Nursing Support Services
Delegated Care in the School Setting

Date of Referral:

REFERRAL FROM A PHYSICIAN/PRIMARY HEALTH CARE PROVIDER IS REQUIRED

Nursing Support Services provides care in the school setting for children (0 – 19) who require assistance with specific tasks related to their care. Delegation of these tasks is determined by the registered nurse on an individual basis for children/youth whose care needs and response to treatment is stable and predictable and can be safely managed by NSS provincial standardised care plans.

ELIGIBILITY FOR SERVICES REQUIRES ALL OF THE FOLLOWING:

- ☐ Child/youth is a resident of BC as defined by BC Medical Services Plan (MSP)
- ☐ Child/youth is enrolled with BC's MSP
- ☐ Child/youth is under the age of 19 (up to the day of their 19th birthday)
- ☐ Child/youth has a parent/guardian that has overall responsibility of their child/youth's care and is fully competent and prepared to provide care in the absence of school staff
- ☐ Child/youth cannot independently and safely perform tasks related to their diagnosis
- ☐ Any child/youth eligible for nursing support services requires at minimum an annual assessment: (1) through NSS to confirm ongoing eligibility and to update a child/youth's medical documentation including nursing care plan and (2) by the most responsible physician/and or medical service(s) to ensure there are current (within preceding 12 months) medical orders supporting the care being provided in the home/community setting, and/or when changes in a child's medical care/needs occur.
- ☐ Referral from a physician licensed to practice in British Columbia or a nurse practitioner registered by the College of Registered Nurses of British Columbia and who confirms the following:
  - ☐ the child/youth can be safely cared for in the school setting
  - ☐ the child/youth has a local physician to provide required medical care, consultation and written physician orders

Is the parent/guardian aware of and has provided consent for this referral? ☐ Yes ☐ No
If no, please obtain consent prior to submission of referral.

Is an interpreter required? ☐ Yes ☐ No
If yes, what language(s)?

CHILD/YOUTH INFORMATION

NAME OF CHILD	GENDER ☐ M ☐ F	PERSONAL HEALTH NUMBER	DATE OF BIRTH (YYYY/MM/DD)
NAME OF PARENT(S)/GUARDIAN(S)		DAYTIME PHONE NUMBER	EVENING PHONE NUMBER
ADDRESS		CITY	POSTAL CODE
NAME OF SCHOOL AND DISTRICT:			
TEACHER:	GRADE:		
List all known medical diagnoses and significant medical history: *A letter may be attached to include all relevant details*	•		

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Current health care needs for the school setting: *A letter may be attached to include all relevant details*	•

REASON FOR REFERRAL (check all that apply. Include ALL details in the order form on page 3. School care must be routine, essential (cannot be given outside school hours), and have a known and predictable response.

☐ **Tube meals** ☐ **Intermittent Catheterization** ☐ **Routine oral/nasal suctioning** ☐ **Routine BG monitoring**

OTHER AGENCIES/ PERSONS INVOLVED IN CHILD'S CARE

Name, position, contact information:	
Name, position, contact information:	
Name, position, contact information:	

PHYSICIAN INFORMATION

REFERRING PHYSICIAN NAME	BC MSC#

ARE YOU A:

☐ PEDIATRICIAN ☐ FAMILY PRACTITIONER ☐ OTHER MEDICAL SPECIALIST *(describe)*

ADDRESS	PHONE NUMBER	FAX NUMBER

PHYSICIAN SIGNATURE *(required)*:	**DATE COMPLETED (YYYY/MM/DD):**

Please attach recent consultations and notes for our review to assist in determining eligibility for services.

Completed referral forms and accompanying documentation may be sent via E-mail (nssreferrals@cw.bc.ca) or fax to 604.708.2127

Nursing Support Services

Delegated Care in the School Setting – Order Form

NSS provides care in the school setting for children (5 – 19 years) who require assistance with specific medical tasks related to their care. It is important to note that delegation is only available for certain tasks (see below) and the decision regarding whether a task can be safely delegated rests with the registered nurse, who carefully considers several factors including: the school environment in which the task will be performed, the complexity of the task itself, the potential risk of harm to the student, the predictability task's outcome, and the school staff's ability to consistently and safely perform out the task. This thorough assessment and determination help to ensure that the well-being and safety of the students remain our utmost priority.

Nursing Support Services (NSS) Care in the School Setting ORDER FORM: Prescriber to Complete

Instructions for Prescriber:

- *Please complete this form as it provides the child-specific orders a nurse requires to establish a delegated care plan for the child/youth.*
- *Care plans will be enacted by school support staff (non-medical professional) while the **child/youth is attending school.***
- *School care must be **routine, essential (cannot be given outside school hours)**, and have a **predictable** response.*
- *For delegated care in the school setting, orders must be updated annually and/or when changes occur in child's medical care needs.*
- *Once a child is on service, **any order changes** need to be given to the NSS Coordinator directly for the delegated care plan to be updated and for school staff to provide care accordingly*

NAME OF CHILD	BIRTH DATE (YYYY/MM/DD)

CONDITION(S) REQUIRING MEDICATION:

Child requires G/GJ/J tube meals at school: Please fill in tube meal details below or if RD to write order, please indicate below

☐ **Pump Feed** Tube type: ☐ G ☐ GJ ☐ J

Bolus feeds: ☐ formula[1]: _____ Total Volume: _____ml Rate: _____ ml/hr Feeding time(s) at school: _____

☐ water Total Volume: _____ml Rate: _____ ml/hr Admin time(s) at school: _____

Continuous Feeds: ☐ formula: _____ Total Volume: _____ml (per day) Rate: _____ ml/hr

Flushes: ☐ timing of flush (i.e. before aftermeds and feeds) _____ Volume ☐ _____ ml

☐ **Syringe Feed** Tube type: ☐ G ☐ GJ ☐ J

☐ formula[1]: _____ Total Volume: ____ml Rate: _____ (__ ml per syringe over ___minutes) Feeding time(s) at school: _____

☐ water Total Volume: _____ml Rate: _____ (__ ml per syringe over ___minutes) Admin time(s) at school: _____

Flushes: ☐ timing of flush (i.e. before aftermeds and feeds) _____ Volume ☐ _____ ml

☐ If ordering **Home Blenderized Tube Feeds**[1] the commercially prepared backup formula is: _____

☐ Feeds as directed by Registered Dietitian[4](RD) Name of RD: _____

Intermittent Catheterization - Please detail care requirements (include catheter size and route) and indicate times while at school below:

Routine oral/nasal suctioning- Please detail care requirements (include catheter size, type and route) below:

Routine BG monitoring - Please detail care requirements (include low and/or high BG parameters and treatment protocols, & mandatory/high risk checks) below:

Name of Medications/Additives to Feeds Required at School[1,2]	Dosage	Frequency	Route[3]	Specific Directions for Use

Continued on next page

[1] For recipe-based feeds the order must also include a list of ingredients.

[2] Oxygen administration only if on continuous rate of flow.

[3] Main routes would be G/GJ/J or mask/NP for oxygen administration. T1D related medications on the T1D order form. Seizure rescue intervention medications on the Seizure order form.

[4] As per BCCH policy Nutrition Orders By Dietitians a feeding order can by written by an RD. If written by an RD, the RD writes the order under the delegated authority of the physician. Therefore, the feeding orders must be made in collaboration with the child's MRP/health care team.

ADDITIONAL COMMENTS/POSSIBLE REACTIONS/CONSEQUENCES OF MISSING MEDICATION:

Name of Prescriber (please print)	Role of Prescriber	Signature of Prescriber	Date Signed (YYYY/MM/DD)	Phone Number
	○ MD ○ RD ○ NP			

To Be Completed By Parent Or Guardian

I request the school/child care to give the medication as prescribed in Section B of this form to my child named in Section A of this form

Name of Parent or Guardian

Signature of Parent or Guardian

Date Signed (YY/MM/DD)

To Be Completed By registered Nurse After The Completed Request Is Returned To The School/Child Care

Comments:

Signature of Registered Nurse Date Signed (YY/MM/DD)

EACH TRAINED CAREGIVER RESPONSIBLE FOR ADMINISTERING OR SUPERVISING OF SELF ADMINISTRATION OF MEDICATION		
Name of Trained Caregiver	Signature	Date Signed (YYYY/MM/DD)