Public Health
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POLICY AND PROCEDURE MANUAL
CENTRAL VALLEY HEALTH DISTRICT

SECTION: SCHOOL NURSING

POLICY # 601BASIC NURSING ASSESSMENTS

POLICY: The school nurse/CVHD RN will be available to do basic nursing assessments as requested. The basic nursing assessment can include but is not limited to assessment of vital signs, checking heart and lung sounds and ear checks.

PURPOSE: To aid in early detection of potential health problems and refer for medical assessment of abnormal findings.

PROCEDURE:

1. Explain procedure to student/staff.

BLOOD PRESSURE-

a. Determine appropriate blood pressure cuff size.
b. Client will be requested to sit with feet flat on floor and forearm supported at heart level on a flat surface.
c. See attached blood pressure reading guidelines for age appropriate readings.
d. If initial reading is elevated, have the client rest for 5 minutes and recheck blood pressure.
e. If second blood pressure reading remains elevated, client will be requested to return for blood pressure recheck within one week or may be referred to client's primary medical provider for evaluation.
f. After 2 consecutive elevated blood pressures within one week or at subsequent visits, client with no known history of health problems, will be referred to the their primary medical provider for evaluation. Clients who are known diabetics or history of heart disease or elevated b/p readings will be referred to their medical provider following one elevated blood pressure reading.
g. General education on blood pressure control:
    i. Weight loss and exercise
    ii. Reduce sodium intake
    iii. Decrease Alcohol and avoid stimulants
    iv. Smoking cessation
    v. Reduce Stress
h. Blood pressure will be documented on the school log sheet and student's yellow card.

PULSE –

a. Radial pulse-locate with 2-3 fingers in the wrist area above the thumb.
b. Apical pulse-chest area (area should be exposed taking care to avoid unnecessary exposure). Place a clean stethoscope on the mid-chest over the apex of the heart, at the 5th intercostals space.
c. Pedal, carotid, post tibia, femoral and brachial pulses will be assessed at the nurse's discretion.

d. Count the pulse for 1 minute. Acceptable Normal pulse range is 60-100 beats per minute
e. Record rate, rhythm, and strength on the school log and student's yellow card. Include pertinent information and observations.
f. Refer for medical follow-up as necessary.

RESPIRATIONS –

a. Observe rise and fall of the student/staff's chest and ease of breathing.
b. Count number of respiratory cycles that occur in 1 minute.
c. Observe regularity and rhythm, depth or use of accessory muscles.
d. Normal rate should be 12-20 respirations per minute.
e. Record findings on school log and student's yellow card.
f. Refer for medical follow-up as necessary.

OXYGEN SATURATION RATE-

a. Respironics finger pulse oximeter will be used according to manufacturer guidelines.
b. Insert client's finger into the pulse oximeter until the fingertip touches the built-in stop guide, centering the finger on the unit.
c. Be aware of conditions that may alter accuracy of readings such as:
    i. Excessive or rapid movements of finger.
    ii. Nail polish may reduce light transmission
    iii. Excess pressure on unit during measurements
d. Allow system to stabilize by observing at least 10 seconds of continuous green colored perfusion 0 display pulses before relying on the displayed digital values.
e. SpO2 values are below 90, refer to physician for evaluation.
f. Document all readings on school log and student's yellow card.

TEMPERATURE MONITORING

a. Student/staff will be assessed for signs and symptoms of elevated temperature.
b. Appropriate mode of temperature evaluation will be determined by RN (I.e. axillary or oral).
c. "Normal" temperature readings are as follows:
    - Oral Temperature 98.6 degrees F
    - Axillary Temperature 97.6 degrees F
    - Tympanic Temperature 99.6 degrees F
    - Temperature reading equal to 100.0 orally is reason to be sent home from school setting or to MD for evaluation.
d. Procedure will be explained to student/staff.
e. Digital thermometer will be turned on and proper monitoring mode selected.
f. All thermometers will be properly disinfected between uses.

Axillary Temperature:

i. Place tip of thermometer in upper aspect of armpit, as high as possible in direct contact with the skin.
ii. Place arm snuggly at the client's side. Do not allow movement of the arm or probe during the measurement cycle.
iii. The unit will beep three times when the final temperature is reached.
iv. Remove thermometer, discard cover, read and record results on school log and the students yellow health card.

Tymapanic Temperature: Using the WelchAllyn Pro 4000 ThermoScan Type 6021

i. Use a new, clean probe cover is placed before each measurement
ii. Thermometer turns on automatically when the probe cover is in place. Wait for the ready signal to beep.
iii. Fit the probe snuggly into the ear canal, then push and release the Start button.
iv. If the probe has not been placed correctly in the ear canal or was moved during the measuring process, a sequence of short beeps will sound
v. A long beep will signal the end of the measuring process. The result is shown on the display.
vi. Remove thermometer, discard cover, read and record results on school log and the students yellow health card.
vii. Consult Users Manual for further direction on use of thermometer.

Oral Temperature:

i. Place probe tip under the client's tongue on either side of the mouth to reach the rear sublingual pocket.
ii. Have the client close his/her lips around the probe.
iii. Hold the probe in place, keeping the tip of the probe in contact with the oral tissue throughout the measurement process.
iv. The unit will beep three times when the final temperature is reached
v. Remove thermometer, discard cover, read and record results on school log and the students yellow health card.

LUNG SOUNDS

a. Have student/staff breathe slowly and deeply through the mouth.
b. Place stethoscope on the skin over the chest area.

c. Record findings on school log and student's yellow card.

HEART SOUNDS

a. Assess heart sounds using a stethoscope placed directly on the student/staff's skin over the heart.
b. Observe for pitch, intensity, duration and timing.
c. Record results on school log and student's yellow card.

EAR CHECKS

a. Student/staff will be individually assessed for symptoms.
   - Pertinent information such as meds, tubes, fever, and previous history of ear problems, etc. will be gathered.
b. Visually inspect the auricle and surrounding tissues for deformities, lumps and skin lesions.
   - If ear pain, discharge or inflammation is present, check for tenderness by moving the auricle and pressing on the tragus and mastoid process.
c. Otoscope will be used to examine the ear canal and tympanic membrane using largest specula that the ear canal will accommodate.
d. Pull ear up and back for older children and adults, down and back for smaller children to aid visualization of the canal and tympanic membrane.
c. Identify wax, discharge or foreign bodies in the ear canal. Note any redness or swelling of the canal.
d. Gently move the speculum, so you can see the entire drum, identify the landmarks.
e. Refer to Bates, A Guide to Physical Examination, page 63, and/or Hauke, Ear Disease, for abnormalities of the eardrum.
f. Document findings on the school log and yellow card.
g. A notification form will be sent home to the parents if excessive ear wax is present.

2. Based on assessment findings and the Nurses judgment, parents will be contacted and recommendation for care will be discussed. (i.e. child to remain in school, go home from school to rest and/ or seek medical follow-up will be discussed.)