Dear Executive Director Evans and Board Members,

The American Diabetes Association (ADA) strongly supports school nurses delegating the administration of insulin and glucagon to other school staff. The ADA would like to commend the Board for your leadership and willingness to update the current delegation rules in Idaho. The ADA asks that in the creation of the new proposed rules the Board includes a rule, an advisory opinion, or language that would clearly allow for the delegation of insulin and glucagon in the school setting. We have concerns that the way the new training requirements for Unlicensed Assistive Personnel (UAP), are being created as they are more intensive than what would be appropriate or needed for a school staff person who is a UPA. The new requirements would be prohibitive and create significant barriers in the school setting for a UAP to assist with a student with diabetes in the school setting, as you know lay people are trained to give insulin and glucagon safely every day. A clarification of delegation in the school setting would allow students with diabetes to have their diabetes medical management needs addressed in the school setting while also solidifying the role of the school nurse as the coordinator and best resource for diabetes treatment in the school setting. As is true for children with other chronic diseases, students with diabetes are more likely to succeed in school when students, parents, school nurses, principals, teachers, other school personnel, and the student’s health care providers work together to ensure effective diabetes management for optimal health and academic success.

The position of the American Diabetes Association and the diabetes medical community is that trained, unlicensed assistive personnel (UAP)’s are not making judgments when they follow a nursing care plan based on physician orders as part of the Individual Health Plan. Such UAP’s in the school setting only deliver insulin by pump or injection. The ADA also believes that a school nurse is the most appropriate person to delegate and train non-medical school staff. The practice of insulin delegation by school nurses has been successful in other states, allowing students safety and freedom to access their education and extra-curricular activities.

A school nurse is the appropriate person to delegate and train non-medical school staff. The practice of insulin and glucagon delegation has been successful in other states, allowing students safety and freedom to access their education and extra-curricular activities. The ADA would like to propose amendments to the Idaho nurse practice regulations as described below. Once adopted, we are committed to working together with the school nurses and the Department of Education to ease the implementation of these regulations, including, for example, the development and distribution of materials and training opportunities for parents, students, school nurses, and school administrators.
Background

Briefly, the fundamental problem is that it is simply not feasible to assure that a licensed professional nurse is available to respond to the 'anticipated health crises' and/or ongoing needs for injectable medications for all Idaho school children at all times they are attending school and education-related events. As the number of students with complex health care needs increase, delegation of injectables to unlicensed assistive personnel will become increasingly necessary in the school setting. Many school nurses are assigned to more than one facility; even nurses working full-time in one school could not have attended all field trips or after-school education-related activities.

As you know, the Idaho nursing scope of practice does not presently allow nurses to delegate injectable medications or PRN-controlled substances. Nonetheless, best practice identifies school nurses as the most qualified person to delegate nursing tasks in schools. School nurses are in the best position to assess the students' needs, work with health care providers and parents/guardians to develop a plan of care, collaborate with parents to identify and train delegatees, provide supervision and monitor outcomes.

We strongly encourage you to consider our recommendations and act to give school nurses a means to safely and comprehensively address the health care decisions that affect students in their schools.

Specific proposal

We recommend that the Idaho Board of Nursing include the following changes to the Idaho Administrative Code into the proposed delegation regulations:

1. The administration of insulin or glucagon may be delegated in the school or child care setting or in a long term care facility to unlicensed assistive personnel (UAPs) in accordance with the requirements of these rules. The selection of the type of insulin and dosage levels shall not be delegated.

2. The administration of insulin or glucagon may not be delegated unless:

   a) The school, child care facility or long term care facility has received a copy of orders signed by a physician which specify the timing of insulin administration and provide detailed directions for determining the appropriate dosage of insulin based on blood glucose level, carbohydrate intake and other appropriate factors. Such physician's orders shall also provide information on the timing and dosage for glucagon administration. In the school or child care setting, these orders shall be provided by the child's parent or guardian.

   b) For a child under the age of 18, the parent or guardian of the child consents in writing to the administration of insulin and/or glucagon by the Delegatee.

   c) The UAP receives appropriate training as described in this section.

3. In the school or child care setting, the orders and authorization described in subsections (2)(a) and (2)(b) shall be valid for not more than one year. Updated orders and authorization must be provided by the parent within one year or at the beginning of the following school year.
(4) Insulin administration by the UAP shall only occur when the UAP has followed the physician’s orders and any instructions from the delegating nurse.

(5) The UAP may administer insulin through insulin injections, the use of an insulin pen, the use of an insulin pump, or by any other insulin delivery means used by the individual.

(6) The UAP shall be trained by the delegating nurse or by another health care professional with expertise in diabetes. The person conducting the training shall certify in writing that the UAP has completed the training and has demonstrated competence in the tasks to be delegated. Appropriate follow up training shall be provided as necessary and at least once per year.

(7) The delegating nurse may delegate to the UAP the counting of carbohydrates or other tasks necessary for the determination of an insulin dose. Such tasks shall be performed in accordance with the physician’s orders.

(8) When the physician’s orders state that the individual is capable of self-administration, the delegating nurse may delegate to the UAP the verification of insulin dosage via pump or injection.

(9) The delegating nurse shall supervise the UAP in the administration of insulin and/or glucagon, and shall be available by telephone or electronic means to the UAP to answer questions or provide instruction.

The safety of Idaho children with diabetes will benefit from clearly stated regulations and supporting mechanisms to authorize professional oversight for insulin and glucagon injection delegation. Experience in other states demonstrates that delegation of this nursing task by school nurses can be a smooth, well-accepted process that reinforces academic success. We are committed to working together with all stakeholders to assure that children with diabetes in our state benefit from lessons learned elsewhere; we stand ready to help develop training opportunities and materials that will assure that these regulations are well-understood and followed.

As a final note, we want to express our appreciation for your thorough consideration and guidance regarding insulin and glucagon delegation by school nurses in the school setting.

If you have any questions or if the American Diabetes Association can provide any further information, please do not hesitate to contact me at 206-295-5532 or at lkeller@diabetes.org.

Sincerely,

Laura Keller
Idaho Director State Government Relations
American Diabetes Association
One School Nurse Response to American Diabetes Association (ADA) regarding care of diabetic student at school

One of the frustrations I have felt working as a school nurse has been what I feel is the disconnect between school nursing and the American Diabetes Association. This is particularly frustrating due to the fact that in my opinion we could be so much more powerful if we worked together. With that goal in mind I requested to have a representative speak at the School Nurse Organization of Idaho conference on June 17th, 2013. Rather than serving to bring together two entities that I believe both have the best interests of young students with diabetes at heart, the nurses learned that the Diabetes Association has set up meetings with the Idaho State Board of Nursing, with the intent of changing board policy that impacts school nurses and school nurses had not been invited to attend. This has prompted me to write an opinion piece based on my experience of caring for students with diabetes at school. I also have had the unique opportunity to spend an entire day in a room with representatives from the ADA and our School District (271) in exploration of the rights of a diabetic elementary student in our school district. I believe these experiences give me an understanding of care for students with diabetes in schools and an understanding of issues regarding their care that the ADA may not be aware of. I will do a point by point “School Nurse” response to the ADA “Safe at School” parent brochure that was handed out at the school nurse conference. I have added some proposals of ways that we might eventually work together for the best interests of students in the school setting.

1. Your child’s diabetes care needs should be met by trained school staff:

   - Staff members trained in monitoring blood glucose and administering insulin and glucagon should always be present

Discussion: Who will train this staff and assure that those trained know how to correctly administer the insulin and glucagon? How many should be trained at each school? What if 3 out of 3 staff who are trained in this area all “call in” the same day? (this has actually occurred at one of our schools) Who is responsible for making sure every day that there is someone there who has been “trained”? Who will come in and train new staff when a trained staff person there leaves? Who will the trained staff person be? The teacher who is already responsible for 29 other students? Do staff members have a right to refuse to take on this huge responsibility? Can schools (or the ADA) actually require non-medical staff to take on these responsibilities? Who decides who is qualified? (It is unfortunate but we have found that many times adults willing to take on a responsibility of this nature are only willing to do so because they really don’t realize how serious it can be and they have a big heart), those who are “in the know” will frequently refuse.) If the State Board of Nursing changes the delegation piece will schools such as ours who are offering a higher level of care be required to “lower our standards”?

Comment: In our district we have “regional schools” that have a nurse on staff every day all day to care for these students. No one has to come in and train them. The nurse is familiar with the student and the student with the nurse. If the nurse calls in sick the “lead nurse” assigns a nurse to the school (who has been oriented to the school). If there is not another nurse available the lead nurse takes responsibility to make sure the parents have been notified that there is no one to care for their child at school (this has occurred only once in the years we have had regional schools!). It is important to note...
here that in CDA parents are given a choice. They may choose to send their child to a regional school that provides nursing care all day every day or they may choose to keep their child in a non-regional school where they take more responsibility for the care of their child. On occasion the parents choose to stay at their “home school” even if it is non-regional. The other side is that we frequently have parents call to ask “which school has the nurse” when their child is diagnosed or they are moving into district. We also have had “out of district” parents who transport their students to a school where there is a full time nurse.

- All staff members who regularly work with your child should recognize the warning signs of low and high blood glucose (hypoglycemia and hyperglycemia) and know how to get help.

**Discussion:** Of course this already done at all schools. Nurses review this with everyone they know will “regularly” be in contact with the student. How often does the teacher have time to check on the student with diabetes? Who is responsible for when the student goes to “switch” or in with another teacher for a portion of their class? What about substitute teachers called in at the last minute? Who will train that person to observe for those “subtle” signs? Who “trains” parent playground aides and crossing guards?

**Comment:** At regional schools the nurse is always available for these students. If the teacher or person in charge “misses something” the nurse does not. The children are safe and their rights under the law are protected. The nurse is continuously “teaching” the student how to best care for themselves. Usually by the time the student reaches 5th or 6th grade they can confidently care for themselves.

- School staff should provide care during before and after school activities, sports, and field trips. You should not have to attend

**Discussion:** This is done already done at our regional schools. Who should be required to attend these before and after school activities? Which of the 3 or so persons trained at the school? Who will identify this? Should the coaches many who are parent volunteers be expected to take on this responsibility? At times if a nurse at a regional school has more than one diabetic student we provide a nurse for a field trip and one for the care of the rest of the diabetic students at the school.

**Comment:** It is “easy” to say what “should” be done, it is much more complicated to take responsibility and actually assure that appropriate care is given.

- Diabetes care should be provided at the school your child would attend if he or she did not have diabetes

**Discussion:** We agree but the problem is, who will provide that care? As mentioned above training of unlicensed personal is cumbersome at best. Is the delegation of life threatening or life saving medications to someone who is not licensed and without background knowledge really in the best interests of what often are very young students who may not even yet know how to identify if they are hypo or hyperglycemic? The Idaho State Board of Nursing as an entity is set up to protect the public
from those who would seek to compromise the care of the citizens of Idaho. This is done because not everyone has the training and expertise necessary to provide all levels of care for some conditions. I have heard representatives from the ADA say that “parents can learn” so “others can learn”. I agree but I also respectfully ask you to acknowledge that parents have a personal and vested interest in that child and they learn what they do through years of caring for that child. The nurses at regional schools frequently assist the parents with this learning curve. I encourage representatives from the ADA to spend an entire day with a nurse at a regional school in our district to get a very realistic picture of the challenges these students face!

Comment: Perhaps the answer here would be to realize that these students do have rights and that would best be provided by having a nurse at every school!

2. School policies should be modified for your child so he or she is allowed to:

In this section the ADA lists what we do as a matter of course in schools in our district. It addresses such things as being allowed to check glucose in the classroom, eating whenever necessary, taking extra trips to the bathroom, postponing academic testing until blood glucoses are in an acceptable range and being excused for absences due to appointments and diabetes related illness. These things are easy. What is not addressed is not so easy:

- What if the child in the classroom “feels low” and due to that fact either doesn’t make the correct decision to test or can’t test. I once walked into a classroom (sub teacher in for the day) and asked student with diabetes how he was doing. He looked up at me and said “42”. I asked him if that was his blood sugar and he again stated “42”. Of course I treated him, I dread to think what would have happened to him had I not been in the habit of checking on him frequently and on a schedule based on his individual needs.
- If three or more adults in a building are responsible for a student it is likely that at any given time those adults will not be in the classroom with the student. That works with a nurse in charge because he/she schedules visits into their day (this can change from day to day based on a nurse’s knowledge regarding individual student changes due to increased/decreased activity, hormonal influences, food changes in the classroom, class schedule changes etc.) The “trained” adult frequently may be called away for other duties or responsibilities. If they are going to be at the school all day with only the responsibility of caring for the diabetic student why not just have a nurse there? The primary responsibility of the nurse is to care for the students with diabetes but they can also care for the medical needs of other students and frequently do so.
- At one point we examined the care of students at the school where there was not a nurse and it is not unusual for the office staff (who must remain in the office) to be one of those responsible for the care of the diabetic student. This in some cases translated to the student with diabetes missing as much as 50% of their class time because they were in the office due to the need to have treatment for low or high blood sugars. Is that really protecting their rights? At regional schools the nurse goes to the student.
The student misses very little if any class time. This is the BEST way to protect the rights of the student with diabetes, which are protected under the 504 law.

- I believe students who have a nurse caring for them at school miss fewer days and have more stable blood sugars. We will continue to follow this in CDA but we are finding that students A1C levels are better during the school year than during the summer. This translates to "years" being added to these precious student's lives. Add to that what they are being taught daily with regard to self care by the nurses and we as a society will save much more in the long run than what would be spent by having a nurse at the school.

Please consider what I have written, at the very least we must all be at the table and the voice of the school nurse must be heard. We are the ones that work with these students every day. It is easy to write about "rights" it is much more difficult to assure that "rights" are actually and realistically provided. We also request that in the future if decisions regarding the health care of students in schools are being discussed that a SNOI representative always be invited to the discussion.

Thoughts and Proposals

I am not sure what the ADA is proposing in Idaho because we were not given that information but some ideas I have are: (of course some of these might require parent approval)

1. School nurses and the ADA work to put together a plan based on the specific needs of individual students. This might mean that some very young, newly diagnosed or developmentally delayed students would always have access to a school nurse. It could also mean that the ADA would help take responsibility for older students or students who were diagnosed very young and have been identified as no longer needing the services of a school nurse. This would provide different levels of care for individual students based on individual need.

2. Most students eventually learn to administer their own insulin. They learn to count carbohydrates and calculate doses based on their own blood sugars and activity levels. They also learn how to treat themselves based on whether they are hyper or hypoglycemic and many times just need some adult verification. This means that an adult overseeing their care is more than enough. The ADA could assist with the training and oversight of these designated adults and the students they are caring for.

3. The ADA would be invited to attend the 504 and IEP meetings of the students involved who have diabetes and give input and direction. This would give the ADA firsthand knowledge of the challenges of each individual student's day at school and allow for their input.

4. Since it appears that the ADA is attempting to re define and relegate how nursing practice is defined perhaps it is not unreasonable to request that the ADA utilize some of its resources to identify and train unlicensed personal in schools to administer insulin. This would take it out of the hands of the school nurse and allow the ADA to take full responsibility in the school setting for students with diabetes who may require insulin and cannot self administer. This might be an ideal solution for Idaho school districts that do not have a school nurse at all. (I know it "seems like" we are trying to define their practice but isn't that what they are trying to do to us?)
5. If we decide a student needs a nurse at school they should have a nurse at school. Hospitals are required to have minimal nursing staff for the safety of their patients. Small children in Idaho unable to care for themselves must be afforded the same rights.

6. If after collaboration a student if found to NOT have the need for a nurse at the school all day every day (and there are many!) the ADA could take over the responsibility for the training, education, before and after school activities, field trips, etc. that require some planning and forethought. This would be a huge relief to the nurses who are already short staffed. Perhaps at times the ADA could even provide some staffing to schools that are already in budget crunches! This would be an ideal way for school nurses and the ADA to partner for much needed services to vulnerable students in the school setting. I would love to be part of a partnership team to work in this area.
Hello,
My name is Nancy Malmberg. I have just retired from a 25 year position as a school nurse in Homedale, Idaho. I was the only R.N. at school with no other nursing help, no aides, etc. I worked with students K-12, including severe and profoundly handicapped students. I have managed many diabetic students at school, from kindergarten to high school. I cannot stress enough that diabetic students need an R.N. (school nurse) who manages care at school and who directly supervises students who are able to do self care.

It is absolutely imperative that a professional R.N. see and evaluate diabetic students several times daily. Very young students who MAY be able to perform their own blood sugar are unable to carry out (safely) the measurement of insulin and the counting of carbs that go along with the blood sugar "number".

Those young students are in need of a professional evaluation. This would involve NURSING ASSESSMENT done regularly during the day.

Older students who are mechanically able to do the blood sugar check and then inject insulin are ALWAYS in need of professional supervision at school. If they are too high or too low, they cannot make a good decision and need professional help. I have had students at school with a bg of over 600 and there is no parent to contact, in that case an R.N. who knows the student and is at school on site is extremely important. An EMT could be called, but he/she knows nothing about the student, what the student may have eaten, what the bg was at breakfast time, has the student been ill, etc.

Those of us (R.N.) who have worked closely with these students know that the older students are very often tempted to alter pump settings so that they can binge on carbs. IT HAPPENS. Only a professional nurse on the spot would be able to access the situation and ask the right questions as well as doing a professional assessment. I have been in many situations over the years when a non-R.N. school employee made a terrible decision when trying to "help" (without my knowledge) a student who was out of control. Even volunteer Quick Response personnel are not qualified to make a professional nursing assessment of a student when the QRU staff have no baseline on that student and know nothing of the student's "normal" demeanor.

My 25 years of school nursing experience tells me that, although many school administrators do not understand this, ONLY an R.N. should follow and assist with management of diabetic students at school.

I think that the ADA is completely wrong in attempting to change these rules regarding who may inject insulin at school. It is not only the injection, it is knowing what kind of insulin, why, when, and then following the student to be safe. THIS REQUIRES A PROFESSIONAL ASSESSMENT. The ADA is trying to prove some kind of point, I don't know why. I sat through a meeting with them at school a few years ago. I was not impressed with the ADA position. Our school decided that they would not follow ADA recommendations. The position of the ADA was that I (as the R.N. in charge) should be required to "train" a non-licensed person to do insulin injections and manage diabetic students at school. I refused to do so. I hope all R.N.'s in a school setting understand that the ADA position puts us and our patients in a very dangerous (and I believe unprofessional, illegal) position.

Sincerely,
Nancy Malmberg, R.N.
Thank you for your comments, Julie. They will be shared with the members of the Board of Nursing at their meeting on July 18, 2013.

Sandra Evans, MAEd, RN, Executive Director
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From: Walker, Julie [mailto:jwalker@slhs.org]
Sent: Friday, July 12, 2013 9:28 AM
To: Sandra Evans
Subject: Safe at School

I am in support of the school nurse delegating the duties of diabetes management in the school, specifically the medication administration, blood glucose monitoring and treatment of hypoglycemia, to trained non medical school personnel. Currently, if no school nurse is available, the parent or family member is required to go to the school to perform these duties, which causes significant hardship and in some cases is impossible to accomplish. The Safe at School law would allow children with diabetes and their families a safe environment and equal educational opportunities.

Children with Type 1 diabetes need timely treatment to address a disease that is constantly changing and being delayed due to no delegated trained person being readily available and can result in unnecessary discomfort to the child and loss of quality education time.