

NEWS

IN

School Health

SCHOOL HEALTH UNIT

SPRING 1997

BE PREPARED: EMERGENCY CARE IN THE SCHOOL SETTING

A chemical spills in a classroom, causing many students to become ill. A clogged air vent results in dangerous air quality conditions for many children. A student collapses on the athletic field. A teacher has a heart attack. All these emergencies, and many more, have occurred recently in Massachusetts schools. All required rapid response to ensure the health and safety of both students and staff.

Establishing an emergency care plan for the school district requires planning, dissemination of the plan and evaluation. To be effective, planning should include both school staff and the local emergency response team. Administrators, teachers, athletic staff, school nurses and school physicians, to name a few, comprise the emergency planning team for many school districts. However, local emergency medical services (EMS) should also be involved at the beginning of the planning process. The school needs to know what emergency resources will respond and how quickly. The EMS staff need to know the school lay-out, resources, and what clinical staff (school physician, school nurses, psychologists, etc.) are available to assist.

In developing the school's emergency care plan, it is wise to anticipate the worst scenario and plan for it. Attention to detail can make the difference between a rapid effective response or a delay, which could seriously affect the clinical outcome for student(s) or staff. Such details include, but are not limited to, accessibility of telephone lines, knowledge of where to call for the local EMS, availability of adequate numbers of staff trained in cardio-pulmonary resuscitation, and assignment of a school member to guide the EMS when they arrive.

Children with certain special health care needs and those assisted with medical technology present special challenges. Each should have an *individualized* health

care plan, including a plan for emergency care. MassSTART (Massachusetts Technology Assistance Resource Team, sponsored by the Department of Public Health) is available to provide consultation to schools on children assisted with medical technology and the development of their care plans.

The school's emergency care plan should be widely disseminated once it receives administrative approval. School nurses often take the lead in sharing the plan at faculty orientation, school committee meetings and on staff professional days. The greater percentage of staff who understand the plan and the specific roles they should assume in an emergency situation, the more likely the successful outcome.

Recognizing that only the most experienced clinical staff are comfortable in an emergency, practice for all staff should be an integral part of the emergency care plan. Some schools have already implemented regularly scheduled drills with their local emergency medical services. During these drills, a mock emergency determines the response of both the responsible school personnel and the local EMS. The drill is then reviewed to determine how response could be improved, should an actual emergency event occur.

This newsletter is designed to assist school districts in the critical task of developing comprehensive, yet practical, plans for dealing with both individual and group emergencies. As you read it, ask yourself, "Does my school have an emergency care plan in place? Has it been tested to determine its effectiveness?" If the answer to either or both these questions is no, we urge you to begin the planning process today. The health and safety of your students and staff depend on it!

Anne H. Sheetz, R.N., M.P.H., C.N.A.A.
Director of School Health

"Ten to twenty-five percent of almost 22 million childhood injuries that occur each year in the United States take place in school or during school-sponsored activities."- Marc Posner, Education Development Center, Newton, MA

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH / BUREAU OF FAMILY AND
COMMUNITY HEALTH / DIVISION OF PREVENTION / SCHOOL HEALTH UNIT

NEWS BRIEFS

THIS COULD SAVE YOUR CHILD'S LIFE: A SCHOOL BUS HANDRAIL HANDBOOK Since 1991, six children have died and many more have been injured because they snagged their clothing, book bags, and other items on handrails as they exited school buses. More than 400,000 school buses have been recalled and manufacturers have absorbed the cost of the repairs. A new booklet, *This Could Save Your Child's Life: A School Bus Handrail Handbook*, shows how to detect and correct potentially dangerous handrails on school buses. To receive a copy of this booklet, write to the Safety Countermeasures Division, National Highway Traffic Safety Administration, NTS-23, 400 Seventh Street, S.W., Washington, DC 20590, or send a fax to (202) 366-7149. For questions about recalls call NHTSA's Auto Safety Hotline, 800-424-9393. Submitted by Heather McLaughlin, MDPH Injury Prevention, 624-5412.

PUBLIC HEALTH FACT SHEET ON MENINGOCOCCAL DISEASE The revised fact sheet was published in February 1997 and is available by calling The Massachusetts Department of Public Health Epidemiology Program at (617) 983-6800.

CHILDREN'S MEDICAL SECURITY PLAN The Department of Public Health extends sincere thanks to all the school nurses who have informed families about the primary care insurance available through the Children's Medical Security Plan. We urge you to continue to reach out to families that may need this insurance. During the month of March, John Hancock sent informational packets for enrolling children in need of emergency medical services to all school nurses. Please call Jacqueline Williams, Community Liaison, Children's Medical Security Plan, at (617) 624-6086 if you have further questions.

CDC GUIDELINES FOR SCHOOL AND COMMUNITY PROGRAMS: PROMOTING LIFELONG PHYSICAL ACTIVITY AMONG YOUNG PEOPLE The Centers for Disease Control has just issued these guidelines for schools. Copies can be downloaded from the Internet at <http://www.cdc.gov>. (On the CDC home page, click on MMWR, select *Recommendations and Reports*, and then select March 7, 1997.) Print copies are available from: CDC, Division of Adolescent and School Health, ATTN: Resource Room, 4770 Buford Highway, Mailstop K-32, Atlanta, GA 30341-3724. Phone: (888) CDC-4NRG.

EYE HEALTH AND SAFETY INFORMATION FOR SPRING The following three products are available from Prevent Blindness Massachusetts: 1) "Play It Safe With Your Eyes" video and curriculum, the only comprehensive video education program on eye health and safety for children in preschool through the second grade. Curriculum contents: 8-minute VHS video, teacher's guide, coloring books, give-away stickers, color poster, audiocassette of Play It Safe song. [Cost: \$89.95, plus: \$8.95 shipping & handling. Total Cost: \$98.90]. 2) "In the Blink of an Eye" video. The new occupational eye safety video featuring Richard Karn of TV's "Home Improvement" emphasizes the importance of wearing eye protection that meets the regulations and standards of the American National Standards Institute (ANSI) and the Occupational Safety and Health Administration (OSHA). Package includes: 11-minute, color poster, guide for safety directors. [Cost: \$20 for 100 stickers, plus \$3.95 shipping and handling. Total Cost: \$23.95]. 3) "First Aid for Eye Emergencies"; this is essential for every first-aid kit, medicine cabinet or work area. Adhesive sticker lists first-aid techniques for chemical burns, blows to the eye, and cuts or punctures of the eye or eyelid. [Cost: \$20 for 100 stickers, plus \$3.95 shipping and handling. Total Cost: \$23.95]. For a free catalog of educational materials and more information about Prevent Blindness Massachusetts, please contact Nancy Venator, Prevent Blindness Massachusetts, (617) 489-0007.

HEPATITIS B IMMUNIZATION REQUIREMENT FOR CHILDREN WHO ENTER KINDERGARTEN IN THE FALL OF 1997, WHO WERE BORN BEFORE JANUARY 1, 1992 The regulations state that only those children born *after* January 1, 1992 are required to have these immunizations. (January 1, 1992 was the date when birth hospitals received the vaccine for newborns.) However, the Department encourages the immunization of children entering kindergarten and born *before* January 1. Free vaccine is available for this purpose.

SCHOOL NURSE AND EMERGENCY MEDICAL SERVICES: ENCOURAGING TEAMWORK

by Paul H. Coffey, B.S., Certified EMT
Basic EMT Training Coordinator
Department of Public Health
Office of Emergency Medical Services

Since the 1970's Emergency Medical Services (EMS) has expanded its role from ambulance drivers with first aid training, to a modern pre-hospital patient care system employing Basic Emergency Medical Technicians (EMTs), EMT-Intermediates and EMT-Paramedics. At the same time, the school nurse has moved from the role of taking temperatures and applying cold compresses to the first and sometimes only health care provider to whom many students have access. Dispensing multiple medications and administering treatments to children with intravenous lines, feeding tubes and tracheostomy tubes are among a few of the many challenges school nurses face as more children with special health care needs attend school in our communities.

The changes in both EMS and school nursing occurred independently and without much notice by the other side. As we both confront patients in a school setting who need advanced care, both groups need to become re-acquainted with the levels of training and services that each can and must provide.

The biggest obstacle to a true teamwork approach is lack of knowledge about the other team members. The start of every school year brings new challenges to the school nurse. As soon as the school day settles into a routine (if that ever happens!), it is a good idea to invite the local EMS responders to the school for a "get acquainted" session. The EMS and providers in your town may include the local police department, local fire department, local ambulance service and

an area Advanced Life Support (ALS) unit(s).

They each should receive a map (floor plan) of your school with room locations. They should learn about the conditions of any student or staff member that might require their services. They should know the hours that the school nurse is scheduled to be at that school and if any other persons have first aid and/or CPR training.

School nurses need to know whether or not the local police and/or fire department (first responders) will respond to every call for medical assistance. Each city and town determines who is sent on a medical call. Do these first responders have an automatic or semi-automatic defibrillator for cardiac arrests? Does the ambulance service provide basic life support with basic level EMTs, or advanced life support with EMT-Paramedics? Does the Basic Life Support (BLS) ambulance service carry epinephrine auto-injectors and/or cardiac defibrillators?

If your town has a BLS ambulance service, do they have access to a regional advanced life support unit? Where is the ALS unit based? Will they respond to the school or meet the ambulance en route to the hospital?

Another step is to ensure that all faculty know how and when to access their local EMS system. Do you dial 9-1-1 to call for help, or do you dial 9 (9-1-1) or 8 (9-1-1)? A handful of communities do not have 9-1-1 yet, so the seven digit local fire, police and EMS telephone numbers should be posted by every telephone.

Important: *Please remind everyone that dialing 9-1-1 on a cellular telephone will NOT connect you with your local police,*

fire and EMS center. Cellular calls are directed to a state police dispatch center that may be hundreds of miles away from your school. No matter whom you call or how you call, make sure the following information is given:

Information Required When You Make a Call to Your Local EMS:

- Give the call-taker the nature of the emergency. What is wrong? Depending on the problem and the dispatch center's capabilities, the call may be directed to another call-taker. DO NOT HANG UP!
- State your name, the street name, the street number and the town or city from which you are calling.
- State the name of the school and the exact location (floor and room number) of the emergency.
- State the closest entrance to use and whether a staff or faculty member will be waiting to guide them.
- Do not hang up! Enhanced 9-1-1 systems will bring up the telephone number and address of most telephone calls. Enhanced 9-1-1 systems cannot bring up specific location information from Centrex or switchboard routed calls or from cellular phone calls.

What EMS May Ask/Tell the Caller:

- How many patients need assistance?
- Is the patient breathing?
- Is the patient conscious?
- Is the patient bleeding?
- What are you or someone else doing to help?
- What is the name and phone number of caller?
- Be sure to send adult to meet the EMTs. (Send the adult back, if more help is coming.)

(Please note: More specific information on handling emergencies is found in "The Comprehensive School Health Manual" published by the Department of Public Health, Bureau of Family and Community Health, pages 2-13 to 2-18. I highly recommend that excerpts of this manual be distributed to any staff who may assist you in caring for students.)

While waiting for EMS to arrive, it will be helpful to have another staff member find and copy the Emergency Information Card for that student. Give the emergency card (page 2-73, *Comprehensive School Health Manual*) to EMTs when they arrive. The information on the card may be very helpful both to the EMS and the hospital.

Check with the EMTs to determine if you or a teacher should accompany the child to the hospital. This issue should be raised in the "get acquainted" session early in the school year (although the EMTs in the ambulance may not be the same ones you met with in September or October).

Finally, if any problems do arise, settle them with the EMS supervisor the next day. If you do not solve it at that level, ask to meet with the head of the local EMS system. Don't be afraid to call for a re-acquaintance meeting from time to time before any problems arise. The more often we can meet and talk before the emergency arises, the easier it is for EMTs and school nurses to work together as a team.

If you need information about the emergency medical services system in general, please call me at (617) 753-8300, or write me at OEMS, 470 Atlantic Avenue, 2nd Floor, Boston, MA 02210.

**EMERGENCY MEDICAL SERVICES
FOR CHILDREN (EMSC)**

by Janet Berkenfield
Massachusetts Department of Public Health

No one wants to think of children having emergency situations. However, when these situations occur, most of us would like to believe that our emergency medical services are prepared to provide our children with the care they need as soon as they need it. We would like to be assured that the ambulance that comes to our door is well equipped, the emergency medical technicians (EMTs) are well trained, and that the hospital to which the child is taken has an emergency department that is well equipped and staffed by providers trained in pediatrics.

Fortunately for most children, emergency situations are relatively infrequent; however when they do occur, our emergency medical service providers need to be well trained and well equipped to give pediatric care, which is different in many ways from that of adults. At the community level, primary care and school health providers need to be integrated into the emergency care system. Pediatricians must have the necessary skills to handle an emergency situation which may occur in their offices. School nurses need the support of parents and school officials to plan ahead for emergencies and closely coordinate their planning with the local emergency medical services.

The emergency care system as we know it in the United States is an outgrowth of the triage system developed during the Korean and Vietnam Wars. That system, brought back to the United States, proved helpful in improving the survival rates of adult patients with cardiac arrest

and other emergent conditions.

Gradually, however, emergency care providers began to realize that children were not faring so well in the EMS system, which had not been developed to respond to their particular needs. In response to this situation, in 1985 Congress appropriated funding for grants to the states to improve the emergency care provided to children, and by 1997 almost all states had received a federal grant to upgrade EMS for children. Grant funds, administered by the federal Maternal and Child Health Bureau, have been used for a variety of initiatives, including the enhancement of pediatric training for EMS providers, the development of standards for ambulance equipment and protocols for pre-hospital treatment, the improvement of EMS for special needs children, and the development of educational programs for school nurses.

Massachusetts has had EMSC grant funding since October 1992. Our vision is not so different from that of other states: Our 911 dispatchers and fire and police first responders should be trained and equipped to provide appropriate care to children; our ambulances should be stocked with child-size equipment; EMTs and paramedics should be adequately trained in pediatrics; our hospital emergency departments should be equipped and staffed to triage or care appropriately for children; and there should be routine referral mechanisms in place to make sure children get to rehabilitation services when they need them. In our communities, primary care physicians, school health providers and parents should be acquainted with injury prevention methods and should be able to recognize a pediatric emergency when it is occurring and respond appropriately. Making this vision a reality is the greater goal of the

Massachusetts EMSC Project. The EMSC Project has developed pediatric ambulance equipment standards and has written pediatric pre-hospital treatment protocols for EMTs and paramedics. It has sponsored a number of training programs primarily for pre-hospital providers, including a pediatrics course for EMT instructors, a refresher course in pediatrics for paramedics, Emergency Nurse Pediatric Care courses for emergency department nurses (co-sponsored with the Emergency Nurses Association), and pediatric Basic Life Support training for EMTs on site in their communities.

The EMSC Project works closely with injury prevention initiatives across the state, strengthening the natural collaboration between EMS providers and injury prevention professionals.

In 1995 the EMSC Project conducted a survey of acute care hospital emergency departments to obtain an inventory of their pediatric resources. Findings indicated that while most hospitals were well equipped to care for children, the training and continuing education levels of emergency department physicians and nurses were quite variable. As a result of these findings, EMSC will be focusing on developing standards for emergency department provider training, as well as actually providing some of that training.

Emergency care for children with special health care needs has been identified as a priority need, and Project staff collaborate closely with the Massachusetts Department of Public Health, Division for Children with Special Health Care Needs, which is funded through the federal Maternal and Child Health Bureau Title V programs. These children are receiving attention from the EMSC through its participation in Project Safe Child. This project is a coalition of tertiary care hospital providers and

representatives from a variety of state and private agencies who have come together to develop improved discharge planning for technology-dependent children and to assure that each child being discharged home has in place an emergency response plan that includes the active awareness and participation of the community EMS agency, the primary care provider, the community hospital and the school.

Another important initiative has been a study of emergency care for children in two Massachusetts communities. The study focused on parent and primary care provider attitudes toward emergency recognition and response in an effort to understand the particular risks faced by children in those communities and the ability of the local EMS system to respond to pediatric emergencies. Results of the study indicated that primary care providers play a critical role in preparing parents to recognize and respond to emergencies, but these providers are not always as well integrated into the emergency care network as they could be. Plans are underway to reach out to pediatricians and family practice physicians to enhance their office readiness to cope with emergencies and to support their role as parent educators on injury prevention and emergency response

Another finding from our community study is that health care providers who may be providing different aspects of emergency care do not always communicate with each other as well as they could. School nurses in particular have expressed concern over their lack of contact with their community's EMS providers, as well as with their own lack of resources for emergency preparedness within the school setting. EMSC staff have had a number of discussions with school nurses across the state on the subject of emergency preparedness. The following

are some of the issues that have been raised:

- In many school systems, the nurse covers several buildings; therefore each school **building** needs staff members trained in CPR and first aid.
- Many nurses need telephone lines into their offices, thus enabling them to summon an ambulance immediately should an emergency occur.
- In many communities, the ambulance service needs to become more familiar with the school. If an ambulance is summoned, the EMTs must know where to go.
- Nurses need to have first aid supplies readily available. The question of oxygen availability was raised repeatedly. In a pediatric emergency, the first concerns are airway and breathing, yet oxygen is not usually stored in most schools.
- Many school districts need to develop emergency plans, which are then approved by the school administration and widely disseminated to the faculty.
- Many nurses report difficulty reaching parents in an emergency. Also, parents may not understand the limits of emergency care in the school.

Plans are underway to develop a statewide School Nurse Advisory Council to develop recommendations for policy on some of these issues.

If you are interested in participating in this, or if you have other issues regarding emergency care in the school that you would like the EMSC Project to work on, please call one of the EMSC staff:

Jonah Goldsmith at (617) 624-5430 or Janet Berkenfield at (617) 624-5431.

**BROOKLINE PUBLIC SCHOOLS
EMERGENCY MEDICAL RESPONSE
PROTOCOL**

by Mary Ann Ferrisi, RN, MEd.
and Dierdre London, RN

The April 1993 issue of *News in School Health* contained an outline of an Emergency Care Program for School Settings. The outline stated that, "Every school should have a current, written plan for emergency care of a student(s) or staff member(s) who experiences a life threatening or potentially life-threatening illness, injury or emotional crisis which requires immediate action. School personnel are responsible for (1) providing immediate first aid care, (2) arranging for appropriate transportation to a health care facility, and (3) notifying a parent or person identified as an emergency contact." The newsletter stimulated the development of an emergency care protocol for the Brookline Public Schools. Prior to this time there had been several emergency incidents warranting great concern by the nursing staff. The number and seriousness of the injuries had escalated. Also the nurses recognized that, in the event of multiple injuries in the school setting, additional medically-trained personnel would be required to assist.

The school nurses first met with the headmaster of the high school and the school physician to gain support for the development of a protocol (or "recipe") for the staff to follow in the event of an emergency. The planned protocol

would also include an educational component. After receiving administrative support, the following action plan was implemented:

Basic Plan: Convene an Emergency Care Committee which included the following: school administrator, school health personnel, physical education staff, parents, Brookline School Health Advisory Committee representation, etc. The Emergency Care Committee would:

1. Identify local emergency resources (police, fire department, ambulance, emergency medical team, poison control center, etc.). Work with these resources to determine what services are available, how they might meet the school's anticipated needs, response time, etc. Meet with representatives of these services and develop a realistic plan.

2. Identify school personnel who will assume responsibility for providing cardio-pulmonary resuscitation and first aid, calling emergency resources, arranging for transportation or other needs, and notifying parents, guardians or other emergency contact(s). Include alternative personnel for back-up in case the assigned person is not available.

Based on its fact-finding, the committee developed an emergency plan for the schools.

Plan Dissemination : At the beginning of the 1993-94 school year we placed the written emergency plan in the staff's opening day informational folders. The nurses also presented an overview of the plan and information on universal

precautions. Latex gloves were distributed.

Training: With the receipt of funding from a person who believed that cardio-pulmonary resuscitation and first aid training are invaluable for our school community, we implemented a training program. First we offered the basic four-hour American Red Cross "Until Help Arrives" course to all interested staff. We then collaborated with the Educational Director of the ambulance service contracting with the Town of Brookline to provide a CPR course for staff. The coordination of this educational piece proved difficult because of the staff's time limitations. All educational programs were offered after school. School nurses gave the first aid training while the ambulance service provided the CPR training.

Since passage of the Education Reform Act, we offer Professional Development Points (PDP's) for these programs to faculty who require them for re-certification. This has proved an incentive for staff to participate in the courses.

Results: During the first year we trained 39 staff in first aid and 12 in CPR. Numbers have increased each year. We fine tune the protocol annually, according to each school building's needs.

While the establishment of an emergency plan for the Brookline Public Schools required many school nursing hours and much tenacity, it has been an extremely important project for our health service program to undertake. It has also proven effective in emergency situations.

**DOES YOUR SCHOOL HAVE AN
EMERGENCY CARE PLAN?**

*For information on developing your plan,
see Chapter 2 of the Massachusetts
Department of Public Health
Comprehensive School Health Manual,
pages 2-13 to 2-18.*

**BLUE HILLS REGIONAL
VOCATIONAL TECHNICAL SCHOOL
SAMPLE EMERGENCY CARE PLAN**

by Kathy Vachon
School Nurse

The following sample emergency care plan, entitled, "Code Blue Emergency Care Procedures," was developed under the leadership of Kathy Vachon, School Nurse, for the Blue Hills Regional Vocational Technical School. The school has kindly offered to share it as an example of some types of activities which other schools should consider in their plans.

An emergency occurs: The department head or teacher in charge notifies the school nurse, at emergency telephone 311 or 288. *(N.B. In certain life-threatening situations, 911 should be called immediately.)*

School Nurse

- Reports to the scene.
- Determines whether to notify ambulance, police or fire department and if the EMERGENCY SUPPORT TEAM (EST) is needed. The Emergency Support Team consists of the school nurse, administrators, athletic director, and teacher volunteers, etc.
- If necessary, notifies receptionist to call **Code Blue** and appropriate agencies.
- Notifies receptionist when emergency is concluded.

Receptionist

- Announces **Code Blue** over the public address system, and location of emergency.
- Calls ambulance when notified by school nurse or designee (828-1313).
- Notifies the Assistant Director of Student Affairs, Assistant Director of Vocational Departments, Academic Coordinator and Administrator of Special Services.
- Notifies remaining administrators and Superintendent-Director if no response from All-Call.
- Informs all incoming calls of a medical emergency. No calls to be connected.

Assistant Director of Student Affairs (Back-up: Administrator of Special Services)

- Remains at the reception desk.
- Turns off all bells.
- Supplies escort to the ambulance. *(N.B. In most cases ambulance should be met at the entrance closest to the incident.)*
- Notifies parents. (Call nurse's office for the number.)
- Serves as a liaison between Canton Police Department, Fire Department, and the school.
- Assistant Director of Student Affairs' secretary reports to the nurse's office.

Emergency Support Team (E.S.T.)

- Emergency Support Team reports to the area as pre-arranged. Any teacher near an Emergency Support Team member is requested to fill in until a substitute arrives.
- All teachers on Prep Period should report to the nearest administrator's office for assignment if necessary.

Administrators

- Administrators in charge of the vocational and academic areas report to the emergency site and notify the receptionist of their arrival.
- The Assistant Director of Student Affairs and Administrator of Special Services report to the reception desk.
 - Remain in close contact with the receptionist.
 - If the situation warrants, notifies the receptionist to contact the school physician.
 - Contacts the receptionist for additional support.
 - All other administrators contact the receptionist to inform her/him of their location and stand by for further instruction.

While the Massachusetts' helmet law does not carry a penalty for non-compliance, it has served to rally safety advocates, medical providers, school and community-based staff, and parents and children themselves to promote the "use your head, wear a helmet" message. The Massachusetts Bicycle Safety Alliance, a volunteer coalition of over 30 statewide and community-based agencies and groups representing medical, injury prevention, education, bicycling advocacy and service organizations, has been promoting bike safety and helmet use through a variety of activities including, media campaigns, incentive programs, hospital-based *Helmet Rx* discount helmet programs, video, curriculum and policy development, sports events, bike rodeos, and professional and consumer education. Safety advocates will have new bike, inline skating and pedestrian safety materials available this summer as a result of a grant from the Governor's Highway Safety Bureau. The Ride and Roll Safely Program, Inc. (formerly the Lexington Bicycle Safety Program) in conjunction with WalkBoston and the Boston Childhood Injury Prevention Program, will develop bicycle, inline skating and pedestrian safety cards and posters for free distribution throughout Massachusetts. Project staff will also survey medical providers, educators, public safety staff, and interested advocates and agencies to assess their needs and activities and will produce a free guide that will showcase innovative programs and resources. To request materials or find out more information, contact Project Coordinator Olga Guttag @ (617) 863-6318 or e-mail olga@oregano.lcs.mit.edu.

Since spring is here and more

youngsters and adults will be pulling out their bikes and strapping on inline skates, now is a great time to get involved in promoting bike/inline skating safety. Safety advocates can participate in many ways, including:

- offering discount helmets and safety literature on-site;
- creating educational displays during Bike Safety Month in May - use a cracked helmet that protected its user from injury to demonstrate effectiveness;
- organizing bike safety clinics, rodeos and helmet "give-aways";
- promoting prevention through media and community outreach;
- sponsoring a bike/inline skating safety poster or essay contest;
- supporting local incentive programs that reward helmet use;
- encouraging local medical providers to set up a "helmet prescription protocol" for their patients;
- setting a good example by always wearing protective equipment when cycling or inline skating.

For more information on the Massachusetts Bicycle Safety Alliance, call Diane Butkus at (617) 624-5428.

TEACHING CHILDREN THE IMPORTANCE OF HANDWASHING

by Carol Anne O'Leary, MS, RNC
Pediatric Nurse Practitioner
Clinical Director
Hamilton School, Everett

It is a well-known fact among health care professionals that handwashing is the best way to prevent the spread of infection. In February, handwashing

education was the focus of a program for the students and staff at the Hamilton School in Everett. Everyone hopes to have a healthier school overall.

The idea for this program began at the school-based health center. In planning for a health education program, Carol Anne O'Leary, nurse practitioner, identified handwashing as the topic that would be most beneficial to children. Because of the great number of colds, sore throats and coughs that children encounter during the year, teaching how to prevent some of these illnesses seemed to be the natural choice. In every classroom there are children who cough, wipe their nose or rub their eyes. Each time they do so, the possibility of spreading germs to others increases. All twenty-six health education classes in the elementary school learned about proper handwashing from Mrs. O'Leary and Ms. Kim Auger, the school's health educator. The program began with a demonstration using the "Glow Germ" light. This is a fluorescent light, marketed by the Brevis Corporation. Synthetic "germs" were applied to several children's hands and then they were asked to wash. Any remaining "germ" would fluoresce under the light. The children were surprised that their usual methods of handwashing were actually quite ineffective.

A video was utilized in teaching proper handwashing technique. All Hands On Deck produced by the Brevis Corporation, was well-received by all ages. The video utilizes an actor posing to be Xzyzx 1391, a germ, to present the reasons for handwashing and demonstrate proper technique. He encourages the viewers to "think like a germ" when it comes to handwashing. A discussion followed the video; then

children went off to the restrooms. The students practiced handwashing under supervision and they were given helpful critique as needed.

After the children had the opportunity to try the new handwashing technique, the "Glow Germ" light was used to examine hands again. In all cases, there was great improvement in the results. The children truly enjoyed being able to see the difference proper handwashing makes. Age-appropriate written activities were used to finish the class and provide a review. These included crossword puzzles, word searches and mazes from the Gerbusters activity book (also available from Brevis). Children were encouraged to share information with their family members. A letter to parents and the guidelines for proper handwashing were sent home with each child.

Follow-up regarding the effectiveness for the program includes reviewing absenteeism rates for the months following the program and comparing them to the previous months. A periodic review of proper handwashing techniques will also be done to help reinforce this healthy habit.

For more information about the Glow Germ Light and supplies, please call the Brevis Corporation at 1-800-383-3377.

TOBACCO NEWS

Tobacco use is the leading cause of preventable disease and death in the United States. Primary smoking claims an estimated 419,000 lives per year. Tobacco addiction typically begins

during childhood or adolescence. Approximately 75% of cigarette smokers tried their first cigarette before their 18th birthday. *Initiation of daily smoking generally occurs during the sixth through ninth grades.* Additionally, a number of surveys conducted throughout the United States show increasingly high rates of smokeless tobacco use, primarily among young males. These young tobacco users underestimate the addictive nature of nicotine in all forms.

Easy access to cigarettes is a prerequisite to early addiction. Strategies to reduce youth consumption of tobacco products basically focus on the supply and demand side of the problem. School-based tobacco prevention curricula and youth access policies reduce youth demand for and supply of tobacco products. The Department of Public Health (DPH), through the Massachusetts Tobacco Control Program (MTCP), recognizes that such a reduction of tobacco use among our youth is a community responsibility. Under the guidance and leadership of DPH/MTCP, activities and projects throughout the commonwealth are being supported, emphasizing tobacco prevention and intervention at the local level, focusing particularly on youth. The MTCP is designed to prevent young people from starting to smoke and to reduce death and disability in the commonwealth due to smoking. Therefore the Department of Public Health and the Department of Education join together in encouraging schools to work closely with MTCP organizations within their communities to address tobacco control issues. Suggestions for collaboration may include:

- Involve representatives from MTCP, Board of Health, D.A.R.E. and the American Cancer Society on the

school health advisory committee that is required in the Department of Education Health Protection grants);

- Complete the school district tobacco control program self-evaluation form, share results with the advisory committee and plan joint strategies to reduce tobacco use. (Copies of the self evaluation tool are available by calling or writing the School Health Unit, Massachusetts Department of Public Health);
- Call or meet with the local Board of Health to learn about planned or implemented tobacco control ordinances within the community;
- If the Board of Health is conducting compliance checks of local vendors to determine whether they are selling tobacco products to minors, ask if any assistance from the school is needed;
- Join your local tobacco control coalition;
- Call or meet with your local Prevention Center to learn what educational materials are available for your school; this includes available training in the TEG and TAP programs for school-based facilitators of tobacco education and cessation groups;
- Identify local cessation programs for adults and refer families, staff members and others who wish to join a program to stop the use of tobacco;

Contact your local MTCP Regional Coordinator for additional information/ guidance, relative to community collaboration/assistance:

UPDATES...

MTCP Greater Boston Region

Alice Delgado, (617) 624-5916

MTCP Central Region

Mark Boldt, (617) 624-5924

MTCP Northeast Region

Joseph Morrissey, (617) 624-5915

MTCP Southeast Region

Sara Sabourin, (617) 624-5918

MTCP Western Region

Pam Schwartz, (617) 624-5917

NUTRITION NEWS

The 1997 update of the "Community Food and Public Assistance for Families Eligibility Guide" is available to interested parties upon request. The guide includes a summary of program benefits, eligibility criteria, application procedures and where to get more information. Please send your request to Maria Bettencourt, DPH, Division of Prevention, 250 Washington Street, 4th floor, Boston, MA 02108-4619.

The Food Stamp Outreach Program is seeking student volunteers to do leafleting of informational flyers in various localities throughout the state. Interested individuals should contact Maria Bettencourt at (617) 624-5440.

Save the date. On June 4, 1997 there will be a videoconference entitled: "Is Food Safe for Kids? Adverse Reactions to Foods." It will be available for viewing at eight sites throughout the state. For more information, contact Maria Bettencourt at (617) 624-5440.

RECOMMENDATIONS FOR USE OF GLOVES: Data indicates that blood exposure can be reduced by adopting the work practice and personal protective equipment recommendations of the Bloodborne Pathogen Standard of the U.S. Occupational Safety and Health Administration (OSHA), published in December 1991 (Federal Register, 29 CFR 1910.1030). Persons occupationally exposed to blood, who do not use gloves, are ten-times more likely to have serologic markers of hepatitis B infection than those who do routinely use gloves when exposure is likely.

Blood drawing and placement of intravenous devices are clearly examples of procedures where gloves, usually latex, are indicated. In all circumstances in which direct exposure to blood, or other potentially infectious material is possible, adequate precautions should be taken, including the wearing of gloves (and if splashes may occur, use of eye protection).

Administration of intramuscular or subcutaneous immunizations is a circumstance that presents a risk of needlestick injury and a small potential for blood exposure. In most circumstances, the risk of exposure and the amount of blood present is very small. Of course, needles and syringes must be safely disposed of immediately and needles must **never** be recapped.

The Department of Public Health does not recommend routine use of latex gloves for administration of vaccines. The benefit of gloves in the setting of the very small risk may be outweighed by inconvenience and cost. The use of gloves can be a personal choice.

Whether or not gloves are used, care to avoid exposure must always be taken and hands **must** be washed between clients. For more information contact Lorraine Peavey, RN, Nurse Educator, STD/HEP B, 5th floor, State Laboratory Institute, 305 South Street, Jamaica Plain, MA 02130, (617) 983-6852.

INJURY/VIOLENCE PREVENTION SERVICES:

The Massachusetts Department of Public Health (MDPH) supports many violence prevention programs in schools, health agencies, and communities. The MDPH Intentional Injury/Violence Prevention Services coordinates violence prevention efforts within the Department of Public Health, and works to develop and expand efforts to prevent violence, including child abuse, youth violence, peer violence, sexual assault, suicide, self-inflicted injury, dating violence, domestic violence, and elder abuse. School staff wanting more information may contact Ellen Connorton, Intentional Injury/Violence Prevention Coordinator, Massachusetts Department of Public Health, Injury Prevention and Control Program, 250 Washington Street, 4th Floor, Boston, MA 02108-4619, phone (617) 624-5433.

In addition, the Injury Prevention and Control Program of the MDPH has produced a limited number of **PEACE Kits--Peace through Education and Community Empowerment**. Each **PEACE Kit** contains strategies, resources and tools designed to reduce violence among adolescents. Specific topics include adolescent violence, gangs and violence, and coalition building. Each kit also contains an 18 minute videotape entitled "Every Voice Counts," which describes practical steps

to community coalition building, a set of overhead transparencies with a script which can be used for a presentation, and materials for a violence prevention awareness campaign. PEACE Kits may be borrowed from the Resource Specialist at your local Massachusetts Prevention Center. Contact your Prevention Center for more information.

NEW MASSACHUSETTS CHILD PASSENGER SAFETY LAW:

On April 9, 1997, the new Massachusetts Child Passenger Safety Law went into effect. This law requires children under age 5 and children who weigh 40 pounds or less to be properly secured in a child safety seat (car seat) when riding in a motor vehicle. A booster seat is required for children under 5 who weigh 40-60 pounds. While the law states that children ages 5 to 12 must wear a safety belt, a booster seat is permissible and recommended for children in this age group who weigh 40-60 pounds. (The Massachusetts Seat Belt Law picks up where this law leaves off, requiring people ages 12 and over to wear a safety belt.) While the law exempts school buses, children who meet the age and weight criteria are required to be secured in a child safety seat when riding in "vehicles for hire," i.e., taxi cabs and limousines. This is a primary enforcement law. A police officer may stop a motor vehicle if one or more children are riding unrestrained. No other reason is needed. The fine is \$25 per unrestrained child.

For more information, and to request fact sheets on the law, please call the Injury Prevention and Control Program, 1-800-CAR-SAFE. The fact sheets are currently available in English, Spanish, Portuguese, Chinese, and Vietnamese and will soon be available in Russian.

**MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
BUREAU OF FAMILY AND COMMUNITY HEALTH
DIVISION OF PREVENTION
SCHOOL HEALTH UNIT
250 WASHINGTON STREET, 4TH FLOOR
BOSTON, MA 02108-4619
PHONE: (617) 624-5070
FAX: (617) 624-5922 OR (617) 624-5075**

*The staff of the School Health Unit
is pleased to welcome
Diane Gorak, B.S.N., M.Ed.
who will share the responsibilities
of providing consultation to
the schools in the Commonwealth.*

Diane will join the unit on April 28, 1997

William F. Weld, Governor
Joseph Gallant, Secretary
David H. Mulligan, Commissioner
Deborah Klein Walker, Assistant Commissioner
Linda Jo Doctor, Division Director