STATEMENT OF PURPOSE:

Student and staff health information is documented according to recommended nursing principles of documentation. Documentation is a critical aspect of nursing practice and risk management. An accurate and complete system of documentation is invaluable in providing data for quality improvement activities; school community needs assessments, and nursing-sensitive outcome measures.

AUTHORIZATION/LEGAL REFERENCE:

34 C.F.R. §§ 99.32 and 99.37. Family Education Rights and Privacy Law (FERPA)
https://www2.ed.gov/policy/gen/guid/fpco/pdf/ferparegs.pdf

18 V.S.A. 1124 -Access to Records
http://legislature.vermont.gov/statutes/section/18/021/01124

26 V.S.A. 1572 - Nurse Practice Act
http://legislature.vermont.gov/statutes/section/26/028/01572

Joint Guidance on the Application of the Family Educational Rights and Privacy Act (FERPA)
And the Health Insurance Portability and Accountability Act of 1996 (HIPAA) To Student Health Records
http://www.ed.gov/policy/gen/guid/fpco/doc/ferpa-hippa-guidance.pdf

School Record Retention & Records Management, Revised & Re-issued: August 22, 2016
http://education.vermont.gov/documents/regulation-school-records-retention-records-management

Vermont Standards Board for Professional Educators - Rules Governing the Licensing of Educators and the Preparation of Educational Professionals, Rule Series 5100:
http://education.vermont.gov/sites/aoe/files/documents/edu-educator-quality-licensing-rules-082217.pdf (pg. 134-140)

Vermont Department of Health Immunization Regulations: June 1, 2016. 13.0 Retention, Transfer and Release of Records http://www.healthvermont.gov/sites/default/files/documents/2016/12/REG_immunization.pdf pg. 7

REQUIRED SCHOOL NURSE/ASSOCIATE SCHOOL NURSE ROLES:

Document subjective and objective nursing assessment data, interventions, plans, and evaluation of outcomes in the student health records or staff records. Documenting of nursing intervention is essential and any template found in any Standards of Practice: School Health Services Manual Section are samples only and school nurse are encouraged to use documentation available in a school's electronic health record.

Use the recommended principles of nursing documentation.

Maintain individual health records (See Confidentiality section) which may include:
- Health assessments
- School screenings or nursing assessments of students; psychological reports according to school policy
- Specific procedures and documentation of administering medication
- Records of injuries and illnesses

- Individual health care plans
- Release of information
- 504 plans
- Correspondence with other agencies, parents/guardians
- Immunization records
- Documentation of training of delegated procedures

Maintain other documentation related to school health services, which may include:

- Accident reports
- Medical incident reports
- Annual immunization reports
- Staff delegation
- Staff records
- Emergency information
- Supervision of staff
- Reports of abuse
- Correspondence with other agencies/health care providers

Follow Vermont School Board Association *sample* policy for education records
http://www.vtvsba.org/model-policy-manual

RESOURCES:

American Nurses Association and National School Nurses Association (2011). *School Nursing Scope and Standards of Practice, 2nd Edition*. Silver Spring, MD: Nursesbooks.org (pgs., 56, 67)

Bergren, M.D., Chormanski, L., Isaac, B.C. (2013) Transforming Data into Information and Knowledge. Costante, C. (Ed.), *School Nurse Administrators: Leadership and Management.* (pp. 365-396). Silver Spring, MD: National Association School Nurses

Bergren, M. D. (2017) Being Confident about HIPAA/FERPA

Brous, E., Boulay, D., & Burger, V. Chapter Six: *The Nurse and Documentation*. In Grant, P. D. & Ballard, D. (2011). Law for Nurse Leaders: A Comprehensive Reference. Springer Publishing: New York.

FERPA Frequently Asked Questions
http://familypolicy.ed.gov/faq-page?src=ferpa#t67n408

Disclosure in Connection with a Health or Safety Emergency
https://www2.ed.gov/policy/gen/guid/fpco/pdf/ferpa-disaster-guidance.pdf

Laubin, M., Schwab, N.C., Doyle, J. (2013) Understanding the Legal Landscape. Costante, C. (Ed.), *School Nurse Administrators: Leadership and Management.* (pp. 459-519). Silver Spring, MD: National Association School Nurses

National Association School Nurses. (February 2014). 2014 *Let's Talk Documentation! Position Documents*
https://schoolnursenet.nasn.org/communities/community-home/librarydocuments/viewdocument?DocumentKey=07717e9c-9cfe-49e6-bae5-41291e4e021a&CommunityKey=00000000-0000-0000-0000-000000000000&tab=librarydocuments

This document may not be altered in any way.

National Association School Nurses & National Association of State School Nurse Consultants. (2014). *School Nursing Services Data: Standardized Documentation, Collection, and Utilization, Joint Resolution.* Retrieved from https://higherlogicdownload.s3.amazonaws.com/NASN/3870c72d-fff9-4ed7-833f-215de278d256/UploadedImages/PDFs/Position%20Statements/Other%20Professional%20Practice%20Documents/joint_resolution_NASN_NASSNC_School_Nursing_Services_Data.pdf

Schwab N.C., Gelfman M.H., Basic Principles of Documentation and Errors in Documentation from: *Legal Issues in School Health Services*, p.311-313, Sunrise River Press, 2001, Revised 2005

Scott, R.L., Bubert, J.S. (2013), Legal Issues Related to School Nursing Practice: The Foundation. In Selekman, J. (Ed.), *School Nursing A Comprehensive Text, (2nd Ed.)* (pp.196-224). Philadelphia: F.A. Davis Company.

Vermont School Boards Association's model policy manual, which includes suggested policy on student records: http://www.vtvsba.org/model-policy-manual

SAMPLE POLICIES, PROCEDURES AND FORMS:

- Vermont School Board Association Model Policy: C. Students, C1 Student Records (12/03/15): (see Resources, above)
- Nursing Principles of Documentation
- Errors in Documentation
- Reportable Incidents
- Length of Time to Hold Records

Nursing Principles of Documentation

- School Health Records are legal documents; do not tamper with a record.
- All written entries should be legible, dated, timed, and signed, and written in ink or on a computer. Usually the ink should be black or blue (so they will copy well if needed).
- Computerized records must be secure and password protected.
- The date and exact time should be included with each entry.
- Documentation should include any nursing action taken in response to a student's problem.
- Nursing documentation should be accurate, objective, concise, thorough, timely, and well organized.
- When Electronic Medical Records are not used, all entries should be legible and written in ink.
- Assessment data should include significant findings, both positive and negative.
- All records, progress notes, individualized health care plans, and flow charts should be kept current.
- Documentation should include only essential information; precise measurements, correct spelling and standard abbreviations should be used.
- School nursing documentation should be based on nursing classification and include uniform data sets.
- The frequency of documentation should be consistent over time and based on district policy, nursing protocols and the acuity of the student's health status.
- Standardized health care plans increase efficiency of documentation and are acceptable to use so long as they are adapted to the individual needs of each student.
- Student symptoms, concerns, and health maintenance questions (subjective data) should be documented in the student's own words.
- Only facts (objective data) relevant to the student's care and clinical nursing judgments based on such facts should be recorded; personal judgments and opinions of the nurse should be omitted. For example, "the student breathing normally" is an opinion, whereas the notation "respirations 20/min; no retractions, rales or wheezing" provides objective data.
  (Scott, Bubert, (2013)

Errors in Documentation

- References to district problems, including staffing shortages, should never be included in student records.
- Terms suggestive of a documentation error should not be used, for example, "accidentally" or "by mistake"; state only the facts of what occurred.
- When a documentation error is made, one single line should be drawn through the documentation error and the nurse's initials should be written next to it. The correct entry should then follow. Entries should never be erased, scratched out, written over, or whited out.
- When an entry is made in the wrong student's record, the entry should be marked "mistake in entry," and a line drawn through the mistaken entry, and marked as above.
- An out of order documentation made on the same day should be identified as out of order.
- Late entries should be avoided. When necessary, a late entry may be added, no later than 7 days, but in the correct date and time sequence. (For example, write today's date and time when entering a note related to care provided yesterday afternoon and mark it "late entry").

Reportable Incidents

Reportable incidents that result in injury or potential injury to students or staff should be documented according to school policy and procedures. These include but are not limited to:

- Injury requiring or probably requiring a physician's or dentist's care;
- Injury referred by the nurse for further evaluation;
- Injury causing concussion, unconsciousness, neck or spinal cord injury;
- Injury causing fracture of a bone or joint dislocation;
- Injury requiring suturing or skin glue closure;
- Injury requiring hospitalization;
- Injury resulting in death or near death;
- Administration of emergency rescue medication, i.e. epinephrine, naloxone, Diastat, etc.
- Failure to administer prescribed medication within the appropriate timeframe, in the correct dosage, or to the correct student. (See 15. First Aid section of the Standards of Practice: School Health Services Manual for sample form)

Actions to be taken

- Incident/Accident reports or Medication Error reports are completed as soon as possible within 24 hours of the occurrence;
  - See First Aid section of this Manual for sample Incident Form
  - See Medication section of the Manual for sample Medication Error Form
- Parent/caregiver or guardian(s) is notified;
- School administration is notified immediately or in a timely manner;
- Documentation in the student health record reflects the facts of the incident and steps taken to rectify the situation;
- Follow-up is completed and documented within 24 to 48 hours as needed; and
- Copies of the report are filed in the Principal's and/or Health Office, separate from the student's record and intended for internal use and analysis [according to SU/SD written policy or procedure].
  (Schwab, Gelfman, 2005)

Records Retention

Health records are treated like any other student record under federal and state laws. “The Family Educational Rights and Privacy Law (FERPA) requires schools to maintain a record of requests for access to and each disclosure of students ‘education records, in addition to maintaining parental notification to the school that any or all directory information for a student shall not be disclosed….

- School Record Retention & Records Management: (See Resources above)
- Vermont Department of Health Immunization Regulations: (see Resources above)

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