

(Writing an) Individualized Healthcare Plan for a Student with Diabetes

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Public Instruction
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Learning Objectives

1

Apply professional standards to writing an IHP for a student with diabetes.

2

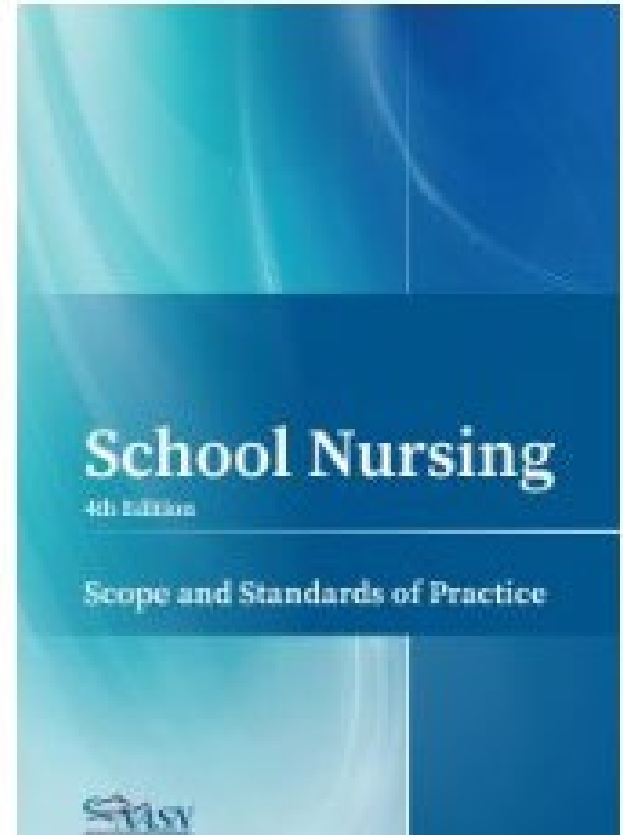
Distinguish between the purpose and content of an Emergency Action Plan (EAP), Diabetes Medical Management Plan (DMMP) and Individualized HealthCare Plan (IHP)

3

Compose an IHP for a student with diabetes

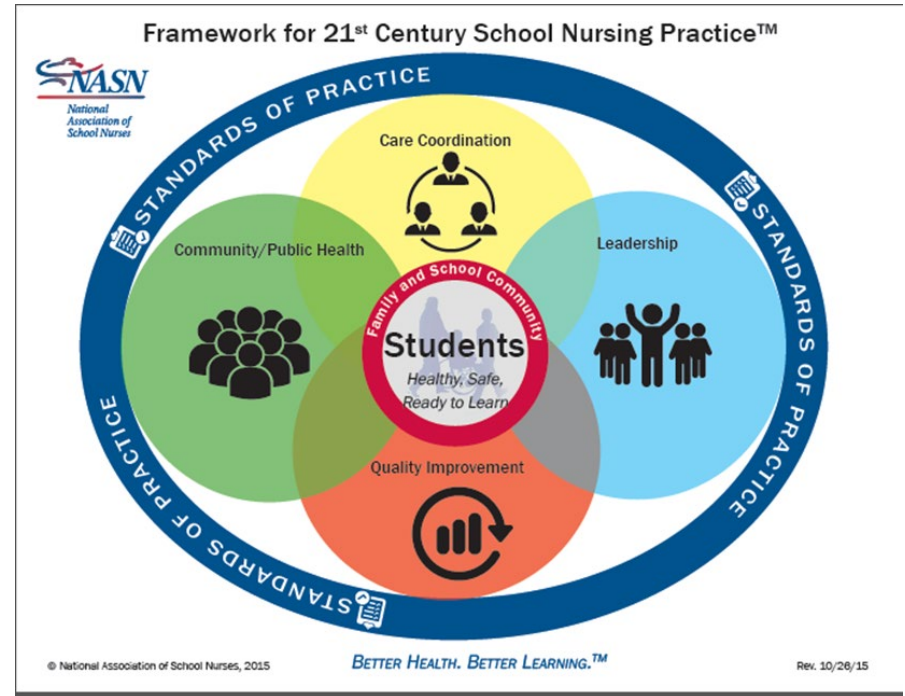
IHP – Individualized Health Plan

Nursing process is the cornerstone of nursing practice and applicable to all areas of nursing including school nursing. The IHP provides a format to record each step of the nursing process.



Professional Standards and IHPs

National Association of School Nurses [NASN]. (2016). Framework for 21st century school nursing practice: National Association of School Nurses. NASN School Nurse, 31(1), 45-53. doi: 10.1177/1942602X15618644





Use of Individualized Healthcare Plans to Support School Health Services

Position Statement

NASN POSITION

It is the position of the National Association of School Nurses (NASN) that the registered professional school nurse (hereinafter referred to as school nurse) initiates and develops an Individualized Healthcare Plan (IHP) for students whose healthcare needs require more complex school nursing services. An IHP is a plan of care written by the registered nurse for students with or at risk for physical or mental health needs (ANA & NASN, 2017). It is the responsibility of the school nurse to annually evaluate the IHP, as well as to update the plan if deemed appropriate, to reflect changes in the student's healthcare needs and address nursing interventions and/or student healthcare outcomes.

BACKGROUND AND RATIONALE

Professional Standards and IHPs

- <https://www.nasn.org/nasn-resources/professional-practice-documents/position-statements/ps-ihps>

Individualized Healthcare Plans

- Foundational document from which other health information flows to other plans
- Uses and documents Nursing Process
- Documentation of student health needs
- (Professional) Nursing care to be provided to meet needs
- Plan to evaluate the outcome of this care

Individualized Healthcare Plans

- IHP's also provide information for the delegation and determining of staffing needs in each school.
- IHP's may or may not be part of IEP process or 504 Plans.
- IHP designed to be stand alone document.

Grade: _____

Health Care Provider: _____

By: _____

Date Reviewed: _____

By: _____

Circle areas of concern: Medical management, dental management, safety, vital functions, elimination, mobility, rest, comfort.

NURSING ASSESSMENT	NURSING DIAGNOSIS	NURSING INTERVENTIONS The school nurse will:	EVALUATION Student Outcome- The student will:

Emergency Action Plan (EAP) - Goal

Maintenance of student's health and safety in an anticipated life-threatening emergency.



EAP – Emergency Action Plan

- Information regarding child's medical condition
- Current and emergency medications
- Appropriate emergency interventions
- Logical step by step order
- Understood by individuals with limited nursing/medical knowledge
- Shared with appropriate building staff

Sample Emergency Action Plan

EMERGENCY ACTION PLAN

Name: _____ DOB: _____
 Address: _____
 School: _____
 Parents/guardians: _____
 Grade: _____

Healthcare Provider: _____

Health Concern:	
If found unconscious/unresponsive, call EMS, initiate CPR Use AED	
IF YOU SEE THIS:	Do This:
Trained Staff Members:	
Emergency Medication Location:	

I was involved in the planning of, and/or agree with, the procedures identified in the above plan. I give permission for this information to be shared with appropriate staff at school.

School Nurse _____ Date _____ Parent _____ Date _____

In case of emergency transport this sheet should accompany student.

DIABETES EMERGENCY PLAN

Student: _____ School: _____

- SIGNS AND SYMPTOMS OF LOW BLOOD SUGAR:**
- Hunger
 - Shakiness, weakness
 - Perspiration
 - Confusion, disorientation
 - Drowsiness, "falling asleep"
 - Headache
 - Paleness
 - Poor coordination
 - Irritability
 - Dizziness, vision disturbances

Fast Acting Glucose Snacks

Juice box 1/2 cup regular pop or soda (not diet)
 3 or 4 glucose tablets 6 or 7 lifesaver candies

Action

- If student complains or signs of low blood sugar noted provide fast acting glucose snack (juice box or 4 glucose tabs preferable).
- May need to squeeze juice box to "force juice in student's mouth." Encourage swallowing. If juice not available, may use other fast acting glucose source. Call for diabetic-trained staff. **DO NOT SEND TO OFFICE WITHOUT ESCORT.**


Action

- If student unconscious or unable to swallow glucose source **CALL 8-911.**
- Call diabetic trained staff member, call school nurse, call parent.
- **DISCONNECT TUBING FROM INSULIN PUMP. Have Glucagon available for trained personnel to administer. Turn student on their side.**

DIABETIC TRAINED STAFF: _____

GLUCAGON LOCATED: _____

Diabetes Medical Management Plan (DMMP)



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Safe at School

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Diabetes Medical Management Plan

SCHOOL YEAR: _____ (Add student photo here)

STUDENT LAST NAME: _____ FIRST NAME: _____ DOB: _____

PARENTS/GUARDIANS: Please complete page 1 and 2 of this form and approve the final plan on page 6.

1. DEMOGRAPHIC INFORMATION – PARENT/GUARDIAN TO COMPLETE

Student First Name: _____ Last Name: _____ DOB: _____ Student's Cell #: _____ Diabetes Type: _____ Date Diagnosed: _____
Month: _____ Year: _____

School Name: _____ School Phone #: _____ School Fax #: _____ Grade: _____

Home Room: _____ School Point of Contact: _____ Contact Phone #: _____

STUDENT'S SCHEDULE Arrival Time: _____ Dismissal Time: _____

Travels to school by (check all that apply):	Meals Times:	Physical Activity:	Travels to:
<input type="checkbox"/> Foot/Bicycle	<input type="checkbox"/> Breakfast _____	<input type="checkbox"/> Gym _____	<input type="checkbox"/> Home <input type="checkbox"/> After School Program
<input type="checkbox"/> Car	<input type="checkbox"/> AM Snack _____	<input type="checkbox"/> Recess _____	Vis: <input type="checkbox"/> Foot/Bicycle
<input type="checkbox"/> Bus	<input type="checkbox"/> Lunch _____	<input type="checkbox"/> Sports _____	<input type="checkbox"/> Car
<input type="checkbox"/> Attends Before School Program	<input type="checkbox"/> PM Snack _____	<input type="checkbox"/> Additional information: _____	<input type="checkbox"/> Student Driver
	<input type="checkbox"/> Pre Dismissal Snack _____		<input type="checkbox"/> Bus

Parent/Guardian #1 (contact first): _____ Relationship: _____ Parent/Guardian #2: _____ Relationship: _____

Cell #: _____ Home #: _____ Work #: _____ Cell #: _____ Home #: _____ Work #: _____

E-mail Address: _____ E-mail Address: _____


Indicate preferred contact method: _____ Indicate preferred contact method: _____

2. NECESSARY SUPPLIES / DISASTER PLANNING / EXTENDED FIELD TRIPS

- A 3-day minimum of the following Diabetes Management Supplies should be provided by the parent/guardian and accessible for the care of the student at all times.

• Insulin	Meter with test strips, lancets, extra battery – required for all Continuous Glucose Monitor (CGM) users	Cartridge, extra Battery/Charging Cord if applicable
• Syringes/Pen Needles	• Treatment for lows and snacks	• Additional supplies:
• Ketone Strips	• Antiseptic Wipes	
• Glucon	• Pump Supplies (Infusion Set)	
• Blood Glucose (BG)		
- View Disaster/Emergency Planning details – refer to Safe at School Guide
- Please review expiration dates and quantities monthly and replace items prior to expiration date.
- In the event of a disaster or extended field trip, a school nurse or other designated personnel will take student's diabetes supplies and medications to student's location.

Name of Health Care Provider/Clinic: _____ Contact #: _____ Fax #: _____
Email Address (non-essential communication): _____ Other: _____



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Safe at School Diabetes Medical Management Plan

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STUDENT LAST NAME: _____ FIRST NAME: _____ DOB: _____

3. SELF-MANAGEMENT SKILLS (DEFINITIONS BELOW)

	Full Support	Supervision	Self-Care
Glucose Monitoring: Meter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CGM <input type="checkbox"/> (Requires Calibration)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carbohydrate Counting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insulin Administration: Syringe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can Calculate Insulin Doses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glucose Management: Low Glucose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Glucose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Self-Carry Diabetes Supplies: Yes No Please specify item: _____

Smart Phone: Yes No

Device Independence: CGM Interpretation & Alarm Management Sensor Insertion Calibration Insulin Pumps Bolus Connects/Disconnects Temp Basal Adjustment Interpretation & Alarm Management Site Insertion Cartridge Change

Full Support: All care performed by school nurse and trained staff (as permitted by state law).
Supervision: Trained staff to assist & supervise. Guide & encourage independence.
Self-Care: Manages diabetes independently. Support is provided upon request and as needed.

4. STUDENT RECOGNITION OF HIGH OR LOW GLUCOSE SYMPTOMS (CHECK ALL THAT APPLY)

Symptoms of High: Thirsty Frequent Urination Fatigued/Tired/Drowsy Headache Blurred Vision Warm/Dry/Flushed Skin Abdominal Discomfort Nausea/Vomiting Fruity Breath Unaware Other: _____

Symptoms of Low: None Hungry Shaky Pale Sweaty Tired/Sleepy Tearful/Crying Dizzy/Intimate Unable to Concentrate Confusion Personality Changes Other: _____

Has student lost consciousness, experienced a seizure or required Glucagon: Yes No If yes, date of last event: _____

Has student been admitted for DKA after diagnosis: Yes No If yes, date of last event: _____

5. GLUCOSE MONITORING AT SCHOOL

Monitor Glucose: Before Meals With Physical Complaints/Illness (Include ketone testing) High or Low Glucose Symptoms Before Exams Before Physical Activity After Physical Activity Before Leaving School Other: _____

CONTINUOUS GLUCOSE MONITORING (CGM)

(Specify Brand & Model: _____)

Specify Wearing Equipment: Device Reader Smart Phone Insulin Pump Smart Watch iPod/iPad/Tablet

CGM is remotely monitored by parent/guardian. Document individualized communication plan in Section 604 or other plan to minimize interruptions for the student.

May use CGM for monitoring/treatment/insulin dosing unless symptoms do not match reading.

CGM Alerts:

Low alarm _____ mg/dL

High alarm _____ mg/dL if applicable

Section 1-5 completed by Parent/Guardian

Please:

- Permit student access to viewing device at all times
- Permit access to School Wi-Fi for sensor data collection and data sharing
- Do not discard transmitter if sensor falls

Perform finger stick it:

- Glucose reading is below _____ mg/dL or above _____ mg/dL
- If CGM is still reading below _____ mg/dL (DEFAULT 70 mg/dL) 15 minutes following low treatment
- CGM sensor is dislodged or sensor reading is unavailable (see CGM agenda for more information)
- Sensor readings are inconsistent or in the presence of alerts/alerts
- Dexcom does not have both a number and arrow present
- Libre displays Check Blood Glucose Symbol
- Using Medtronic system with Guardian sensor

Notify parent/guardian if glucose is:

below _____ mg/dL (<55 mg/dL DEFAULT)

above _____ mg/dL (>300 mg/dL DEFAULT)

Name of Health Care Provider/Clinic: _____ Contact #: _____ Fax #: _____
Email Address (non-essential communication): _____ Other: _____

<https://diabetes.org/sites/default/files/2022-11/DMMP-updated-11-11-22.pdf>

Diabetes Medical Management Plan (DMMP)

STUDENT LAST NAME: _____ FIRST NAME: _____ DOB: _____

6. INSULIN DOSES AT SCHOOL - HEALTHCARE PROVIDER TO COMPLETE

Insulin Administered Via:
 Syringe Whole Units Half Units Insulin Pump (Specify Brand & Model: _____)
 Port Smart Pen Insulin Pump is using Automated Insulin Delivery (automatic dosing) using an FDA-approved device
 Other Insulin Pump is using DIY Looping Technology (child/parent manages device independently, nurse will assist with all other diabetes management)

DOSING to be determined by Bolus Calculator in insulin pump or smart pen/meter unless moderate or large ketones are present or in the event of device failure (provide insulin via injection using dosing table in section 6A).

Insulin Administration Guidelines
 Insulin Delivery Timing: Pre-meal insulin delivery is important in maintaining good glucose control. Late or partial doses are used with students that demonstrate unpredictable eating patterns or refuse food. Provide substitution carbohydrates when student does not complete their meal.

Prior to Meal (DEFAULT)
 After Meal as soon as possible and within 30 minutes
 Snacking avoid snacking _____ hours (DEFAULT 2 hours) before and after meals

Partial Dose Prior to Meal: (preferred for unpredictable eating patterns using insulin pump therapy)
 Calculate meal dose using _____ grams of carbohydrate prior to the meal
 Follow meal with remainder of grams of carbohydrate (may not be necessary with advanced hybrid pump therapy)
 May advance to Prior to Meal when student demonstrates consistent eating patterns.

For injections, Calculate Insulin Dose To The Nearest:
 Half Unit (round down for < 0.25 or < 0.75 and round up for > 0.25 or > 0.75)
 Whole Unit (round down for < 0.5 and round up for > 0.5)

Supplemental Insulin Orders:
 Check for KETONES before administering insulin dose if BG > _____ mg/dL (DEFAULT >300 mg/dL or >250 mg/dL on insulin pump) or if student complains of physical symptoms. Refer to section 8 for high blood glucose management information.
 Parents/guardians are authorized to adjust insulin dose +/- _____ units
 Insulin dose +/- _____ units
 Insulin dose +/- _____ %
 Insulin to Carb Ratio +/- _____ grams/units
 Insulin Factor +/- _____ mg/dL/unit

Additional guidance on parent adjustments:

Name of Health Care Provider/Clinic: _____ Contact #: _____ Fax #: _____
 Email Address (non-essential communication): _____ Other: _____

STUDENT LAST NAME: _____ FIRST NAME: _____ DOB: _____

6A. DOSING TABLE - HEALTHCARE PROVIDER TO COMPLETE - SINGLE PAGE UPDATE ORDER FORM

Insulin: (administered for food and/or correction)
 Rapid Acting Insulin: Humalog/Admelog (Lispro), Novolog (Aspart), Apidra (Glulisine) Other: _____
 Ultra Rapid Acting Insulin: Fiasp (Aspart) Lyumjev (Lispro-asbc) Other: _____
 Other insulin: Humulin R Novolin R

Meal & Times	Food Dose		Glucose Correction Dose		PE/Activity Day Dose
	I Carbohydrate Ratio: Total Grams of Carbohydrate divided by Carbohydrate Ratio = Carbohydrate Dose	II Fixed Meal Dose	I Use Formula See Sliding Scale 6B Formula: (Pre-Meal Glucose Reading minus Target Glucose) divided by Correction Factor = Correction Dose	II See Sliding Scale 6B May give Correction dose every _____ hours as needed (DEFAULT 3 hours)	
<input type="checkbox"/> Breakfast	Breakfast Carb Ratio = _____ g/unit	Breakfast _____ units	Target Glucose is: _____ mg/dL & Correction Factor is: _____ mg/dL/unit	<input type="checkbox"/> No Correction dose	Carb Ratio _____ g/unit Subtract _____ % Subtract _____ units
<input type="checkbox"/> I AM Snack	AM Snack Carb Ratio = _____ g/unit	AM Snack _____ units	Target Glucose is: _____ mg/dL & Correction Factor is: _____ mg/dL/unit	<input type="checkbox"/> No Correction dose	Carb Ratio _____ g/unit Subtract _____ % Subtract _____ units
<input type="checkbox"/> Lunch	Lunch Carb Ratio = _____ g/unit	Lunch _____ units	Target Glucose is: _____ mg/dL & Correction Factor is: _____ mg/dL/unit	<input type="checkbox"/> No Correction dose	Carb Ratio _____ g/unit Subtract _____ % Subtract _____ units
<input type="checkbox"/> I PM Snack	PM Snack Carb Ratio = _____ g/unit	PM Snack _____ units	Target Glucose is: _____ mg/dL & Correction Factor is: _____ mg/dL/unit	<input type="checkbox"/> No Correction dose	Carb Ratio _____ g/unit Subtract _____ % Subtract _____ units
<input type="checkbox"/> Dinner	Dinner Carb Ratio = _____ g/unit	Dinner _____ units	Target Glucose is: _____ mg/dL & Correction Factor is: _____ mg/dL/unit	<input type="checkbox"/> No Correction dose	Carb Ratio _____ g/unit Subtract _____ % Subtract _____ units

6B. CORRECTION SLIDING SCALE
 Meals Only Meals and Snacks Every _____ hours as needed
 _____ mg/dL = _____ units to _____ mg/dL = _____ units
 _____ mg/dL = _____ units to _____ mg/dL = _____ units
 _____ mg/dL = _____ units to _____ mg/dL = _____ units

6C. LONG ACTING INSULIN
 Lantus, Basaglar, Toujeo (Sargline) _____ units
 Levemir (Detemir) _____ units Daily Dose _____ units
 Tresiba (Degludec) _____ units Overnight Field Trip Dose _____ units
 Other _____ units Disaster/Emergency Dose _____ units
 Subcutaneously

6D. OTHER MEDICATIONS
 Metformin _____ units Daily Dose _____ units
 Other _____ units Overnight Field Trip Dose _____ units
 Disaster/Emergency Dose _____ units
 Route _____

Signatures is required here if sending ONLY this one-page dosing update.
 Diabetes Provider Signatures: _____ Date: _____

Name of Health Care Provider/Clinic: _____ Contact #: _____ Fax #: _____
 Email Address (non-essential communication): _____ Other: _____

<https://diabetes.org/sites/default/files/2022-11/DMMP-updated-11-11-22.pdf>

Diabetes Medical Management Plan (DMMP)

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STUDENT LAST NAME: _____ FIRST NAME: _____ DOB: _____

7. LOW GLUCOSE PREVENTION (HYPOGLYCEMIA)

Allow Early Interventions

Allow Mini-Dosing of carbohydrate (i.e., 1-2 glucose tablets) when low glucose is predicted, sensor readings are dropping (down arrow) at _____ mg/dL (DEFAULT 80 mg/dL, prior to exercise) or with symptoms.

Allow student to carry and consume snacks. School staff to administer

Allow Trained Staff/Parent/Guardian to adjust mini dosing and snacking amounts (DEFAULT)

Insulin Management (Insulin Pumps)

Temporary Basal Rate Initiate pre-programmed rate as indicated below to avoid or treat hypoglycemia.

Pre-programmed Temporary Basal Rate Named _____ (Omnipod)

Temp Target (Medtronic) Exercise Activity Setting (Tandem) Activity Feature (Omnipod 5)

Start _____ minutes prior to exercise for _____ minutes duration (DEFAULT 1 hour prior, during, and 2 hours following exercise).

Initiated by: Student Trained School Staff School Nurse

May disconnect and suspend insulin pump up to _____ minutes (DEFAULT 60 minutes) to avoid hypoglycemia, personal injury with certain physical activities or damage to the device (keep in a cool and clean location away from direct sunlight).

Exercise (Exercise is a very important part of diabetes management and should always be encouraged and facilitated).

Exercise Glucose Monitoring

prior to exercise every 90 minutes during extended exercise following exercise with symptoms

Delay exercise if glucose is < _____ mg/dL (120 mg/dL DEFAULT)

Pre-Exercise Routine

Fixed Snacks: Provide _____ grams of carbohydrate prior to physical activity if glucose < _____ mg/dL

Added Carbs: If glucose is < _____ mg/dL (120 DEFAULT) give _____ grams of carbohydrates (15 DEFAULT)

TEMPORARY BASAL RATE as indicated above

Encourage and provide access to water for hydration, carbohydrates to treat/prevent hypoglycemia, and bathroom privileges during physical activity

8. LOW GLUCOSE MANAGEMENT (HYPOGLYCEMIA)

Low Glucose below _____ mg/dL (below 70 mg/dL DEFAULT) or below _____ mg/dL before/during exercise (DEFAULT is < 120 mg/dL)

1. If student is awake and able to swallow give _____ grams of fast acting carbohydrate (DEFAULT 15 grams). Examples include 4 ounces of juice or regular soda, 4 glucose tabs, 1 small tube glucose gel.

School nurse/parent may change amount given

2. Check blood glucose every 15 minutes and re-treat until glucose > _____ mg/dL (DEFAULT is 80 mg/dL or 120 mg/dL before exercise).

SEVERE LOW GLUCOSE (unconscious, seizure, or unable to swallow)

Administer Glucagon, position student on their side and monitor for vomiting, call 911 and notify parent/guardian. If BG meter is available, confirm hypoglycemia via BG fingerstick. Do not delay treatment if meter is not immediately available. If wearing an insulin pump, place pump in suspend/stop mode or disconnect tubing from infusion site. Keep pump with student.

Gvoke PFS (prefilled syringe) by SC Injection 0.5 mg 1.0 mg

Gvoke HypoPen (auto-injector) by SC Injection 0.5 mg 1.0 mg

Gvoke Kit (ready to use vial and syringe, 1mg/0.2 mL) by SC Injection

Zegalogue (dasiglucagon) 0.5 mg SC by Auto-Injector Zegalogue (dasiglucagon) 0.6 mg SC by Pre-Filled Syringe

Baqsimi Nasal Glucagon 3 mg

Name of Health Care Provider/Clinic: _____ Contact #: _____ Fax #: _____
 Email Address (non-essential communication): _____ Other: _____

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STUDENT LAST NAME: _____ FIRST NAME: _____ DOB: _____

9. HIGH GLUCOSE MANAGEMENT (HYPERGLYCEMIA)

Management of High Glucose over _____ mg/dL (Default is 300 mg/dL OR 250 mg/dL if on an insulin pump).

1. Provide and encourage consumption of water or sugar-free fluids. Give 4-8 ounces of water every 90 minutes. May consume fluids in classroom. Allow frequent bathroom privileges.

2. Check for Ketones (before giving insulin correction)

a. If Trace or Small Urine Ketones (0.1 – 0.5 mmol/L, if measured in blood)

- Consider insulin correction dose. Refer to the "Correction Dose" Section 6.A-B. For designated times correction insulin may be given.
- Can return to class and PE unless symptomatic
- Recheck glucose and ketones in 2 hours

b. If Moderate or Large Urine Ketones (0.5 – 1.4 mmol/L or >1.5 mmol/L blood ketones). This may be serious and requires action.

- Contact parent/guardian or, if unavailable, healthcare provider
- Administer correction dose via injection. If using Automated Insulin Delivery contact parent/provider about turning off automatic pump features. Refer to the "Blood Glucose Correction Dose" Section 6.A-B
- If using insulin pump change infusion site/cartridge or use injections until diazepam.
- No physical activity until ketones have cleared
- Report nausea, vomiting, and abdominal pain to parent/guardian to take student home.
- Call 911 if changes in mental status and labored breathing are present and notify parent/guardian.

Send student's diabetes log to Health Care Provider (include details): If pre-meal blood glucose is below 70 mg/dL or above 240 mg/dL more than 3 times per week or you have any other concerns.

SIGNATURES

This Diabetes Medical Management Plan has been approved by:

Student's Physician/Health Care Provider: _____ Date: _____

I, (parent/guardian) _____ give permission to the school nurse or another qualified health care professional or trained diabetes personnel of (school) _____ to perform and carry out the diabetes care tasks as outlined in this Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the school nurse or another qualified health care professional to collaborate with my child's physician/health care provider.

Acknowledged and received by: _____ **Acknowledged and received by:** _____
 Student's Parent/Guardian: _____ Date: _____ School Nurse or Designee: _____ Date: _____

Name of Health Care Provider/Clinic: _____ Contact #: _____ Fax #: _____
 Email Address (non-essential communication): _____ Other: _____

<https://diabetes.org/sites/default/files/2022-11/DMMP-updated-11-11-22.pdf>

How to write - IHPs

- Use Nursing Process
- Document Nursing Process
- Use Standardized Nursing Language
- Use templates

Will, I. S., Arnold, M.W., & Zaiger, D. S. (Eds.), Individualized healthcare plans for the school nurse: A comprehensive resource for school nursing management of health conditions (2nd ed.) Forest Lake, MN: Sunrise River Press.

[NASN SchoolNurseNet](#) seek examples from other school nurses (make sure they are IHPs and not student health plans)

IHP Components:

Assess

Plan - Diagnosis

Implement – Intervention

Evaluate – Student Outcome

How to Write an IHP

- Determine what Assessments you would make.
- What are possible nursing Diagnoses?
- What nursing Interventions would you use ?
- What are your Goals or expected Outcomes for your student?

SAMPLE Individual Health Care Plan (IHP)

Page ____ of ____

For health needs that may result in an emergency and/or need management or monitoring.


Student Name: _____ Medical Diagnosis: _____ Part of IEP: Yes No
School: _____ Date Initiated: _____
Grade: _____ Health Care Provider: _____ By: _____

Date Reviewed: _____
By: _____

Circle areas of concern: Medical management, dental management, safety, vital functions, elimination, mobility, rest, comfort.

NURSING ASSESSMENT	NURSING DIAGNOSIS	NURSING INTERVENTIONS The school nurse will:	EVALUATION Student Outcomes- The student will:
		1.	


Assessments

- **History**
 - **Current status**
 - **Self-care**
 - **Psychosocial and cultural**
 - **Academic/school modifications**
- 

Possible Nursing Diagnoses for Type 1 Diabetes

- Risk for unstable blood glucose due to...
- Knowledge deficit related to...
- Ineffective coping related to...
- Ineffective therapeutic regimen management

Interventions

- **Coordinate and implement the DMMP in collaboration with student, family, healthcare team and school staff.**
 - **Develop EAP/train staff**
 - **Delegate care to staff**
 - **Provide health education to staff/classmates**
- 

Outcomes/Goals

Student will...

- Recognize the symptoms or high or low glucose levels and respond appropriately
- Demonstrate age-appropriate proper use of BS testing equipment or monitoring
- Verbalize confidence in self- management and feelings about diabetes diagnosis to school nurse
- Demonstrate compliance with DMMP
- Have minimal disruptions in their educational program, attendance and academic progress due to diabetes

To make expected student outcomes measurable include timeframe such as percentage or days per week or specific date

NURSING ASSESSMENT	NURSING DIAGNOSIS	NURSING INTERVENTIONS The school nurse will:	EVALUATION/OUTCOMES The student will:
<p>Review health information provided by the parent: Medical history such as age of onset, hospitalizations, other current or chronic illnesses</p> <p>History of severe hypoglycemia</p> <p>Supports for student and family</p> <p>Student's self-care knowledge</p> <p>Past or current 504 plan or IEP</p> <p>Health care needs during the school day</p> <p>After school activities</p> <p>Field trip needs</p>	<p>Risk of injury</p> <p>Risk of unstable blood sugar level</p> <p>Self-care deficit</p> <p>Ineffective coping'</p> <p>Ineffective therapeutic regimen management</p>	<p>Provide student specific information to designated school staff</p> <p>Develop EAP</p> <p>Develop and implement use of blood glucose log</p> <p>Obtain medical orders</p> <p>Delegate care (list) to school staff</p>	<p>Recognize and report symptoms of low blood sugar level to teacher 90% of the time.</p> <p>Demonstrate age-appropriate use of BS testing equipment 4 out of 5 days per week.</p> <p>Verbalize confidence in self-management to the school nurse by the end of the term.</p> <p>Verbalize feelings about diabetes diagnosis to school nurse or trusted adult as needed.</p> <p>Demonstrate compliance with DMMP 90% of time during school and after school activities.</p> <p>Takes self-care supplies to after school activities 100% of the time.</p> <p>Have minimal disruptions to educational program, attendance and academic progress as demonstrated by missing less than 10 minutes of class time per day and less than 15 days of school each year.</p>



Adding timelines makes outcomes more measurable

SAMPLE DIABETES Individual Health Care Plan (IHP)

Page ____ of ____

For health needs that may result in an emergency and/or need management or monitoring.

Student <u>Name</u> : _____	Medical Diagnosis: _____	Part of IEP: Yes No
School: _____	Health Care Provider: _____	Date Initiated: _____
Grade: _____	_____	By: _____
	_____	Date Reviewed: _____
		By: _____

Underline areas of concern: Medical management, dental management, safety, vital functions, elimination, mobility, rest, comfort.

NURSING ASSESSMENT	NURSING DIAGNOSIS	NURSING INTERVENTIONS <small>The school nurse will:</small>	EVALUATION <small>Student Outcomes- The student will:</small>
<p>The student is very knowledgeable regarding their diabetes management. They most often can recognize hypoglycemic states. Their primary symptom of low glucose levels is being belligerent. They have a very supportive family. They manage their blood sugar with and insulin pump and continuous glucose monitor.</p>	<p>High Risk for Physiological Injury due to development of acute complications related to hypoglycemia (low blood sugar) or ketoacidosis (high blood sugar)</p>	<p>Hypoglycemic Management Activities:</p> <ol style="list-style-type: none"> 1. School nurse will develop- emergency action plan - and instruct staff in how to respond to low blood sugar levels 2. School nurse will observe _____ - check his blood sugar levels bi-weekly. <p>Hyperglycemia Management</p> <ol style="list-style-type: none"> 3. Activities: 4. School nurse will train staff and supervise student in administration of insulin. 5. School nurse will observe _____ self-administer insulin bi-weekly. 	<ol style="list-style-type: none"> 1. _____ will recognize and treat early signs of hypoglycemia appropriately and know how to recognize and respond to early signs of ketoacidosis. 2. _____ will manage or have assistance managing hypoglycemic reactions. 3. _____ will have minimal low blood sugar reactions in school.

OUTCOME: Risk Control

Indicators	Never Demonstrated 1	Rarely Demonstrated 2	Sometimes Demonstrated 3	Often Demonstrated 4	Consistently Demonstrated 5
___ recognizes own low blood sugar reactions					
Staff follows emergency care plan					
___ monitors own blood glucose levels					

References

*Will, I. S., Arnold, M.W., & Zaiger, D. S. (Eds.).2017. *Individualized healthcare plans for the school nurse: A comprehensive resource for school nursing management of health conditions (2nd ed.)* Forest Lake, MN: Sunrise River Press.