The Diabetes Dilemma

Demanding the Best for Our Children

A Union of Professionals
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The Diabetes Epidemic in Our Schools

About 17 million people in the United States, or 6.2 percent of the population, have diabetes. About 151,000 of these diabetics are children—that computes to one in every 400 school-age children.

The nature of diabetes requires that proper care and management take place every day throughout the day. People with diabetes are at great risk of developing serious health complications over time, including heart disease, blindness and stroke. That is why proper diagnosis and care are so important.

There are two common categories of diabetes. Type 1 diabetics require insulin. Type 1 diabetes is sometimes referred to as juvenile diabetes because it normally develops in children. These children must have daily insulin injections, and their glucose levels must be regularly monitored—sometimes several times a day. Each year, more than 13,000 young people are diagnosed as having Type 1 diabetes.

Type 2 diabetics produce some level of insulin but there is a problem with the body's response to the insulin. People with Type 2 may be treated with oral medications, exercise and nutrition but may also require insulin injections. Although Type 2 diabetes is generally associated with overweight older people, it is increasingly being diagnosed in children and adolescents. Researchers at the Centers for Disease Control and Prevention (CDC) in Atlanta estimate that among new cases of childhood diabetes, between 8 percent and 43 percent are diagnosed as Type 2.

Children with diabetes face the possibility of two significant challenges every day: hyperglycemia and hypoglycemia. Hyperglycemia results when blood glucose levels are too high, and hypoglycemia results when these levels are too low. Either is serious if not properly identified and treated. Symptoms of hyperglycemia can include increased thirst and hunger, increased urination, dry mouth, blurred vision or drowsiness. Hyperglycemia can be alleviated by following a daily regime of insulin, proper diet and physical activity. However, a student with extremely high blood sugar levels or higher than normal levels lasting more than a couple of days should be seen by a physician. In rare cases, hyperglycemia can result in coma and death. Hypoglycemia is associated with feeling shaky, nervous, tired, sweaty, cold, hungry, confused, irritable or impatient. The student can be given 1-2 teaspoons of sugar or honey, regular soda, 5-6 pieces of hard candy, glucose gel or tablets or a cup of milk to raise his or her blood sugar level. Blood glucose tests should be performed and if levels remain low, emergency services should be called. If not treated properly, hypoglycemia can result in convulsions, coma or even death.

School-age children with diabetes are protected under the Americans with Disabilities Act, Section 504 of the Rehabilitation Act of 1973 and the Individuals with Disabilities Education Act (IDEA). These protections require that schools provide necessary accommodations for diabetic children, including appropriate healthcare. These children should not be provided substandard care just because they are in school. All children with special healthcare needs should have the services of a full-time school nurse.

Several state legislatures are being asked to consider legislation that would train nonmedical staff (teachers, paraprofessionals and others) who would be called “trained diabetes personnel” to provide both routine and emergency care to students with diabetes. This legislation is potentially dangerous for these children who should be receiving the highest quality of care, and it also poses a threat of liability for school districts.

Our Concerns

Inadequate Training. The training that would be offered under the proposed new legislation to school staff who are not healthcare professionals would not be sufficient to guarantee competence. A simple two- to eight-hour training module can never replace the years of training a school nurse receives. Current legislative proposals include no oversight of training quality, no continuing education requirement and no proof of competency. Think of it like this: A school support staff employee receives four hours of training in August but does not use what he or she has been taught until an emergency situation arises in April. Would this staff member be adequately prepared to respond in an emergency to something he or she had not thought about in eight months? Medical literature supports the fact that if medical personnel do not *continually* practice their skills, they are unable to maintain proficiency—which may lead to medical errors. "Trained diabetes personnel" cannot be expected to remain proficient in responding to emergencies unless they are in a position to continually practice their skills.

The same is true for the day-to-day care students with diabetes require. Assessing a student's condition in order to take the appropriate action requires significant knowledge and training. Different conditions can exhibit similar symptoms. For example, it can be difficult to tell whether a child is experiencing high blood sugar, low blood sugar or some other health-related problem. And if the wrong assessment is made and the child is treated incorrectly, it can be dangerous.

Certainly, people who are not medical professionals, such as parents, can be trained to care for their diabetic children. However, a parent has much more invested in the care of that child and performs the necessary tasks on a daily basis. This is very different from a teacher or school employee who may be responsible for dozens of children while at the same time trying to perform medical procedures in an emergency situation for which the employee may have been trained many months before. The school environment is distracting for both the nonmedical school employee and the diabetic students. At home, these children may be focused and attentive to blood glucose readings and signs of low blood glucose. However, that environment is very different from a school setting where they are taking a test, playing ball, and always trying not to let their diabetes get in the way of being just like all the other kids.

Potential for Medical Errors. An inaccurate observation by nonmedical school staff could delay appropriate treatment and result in unintended and dangerous consequences. This is a major safety issue for a child with diabetes. Assessing a student's condition is not something that can be taught in a quick training session. For example, in one high school, a secretary was trained to provide care and assistance to students with health needs, including the administration of medications. When one of the diabetic students showed up in the wrong classroom and seemed "out of it" the secretary called police thinking he was using illegal drugs. No one thought to test his blood glucose level or give him snacks as they were instructed.

Any time a medication is administered, there is the potential for error. A University of Iowa study showed that medication errors in schools were more than *three times* more likely to occur when someone other than a school nurse was involved.

A school health assistant in Texas, thinking she could inject a diabetic student with insulin after watching the school nurse perform the procedure dozens of times, gave the child 200 units of insulin rather than the prescribed two units, believing that one insulin syringe was the equivalent of one unit. The child became very ill and was hospitalized, fortunately with no long-term consequences. However, the outcome could have been fatal had the parent not been there when the child came home from school.

Glucagon is an unstable hormone used to raise a diabetic's blood sugar level. Glucagon administration by injection requires mastering a multistep delivery system. While generally safe, glucagon can have side effects, including vomiting and the potential of aspirating food particles and fluid, that nonmedical personnel in schools are unlikely to know how to handle.

Cross Contamination. Unlike clinics or hospitals, schools are not sterile environments. Unlicensed personnel who are required to give injections are generally unaware of the potential for cross contamination and the disastrous consequences that can result. Cross contamination is the unintentional transfer of microorganisms or bodily fluids from one person to another. The risk for cross contamination is greatest when needles are used and can involve student-to-student transfer and/or contamination between student and caregiver. Cross contamination can lead to a transfer of infection, Hepatitis, AIDS, and a host of other illnesses. These are serious diseases that can be carried in people's blood, many times without them even knowing it.

Solutions

Every child with diabetes should have an individualized health plan (IHP) that provides clear instructions on how to respond to an emergency. The proposed legislation calls only for the use of a diabetes medical management plan (DMMP), which must be signed by the child's physician and parent. However, the DMMP is unnecessary when an IHP spells out the healthcare needs of the child. Unlike the IHP which is created by a team of school professionals, the DMMP is not developed with the input of any school official.

Teachers and school staff employees who are not health professionals should be educated about possible symptoms that a student may exhibit and be trained to be aware of the nuances of diabetes and to be sure that diabetic students have access to snacks and are able to self-test and medicate when appropriate. In the event of hypoglycemia, juice or glucose gel can be provided and generally the student can return quickly to class. If a school nurse is not available to attend to an emergency involving severe hypoglycemia or hyperglycemia, emergency medical services should be activated immediately by dialing 911 so that the student can be assessed and treated by a qualified health professional. This is the same action that would be taken for any child with a chronic condition who required emergency medical care during the school day. Why should a child with diabetes receive anything less?

What School Nurses Should Know

Every school nurse must be knowledgeable about the nurse practice act in his or her state and what it allows in terms of delegation. In states that do not allow the delegation of medication administration, school nurses should not train or delegate nursing tasks to "trained diabetes personnel." In all states, the *assessment* of a child's condition to determine the appropriate course of action is clearly a violation of nurse practice acts—statutes that were put into place in each state to protect the health and well-being of the general public.

Where delegation is permissible, the school nurse must first agree to train the "trained diabetes personnel." If you agree to take on this task, you must determine which school staff members should be trained and continue to mentor and supervise them throughout the school year. The training should not include the assessment of a student's condition, but only general, routine tasks permitted under statute. You should be aware that the school nurse who trains or delegates may be potentially liable for any adverse outcomes.

What Teachers and Other School Employees Should Know

You may be asked to become one of the "trained diabetes personnel" in your school building. First, you should become knowledgeable about the nurse practice act in your state. If it does not allow for the delegation of nursing tasks, you should not be administering medications to students. You may unintentionally be practicing nursing without a license, even if you have been trained by a diabetes expert.

If your state does allow for delegation, you must make the determination, along with the school nurse, regarding your ability and desire to be trained to perform routine and emergency care to students with diabetes. No one but the school nurse can delegate nursing procedures or tasks to you—not the principal, superintendent or a school board member. If you are trained as one of the "trained diabetes personnel," you should only perform those tasks for which you have been trained and should always look to the school nurse for guidance.

If a diabetic student in your classroom has been cleared for self-testing and self-medicating by the school nurse, it is important that other students in the classroom understand the procedures. Briefly explain what the student is doing; this will dispel any undue curiosity or alarm about the self-testing or self-medicating procedures. It is important to stress, however, that the lancets used for finger-pricks and the syringes used to inject insulin are to be used only by the student with diabetes. There have been incidents where students have had access to lancets and subsequently stuck other students, creating alarm among students, parents and teachers alike.

What School Districts Should Know

The use of "trained diabetes personnel" in schools is potentially a liability for the school district that employs them. Although the legislation thus far has had provisions that immunize school districts and school employees from liability for civil damages if they act "as a prudent person would," it does not exempt the school district or employees from charges of negligence, a standard that is often easy to reach.

It is certainly appropriate for school employees to understand diabetes, to be informed about a student's condition, watch a student's behavior before meals and snacks, make sure meals are eaten on schedule, not assign exercise just before a meal when a student may need food, and keep a source of sugar readily available. However, when it comes to monitoring blood glucose levels (or assisting those who can generally do this on their own), injecting insulin, or responding in an emergency, a licensed registered nurse should be involved. Anything less is dangerous for the student, the employee and the school district.

In addition, legislation that forces schools to provide specialized training to nonmedical school employees is an unfunded mandate being thrust upon districts already struggling with budget shortfalls. This money could be better spent on the salary and benefits of a full-time school nurse in those schools.

Demand the Best for Our Children

The best solution for caring for students with diabetes is to ensure that there is a full-time school nurse in every school building, and more than one in larger schools or in schools that have high populations of students with chronic conditions. Medically fragile students are found in more than one-third of the nation's 80,000 schools. However school districts are hiring fewer school nurses each year rather than more. No one can be trained in a few hours to perform health services for a student with diabetes or other serious conditions without the education and expertise that a school nurse has.

If a school district suddenly realized it had to lose a teaching position, would a bus driver, secretary or food service worker be asked to step in and teach? Why should they be asked to step in for the school nurse?

The use of "trained diabetes personnel" means that we are providing less than the best for our most vulnerable population—children with special needs. We must demand the best for our children. Every child needs and deserves a school nurse.

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