Guide for Assessing Student Health Conditions

Level I
Nursing Process for General Student Population

Description: Intermittent acute illness/injury events; normal growth and development

Asthma Example: Student identified on health factors list (eSIS) as having asthma. No known events at school, no contact from parents/staff/student. Student may have rescue inhaler at school. Asthma is well managed, no exacerbations or hospitalizations in past year.

Seizure Example: Student with history of febrile seizure(s). No further seizure activity, no anti-epileptic medication

Severe Allergic Reaction (SAR) Example: Student has penicillin allergy

Nursing Assessment: No identified/ongoing nursing intervention at school

Nursing Plan:

1. Staff to respond to acute event using first aid procedures in *Responding to Student Injury & Illness Guidebook*
2. Verify at least annually with principal importance of having adequate number of first aid trained staff
3. Provide *Responding to Student Health Conditions* document to all staff: individual teacher notification not required

Nursing Documentation:

1. Document encounters on forms validating all nursing assessment; possible nursing diagnosis label **Self-Health Management, Readiness for Enhanced (525.4)**
2. Submit time on *Service Report*

Level II
Nursing Process for Chronic/Risk for Emergent Health Conditions

Description: Physical/social-emotional condition(s) that is currently uncomplicated and predictable

Asthma Example: Frequent use of rescue inhaler; at least weekly. Frequent health room visits require assessment and intervention by nurse.

Seizure Example: Student well controlled with medication with rare breakthrough seizures

SAR Example: Parents have reported a severe allergy; student has antihistamine at school for reaction

Behavioral Example: On medication for depression, mood and attendance improving

Miscellaneous Example: Student with muscular dystrophy but no ongoing nursing needs at school. RN chooses to monitor student annually

Nursing Assessment: Staff can safely meet student needs using first aid procedures supported by *Responding to Student Injury & Illness Guidebook*

Nursing Plan:

1. Monitor student's health status at least annually
2. Verify at least annually with principal responsibility for having adequate number of first aid trained staff
3. Provide *Responding to Student Health Conditions* document to all staff: individual teacher notification not required unless determined by nursing assessment

Nursing Documentation:

1. Document on forms validating all nursing assessment
2. Nursing diagnosis, interventions and ongoing plan documented on SHMP template
3. Tabulate and enter time in the chronic illness database (accountability database). Record on *Service Report* only when an encounter unrelated to the chronic/emergent condition presents

Level III
Nursing Process for Medically Complex

Description: Physical and/or emotional condition that requires daily or emergency intervention at school and close monitoring by an RN

Asthma Example: Frequent use of rescue inhaler: at least daily. Frequent health room visits and/or PMD/hospital visits require assessment and intervention by nurse. Student may/may not have nebulizer.

Seizure Example: Student requires immediate intervention with Vagal Nerve Stimulator (VNS) and/or rectal Diastat when seizure activity occurs

SAR Example: Student with life-threatening allergy. EpiPen available at school

Diabetes Example: Diabetic student with blood glucose monitoring supplies and Glucagon at school. Student may/may not be independent self-manager

Behavioral Example: Student discharged after emergent hospitalization for eating disorder, long history of cutting and emergent hospitalizations

Miscellaneous Example: Student requires clean intermittent catheterization daily at school

Nursing Assessment: Needs more than a first aid response

Nursing Plan:

1. Monitor student's health status as defined by the Oregon Nurse Practice Act
2. Work with principal to identify designated caregivers
3. Teach delegated/TAE procedures and monitor designated caregivers
4. Provide individualized teacher notification on a "need to know basis."

Guide for Assessing Student Health Conditions

Level III - Nursing Process for Medically Complex (continued)

5. Participate in 504/IEP plans to maximize student's safety and learning. Teach school staff how to work with student's health condition to maximize potential for learning

Nursing Documentation:

1. Narrative on forms validating all nursing assessment
2. Nursing diagnosis, interventions and ongoing plan documented on SHMP template
3. Procedure templates are utilized to develop individualized procedure(s)
4. Tabulate and enter time in the chronic illness database (accountability database). Record on *Service Report* only when an encounter unrelated to the chronic/emergent condition presents

Level IV

Nursing Process for Medically Fragile

Description: Daily possibility of life-threatening event requiring the skill and judgment of a professional nurse

Asthma Example: Student uses rescue inhaler 3-4 times in 24 hour. Peak flows are 65% or less of student's expected normal. Hospitalizations and/or emergent ED visit(s) have occurred in past year

Seizure Example: Severe seizure disorder requiring immediate intervention with VNS and/or rectal Diastat; student has frequent cluster seizures making it difficult for unlicensed staff to identify beginning and/or end of seizure activity. Student often has prolonged post-ictal phase

SAR Example: Severe and/or multiple life-threatening allergies necessitating wide-ranging accommodations in the school setting

Diabetes Example: Student with highly variable blood glucose levels, and/or student requiring insulin administration at school, and/or non-compliant student, and/or student with cognitive impairment, and/or newly diagnosed student

Nursing Assessment: Licensed nurse must be readily available for assessment and/or intervention

Nursing Plan:

1. Monitor student's health status as conditions warrants and in accordance with the Oregon Nurse Practice Act
2. Work with principal to identify designated caregivers
3. Teach delegated/TAE procedures and monitor designated caregivers
4. Provide individualized teacher notification on a "need to know basis."
5. Participate in 504/IEP plans to maximize student's safety and learning. Teach school staff how to work with student's disability to maximize potential for learning

Nursing Documentation:

1. Narrative on forms validating all nursing assessment
2. Nursing diagnosis, interventions and ongoing plan documented on SHMP template
3. Individualized procedure templates are utilized
4. Tabulate and enter time in the chronic illness database (accountability database). Record on *Service Report* only when an encounter unrelated to the chronic/emergent condition presents

Level V

Nursing Process for Nursing Dependent

Description: Student requires ongoing assessment and intervention by licensed nurse; nursing tasks cannot be delegated

Example: Student with tracheostomy that requires nursing assessment & care to maintain airway

Example: Student with multiple health conditions e.g. compromised airway, severe seizure disorder, GT feedings, etc. that requires skilled nursing assessment and intervention

Nursing Assessment: Student requires direct and continuous care by a licensed nurse (1:1)

Nursing Plan:

1. Continuously monitor student's health status
2. Identify with principal designated caregivers for event nurse incapacitated or needs assistance in emergency situation
3. Teach TAE procedures and monitor designated caregivers
4. Participate in 504/IEP plans to maximize student's safety and learning. Teach school staff how to work with student's disability to maximize potential for learning

Nursing Documentation:

1. Narrative on forms validating all nursing assessment
2. Nursing diagnosis, interventions and ongoing plan documented on SHMP template
3. Individualized procedure templates are utilized
4. Tabulate and enter time in the chronic illness database (accountability database)

Prioritization:

The RN completes assessment *prn* for Level 1 and documents outcomes, working with school staff to remove from the data base students whose parents do not have a current or level ll or higher risk for a medical condition.

Individualization:

The RN uses professional judgment to identify rationale for deviancies from the categorizations and procedures listed here.