Other School Health Services

In addition to health assessments, population screening, services associated with the students with special needs, and medication administration, school divisions may offer a variety of health services. A few services that are typically offered by school divisions in Virginia have been selected and highlighted in this section.

Subsections

The following subsections contain information on other health services that may be offered by school divisions.

- Managing Illnesses/Injuries, and Crises
- Referring to Child Protective Services
- Home Visits
- Nursing Liaison Services to Homebound Students
- Students Requiring Specialized Health Care Procedures
- Infectious Disease Control

Managing Illnesses/Injuries and Crises

Each school is responsible for the safety and well-being of students, staff, and visitors during school hours on school property, and during school-sponsored activities. Schools and their staff must be ready to manage first aid emergencies, disasters, and crises that occur in the school or impact the school from outside. It is important that schools have written procedures and policies for managing first aid emergencies, disasters, and crises. In addition, the school and staff need to have the knowledge of the policies and procedures so that they can handle these situations competently.

Authorization

***Code of Virginia,* Section 54.1-2969, Authority to Consent to Surgical and Medical Treatment of Certain Minors.**

Excerpt: See Appendix A for *Code of Virginia,* § 54.1-2969.

***Code of Virginia,* Section 8.01-225, Persons Rendering Emergency Care, Obstetrical Services, Exempt From Liability.**

Excerpt: See Appendix A for *Code of Virginia,* § 8.01-225.

***Code of Virginia,* Section 22.1-274 E, School Health Services (Certification of School Employees in CPR).**

Excerpt: See Appendix A for *Code of Virginia,* § 22.1-274.

***Code of Virginia,* Section 22.1-278.1, School Safety Audits Required.**

Excerpt: See Appendix A for *Code of Virginia,* § 22.1-278.1.

Managing Illnesses and Injuries

Note: The following information, on managing illnesses and injuries, is adapted from the following publications:

- *School Health: A Guide for Health Professionals* **(**1997 Revision)
  Committee on School Health
  American Academy of Pediatrics
  141 Northwest point Boulevard
  P.O. Box 927
  Elk Grove Village, IL 60009-9027

- *School Nursing and Health Services: A Resource Guide* (June 1998)
  Cindy Ericksen, RN-C, MSN, FNP
  Consultant, School Nursing/Health Services
  Wisconsin Department of Public Instruction
  Madison, WI 53293-8782
  Telephone: (800) 243-8782

- *First Aid Guide for School Emergencies* (1998)
  Tarr, J. (developer) with Ford, N., Henry, J., Cox, A. (editors)
  Virginia Department of Health
  P.O. Box 2448
  Richmond, VA 23218-2448
  Telephone: (804) 786-7367

Introduction. Many minor injuries and illnesses occur in students and staff during the course of the school day. Students, employees, and visitors may have medical emergencies at school or off the school premises (e.g., on the school bus or field trips). Students with chronic health problems or disabilities often are at greater risk for injury, illness, or extreme medical emergencies. School personnel and selected students in elementary and secondary schools should be able to provide first aid in emergencies and know how to perform cardiopulmonary resuscitation (CPR). Timely and appropriate administration of first aid and CPR can save lives and minimize disability.

Standing Orders and Nursing Protocols. Standing orders and nursing protocols are helpful in meeting the health needs of school children. Both standing orders and nursing protocols help in the management of medical problems and are useful in the school setting. Standing orders and nursing protocols help to insure convenience, consistency, completeness, and continued learning. Additionally, health professionals can use the standing order to defend their actions. Standing orders and nursing protocols serve as the primary guidelines for health care providers at all levels of expertise (e.g., registered nurses, licensed practical nurses, and unlicensed healthcare providers).

Standing orders (i.e., *general orders*) refer to those orders, rules, or regulations that have been determined by a physician and are used by other health professionals in carrying out medical procedures. They apply to any student for whom the order may be applicable and must be based on federal/state laws and regulations and local school policy. Standing orders are used to provide the school nurse or nurse practitioner with specific orders of treatment for specific medical problems, such as ipecac in certain poisonings; epinephrine in allergic reactions (anaphylaxis); or acetaminophen for fever, headaches, sprains, or menstrual cramps.

When legally sanctioned and indicated for the safety of the student body, a standing order may also be used to provide school personnel other than nurses with instructions for action and treatment on specific medical emergency. A standing order for personnel who are not health professionals must be more detailed and provide more direction. The

school division is responsible for seeing that school staff have sufficient training in emergency techniques to carry out the standing order.

The registered nurse and the school's physician or medical advisor should review standing orders on an annual basis and revise as necessary.

Samples of standing orders are presented in the book *School Health: A Guide for Health Professionals*, 1997 Revision, Committee on School Health, American Academy of Pediatrics.

Note: *Student-specific treatment orders* (i.e., *specific orders*) for known health problems are written by the individual student's health care provider—in consultation with the student's parents and school nurse—and are part of the student's individualized healthcare plan (IHP). Standing orders for the general student body do not supplant medical orders for individual students. Permission from the student's parent(s)/guardian(s) must be acquired for implementing either of the two types of orders: *standing orders* or *specific treatment orders*.

Nursing protocols are explicit or general guidelines that describe steps to be taken in the nursing management of specific health problems. In contrast to standing orders, protocols usually include strategies for obtaining relevant historical data and significant physical findings as well as plans of action.

Nursing protocols are used to enhance standardization of care and thoroughness of service throughout the school division. Standardized nursing routines direct the health care of children at school. Some are based on accepted nursing practice, as outlined by each state's Nursing Practice Act. (See Appendix A, *Code of Virginia*, § 53.1-3000, for the Virginia Nurse Practice Act.) Nursing protocols are most appropriately used in circumstances in which the outcome of care given can be predicted with considerable accuracy.

Nursing protocols provide guidelines for the observation of a medical condition, its management, referral and recommendations to the student, the student's parent(s)/guardian(s), and school staff. A typical protocol describes the physical characteristics of a medical problem, states what the nurse should do, and recommends follow-up.

Nursing protocols can be utilized in sports programs, in screening programs, and in the management of specific health problems or complaints. The degree to which protocols are used depends upon the school division's responsibility for providing health care services. Nursing protocols must reflect the level of training of the school's health care personnel.

Protocols for nurse practitioners may include guidelines for in-depth clinical assessment and management of a wide range of primary health care problems, but call for referral to a pediatrician or other specialist when indicated.

Protocols for the registered nurse (RN) involve guidelines for the clinical assessment and management of routine primary health problems. Referral is made to the school nurse practitioner, physician, or other health care provider when in-depth assessment and management are indicated.

Protocols developed for the licensed practical nurse (LPN) and unlicensed healthcare personnel (UAP) must be much more specific and emphasize information gathering and early referral to a registered nurse or other appropriate health professional.

Protocols can be written by the registered nurse (in consultation with the student's parents and health care provider) for use by the classroom teacher in the event that a set of symptoms, medical complications, or other problems occur. This type of protocol would provide the classroom teacher with specific guidelines for managing a child with a known health problem until professional help was available.

Samples nursing protocols can be obtained from School Health Alert, P.O. Box 150127, Nashville, TN 37215, Web site: http://www.schoolnurse.com/index.html, and are presented in the book *School Health: A Guide for Health Professionals*, 1997 Revision, Committee on School Health, American Academy of Pediatrics.

First Aid. First aid involves the administration of emergency assistance to individuals who have been injured or otherwise disabled, prior to the arrival of a physician or transportation to a hospital or a physician's office. First aid should never be the substitution for definitive medical care. [93]

- Please refer to the latest edition of the flipbook *First Aid Guide for School Emergencies*, published by the Virginia Department of Health, for guidance on administering immediate and temporary care to an ill or injured person. It contains practical, step-by-step instructions that describe what to do when caring for an injured or ill individual. The flipbook is designed for use by teachers, school nurses, clinic aides, and other staff members who are responsible for the health and safety of students and others in the school setting. (See Appendix B for a copy of the 1998 flipbook, which has been reformatted for this manual.)

- The flipbook *First Aid Guide for School Emergencies* should be posted in a place that is easily accessible to all staff members. It is recommend that <u>all</u> staff become familiar with the contents of the flipbook <u>prior</u> to handling an emergency.

Written Procedures. Each school division should have written procedures for managing emergencies involving students, school personnel, and visitors. The school division staff should be knowledgeable about the emergency management procedures. The school is responsible for the safety and well-being of students, staff, and visitors during school

[93] Thomas, Clayton L. (Ed). (1993). *Taber's ® Cyclopedic Medical Dictionary*, Philadelphia, Pa.: F.A. Davis Company.

hours on school property and during school-sponsored activities. Therefore, local school division policies should address:

- Preventive measures to limit injuries.
- Policies to define what action will be taken when a serious injury or medical emergency occurs.
- Facilities and supplies to accommodate basic first aid and care of ill or injured students, staff members, or visitors.

Please refer to Appendix A for *Code of Virginia*, § 54.1-2969, Authority to consent to surgical and medical treatment of certain minors, and for *Code of Virginia*, § 8.01-225, Persons rendering emergency care, obstetrical services, exempt from liability.

Procedures.

1. Prior to an emergency:

   - The most recent edition of the flipbook *First Aid Guide for School Emergencies* (Appendix B) should be readily available in the school health office (i.e., school clinic) of each school building. This guide contains a comprehensive listing of first aid measures needed to manage student, school personnel, and visitor emergencies.
   - An emergency information card system for students should be maintained in the school health office. A similar system for staff members should be maintained following local school division policies.
   - Each school should have contingency plans for emergencies that include staff certified in cardiopulmonary resuscitation. [94]

     Note: The *Code of Virginia*, §22.1-274, requires that

     > *Each school board shall ensure that, in school buildings with an instructional and administrative staff of ten or more, at least two instructional or administrative employees have current certification in cardiopulmonary resuscitation or have received training, within the last two years, in emergency first aid and cardiopulmonary resuscitation. In school buildings with an instructional and*

[94] Virginia Board of Education. (September, 1997). *Regulations Establishing Standards for Accrediting Public Schools in Virginia*. Richmond, Va.: Virginia Department of Education.

> *administrative staff of fewer than ten, school boards shall ensure that at least one instructional or administrative employee has current certification in cardiopulmonary resuscitation or has received training, within the last two years, in emergency first aid and cardiopulmonary resuscitation.*

2. When an emergency occurs

   - See *First Aid Guide For School Emergencies*, Virginia Department of Health, 1998, (Appendix B) for guidance on administering immediate and temporary care to an injured or ill individual.

   - Parents/guardians of students should be notified of all emergencies/injuries so that further observation/follow-up care can be provided at home.

   - Injuries should be carefully documented to preclude misinformation and to provide an accurate recording of events prior to the injury and the subsequent administration of first aid.

   - The teacher or other staff member who is responsible for the student at the time an injury occurs should complete and file an injury report according to local school division policies.

   - Staff members sustaining work-related injuries should follow the appropriate guidelines for Worker's Compensation Insurance.

3. Ongoing Evaluation

   - The *Code of Virginia*, § 22.1-278.1, requires an assessment of the safety conditions in each public school to:

     > (i) identify and, if necessary, develop solutions for physical safety concerns, including building security issues and (ii) identify and evaluate any patterns of student safety concerns occurring on school property or at school-sponsored events. Solutions and responses may include recommendations for structural adjustments, changes in school safety procedures, and revisions to the school board's standards for student conduct. *(See Appendix A for complete excerpt.)*

   - *School nurses should have knowledge of the school safety audit process and are encouraged to participate as part of the audit team.*

   - *School nurses should audit injury reports to identify areas of high risk in the school, including causative factors, and submit a report of findings to the principal for corrective action.*

- *School nurses should supplement the curriculum with classroom health lessons and individual health counseling as necessary, based on information derived from environmental monitoring and/or review of injury reports.*

Extreme Emergencies.

- All school personnel should be able to identify members of the response team and initiate the local school division's established system of triage for extreme medical emergencies.

- In extreme emergencies, the school principal or his/her designee may make arrangements for immediate hospitalization of injured or ill students, contacting parents/guardians in advance, if possible.

- The school nurse and/or other designated school personnel, with the emergency information card, should accompany the student to the hospital and remain until the parent/guardian assumes responsibility.

Chronically Ill. Individual health plans for chronically ill children should address potential emergency situations based on each student's health condition and provide precise instructions/physician's orders for specific treatments in certain defined emergency circumstances. Local school division policies for managing school emergencies should be reviewed and approved by a consulting physician (e.g., school physician, private physician, local health department medical director or physician, school health advisory board).

Report Forms. Please see Appendix E for sample student injury report form.

Managing Crises

Note: The following information, on Managing Crises, is from the following publication:

Resource Guide for Crisis Management in Schools
Division of Instruction
Office of Compensatory Programs
Virginia Department of Education
P.O. Box 2120
Richmond, VA 23218-2120
Telephone: (804) 225-2871

Effective Crisis Management. A crisis can occur at anytime whether or not schools plan for it. It is unlikely that any school will escape the necessity of responding to a significant crisis. A crisis can impact a single building or the entire school division, depending on the nature of the crisis. Establishing a *Crisis Management Plan* anticipates potential problems and establishes a coordinated response to minimize school community stress and disruption.

Crisis management is that part of a school division's approach to school safety that focuses more narrowly on a time-limited, problem-focused intervention to identify,

confront, and resolve the crisis, restore equilibrium, and support appropriate adaptive responses.

The essential elements of crisis management in schools include the following:

- **Policy and Leadership.** Provides both a foundation and a framework for action. The chances of effectively managing a crisis are increased with a division level plan and individual building plans that operate within the framework of the division plan but are tailored to the conditions and resources of the individual school. Leadership is necessary to ensure effective implementation of plans and maintenance or preparedness.

- **The Crisis Response Team.** A school Crisis Response Team can be a highly effective organizational unit for dealing with a variety of crises. Such teams can operate at three levels: (1) individual school building, (2) central office, and (3) community. Well-functioning teams at each level provide a network that can support action whenever crises arise.

- **The School Crisis Management Plan.** A school that is *prepared* before a crisis occurs will be much more likely to manage students and staff effectively. *An unprepared school is asking for chaos.*

- **Communications.** When a crisis occurs, effective communication is essential—within the school and the school division, with parents and the community at large, and with the media. Effective communication can speed the restoration of equilibrium; poor communication can make a bad situation much worse.

- **Training and Maintenance.** Preparation for and response to crises rely on people understanding policies and procedures and knowing what they are to do. These are achieved through *training.* Maintaining preparedness is an ongoing process that involves debriefing following crises, periodic review and updating, and ongoing training.

Policy and Leadership. Policy provides both a foundation and a framework for crisis management. Leadership, however, is necessary to ensure effective implementation and maintenance of preparedness.

School division policies typically include the following elements:

- A definition of "crisis."

- A requirement that each school establish a crisis management *team* and develop a crisis management *plan.*

- Specifications for *membership* of the crisis management team, usually including provision for accessing, in the event of crisis, additional resources from within the school division and/or community.

- Specifications for issues to be addressed in each school's crisis management plan, usually including designation of chain of *command*, development of *protocols* for management of specific types of crises, coordination of *communications*, provisions for *support services*, staff inservice *training*, and periodic *review* of the plan.

Note: A sample policy is presented in *Resource Guide for Crisis Management in Schools*, Virginia Department of Education.

Leadership at the central office includes developing a division plan as a management plan. *Resource Guide for Crisis Management in Schools* presents the following six major phases in the plan's development:

1. **Analysis of resources.** Encompasses review of current policies and procedures, determination of geographic location of schools in terms of proximity to hazards and resources, assessment of transportation and communications capabilities, and examination of the compatibility of school division's plan with individual plans.

2. **Development of the emergency plan**. Includes identification of tasks and assignment of roles for division personnel, establishment of alternative communications and evacuation systems, and developing preparation for both on- and off-campus emergencies.

3. **Coordination of the division plan with school and community plans.** Involves inclusion of and coordination with fire, law enforcement, and emergency officials—including many different views results in a more comprehensive and effective plan.

4. **Making the plan public.** Includes broad dissemination of plan, particularly to school and community groups who might be able to contribute to the management of an emergency.

5. **Training all staff and volunteer personnel.** Involves provision of school-based training to all personnel. The plan cannot be implemented properly unless school personnel, including volunteers, understand the plan and what is expected of them.

6. **Sharing the plan with state and local agencies.** Entails sending copies of plan to local fire, law enforcement, and emergency agencies.

Note: Sample central office personnel roles and responsibilities are presented in *Resource Guide for Crisis Management in Schools*, Virginia Department of Education.

Leadership of the principal at the individual school level is crucial for effective crisis management. As the highest level executive in the school, the principal bears responsibility for all decision and actives. *Resource Guide for Crisis Management in* Schools presents the following actions for crisis preparation, as recommended by the National School Safety Center (1995):

- Review district-wide emergency policies.

- Identify community resources.
- Establish a clear chain of command.
- Identify a command post.
- Appoint a crisis response team.
- Assign roles.
- Established inservice training program.
- Establish a warning signal.
- Prepare an emergency kit.
- Establish procedures to identify wounded or dead.
- Prepare students.
- Develop plans for transportation, crowd control, student release, and evacuation.

Establishing the Crisis Response Team. A school Crisis Response Team can be a highly effective organizational unit for dealing with a variety of crises, such as injuries, drug overdoses, suicides, incidents of violence, and weather emergencies. Crisis Response Teams in a school division can operate at three levels: individual building, central office, and community response teams. Well-functioning teams at each level provide a network that can take action whenever a crisis arises.

The crisis network should include a ***building-level team*** in each school. The principal usually leads the building-level crisis team, with an alternate leader designated in the principal's absence. In addition to teachers, the team might include a coach, guidance counselor, school nurse, school psychologist, school social worker, school security personnel, school secretary, and custodian. The team typically has responsibility for the following:

1. Establishing a protocol for dealing with crises.

2. Establishing a systematic approach for identifying, referring, and intervening with students identified as at-risk for suicide or other destructive behaviors.

3. Orienting staff to procedures and training to fulfill designated roles, including conducting drills.

4. Providing information to students, staff, and community on crisis management.

5. Providing assistance during a crisis in accordance with designated roles and providing follow-up activities.

6. Conducting debriefing at the conclusion of each crisis episode to critique the effectiveness of the building's Crisis Management Plan.

Note: Sample building-level personnel roles and responsibilities are presented in *Resource Guide for Crisis Management in Schools*, Virginia Department of Education.

In addition to a building-level team in each school building, the crisis network should include a ***central-office team***. This central-office crisis team might include the

Superintendent or someone designated by the Superintendent, a representative of each school crisis team, administrator(s) for school security, and for pupil services, including school psychology and social work supervisors. It might also include consultants outside the school system. The central-office crisis team might have responsibility for the following:

1. Overseeing and coordinating the building-level teams.

2. Authorizing resources for areas where they are most needed.

3. Collecting and disseminating educational materials to schools for training crisis team members and faculty.

4. Establishing a central library of materials on violence, suicide, and other crisis management issues for use by faculty, staff, and students.

5. Conducting mock crisis events to test the crisis management procedures.

6. Evaluating response to crises with a report to the Superintendent and a plan for follow-up.

7. Establishing a community support team and encouraging input and support from its members.

Note: Sample central office personnel roles and responsibilities during school emergencies are presented in *Resource Guide for Crisis Management in Schools*, Virginia Department of Education.

Furthermore, in addition to the building-level and central-office level crisis teams, the crisis network should include a ***community support network***. This community support network should include representatives from the community and government agencies. Additionally, this network might include personnel from mental health and law enforcement agencies, emergency medical personnel, and specialized resources, such as domestic violence shelters, rape, runaway, and victim's advocacy services.

Schools should maintain periodic contact with community agencies and organizations and invite them to participate in meetings with school Crisis Management Teams.

Developing the School Crisis Management Plan. In setting up a Crisis Management Plan, the following activities are important:

1. Decide who will be in charge during the crisis.
2. Select the Crisis Response Team.
3. Develop clear and consistent polices and procedures.
4. Provide training for the Crisis Response Team.

5. Establish a law enforcement liaison.
6. Establish a media liaison and identify suitable facilities where reporters can work and news conferences can be held.
7. Establish a working relationship with community health agencies and other resources groups.
8. Set up "phone trees."
9. Plan to make space available for community meetings and for outside service providers involved in crisis management.
10. Develop necessary forms and information sheets.
11. Develop a plan for emergency coverage of classes.
12. Establish a code to alert staff.
13. Develop a collection of readings.
14. Have a school attorney review crisis response procedures and forms.
15. Hold a practice "crisis alert" session.
16. Hold an annual in-service meeting on general crisis intervention.

Note: Sample crisis management plan checklists, procedures, reports, and postvention guidelines and handouts are presented in *Resource Guide for Crisis Management in Schools*, Virginia Department of Education.

School Communications. Communication is a critical part of crisis management. School staff members and students must be told what is happening and what to do. Parents of students and families of staff members must be informed about the situation, including the status of their child or family member. Timely contact with law enforcement and other emergency services is necessary for effective response. School Board members must be kept informed and updated information must be transmitted to central office and to other affected schools. The press must be informed and kept updated. Additionally, groups that are part of the school community (e.g., PTA, school health advisory board) can assist with getting accurate information into the community.

Note: Guidance on dealing with rumors, using technology for communication, voice and hand signals, using code messages, and sample communication announcements are presented in *Resource Guide for Crisis Management in Schools*, Virginia Department of Education.

Training and Maintaining Preparedness. A crisis management plan cannot be implemented properly unless staff members know what the plan is and what is expected of them in the event of an emergency. In addition to staff training, it is important for students to know (and practice) emergency procedures. School-based training should be provided to all personnel, including instructional, custodial, and food service employees,

temporary employees, and volunteers. Inviting parent leaders (e.g., PTA officers) should be considered—they have important roles in communicating with other parents and in helping restore equilibrium in the event of a major crisis. The training should include practice scenarios. A mock disaster drill coordinated with local emergency preparedness groups may also be conducted.

Training and inservice activities should be designed to meet three distinct needs:

1. How to prevent certain types of emergencies.
2. How to respond when emergencies occur.
3. How to deal with the aftermath of an emergency.

Note: Guidance on training content and sample training agendas, scenarios, and plans are presented in *Resource Guide for Crisis Management in Schools*, Virginia Department of Education.

Quick Guide to Crisis Management. The following samples of guidelines and checklists for the management of specific types of crises are presented in *Resource Guide for Crisis Management in Schools*, Virginia Department of Education.

- Minor Injuries at School
- Injuries to and From School
- Aircraft Disaster
- Allergic Reaction
- Angry Parent/Employee/Patron
- Assault by Intruder
- Bomb Threat
- Bus/Auto Injuries
- Chemical Spill
- Childnapping or Lost Child
- Death (destruction of part or whole building; e.g., tornado, plane crash, bomb)
- Disaster
- Disaster Preventing Dismissal (e.g., hurricane, tornado, sniper, plane crash)
- Fighting (violence between two or more students; i.e., physical fighting)
- Fire Arson, or Explosives
- Gas Leak
- Hostage, Armed / Dangerous Intruder
- Injury
- Intruder or Trespasser
- Life-Threatening Crisis (major life-threatening crisis to individual)
- Perceived Crises
- Poisoning
- Power Failure / Lines Down
- Rape
- Shootings, Woundings, Attacks

- Suicide Threats (for potentially suicidal students)
- Vandalism
- Weapons Situation
- Weather (e.g., tornado, inclement weather, earthquake)

Resources

- National School Safety Center
  141 Duesenberg Drive, Suite 11
  Westlake Village, CA 91362
  Telephone: 805-373-9977
  Web site: http://www.nssc1.org/
- Federal Emergency Management Agency (FEMA)
  Office of Emergency Information
  500 C. Street S.W., Room 824
  Washington, D.C. 20472-0001
  Telephone: (202) 646-4600,
  Web site: http://www.fema.gov/
- Virginia Department of Education
  Safe and Drug-Free Schools and Community Program
  Office of Compensatory Programs
  P.O. Box 2120
  Richmond, VA 23218-2120
  Telephone: (804) 225-2871
  Web site:
  http://www.pen.k12.va.us/VDOE/Instruction/comp.html
- Virginia Department of Emergency Services
  10501 Trade Court
  Richmond, VA 23236
  Telephone: (804) 897-6500
  Telephone: (804) 674-2499
  Web site:
  http://www.vdes.state.va.us/
- Virginia Department of Health
  Center for Injury and Violence Prevention
  P.O. Box 2448
  Richmond, VA 23218-2448
  Telephone: (804) 692-0104
  Web site:
  http://www.vdh.state.va.us/fhs/injury/center.htm
- Virginia Department of State Police
  Comprehensive Crime Prevention Program
  P.O. Box 27472
  Richmond, VA 23261-7472
  Telephone**:** 1-800-552-9965
  Web site:
  http://www.vsp.state.va.us/vsp.html

Note. Please see “Injury and Violence” in Chapter III for additional resources.

Referring to Child Protective Services

Authorization

***Code of Virginia,* Section 63.1-248.2, Definitions (of Abuse and Neglect).** The *Code of Virginia*, § 63.1-248.2 defines an "abused or neglected child" as any child less than 18 years of age:

> 1. *Whose parents or other person responsible for his care creates or inflicts, threatens to create or inflict, or allows to be created or inflicted upon such child a physical or mental injury by other than accidental means, or creates a substantial risk of death, disfigurement, or impairment of bodily or mental functions.*
>
> 2. *Whose parents or other person responsible for his care neglects or refuses to provide care necessary for his health. However, no child who in good faith is under treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination shall for that reason alone be considered to be an abused or neglected child.*
>
> 3. *Whose parents or other person responsible for his care abandons such child.*
>
> 4. *Whose parents or other person responsible for his care commits or allows to be committed any act of sexual exploitation or any sexual act upon a child in violation of the law.*
>
> 5. *Who is without parental care or guardianship caused by the unreasonable absence or the mental or physical incapacity of the child's parent, guardian, legal custodian or other person standing in loco parentis.*

Excerpt: See Appendix A for *Code of Virginia*, § 63.1-248.2.

***Code of Virginia,* Section 63.1-248.3, Physicians, Nurses, Teachers, Etc., to Report Certain Injuries in Children; Penalty for Failure to Report.**

Excerpt: See Appendix A for *Code of Virginia,* § 63.1-248.3

***Code of Virginia,* Section 63.1-248.4 Complaints by Others of Certain Injuries to Children.**

Excerpt: See Appendix A for *Code of Virginia,* § 63.1-248.4

***Code of Virginia,* Section 63.1-248.5 Immunity of Person Making Report, Etc., From Liability.**

Excerpt: See Appendix A for *Code of Virginia,* § 63.1-248.5

***Code of Virginia* Section 63.1-248.10 Authority to Talk to Child or Sibling**

Excerpt: See Appendix A for *Code of Virginia,* § 63.1-248.10

***Code of Virginia* Section 63.1-248.13 Photographs and X Rays of Child; Use as Evidence**

Excerpt: See Appendix A for *Code of Virginia,* § 63.1-248.13

***Code of Virginia* Section 63.1-248.17 Cooperation by State Entities.**

Excerpt: See Appendix A for *Code of Virginia,* § 63.1-248.17

Note. Certain situations have not been considered abuse/neglect by the courts. These include:

1. Failure to provide immunizations to children. (§ 32.1-46 of the *Code of Virginia* requires that parents/guardians immunize their children at designated intervals. However, not immunizing a child does not constitute abuse or neglect under Virginia statutes.)

2. Parental substance abuse where there is no demonstrated adverse impact on the care of the child, is not reportable to Child Protective Services (CPS). However, chronic parental substance abuse where the child's health or safety has been neglected or endangered is reportable to CPS.

3. Virginia law requires the use of seat belts. The intent of the law is to protect children from serious injury in the event of an accident. However, this is a civil law, with designated fines and penalties, to be implemented by law enforcement authorities.

Overview

School personnel are in a unique position to assist children who may be victims of abuse/neglect. The day-to-day contact teachers and other school staff have with students provides the opportunity for immediate and ongoing assessment of children who may be in need of assistance. For this reason it is important for all school personnel to be familiar with:

- Reasons for abuse, types of abuse, and those at particular risk for abuse.

- The legal responsibilities for reporting actual proof of or suspicion of abuse.

- The method for reporting (including that which is specific to the particular school division where the individual is employed).

- Resources available for the individual reporting the abuse and the individual being subjected to the abuse.

Reasons for Abuse and Neglect

Child abuse and neglect are universal problems that occur across economic, cultural, and ethnic lines. Research indicates that there are circumstances which increase the likelihood abuse and neglect may occur in some families. (It is important to remember that the abuser is not always a parent and can be any childcare provider, teacher, foster parent, or anyone responsible for the care of a child.) Circumstances that may predispose a person to abuse and neglect include:

- A parent or individual who may have been abused or neglected as a child may continue this pattern when raising their own children.
- Increase in stress in life, including marital, financial, and employment difficulty.
- Substance abuse in the home.
- Parents and child care providers who lack the skill and knowledge for the role.
- Individual's inability to tolerate frustration and inability to control the impulse to act.
- Families and individuals who feel isolated from family, friends, and community.

Operational Definitions of Abuse

Physical Abuse. Physical abuse is defined as any act, whether intentional or not, that causes harm to a child. Intentional physical injury usually is related to severe corporal punishment; however, physical abuse ranges from minor cuts and bruises to severe neurologic trauma and death.

Physical Neglect. Physical neglect occurs when caretakers do not provide for a child's physical survival needs (including adequate food, clothing, shelter, hygiene, supervision, and medical and dental care) to the extent that the child's health or safety is endangered.

Sexual Abuse. Sexual abuse is defined as acts of sexual assault or sexual exploitation of minors. This category includes a wide spectrum of activities and may occur only once in a child's life or may be a long term situation of sexual abuse or exploitation. Specifically, sexual abuse includes the following sexual acts: incest, rape, intercourse, oral-genital contact, fondling, sexual propositions or enticement, indecent exposure, child pornography, and child prostitution. Sexual abuse is most commonly carried out by someone a child knows and does not always involve violence. Males and females,

infants and adolescents are all subject to sexual abuse. The abuser may be an adult or another child.

Emotional Maltreatment. Emotional maltreatment is a pattern of acts by the child's caretaker that results in psychological or emotional harm to the child's physical health and development. Patterns of emotional maltreatment include rejection, intimidation, ignoring, ridiculing, or isolation.

Assessing for Signs of Abuse and Neglect

The following are guidelines for school personnel to consider for the overall assessment of a suspected case of child abuse.

Physical Abuse/Neglect. A significant factor in distinguishing whether an injury is unintentional or as the result of abuse is an inconsistency between the history of an injury and the injury itself. When considering a physical injury consider the information that is summarized in the following chart.

Type of Information and Rationale Used to Distinguish Unintentional Injuries From Those That Result From Abuse

Information	Rationale
Location of the injury	Children are more likely to sustain unintentional injuries on the knees, elbows, shins, and forehead. Injuries located on nonprotuberant areas (such as the back, thighs, genital area, buttocks, back of the legs or face) are more likely the result of intentional injury.
Number and frequency of injuries	Unless a child has been in a serious accident, he/she is unlikely to have a number of injuries concurrently nor is it likely that the injuries would be at various stages of healing.
Size and shape of the injury	Unintentional injuries rarely have a defined shape. Intentional injuries, such as burns (e.g., from cigarettes, immersion in hot liquids, burns from irons, and ropes) or other objects (e.g., sticks, belts, hairbrushes, and human bite marks), will have a definitive, definable appearance.
Description of how the injury occurred	Unintentional injuries, when described by a child, generally have a reasonable explanation and one that is consistent with the appearance of the injury. Descriptions of injuries by a child that are inconsistent with the presentation are cause for suspicion.
Consistency of injury with the child's developmental capability	A child presenting with an injury that he/she is developmentally or physically incapable of causing (e.g., child is too small to generate a force sufficient to create that type of injury) should be considered for intentional abuse by their child caretaker.
Behavioral indicators of physical abuse/neglect	School personnel should also observe children for behaviors that may result from intentional physical abuse/neglect by a child's caretaker. Examples include: wariness of physical contact with adults,

Type of Information and Rationale Used to Distinguish Unintentional Injuries From Those That Result From Abuse

Information	Rationale
	apprehension when another child cries, fear of his/her parent(s), stated fear of going home or crying when it is time to go, and report of an injury inflicted by a parent.

Mental Abuse/Neglect. There are a variety of behaviors a child may exhibit as a result of mental abuse/neglect. It is important when assessing for this type of abuse to examine specific behaviors of a child as well as develop an overall picture of the child's ability to interact and communicate with children and other adults. When assessing a child for mental abuse/neglect, it is important to place the behavior within the context of the child's developmental, emotional, and physical age. The following chart lists particular behaviors and interaction styles that may be indicators of mental abuse or neglect.

Behaviors and Interaction Styles That May be Indicators of Mental Abuse or Neglect

Behavior	Example
Habit Disorders	♦ Biting. ♦ Sucking. ♦ Rocking. ♦ Enuresis. ♦ Over- or under-eating without physical cause.
Conduct Disorders	♦ Withdrawal. ♦ Antisocial behavior, such as destructiveness, cruelty, and stealing.
Neurotic Traits	♦ Sleep disorders. ♦ Speech disorders. ♦ Inhibition of play.
Others	♦ Psychoneurotic traits. ♦ Overly compliant, passive, and undemanding. ♦ Extremely aggressive, demanding, or angry behavior. ♦ Over-adaptive behaviors that are either inappropriately adult or infantile. ♦ Delays in physical, emotional, and intellectual development. ♦ Attempts at suicide. ♦ Frequent comments and behavior suggesting low self esteem.

Sexual Abuse. A child that has been a victim of sexual abuse—whether it is a single incident or a long term pattern of sexual abuse—is unlikely to reveal this information directly to anyone. More than likely, a child will send signals to those around him/her that something is wrong. School personnel need to be attuned to the type of clues that may indicate a child is in a sexually abusive situation. The signs may be physical, emotional, and or reflected in developmentally inappropriate behavior by the child.

The information below has been divided into two age groups: the younger child and the older child. The information of potential signs of sexual abuse is by no means a complete list of the possible behaviors a child might exhibit when involved in a sexual abuse/neglect situation. School personnel may refer to this list as a guideline for further exploration and to

classify behaviors they might be seeing in a child. It is strongly recommended that school personnel become familiar with available resources.

Young Child. A young child (i.e., toddlers, preschoolers, early elementary school-age) may have difficulty verbalizing their fears and concerns as well as the actual sexual abuse to which they are being subjected. This is especially true for children with disabilities. The following chart summarizes behavioral and physical signs that may be indicators of sexual abuse in the young child.

Signs That May Indicate Sexual Abuse in the Young Child

Type of Sign	Sign
Behavioral	♦ Reports sexual abuse. ♦ Sleep disturbances, such as fear of falling asleep and nightmares. ♦ Sudden changes in behavior and/or regressive behavior. ♦ Excessive masturbation. ♦ Detailed and age-inappropriate understanding and verbalization of sexual behavior. ♦ Highly sexualized play. ♦ Inappropriate behavior with peers and adults that is seductive in nature.
Physical	♦ Stomach aches. ♦ Dysuria (painful urination) or enuresis (involuntary urination after the age at which bladder control should have been established). ♦ Encopresis (involuntary soiling with feces after the age at which control of defecation should have been established). ♦ Complaints of genital irritation, laceration, abrasion, bleeding, discharge, or infection. (Venereal disease should be considered in children with anal or genital infection, discharge, or irritation.) ♦ A gagging response, sore throat, or mouth or throat lesions (as the result of oral-genital contact). ♦ Other signs of physical abuse.

Older Child. Older children may be able to verbalize and label what is happening to them in a sexually abusive situation; however, feelings of embarrassment, humiliation, guilt, a sense of responsibility, and fear may prevent them from talking with anyone. In fact, like young children, signs of sexual abuse in older children may emerge in regressive or sudden behavioral changes, physical signs of injury, or withdrawal. The following chart summarizes behavioral and physical signs that may be indicators of sexual abuse in the older child.

Signs That May Indicate Sexual Abuse in the Older Child

Type of Sign	Sign
Behavioral	♦ Reports sexual abuse. ♦ Poor relationships with peers. This may take the form of withdrawal from established relationships; an inability to establish new relationships; aggressive, violent, or sexually promiscuous behavior. ♦ Poor self esteem. ♦ General feelings of shame or guilt.

Signs That May Indicate Sexual Abuse in the Older Child

Type of Sign	Sign
	♦ Eating disorders (bulimia and anorexia). ♦ Excessive concern about homosexuality (especially boys). ♦ Deterioration in academic performance. ♦ Role reversal with parent and overly concerned about younger sibling(s). ♦ Running away. ♦ Drug abuse. ♦ Moderate to severe anxiety or depression.
Physical	♦ Attempts at suicide. ♦ Unexplained vaginal discharge, pregnancy, and/or venereal disease. ♦ Bruises and/or bleeding of external genital, vaginal, or anal areas and inner thighs. ♦ Gagging response, sore throat, or mouth or throat lesions (as the result of oral-genital contact). ♦ Difficulty sitting or walking. ♦ Other signs of physical abuse.

Other Information. Other information about the child and their family is important to incorporate into an evaluation of possible sexual abuse of a child. In a family where there is a history of the following, a suspicion of sexual abuse may be warranted: abuse of the child or other children; alcoholism; isolation of the family as a whole; overly restrictive control by a father of his female children; expectations by parents that children act more like adults; or vague reports by a parent that their child may have been sexually abused by a stranger or a member of their family.

Inappropriate Sexual Activity Between Children. There are situations in which children sexually abuse other children. These are not situations in which the activity is considered to be the normal sexual curiosity that is developmentally appropriate. These are situations in which (1) a child is the victim of another child, (2) violence may be a component, (3) there is a lack of adult supervision that enables this activity to take place, (4) a child is in a caretaker role of another child, and (5) it is possible that the child inflicting the abuse may be a victim of abuse themselves. These situations must be examined carefully. Children who abuse and victimize other children need to be referred for evaluation. Children 12 years and older engaging in repetitive sexual abuse and violence against other children should be referred to law enforcement for court supervision and services.

Reporting Abuse/Neglect

Who Makes the Report. Anyone may report abuse or neglect; however, under Virginia law, certain professionals are required to report when they suspect that a child is an abused or neglected child. These professionals include:

♦ Persons licensed to practice medicine or any of the healing arts.

- Hospital residents or interns.
- Nurses.
- Social workers.
- Probation officers.
- Teachers or other persons employed in a public or private school, kindergarten, or nursery school.
- Persons providing full- or part-time child care for pay on a regular basis.
- Accredited Christian Science practitioners.
- Mental health professionals.
- Law enforcement officers.
- Any mediator eligible to receive court referrals.
- Professional staff persons employed by a public or private hospital, institution, or facility in which children are placed.
- Person associated with or employed by any private organization responsible for the care, custody, and control of children.

Suspicion of Abuse/Neglect. The law does not require the professional to have proof or be convinced abuse or neglect has taken place. Suspicion is all that is needed. The *Code of Virginia,* § 63.1-248.5, provides protection from criminal and civil liability to persons reporting abuse/neglect and/or participating in judicial proceedings related to a report of abuse/neglect unless the report has been made with malicious intent or bad faith. The reporter must make available to the local Department of Social Services all information that is the basis for the suspicion. This can include confidential information about the child/family that is contained in the school record. In fact, under the *Code of Virginia*, § 63.1-248.3, not reporting suspicion of abuse/neglect in a timely manner (medical professionals must make a report within 72 hours of first suspicion) is a misdemeanor and the individual is referred to the Commonwealth Attorney for judicial action.

How and to Whom the Report is Made. The law makes allowances for "chain of command" reporting. The school division or school can establish a policy that states that a person (possibly a classroom teacher or school nurse) who suspects that a child is abused or neglected can report their suspicion to a designated person in the school, who in turn reports the matter to the local Department of Social Services. The chain of command must respond immediately with a report of suspected child abuse. It is suggested that each school/school division develop a plan for reporting child abuse and identify the contact person(s) for the local Department of Social Services.

The *Code of Virginia*, § 63.1-248.17, requires all law enforcement departments, other state and local departments, agencies, authorities, and institutions to cooperate with each local Department of Social Services in the detection and prevention of child abuse. Reports can be made to the local Department of Social Services during working hours or to the State Child Abuse Hotline in Richmond (1-800-552-7096). The hotline operates 24 hours a day, year round. Information received on the hotline is forwarded to the appropriate locality for investigation. Reports can be made anonymously. Documentation is completed according to school/school division policy. It is suggested that as part of the school/school divisions' plan for reporting child abuse, appropriate forms for documentation be developed.

What Information Should be Provided. When making a report of suspected abuse/neglect have the following information available.

- The name, address, and telephone number of the child and parents or other person(s) responsible for the child's care.
- The child's birth date, age, sex, and race.
- Names and ages of siblings and what schools or grades they attend.
- Names and ages of other people who live with the child and their relationship to the child.
- As much information as possible about the incident involving the child, especially where, when, and who was present.
- History of prior injuries or maltreatment of the child or siblings if this is the case.
- Any other pertinent information that the school may have available.
- Reporting person's name, address, and phone number.

When describing an injury (e.g., cut, mark, bruise) be specific.

- Note the exact location on the body.
- Note the size of the mark—estimate in inches or in relation to a common object (e.g., size of a quarter, size of an egg, shape of an iron).
- Note the color of the injury. Injuries often change color with the passage of time. The colors can range from red to black to purple to green and yellow. Note the presence of bruising in multiple areas that may be in various stages of healing.

In general, relate exactly what the child said in his/her own words. Be careful not to interpret what the child said.

Interviewing the Child

When interviewing the child:

- Make sure the child is comfortable. Remain calm and reassuring. Do not rush. If the interviewer reacts with shock, anger, or disgust at what the child tells, the child may interpret that he/she is at fault and has done something wrong, and may be unwilling to reveal further information.
- Attempt to gain pertinent information, using open-ended questions.
- Be careful not to plant ideas or interpretations of what happened in the child's mind.
- Explain the purpose of the interviews in language appropriate to the child's developmental level.
- Let the child know the interviewer will be talking to someone who will try to help him or her, without making any promises to the child that cannot be kept.

What Happens After a Report is Made

Many times school personnel are unaware of what occurs after a report is made and may not understand why what appears to be an "obvious" situation cannot be investigated. There are specific criteria that must be met for the local Department of Social Services to proceed with an investigation once they receive the information. The criteria are:

- The child must be under 18 years of age.
- There must be a caretaker relationship between the victim and the alleged abuser/neglecter (a caretaker is anyone, including a teenager, sibling, or adult, who is responsible for that child).
- The allegation must fall into a definition of abuse/neglect.
- The department must have jurisdiction for that report in order to pursue an investigation.

If the above criteria are met, the department is obligated to investigate. The law gives the department 45 days to complete an investigation. There is no standard at this time that states how soon an investigation must start. Generally, that is a function of how severe the risk to the child appears to be from the information presented. If the department does not have the legal authority to investigate the allegations, the report may be handled differently. If the person responsible for the suspected abuse was not a "caretaker" (and the Department of Social Services could not intervene), the suspected incident should be referred directly to the parents, police, or another agency. The local Department of Social Services will be able to identify other options.

How an Investigation of Abuse/Neglect is Conducted

Once the department has accepted a report, it will be investigated. The social worker investigating the allegations tries to interview a child in a neutral setting, such as a school. The *Code of Virginia,* § 63.1-248.10, gives the Child Protective Services social worker the authority to interview the child and any siblings without the prior consent of the parent/guardian. The child and siblings may be interviewed without the presence of the parent, guardian, school personnel or any other individual standing in loco parentis. Additionally, the *Code of Virginia,* § 63.1-248.13, allows the social worker to take photographs of the child without the consent of the parent/guardian.

The investigative worker will also talk with the alleged abuser/neglecter, the parents/guardians (if different) and any other individual who may have information about the child's care related to the allegations—such as a doctor, teacher, and neighbors.

The decision as to whether or not child abuse or neglect occurred must be make within 45 days after a report is received. The decision is based on the information gathered during the investigation. There are two possible findings:

- "Founded"– Abuse/neglect has occurred.
- "Unfounded"– No evidence that abuse/neglect has occurred.

The Child Protective Services Investigation and any subsequent services provided to the child and the family are confidential. If the person reporting the abuse is not an anonymous reporter, the department may notify that person very briefly of the investigative outcomes. The only time more detailed information is released is when the family gives express written consent.

If a Report of Suspected Child Abuse or Neglect is Not Accepted by Child Protective Services

If the criteria for investigation are not met, Child Protective Services will not pursue the report. When CPS does not investigate a report, it usually means that the situation does not meet the legal definition of abuse/neglect, law enforcement has the responsibility to investigate, or the family's problems can be more effectively addressed by a different type of service. If the person reporting the abuse disagrees with the decision not to pursue the investigation, then the school personnel responsible for the reporting of abuse/neglect situations may discuss their concerns with the CPS supervisor.

If the situation is labeled "unfounded," it does not mean that the family may not be having problems. It just means that according to the law and the Department of Social Services policy the situation cannot be labeled as abusive/neglectful. The social worker may recommend a course of action, including other community based services available (e.g., mental health treatment, substance abuse services, court services, and shelter care).

The school may be instrumental in providing assistance to the family to prevent the abuse or neglect of children. Such prevention programs may be in the form of support groups and educational programs as well as students utilizing the many programs developed for awareness and education of family problems and situations.

Professionals who have had unsatisfactory reporting experiences in the past may be reluctant to report a second case of abuse/neglect to the local Department of Social Services. It is possible that the experience the professional had may have been unsatisfactory and that they may have developed a distrust of the system for investigating abuse/neglect situations, feeling that nothing will be done again. **Professionals must keep in mind that they are legally bound to report a case of suspected child. In addition, if the incident is not reported nothing will be done. Abused and neglected children cannot be protected unless they are first identified, and the key to identification is reporting**.

Resources

Struck, L.M. & Bar-on M. (1995). *Assistance for Medical Professionals in the Diagnosis and Management of Suspected Child Abuse and Neglect.* Commonwealth of Virginia, Department of Social Services, Child Protective Services, in collaboration with Medical College of Virginia, Virginia Commonwealth University, Children's Medical Center.

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Home Visits

Authority

Regulations. Some regulations that govern the delivery of services to students may require the use of home visits for students who are confined for periods of time that prevent normal school attendance. See the following:

- *Regulations Governing Special Education Programs for Children with Disabilities in Virginia*, (Effective January 1994).[95]
- *Regulations Establishing Standards for Accrediting Public Schools in Virginia,* (September, 1997). [96]

Overview

Home visits made by members of the interdisciplinary team offer an excellent opportunity to foster communication between school and home. Advantages include:

- Convenience for the family.
- Option for those families unwilling or unable to travel.
- Family control of the setting and the potential for active participation in meeting the student's health needs.
- The opportunity to gain a more accurate assessment of the student's family structure and behavior in the natural environment.
- The opportunity to make observations of the home environment and to identify both barriers and support for reaching family health promotion goals.

[95] Virginia Department of Education (Effective January 1994). *Regulations Governing Special Education Programs for Children with Disabilities in Virginia*. Richmond, Va.: Author.

[96] Virginia Board of Education. (September, 1997). *Regulations Establishing Standards for Accrediting Public Schools in Virginia*. Richmond, Va.: Virginia Department of Education.

Recommendation

Objectives for a Home Visit. During home visits, school health personnel can:

- Establish rapport with the student's family support system.
- Assess family strengths and needs, including limitations and barriers to the student's achievements, the student's need for community health resources, and the student's behavior and reactions to home situations.
- In partnership with the family, plan school health services that promote and support family goals to maximize functional capabilities, including the student's self-care, independence, and future school attendance.
- Provide for family/student participation in health promotion, maintenance, and restoration, including providing information needed to make decisions and choices about using health care resources.

Procedure for a Home Visit. In preparing for the home visit, school health personnel should:

- Review available school and health records prior to home visit.
- Review current health care plans.
- Identify objectives for the visit.
- Contact student's health care provider, when appropriate, for questions and/or concerns.
- Plan time of visits to optimize safety and effectiveness.
- Make an appointment in advance of the visit.
- Log in and out at school office, noting the telephone number and address of the home to be visited, time of departure, and expected return.
- Wear identification (e.g., name badge).
- Avoid going alone to neighborhoods known to be dangerous.

During the home visit, school health personnel should:

- Explain purpose of the visit.
- Observe the home and surrounding environment, significant sociocultural influences, and interaction of family members.

- Identify health care needs/problems, based on subjective and objective data, and involve the family members in the process.
- List problems in order of importance in accordance with family perceptions.
- Discuss alternative solutions and available community resources.
- Make referrals as necessary to appropriate health care providers.
- Assist in the development of a plan for the appropriate interventions(s) and establish a time to evaluate the effectiveness of the plan.
- Share the plan with appropriate persons involved in the health care of the student.

After the home visit, school health personnel should record and document:

- Subjective and objective data, problems identified, and plan of action including time line for achieving planned interventions.
- Future plans and recommendations for home visits.

Resources

For more information, refer to:

Stanhope, M. and Lancaster, J. (1991). *Community Health Nursing: Process and Practice for Promoting Health,* 3rd Edition. St. Louis, Mo.: The C. V. Mosby Company.

American Nurses Association. (1998). *Standards of Clinical Nursing Practice*. Kansas City, Mo.: Author.

School Health Program Manual. (1990). South Carolina Department of Health and Environmental Control.

National Association of School Nurses, Inc. (1998). *Standards of Professional School Nursing Practice.* Scarborough, Maine: Author.

Nursing Liaison Services to Homebound Students

Authority

Regulations. Virginia Board of Education. (September, 1997). *Regulations Establishing Standards for Accrediting Public Schools in Virginia*. Richmond, Va.: Virginia Department of Education.

Regulations. Virginia Department of Education (Effective January 1994). *Regulations Governing Special Education Programs for Children with Disabilities in Virginia.* Richmond, Va.: Author.

Overview

Students with acute and chronic illnesses, severe injuries, medically high-risk pregnancies, or recovering from surgery may require periods of homebound instruction. Though medical/nursing care will be provided by the private medical provider or a community agency, the school nurse may serve as a liaison between the school, family, and medical provider in planning for the transition from homebound status to school attendance.

The rationale for homebound instruction includes the following:

- Extended absence from school contributes to desocialization, isolation, and potential dropout of students, especially those who have a chronic illness or are pregnant.
- School nursing intervention is essential to facilitate appropriate case management of chronically ill or pregnant students and reduce absences caused by short-term illnesses.
- Appropriate case management and coordination of services support the transition from homebound to school attendance.

Recommendation

Procedure. The following procedure is recommended for school nurse visits to homebound students:

1. When homebound instruction is deemed necessary, the school nurse will be notified by the appropriate school personnel.

2. The school nurse contacts the family and student through telephone calls and home visits to assist the family in the utilization of appropriate community health care services.

3. The school nurse interprets medical information for school personnel and assists the student in making the transition from hospital and/or home to school.

4. Frequently it will be necessary to have a written individualized healthcare plan (IHP) that has been implemented prior to the student's return to school. The IHP should be developed by the registered nurse (RN), in collaboration with the school health team, consisting of the parents, student, physician, school administrator, classroom teacher, homebound teacher and other appropriate personnel. The IHP should be shared with all persons who interact with the student at school.

Resources

For more information, refer to:

Gerber, Mary L. Villars, Kulb, Kathleen M., Luehr, Ellen, Miller, Wanda R., Silkworth, Cynthia K., and Will, Susan I.S. (1993). *The School Nurse's Source Book of Individualized Healthcare Plans.* North Branch, Minn.: Sunrise River Press.
Note: In 1996, the Virginia Department of Health sent *The School Nurse's Source Book of Individualized Healthcare Plans* to all Virginia school divisions via the School Nurse Coordinator/Contact Person.

Virginia Board of Education. (September, 1997). *Regulations Establishing Standards for Accrediting Public Schools in Virginia*. Richmond, Va.: Virginia Department of Education.

Virginia Department of Education (Effective January 1994). *Regulations Governing Special Education Programs for Children with Disabilities in Virginia.* Richmond, Va.: Author.

Virginia Department of Education. (1990). *Guidelines for Homebound Instruction.* Richmond, Va.: Author.

Students Requiring Specialized Health Care Procedures

Resource. Refer to Keen, T. (Ed.). with Ford, N., Henry, J., and Cox, A. (Consulting Eds.). (1996). *Guidelines for Specialized Health Care Procedures*. Richmond, Va.: Virginia Department of Health.

Guidelines for Specialized Health Care Procedures is a resource document for school and public health personnel. The manual is intended to enhance the educational process by providing guidance to school administrators, school nurses, teachers, and other staff members on the care of students with special health care needs. It presents up-to-date, practical health information and recommendations for developing local programs and policies related the health care services to be provided for these students.

Note. In 1996-97, the Virginia Department of Education sent the manual, *Guidelines for Specialized Health Care Procedures,* to all Virginia public schools and accredited nonpublic schools.