcare professional, the school nurse is the multidisciplinary evaluation team member qualified to evaluate health concerns. Under IDEIA the student's federal civil right to a nondiscriminatory comprehensive evaluation is not upheld if non-nursing educational professionals who are unqualified to conduct a health assessment assume this role (Shannon & Yonkaitis, 2017). If a school nurse does not conduct a health evaluation, the evaluation team lacks important information. During the health evaluation, information is obtained regarding potential health-related barriers to student learning. This information assists in determining if the student "qualifies" for special education programming or accommodations. The health evaluation also provides essential information to determine related services, programs, and accommodations and provides the basis for individualized healthcare plans (IHP) and emergency action plans (EAP) - known in some school districts as emergency care plans.

Section 504 of the Rehabilitation Act of 1973 established legal support for students with disabilities. This federal civil rights law ensures that every student is entitled to a free and appropriate public education (FAPE) (U.S. Department of Education [USDE], 2010). Under Section 504, FAPE consists of the provision of any necessary supports for the student in the general education classroom with related aids or services designed to meet the student's individual educational needs as adequately as those needs of nondisabled students are met (USDE/

Office of Civil Rights [OCR], 2015). An individual with a disability means any person who "(i) has a mental or physical impairment that substantially limits one or more major life activities; (ii) has a record of such an impairment; or (iii) is regarded as having such an impairment" [34 C.F.R. §104.3(j)(1)]. An impairment under Section 504 standards can be a health-related condition such as diabetes, epilepsy and allergy; or it can be a disability such as low vision, impaired hearing, heart disease or chronic illness that limits that child's ability to receive an appropriate education as defined by Section 504.

In 1975, the Education for All Handicapped Children Act was passed. It provides specialized educational programming for exceptional children, further reinforcing the rights of school children (USDE/ OCR, 2010). In an effort to broaden the definition of a disability, the Americans with Disabilities Act Amendments Act (ADAA) was passed and became effective in 2009. The Section 504 regulatory provision at 34 C.F.R. 104.35(c) requires that evaluation team members must be knowledgeable regarding the needs of the student and draw from a variety of sources (USDE/ OCR, 2015).

RATIONALE

The American Academy of Pediatrics (AAP) recognizes the role of the school nurse as the healthcare expert in the school setting (AAP, 2016). The Every Student Succeeds Act (ESSA) of 2015 recognizes school nurses as "Specialized Instructional Support Personnel" who provide leadership of chronic disease management as part of a comprehensive plan of services for student success (ESSA, 2015).

School nurses are the link between the healthcare and educational communities and are valuable resources to students, families, staff, and communities. School nurses use their professional knowledge to assess and identify students who have health, socio-emotional, or developmental issues that increase risks for learning problems and other school-related challenges. Input from school nurses is essential to determine the impact that health conditions have on learning and on the ability of individual students to participate in their educational programs (Minchella & Brubaker, 2017). If health-related barriers are not recognized, appropriately interpreted, and addressed, students risk academic failure. Although the referral processes for special education or Section 504 can be requested by anyone, the school nurse has the expertise and duty to identify students with health-related disabilities and should initiate an evaluation for medical/health reasons (Alfano, Forbes, & Fisher, 2017).

The school nurse uses information obtained during the process of developing an IHP to assist with eligibility determination and, when indicated, to assist IEP and 504 Plan teams to determine educational modifications and accommodations. The creation of an IHP uses the nursing process and demonstrates adherence to professional scope and standards (American Nurses Association [ANA] & NASN, 2017). Development of an IHP is strictly the responsibility and within the scope of practice of a school nurse.

School Nurse Responsibilities

It is the responsibility of the school nurse to understand the federal and state laws related to working with students with disabilities, long term illnesses, or other disorders (Alfano et al., 2017; Ellermeier, Will, & Strawhacker, 2017; Galemore & Sheetz, 2015; Minchella & Brubaker, 2017). State laws may require specialized licensure or credentials prior to performing IEP evaluations or for team participation in developing IEPs (Shannon & Yonkaitis, 2017).

The school nurse is the appropriate person to provide care coordination for health-related disabilities in the school setting (ANA & NASN, 2017). "While the IEP team as a whole tackles the academic, developmental, social, and emotional needs of the student, the responsibility of addressing the healthcare needs of the student falls squarely on the school nurse" (Alfano et al., 2017, p.145).

When health services are determined to be necessary for students to access their educational programs, it is the school nurse's role to provide a direct or related service in an IEP. In those cases, the school nurse is responsible for supplying specific information describing which type of health services should be provided and how often the service(s) need to be provided (Galemore & Sheetz, 2015; Minchella & Brubaker, 2017).

The school nurse's role in the Section 504 or IDEIA process may include:

- Assisting in identifying students who may need special educational or health-related services/accommodations (Child Find) (Gibbons, Lehr, & Selekman, 2013).
- Assessing the identified student's functional and physical health status in collaboration with the student, parent(s)/guardian(s), teachers and other school staff, and healthcare providers (Gibbons et al., 2013).
- Developing IHPs and EAPs based on nursing assessments.
- Recommending health-related accommodations or services that may be required for the student to access the educational program.
- Assisting students, parent(s)/guardians, and teachers to identify and remove health-related barriers to learning (Gibbons et al., 2013).
- Providing in-service training for teachers and staff regarding the individual health needs of the student (Gibbons et al., 2013).
- Training and supervising unlicensed assistive personnel to provide specialized healthcare services in the school setting according to state delegation guidelines (Gibbons, Lehr, & Selekman, 2013, p. 269- 270).
- Participating in transition planning, including promotion of successful post-school employment and/or education, and transition of medical care.
- Evaluating the effectiveness of the health-related components of the IEP and/or 504 plan with the student, parent(s), and other team members and revising the plan(s) as needed (Gibbons et al., 2013, p. 269- 270).

The school nurse plays an integral role in planning, implementation, and evaluation of IEPs and Section 504 Plans. For a student with disabilities, it is the school nurse's role to identify needed health accommodations, outline a plan of care, provide nursing services, and evaluate the health-related components of the IEP and/or 504 Plan. An IHP is written to meet professional school nurse standards (ANA & NASN, 2017; Ellermeier et al., 2017). The student's IHP and/or EAP may guide the student's Section 504 Plan health-related accommodations. As IHPs and EAPs are fluid documents, IHPs and EAPs should not be included in an IEP but might be referenced to provide rationale for the needed service(s) (Galemore & Sheetz, 2015; Ellermeier et al., 2017).

CONCLUSION

The school nurse is the recognized healthcare expert in the school setting (AAP, 2016; ESSA, 2015). School nurses have the unique knowledge and experience essential to evaluate the health of students in order to identify health-related barriers to learning and the accommodations necessary to provide access to education. School nurses work collaboratively with other team members to identify, evaluate, and develop plans for students in need of services. School nurses should be involved in and present at all meetings where an IEP and/or Section 504 plan related to a student's health condition is being discussed and developed. School nurses are integral to ensuring the civil rights of all students so that they can achieve optimal success and well-being at school (Yonkaitis & Shannon, 2017).

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Immunizations

National Association of School Nurses

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that immunizations are essential to primary prevention of disease from infancy through adulthood. Promotion of immunizations by the registered professional school nurse (hereinafter referred to as school nurse) is central to the public health focus of school nursing practice (American Nurses Association [ANA] & NASN, 2011). NASN supports the Advisory Committee on Immunization Practices (ACIP) vaccine recommendations that are adopted by the Centers for Disease Control and Prevention (CDC) (CDC, 2014a, 2014b). The school nurse is well-poised to create awareness and influence action to increase the uptake of mandated and recommended immunizations. The school nurse should use evidence-based immunization strategies, such as school-located vaccination clinics, reminders about vaccine schedules, state immunization information systems (IIS), strong vaccination recommendations, and vaccine education for students, staff, and families. Using these strategies will help reduce health-related barriers to learning (Guide to Community Preventive Services, 2008, 2009, 2010; Ylitalo, Lee, & Mehta, 2013; Bobo, Carlson, & Swaroop, 2013).

BACKGROUND

The impact of vaccines in reducing and eliminating vaccine-preventable diseases has been one of the 10 great public health achievements in the United States (CDC, 2011). The CDC estimates that vaccination of children born between 1994 and 2013 will prevent 322 million illnesses, help avoid 732,000 deaths, and save nearly $1.4 trillion in total societal costs (CDC, 2014c).

While immunization rates remain high for vaccines mandated for school entry, recommended childhood vaccines remain below the Healthy People 2020 recommended targets (US Department of Health and Human Services [USDHHS], 2010). In addition, pockets of unvaccinated children exist across the country, resulting in increasing outbreaks of diseases previously nearly eradicated and have resulted in recent outbreaks of measles and pertussis (CDC, 2014d , 2014e). The success of vaccines in disease prevention and eradication has resulted in a shift in public focus from the risk of diseases to the risk of vaccines (Freed, Clark, Butchart, Singer, & Davis, 2010).

Access to accurate, recordable, and retrievable vaccine information is an issue of growing importance. Families today frequently relocate and need access to their children's immunization information; natural disasters have been known to destroy immunization records; and immunization records are often incomplete. Access and participation in state IIS, previously known as immunization registries, is an evidence-based strategy known to increase accurate and timely vaccine uptake (Guide to Community Preventive Services, 2010). While a national IIS is the ideal, technical and administrative requirements of current state IIS vary greatly. National consensus is that efforts should focus on robust use and interoperability of state systems (Bobo, Etkind, Martin, Chi, & Coyle, 2013).

Expansion of recommended immunizations (e.g., universal seasonal influenza vaccination and adolescent vaccines) presents additional challenges for reaching the Healthy People 2020 national health goals for vaccination coverage. The current vaccine delivery infrastructure might be the most limiting factor in achieving vaccine coverage targets. School-located vaccination has been shown to be an important venue for vaccine delivery, from polio vaccination in 1955 to the most recent H1N1 pandemic. Returning to the school as a point of vaccine delivery capitalizes on the trusted position of schools and school nurses and has the potential of not only increasing immunization rates but also increasing the standardization and retrievability of documentation of vaccinations provided. Vaccine delivery in schools is supported by the Guide to Community Preventive Services (2009), NASN (Bobo, Etkind, & Talkington, 2011) and other reports in the literature (Williams et al., 2012; Wilson, Sanchez, Blackwell, Weinstein, & Amin, 2013).

The historic role of school nurses in maintaining immunization compliance in students is evolving. The role now includes record review, referral, assisting families and students with their decision to vaccinate, immunization

champion and advocate, and immunization provider. As a trusted source of health information, school nurses can influence vaccine uptake through education about the role of children in vaccine-preventable disease transmission and dispelling myths about the various vaccines. The presence of a school nurse, according to Salmon et al. (2004), also reduces the number of exemptions families take.

RATIONALE

NASN supports the ACIP vaccine recommendations that are adopted by the CDC and state and local vaccine mandates. NASN also supports full access of state IIS by school nurses. State IIS can provide consolidated vaccination data that can be used to design effective school-located immunization programming, leading to increased and sustained high immunization rates. State IIS are important tools for school nurses to use to facilitate immunization compliance, identify the immunization status of students in the event of disease outbreaks, and prevent duplication of vaccinations when records have been lost, destroyed or misplaced (CDC, 2013; American Academy of Pediatrics [AAP], 2006; Guide to Community Preventive Services, 2010).

School nurses are ideally positioned within their communities to educate students, families, and school staff about the critical role vaccines play in preventing disease, allowing students and staff to remain healthy and in school. The school nurse can play an important role in enhancing vaccine uptake by providing a strong vaccine recommendation; educating about vaccine-preventable diseases, vaccine myths, vaccine safety, and recommended vaccine schedules; and addressing vaccine hesitancy. It is imperative that school nurses are vigilant in assuring that they are up-to-date on the most current scientific and scholarly evidence in the area of immunizations and are not influenced by unsupported and non-scientific media reports. It is vital that they rely on the expert agencies (e.g., CDC, National Institute of Health, Department of Health and Human Services) for the correct information to educate themselves, families, administrators, teachers, and the community.

CONCLUSION

The proven benefits of immunizations and vaccine uptake do not always coincide. Collective memory of the impact of vaccine-preventable diseases such as diphtheria and polio has faded, largely due to the effectiveness of vaccines over the past several decades (Immunization Action Coalition, 2014), and recent unfounded fears about vaccine side effects have affected vaccine uptake (Freed et al., 2010; Kennedy, LaVail, Basket, & Landry, 2011; Kennedy, Basket, & Sheedy, 2011). Schools and school nurses can improve vaccine uptake among students and staff by providing evidence-based information about vaccine and providing a strong vaccine recommendation, thus averting nonmedical exemptions. School nurses should also role-model immunization compliance themselves. They can also remind students, families, and staff of immunization schedules and report and retrieve immunization information from state IIS. Schools and school nurses can partner with other stakeholders to deliver and/or access vaccines. By implementing these strategies, schools and school nurses have a key role to play in reaching the Healthy People 2020 vaccine targets.

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Individualized Healthcare Plans: The Role of the School Nurse

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (hereinafter referred to as school nurse), in collaboration with the student, family and healthcare providers, shall meet nursing regulatory requirements and professional standards by developing an Individualized Healthcare Plan (IHP) for students whose healthcare needs affect or have the potential to affect safe and optimal school attendance and academic performance. Because health conditions can be complex and unfamiliar to school staff and the student's requirement for nursing care can be frequent and sometimes emergent, accurate and adequate documentation of chronic medical conditions and individual needs is critical (Lyon, 2012). Development of IHPs is a nursing responsibility, based on standards of care regulated by state nurse practice acts and cannot be delegated to unlicensed individuals (National Council of State Boards of Nursing [NCSBN], 2005). It is the responsibility of the school nurse to implement and evaluate the IHP at least yearly and as changes in health status occur to determine the need for revision and evidence of desired student outcomes.

BACKGROUND

The IHP is a document based on the nursing process. Since emerging in the 1970s, the nursing process is the cornerstone of nursing practice, using a scientific approach in the identification and solution of health problems in nursing practice (Hermann, 2005). The American Nurses Association (ANA) and NASN define the nursing process as a "circular, continuous and dynamic critical-thinking process comprised of six steps and that is client-centered, interpersonal, collaborative, and universally applicable" (American Nurses Association [ANA] & NASN, 2011, p. 76). Documentation of these steps for individual students who have healthcare issues results in the development of an IHP, a variation of the nursing care plan. The term IHP refers to all care plans developed by the school nurse, especially those for students who require complex health services on a daily basis or have an illness that could result in a health crisis. These students may also have an Individualized Education Plan (IEP), a 504 Student Accommodation Plan to ensure school nursing services and access to the learning environment, or an Emergency Care Plan (ECP) for staff caring for these students (Hermann, 2005).

RATIONALE

Development of the IHP by the school nurse provides a framework for meeting clinical and administrative needs:

Demonstrates Standard of School Nursing Practice

Development and implementation of the IHP is documentation of professional performance in accordance with standards of school nursing practice, the professional expectations that guide the practice of school nursing (ANA & NASN, 2011). The *Standards of School Nursing Practice* are "authoritative statements of the duties that school nurses, regardless of role, population, or specialty within school nursing are expected to competently perform" (ANA & NASN 2011, p. 4). These standards "describe a competent level of nursing care as demonstrated by the critical thinking model known as the nursing process" (ANA & NASN, 2011, p. 12).

Documents the Nursing Process

Creation of the IHP incorporates and documents the nursing process in student care in accordance with state nurse practice acts. The nursing process provides a framework for the nurse's responsibility and accountability. "The RN may delegate components of care but does not delegate the nursing process itself. The practice pervasive

functions of assessment, planning, evaluation and nursing judgment cannot be delegated" (ANA & NCSBN, 2005, p.2).

School Nursing: Scope and Standards of Practice (ANA & NASN, 2011) outlines how implementation of each step of the nursing process strengthens and facilitates educational outcomes for students. These steps parallel components of a well-developed IHP.

> Standard 1. Assessment: The school nurse collects comprehensive data pertinent to the healthcare consumer's health and/or situation.
>
> Standard 2. Nursing Diagnosis: The school nurse analyzes the assessment data to determine the diagnoses or issues.
>
> Standard 3. Outcome Identification: The school nurse identifies expected outcomes for a plan individualized to the healthcare consumer or the situation.
>
> Standard 4. Planning: The school nurse develops a plan that prescribes strategies and alternatives to attain expected outcomes.
>
> Standard 5. Implementation: The school nurse implements the identified plan.
>
> Standard 6. Evaluation: The school nurse evaluates progress toward attainment of outcomes.

Provides Legal Documentation

A school nurse plans safe care for students and demonstrates an appropriate standard of professional care when the IHP is used as the foundation for student health interventions. "Judicious use of the IHP as a vehicle to ensure safe nursing services and continuity of care for students with special (health) needs is a standard of care against which a school nurse's conduct can be judged in a legal proceeding" (Hootman, Schwab, Gelfman, Gregory, & Pohlman, 2005, p. 190). Along with applicable laws including state nurse practice acts, expert testimony, organizational policies and procedures, the standard of care is a significant factor used by courts in professional liability cases (Pohlman, 2005).

Clarifies Clinical Practice

The IHP's clinical purposes include clarifying and consolidating meaningful health information, establishing the priority set of nursing diagnoses for a student, providing communication to direct the nursing care of a student, documenting nursing practice, ensuring consistency and continuity of care as students move within and outside school districts, directing specific interventions, identifying (safe and appropriate) delegation of care, and providing methods to review and evaluate nursing goals and student outcomes (Hermann, 2005**).** It is important to note that student-centered outcomes are developed early in the IHP process to guide interventions and provide a basis for evaluation to take place. The IHP is the document that combines all of the student's healthcare needs into one document for management in the school setting (Zimmerman, 2013).

Provides Administrative Information

The IHP serves administrative purposes, which include defining the focus of nursing; validating the nurse's role in the school; facilitating management of health conditions to optimize learning; differentiating accountability of the nurse from others in the school; providing criteria for reviewing and evaluating care (quality assurance); providing data for statistical reports, research, third-party reimbursement and legal evidence; and creating a safer process for delegation of care in the school setting (Hermann, 2005).

Serves as the Foundation for Health Portion of Other Educational Plans and Emergency Plans

The IHP provides the health information and activities that can be incorporated into the health portion of other school-educational plans to foster student academic success and to meet state and federal laws and regulations. These include the Individualized Education Plan (IEP) in accordance with the Individuals with Disabilities Education

Improvement Act (P.L. 108-446, 2004) and a 504/ADA plan in accordance with Section 504 of the Rehabilitation Act (P.L. 102-569, 1992) and the Americans with Disabilities Act (P.L. 110-325, 2008).

The student Emergency Care Plan (ECP) is an emergency plan developed by the registered professional school nurse and is based on the IHP or is sometimes used instead of an IHP. The ECP is written in clear action steps using succinct terminology that can be understood by school faculty and staff who are charged with recognizing a health crisis and intervening appropriately (Zimmerman, 2013). The ECP is distributed to these individuals with the expectation that the information will be treated with confidentiality. The names of the individuals who have a copy of the ECP should be listed at the bottom (Zimmerman, 2013).

CONCLUSION

It is the responsibility of the registered professional school nurse to develop an IHP and ECP for students with healthcare needs that affect or have the potential to affect safe and optimal school attendance and academic performance. The IHP is developed by the school nurse using the nursing process in collaboration with the student, family and healthcare providers. The school nurse utilizes the IHP to provide care coordination, to facilitate the management of the student's health condition in the school setting, to inform school-educational plans, and to promote academic success. The ECP, written by the school nurse, is for support staff with an individual plan for emergency care for the student. These plans are kept confidential yet accessible to appropriate staff.

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LGBTQ Students: The Role of the School Nurse

Position Statement

SUMMARY

All students -- regardless of their sexual orientation, gender identity, or gender expression -- are entitled to a safe, supportive and inclusive school environment with equal opportunities for achievement and participation. It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (hereinafter referred to as school nurse) is a vital member of the team to support students' health and well-being and to advocate for policies and practices in the schools that provide for the physical, psychological, and social safety of all students.

BACKGROUND

For the purposes of this position statement, the terms *sexual* and *gender minority* or *LGBTQ* are used to describe students who may identify as lesbian, gay, bisexual, transgender, or questioning. Sexual minority persons are those who identify themselves as gay, lesbian, or bisexual or are unsure of their sexual orientation, or those who have had sexual contact with a person of the same sex or with both sexes (American Academy of Pediatrics [AAP], 2013; Centers for Disease Control and Prevention [CDC], 2014; Kann et al., 2011). Many adolescents do not identify with any sexual minority group and may have had sexual relations with the same sex or with both sexes and those who struggle with their sexual identity and or expression and may be referred to as questioning (AAP, 2013). Gender non-conforming is a term used for people whose gender expression differs from stereotypical expression, those described as androgynous, and includes people who identify outside traditional gender categories or identify as both genders (Gay, Lesbian, Straight Education Network [GLSEN], 2014). Transgender is used to describe a person whose gender identity is different from that traditionally associated with his or her biological sex, external genitalia or assigned sex at birth (CDC, 2014); and it is also used to encompass a broad range of gender identities associated with gender non-conformity (GLSEN, 2013). *Queer* is an umbrella term that is embraced by some youth to describe a sexual identity, gender identity or gender expression; and some LGBT people may consider it offensive (GLSEN, 2013. It is good practice to use terms that a student uses to self-identify their sexual or gender identity or gender expression.

Gender dysphoria is defined by the American Psychiatric Association (2013) as extreme discomfort of individuals with primary and secondary sex characteristics of their assigned birth sex. In 2015, the Substance Abuse and Mental Health Services Administration (SAMHSA) supported ending conversion therapy for youth which is an attempt to change an individual's sexual orientation, gender identity, or gender expression through medical or behavioral interventions as it is not supported by credible evidence and may cause serious harm to young people. It perpetuates outdated views of gender roles and identities and the negative stereotype that being a sexual or gender minority or identifying as LGBTQ is an abnormal aspect of human development (SAMHSA, 2015).

Currently 31 states have no legislation that protects LGBTQ youth from discrimination, and in eight states there are "no promo homo" laws that forbid educators from discussing LGBTQ issues (Orr, Baum & Sherouse, 2015; Teaching Tolerance, 2013). Title IX of the Education Amendments of 1972 protects against discrimination and harassment based on sex in any educational program or activity that receives federal funding and includes those who do not conform to stereotypical sexual or gender identities (GLSEN, 2014; Orr et al., 2015; U.S. Department of Education, Office for Civil Rights , 2015).

The LGBTQ population is multi-faceted with many subgroups, which makes defining the population needs difficult (Institute of Medicine [IOM], 2011). LGBTQ youth are identifying earlier and in larger numbers due to internet online support and an increase in the number of role models (Russell, Kosciw, Horn, & Saewyc, 2010). GLSEN re-

ported that transgender students received much higher levels of harassment and violence than LGB students, which resulted in transgender students missing more school, receiving lower grades, feeling isolated and not part of the school community (Greytak, Kosciw, & Diaz, 2009). In 2013, 9.5 % of students in the school climate report identified as transgender (Kosciw, Greytak, Palmer, & Boesen, 2014).

In 2012, the Human Rights Campaign survey of LGBTQ youth identified family rejection (26%), school/bullying problems (21%), and fear of being out or open (18 %) as the top three problems they faced. LGBTQ youth experience physical, mental, and social health risks that are higher than their heterosexual peers (CDC, 2014; SAMHSA, 2015). Those increased risks may include but are not limited to loneliness, lack of acceptance, violence, bullying, sexually transmitted infections, unintended pregnancies, substance abuse, anxiety, depression and suicide (AAP, 2013; CDC, 2014; Kann et al., 2011; Kosciw et al., 2014).

Sexual and gender minorities experience chronic stress as a result of their stigmatization. This is known as minority stress and is due to the stresses of prejudice, discrimination, parental rejection, and violence -- not their identity (AAP, 2013; IOM, 2011; SAMSHA, 2015). According to the 2013 GLSEN school climate report, 74.1% of LGBT youth were verbally harassed; 36.2% were physically harassed; 55.5 % felt unsafe because of their sexual identity and 37.8% for their gender expression; 30.3% were truant for safety concerns. 55.5% of LGBT students faced discriminatory policies and practices at school while transgender students were significantly more impacted by these practices. (Kosciw et al., 2014; SAMHSA, 2015).

Studies also indicate that characteristics of social environments, including school and families can either increase or reduce vulnerability, and resilience can shape physical and mental health outcomes (Hatzenbuehler, Birkett, Van Wagenen, & Meyer, 2014; Kosciw et al., 2014; Russell et al., 2010; SAMHSA, 2015). School-based organizations have been shown to improve school climate as they can help to assure LGBTQ youth that they are not alone, improve school connectedness, and promote communication and understanding within the school community (AAP, 2013; CDC, 2014; Hatzenbuehler et al., 2014; Kosciw et al., 2014; Teaching Tolerance, 2013).

RATIONALE

School nurses have an ethical responsibility to provide care to all students, families, school staff and community equally regardless of sexual orientation, gender identity or gender expression; to maintain confidentiality and to respect the individual's right to be treated with dignity (American Nurses Association & National Association of School Nurses, 2011; NASN, 2015). Utilizing the Framework for the 21st Century School Nursing Practice (NASN, 2015), school nurses are responsible for care coordination and should be actively involved in improving the health and safety of the school environment for all students, including LGBTQ students.

School nurses are uniquely qualified to:

- Collaborate with school personnel, community healthcare providers, families and LGBTQ students to promote improved physical and mental health outcomes and improve academic achievement (AAP, 2013; Orr, Baum, & Sherouse, 2015).
- Recognize that the health risks are disproportionately higher for LGBTQ students and provide culturally competent care in a safe, private and confidential setting (AAP, 2013).
- Make referrals for evidence-based care to healthcare professionals knowledgeable about the healthcare needs of LGBTQ youth.
- Provide support and resources for families about local and national organizations that are available to help them to support their children.
- Advocate for the creation and enforcement of inclusive zero tolerance bullying policies, attend and promote the professional development of school leadership and personnel to understand and meet the needs of LGBTQ students, promote inclusive health education and curriculum for all students, and encourage a welcoming inclusive

environment with safe spaces in the school, i.e., health office, counselor's office, and classrooms (AAP, 2013; CDC, 2014; GLSEN, 2013; GLSEN, 2014; Teaching Tolerance, 2013).

- Promote student-led Gay Straight Alliance and other clubs supported by faculty and administrators to improve the school climate for all students, regardless of their sexual orientation or gender identity or gender expression (AAP, 2013; CDC, 2014; Hatzenbuehler, et al., 2014; Kosciw et al., 2014; Teaching Tolerance, 2013).
- Provide support for students by advocating for practices and policies that promote the physical, psychological and social safety of all students regardless of their sexual orientation, gender identity or gender expression.
- Encourage the use of gender neutral school forms, dress codes, changing space and bathrooms; use the students' preferred names and pronouns and to protect confidentiality when contacting others if the student is not "out/open" to family or to others at school (Orr et al., 2015; Teaching Tolerance, 2013).

CONCLUSION

School nurses are uniquely positioned to model and promote respect for diversity, reduce stigma and provide confidential health services for LGBTQ students in a safe environment. Supportive families, communities and schools are factors that can help to improve health outcomes for students to live full lives regardless of sexual orientation, gender identity or gender expression. School nurses are leaders who can foster the supportive school environment and make a positive impact in the lives of everyone in the school community (NASN, 2015).

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Marijuana and Children

NASN
National Association of School Nurses

Position Statement

SUMMARY

Registered professional school nurses (hereinafter referred to as school nurses) promote wellness and disease prevention to improve health outcomes for our nation's children. It is the position of the National Association of School Nurses (NASN) that the marijuana plant remain under the United States Drug Enforcement Agency's (DEA) Schedule I category of the Controlled Substances Act (CSA), 21 U.S.C. § 801, et seq. (DEA, 2011, p.2). To date there is not sufficient scientific evidence for U.S. Food and Drug Administration (FDA) to approve the smoked marijuana plant for medical use. NASN believes any marijuana made available for the purpose of adult recreational use facilitates youth access and is not in the best interest of the health and well-being of students.

BACKGROUND

In 1970, Congress enacted laws against marijuana based in part on the conclusion that marijuana has no scientifically proven medical value. The Food and Drug Administration (FDA), responsible for approving drugs as safe and effective medicine, has thus far declined to approve smoked marijuana for any condition or disease. The FDA has noted "there is currently sound evidence that smoked marijuana is harmful" and "that no sound scientific studies support medical use of marijuana for treatment in the United States, and no animal or human data support the safety or efficacy of marijuana for general medical use" (DEA, 2011, p.3). Although the Federal law remains, beginning in 1996, with the State of California passing Proposition 215, twenty states have legalized marijuana for medical use. Two of these states, Washington and Colorado, have enacted recent laws that legalize recreational use. For more information regarding federal and state laws, resources from The National Conference of State Legislators can be accessed at http://www.ncsl.org/issues-research/health/state-medical-marijuana-laws.aspx (National Conference of State Legislators, 2013).

RATIONALE

The National Institute on Drug Abuse (NIDA) (2012) summary below outlines the safety risks of smoked marijuana use and the physical and mental health consequences. These repercussions affect the health, safety and education of adolescents.

Acute (present during intoxication)

- Impairs short-term memory
- Impairs attention, judgment, and other cognitive functions
- Impairs coordination and balance
- Increases heart rate
- Creates psychotic episodes

Persistent (lasting longer than intoxication but may not be permanent)

- Memory and learning skills impairment
- Sleep impairment

Long-term (cumulative effects of chronic abuse)

- Can lead to addiction
- Increases risk of chronic cough, bronchitis
- Increases risk of psychosis, schizophrenia in vulnerable individuals
- May increase risk of anxiety, depression

“Because it seriously impairs judgment and motor coordination, smoked marijuana also contributes to accidents while driving. A recent analysis of data from several studies found that marijuana use more than doubles a driver’s risk of being in an accident. Further, the combination of marijuana and alcohol is worse than either substance alone with respect to driving impairment” (NIDA, 2012, para. 12).

The statistics below from the Office of National Drug Control Policy (ONDCP) (2010a, p.1) illustrate trends in the perception of harm from smoking marijuana also have been declining over the same period of time. Prior research indicates that declines in these perceptions are predictive of increases in use.

- **Past-month use of marijuana among 10th graders** increased from 13.8% in 2008 to 17.6% in 2011.
- **Past-month use of marijuana among 12th graders** increased from 18.3% in 2006 to 22.6% in 2011.
- **Drug use has increased among certain youth minority populations.** Illicit drug use has increased by 43 percent among Hispanic boys and 42 percent among African American teen girls since 2008.

Marijuana is a frequent precursor to the use of more dangerous drugs and signals a significantly enhanced likelihood of drug problems in adult life. One study found that among adults (age 26 and older) who had used cocaine, 62 percent had initiated marijuana use before age 15. The same study showed less than one percent of adults who never tried marijuana went on to use cocaine (Gfroerer et al., 2002). Furthermore, long-term studies on patterns of drug usage among young people show that very few of them use other drugs without first starting with marijuana (ONDCP, 2010b, p.11). The American Academy of Pediatrics’ (AAP) position statement on the issue of marijuana legalization based on their technical report (AAP, 2004b) states that “any change in the legal status of marijuana, even if limited to adults, could affect the prevalence of use among adolescents” (AAP, 2004a, p. 1825).

A study from the University of Pittsburgh illustrates how the adolescent brain may be more vulnerable to addictions. The study found “a strong reward-related activation in the adolescent but not in the adult dorsal striatum, a structure associated with the formation of habits and the adaptive control of behavioral patterns” (Moghaddam & Sturman, 2012, p.4). Another recent study demonstrated the neurotoxic effects of cannabis on the adolescent brain. Adolescents with cannabis dependence (before age 18) became more persistent users compared to adult persistent users and demonstrated a marked decrease in IQ score (Meier & Caspi, 2012). Furthermore, “cessation of cannabis did not fully restore neuropsychological functioning among adolescent onset former persistent cannabis users” (Meier & Caspi, 2012, p. 5).

School nurses are in a strategic position to educate students about the life-long effects and legal consequences of smoking marijuana. According to NIDA (2010), risk of drug abuse increases greatly during times of transition such as changing schools, moving, or divorce. If we can prevent drug abuse, we can prevent drug addiction. In early adolescence, when children advance from elementary through middle school, they face new and challenging social and academic situations. “Often during this period, children are exposed to abusable substances such as cigarettes and alcohol for the first time. When they enter high school, teens may encounter greater availability of drugs, drug abuse by older teens, and social activities where drugs are used.” (NIDA, 2010, p. 11).

As advocates for students, school nurses may choose to engage in public policy conversations surrounding legal reform. Bipartisan organizations such as Smart Approaches to Marijuana (SAM) provide a suggested framework that includes appropriate referral for driving under the influence of marijuana and increased intervention and prevention (SAM, 2013).

CONCLUSION

NASN recognizes this overwhelming evidence about the significant negative effects of marijuana use among young people. Therefore, NASN supports that the health and wellness of children in the United States is best served by

adhering to medical evidence that smoked marijuana for medicinal use is not recommended for this age group. Additionally, NASN recognizes that marijuana made available for adult recreational use poses the potential for increased prevalence and abuse potential among youth. The well-documented, serious cognitive effects; health implications; and safety concerns of recreational marijuana use lead NASN to conclude that the legal availability of marijuana presents more accessibility to the student population and, therefore, puts students at higher risk of use and health consequences.

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Medication Administration in Schools

National Association of School Nurses

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (hereinafter referred to as school nurse) be responsible for medication administration in the school setting, leading the development of written medication administration policies and procedures that focus on safe and efficient medication administration at school. Well-written policies and procedures will enable schools to fulfill their obligations to provide health-related services to all children, including those with special healthcare needs under the Individuals with Disabilities Education Improvement Act (2004) and Section 504 of the Rehabilitation Act (1973) as amended through the Americans with Disabilities Amendment Act [ADAA] in 2008.

Policies and procedures should address (Ryan, Katsiyannis, Losinski, Reid, & Ellis, 2013; U.S. Food and Drug Administration [FDA], 2013):

- delegation (when permissible by state law), training and supervision of unlicensed assistive personnel (UAP);
- student confidentiality;
- medication orders;
- medication doses that exceed manufacturer's guidelines;
- proper labeling, storage, disposal, and transportation of medication to and from school;
- documentation of medication administration;
- rescue and emergency medications;
- off-label medications and investigational drugs;
- prescription and over-the-counter (OTC) medications;
- complementary and alternative medications; and
- psychotropic medications and controlled substances.

The administration of medication by non-nursing school staff, when allowed, should be addressed (Ryan et al., 2013). These policies and procedures shall be consistent with federal and state laws including state nurse practice acts, rules, regulations, and any other laws that may apply, as well as standards and established safe, evidence-based information (Ryan et al., 2013; Bobo, 2014).

Background

Medication administration to students is one of the most common health-related activities performed in school. Historically, administering medication within the school setting has been a school nurse responsibility. However, as many districts and schools struggle financially, it is not uncommon for students to receive medication from non-nursing school employees who have had no medical training. This trend has caused an alarming increase in the number of medication errors made by UAP (Institute for Safe Medication Practices [ISMP], 2012). It is especially important that evidence-based medication policies and procedures be in place in those schools where a registered nurse is not present every day.

It is estimated that up to 27% of children have chronic health conditions (Van Cleave, Gortmaker, & Perrin, 2010). As more students with chronic conditions enter school systems each year, awareness of the factors which can promote and support their academic success increases. This includes the need for medications which enhance students' overall health or stabilize their chronic health conditions.

Medications, when administered and used appropriately, can improve student health but may be harmful if administered incorrectly. Errors in medication administration are the most common medical errors (Cloete, 2015). Examples of medication errors include administering medication to the wrong person, giving the wrong dose, or not giving a dose as scheduled. For the safety of students, it is critical that evidence-based policies and procedures exist regarding medication administration. School nurses have the health expertise needed to develop, promote, and implement policies that are evidence-based; reduce errors; and increase the proper use and storage of medications in school settings (American Academy of Pediatrics [AAP], 2016; ISMP, 2012).

RATIONALE

To reduce errors and increase safety, written policies and procedures for schools should include documentation from a licensed provider for the medication; proper labeling of medications brought to school; training of other staff involved in medication administration; storage of medication; process for administering medication (including proper identification of student and medication); documentation of medication administration, errors, reactions or side effects of medication; and proper disposal of medications (National Coordinating Council for Medication Error Reporting and Prevention [NCCMERP], 2007; 2015; FDA, 2013; Ryan et al., 2013). The principles of leadership, care coordination, quality improvement, public health/community, and standards of practice guide the practice of school nurses, including their role in medication administration (NASN, 2016).

Leadership
As the expert healthcare provider in the educational setting, the school nurse is critical to the safe and effective administration of medication to students. The school nurse should lead in the development, implementation, and evaluation of medication administration policies and procedures at the school or district level. Training and supervision of UAPs who administer medications should be done by the school nurse, and consideration of safety and school nurse workload is essential. There is a decrease in errors when a culture of safety exists that includes proper oversight and written policies in place (U.S. Department of Health and Human Services [USDHHS], 2011).

School medication policies and procedures must be in accordance with all applicable laws, including nurse practice acts (NPA). For example, delegation and training are often specifically noted in states' NPAs. Registered nurses possess the knowledge about how to comply with NPAs and issues such as over-the-counter medications, off-label usage, and alternative medications in a safe, evidence-based manner (American Nurses Association [ANA], 2012; AAP, 2016).

Care Coordination
Medication administration is often part of a larger plan for the care and management of acute and chronic health conditions. There must be communication and collaboration between parents, providers, and schools regarding each student's medication that describes what is to be given, the purpose, frequency, and side effects of the medication (NCCMERP, 2007; American Academy of Pediatrics, American Public Health Association, & National Resource Center for Health and Safety in Child Care and Early Education, 2011). School nurses are the health professionals in the school who coordinate care for the student, including medication administration.

Quality Improvement
The necessity for student use of medication at school has risen over the last two decades because many students who attend school have complex and chronic medical problems (ISMP, 2012). Research has shown that there are fewer medication errors in schools when medications are provided by a school nurse and when evidence-based policies are routinely followed (ISMP, 2012). Medication policies and procedures should include provisions for evaluation of medication practices and policies, including reviews of documentation and occasional audits, to identify possible concerns and adjust practice or policy as needed (USDHHS, 2011).

Community/Public Health
School nurses understand the unique needs and environments of their populations, which should be addressed in schools' medication policies and guidelines (NCCMERP, 2015). School nurses can identify and address issues that

may affect management of acute and chronic health conditions, such as environmental factors and socio-economic challenges, including obstacles to obtaining medications and delivery of medication to the school (Blaakman, Cohen, Fagnano, & Halterman, 2014). Evidence indicates that school nurses can provide culturally appropriate, sensitive information for students and families regarding management of health issues, including proper use of medications (McNaughton, Cowell & Fogg, 2014).

CONCLUSION

The school nurse should lead the development of school district policies and procedures relating to medication administration in the school setting and, where delegation of medication is permitted, the school nurse should be responsible for the delegation, training and supervision of UAP. The school nurse is the professional with the clinical knowledge and understanding of the complex issues surrounding the safe administration of medication and the responsibility to protect the health and safety of students (AAP, 2016; ANA, 2012). As the health leader in the school setting, the school nurse promotes current evidence-based practices so students requiring medication during the school day can safely have their needs met and remain in school ready to learn (Maughan, 2016).

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Resources for Supporting Information:

NASN position statements:
The Role of the 21st Century School Nurse (June 2016)
Delegation, Nursing Delegation to Unlicensed Assistive Personnel in the School Setting (June 2014)
Unlicensed Assistive Personnel: Their Role on the School Health Services Team (January 2015)
School Nurse Workload: Staffing for Safe Care (January 2015)

AAP: Role of the School Nurse in Providing School Health Services (2016)
AAP: Guidance for the Administration of Medication in School (2009)

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Naloxone Use in the School Setting: The Role of the School Nurse

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that the safe and effective management of opioid pain reliever (OPR)-related overdose in schools be incorporated into the school emergency preparedness and response plan. The registered professional school nurse (hereinafter referred to as school nurse) provides leadership in all phases of emergency preparedness and response. When emergencies happen, including drug-related emergencies, managing incidents at school is vital to positive outcomes. The school nurse is an essential part of the school team responsible for developing emergency response procedures. School nurses in this role should facilitate access to naloxone for the management of OPR-related overdose in the school setting.

BACKGROUND

Deaths from prescription painkillers (opioid or narcotic pain relievers) have reached epidemic levels in the past decade according to the Centers for Disease Control and Prevention (CDC) (2014a). A crucial mitigating factor involves the nonmedical use of prescription painkillers—using drugs without a prescription or using drugs to obtain the "high" they produce. In 2010, the CDC stated about 12 million Americans (age 12 or older) reported nonmedical use of prescription painkillers in the past year (CDC, 2014a). The 2013 Partnership Attitude Tracking Study (PATS) stated almost one in four teens (23 percent) reported abusing or misusing a prescription drug at least once in his or her lifetime, and one in six (16 percent) reported doing so within the past year (Feliz, 2014). According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health in 2013, there were 2.2 million adolescents ages 12 to 17 who were current illicit drug users (SAMHSA, 2014). Given the magnitude of the problem, in 2014 the CDC added OPR overdose prevention to its list of top five public health challenges (CDC, 2014b).

RATIONALE

Schools should be responsible for anticipating and preparing to respond to a variety of emergencies (Doyle, 2013). The school nurse is often the first health professional who responds to an emergency in the school setting. The school nurse possesses the education and knowledge to identify emergent situations, manage the emergency until relieved by emergency medical services (EMS) personnel, communicate the assessment and interventions to EMS personnel, and follow up with the healthcare provider. Harm reduction approaches to OPR overdose include expanding access to naloxone, an opioid overdose antidote, which can prevent overdose deaths by reversing life-threatening respiratory depression. When administered quickly and effectively, naloxone has the potential to immediately restore breathing to a victim experiencing an opioid overdose (Hardesty, 2014).

Naloxone saves lives and can be the first step towards OPR abuse recovery. It provides an opportunity for families to have a second chance with their loved ones by getting them into an appropriate treatment regimen (Lagoy, 2014). Ensuring ready access to naloxone is one of the SAMSHA's five strategic approaches to prevent overdose deaths (SAMHSA, 2013).

CONCLUSION

OPR overdose kills thousands of Americans every year. Many of these deaths are preventable through the timely provision of an inexpensive, safe, and effective drug and the summoning of emergency responders (Davis, Webb & Burris, 2013). School nurses must be familiar and sensitized to the legal issues, which vary from state to state in

terms of the prescription and availability of naloxone. They should review local and state policy on how to access naloxone and implement its use as part of their school emergency response protocol.

It is also important to prevent students from ever misusing opiates. School nurses are crucial primary prevention agents in school communities. Through utilization of prevention materials, school nurses can provide valuable awareness and education on the dangers of prescription drug misuse to K-12 students and their families. In addition, school nurses can help families recognize signs and symptoms of substance abuse, guide them to locate resources, and assist them in making referrals for treatment of OPR addiction.

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Overweight and Obesity in Children and Adolescents in Schools - The Role of the School Nurse

National Association of School Nurses

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (hereinafter referred to as the school nurse) has the knowledge, expertise, and skills to promote the prevention and reduction of overweight and obesity among children and adolescents in schools. Grounded by standards of practice within the *Framework for 21st Century School Nursing Practice*™ (NASN, 2015), school nurses can identify, assess, refer, and follow-up with children and adolescents who are at risk for health problems associated with overweight or obesity. School nurses can provide cost-effective, sustainable school-based overweight and obesity interventions that address the complex physical, social, and health education needs of children and adolescents who are overweight or obese (NASN, 2013; Schroeder, Travers, & Smaldone, 2016). School nurses also lead in the development of local school health policies and district/community policies that support wellness, healthy nutrition, increased physical activity, and healthy lifestyle behaviors for all students (NASN, 2013).

BACKGROUND

Overweight and obesity among children and adolescents have emerged as one of the most serious health concerns in communities across the nation (Gungor, 2014; Segal, Rayburn, & Martin, 2017). The associated physical, psychosocial, and economic consequences of overweight and obesity have a negative impact on children, families, communities, the military, and society at large (NASN, 2013). Overweight and obesity in the United States often begin in childhood and can be largely preventable. Overweight for children is defined as a body mass index (BMI) at or above the 85th percentile and less than the 95th percentile for children of the same age and gender, and obesity is defined as a BMI greater than the 95th percentile for children of the same age and gender (Centers for Disease Control and Prevention [CDC], 2016a). From 2011-2014, the prevalence of obesity for children and adolescents, 2-19 years old, remained stable at 17% (CDC, 2016b; Ogden, Carroll, Fryar, & Flegal, 2015). In the past fifteen years, significant progress has been made towards preventing and stabilizing obesity rates (Segal et al., 2017). Signs of progress can be attributable to communities that have implemented comprehensive obesity prevention strategies to make healthy foods and beverages accessible in their schools and communities and have integrated physical activity into their daily lives (Segal et al., 2017). Despite these positive trends, obesity remains an American epidemic affecting 12.7 million (one in every six) children and adolescents ages 2-19 years old (Segal et al., 2017; CDC, 2016b; Ogden et al., 2015).

Quality nutrition and physical activity are essential for optimal growth, development, and well-being. The global shift in diet intake of energy-dense foods that are high in fat and sugar but low in nutrients has contributed greatly to childhood obesity (World Health Organization [WHO], 2017a). More than 90% of American children have poor diets and less than half get the recommended 60 minutes of daily physical activity (Segal et al., 2017; WHO, 2017a).

Obesity also disproportionally affects low-income families in rural communities as well as certain racial and ethnic groups, including Blacks, Latinos, and Native Americans (Segal et al., 2017). Social inequities are evident in these communities and contribute to the overweight and obesity epidemic. Children have few safe outdoor spaces to play or accessible routes to walk or bike to school. Many of these communities also have small food outlets and fast food restaurants that sell and advertise unhealthy food and beverages. Fresh and healthy foods are not readily available and are unaffordable for most low-income families. Where families live, work, play, and attend school, all have a major impact on the choices they are able to make (Segal et al., 2017).

Overweight and obesity in children and adolescents may also influence their ability to be attentive and remain in class (NASN, 2013). Research has shown that children and adolescents who are obese have lower educational engagement, more behavioral problems, and more school absences (NASN, 2013; Segal et al., 2017). Recent studies have also found that students who are obese are more likely to repeat a grade, have lower grade point averages and lower reading scores (Segal et al., 2017).

The cause of overweight and obesity in children and adolescents is not completely understood but thought to be complex and have multiple contributing factors including (CDC, 2016a; National Institutes of Health [NIH], 2017; WHO, 2017b)

- diet and insufficient physical activity
- heredity/genetics
- family/social factors
- behavioral/cultural factors
- environmental/socioeconomic status
- media marketing

The immediate and long-term effects of overweight and obesity impact the physical, emotional, and social health of children and adolescents and places them at a higher risk for the following health conditions (CDC, 2016a; Hoelscher, Kirk, Ritchie, & Cunningham-Sabo, 2013; NIH, 2017):

- high blood pressure and high cholesterol (cardiovascular disease);
- breathing problems such as asthma and sleep apnea;
- type 2 diabetes, impaired glucose tolerance, insulin resistance;
- fatty liver disease, gallstones, gastro-esophageal reflux;
- psychological problems such as anxiety and depression;
- joint and musculoskeletal disorders;
- poor self-esteem and quality of life;
- social problems such as bullying; and
- some cancers.

RATIONALE

The WHO (2017b) and the CDC (2017) recognize that the prevention of overweight and obesity is the most feasible option for reversing the childhood obesity epidemic. *Healthy People 2020* (USDHHS, 2017) identifies specific goals to achieve and promote maintenance of healthy body weight and daily physical activity. Since most children spend a large portion of their day at school, the school is an ideal setting and one of the most efficient systems to reach children and adolescents to provide health services and strategies to prevent overweight and obesity (CDC, 2014). School nurses are in a position to reach a large number of children and adolescents, and they are able to address the potentially serious health problems that result from overweight and obesity. The American Academy of Pediatrics Council on School Health (2016) recognizes the important role that school nurses have in children and adolescents' continuum of care and states that the daily presence of a school nurse may contribute to the reduction of childhood obesity.

Reducing and preventing overweight and obesity at an early age is critical considering the probability that children and adolescents who are overweight or obese will remain so in adulthood (NASN, 2013). Without intervention, children and adolescents who are overweight or obese could be the first generation to live shorter, less healthy lives than their parents (NASN, 2013; Segal et al., 2017). Research studies have demonstrated that school programs are effective in preventing childhood obesity by encouraging healthier diets and increased physical activity (Segal et al., 2017). The school nurse can create a culture of health that supports balanced nutrition and physical activity for all students within the school setting.

Overweight and obesity are sensitive issues for students and families and must be addressed with compassion, understanding, and caring (NASN, 2013). School nurses can promote and implement the following overweight and obesity prevention school-based strategies (NASN, 2013):

- identifying students who may need further evaluation by conducting BMI assessments with appropriate safeguards (Segal et al., 2017);
- assessing students for possible risk factors associated with overweight and obesity (hypertension, acanthosis nigricans, risk for type 2 diabetes, and family history) (NASN,2013);
- making necessary referrals to healthcare providers for further assessment and treatment;
- developing Individualized Healthcare Plans that address elevated BMIs and recommendations for lifestyle modifications;
- providing individual counseling and motivational interviewing to support weight-related behavior change (Missouri Department of Health and Senior Services, 2015; Pbert et al., 2013);
- promoting individual nutrition and physical activity assessments to help children and adolescents identify healthy behaviors and set healthy goals;
- encouraging follow up for counseling and ongoing psychological support for students;
- promoting healthy messages that encourage the consumption of healthy foods and daily physical activity;
- serving as a role model and encouraging role modeling of healthy lifestyle choices by parents and teachers; and
- educating students, parents, and the school community about evidence-based overweight and obesity prevention strategies, healthy lifestyle behaviors, daily physical activity requirements, and preventable health risks associated with overweight and obesity.

School nurses also provide leadership in initiating and leading the school community to influence policy and strategies that address the prevention of overweight and obesity. School nurses can effectively improve the health of children and their families by promoting the following efforts (Alliance for a Healthier Generation, 2017):

- developing and implementing wellness policies that include healthy nutrition and physical activity;
- promoting safe walk-to-school and bike-to-school programs;
- advocating for
  - shared use of recreational facilities;
  - research to determine the behavioral and biological causes of overweight and obesity;
  - nutritional school breakfasts and lunches;
  - compliance with the United States Department of Agriculture's Smart Snacks Nutrition Standards;
  - accessible drinking water throughout the school day and during meals;
  - daily physical education; and
  - education and resources for low income families on how to grow their own gardens.

CONCLUSION

Overweight and obesity remain an American epidemic, affecting one in every six children. Overweight and obesity prevention is an investment in our children's ability to be healthy, safe, engaged and ready to learn. School nurses are in key positions to provide cost-effective, sustainable, overweight and obesity prevention strategies that address the needs of children and adolescents who are overweight or obese (NASN, 2013; Schroeder, Travers, & Smaldone, 2016). The principles of care coordination, community/public health, and leadership--included in the *Framework for 21st Century School Nursing Practice*™-- guide the practice of school nurses in the identification, prevention, and treatment of children and adolescents who are overweight or obese in schools (NASN, 2015). School nurses recognize the positive impact of healthy eating and physical activity on academic success, promote a culture of health and well-being for all students, and have an important role in affecting policy change that will improve the health of our students and communities in which they live.

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The Patient Protection and Affordable Care Act: The Role of the School Nurse

National Association of School Nurses

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (hereinafter referred to as school nurse) serves a vital role in the delivery of health care to our nation's students within the healthcare system reshaped by the Patient Protection and Affordable Care Act of 2010, commonly known as the Affordable Care Act (ACA). This law presents an opportunity to transform the healthcare system through three primary goals: expanding access, improving quality and reducing cost (U. S. Government Printing Office, 2010). School nurses stand at the forefront of this system change and continue to provide evidence-based, quality interventions and preventive care that, according to recent studies, actually save healthcare dollars (Wang et al., 2014). NASN supports the concept that school nursing services receive the same financial parity as other healthcare providers to improve overall health outcomes, including insurance reimbursement for services provided to students.

BACKGROUND

Throughout the early twentieth century, American industrialists and organized labor recognized that worker illness led to lost productivity (Owen, 2009). Presidents Roosevelt, Truman, Eisenhower and Kennedy supported a national medical insurance plan financed via social security payroll taxes (Owen, 2009). In 1965, President Lyndon B. Johnson signed legislation authorizing Medicare and Medicaid, the first national medical insurance plan (Owen, 2009). Created in 1997, the Children's Health Insurance Program (CHIP) provides affordable healthcare coverage to low-income children not eligible for Medicaid (U.S. Government Accounting Office, 2013). In 2010, President Barack Obama signed comprehensive health reform into law. The ACA aims to expand coverage, improve the healthcare delivery system and control healthcare costs (U. S. Government Printing Office, 2010).

This law also requires health insurance providers to provide "minimum essential benefits" to all Americans, regardless of their health status, age, gender or other pre-existing conditions for any plan offered through an employer or on the health insurance exchange. These benefits include the following:

- Ambulatory services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorders services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care (Bagley & Levy, 2014).

Additionally, the ACA reauthorized CHIP through 2015 (Foxhall, 2014). Beginning in 2016, states that cannot afford to sustain CHIP coverage are required to ensure that CHIP-eligible children be covered either by Medicaid or a health plan available from the health insurance exchange. Under the ACA, states have the option to receive a federal match to expand Medicaid to children and families with household incomes at or below 138 percent of the federal poverty level (Hahn & Sheingold, 2013). In states that do not accept Medicaid expansion, families with incomes below 100 percent of the federal poverty level and who are not currently eligible for Medicaid will not

have access to health insurance (Hahn & Sheingold, 2013). Americans whose household incomes range from 100 to 400 percent of the federal poverty level will have the option to purchase a health plan on the health insurance exchange and may qualify for federal tax subsidies to help offset the cost of premiums. Research demonstrates that mortality rates decrease when Medicaid coverage is expanded; thus a state's failure to expand Medicaid eligibility has the potential to significantly impact overall community and individual health (Hahn & Sheingold, 2013).

RATIONALE

NASN supports access to quality health care for all children, including the essential health benefits provided by the ACA. Research studies estimate that 25 percent of children and adolescents in the United States have chronic health conditions (Halfon & Newacheck, 2010) and that more than 7 percent, or 1 out of every 14 children, are without health insurance (Martinez & Cohen, 2013, U.S. Department of Health and Human Services, 2012). Rates of uninsured (9.3 percent) and under insured (34.3 percent) are higher for children with special healthcare needs (Child and Adolescent Health Measurement Initiative [CAHMI] 2012).

School nurses are healthcare professionals with the skills and expertise to assist students and their families in accessing health insurance, to provide vital health services to students and to coordinate care with other healthcare providers. Inclusion of the school nurse as the leader of the school health team ensures that health is prioritized in the school environment and that school health services are a part of the larger continuum of health care across all settings. School nursing interventions that promote healthy lifestyles choices as the norm have a lasting impact to influence overall student health (Frieden, 2010). Recent studies show that every dollar invested in school nursing saves $2.20 overall (Wang et al., 2014). Furthermore, by working to the fullest extent of their education and training (IOM, 2011), school nurses have the knowledge and skill to:

- Promote population health and the prevention of chronic diseases;
- Coordinate health care among students, families and healthcare providers;
  - Reduce the number of emergency room visits;
  - Provide transitional care to prevent re-hospitalization;
  - Serve as the liaison between families of children with chronic disease and their primary healthcare providers;
- Provide critical primary (e.g., health education, immunizations), secondary (e.g., health screenings) and tertiary (e.g., chronic disease management) care to students;
- Assist in efforts to enroll families for insurance coverage;
- Advocate for and enable improved overall health care for students;
- Advocate for meaningful use of the abundance of school nursing data and promote full utilization of electronic health records;
- Assess student health conditions and provide appropriate care in the educational setting; and
- Assess, plan and implement programs to impact school community health outcomes.

CONCLUSION

School nurses keep students healthy in the communities in which the students live, learn and play. NASN actively supports the position that school nursing services receive the same financial parity as other healthcare providers to improve overall health outcomes, including insurance reimbursement for services provided to students. School nurses serve a vital role in implementing the provisions of the ACA and stand ready to collaborate with students, families, and licensed healthcare providers to improve healthcare access and insurance coverage.

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Pregnant and Parenting Students – The Role of the School Nurse

National Association of School Nurses

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (herein after referred to as school nurse) has a crucial leadership role on the school team to support the health, well-being and educational success of pregnant and/or parenting students.

The school nurse contributes to the health and academic success of pregnant and parenting students by providing evidence-based nursing interventions. All school-based interventions and services for pregnant and/or parenting students should be age appropriate, culturally sensitive, and student centered. Adequate support is critical for achieving high school graduation and successful parenting. The interventions provided by school nurses may include assistance in pregnancy identification, referral or provision of quality prenatal care, childcare referrals, parenting education, and education regarding prevention of future pregnancy, referral to clinical services and healthcare, as well as leadership on interdisciplinary teams. The school nurse should focus on developing Individualized Healthcare Plans and work with teams to establish systems that will accommodate the student so that she/he is able to maintain school attendance ultimately leading to graduation success. School nurses should also collaborate with colleagues and advocate for comprehensive education and services to prevent the incidence of pregnancy in adolescence.

BACKGROUND

Title IX of the Education Amendment Act of 1972 intended to end sex discrimination in education and prohibits discrimination against pregnant and/or parenting students seeking an education (American Civil Liberties Union, 2015). Schools are required to provide the same level of services to services to pregnant and parenting (female and male) students who are similarly able or unable to participate in school activities (National Women's Law Center, 2012). The overall birth rate for adolescents 15-19 years old in 2013 was 29.4 per 1,000 (U. S. Department of Health and Human Services, Office of Adolescent Health [USHHS/OAH], 2014). This is a record low for US teens, and a drop of 6% from 2011. During this same period, birth rates also fell 8% for women aged 15–17 years and 5% for women aged 18–19 years (Centers for Disease Control and Prevention [CDC], 2015). Although these trends are positive, the rate is still higher than other developed countries.

Thirty percent of adolescent girls cite pregnancy or parenthood as a primary reason for dropping out of school (Manlove, Steward-Streng, Peterson, Scott, & Wildsmith, 2013), and Hispanic and African American teen dropout rates for pregnancy are 36 and 38%, respectively (National Conference of State Legislatures, 2015). Teen mothers who have a child before age 18 are less likely to graduate (fewer than 38 percent) and only 19% earn a GED (Azar, 2012). Two of three African American teen mothers finish high school or its equivalent by age 22 (Azar, 2012). Those that are Hispanic, however, are the least likely to finish high school, with less than half finishing by age 22 (Ng & Kaye, 2012).

RATIONALE

Adolescent childbearing may significantly reduce potential educational success, especially among urban minority youth; however, poverty and its consequences may exert even more influence (Bausch, 2011). School nurses play a key role in preventing poor pregnancy outcomes (Platt, 2014) and improving educational outcomes by implementing the following nursing interventions which are evidence-based and support the health and well-being of pregnant and/or parenting students (Bausch, 2011; Azar, 2012; Johnson, 2013; USHHS/OAH, 2014):

- Provide health education;

- Recognize signs of pregnancy;
- Discuss reproductive options with the student;
- Intervene to counter pregnancy denial;
- Assist students and their families in making healthy choices;
- Offer emotional support by fostering communication between parent and [pregnant and/or parenting] student;
- Advocate for comprehensive human development and sex education;
- Develop activities that build on student assets;
- Enhance student connections to school;
- Link students to reproductive health services;
- Connect to community education regarding the consequences of adolescent pregnancy;
- Build a support network for students including the core services of:
  - Developmentally appropriate childcare,
  - Preventive health care for infants and children,
  - Case management, and
  - Economic assistance.

These interventions will also support the transition to fatherhood for adolescent males. School nurses should encourage access for adolescent male students to their children in order to support bonding which may help to prevent disengagement of young men in the parenting process and foster future involvement in their children's lives (Johnson, 2013).

CONCLUSION

Childbearing adolescents are less likely to finish high school, more likely to rely on public assistance, more likely to be poor as adults, and more likely to have children similarly affected, which consequentially affects the parents themselves, their children, and society (USHHS/OAH, 2014). This is particularly of concern for minority youth. School nurses are well positioned to identify and support at-risk students (Platt, 2014) and are leaders in health education and public health. Teen pregnancy (prevention) is a *winnable* public health battle (CDC, 2014). School nurses advocate for adolescent parents and play a key supportive role in their positive academic outcomes and in promoting a healthy start for their children (Johnson, 2013).

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Reimbursement for School Nursing Services

Position Statement

National
Association of
School Nurses

SUMMARY

The National Association of School Nurses (NASN) believes school nursing services that are reimbursed in other healthcare environments should also be reimbursed in the school setting. The registered professional school nurse (hereinafter referred to as the school nurse) provides the health services in the school setting to improve the students' ability to remain in the classroom and increase their opportunity for academic achievement. Healthcare services provided by the school nurse are reimbursable services in other healthcare settings, including hospitals, clinics, and home care settings.

Historically, local and state tax monies targeted to fund education programs have paid for school health services. School nurses are in a unique position to advocate, encourage, and facilitate improving clinical care to students. This care matches the services provided by community healthcare professionals and as such school health programs should be able to apply for to reimbursements just like their community counterparts. Restructuring reimbursement programs will enable healthcare funding streams to assist in paying for school nursing services delivered to students in the school setting. Developing innovative health funding opportunities will help to increase access, improve quality, and reduce costs. A goal of NASN is to promote a comprehensive and cost-effective healthcare delivery model that integrates schools, families, providers, and communities while at the same time keeping students healthy, safe, and ready to learn.

BACKGROUND

Historically, third-party payers--including Medicaid, the Children's Health Insurance Program (CHIP), and private insurance companies--have provided reimbursements for healthcare services. Medicaid, Title XIX of the Social Security Act, enacted in 1965, regulates the coverage and payment for many healthcare services. Medicaid is a federal-state funded partnership, and each state has a State Plan approved through the Centers for Medicare and Medicaid services that define the health services covered (National Alliance for Medicaid in Education [NAME], 1997). For Medicaid to reimburse health services, a child (student) must be eligible based on family income or disability; the provider (school nurse) must be qualified to provide such service; and the service must be reimbursable according to Medicaid guidelines. The place of service, such as the setting of a school district, should not preclude payment for a reimbursable service (Medicaid.gov., 2014).

CHIP is a program designed to cover uninsured children in families who do not qualify for Medicaid and those who cannot afford private insurance. CHIP is administered by individual states but is jointly funded by both the federal government and states (Medicaid.gov, n.d.). Individual states may choose how CHIP funding is used through one of three options: Medicaid expansion, as a separate children's insurance, or as a combination of the two (Medicaid.gov, n.d). Medicaid sets the standard for coverage of benefits and reimbursement (Lowe, 2013). The majority of children enrolled in CHIP are covered through Medicaid (The Commonwealth Fund, 2017).

Individualized Education Program (IEP) Health-related Nursing Services

Covered reimbursable nursing services include both direct and case management services as long as the student receiving services is in special education, has a current IEP, and qualifies for Medicaid. Individuals with Disability Education Improvement Act (IDEIA) (2004) stipulates that, if a child is receiving a related service, the state Medicaid agency must assume the financial responsibility prior to the local education agency (LEA).

Early Periodic Screening, Diagnosis, and Treatment (EPSDT)

Some school districts provide nursing services under EPSDT. EPSDT is a mandatory set of services and benefits for

individuals under the age of 21 enrolled in Medicaid (Title XIX of the Social Security Act of 1965, Revised 1984). This is the only area in the current law in which Medicaid can reimburse for preventive services. Some school districts may offer EPSDT services to reduce barriers to healthcare disparities, making needed health services available to children. EPSDT provides for the early identification, assessment, and treatment of health conditions.

Vaccines
To promote immunization compliance, some school districts provide immunizations to Medicaid-eligible children under the federal Vaccines for Children (VFC) Program. The vaccines are offered free of charge; however, school districts receive reimbursements for the assessment and administration of the vaccinations. Some school districts provide influenza vaccinations, which are also reimbursable.

Nurse Practitioner Services
Many school districts hire advanced practice nurses, such as pediatric or family nurse practitioners, as school nurses or in addition to school nurses to provide primary care services, including chronic disease management, EPSDT services and treatment of minor illnesses. This is a cost-effective way to expand access where children learn and play and to provide primary care in coordination with other health providers. Nurse practitioners can also manage and prescribe medication if allowed under their state nurse practice acts and coordinate with registered nurses in the school to reduce unnecessary healthcare utilization, such as emergency room visits. Providing these services in school also helps to reduce health-related barriers to learning, thereby improving overall outcomes.

School-based Health Centers (SBHC)
Many models exist for school-based health centers. Some school districts provide in-kind space for school-based health centers, and community agencies provide and receive reimbursements for the services. Other school districts may hire the providers for a school-based health center, and the district receives the reimbursements. There may also be a variety of hybrid models, which provide advanced practice nursing services. Although the majority of SBHC are privately funded, approximately one-third rely on school districts for financial support (Price, 2017). Price (2017) adds that, while fee-for-service produces the largest revenue, some centers receive monthly or annual capitated payments and reimbursement for care coordination. NASN believes that it is worth exploring innovative ways to complement the care provided by school nurses by offering an additional comprehensive range of services through a sustainable mechanism (NASN, 2017).

Chronic Disease Management
School nurses provide chronic disease management to children during the school day for asthma, diabetes, attention deficit hyperactivity disorder (ADHD), hearing disorders and many other chronic health conditions. Management of chronic health conditions is a health service that is reimbursable in other healthcare delivery systems. Effective chronic disease management includes a key component of care coordination. Managing chronic diseases and coordinating care may lead to a reduction in emergency department visits, decreased absences from school, improved student health outcomes, and overall cost savings. School nurses often have the tools necessary to link school staff, students, families, community, and healthcare providers to promote a healthy school environment for students with chronic health conditions (Leroy, Wallin, & Lee, 2017). Many states have passed legislation related to chronic disease management of diabetes and anaphylaxis. Best practice in establishing reimbursement for these students is to follow the practice guidelines of the state Medicaid agency that is in compliance with other healthcare providers in the community. Reimbursement for nursing services is not restricted to only those services provided in community healthcare centers but is available for nursing services provided within the school setting as well (Medicaid.gov., 2014).

Administrative Claiming
Medicaid allows for the provision of administrative activities, including Medicaid outreach and facilitating Medicaid enrollment. These administrative activities are reimbursable through state Medicaid programs. School nurses in many states are participating in time studies for reimbursement for Medicaid administrative claiming (NAME, 2003). Examples of some school nursing services that may be eligible for reimbursement include, but are not limited to, assisting a student and/or family in completing and processing Medicaid enrollment forms, informing potential Medicaid eligible students and their families about the services provided by Medicaid, providing

information about EPSDT, referring an individual or family to apply for Medicaid benefits, providing assistance in implementing health/medical regimens, coordinating health-related services, and making referrals for a student to receive necessary health/medical evaluations or examinations.

Patient Protection and Affordable Care Act (PPACA)
Schools and school nurses are in a unique position to engage in health reform implementation. The law, known as the Patient Protection and Affordable Care Act (PPACA) (2010), has three major goals: expanding access, improving quality, and reducing costs. The PPACA includes provisions which will help more children obtain healthcare coverage, end lifetime and most annual limits on care, allow young adults under 26 to stay on their parents' health insurance, provide children and adults access to recommended preventive services without additional costs, and prohibit insurance companies from denying coverage due to pre-existing health conditions. The PPACA presents an opportunity to transform the way care is delivered in this country by exploring various models of integrated and coordinated care, which improve quality, expand access, and save money – with a particular focus on investing in evidence-based strategies that promote wellness and disease prevention.

Section 504
Section 504 of the Rehabilitation Act of 1973 (2000) is a federal civil rights statute that grants to individuals legal protection against discrimination on the basis of disability. All school districts that receive federal dollars must comply with Section 504. The U.S. Department of Education Office of Civil Rights administers Section 504. For a student with a physical or mental impairment that causes a substantial limitation of a major life activity, or major bodily function, related services must be provided without cost, including medication administration, medication management, and chronic disease management. Funds available from any public or private agency may be used to meet the requirement of providing related services. An insurer or similar third party, such as medical assistance, has a valid obligation to pay for services provided to a person with a disability (Civil Rights Act of 1964, 34C.F.R. 104.33).

RATIONALE

The responsibility of a school system is to provide quality education for children. However, in order for children and adolescents to be successful learners, they must have their healthcare needs met. The school setting provides a unique opportunity to enroll eligible children in the Medicaid program and to assist children who are already enrolled in Medicaid to access the benefits available to them (Medicaid.gov, n.d.). This is one example of reimbursement of professional school nursing services from a third- party payer. When reimbursement programs are restructured, revenue will be available to support essential school nursing services.

The position of NASN is school nurses must take a leadership role in making the case for innovative health financing proposals, including restructuring existing reimbursement programs to support, expand, and promote access to school health services. Harnessing healthcare funding to assist in paying for school nursing services delivered to students in the school setting is the only sustainable way forward. School nurses are keenly aware of the health needs of students and possess the expertise, assessment skills and judgment to provide direct, comprehensive health services for students. School nurses contribute to their local communities by helping students stay healthy, in school, and ready to learn and by keeping parents and families at work. Providing services that will enable children to have a healthy and successful future will equip them to become productive citizens in society. This is the message that school nurses need to convey to their local, state, and national policymakers, elected officials, school administrators and other stakeholders.

CONCLUSION

The Robert Wood Johnson Foundation publication, *Why School Nurses Are the Ticket to Healthier Communities* (2016), points out that, because school nurses are integrated into their schools and communities, they can address unmet health needs so that students can focus on learning. This statement highlights the reality that school nurses serve on the frontlines as the nation's safety net for our most vulnerable children and is also a position that is valued by NASN. School nurses are uniquely equipped to address some of our most pressing health concerns while delivering quality, cost-effective health care.

School communities must recognize that school nurses are providing comparable, quality care to students as other healthcare providers. It is NASN's position that school nursing services should be reimbursable through third-party payers, such as Medicaid or private insurance companies; and, in turn, those monies can provide needed revenue to support the delivery of essential school health services. This proactive thinking will ultimately help to eliminate or reduce health-related barriers to learning and improve academic achievement.

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Use of Restraints, Seclusion and Corporal Punishment in the School Setting

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (hereinafter referred to as school nurse) is an essential advocate for the health and well-being of all students. Promoting a safe and secure environment is vital to the educational success and emotional development of children. The use of restraints, seclusion or corporal punishment can potentially cause injury or death. Restraint and seclusion should only be used as a brief intervention where there is the risk of imminent danger to the child, staff, or classmates and only where permitted by law (Mohr, LeBel, O'Halloran, & Preustch, 2010; USDE, 2012). In addition, school nurses are in a position to promote alternative non-violent forms of positive behavior support in the school setting.

BACKGROUND

In May 2009, the United States Government Accountability Office (USGAO) published a report citing the lack of consistency in state laws governing seclusion and restraint in the school setting (USGAO, 2009). The report highlighted cases that led to the physical injury and death of students (USGAO, 2009) and the lack of background checks and adequate training for those in supervisory positions (USGAO, 2009). The report described or defined restraints and seclusion as follows:

- Physical restraint -- prevention, by personnel, of the ability for a student to move freely;
- Mechanical restraint -- any device that is intended to restrict movement except equipment that has been prescribed by a healthcare professional; and
- Seclusion -- the involuntary, solitary separation of a student to an area where he or she is physically prohibited from leaving.

In March 2010, the United States House of Representatives passed H.R. 4247, "The Preventing Harmful Restraint and Seclusion in Schools Act" (later amended to "Keeping All Students Safe Act") (Civic Impulse, 2014a) prohibiting the use of mechanical or chemical restraints or any restraint that restricted breathing.
The report defined chemical restraint as follows:

- A drug or medication used on a student to control behavior or restrict freedom of movement that is not—
  (i) Prescribed by a licensed physician or other qualified health professional acting under the scope of the professional's authority under state law for the standard treatment of a student's medical or psychiatric condition; and
  (ii) Administered as prescribed by the licensed physician or other qualified health professional acting under the scope of the professional's authority under state law.

The law also required that physical restraint and seclusion should not be included in a student's individual education plan (IEP) although such measures may be written into the crisis plan of a school "provided that such school plans are not specific to any individual student" (Civic Impulse, 2010a, p. 14). The act was amended in October 2010 after complaints were issued by a number of disability organizations, citing a "double standard of accountability" (LeBel, Nunno, Mohr & O'Halloran, 2012, p. 77) specifically aimed at those students with behavioral disorders. In April 2011, the United States House of Representatives refiled the bill as H.R. 1381 and retained the

name “Keeping All Students Safe Act” (Civic Impulse, 2014b). To provide support and information for school districts, educators, and parents on how to implement a safe learning environment for all students, the United States Department of Education (USDE) published a set of guidelines entitled *Restraint and Seclusion: Resource Document* (USDE, May 2012).

Corporal punishment-- which is currently allowed in 19 states-- can also adversely affect students’ self-image, can lead to anxiety and depression, can result in physical harm, inhibits the development of appropriate social skills, can cause lack of involvement in school work, and is possibly linked to domestic violence (Han, 2011; Rollins, 2012). The “Ending Corporal Punishment in Schools Act of 2014’’ was introduced to 113TH CONGRESS 2D SESSION. It describes corporal punishment as generally involving paddling or striking students with a wooden paddle, which can lead to abrasions, bruising, muscle injury or life threatening hemorrhages (Civic Impulse, 2015).

RATIONALE

The role of the school nurse is to advance the well-being, academic success, and lifelong achievement of students (NASN, 2010). To that end, school nurses provide leadership in:

- Recognizing that restraining/secluding a student either directly or indirectly is contrary to the fundamental goals and ethical traditions of nursing (American Nurses Association [ANA], 2012);
- Recognizing that corporal punishment places students at risk for negative outcomes that include physical injury, increased aggression, altered social development, and mental health issues (Rollins, 2011);
- Facilitating optimal development and positive response to interventions;
- Assessing the physical and mental health needs of students;
- Identifying the meaning and/or purpose of student behavior;
- Providing therapeutic health interventions to prevent and/or de-escalate harmful behavior and/or potential health problems;
- Developing and promoting health, safety, and wellness policies and training needs of staff as they relate to behavioral interventions while facilitating a healthy environment;
- Providing care coordination linking the student, family, healthcare provider and school;
- Actively collaborating with others to build student and family capacity for adaptation, self-management, self-advocacy, and learning;
- Supporting the development of policy that includes staff training for the prevention of restraints in school settings to address violent and other unwarranted behaviors;
- Recognizing that students are more likely to achieve when they:
    - Have clear expectations and routines,
    - Are acknowledged for positive behavior, and
    - Are treated in a manner that preserves their human dignity (ANA, 2012; USDE, 2012).);
- Recognizing that school nurses should advocate for reduction of the use of restraint/seclusion and the elimination of corporal punishment in schools by:
    - Encouraging the use of policies and procedures to keep students and school personnel safe (LeBel et al., 2012),
    - Identifying the meaning/purpose of student behavior, which may lead to the use of restraint/seclusion (USDE, 2012),
    - Promoting a systematic approach to assessment, intervention and evaluation as the best means of response to behavior (ANA, 2012), and
    - Recognizing that adequate consistent staffing ratios in all classrooms are necessary, especially in at-risk classrooms (USDE, 2012),
- Recognizing that schools should provide prevention strategies, including positive behavioral support training and de-escalation methods for all school staff and administrators (USDE, 2012);
- Recognizing that schools should have clear policies related to the brief use of restraint/seclusion, where there is the risk of imminent danger to the child, staff or classmates, including the reporting process to alert parents/guardians and appropriate school staff (USDE, 2012); and

- Recognizing that, if restraint/seclusion must be utilized to protect the safety of the student, staff or fellow classmate:
    - It should be a developmentally appropriate method of restraint used in the least restrictive manner (ANA, 2012),
    - The child should be closely monitored on a one-to-one basis, and
    - It should be used only in accordance with applicable law.

Organizations that utilize restraints/seclusion should keep and analyze data about such use to provide constructive insight about how to decrease the need for such measures and promptly implement appropriate remediation.

CONCLUSION

NASN recognizes that restraining or secluding a student, either directly or indirectly, can potentially cause injury or death. Where there is the risk of imminent danger to the child, staff or classmates, and the law permits NASN supports schools developing specific policies related to brief use of restraints/seclusion and the use of alternative non-violent forms of positive behavior support in the school setting. School nurses are leaders within their schools and communities and are positioned to support the implementation of the USDE recommendations while advocating for policies that promote a safe and secure learning environment for students.

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Role of the Licensed Practical Nurse/ Licensed Vocational Nurse in the School Setting

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that the Licensed Practical Nurse or Licensed Vocational Nurse (LPN/LVN) can be a valuable member of the school health team led by the registered professional school nurse (hereinafter referred to as school nurse). The LPN/LVN performs nursing functions and shared nursing responsibilities, according to the scope of practice outlined by the nurse practice act of the state in which the LPN/LVN is licensed, and under the supervision of the school nurse (Schwab, Hootman, Gelfman, Gregory, & Pohlman, 2005).

BACKGROUND

LPNs/LVNs are nurses who complete a 12-month program offered through vocational high schools or community colleges followed by passing the state licensure exam. Their practice is guided by state nurse practice acts that outline the scope of their practice and include working under the supervision of a registered nurse (RN). Each state's nurse practice act regulates the scope and practice of both the RN and the LPN/LVN (Laubin, Schwab, & Doyle, 2013). Registered nurses complete two to four years of pre-service preparation at a community college or university followed by passing the state licensure exam.

The demand for health services in schools has increased over the last few decades partly because of an increased number of students with special healthcare needs and disabilities. In the school setting, there are increasing numbers of students with disabilities and chronic conditions (i.e. intellectual disability, hearing impairment, speech or language impairment, visual impairment, emotional disturbance, orthopedic impairment, autism, traumatic brain injury, other health impairment, learning disability, asthma, diabetes, seizures and life-threatening food allergies) requiring nursing services. The needs of the students may include medication administration, care coordination for students with chronic disease, intermittent catheterization, tracheostomy care and suctioning, gastrostomy care and feedings, skin assessment, positioning, or equipment monitoring (Caldart-Olson & Thronson, 2013).

Federal regulations define the right of students with special health needs to receive the services they need to attend public school, including school health services. The laws guarantee access to education and support services for special education and regular education students with disabilities and with special healthcare needs (Gibbons, Lehr, & Selekman, 2013). Individuals with Disability Education Improvement Act (IDEIA) (2004), Rehabilitation Act of 1973 (§504) (2000), and the Americans With Disabilities Act of 1990 (ADA) (2000) are three federal laws that stipulate that students with special healthcare needs have the right to be educated with their peers in the least restrictive environment (Gibbons et al., 2013). These students also have the right to receive support and accommodations for conditions that adversely affect their capacity for learning (Schwab et al., 2005).

RATIONALE

Sharing some nursing tasks provides the school nurse an opportunity to fully implement the school nurse role including development of Individualized Healthcare Plans and carrying out the health education and case management tasks (Fleming, 2011). In order to safely create an effective school health team and determine the appropriate use of nursing resources, the **school nurse** should consider the following action steps:

1. Complete nursing assessments for students with disabilities and chronic conditions in the school, and determine the individual healthcare needs.

2. Examine the unique parameters of the state's nurse practice act – the definitions of scope of practice. These state-specific statutes will determine what nursing tasks the LPN/LVN can carry out in that state (American Nurses Association [ANA], 2012).

3. Review if the LPN/ LVN can work independently. Some nurse practice acts preclude an LPN/ LVN from functioning independently because in these states an LVN/ LPN can only work under the direct supervision of a registered nurse. In states such as these, LPNs/ LVNs may only be assigned to positions where they have onsite supervision by a registered nurse such as one-on-one nursing services or a second nurse in large high schools.

4. Determine which nursing tasks and actions can be appropriately assigned or delegated in accordance with state nurse practice acts to the LPN/ LVN. Some examples include medication administration, delegated student-specific tasks, and assisting in managing the minor injuries and illness complaints that make up a large portion of health room visits.

5. Plan for the process of RN supervision based on the number of students served and the acuity of the needs of the students served. The state's nurse practice act will outline requirements for RN supervision. Consider whether onsite supervision is required or if one RN may supervise more than one school (National Association of State School Nurse Consultants & NASN, 2012).

CONCLUSION

LPNs/LVNs can be a valuable part of school health teams that provide nursing services to meet the increasing number and acuity of student healthcare needs. The RN leads the school health team, performs the nursing assessment and develops the Individualized Healthcare Plan (IHP). The RN is the professional accountable for assessing the individual student healthcare needs and determining who has the capability and competence to provide appropriate care for the student (Resha, 2010). The scope of practice of LPNs/LVNs may include implementing the IHP and administering medications under RN supervision according to state nurse practice acts. LPNs/LVNs must work closely with the school nurse so that the healthcare needs and safety of all students are provided for during the school day. As more children with special healthcare needs enter the school system, the roles of the school nurse and the LPN/LVN become even more critical in assuring the rights, safety, and educational experiences of all students.

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http://www.nasn.org/PolicyAdvocacy/PositionPapersandReports/NASNPositionStatementsFullView/tabid/462/ArticleId/87/Role-of-the-School-Nurse-Revised-2011

Education, Licensure, and Certification of School Nurses (2012)
http://www.nasn.org/portals/0/positions/2012pseducation.pdf

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The Role of the 21st Century School Nurse

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that every child has access all day, every day to a full time registered professional school nurse (hereinafter referred to as school nurse). The school nurse serves in a pivotal role that bridges health care and education. Grounded by standards of practice, services provided by the school nurse include leadership, community/public health, care coordination, and quality improvement (NASN, 2016a).

BACKGROUND

The practice of school nursing began in the United States on October 1, 1902, when Lina Rogers, the first school nurse, was hired to reduce absenteeism by intervening with students and families regarding healthcare needs related to communicable diseases. After one month of successful nursing interventions in the New York City schools, she led the implementation of evidence-based nursing care across the city (Struthers, 1917). Since that time, school nurses continue to provide communicable disease management, but their role has expanded and is increasingly diverse.

A student's health is directly related to his or her ability to learn. Children with unmet health needs have a difficult time engaging in the educational process. The school nurse supports student success by providing health care through assessment, intervention, and follow-up for all children within the school setting. The school nurse addresses the physical, mental, emotional, and social health needs of students and supports their achievement in the learning process.

Students who are medically fragile or who deal with chronic health issues are coming to school in increasing numbers and with increasingly complex medical problems that require complicated treatments commonly provided by the school nurse (Lineberry & Ikes, 2015). Chronic conditions such as asthma, anaphylaxis, type 1 and type 2 diabetes, epilepsy, obesity, and mental health concerns may affect the student's ability to be in school and ready to learn.

The National Survey of Children with Special Healthcare Needs has determined that 11.2 million U.S. children are at risk for chronic physical, developmental, behavioral, or emotional conditions. These students may require health related services in schools (U.S. Department of Health and Human Services, Maternal and Child Health Bureau, 2013).

School nurses address the social determinants of health, such as income, housing, transportation, employment, access to health insurance, and environmental health. Social determinants are identified to be the cause of 80% of health concerns (Booske, Athens, Kindig, Park, & Remington, 2010). In the United States, nearly one quarter of children attending school live in households below the federal poverty level (United States Census Bureau, 2014). Children from lower income families have a more difficult time accessing medical treatment for chronic diseases (Perrin, 2014).

RATIONALE

School nursing is a specialized practice of nursing that advances the well-being, academic success, and lifelong achievement and health of students. Keeping children healthy, safe, in school, and ready to learn should be a top priority for both healthcare and educational systems. With approximately 50.1 million students in public

elementary and secondary schools, educational institutions are excellent locations to promote health in children (National Center for Education Statistics, n.d.) and the school nurse is uniquely positioned to meet student health needs.

Leadership

School nurses lead in the development of policies, programs, and procedures for the provision of school health services at an individual or district level (NASN, 2016a), relying on student-centered, evidence-based practice and performance data to inform care (Robert Wood Johnson Foundation, 2009). Integrating ethical provisions into all areas of practice, the school nurse leads in delivery of care that preserves and protects student and family autonomy, dignity, privacy, and other rights sensitive to diversity in the school setting (American Nurses Association [ANA] & NASN, 2011).

As an advocate for the individual student, the school nurse provides skills and education that encourage self-empowerment, problem solving, effective communication, and collaboration with others (ANA, 2015a). Promoting the concept of self-management is an important aspect of the school nurse role and enables the student to manage his/her condition and to make life decisions (Tengland, 2012). The school nurse advocates for safety by participating in the development of school safety plans to address bullying, school violence, and the full range of emergency incidents that may occur at school (Wolfe, 2013).

At the policy development and implementation level, school nurses provide system-level leadership and act as change agents, promoting education and healthcare reform. According to the ANA (2015b), registered nurses believe that it is their obligation to help improve issues related to health care, consumer care, health, and wellness. Educational preparation for the school nurse should be at the baccalaureate level (NASN, 2016b), and school nurses should continue to pursue professional development and continuing nursing education throughout their careers (Wolfe, 2013).

Community/Public Health

School nursing is grounded in community/public health (Schaffer, Anderson, & Rising, 2015). The goal of community/public health moves beyond the individual to focus on community health promotion and disease prevention and is one of the primary roles of the school nurse (Wold & Selekman, 2013). School nurses employ cultural competency in delivering effective care in culturally diverse communities (Office of Minority Health, 2013).

The school nurse employs primary prevention by providing health education that promotes physical and mental health and informs healthcare decisions, prevents disease, and enhances school performance. Addressing such topics as healthy lifestyles, risk-reducing behaviors, developmental needs, activities of daily living, and preventive self-care, and the school nurse uses teaching methods that are appropriate to the student's developmental level, learning needs, readiness, and ability to learn. Screenings, referrals, and follow-up are secondary prevention strategies that school nurses utilize to detect and treat health-related issues in their early stage (NASN, 2016a). School nurses provide tertiary prevention by addressing diagnosed health conditions and concerns.

Student absences due to infectious disease cause the loss of millions of school days each year (Centers for Disease Control and Prevention, 2011). Based on standards of practice and community health perspective, the school nurse provides a safe and healthy school environment through control of infectious disease, which includes promotion of vaccines, utilization of school-wide infection control measures, and disease surveillance and reporting. Immunization compliance is much greater in schools with school nurses (Baisch, Lundeen, & Murphy, 2011).

The school nurse strives to promote health equity, assisting students and families in connecting with healthcare services, financial resources, shelter, food, and health promotion. This role encompasses responsibility for all students within the school community, and the school nurse is often the only healthcare professional aware of all the services and agencies involved in a student's care.

Care Coordination

School nurses are members of two divergent communities (educational and medical/nursing), and as such are able to communicate fluently and actively collaborate with practitioners from both fields (Wolfe, 2013). As a case manager, the school nurse coordinates student health care between the medical home, family, and school. The school nurse is an essential member of interdisciplinary teams, bringing the health expertise necessary to develop a student's Individualized Education Plan or Section 504 plan designed to reduce health related barriers to learning (Zimmerman, 2013). Creating, updating, and implementing Individualized Healthcare Plans are fundamental to the school nurse role (McClanahan & Weismuller, 2015).

School nurses deliver quality health care and nursing intervention for actual and potential health problems. They provide for the direct care needs of the student, including medication administration and routine treatments and procedures (Lineberry & Ickes, 2015). Education of school staff by the school nurse is imperative to the successful management of a child with a chronic condition or special healthcare need and is codified as a role of the school nurse in the Every Student Succeeds Act (2015).

Current school health practice models and school nurse workloads may require school nurses to delegate healthcare tasks to unlicensed assistive personnel in order to support the health and safety needs of students (Shannon & Kubelka, 2013). However, the availability of school nurses to work directly with students to assess symptoms and provide treatment increases students' time in the classroom and parents' time at work (Lineberry & Ickes, 2015).

Quality Improvement

Quality improvement is a continuous and systematic process that leads to measurable improvements and outcomes (Health Resources and Services Administration, 2011) and is integral to healthcare reform and standards of practice (Agency for Healthcare Research and Quality, 2011). Continuous quality improvement is the nursing process in action: assessment, identification of the issue, development of a plan of action, implementation of the plan, and evaluation of the outcome. Data collection through this process is a necessary role of the school nurse.

Formal school nursing research is needed to ensure that delivery of care to students and school communities by the school nurse is based on current evidence. School nurses utilize research data as they advocate and illustrate the impact of their role on meaningful health and academic outcomes (NASN, 2016a).

CONCLUSION

It is the position of NASN that school nurses play an essential role in keeping children healthy, safe, and ready to learn. The school nurse is a member of a unique discipline of professional nursing and is often the sole healthcare provider in an academic setting. Twenty-first century school nursing practice is student-centered, occurring within the context of the student's family and school community (NASN, 2016a). It is essential that all students have access to a full time school nurse all day, every day (American Academy of Pediatrics, 2016).

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The Complementary Roles of the School Nurse and School Based Health Centers

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that the unique combination of school nursing services and school-based health centers (SBHCs) facilitate positive health outcomes for students. The registered professional school nurse (hereinafter referred to as school nurse) is responsible for management of the daily health needs of the student population. SBHCs, operating as medical clinics, complement the work of school nurses by providing a readily accessible referral site for students who are without a medical home. School nurses work collaboratively with SBHCs to provide an array of health services to keep students healthy, in school, and ready to learn. School nurses and SBHCs both function as health safety nets for children in need (Robert Wood Johnson Foundation [RWJF], 2010; Bavin, 2012) and should collaborate to provide comprehensive health care to students.

BACKGROUND

School nursing began in the early 1900s with Lena Rogers addressing attendance issues created when students were excluded unnecessarily from school (Keeton, Soleimanpour, & Brindis, 2012). SBHCs were established during the 1970s to provide medical services to those students who could not afford or access primary health care. There is a distinct difference in the services provided by school nurses and the SBHC. The School Based Health Alliance (SBHA) and NASN agree that SBHCs do not duplicate or replace school nursing services (RWJF, 2010). School nurses are part of the hidden healthcare system (RWJF, 2010). School nurses have been shown to save medical care costs as well as parent and teacher productivity (Wang et. al., 2014). School nurses are responsible for the day-to-day health of students and the larger school community through (Cornell & Selekman, 2013; RWJF, 2010):

- management of chronic disease and life-threatening health conditions,
- individual and population-based disease surveillance,
- health promotion,
- assistance in securing insurance and healthcare providers,
- preparation for and response to medical emergencies,
- care for students dependent on medical technology,
- mental health services,
- screenings and referrals,
- immunization compliance,
- medication management,
- healthcare planning and education,
- follow-up care, and
- care coordination.

SBHCs provide a variety of healthcare services to meet the unique needs of the community in which they reside; thereby overcoming barriers of a diverse range of clients (Keeton, Soleimanpour, & Brindis, 2012). These services may include primary care, comprehensive health assessments, treatment of acute illness and prescriptions for medications (Barnett & Allison, 2012). SBHCs improve access to care by removing barriers that may include (Guo, Wade, Pan, & Keller, 2010):

- financial (lack of insurance or low income),
- providers who will accept the student's insurance,

- lack of transportation to appointments,
- scheduling conflicts, and
- parent/guardians work schedules.

Both school nurses and SBHCs have shown a direct impact on educational outcomes such as attendance. School nurses send home 13% fewer students than unlicensed school personnel (Pennington & Delaney, 2008). Bonaiuto (2007) demonstrated that students who have access to school nurse case management had improved attendance rates. Students enrolled in SBHC services had a significant decrease in the number of early dismissals from school when compared to students who did not have access to SBHCs (Van Cura, 2010).

RATIONALE

School nurses provide the critical link between the education system, students, families, the school community, the community at-large, and the medical community. School nurses are leaders in the school community, providing oversight for the health and safety of the students through school health policies and programs. SBHCs provide the school nurse with a referral site for needed medical intervention. Within that framework, the school nurse functions as part of the healthcare team by advocating for development of SBHCs and facilitating student access to the full array of services provided by the SBHC. In addition, school nurses refer and coordinate care for students enrolled in SBHCs. School nurses should have input into the development of SBHCs in their school systems and should sit on advisory boards for SBHCs (Cornell & Selekman, 2013).

The school nurse and the SBHC staff should work collaboratively to develop a shared case management structure, to coordinate nursing and treatment care plans for students who require follow-up, and to collect data to study outcomes and cost effectiveness of care. The collaboration between the school nurse and the SBHC staff includes the development of policies and systems that ensure the quality and confidentiality of care received by students and the implementation of wellness and disease prevention programs to improve health outcomes for all members of the school community (Cornell & Selekman, 2013).

CONCLUSION

School nurses are leaders in the school community, providing oversight for the health and safety of the students through school health policies and programs. SBHCs provide primary medical care that may include dental and mental health services. Together, school nurses and SBHCs work to provide for medical needs and promote health in school so that students are ready to learn. School nurses are the critical link between the education system, students, families, community, and medical care. School nurses and SBHC staff should work as partners to develop policies, collect data and evaluate processes to improve health outcomes for the students and communities they serve.

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School-located Vaccination

NASN
National Association of School Nurses

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that reaching high vaccination coverage of school-age children and their families, as outlined in Healthy People 2020 (U. S. Department of Health and Human Services [USDHHS], 2017), is an important public health objective. NASN further recognizes that challenges still remain in meeting this goal and schools can play a key role in the deterrence of vaccine preventable diseases (VPD).

The National Vaccine Plan, 2015-2016 Mid-Course Review, states that there are still opportunities to eliminate financial and system barriers for providers and consumers to facilitate access to routine, recommended vaccines. Highlighted in Goal #4, Health care providers must continue to improve access to and acceptance of vaccination providers in nontraditional healthcare settings. School-located vaccination (SLV) can augment other emerging alternative vaccination sites (USDHHS, 2016).

The registered professional school nurse (hereinafter referred to as the school nurse) is in a critical position to create awareness, influence action, and provide leadership in the development of SLV programs. School nurses are trusted professionals within the school and community settings and can play a pivotal role in the success of SLV. They are ideally placed to identify students who have missed vaccines (Swallow & Roberts, 2016). Studies also show that SLV is key for adolescents who have significantly lower rates of vaccination due to lower rates of office-based visits (Bernstein & Bocchini, 2017).

BACKGROUND

Historically, SLV has been shown to enhance vaccination rates. In 1875, New York City used schools to deliver the smallpox vaccine. Schools were again utilized in the 1950s to deliver the Salk polio vaccine. In 1969, schools held vaccine clinics to administer the rubella vaccine, in the 1990s to conduct hepatitis B catch-up clinics, and again in 2009 for varicella and H1N1 vaccines (Mazyck, 2009; Lambert & Merkel, 2000; Hodge & Gostin, 2002). In the 2012-13 school year, an SLV project in rural Kentucky administered the HPV vaccine, significantly improving vaccination rates (Vanderpool et al., 2015).

However, broad adoption of SLV has been slow. Reasons for this are varied, but a major reason is that the beliefs of widespread morbidity and mortality caused by vaccine-preventable diseases have faded from memory. VPDs in a variety of locations remind us that they have not been completely eradicated and that there is continued vulnerability of VPDs. Other factors that may be influencing SLV are informed consent, privacy and confidentiality, and harm from fear and anxiety (Braunack-Mayer et al., 2015). The shift to the use of SLV in administering routinely recommended vaccines will require careful planning to implement known strategies designed to assure appropriate reimbursement for cost-effective services. SLV provides an important opportunity to immunize youth with limited access to healthcare services in the community at large (Middleman, 2016).

In November 2010, a cross-sector, interdisciplinary meeting was co-hosted by NASN, the National Association of City and County Health Officials, and the Association of State and Territorial Health Officials in Washington DC. Participants were drawn from organizations representing public health, education, medical practice, government agencies, patient advocacy, and industry. The group identified two key challenges to developing, sustaining, and

expanding SLV: 1) funding and 2) documentation (Bobo, Etkind, & Talkington, 2010). These challenges still exist today.

In a recent study, Illinois Medicaid managed care providers and billing personnel lacked clarity in how to obtain coverage for immunizations that are administered outside of the medical home (Limper & Caskey, 2016).

RATIONALE

SLV has a long history in the United States and has successfully contributed to lower morbidity and mortality due to vaccine-preventable diseases (Limper et al., 2014). The school is an ideal place to reach 52 million children from all cultures, socioeconomic groups, and age groups that attend each day; and the school is conveniently located in a familiar and trusted community environment. SLV also offers a convenient option for parents to have their children receive needed vaccinations without having to arrange for a healthcare provider visit or take off time from work (Shlay et al., 2015).

One strategy to improve immunization rates in the United States is to capitalize on the trusted position of schools and school nurses to establish SLV. The school nurse can play a critical role in planning SLV because of understanding both the needs of the community and the school. For example, school nurses

- have experience collaborating with community partners, including local and state public health departments, school officials, other nurses, teachers, emergency planning authorities, child health agencies, families, community leaders, and local healthcare providers. The school and public health partnership is a familiar model for the delivery of health care in many communities. This collaboration is key to successful SLV.
- are considered a trusted source of health information by school boards and school officials. They can educate these groups on the impact of vaccination on school attendance.
- can provide accurate information and dispel myths about vaccines.
- are familiar with the health status of students and thus able to mitigate potential contraindications for vaccines.
- understand the implications of Family Educational Rights and Privacy Act (FERPA) and Health Insurance Portability and Accountability Act (HIPAA) related to recording and sharing immunization records.

In addition, schools and school nurses can provide significant logistical assistance in implementing SLV. Some of these include the following:

- Schools have the space and capacity to host SLV (e.g. gymnasium, library, cafeteria). Schools can also provide a space for safe storage of vaccines in a controlled environment.
- School start and dismissal times provide the framework for scheduling SLV with the least disruption of the school day.
- Schools can assist with securing volunteers such as parents, nursing students and other community partners to participate with SLV.
- School nurses understand mandated and recommended vaccination schedules and the complexities of vaccine administration.
- School nurse relationships with parents/families can be critical in obtaining consent for vaccination.
- School nurses can create SLV as the norm to enhance community-wide emergency preparedness.

CONCLUSION

SLV can reach children in the school environment and can complement the work of office-based healthcare providers. School nurses are well-versed in the importance of deterring and eradicating vaccine preventable diseases and the issues that are unique to their school community. NASN supports the continued efforts of school

nurses and their community partners in developing SLV opportunities when it is appropriate for the health and well-being of their students and the community at large.

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School Nurse Workload: Staffing for Safe Care

NASN
National Association of School Nurses

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that daily access to a registered professional school nurse (hereinafter referred to as a school nurse) can significantly improve students' health, safety, and abilities to learn. To meet the health and safety needs of students, families, and school communities, school nurse workloads should be determined at least annually, using student and community specific health data.

BACKGROUND

School nurse-to-student ratios were first recommended in the 1970s, when laws were enacted to protect the rights for all students to attend public school, including those with significant health needs. Those laws included The Rehabilitation Act of 1973, Section 504 (1973) and Public Law 94-142, the Education for all Handicapped Children Act (1975), reauthorized in 2004 as the Individuals with Disabilities Education Improvement Act [IDEIA], (2004). Although evidence to support ratios was limited, some states and NASN recommended one school nurse to 750 students in the healthy student population; 1:225 for student populations requiring daily professional nursing services; 1:125 for student populations with complex healthcare needs; and 1:1 for individual students requiring daily, continuous professional nursing services (American Nurses Association [ANA]/NASN, 2011). While a ratio of one school nurse to 750 students has been widely recommended and was acknowledged in Healthy People 2020 (U.S. Department of Health and Human Services [USDHHS], 2014a) and by the American Academy of Pediatrics [AAP] (2008), a one-size-fits-all workload determination is inadequate to fill the increasingly complex health needs of students and school communities (AAP, 2008; ANA/NASN, 2011).

In addition to the laws that established rights for children with disabilities to attend school, medical advances have increased the number of students with special healthcare needs in schools. The Centers for Disease Control and Prevention (CDC) (2013) estimates that one in eight children are born prematurely, are more likely to have neurologic deficits and cognitive delays, and need lifetime health accommodations and/or require academic accommodations (Martin & Osterman, 2013; World Health Organization [WHO], 2012; Zirkel, Granthom, & Lovato, 2012). Students diagnosed and treated for cancer (American Cancer Society, 2012) or other life-threatening conditions such as congenital heart disease (American Heart Association 2014) return to schools sooner and often require special nursing care. Students who in the past would have been cared for in therapeutic settings now attend and must receive care in schools (Fauteux, 2010). Furthermore, the percentage of students who have chronic conditions such as asthma and diabetes, which require health care at school, has increased significantly (Van Cleave, Gortmaker, & Perrin, 2010; CDC, 2011a).

A growing body of evidence also indicates the impact social determinants have on health and the ability to address health concerns (CDC, 2014a). Where and how children live and play impacts their health. Shifting cultural, economic, political and environmental influences result in students and school communities with frequently changing health and social needs. These factors include economic instability, international strife, globalization, immigration, violence, and natural disasters (Weeks et al., 2013). The U.S. 2010 census revealed that the number of people who spoke a language at home other than English more than doubled between 1980 and 2010 (Ryan, 2013), and communication barriers challenge access to health care (Meyer, 2012). Global travel brings students in contact with infectious diseases such as H1N1 influenza, polio, Middle East Respiratory Syndrome (MERS), measles, and Ebola virus (CDC, 2010, 2012, 2014b, 2014c, 2014d). Increased mental health problems in students result from stress, disaster, and trauma (Chau, 2012; Harvard Educational Review, 2011; National Association of School Psychologists, 2012; WHO, 2012). Poverty continues to be a concern. Lower socioeconomic status is linked to poor health outcomes due to stressed environmental conditions, risky health behaviors, and limited access to

health care (CDC, 2014a). Students and families affected by these challenges increasingly rely on access to school nurses for care.

School nurses serve as case managers, bringing providers, families, and schools together to support the health of our children and youth. School nurses facilitate children's access to medical and dental "homes" and coordinate the care essential to addressing and improving their health (AAP, 2008; Association for Supervision and Curriculum Development (ACSD), 2014; Engelke, Swanson, & Guttu, 2014; Health Resources and Services Administration, n.d.). Schools are identified as primary locations to address student health issues, and the school nurse is often the healthcare provider that a student sees on a regular basis (Albanese, 2014; The Patient Protection and Affordable Care Act, 2010; Institute of Medicine [IOM], 2011, 2012). School nursing is a key component of the coordinated school health framework and is included in the *Whole School, Whole Community, Whole Child* model (ASCD, 2014; CDC, 2014e).

Appropriate school nurse staffing is related to better student attendance and academic success (Cooper, 2005; Moricca et al., 2013). When there is a school nurse present, a principal gains nearly an hour per day and teachers an extra 20 minutes a day to focus on education instead of student health issues (Baisch, Lundeen, & Murphy, 2011; Hill & Hollis, 2012). Baisch, Lundeen, & Murphy (2011) found that increased school nurse staffing resulted in improvements in immunization rates, vision correction, and identification of life-threatening conditions. Wang et al. (2014) determined that for every dollar spent for school nursing, $2.20 was saved in health care procedures and parent time away from work. Full-time school nurses in the schools studied by Wang et al. (2014) were attributed to preventing excess medical costs and to improved parent and teacher productivity.

Inadequate staffing can lead to adverse consequences (Kerfoot & Douglas, 2013). For example, the lack of access to a school nurse, who could have identified declining health status and provided or obtained necessary care, may have contributed to the 2014 deaths of two students in Philadelphia schools (Boyle, 2014; Superville & Blad, 2014). Insufficient staffing also leads to inconsistent care of students and to increased nurse turnover, which results in additional costs to school districts (American Association of Colleges of Nursing, 2014; Duffield et al., 2011; Hoi, Ismail, Ong, & Kang, 2010).

RATIONALE

The determination of adequate nurse staffing is a complex decision-making process (ANA, 2014; Weston, Brewer, & Peterson, 2012). Individual state laws which regulate nursing practice to protect public health, safety and welfare must be followed. Student acuity status must be determined, as well as student care needs, including medications, health procedures, care coordination, case management, and staff training / supervision. In addition, a community health needs assessment will identify the social determinants that impact the health of students so that school nurses and administrators can plan to address those needs. Social determinants of community health and health disparities must be accounted for when determining school nurse staffing including how students and their families are affected by (CDC 2011b, 2014a; Fleming, 2011; Meyer, 2012; USDHHS, 2014b):

- Health behaviors, health condition and disease prevalence, immunization levels;
- Socioeconomic status, employment, education level;
- Housing status, food security, transportation access;
- Social and cultural supports and influences, discrimination;
- Access to healthcare, health insurance, and social services;
- Environmental stresses; and
- Language and communication barriers.

RECOMMENDATIONS

NASN and the National Association of State School Nurse Consultants (NASSNC) (2012, 2014) assert that every student needs direct access to a school nurse so that all students have the opportunity *to* be healthy, safe, and ready to learn. In order to achieve adequate school nurse staffing, NASN recommends:

- Using a multifactorial health assessment approach that includes not only acuity and care but also social determinants of health to determine effective school nurse workloads for safe care of students.
- Developing evidence-based tools for evaluating factors that influence student health and safety and for developing staffing and workload models that support this evidence.
- Conducting research to determine the best models for school nurse leadership in school health, such as RN only, RN-led school health teams, and RNs certified in the specialty practice of school nursing.
- Increasing involvement of school nurses at national, state, and local levels in policy decisions that affect the health of students.

CONCLUSION

NASN believes that school nursing services must be determined at levels sufficient to provide the range of health care necessary to meet the needs of school populations. Social determinants of health and student health care needs must be considered when implementing appropriate school nurse staffing and workloads. Maintaining the health and safety of students is critical to the educational success and well-being of our nation's children.

Related NASN Position Statements

- *Role of the School Nurse* (2011) http://www.nasn.org/PolicyAdvocacy/PositionPapersandReports/NASNPositionStatementsFullView/tabid/462/smid/824/ArticleID/87/Default.aspx

- *School Nurse Role in Electronic School Health Records* (2014) http://www.nasn.org/PolicyAdvocacy/PositionPapersandReports/NASNPositionStatementsFullView/tabid/462/smid/824/ArticleID/641/Default.aspx

- *Child Mortality in the School Setting* (2012) http://www.nasn.org/PolicyAdvocacy/PositionPapersandReports/NASNPositionStatementsFullView/tbid/462/ArticleId/297/Child-Mortality-in-the-School-Setting-Adopted-2012

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health care (CDC, 2014a). Students and families affected by these challenges increasingly rely on access to school nurses for care.

School nurses serve as case managers, bringing providers, families, and schools together to support the health of our children and youth. School nurses facilitate children's access to medical and dental "homes" and coordinate the care essential to addressing and improving their health (AAP, 2008; Association for Supervision and Curriculum Development (ACSD), 2014; Engelke, Swanson, & Guttu, 2014; Health Resources and Services Administration, n.d.). Schools are identified as primary locations to address student health issues, and the school nurse is often the healthcare provider that a student sees on a regular basis (Albanese, 2014; The Patient Protection and Affordable Care Act, 2010; Institute of Medicine [IOM], 2011, 2012). School nursing is a key component of the coordinated school health framework and is included in the *Whole School, Whole Community, Whole Child* model (ASCD, 2014; CDC, 2014e).

Appropriate school nurse staffing is related to better student attendance and academic success (Cooper, 2005; Moricca et al., 2013). When there is a school nurse present, a principal gains nearly an hour per day and teachers an extra 20 minutes a day to focus on education instead of student health issues (Baisch, Lundeen, & Murphy, 2011; Hill & Hollis, 2012). Baisch, Lundeen, & Murphy (2011) found that increased school nurse staffing resulted in improvements in immunization rates, vision correction, and identification of life-threatening conditions. Wang et al. (2014) determined that for every dollar spent for school nursing, $2.20 was saved in health care procedures and parent time away from work. Full-time school nurses in the schools studied by Wang et al. (2014) were attributed to preventing excess medical costs and to improved parent and teacher productivity.

Inadequate staffing can lead to adverse consequences (Kerfoot & Douglas, 2013). For example, the lack of access to a school nurse, who could have identified declining health status and provided or obtained necessary care, may have contributed to the 2014 deaths of two students in Philadelphia schools (Boyle, 2014; Superville & Blad, 2014). Insufficient staffing also leads to inconsistent care of students and to increased nurse turnover, which results in additional costs to school districts (American Association of Colleges of Nursing, 2014; Duffield et al., 2011; Hoi, Ismail, Ong, & Kang, 2010).

RATIONALE

The determination of adequate nurse staffing is a complex decision-making process (ANA, 2014; Weston, Brewer, & Peterson, 2012). Individual state laws which regulate nursing practice to protect public health, safety and welfare must be followed. Student acuity status must be determined, as well as student care needs, including medications, health procedures, care coordination, case management, and staff training / supervision. In addition, a community health needs assessment will identify the social determinants that impact the health of students so that school nurses and administrators can plan to address those needs. Social determinants of community health and health disparities must be accounted for when determining school nurse staffing including how students and their families are affected by (CDC 2011b, 2014a; Fleming, 2011; Meyer, 2012; USDHHS, 2014b):

- Health behaviors, health condition and disease prevalence, immunization levels;
- Socioeconomic status, employment, education level;
- Housing status, food security, transportation access;
- Social and cultural supports and influences, discrimination;
- Access to healthcare, health insurance, and social services;
- Environmental stresses; and
- Language and communication barriers.

RECOMMENDATIONS

NASN and the National Association of State School Nurse Consultants (NASSNC) (2012, 2014) assert that every student needs direct access to a school nurse so that all students have the opportunity *to* be healthy, safe, and ready to learn. In order to achieve adequate school nurse staffing, NASN recommends:

- Using a multifactorial health assessment approach that includes not only acuity and care but also social determinants of health to determine effective school nurse workloads for safe care of students.
- Developing evidence-based tools for evaluating factors that influence student health and safety and for developing staffing and workload models that support this evidence.
- Conducting research to determine the best models for school nurse leadership in school health, such as RN only, RN-led school health teams, and RNs certified in the specialty practice of school nursing.
- Increasing involvement of school nurses at national, state, and local levels in policy decisions that affect the health of students.

CONCLUSION

NASN believes that school nursing services must be determined at levels sufficient to provide the range of health care necessary to meet the needs of school populations. Social determinants of health and student health care needs must be considered when implementing appropriate school nurse staffing and workloads. Maintaining the health and safety of students is critical to the educational success and well-being of our nation's children.

Related NASN Position Statements

- *Role of the School Nurse* (2011) http://www.nasn.org/PolicyAdvocacy/PositionPapersandReports/NASNPositionStatementsFullView/tabid/462/smid/824/ArticleID/87/Default.aspx

- *School Nurse Role in Electronic School Health Records* (2014) http://www.nasn.org/PolicyAdvocacy/PositionPapersandReports/NASNPositionStatementsFullView/tabid/462/smid/824/ArticleID/641/Default.aspx

- *Child Mortality in the School Setting* (2012) http://www.nasn.org/PolicyAdvocacy/PositionPapersandReports/NASNPositionStatementsFullView/tbid/462/ArticleId/297/Child-Mortality-in-the-School-Setting-Adopted-2012

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All position statements from the National Association of School Nurses will automatically expire five years after publication unless reaffirmed, revised, or retired at or before that time.

School-Sponsored Before, After and Extended School Year Programs: The Role of the School Nurse

National Association of School Nurses

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (hereinafter referred to as school nurse) has the educational and clinical background to coordinate the necessary school health services to provide students with the same health, nutrition, and safety needs while attending school-sponsored before, after, and extended school year programs as the students receive during the traditional school day/year. In 2010, the White House Task Force on Obesity called for an increase in access to safe supervised physical activities beyond the school day (White House Task Force on Childhood Obesity Report to the President, 2010); and, as these programs have expanded, the necessity for providing quality, effective healthcare services during these hours has developed. As the expert in school health services delivery models of health care, the school nurse is an essential facilitator for student access to these programs. The school nurse plays a vital role in preparing the school-sponsored before and after school and extended school year program personnel with the necessary resources to respond to a health emergency.

BACKGROUND

Each afternoon throughout the United States, 15 million children -- more than a quarter of our child population -are alone and unsupervised after school (Afterschool Alliance, 2009). Research continues to support the premise that students who receive adult supervision and additional learning opportunities outside of the traditional school day show improved academic achievement, are less likely to engage in unhealthy behaviors, and have a better attitude toward school (Centers for Disease Control and Prevention [CDC], 2009). Students continue to have the same health, nutrition, and safety needs when enrolled in school programs that occur beyond the traditional school day. School-sponsored extended school year programs and before and after school programs that are a part of the school system should, at a minimum, engage the school nurse to act in an advisory capacity to address these student needs (Afterschool Alliance, n.d.).

RATIONALE

On-site, school-sponsored before and after school programs, as well as extended school year programs, are on the increase in school districts across the United States primarily due to funding from federal, state, and local monies. No Child Left Behind mandated before, after, and summer school programs for students in low performing schools starting in 2002, and currently over 1.6 million students across the United States benefit from these programs (Afterschool Alliance, 2013.) Programs are offered to all students, including students receiving special education services and those with identified health conditions. School nurses will likely have such programs in their local school districts. The Scope and Standards of Practice for School Nurses (American Nurses Association [ANA]/National Association of School Nurses [NASN], 2011) promotes a safe and healthy environment; therefore, the school nurse should function as both a resource and an advocate for health-related issues in the school setting, including school-sponsored before, after, and extended school year programs. The staff planning and providing these school-sponsored programs will need consultation on various medical concerns, including response to health-related emergencies, disaster preparedness, first aid, CPR, recognition of signs and symptoms of child abuse and neglect, and procedures for protecting against blood borne pathogens. The school nurse should be engaged by program leaders to provide this consultation. Students with special healthcare needs may require nursing services beyond the regular school day; and supplies, staff, and nursing services for providing these additional services should be considered.

In on-site, school-sponsored extended school year and before and after school programs, the school nurse may explore the use of delegation to provide effective healthcare services, if allowable, according to the State Nurse Practice Act. Delegation is defined as the assignment of the performance of a nursing activity to a non-nurse. Accountability remains with the registered nurse. State laws and regulations must be followed and standards of school nursing practice must be upheld (ANA & NASN, 2011). The implications of appropriate delegation of nursing tasks for school nurses center around four major themes: development of school policies, competence in the five rights of delegation, education, and relationship building (Resha, 2010).

When engaged by school-sponsored extended school year and before and after school program leaders, the school nurse can provide expertise on a variety of issues faced by school staff, including but not limited to:

- Maintaining confidentiality,
- Management of chronic diseases, such as asthma and diabetes,
- Management of health care for children with disabilities,
- Management of allergy exposure and anaphylaxis,
- Management of seizures,
- Management of medication administration,
- Management of communicable diseases,
- Nutrition and food safety issues,
- Mental health and substance abuse issues and referrals,
- Environmental safety issues, and
- Management of medical emergencies and disaster preparedness.

The school nurse should ensure emergency response plans are in place to address health-related events that could occur either at school or during school-related activities in the school setting, including before, after, and extended school year programs. Emergency preparedness must be a priority every day. When the school nurse is not available at the school, the school nurse often remains responsible for training and developing plans for use by others serving the school (Cosby, Miller, & Youngman, 2013). Successful integration of students who are dependent on medical technology requires a coordinated effort among the school nurse, educational staff, primary care physician, family, and -- when appropriate -- the student (Raymond, 2009).

CONCLUSION

School nurses are the healthcare experts in their buildings and should be engaged with program leaders to take an active role in this process outside the school day as well as during the more traditional school day. When involved with on-site, school-sponsored before, after, and extended school year programs, the school nurse will advance the academic achievement of participating students by promoting the health and safety aspects of these programs. It is imperative, therefore, that the school nurse is an active participant in providing guidance to school-sponsored program staff so they can intervene with actual and potential health problems experienced by the students in attendance. In order to achieve this, the school nurse should recommend any necessary budgetary resources needed to ensure supplies, staff, and programs are made available for the safe delivery of health care, including delegating nursing-related tasks as directed by their state nurse practice act and – when agreed upon – providing direct nursing services.

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School-sponsored Trips - The Role of the School Nurse

National Association of School Nurses

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN), that the registered professional school nurse (hereinafter referred to as school nurse) is the expert healthcare provider in the school setting who can support and guide students and staff in meeting the healthcare needs of students both at school and on school-sponsored trips such as extracurricular activities, field trips, intramural athletic events, and interscholastic athletic events (NASN 2016; Connecticut State Department of Education, 2014). All students, including students with special needs, have the right to participate in school-sponsored trips (U. S. Department of Education [USDE]/ Office of Civil Rights [OCR], 2016). The school nurse's role is critical in planning, coordinating, and educating staff, families, and students to assure appropriate care for all students every day at school and during school-sponsored trips (NASN, 2016; Yonkaitus & Shannon 2017).

BACKGROUND

School-sponsored trips are offered to complement and enhance the educational experience for students. A trip may be as simple as a local excursion for just a few hours or as complicated as a trip for several days/nights to a different city, state, or country. While schools may invite the parents/guardians of a student with special healthcare needs to accompany the student on the trip, school officials cannot require that a parent/guardian of a child with special healthcare needs attend if parents of students without special healthcare needs are not required to accompany their children (USDE/OCR, 2016).

Beginning in the 1960's, the United States began enacting laws to support students with special needs (Galemore & Sheetz, 2015). The rights of students with disabilities are protected through the Individuals with Disabilities Education Improvement Act (IDEIA) (2004) and Section 504 of the Rehabilitation Act of 1973 (Yonkaitis & Shannon, 2017). All schools that receive federal funds are subject to Section 504 and the American with Disabilities Act (ADA) of 1990 (USDE/OCR, 2017). Under Section 504 regulations, equal access includes serving students with disabilities in the academic and non-academic settings, including school-sponsored trips. To guarantee that students with disabilities have equal access to school programs, Section 504 requires that schools provide modifications and/or accommodations. If a student with a disability needs an accommodation or related aids or services to participate in the field trip, those services must be provided (USDE/OCR, 2016). Local school districts are responsible for providing the needed accommodations to students with disabilities to safely participate alongside their classmates on school-sponsored trips.

In 2015, the Every Student Succeeds Act (ESSA) identified the school nurse as the healthcare expert to manage students with chronic healthcare needs, including those with disabilities (ESSA, 2015). In 2011-2012 approximately 25% of children aged 6 to 17 years were reported to have a special health care need (Child Health USA, 2014). School nurses are responsible for informing educational communities about the medical needs of students so that they may safely participate in school-sponsored trips. For example, a student with a life-threatening allergy could qualify for a 504 plan that would include modifications so that the student may participate safely on a field trip (Galemore & Sheetz, 2015).

RATIONALE

A system should be present which engages the school nurse in all planning phases of the school-sponsored trip to ensure that a comprehensive plan for student care and safety is in place. According to federal mandates, schools must provide equal opportunities to access participation in all activities, both academic and extracurricular, including access to health services (Erwin, Clark, & Mercer, 2014). To promote proper access to health services, the school nurse should perform individual health assessments and develop or update individual health plans (IHPs) annually. These timely plans will enable appropriate, safe care for students with special healthcare needs throughout the school year, including for potential school-sponsored trips. The student's healthcare needs on school-sponsored (field) trips are determined through a collaborative process coordinated by the school nurse, reviewed at least annually, and as needed throughout the school year (NASN, 2016). The IHP outlines the plan for meeting the healthcare needs of the student at school and during school-sponsored trips and is utilized to create emergency care plans or ECPs (Erwin et al., 2014).

The school nurse's knowledge of the individual needs of students places the school nurse in a unique position to coordinate care that enables the student to fully participate in a safe and healthy school-sponsored trip experience (NASN, 2016).

Planning steps may include

- assessing trip plans, including transportation methods, student's dietary issues and needs; accompanying staff; layout/structure of the planned visitation site(s); duration of the trip; and proximity/access to emergency medical care;
- addressing medical issues such as medication, medical treatments, and procedures required during the trip, as well as the potential for health emergencies; and
- determining the cost of accommodations. Currently, the costs associated with providing accommodations are the responsibility of the school district and must be considered in the initial planning phases of a proposed school-sponsored trip (USDE/OCR, 2016).

For in-state school-sponsored trips, depending on state regulations, the school nurse may be able to consider delegating some tasks required during the trip to a non-nurse staff member, such as a teacher (Bobo, 2014). The school nurse will utilize appropriate principles of nursing delegation as described in the national guidelines written by The National Council of State Boards of Nursing (NCSBN, 2017), the state Nurse Practice Act, and other state school nurse delegation guidelines. If the school nurse determines that medical care cannot be legally or safely delegated, the school nurse will need to determine and coordinate the nursing staff required to accompany the student. The school nurse will need to arrange for proper staffing in the school health office if it is determined the school nurse should accompany the child on the trip (Erwin et al., 2014).

If the school-sponsored trip takes place in a different state or country and requires the presence of the school nurse, there will be licensing laws that need to be considered, so that the school nurse can legally provide nursing services in that state or country. The Nurse Licensure Compact (NLC) allows nurses to have one multistate license with the ability to practice in both their home state and other compact states (NCBSN, 2017). Some states do not have a compact law. The school nurse must act accordingly, relating to all facets of practice. For trips occurring out of the United States, the nurse or a school representative should contact the U.S. State Department, which will direct the inquiry to the appropriate international contact (Erwin et al., 2014).

CONCLUSION

School-sponsored trips may be common occurrences in the educational lives of students and can be some of their most enjoyable. School districts that receive federal funding are legally bound to assure that all students have access to these opportunities (USDE/OCR, 2016), regardless of disability or healthcare needs. It is the position of NASN that the school nurse's role is critical in the planning, coordination, and education of staff, families, and students. Providing appropriate care and protecting the needs and rights of ALL students allows for a safe, enjoyable educational experience for each person participating in these trips.

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School Violence – The Role of the School Nurse

National Association of School Nurses

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that registered professional school nurses (hereinafter referred to as school nurses) advance and encourage safe school environments by promoting the prevention and reduction of school violence. School nurses serve on the front line and are readily able to identify potential violence and intervene to diminish the effects of violence on both school children as individuals and populations in schools and the community (King, 2014). School nurses collaborate with school personnel, healthcare providers, parents, and community members to identify and implement evidence-based programs promoting violence prevention. These evidence-based programs promote violence prevention through early intervention, communication, positive behavior management and conflict resolution. As identified in the *Framework for the 21st Century School Nurse Practice™* (NASN, 2015), the school nurse supports evidence-based practices and care coordination to provide an environment where students can be healthy, safe, and ready to learn.

BACKGROUND

Violence is defined as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation" (World Health Organization, 2017, para. 2). School violence is youth violence that occurs on school property, on the way to and from school or school-sponsored events, or during a school-sponsored event. A young person can be a victim of, a perpetrator of, or a witness to school violence (Centers for Disease Control and Prevention [CDC], 2016). Selekman, Pelt, Garnier, and Baker, (2013) describe school violence as including fighting/assaults (with or without weapons by two or more individuals); bullying; physical, sexual, and psychological child abuse; dating violence; and violence against oneself (intentional non-suicidal self-injury. School violence has an impact on the social, psychological, and physical well-being of students and staff. It disrupts the teaching-learning process through fear, intimidation, absenteeism, or class disruption and affects the victim, the aggressor, and the bystanders. The CDC (2016) found that violence and bullying may have a negative effect on health throughout life.

School nurses recognize the multiple factors that may increase or decrease a youth's risk of becoming a perpetrator or victim of school violence, and school nurses may be able to identify students at risk. The CDC (2017) has identified potential risk factors and protective factors that may be considered when assessing student characteristics that are common among others that become a perpetrator or victim, including individual and family characteristics. These factors include a history of victimization, disabilities, emotional problems, substance abuse, low IQ, authoritarian parenting, low family involvement, low-income family functioning, gang involvement, school failure, transient lifestyle and diminished economic opportunities. By recognizing these social determinants and assessing the child, the school nurse may be able to identify those at greatest risk of being involved in violence as the victim or the perpetrator. Once identified, these students can be supported by school staff and encouraged to be involved in school activities and social engagements. If students feel connected and supported by their non-deviant peers and school staff, they are less likely to commit a violent act or be in a setting where they can be victimized.

The authors of *Indicators of School Crime Safety: 2016* state:

> In 2015, three percent of students ages 12-18 reported that they were afraid of an attack or harm at school, and five percent of students avoided either a school activity or one or more places in school because of fear of being attacked or harmed by someone. From July of 2013 to June of 2014, there were 48 school-associated violent deaths including 26 homicides, 20 suicides, 1 legal intervention death, and

one undetermined violent death (of those 48 violent deaths, 12 homicides and 8 suicides were school-age children). In the 2013-2014 school year, 65 percent of public schools reported one or more incidents of violence translating to around 15 crimes per 1000 students. In 2015, there were about 84,100 nonfatal victimizations at school (Musu-Gillette, Zhang, Wang, Zhang, & Oudekerk, 2017, pp. iii-iv).

The CDC (2016, para. 2) reports the following:

- Approximately 9% of teachers report that they have been threatened with injury by a student from their school.
- Five percent of school teachers reported that they had been physically attacked by a student from their school.
- In 2013, 12% of students ages 12–18 reported that gangs were present at their school during the school year.
- In a 2015 nationally representative sample of youth in grades 9-12
    - 7.8% reported being in a physical fight on school property in the 12 months before the survey.
    - 5.6% reported that they did not go to school on one or more days in the 30 days before the survey because they felt unsafe at school or on their way to or from school.
    - 4.1% reported carrying a weapon (gun, knife, or club) on school property in one or more days in the 30 days before the survey.
    - 6.0% reported being threatened or injured with a weapon on school property one or more times in the 12 months before the survey.
    - 20.2% reported being bullied on school property, and 15.5% reported being bullied electronically during the 12 months before the survey.

Musu-Gillette et al., 2017 in *Indicators of School Crime and Safety: 2016* cites that in public schools

- sixteen percent during the 2013-2014 school year reported that bullying occurred among students on a daily or weekly basis (p. vi).
- seven percent of students in 2013 reported cyberbullying anywhere during the school year (p. 80).
- in the 2013-2014 school year, five percent reported student verbal abuse of teachers occurred on a daily or weekly basis, and 9 percent reported student acts of disrespect for teachers other than verbal abuse on a daily or weekly basis (p. vi).
- eleven percent reported gang activities during the 2015 school year (p. 64).

Less visible statistically are the effects of witnessed violence and increased prevalence of violence as a coping mechanism in schools and the community. Children who witnessed violence, even as infants, have been shown to experience mental health distress, resulting in behavior and mental health issues during the school day (Selekman et al., 2013). Violence has become a significant health risk and is not limited to violent acts committed in the school setting but also in homes, neighborhoods, and communities which affect the learning and behaviors of children at school (Selekman et al., 2013).

RATIONALE

School nurses also play a vital role in violence intervention. Hassey and Gormley (2017) identified eight types of violence and the role of the school nurse in each type. The eight types of violence include bullying, mental health crisis, physical assault, sexual assault, student on student, student on staff, staff on the student, and escalating violence/violent intruder. Each type may begin with the school nurse assessing the situation, followed by appropriate actions and referrals deemed necessary for the situation. The school nurse works with students, families, and the school community to implement a multi-strategy approach to school violence (David-Ferdon et al., 2016). For individual students and families, school nurses have the expertise to assist students in developing problem-solving and conflict resolution techniques, coping and anger management skills, and positive self-images:

- Identify behaviors that could be purposeful misbehavior--such as bullying, outbursts, sleeping in class or running away--and physical symptoms--such as headaches, stomachaches, and frequent trips to the clinic as possible effects of violence (King, 2014).

- Facilitate programs that engage parents in school activities that promote connections with their children and foster communication, problem-solving, limit setting, and monitoring of children.
- Serve as positive role models, developing mentoring programs for at-risk youth and families.
- Educate students and their parents about gun safety (Selekman et al., 2013).

Creating protective community environments is necessary for a multi-strategy, multi-disciplinary approach to violence prevention (David-Ferdon et al., 2016). School nurses contribute expertise in creating a protective environment in schools by

- serving on school safety and curriculum committees, identifying, advocating, and implementing universal school-based prevention programs within the school community (David-Ferdon et al., 2016).
- supporting the efforts of administration by collaborating with a multi-disciplinary team of colleagues in the areas of social work, counseling, school discipline, and law enforcement to provide and maintain security.
- assisting in the development of district and school discipline policy, including zero tolerance for weapons on school property and buses, and code of conduct documents.
- supporting activities and strategies to help establish a climate that promotes and encourages respect for others and the property of others.
- advocating for adult presence in high-risk areas and times, such as in hallways during class changes and before and after school and outside of the building before and after school.
- facilitating partnerships between the school and local healthcare agencies.

When violence occurs, school nurse interventions to address violent behaviors include their ability to

- coordinate emergency response until rescue teams arrive.
- provide nursing care to injured students.
- apply crisis intervention strategies that help de-escalate a crisis situation and help resolve the conflict;
- identify and refer those students who require more in-depth counseling services.
- participate in crisis intervention teams.

CONCLUSION

School nurses promote violence prevention by facilitating a school environment that values connecting students, families and the community in positive engagement and creating a school environment of safety and trust where students are aware that caring, trained adults are present and equipped to take action on their behalf. They engage in classroom discussions that facilitate respectful communication among students and staff and advance the education of the school community to build skills in communication, problem-solving, anger management, coping and conflict resolution. The expertise of school nurses in evidence-based practice of health care in the school setting is beneficial in violence prevention in schools.

School nurses advance and encourage safe school environments by promoting the prevention and reduction of school violence through evidence-based practice methods. The school nurse recognizes potential threats and collaborates with the appropriate personnel to get students the resources and supports they need to be healthy, safe and ready to learn.

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Service Animals in School

National Association of School Nurses

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that registered school nurses (hereinafter referred to as school nurses) are integral to the team planning process necessary to successfully integrate "service animals" into schools. A request to bring a service animal into the school setting presents questions due to the complex disability discrimination laws, emerging medical and psychological data concerning service animal benefits (Winkle, Crowe & Hendrix, 2012), various interpretations of what criteria to use to distinguish between a trained service animal and a household pet, and potential effects on other students and staff. School nurses assess, plan, and coordinate care to develop an Individualized Healthcare Plans (IHP) for students with special healthcare needs, including students who may require the use of a service animal during the school day. Just as a student may need a wheelchair or other adaptive device, service animals are essential to some students' ability to be at school. School nurses are leaders in the development and evaluation of school health policies and programs that address the health and safety needs of students in the school environment (ANA & NASN, 2011).

BACKGROUND

Animals that provide for the physical and mental well-being of humans are perhaps the most admired of all working animals. "Service animal" is a term that distinguishes those animals that serve individuals with physical or mental disabilities, usually on a one-on-one basis, from pets or other types of skilled animals, such as police dogs (Ensminger, 2010). The term, though primarily legal, is used quite broadly in today's society.

In the past 20 years there has been an expansion of the diversity of service animals being utilized by persons with disabilities, with different opinions as to what truly is a "service animal". Effective March 15, 2011, the Americans with Disabilities Act (ADA) regulations define a service animal as "a dog that is individually trained to do work or perform tasks for the benefit of an individual with a disability" (United States Department of Justice [USDJ], 2011). In addition, there is a new, separate provision which includes miniature horses in the definition of a "service animal" if the miniature horse has been individually trained to do work or perform tasks for people with disabilities (Jacobs, 2011). Examples of such work or tasks include:

- guiding people who are blind,
- alerting people who are deaf,
- pulling a wheelchair,
- alerting and protecting a person who is having a seizure,
- reminding a person with mental illness to take medications,
- sensing and alerting a person with diabetes experiencing low blood sugar,
- calming a person with Post Traumatic Stress Disorder (PTSD) during an anxiety attack, or performing other duties.

Service animals are working animals. A service animal has been trained to provide work or tasks directly related to the person's disability. Animals whose sole function is to provide comfort or emotional support do not qualify as service animals under the ADA (USDJ, 2011). Children who may require a service animal in school are supported by the ADA regulation, Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), Individuals with Disabilities in Education Act (20 U.S.C. 1400 et seq), as well as state and local laws.

RATIONALE

School districts recognize that service animals may be used to provide assistance to some students/staff with disabilities, which includes the presence of the service animal in the school, on school property; including school buses, and at school activities. Schools have a legal responsibility to provide planning and services for children with

special healthcare needs, including allowing service animals into schools. Planning promotes quality care for students with special healthcare needs in school and enhances the student's academic success.

Communication among the family, school, and healthcare provider is critical and may uncover adaptations or alternatives to the service animal's presence in schools. However, if a student presents with a service animal unannounced, some educational legal experts advise to allow the animal similarly to allowing a student to use a wheelchair or crutches. In some states' laws, neither the person nor the service animal "shall be denied right of entry and use of facilities of any public place of accommodation" (Illinois Human Rights Act, 2006).

Initial questions to ask upon receiving a request for a service animal to accompany a child in school include the following:

- Is the service animal required because of a defined disability (per Section 504 definitions)?
- Will the animal impact the student's academic and behavioral functions to support his or her education?
- Does the student need the service animal for equal access to educational services and programs?
- What work or task has the service animal been trained to perform?
- How will the service animal alert its handler/student to an impending incident, such as an oncoming seizure or low blood glucose?
- How will having a service animal in a building affect students/staff that may have an allergy to the service animal or a distinct fear of the animal?

School district policy concerning service animals should address the following:

- Compliance with current federal, state and local laws regarding service animals in schools (Wisch, 2013).
- Written documentation from a veterinarian that the service animal is in good health and properly vaccinated. Although such documentation is not legally required, it helps confirm that the animal is safe to be around other students at the school (Virginia Department of Education, 2011).
- Provision of training for staff and students in rationale for, and interaction with, the service animal.
- Education of students, staff members and the community on the role of service animals and the laws permitting them access to public places.
- Control of the service animal in school. "Service animals must be harnessed, leashed, or tethered unless these devices interfere with the service animal's work or the individual's disability prevents using these devices. In that case, the individual must maintain control of the animal through voice, signal, or other effective controls" (USDJ, 2011, para. 6).
- Schools may exclude any service animal if that animal is out of control; the animal's handler does not take effective action to control it; or the animal is not housebroken (USDJ, 2011).

Other factors that the school should consider include the following:

- Review any existing state law regarding service animals.
- According to the law, schools are not responsible for care, including elimination needs, food or a special location for service animals (USDJ, 2011). The animal's owner/family is responsible for the "care and supervision of the service animal" (USDJ, 2011). However, many students who have service animals are not able to provide care for their animal at school. Communication and planning between school and home are essential in making adaptations to this rule (Minchella, 2011).
- When there is more than one service animal in a school building, special arrangements should be made so the animals can meet each other in a controlled setting.
- When a miniature horse is the service animal, the type, size, and weight of the miniature horse and whether the facility can accommodate these features without compromising legitimate safety requirements that are necessary for safe operation should also be considered. Other requirements which apply to service animals shall apply to miniature horses (USDJ, 2011).
- Although many service animals wear a vest identifying them as such, there is no federal requirement that the service animal wear a harness, backpack, or vest identifying it as a service animal. In some states, such a requirement is expressly prohibited (Illinois State Board of Education, 2012).

CONCLUSION

The school nurse identifies student health issues and special needs that are relevant to the student's educational progress and, along with the multi-disciplinary team, recommends services or program modifications that the student may need or require. The school nurse is a leader in educating, advocating, supporting placement of, and evaluating the success of these services. Communication and planning are essential in supporting the student with a service animal. The school nurse plays a key role in facilitating this communication and planning process.

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Sexual Health Education in Schools

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that developmentally appropriate evidence-based sexual health education should be included as part of a comprehensive school health education program and be accessible to all students. NASN recognizes the role of parents and families as the primary source of education about sexual health. The registered professional school nurse (hereinafter referred to as school nurse) is a valuable resource to parents and educators in this area and supports the implementation of evidence-based sexual health education programs that promote healthy sexual development for all students.

BACKGROUND

The social and health risks of adolescent sexual activity are well known (Dee et al., 2017). While teen pregnancy and birth rates in the United States continue to decline, rates remain higher than in other industrialized countries; and racial, ethnic and geographic disparities persist (Centers for Disease Control and Prevention [CDC], 2016a). In addition, the rates of sexually transmitted infections (STIs) are at an unprecedented high in the United States, and more than half of newly acquired infections occur among adolescents and young adults (CDC, 2016b).

Sexual health as defined by the World Health Organization (WHO) is "… a state of physical, emotional, mental and social well-being in relation to sexuality..." (WHO, 2015, pp. 5), suggesting a whole child approach to sexual health education and not merely the absence of unplanned pregnancy or sexually transmitted infections. For decades, studies have shown that the majority of parents in the United States support sexual health education in schools. In addition, findings indicated that most parents supported abstinence-based rather than abstinence-only programs (Barr et al., 2014). Finally, a May 2016 nationwide survey of middle and high school parents found that 70% believe sex education and pregnancy prevention should "definitely be covered" in sexual health education programs (Singer, 2016).

According to the 2014 School Health Policies and Practices Study (CDC, 2015a), 72% of high schools in the United States required students to receive education on pregnancy prevention, and 83.1% required instruction on STI prevention. Topics listed as part of required instruction by order of frequency included abstinence as the most effective method to avoid pregnancy and STIs, the relationship between alcohol or other drug use and risk for STIs and pregnancy, and resisting peer pressure to engage in sexual behavior. A worrisome trend is that the percentage of schools in which students are required to receive instruction on human sexuality, pregnancy, and STI prevention has steadily declined since 2000 (CDC, 2015a).

Healthy students are more likely to achieve academic success (CDC, 2014). Szydlowski (2015b) asserts that when teens receive accurate sexual health education information and skills, they can reduce health risk factors that may impact their success in school. Data from the 2015 Youth Risk Behavior Surveillance Survey (YRBSS) indicated that, among high school students, 41% have had sexual intercourse at least once; and 30% had sexual intercourse in the three months prior to participating in the survey, reflective of a decline from previous surveys (CDC, 2015b).

Although teens may be having less sex, condom use and HIV testing are declining (CDC, 2015b). Of those who had intercourse in the past three months, 43% did not use a condom the last time they had sex; 14% did not use any method to prevent pregnancy; and 21% used substances before last sexual intercourse (CDC, 2015b).

For the first time, the CDC analysis of national data gathered from the 2015 YRBS included information on the health risks of lesbian, gay, and bisexual (LGB) high school students. These findings demonstrate that LGB youth report a higher incidence of bullying at school or online, physical and sexual dating violence, drug and alcohol use, and suicide-related behaviors than their straight peers (Kann, Olsen, & McManus, 2016). In the most recent Gay, Lesbian, and Straight Network (GLSEN) National School Climate Survey, over 31% of LGBTQ students reported missing at least one day of school during the past month due to safety concerns. Students who attended schools with LGBTQ-inclusive curriculum were less likely to miss school (18% vs. 35%) for safety reasons (Kosciw, Greytak, Giga, Villenas, & Danischewski, 2016). Although not a direct measure of school performance, absenteeism has been linked to low graduation rates, which can impact future success in life (CDC, 2014).

In addition to the disparities of risk for sexual minority youth, there are racial/ethnic differences. Black high school students are more likely to have had intercourse than white and Latino students; and more black high school students and Latino students initiated sex before the age of 13 compared to white students (Kaiser Family Foundation, 2014).

Students with disabilities defined as "... a physical or mental impairment that substantially limits one or more major life activities" (Americans with Disabilities Act of 1990 [ADA], Title II Regulations, 2016, p. 187), and those with intellectual disabilities (ID) as characterized by "...significant limitations both in intellectual functioning and in adaptive behaviour as expressed in conceptual, social, and practical adaptive skills" (Luckasson & Schalock, 2013, pp. 96) benefit from sexual health information. Low levels of knowledge can impede the recognition of sexual abuse situations, safe sex practices, and the development of positive attitudes toward sexuality (Schaafsma, Kok, Stoffelen, & Curfs, 2015). Szydlowski (2016) compiled general guidelines for sexual health educators for those with disabilities. Sexual health education needs to be tailored to the students with disabilities based on their ability, learning style, and maturity, in addition to parent values and beliefs (Szydlowski, 2016).

RATIONALE

School nurses support sexual health education that is accessible, inclusive, and developmentally and culturally appropriate for all students. Academic achievement is linked to student health (CDC, 2014). Health risk behaviors, such as early sexual initiation, are associated with lower grades and test scores, and lower educational attainment (CDC, 2016c). Evidence-based sexual health education provides accurate, complete, and developmentally appropriate information and skill development that allow young people to make decisions that are informed, responsible, and healthy (Szydlowski, 2015b). Evidence-based sexual health education can improve academic success; prevent dating violence, and bullying; help youth develop healthier relationships; delay sexual initiation; reduce unplanned pregnancy, HIV, and other STIs; and reduce sexual health disparities among LGBTQ youth (Szydlowski, 2015b). Evidence-based sexual health education reduces sexual risk behavior by delaying sexual initiation, reducing pregnancy and STIs, and increasing contraceptive use -- thereby protecting student health (Szydlowski, 2015b).

The National Sexuality Education Standards (Future of Sex Education Initiative [FOSE],2012) support a strategic and coordinated approach that includes family and community involvement, skill development and school health

services. Furthermore, the Sexuality Information and Education Council of the United States (SIECUS) (2017) supports sexual health education that is appropriate to the student's age, developmental level, cultural background, and community values. SIECUS further advocates for sexual health education to augment the sexual health education provided by the family and their healthcare professionals. SIECUS specifies that sexual health education provided in an educational setting needs to be taught by an instructor trained on the principles, content and best practices of sexual health education. On behalf of Advocates for Youth, Szydlowski (2015a) emphasizes youth friendly sexual health education to assist with the positive development of sexual health, beginning in youth and continuing throughout adulthood.

The National Sexuality Education Standards recommend that an evidence-based sexual health education program include the following characteristics (FOSE, 2012, p.9):

- Focuses on specific behavioral outcomes;
- Addresses individual values and group norms that support health-enhancing behaviors;
- Focuses on increasing personal perceptions of risk and harmfulness of engaging in specific health risk behaviors, as well as reinforcing protective factors;
- Addresses social pressures and influences;
- Builds personal and social competence;
- Provides functional knowledge that is basic, accurate and directly contributes to health-promoting decisions and behaviors;
- Uses strategies designed to personalize information and engage students;
- Provides age- and developmentally appropriate information, learning strategies, teaching methods and materials;
- Incorporates learning strategies, teaching methods, and materials that are culturally inclusive;
- Provides adequate time for instruction and learning;
- Provides opportunities to reinforce skills and positive health behaviors;
- Provides opportunities to make connections with other influential persons; and
- Includes teacher information and plan for professional development and training to enhance effectiveness of instruction and student learning.

In addition, in terms of specific content, an emerging model for sexual health education is the rights-based approach, which employs a vast, comprehensive sexual education program with a focus on human rights, gender equality, access to healthcare services, and critical thinking (Constantine et al., 2015). Preliminary findings have supported that education based on theories of human rights, gender equality, and sexual development can positively impact healthy sexual behavior among adolescents (Constantine et al.).

CONCLUSION

Health education and promotion, disease prevention, and risk reduction are essential practice components for the 21st century school nurse to help students stay healthy, safe and ready to learn (NASN, 2016). School nurse leaders advocate for and support the delivery of evidence-based sexual health education that is "...medically accurate, developmentally appropriate, and … provides students with the skills and resources that help them make informed and responsible decisions" (FOSE, 2012, p.8). School nurses -- working in collaboration with parents, students, health educators, curriculum specialists, and other school and community stakeholders -- strive to dismantle barriers and support access to evidence-based sexual health education that allows all students to make informed, responsible, and healthy decisions.

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Prevention of Skin Cancer due to Ultraviolet Ray Exposure - The Role of the School Nurse

National Association of School Nurses

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (hereinafter referred to as school nurse) is an essential member of the school health team when addressing the issue of student exposure to ultraviolet (UV) rays. The school nurse is in a key position to empower students to make informed choices regarding health-related behaviors (Banfield, McGorm, & Sargent, 2015) and to provide sun protection education to students, families, and school staff.

BACKGROUND

Overexposure to the sun's UV rays or to artificial sources like tanning beds can cause harmful effects to the body (Centers for Disease Control and Prevention [CDC], 2017). The most common harmful effect is skin cancer. Skin cancer, a preventable cancer, is the most common type of cancer in the United States; more than five million annual cases of skin cancer can be prevented by skin protection and avoidance of tanning beds (American Cancer Society, 2017). Each year in the United States, the cost of treating skin cancer exceeds $8.1 billion (United States Department of Health & Human Services [USDHHS], 2014). Sun exposure is the leading cause of melanoma skin cancer (Kleier, Hanlon, & MacDougall, 2017). Pediatric melanoma, the most serious form of skin cancer, increased by 2% each year between 1973 and 2009 (Kleier et al., 2017; Wong, Harris, Rodriguez-Galindo, & Johnson, 2013).

Approximately 25% of UV exposure occurs during childhood and adolescence because of increased opportunities for exposure. Exposure to UV radiation during childhood plays a very important role in the future development of skin cancer, especially melanoma and basal cell cancer (Kleier et al., 2017). People who have a history of one blistering sunburn during childhood have double the risk of developing melanoma later in life compared to those who did not have such exposures (Kleier et al., 2017).

Sunscreen is considered an over-the-counter medication by the Food and Drug Administration (U.S. Food and Drug Administration, 2017). FDA recommends sunscreen products to be used as directed by the Drug Facts label. NASN recommends that school nurses provide their professional expertise in assisting school boards or other governing bodies in writing medication administration policies and procedures that focus on safe, efficient medication administration to all students in accordance with each state's nurse practice act (NASN, 2017). Currently seven states have laws that allow students' use of sunscreen at school without a physician's order, and six additional states have pending legislation (Farquhar, 2017). It is important for school nurses and other school staff to be aware of pending legislation as each state's requirements are different, and not all legislation addresses school district or school employees' liability (Moore, 2017).

Tanning beds, unlike sun exposure, provide concentrated UV exposure despite location, or time of day, causing further risks of skin cancer (USDHHS, 2014). According to the National Conference of State Legislatures, 14 states and the District of Columbia currently ban the use of tanning beds by minors, and 42 states and the District of Columbia regulate use of tanning beds by minors (Moore, 2017).

RATIONALE

School nurses are in an ideal position to promote, model and educate students, staff and families about the need for conscientious UV ray protection. Children and adolescents spend most of their waking hours during the week at school. Some of that time is spent in outdoor activities, usually during the time of day when sun exposure is most

damaging (Guy, Holman, & Watson, 2016). Early education about the dangers of sun and the protection of oneself is critical. Sunburn can be prevented, and preventative measures should become part of a daily self-care practice. The CDC's Skin Cancer Prevention Progress Report (2017a) highlights several education programs that school nurses can access to teach students about the effects of UV radiation, the types of skin cancers it can cause, and the importance of protecting themselves from too much UV exposure.

School-based health education to promote skin cancer prevention is most effective when it is provided consistently and introduced sequentially in every grade from preschool through twelfth grade. School nurses are in the position to support preventive exposure to UV rays by providing students, families and policy makers with information on the following:

- wearing of sunglasses, hats, and protective clothing
- avoiding outdoor play during peak sun intensity hours when UV ray exposure is greatest
- playing in shaded areas (whether by natural or installed shading devices)
- using sunscreen properly and consistently (CDC, 2017b; American Academy of Pediatrics [AAP], 2017)
- avoiding sun tanning and tanning beds (AAP, 2011)

The AAP (2017) and CDC (2017b) both recommend that a broad-spectrum sunscreen be at a minimum sun protective factor (SPF) of 15 or higher and be applied before going outside (even on cloudy days) and every two hours, especially after swimming or sweating.

As a member of the school health team, the school nurse is in a position to influence policy development to help limit exposure to UV rays. School nurses need to be aware of state legislative efforts to minimize childhood exposure to UV rays, related both to application of sunscreen and banning of tanning beds by minors. School nurses need to work with legislators and other stakeholders to help them understand nurse practice acts and requirements for safe and efficient medication administration in a school setting.

CONCLUSION

Skin cancer can be prevented through education and proper protection. School nurses are in a position to provide education to students, school staff, community members, and policy makers that can help reduce student exposure to harmful UV rays whether it be through sun exposure or artificial sources (tanning beds). School nurses should advocate for preventative measures, such as use of sunscreen (according to district policy and state nurse practice act); use of protective clothing, wide brim hats, and sunglasses; the installation of shading devices for play areas; and laws that reduce UV ray exposure from artificial sources.

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Supervision and Evaluation of the School Nurse

NASN
National Association of School Nurses

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (hereinafter referred to as the school nurse) should be clinically supervised and evaluated by a registered nurse knowledgeable of the scope and standards of practice for school nursing. The school nurse job description and performance evaluation should be based on the standards of school nursing practice, the standards of professional performance, and related competencies described in the current version of "School Nursing: Scope and Standards of Practice" (American Nurses Association [ANA] & National Association of School Nurses [NASN], 2011).

BACKGROUND

The school nurse is often the only healthcare provider in a school. However, school nurses may be supervised and evaluated by school administrators who have little or no knowledge and understanding of the school nurse role. Liability exists when school administrators, who do not fully understand the scope and standards of school nursing practice, are responsible for supervising and evaluating the clinical competency of the school nurse (Hootman, 2013; McDaniel et al., 2013).

NASN, in collaboration with the ANA, has developed standards of practice that apply to the specialty practice of school nursing. These standards provide a framework for the expansive scope of practice and authoritative statements of the duties that school nurses are expected to competently perform. To be truly meaningful, the standards statements and the accompanying competencies must be further refined to reflect the context of practice, district policies, and state nurse practice acts. The standards of practice and professional performance for school nursing provide the tools to focus on the tasks that promote the health and academic achievement of all students (McDaniel, Overman, Guttu & Engelke, 2013) and guide the evaluation of competencies needed to meet these standards.

RATIONALE

In order to meet students' health needs and to function effectively with school and community team members, school nurses need supervision and evaluation to maintain and improve competence in this independent practice. Accurate job descriptions and an evaluation process that includes both an administrative and a clinical nursing component are essential and should be based on the standards of practice and professional performance for school nursing practice. School nurses are instrumental in creating and revising job descriptions and the competencies to be included in a performance evaluation (McDaniel et al., 2013).

Clinical Supervision

As the health needs of today's students have increased in the school setting, school nurses have expanded their base of knowledge and skills to safely care for them (Resha, 2009). School nurses need the support provided by clinical supervision, which requires "specialized, professional knowledge, skills and related credentials for the practice of school nursing. It promotes, enhances and updates the professional growth of school nurses in terms of their professional and clinical skills and knowledge" (Connecticut State Department of Education, 2009, p. 20).

The National Association of State School Nurse Consultants' (NASSNC) 2007 position paper supports clinical supervision of school nurses by licensed, experienced registered nurses rather than a non-nurse supervisor. NASN

and the NASSNC recommend that school nurses be supervised and evaluated by a school nurse because the integrity and quality of nursing practice is enhanced when clinical supervision is provided (Somerville, 2013).

If school districts do not have an administrator who is a school nurse, it is recommended that a designated lead school nurse provide clinical supervision.

Performance Evaluations

School nurses function as independent practitioners who are accountable under the scope of their professional license, applicable district policies and procedures and their state's nurse practice act. For this reason, professional accountability through a performance evaluation process is essential to ensure professional competency and growth (Beirne, 2009).

In the 2008 position statement "Professional Role Competence" the ANA states,

> The public has a right to expect registered nurses to demonstrate professional competence throughout their careers. ANA believes the registered nurse is individually responsible and accountable for maintaining professional competence. The ANA further believes that it is the nursing profession's responsibility to shape and guide any process for assuring nurse competence. Regulatory agencies define minimal standards for regulation of practice to protect the public. The employer is responsible and accountable to provide an environment conducive to competent practice. Assurance of competence is the shared responsibility of the profession, individual nurses, professional organizations, credentialing and certification entities, regulatory agencies, employers, and other key stakeholders (para. 1).

Best practice requires a nurse in the role of supervisor, coach, mentor or preceptor to evaluate the clinical practice of the school nurse, identify the professional competencies outlined in the job description, and determine the need for professional development (Beirne, 2009; Hootman, 2013). Performance evaluations can also be enhanced through a process of self-evaluation and the development of a professional portfolio that documents competencies that meet standards of school nursing practice. Additional performance indicators, not related to the practice of nursing, can be evaluated by educational administrators and others (ANA & NASN, 2011; McDaniel et al., 2013).

In districts without school nurse administrators, a self-evaluation process and use of a professional portfolio become increasingly important. Contracting with a school nurse supervisor in another school district for the nursing component of a performance evaluation is recommended. School nurses without nurse administrators can take a leadership role in assisting their administration in developing a performance evaluation tool that includes a self-evaluation based on scope and standards of school nursing practice and non-nursing performance indicators. Co-development of a performance evaluation tool can increase the administration's understanding of the school nurse role in the school setting (Green & Reffel, 2009).

CONCLUSION

Student health and safety and the continuous improvement of individual school nursing practice is the goal of performance management (Somerville, 2013), supervision and evaluation. The school nurse can "provide valuable, needed services to students if he or she has core skills and knowledge, mastery of competencies, and is supported by a supervisor who offers guidance, encourages professional development and provides evaluation" (Connecticut State Department of Education , 2009, p.25).

As the only healthcare provider in the school setting, the school nurse is often supervised and evaluated by a non-nurse staff member. According to the guidelines developed by the ANA and NASN's (2011) scope and standards of practice, the school nurse's performance evaluation should consist of three components: a self-evaluation completed by the school nurse, a clinical evaluation performed by another registered nurse and a non-clinical evaluation, which may be completed by a non-clinical supervisor.

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The Role of School Nursing in Telehealth

National Association of School Nurses

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that utilization of telehealth technology may be a valuable tool to assist registered professional school nurses (herein referred to as a school nurse) to provide school health services. The health of many students is impacted by lack of access to primary care and specialty services due to health disparities caused by poverty and other social determinants of health. Technology and telehealth can assist the school nurse in addressing these issues. The school nurse is on the frontlines of school health services and has the expertise to provide the critical link and oversight to successfully implement and utilize telehealth/telemedicine technology in the school setting.

BACKGROUND

The terms *telehealth* and *telemedicine* are often used interchangeably although telehealth is considered a broader term that includes not just clinical services but education and training (Institute of Medicine [IOM], 2012). The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) (2015) defines telehealth as:

> The use of electronic information and telecommunication technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health and health administration. Technologies include video conferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

The use of telehealth often focuses on populations who have barriers to access health care such as those in rural communities, those living in poverty, or those who are homebound (IOM, 2012). Telehealth provides a potential strategy to remove barriers by:

- Providing extended health and mental health care,
- Providing timely access to meet urgent and emergent healthcare needs,
- Promoting collaboration between regional health centers and healthcare providers in remote areas,
- Decreasing absenteeism and time out of class, and
- Decreasing lost work time for parents/caregivers
  (Children's Health Fund, 2016; Ollove, 2017; Reynolds & Maughan, 2015).

Telehealth in schools has mainly focused on primary care services. The Centers for Disease Control and Prevention (CDC) and ASCD recommend a broader, coordinated, collaborative approach to student health. School nurses are well positioned to integrate telehealth into the Whole School, Whole Community, Whole Child model of care (ASCD & CDC, 2014). According to the American Academy of Pediatrics (2015), telehealth should be utilized as part of a coordinated system to decrease fragmentation and piecemeal approaches to care.

Challenges exist related to telehealth technology such as sustainability, cost to implement and maintain equipment, privacy, liability, and provider reimbursement (IOM, 2012). When creating budgets for implementing and sustaining a telehealth program, developers and providers should include funding for schools and school nurses. New funding reimbursement models which include team approaches to reimbursements that include school nurse services should be considered. In states which do not currently have provision for Medicaid

reimbursement for telehealth services, school nurses and stakeholders should advocate for establishing this provision.

RATIONALE

School nurses collaborate with other school health services team members to address the health needs of the entire school population (NASN, 2016). Telehealth can be used for health education and health promotion. As a primary care partner, telehealth can assist the school nurse in decreasing communicable disease outbreaks through availability of providers to quickly diagnose and treat illness (Ollove, 2017) and improve student attendance by assisting school nurses in the management of chronic conditions (Reynolds & Maughan, 2015). The use of telehealth to address physical or mental/emotional health can improve student attendance and may enhance parents' and caregivers' work productivity (Ollove, 2017). Researchers have found that collaboration between healthcare providers/specialists and school nurses and others via telehealth was efficient, decreased miscommunications between parties, improved student health, and increased parent resources and connections (Mackert & Whitten, 2007; Young & Ireson, 2003; Reynolds & Maughan, 2015).

School nurses are responsible for student health and health issues arising in school and understand the priorities of both health and education in the school setting (NASN, 2016). Advances in technology and the availability of telehealth services can assist school nurses to improve both healthcare access and health in student populations, particularly those who are underserved. School nurses should be involved with other health and education leaders in the development of telehealth policies, standards, and guidelines related to:

- Enrolling students in telehealth programs,
- Ensuring proper consent and parent/caregiver involvement,
- Triaging and coordinating students who would benefit from a consultation via telehealth (including decision tree protocols),
- Sharing of confidential information that meets both HIPAA and FERPA requirements,
- Monitoring appropriate outcomes and evaluation,
- Following up telehealth-visit/consultation, and
- Coordinating school nursing services with other healthcare services.

Telehealth may also facilitate communication and consultation between school nursing colleagues regarding complex cases (Mackert & Whitten, 2007). Telehealth in the school can be used as a conduit for individual and population-based education for students, families, and staff as part of a larger coordinated school health services effort (Reynolds & Maughan, 2015). Telehealth has the potential for future use in areas such as remote connections for school nurses to help students access dental and eye exams, voice disorder treatments, nutritional and obesity counseling and behavioral/mental health counseling and assessment (Kelchner et al., 2014). The use of telehealth services is expected to grow from 250,000 persons in 2013 to 3.2 million persons in 2018 (National Conference of State Legislators Partnership Project on Telehealth, 2015). Technology continues to advance and school nurses must stay current and embrace innovative technologies as they explore new ways to keep students healthy, safe, and ready to learn.

CONCLUSION

Students will continue to have complex social, emotional, and physical health needs which must be addressed to ensure their success in school. Functioning as the bridge between health and education, school nurses address a wide range of student needs and are uniquely qualified to focus on the needs of students at greatest risk of health disparities. School nurses are the vanguard of individual and population-based student health care and have the expertise to utilize telehealth technology. While neither telehealth nor any other technology replaces the registered professional school nurse, the availability of telehealth provides a valuable tool to assist the school nurse in providing a more complete, coordinated approach to student health services in school.

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Transition Planning for Students with Chronic Health Conditions

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that all children with chronic health conditions should receive coordinated and deliberate transition planning to maximize lifelong functioning and well-being. Transition planning refers to a coordinated set of activities to assist students with chronic health conditions to begin in school, and then move from one school to another, from hospitalization back to school, and from the secondary school system into their next stage of life (Selekman, Bocheneck, & Lukens, 2013). The registered professional school nurse (hereinafter referred to as school nurse) has the perspective and skills to provide care coordination and lead the planning team to address transitions for students with chronic health conditions.

BACKGROUND

Increasing numbers of children with special healthcare needs and complex medical conditions attend school on a regular basis (American Academy of Pediatrics [AAP], 2008). According to Murphy and Carbone (2011), there are 10 million U.S. children with special healthcare needs. Advances in medicine and technology allow most children with chronic conditions to reach adulthood. Changes in healthcare delivery (e.g., reduced hospital stays and increased outpatient care) have shifted the burden of care to the community (Shaw & McCabe, 2008). For example, Lotstein and colleagues (AAP, 2013) identified that youth with type 1 diabetes are at an increased risk for poor glycemic control after transition from pediatric to adult care and need additional support with moving to adult care. In 2011, the AAP reported that transition planning has been uncertain, incomplete, or late; and the transfer of care has not been clearly planned.

Federal laws support transition planning for students with chronic health conditions by requiring schools to provide students with equal opportunity to participate in academic, nonacademic, and extracurricular activities.

- The Individuals with Disabilities Education Improvement Act (IDEIA), 2010 regulations, entitles students with disabilities and those who need specialized instructions to receive the services needed to have access to a free and appropriate education (FAPE) in the least restrictive environment. IDEIA has a limited set of recognized impairments and criteria. These impairments have an adverse effect on educational performance necessitating special education, specific to learning (Zirkel, Granthom, & Lovato, 2012).

- For those students who do not qualify for services under IDEIA, Section 504 of the Rehabilitation Act (1973) requires that reasonable accommodations be provided so that the student can fully participate in the educational experience.

- The Americans with Disabilities Act (ADA) (2008) prohibits discrimination based on disability.

  Eligibility under Section 504 and the ADA equates to meeting three essential elements for the definition of disability, which includes (a) physical or mental impairment that (b) substantially limits (c) one or more major life activities (Zirkel, Granthom, & Lovato, 2012).

In addition to support provided by federal law, Lineham (2010) found that planning for timely and seamless transitions should be in place to avoid interruptions of students' access to the services needed to fully participate at school. Providing for the health needs of students with chronic health conditions and enabling them to have

access to the same educational opportunities as their peers have positive benefits (Wideman-Johnston, 2011). These benefits include enhancing their self-identity and increasing resiliency.

RATIONALE

Transition planning includes coordinated, deliberate, and community-based strategies to ensure positive health and academic outcomes for the student with a chronic illness, disability or injury (Craig, Eby, & Whittington, 2011). The goal of transition planning is to maximize the student's health and academic experience. Communication between the healthcare provider and school is critical to raising awareness of the transition needs of the student and determining how to best address these needs (Glang et al., 2008). For example, when transitioning a child into the school system after a prolonged hospitalization for injury or illness, both the child and the school environment must be evaluated to identify services and accommodations needed for the student to fully engage in his or her educational experience (AAP, 2008). The transition planning for adolescents with special healthcare needs transitioning to adulthood includes the development of self-management and decision-making skills to foster active participation in maintaining his/her own health (AAP, 2011).

Transition plans for students with chronic health conditions should be developed for each planned transition in collaboration with the healthcare provider, parent/guardian, student, teachers, and other appropriate school staff. According to the AAP (2008), school nurses are positioned to take the lead in making these transition plans. These plans should identify, support, or promote access to needed services and resources both within and outside the school setting. Transition plans should focus on providing the needed accommodations and services to meet academic, social, and emotional needs; stimulate academic motivation; and promote adjustment to the school setting (Shaw & McCabe, 2008). The development and implementation of a transition plan can improve the quality of life for the child and his or her family by providing the support needed to promote student health and academic success. Individualized transition planning that is started with the healthcare provider prior to school entry empowers the parents/guardian to clarify the needs of their child and identify preferred strategies to meet those needs (Glang et al., 2008). In addition, the school and school nurse are better prepared to implement the transition plan in a coordinated and seamless manner.

It is important to address the following issues when transition planning with students that have chronic health conditions:

- Privacy of student health information -- "The *HIPAA* Privacy Rule allows covered healthcare providers to disclose PHI about students to school nurses, physicians, or other healthcare providers for treatment purposes, without the authorization of the student or student's parent. For example, a student's primary care physician may discuss the student's medication and other healthcare needs with a school nurse who will administer the student's medication and provide care to the student while the student is at school." (U.S. Department of Health and Human Services, 2008, p. 1).

- Transition plans must be individualized. Students with similar medical conditions may respond to and adjust differently as a result of temperament, comorbidities, stage of disease, family factors and social support (Shaw & McCabe, 2008).

- The school nurse should lead the school health team. Since school nurses often cover multiple schools, the school nurse may need to delegate nursing tasks when allowed by district policy and state law in order to implement the transition plan for a student.

- In accordance with state law, when nursing tasks are delegated to other members of the school health team, the school nurse remains accountable for the decision to delegate, for training the delegate and for providing ongoing supervision of the delegate (American Nurses Association [ANA], 2012; Kruger, Toker, Radjenovic, Comeaux, & Macha, 2009).

The role of the school nurse is essential in caring for children with chronic health conditions (Kruger et al., 2009). In order to effectively support transitions for students with chronic health conditions, school nurses should do the following:

- Be knowledgeable about applicable local, state and federal law;
- Maintain clinical competence to provide direct care and/or delegate care for children with chronic health conditions, injuries or disabilities;
- Develop a relationship with the student's healthcare provider and family to assure that the medical orders and resulting individual health plans are implemented correctly;
- Provide consultation and/or referral to the medical home and community resources (AAP, 2008);
- Identify needs across the coordination team for continuing education regarding chronic conditions (Kruger et al., 2009);
- Influence the development of policies surrounding chronic disease management and coordinated school health programs (AAP, 2008);
- Ensure that there is adequate communication and collaboration between the student and family, healthcare provider, school officials, and providers of community-based resources (AAP, 2008); and
- Ensure continuity, compliance and supervision of care for the child with a chronic condition or injury who attends school (AAP, 2008).

CONCLUSION

The education system is greatly impacted by children with chronic health conditions. School nurses must advocate for meeting the healthcare needs and services that these children require. Effective transition planning is a shared responsibility of all professionals involved in the care of children with chronic conditions (Lineham, 2010). Transitioning -- whether at the time of beginning school, from school to school, school to adult life or between the hospital and school environment -- provides an opportunity for care coordination led by the school nurse.

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Unlicensed Assistive Personnel: Their Role on the School Health Services Team

National Association of School Nurses

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that, where laws permit, unlicensed assistive personnel (UAP) can have valuable and necessary roles as assistants to school nurses. It is the professional responsibility of the registered professional school nurse (herein after referred to as school nurse) to identify UAP in the school setting and to train, evaluate for competency, monitor and supervise the selected individuals. The school nurse is accountable for ensuring continued competency of UAP beyond the initial documented training and for maintaining competency to provide health services to individual students according to individualized healthcare plans (IHPs) and/or district policies.

BACKGROUND

In school-age children, the incidence of chronic conditions such as asthma, diabetes, and life-threatening food allergies is increasing. Also on the rise is the number of complex medical conditions in school populations. All of these conditions require healthcare planning and management and may require that school nurses make care decisions including nursing delegation to UAP where appropriate (Hootman, 2013). As school nurses create IHPs for students, student safety is of paramount importance in implementation, including the decision to enlist assistance by UAP (American Nurses Association [ANA], 2012 ANA & National Council of State Boards of Nursing [NCSBN], 2006; Caldart-Olson & Thronson, 2013; Gordon & Barry, 2009). The school nurse must clearly state to school administration and UAP that ongoing supervision is a necessary component of nursing delegation.

Because a UAP works under the direction of the school nurse, the school nurse must conduct documented training, must supervise the UAP and must be in control of the decision to delegate a healthcare task (Bobo, 2014; Caldart-Olson & Thronson, 2013; Gibbons, Lehr & Selekman, 2013). The UAP must agree to function according to the written instructions of the school nurse. Informing the UAP of the laws that cover and protect them, including state and federal laws and statutes as well as district guidelines and policies, is critical to protect all parties from harm and liability (Shannon & Kubelka, 2013). The capacity of school nurses to effectively provide required supervision of multiple UAP must be considered before using UAP (Hootman, 2013).

In order to protect the UAP, the school and the health and safety of students, the school nurse must follow the scope and standards of school nursing which include carrying out the steps of nursing delegation, thereby setting the boundaries within which UAP can safely and legally function ANA (2013). To facilitate a better understanding of the school nurse role and the impact of UAP coverage, communication is needed between school nurses, school administrators, school personnel and families (Shannon & Kubelka, 2013; Bobo, 2014). It is important for administrators to understand that school nurses must address the following questions prior to delegation (ANA, 2012; Bobo, 2014; Resha, 2010; Raible, 2012; Hootman, 2013; Caldart-Olson & Thronson, 2013).

1. Is this the right task to be delegated?
2. Are the right circumstances in place to allow delegation?
3. Is this the right person for this task?
4. Is there appropriate communication and direction between the nurse and the UAP?
5. Is the school nurse in a position to monitor, evaluate and provide ongoing supervision of the UAP?

UAP in schools may not have health services as their primary employment role and may be called upon intermittently to assist the school nurse. UAP are school personnel who do not hold a healthcare license but are trained to provide care to students under the direction and supervision of a school nurse. Therefore,

paraprofessionals, classroom assistants, administrators, teachers, bus monitors or drivers, playground attendants or office staff may perform healthcare tasks as needed and serve as UAP. In some schools, UAP may be employed specifically to work in the health office and may be identified as health clerks, nursing assistants, health aides, patient care technicians, nurses' aides, certified nursing assistants, health techs, clinic assistants or self-care aides (Bobo, 2014; Raible, 2012; Foley, 2013; Davis-Aldritt, 2013).

Whenever a UAP is responsible for the care and safety of a student, documented training by the school nurse should occur prior to delegation of the nursing task (ANA, 2012; Davis-Aldritt, 2013; Hootman, 2013). The decision to include UAP as part of a student healthcare team is made by the school nurse and guided by district policies and the students' IHP. (Karsting, 2012). There may be times when it is inappropriate for school nurses to delegate to UAP; and standards of nursing delegation, state statutes and local policies will guide those decisions and support their rationale (Hootman, 2013). Schools must realize that, even with exemplary UAP training and supervision, adverse events can occur, (e.g., medication errors, failure to recognize early onset of health emergencies related to chronic illnesses such as asthma and diabetes) increasing the loss of school time by students (Vollinger, Bergren, & Belmonte-Mann, 2011). School nurses, therefore, make decisions regarding use of UAP based on the situation at hand, the environment, the experience and training of the UAP and the health status of the student.

RATIONALE

UAP, although not health professionals, can play important roles within school health teams when appropriate nursing delegation is in place (Hootman, 2013). Key factors guiding delegation to UAP in addition to state statutes and rules include safety issues, medical needs of the student, and UAP competence -- including education, attentiveness, availability or proximity to the students they care for (Vollinger et al., 2011; Bobo, 2014; ANA & NCSBN, 2006; Resha, 2010; Gordon & Barry, 2009). Other key factors include the school nurse's ability to train, monitor, supervise and evaluate the UAP (Hootman, 2013).

UAP may assist school nurses thereby allowing school nurses time to fully implement professional school nursing roles including care coordination for students, and development of IHPs, Emergency Care Plans (ECP), 504 plans and Individualized Educational Plans (IEPs). UAP assistance also allows school nursing time to contribute to the education of students with special healthcare needs through assessment, planning, providing proper nursing care, and evaluating outcomes. School nurse professional practice requires critical thinking and judgment integral to the nursing process, as well as health promotion, disease prevention and addressing special health issues (Hootman, 2013; Foley, 2013; Davis-Aldritt, 2013; Resha, 2010; Quelly, 2014).

When the school nurse determines the appropriateness of using a UAP and conducts the proper documented training and supervision, the UAP can contribute to the healthcare needs of students in schools (Shannon & Kubelka, 2013; Resha, 2010). Tasks that may be performed by and delegated to UAP are dependent on state nurse practice laws. If allowed by law, tasks UAP can perform with proper training and oversight by the school nurse include first aid, screenings, maintaining student health records, non-complex daily procedures and other health office tasks. In addition to following verbal and written directions, UAP may also be trained to do selected emergency procedures, perform selected student-specific nursing tasks and administer medications allowable in their states (Raible, 2012; Hootman, 2013; Foley, 2013; Davis-Aldritt, 2013; Bobo, 2014).

CONCLUSION

Where laws permit, the use of unlicensed assistive personnel who are trained, monitored, supervised and assessed by the school nurse can be a positive asset to the healthcare team**.** UAP perform valuable supportive roles in meeting healthcare needs of students and in assuring that available resources are managed both safely and effectively. The use of UAP in schools for specific tasks is a decision the school nurse makes on a case-by-case basis and is determined through a nursing decision-making process that includes the five components of nursing delegation (ANA, 2012;ANA/NCSBN, 2006; Bobo, 2014).

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Related NASN Position Statements:
Nursing Delegation to Unlicensed Assistive Personnel in the School Setting (2014)
http://www.nasn.org/PolicyAdvocacy/PositionPapersandReports/NASNPositionStatementsFullView/tabid/462/ArticleId/21/Delegation-Nursing-Delegation-to-Unlicensed-Assistive-Personnel-in-the-School-Setting-Revised-June-2

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Whole School, Whole Community, Whole Child: Implications for 21st Century School Nurses

National Association of School Nurses

Position Statement

SUMMARY

It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (hereinafter referred to as school nurse) be knowledgeable about and participate in the implementation of Whole School, Whole Community, Whole Child (WSCC) approach in the educational setting (ASCD & Centers for Disease Control and Prevention [CDC], 2014). The WSCC approach combines and builds upon the Coordinated School Health (CSH) model and the ASCD's (formerly known as the Association for Supervision and Curriculum Development) Whole Child approach to learning and promotes greater alignment between health and educational outcomes. WSCC is student centered, with the overarching goal of keeping students healthy, safe, engaged, supported, and challenged. The WSCC model emphasizes the need to coordinate policy, process, and practice to achieve improved student health and education outcomes. This collaboration in support of students encompasses health services, health education, employee wellness, counseling, psychological and social services, nutrition environment and services, physical education and physical activity, physical environment, social emotional climate, family engagement, and community involvement. WSCC recognizes the critical role of ongoing collaboration between school and community in fostering student success (Lewallen, Hunt, Potts-Datema, Zaza, & Giles, 2015). The school nurse occupies a pivotal position as a leader who uses professional education and skills to assist schools and communities in the implementation and evaluation of the WSCC model (Galemore, Bowlen, Combe, Ondeck, & Porter, 2016).

BACKGROUND

The concept of a comprehensive school health program was introduced in the late 1980s in response to the status of children's health and education. In 2007, the CDC incorporated this concept into the CSH model. CSH is an organized set of policies, procedures and activities designed to protect and promote the health and well-being of students and school staff (Allensworth & Kolbe, 1987). In 2013, ASCD and the CDC convened experts from the field of education and health to discuss lessons learned from implementation of the CSH and Whole Child approaches, resulting in the development of the WSCC model (ASCD & CDC, 2014). The new WSCC model serves as a blueprint for integrating programs guiding policy development and practices in the school setting (Galemore et al., 2016). School nurses utilizing the WSCC approach have reported successful outcomes in the areas of student and employee wellness, health advocacy, professional learning communities, and community support (Galemore et al., 2016).

RATIONALE

The WSCC approach offers important opportunities to improve the health and education outcomes of students by highlighting the five whole child tenets and by noting the importance of coordination between the ten school

community based components. School nurses work collaboratively within the context of the WSCC model when they implement the principles of the NASN Framework for 21st Century School Nursing Practice™ which include Standards of Practice, Care Coordination, Leadership, Quality Improvement, and Community/Public Health(Maughan, Duff, & Wright, 2016; NASN 2016). School nurses, collaborating with stakeholders across the WSCC model, utilize the full range of Framework principles to influence student health and academic achievement.

Health Services: The school nurse provides emergency care assessments and interventions, management of acute and chronic health conditions, referral and support to access primary care, preventive services, communicable disease control measures, counseling for health promotion, and identification and management of health-related barriers to student learning. The NASN Framework provides guidance for student-centered nursing care that occurs within the context of the students' family and school community and provides guidance for the practicing school nurse to reach the goal of supporting student health and academic success by contributing to a healthy and safe school environment (NASN, 2016).

Health Education: The school nurse provides education to small groups and individuals on topics such as asthma and diabetes to promote healthy life choices, increase compliance with prescribed regimens and improve student attendance and academic outcomes. The school nurse reviews and recommends evidence-based health education curricula addressing physical, mental, emotional, and social dimensions of health to help students develop health knowledge, positive attitudes, and skills to make health-promoting decisions, achieve health literacy, and adopt health-enhancing behaviors. The school nurse uses data from local, state, and national sources to determine the current risks and protective factors for students.

Employee Wellness: The school nurse works collaboratively with the school health services team to provide health information and health promotion activities, may monitor chronic conditions, provide health resources, and referrals.

Counseling, Psychological, and Social Services: The school nurse collaborates with school counseling, psychology and social work staff to identify student psychosocial problems and provide input and supportive interventions. Services focus on cognitive, emotional, behavioral, and social needs of students and families aimed at improving students' mental, emotional, and social health through assessment, intervention and referral.

Nutrition Environment and Services: The school nurse promotes the integration of nutritious, affordable, and appealing meals, nutrition education, and an environment that promotes healthy eating behaviors for all students. The school nurse provides education about nutritious foods, monitors menus, and encourages the inclusion of healthy foods on menus, in vending machines, in fundraising and classroom parties/snacks. The school nurse provides information to food service regarding students' special nutritional needs, including food allergies and potential anaphylaxis to promote student safety.

Physical Education and Physical Activity: The school nurse collaborates with physical educators to meet physical education goals, provides information to students about physical activity, helps design appropriate programs for students with special health concerns, and advocates for planned, sequential K through 12 curricula that promote lifelong physical activity.

Physical Environment: The school nurse promotes a safe physical and psychological school environment that is supportive of learning by monitoring, reporting and intervening to correct hazards; collaborating with the development of crisis intervention/disaster plans; and advocating for adaptations for students with special needs.

Social and Emotional Climate: The school nurse promotes a positive social and emotional school climate that is safe, healthy, and supportive of learning by advocating for evidence-based K through 12 curricula that provide ongoing education to support psychosocial understanding and support for all students.

Family Engagement: The school nurse promotes family and school partnerships working together to support and improve learning by sharing opportunities to get involved at school and within the broader community.

Community Involvement: The school nurse takes a leadership role in collaborating with community partners to identify and provide programs to meet the physical and mental health needs of children and families. The school nurse can help strengthen collaboration among agencies and stakeholders to review and analyze community data to help make informed decisions.

CONCLUSION

The implementation of the WSCC model requires collaboration between health and education leaders who understand the importance of the link between student health and academic success. The school nurse is an important member of this interprofessional team. School nurses utilize 21st Century School Nursing Framework™ principles to operationalize the WSCC model in the day-to-day policies and practices focused on the student. "By focusing on children and youth as students, addressing critical education and health outcomes, organizing collaborative actions and initiatives that support students, and strongly engaging community resources, the WSCC approach offers important opportunities for school improvements that will advance educational attainment and healthy development for students." (Lewallen et al., 2015, p.737). School nurses have access to the entire school community and are in a unique position to bring stakeholders together to focus on the child through WSCC (Galemore et al., 2016) With careful planning, implementation, and evaluation efforts, use of the WSCC model and the Framework for 21st Century School Nursing Practice™ has the potential to improve school and community life in the present and in the future (Rooney, Videto, & Birch, 2015).

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Global School Nursing

NASN
National Association of School Nurses

Resolution

Whereas, the National Association of School Nurses (NASN) recognizes the growing impact of globalization on the health and safety of all children; and

Whereas, NASN recognizes that with the increase in mobility across the world children cross borders; and diseases, health concerns, and environmental issues know no boundaries; and

Whereas, NASN recognizes that school nursing is a specialized practice of professional nursing that occurs throughout the world; and

Whereas, NASN recognizes that school nurses throughout the world share an interest in the health and well-being of children and adolescents; and

Whereas, NASN recognizes that exchanging professional knowledge and expertise with school nurse colleagues will promote professional development; therefore, be it

Resolved, that in an effort to meet the needs of students throughout the world, NASN will continue to support the profession of school nursing internationally to serve as the expert resource in advancing the well-being, academic success, and lifelong achievement of students within their international community setting.

Adopted: 2010
Revised: June 2014

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Emergency Use of Stock Albuterol in the School Setting

Position Brief

SUMMARY

It is the position of the National Association of School Nurses (NASN) that schools should stock albuterol for emergency use by the registered professional school nurse (hereinafter referred to as school nurse) for students with symptoms of respiratory distress as specified in the standing order or protocol. To optimize student health, safety and learning, a school nurse should be present in every school, all day, every day to assure appropriate and timely assessment and treatment. Although students perform better academically and are more likely to succeed in school when they are consistent in attendance and physically present in class, unfortunately, 49% of students with asthma report missing one or more asthma-related days per school year (Centers for Disease Control and Prevention [CDC], 2015). Additionally, research shows that over 60% of asthma deaths in children are the result of a sudden asthma attack that can be fatal within an hour (American Lung Association, 2014). It is recommended that students with asthma should begin treatment at the first sign of respiratory distress to decrease the risk of possible hospitalization and to preserve life (Allergy and Asthma Network, 2016).

To enhance student safety, NASN recommends that schools should:

- Assure that school nurses are available in every school, all day, every day so that students who have symptoms of serious health problems have access to nursing assessment and treatment as soon as possible.
- Develop policies for the emergency management of students with symptoms of respiratory distress which may require treatment with albuterol.
- Ensure that albuterol policies are developed within the context of applicable state and national legislation, regulations, guidelines, and provider orders to protect the health and safety of students.
- Provide albuterol for use by the school nurse for students with symptoms of respiratory distress.

NASN recommends that school nurses should:

- Identify and assess students at risk for underlying chronic health conditions such as asthma or potential allergic reactions which may lead to respiratory distress requiring treatment with albuterol.
- Collaborate with parents, students and healthcare providers to develop Individualized Healthcare Plans, Asthma Action Plans, or Emergency Care Plans to address the needs of students with asthma, potential anaphylaxis or other chronic health conditions.
- Administer albuterol according to standing orders and protocols when students experience respiratory distress.
- Educate unlicensed assistive personnel, teachers, and other staff about signs of respiratory problems for which a school nurse should be immediately notified.
- Re-assess, document and notify parents or guardian about response to treatment.

RATIONALE

Approximately 10% of children in the United States have asthma. About 60% of these students experience respiratory distress each year (Gerald et al., 2016). These instances of respiratory distress resulted in 13.8 million missed school days in 2013 alone (CDC, 2015). According to the research conducted by Ginsburg, Jordan & Chang (2014), students who miss more school than their peers have consistently lower scores on standardized testing. Additional research has found an association between asthma with increased absences and decreased academic achievement (Michael, Merlo, Basch, Wentzel, & Wechsler, 2015). With the administration of stock albuterol at

school, more students could safely remain in school and decrease missed class time. In addition, the availability of stock albuterol in the school setting addresses the Healthy People 2020 objectives related to reduction of the adverse effects of asthma for school-age children (U. S. Department of Health and Human Services, Office of Disease Promotion and Health Promotion, 2017).

Albuterol can be a life-saving medication in treating students who experience respiratory distress. NASN supports school policies which promote access to albuterol. NASN believes it is critical for states and school districts to develop policies which allow and promote stock albuterol in the school setting and which permit access and administration of albuterol by school nurses in order to protect the safety of students and keep them in school, healthy, safe and ready to learn.

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Human Trafficking-
Implications for 21st Century School Nurses

National Association of School Nurses

Position Brief

SUMMARY

It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (hereinafter referred to as school nurse) be knowledgeable about the scope of human trafficking. In particular, school nurses should be able to recognize signs that a child may have been exposed to a trafficker, may be in the process of being groomed into trafficking, or may already be a victim of trafficking and be prepared to respond within a trauma-informed framework. Prevention, early recognition, and support of children/youth who are victims or suspected victims of human trafficking are critical to their present and future physical/emotional well-being.

RATIONALE

The federal law defines human sex trafficking as the

> "recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act, in which a commercial sex act is induced by force, fraud, or coercion, or in which the person forced to perform such an act is under the age of 18 years" (Trafficking Awareness Training for Health Care Act 2014).

Human trafficking is a major global health and human rights problem, affecting predominantly women and girls, but also men and boys. In the United States, human trafficking has been identified in cities, suburbs, and rural areas in all 50 states (Grace et al., 2014). Studies generally indicate that the age range of entrance into sex trafficking and commercial exploitation is approximately 12 to 16 years (Greenbaum, Crawford-Jakubiak, & American Association of Pediatrics [AAP] Committee on Child Abuse and Neglect, 2015). Labor trafficking, another form of human trafficking, can take many forms which include debt bondage where a child incurs a debt he or she is never able to pay off or where a child is forced to work in someone's home for long hours with little or no pay (National Center on Safe Supportive Learning Environments, 2017).

Schools are just one of the many venues traffickers use to recruit children, controlling them through physical, psychological, or emotional means. Human trafficking, whether sex trafficking or labor trafficking, is a form of modern-day slavery. Human trafficking robs human beings of their freedom and their dignity (U.S. Department of Homeland Security, 2017). It destroys families, knows no boundaries, and is a federal crime (Trafficking Awareness Training for Health Care Act 2014). School nurses and other school staff are well positioned to help with identification and intervention for this mostly hidden crime.

Schools strive to create a safety net for students by building healthy environments, ensuring student safety, promoting health, and assuring readiness to learn (Lewallen, Hunt, Potts-Datema, Zaza, & Giles, 2015). School nurses are an integral part of the school team, partnering with law enforcement and community health agencies, to recognize and respond to suspected human trafficking. School nurses use their assessment skills to provide pro-active surveillance that is critical to help identify risks associated with human trafficking.

In addition, school nurses serve as health experts on the school teams and can increase staff awareness, educate staff on indicators and the nature of trafficking crimes, increase parent and student awareness of the risks and realities of trafficking, and assist in the development of district or school-wide protocols for identifying a suspected victim or responding to a disclosure from a suspected victim.

School nurses have the opportunity to interact with children daily. Understanding how human trafficking intersects on school grounds is imperative to prevent another child from becoming a victim.

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Wearable Medical Technology in Schools – The Role of the School Nurse

National Association of School Nurses

Position Brief

SUMMARY

It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (hereinafter referred to as school nurse) be involved in planning the care for students with wearable medical technology in the school setting. In addition, the school nurse should lead the development of written policies and procedures that focus on safe and effective use of wearable medical technology in schools, including raising concerns over inadequate Wi-Fi capabilities and complying with Health Insurance Portability and Accountability Act of 1996 (HIPPA) and Family Education Rights and Privacy Act (FERPA).

RATIONALE

Many students who attend school have special healthcare needs. According to the Child and Adolescent Health Measurement Initiative (2016), up to 19.4% of children have chronic health conditions. Students with healthcare needs may use multiple types of medical technologies. As more students with chronic conditions enter school systems each year, school personnel must be aware of factors that help promote and support academic success for those students. These factors may include wearable medical technology to manage their healthcare needs.

Wearable medical technology refers to devices that attach to the body to treat or monitor physiological conditions with remote or wireless technology (Insights Association, 2015). Wearable devices are worn externally, while implantable devices are surgically placed. Types of technology that students use, ways they can be used, and instructions for use change rapidly due to advances in technology.

Some examples of wearable and implantable medical technology include-- but are not limited to --

- Insulin pumps and continuous glucose monitoring systems,
- Seizure sensors and vagus nerve stimulators,
- Electrocardiogram monitoring systems,
- Oxygen level and heart rate monitoring systems,
- Pacemakers and implantable cardioverter defibrillators,
- Intrathecal baclofen pumps,
- Ventilators, and
- Cochlear implants and hearing aids.

Both wearable and implantable medical devices require that the school nurse be knowledgeable in the care and use of the device, recognize device malfunction, and provide direct care as necessary. The school nurse may need to monitor students' wearable medical technology remotely, respond to transmitted data, and plan or direct student care based upon this data.

The role of the school nurse in wearable medical technology should include (Obst & Roesler, 2017)

- Leading the development of written policies and procedures that define the ability and limits of schools and school staff to monitor and respond to wearable technology data.
- Writing the Individualized Healthcare Plan (IEP) and the Emergency Action Plan (sometimes referred to as Emergency Care Plan).
- Training staff about the specific use of the medical technology, including safety precautions, signs of malfunction, and actions to take in case of malfunction.

- Developing a plan for potential device or WiFi failure.
- Participating in multidisciplinary teams to plan for students who have IEPs or Section 504 Plans to include the use of medical technology in the plans.
- Keeping updated about changes in the medical technology.
- Complying with the HIPPA and FERPA.

Many wearable medical technologies require wireless internet connection to transmit data. According to the Education Superhighway (2017), 83% of school districts in America currently have sufficient Wi-Fi in every classroom. While this percentage has increased in recent years, 17% of schools still do not have adequate Wi-Fi service. Another role of the school nurse may be to advocate for access to the internet for students whose devices require the internet to function effectively.

Two common risks with wireless internet connections are cybersecurity and disruption of the wireless radio frequency (McNerny, Rivera, & Blackwell, 2016). The families of students with technologies that require a wireless internet connection should understand that there may be privacy issues as well as unavoidable Wi-Fi failure when network congestion or signal interruption occurs in educational settings. A plan for managing the needs of the student should be in place for those situations.

The school nurse must be knowledgeable about state and federal laws and regulations governing the downloading of applications or communications which contain medical information protected under HIPPA and FERPA and prevent the sharing of that information on any non-encrypted device. School nurses should never use personal devices to monitor student medical technology. For example, a school nurse should not communicate blood glucose readings via text with a parent or school staff on their personal cell phone (National Forum on Education Statistics, 2016). Depending on the applicable laws in certain states, an encrypted phone or tablet provided by the school district for the sharing of that information may be permissible (Czuprynski & Smith, 2017).

The school nurse should be involved in planning the care for students with wearable medical technology in the school setting. As health leaders, the school nurse has clinical knowledge about the complex issues surrounding student health (APA, 2016; Maughan, 2016), including wearable medical technology. The involvement of the school nurse in creating policies and procedures regarding wearable medical technologies and the need for school nurse management in the school setting are critical so that all students can stay healthy, safe, and ready to learn.

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Early School Start Times

Consensus Statement

SUMMARY STATEMENT

Optimal sleep during growth and development is critical for the health, safety and academic success of our nation's youth. Over half of high school youth and near one third in middle school report 7 hours or less sleep on school nights (National Sleep Foundation, 2014). These reports are in sharp contrast to recommended adolescent (age 12-17) sleep requirements of approximately 9 to 10 hours (Carskadon, 2011). The registered professional school nurse (hereinafter referred to as school nurse) is in a pivotal position to collaborate with students, families, teachers, pediatric nurses, school administration officials, and other health care professionals to address factors contributing to insufficient sleep. A significant modifiable factor contributing to insufficient sleep during adolescence is early school start times during middle school and high school. The National Association of School Nurses (NASN) and the Society of Pediatric Nurses (SPN) support delaying school start times for middle school and high school students as proposed in the policy statement on School Start Times for Adolescents by the American Academy of Pediatrics (Adolescent Sleep Working Group, 2014). This recommendation is based upon the following key factors in adolescent sleep:

- Adolescents require approximately 9-10 hours of sleep nightly (Carskadon, 2011).
- Developmental and physiological changes in adolescent sleep contribute to shifts in nighttime sleep times and later bedtimes, but not necessarily a decrease in sleep requirement (Carskadon, 2011).
- Home electronic media use by adolescents before bedtime affects sleep quality (National Sleep Foundation, 2014).
- Parents/guardians are unaware of adolescent sleep needs and/or the sleep duration of their adolescents (American Academy of Pediatrics [AAP] Adolescent Sleep Working Group, 2014).
- Parent/guardian enforced bedtimes throughout adolescence is associated with longer sleep duration (Short et al., 2011).
- Delaying school start times for adolescents to no earlier than 8:25 am is associated with longer sleep duration on school nights (Boergers, Gable, & Owens, 2014).
- Delay of school start times is associated with improved mood and reduced daytime sleepiness (Boergers, Gable, & Owens, 2014).
- Insufficient sleep and irregular sleep/wake patterns are associated with an increased risk for daytime sleepiness, academic and emotional difficulties, safety hazards, and cardio-metabolic disease (AAP, Adolescent Sleep Working Group, 2014).

RATIONALE

The need for sleep is a biological necessity for all mammals, and studies have shown that the absence of sleep results in impairment of functional ability (Iber, 2013). During the four stages of sleep – REM, N1, N2, and N3 - task learning is refined through the enhancement and pruning of synaptic connections. Each sleep stage has a responsibility for temporarily storing, evaluating, discarding "nonsense" information and preserving new and valued knowledge (Iber, 2013).

During adolescence, the secretion of the melatonin hormone begins later in the day resulting in a corresponding delay in the desire to sleep (Carskadon, 2013). The postponement of this biological event is further delayed if the adolescent is not in a dimly lit environment – often the case if there is homework to finish. However, although staying awake longer is easier for the adolescent, the desire to sleep longer is unavoidable. This becomes problematic when the total amount of sleep is reduced, as is often the case during the school year. In addition, studies have shown that children and adolescents from low income or racial and ethnic minorities are at a greater risk for sleep disorders due to overcrowding, excessive noise, and concerns for their own or their family safety (Owens, 2014).

In Healthy People 2020 (2014), a new core indicator has been developed entitled *Sleep Health* which calls for a reduction in

- adolescent sleep loss;
- unhealthy sleep behaviors (irregular sleep/wake patterns, overuse of electronic media in the bedroom, and the consumption of excessive caffeine); and
- the potential consequences of inadequate sleep (depression and suicidal ideation, obesity, auto accidents attributed to drowsiness, and poor academic performance) (Owens, 2014).

NASN and SPN highlight a contributing – and modifiable – factor to promoting an increase in sleep obtained by teenagers is to delay the start of school day for middle and high school students. NASN and SPN acknowledge the challenges of alterations in after-school sports and activities, along with adjustments to parental/guardian schedules and other modifiable factors such as the need for families to

- self-regulate sleep habits;
- set bedtime limits;
- set limits on social networking; and
- discuss the use of electronic media in the bedroom.

SPN and NASN stand ready to collaborate with administrators, teachers, parents, school boards and communities to address this public health issue by

- Working with parents to understand developmental changes in sleep/wake patterns during adolescence.
- Educating parents on the importance of setting bedtime limits.
- Identifying adolescents at risk.
- Working with teachers and parents to monitor academic course loads and extracurricular activities.
- Identifying strategies to promote optimal sleep.
- Limiting the use of caffeine and other stimulants.
- Limiting the use of electronic media and social networking.

Adolescence is a time when sleep patterns change and biological clocks alter, often leading to poor quality and insufficient sleep. Their ability to concentrate, problem-solve and assimilate new information is impaired. SPN and NASN encourage all parties involved to consider implementing later school start times for teens.

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School Nursing Services Data:
Standardized Documentation, Collection, and Utilization
Joint Resolution

National Association of School Nurses (NASN) & National Association of State School Nurse Consultants (NASSNC)

Whereas, school nurses positively influence the health outcomes of students (NASN, 2013) and the health of students affects their learning skills, motivation, and school engagement (Forrest, Bevans, Riley, Crespo, & Louis, 2012);

Whereas, school nurses document significant amounts of individual and population level health data – particularly for students with specific health care needs, and those outside of traditional health care settings (Johnson, Bergren, & Westbrook, 2012); and

Whereas, school health services data should be an integral part of education and health data, but is currently missing in the analysis of health and education outcomes because this information is not uniformly collected, collated, or reviewed (Healthy Schools Campaign & TFAH 2012), and

Whereas, school nurses contribute to a system of care for students, but without integrated health and education networks, this care is at risk of being fragmented, resulting in higher costs, limited quality, and reduced satisfaction (Johnson & Bergren 2011); and

Whereas, the aggregation of population level data in school health records has the potential to demonstrate the prevalence of health conditions; provide research on longitudinal outcomes; and identify community strengths and opportunities for improvement that will benefit all students and the school community (Johnson, et al., 2012); and

Whereas, the development of standardized variables as part of a common school health dataset with a process for data collection similar to processes used in health and education data management, is critical to providing consistent , quality care for all students (Johnson, et. al., 2012); and

Now, Therefore, Be It Resolved that NASN and NASSNC will lead in the development of a standardized dataset for all nurses working in school settings to use as the foundation for compiling and collecting data on the student population. This comprehensive dataset will focus on the broad aspects of the health needs of students and the outcomes of school nursing interventions, including analysis of nursing-sensitive student outcomes. The goals of this process include integrating school nursing services data into other established datasets (health and education) to provide a comprehensive analysis; addressing the current and emerging health needs of students; providing concrete insight about the correlation between student outcomes and evidence-based models of school nursing practice.

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