

CURRENT TOPIC

School nursing: past, present, and future

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The School Health Service (SHS) began 90 years ago when the Education Act of 1907 introduced periodic medical inspections to address government concern over the poor health of school children and of recruits for the Boer war. Responsibility for the SHS passed from local authorities to the NHS in 1974.¹ Although the only statutory duties² are to provide inspections of pupils at "appropriate intervals", the SHS offers a range of other services whose relevance and effectiveness have increasingly come under scrutiny.

The Polnay report³ preferred the term "health services for school age children". Although this was a sound recommendation, SHS staff are still easily identifiable and to many purchasers the SHS is now virtually synonymous with school nursing. Community paediatricians and senior nurses with management responsibilities are often consulted about this service, which fulfils many functions (see appendix). School nurses work in a complex community, where both teachers and children have physical and mental health problems and needs. They have inherited many of the traditional duties of school doctors, notably universal screening and inspection of children. School health staff participate in various tasks prescribed by government statute or guidance and also respond to perceived local needs. It is perhaps not surprising that they have difficulty in assessing their optimum staffing (L Cotton *et al*, unpublished data, 1998),⁴ defining their role⁵ or measuring their own effectiveness.

This article will argue that community paediatricians and nursing managers must not be paralysed by the lack of trial based data, which may be impossible to obtain. Advice based on a logical appraisal of need will be better than an approach driven solely by political fashion or short term financial considerations. The paper does not attempt to consider all the tasks listed in the appendix, but focuses on those identified as central to school nursing in a recent survey.⁶ It refers to trials and systematic reviews where available, but also takes account of statutory requirements, and opinions expressed by parents, pupils, and teachers. Guidance from the Department of Health and the Department for Education and Employment provides insights into what our colleagues in education want from the health service.

What are the perceived needs?

Five main themes emerge from recent reports on health needs in school age children.⁷ These are: routine screening and surveillance; safe-guarding health and welfare of children; a confidential advice service for children and young people; family support; health promotion.

ROUTINE SCREENING AND SURVEILLANCE

Until about 10 years ago, all school entrants were examined by a doctor to identify defects and disorders that had been missed or not treated. The literature in support of periodic medical inspections is largely confined to lists of conditions detected; there are no data as to the importance of the findings, or the extent to which the child gained benefit from detection and treatment.⁷ Nevertheless, universal access to free preschool primary health care and child health surveillance should mean that, by the age of 5 years, few important physical disorders remain undetected. This may not be true in certain high risk situations, such as highly mobile families, and it would make sense to identify such children for special consideration, although there is virtually no information on how or whether this might work.

In the modern NHS, routine physical health assessment of school children seems to perform poorly as a screening procedure, and the benefit of such assessment is probably very small in proportion to the time invested. However, there are three individual screening procedures at school entry⁸ that may still be justifiable, and could be done by an appropriately trained and supervised aide rather than a qualified nurse. These procedures are a visual acuity test,⁹ a hearing assessment, and the measurement of height and weight. The role and value of the hearing test are the subject of current research.¹⁰ There is no evidence to support any subsequent hearing test after school entry, and routine repeat vision tests after the age of 5 probably also have a very low yield.¹¹ A review of their value is needed urgently. Height monitoring of "short" children after the initial measurement at school entry is also of dubious value.¹²

An experienced school doctor can identify developmental disorders and predict school failure using a neurodevelopmental examination,¹³ but there is no evidence that the outcome is substantially altered by this process.¹⁴ Teachers are the obvious people to recognise children with problems, who can then be offered appropriate assessment. The

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introduction of statutory baseline assessment should formalise this process.¹⁵

When doctors stopped doing routine school entrant examinations, the school nurses took on the task of assessing health by questionnaire and interview, combining this with health education in a health care interview. Any problem is referred to a doctor.^{16 17} Together with follow up checks arising from this initial assessment, the health care interview occupies the largest proportion of school nurses' time in many districts (L Cotton *et al*, unpublished data, 1998). There are no data on the effectiveness of the health care interview in identifying new disorders, but there seems no reason to think it would be any better than an assessment by a doctor, and neither does this policy appear to be any cheaper.⁷ The benefits of the health education included in the health care interview also are unknown and information is needed on whether an interview with a school entrant and their parent leads to changes in knowledge, attitude, and behaviour that justify the cost in nursing time.

What needs are met by a health care interview? It offers reassurance for parents¹⁸; it can ensure that parents know about the SHS and meet the school nurse; it can identify inadequate routine preschool health care, as for example in children who are "looked after"¹⁹ or new immigrants; it ensures that relevant information about children with health problems is available to the school. The goals of the health care interview should be defined more precisely, to determine whether they are relevant to current needs, and to decide whether they could be achieved equally well by other means.

SAFEGUARDING HEALTH AND WELFARE

Support for children with medical needs and problems in school is perceived by teachers and education managers as an important need. The SHS should: "provide information, training and support where medication is needed in schools and may take responsibility for other aspects of support; it should advise on health issues; it may help schools draw up individual health care plans".²⁰ School nurses are likely to be "the main contact (with the NHS) for schools". Their expertise does not extend to answering all the queries raised by teachers, and their numbers are insufficient to provide extensive hands on nursing care, so they need to liaise with general practitioners, paediatricians, community paediatric nurses, and classroom assistants.

Paediatricians and general practitioners caring for children with long term problems affecting their schooling have a responsibility to ensure that, with the parent's consent, they and their trainees convey clear information to schools about a child's condition and needs or, better still, visit when the problem is complex.²¹ Nevertheless, help may be needed to translate medical advice into practical guidance for the realities of school life.

Young people with long term health problems or disabilities often need help in the transition from children's to adult services. There is official guidance on the role of the education authority and the contribution to be made by

health services for children who have a "statement of special educational need",²² but the needs of those disabled and sick children who do not have a statement are often neglected.²³ School nurses should perhaps be more proactive in addressing this deficiency.

Child protection in schools is primarily the responsibility of the individual school and each school has a designated teacher. School nurses often participate in child protection work in schools, although their role varies according to circumstances and the age of the child.²⁴

CONFIDENTIAL ADVICE

Teachers are often the first confidante of a young school child. Older pupils realise that teachers prefer not to discuss confidential matters and will refer them to their general practitioner or to the school doctor or nurse.²⁵ Pupils expect that confidentiality will be preserved by health professionals,^{26 27} but even the fear of being seen going into the "medical" room can intimidate some pupils. A routine vision test and height measurement at the start of secondary school allows pupils to meet the nurse without embarrassment,²⁸ although this subterfuge is probably unnecessary.

Advice and consultation for pupils can be provided in school as a "drop in" service²⁹ or in premises elsewhere. Drop in clinics benefit from the input of staff with family planning expertise, but must not be perceived as purely dealing with sexual health and contraception; they should offer help with other issues such as stress, anxiety and depression, abuse, or worries about eating and skin disorders. Experience in the USA shows measurable benefits for pupil health.³⁰⁻³³

Children with chronic health problems make a distinction between getting medical advice, for which they turn to their lead specialist health professional, and building a supportive relationship in school, where a teacher may be more accessible for help than the school nurse (J Lightfoot, personal communication, 1999).

Opinions are divided on three issues. The first is whether a drop in service should be within the school or in a separate setting, or both. The second is to what extent the needs catered for by drop in clinics could be met by primary care teams^{34 35}; could health centres be more friendly to adolescents and advertise the confidentiality of the service offered?³⁶ Is there a place for reciprocal arrangements whereby health centres will see adolescents who are on the list of another general practitioner? Lastly, some school nurses are consulted by teachers, usually on stress related issues. Although this may be a matter for an occupational health service, many teachers find this informal advice very useful.

FAMILY SUPPORT

Many of the problems experienced by school children affect their family or community as well as the school. In some cases, the result is declining attendance and eventual dropping out of school, or deteriorating behaviour resulting in exclusion.^{37 38} The prime responsibility falls on the educational social work service (educational welfare officers) and the educational

psychologist, but there is a need for collaboration between the school and health professionals to identify these children before a crisis is reached and, in association with parents, the primary care team and other agencies, intervene to prevent these serious adverse outcomes.³⁹ Teachers feel they are often perceived as criticising or judgmental, whereas the nurse, because she is employed by the NHS, may be regarded as a mediator. Joint funding of posts between education and health might help to develop this potentially important role.

HEALTH PROMOTION

Telling pupils not to indulge in certain behaviours may increase their knowledge and perhaps alter their attitude, but has much less effect on what they do. Many children are unimpressed by health education in schools, because it is not supported by the life style that they see around them—for example, heavy smoking by staff, bullying, lack of play and sports facilities, and the poor quality of school food.⁴⁰ But schools do make a difference (A Sowden and D Lister-Sharpe, unpublished data, 1999). The atmosphere and ethos of the school, and the emotional well being and self esteem of the children, are crucial to successful health promotion and life style changes; hence, the current government enthusiasm for the “healthy school”.⁴¹ Creating this ethos is essentially a task for the head teacher and staff. The school nurses’ role in classroom teaching is limited by lack of time but their input is valued by teachers and staff because of their broader health knowledge, their comfortable non-judgmental style when talking about the body and bodily functions, and the fact that they are outsiders who can answer questions and subsequently give confidential individual health advice in a clinic setting.⁶

What next?

What advice should be offered to commissioners about the SHS? First, acknowledge that routine physical health checks and surveillance, although not without value, are no longer the priority needs in the SHS. These activities should be reduced to the minimum justified by the evidence, to release time for other tasks.

Second, there is no argument about the existence of the other needs discussed in this article; only about how and whether we can meet them. School nurses who wish to modernise their service to meet these needs deserve support. The evidence base is weak and more research is needed urgently—qualitative studies, consensus development, and randomised trials.

Third, we need a national sense of direction about the role of health services and the SHS for children of school age. This must be based on the needs of children rather than the interests of the professionals, but an evolutionary approach that utilises existing resources is surely preferable to sudden and draconian changes. The needs are too great to be met by simply redefining the role of one small group of professionals.

Fourth, we need to review the role of paediatricians in the secondary care aspects of school health.⁴² They contribute to the assessment and care of children with both physical and mental

health problems, but there seem to be substantial differences between districts in what is provided and the relations with other disciplines (clinical and educational psychology, child psychiatry etc) are ill defined.

Finally, we need research on how to define, quantify, and meet the needs of children and young people in school. Important issues include ways of providing care and support for children with health care needs in school; how to ensure more efficient transfer of information from health professionals to school; how best to identify and support looked after children in school; what kinds of confidential advice services work best for young people and in what situations; how primary care teams could improve their image with teenagers; and what contribution could be made by health professionals to reduce adverse outcomes such as teenage pregnancy, dropping out, exclusions, and leaving school with no qualifications or prospects. Anyone who has undertaken research in this area knows how difficult it is even to define the questions clearly. Collaboration across disciplines is the first and indispensable key to progress.

Primary care groups are often unaware of the work done in the school health service. Definition, quantification, and clarification of these roles and tasks must be undertaken as a matter of urgency so that primary care groups know what they are commissioning and why.

This work originates from a study carried out under NHSE grant number 7-06 (Cotton L, *et al*). I thank all my colleagues who took part in that study, my paediatric and nursing colleagues in Community Health Sheffield, and also the following for helpful discussions and comments: A Waterston, S Stewart-Brown, J Lightfoot, D Elliman, PWD Meerstadt, L Polnay, and G Lindsay.

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Appendix

Services that may be provided within the school health service

ROUTINE SCREENING AND SURVEILLANCE

Medical examination of school entrants (age group 4–5 years) *or*
 Developmental examination of school entrants *or*
 Assessment of school entrants in person by school nurse *or*
 Assessment of school entrants by school nurse using questionnaire to parents
 Vision test at school entry
 Hearing test at school entry
 Height and weight at school entry
 Vision, hearing, and height in subsequent years
 Screening for scoliosis
 Immunisation

SAFEGUARDING HEALTH AND WELFARE

Child protection: examination, advice, support, and liaison
 Provision and interpretation of information relating to special needs children and children with health problems
 Medical examination for the “statementing” procedure
 Medical, psychological, and social evaluation of children referred because of problems in school
 Prepare and support care plan for “special needs” children in collaboration with a special needs coordinator
 Hands on nursing care—for example, gastrostomies, tracheotomies, tube feeding, and medications
 Responding to concerns about head lice
 First aid
 Environmental health issues—for example, school toilets

CONFIDENTIAL ADVICE

Counselling and consultation
 Health education
 Advice regarding health of children on school journeys, or those participating in unusual sports
 Informal support and advice network for teachers’ own health problems

FAMILY SUPPORT

Support to educational social work service; working with parents for children out of school etc

HEALTH PROMOTION

Support to “healthy schools” programme—individually and for the whole school
 Teaching in classroom; in drop in sessions etc