The Queen's Nursing Institute

Transition to the School Nursing Service

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Chapter 1 - Moving into the community to work with a School Health Team

Introduction: Welcome to the Community

School Nursing Teams vary across the country but they are generally led by a qualified Specialist Public Health Nurse and may include Registered Nurses, Nursery Nurses, Health Care Assistants and Administrators. They form part of a broader School Health Team (SHT) who work together towards improving the health and well-being of children, young people and their families. You will be working with a committed team of people who value their role and work with a wide variety of other professionals as well as children and young people themselves. This resource will guide you through what it is like to work in the community and some of the issues that you may encounter in a SHT. Reflection on your practice is encouraged from the start and you will need to identify a mentor to help you on your journey.

This chapter will introduce you to the role of the school health team (SHT) within the community. It will:

- Provide you with a brief overview of the history of school nursing in the UK.
- Consider what skills you will need to work in the SHT
- Outline the key roles that a nurse working with the SHT will be undertaking
- Explore the different roles and responsibilities of different professionals in the community setting

How did school health start?

The first school nurses emerged at the same time as health visitors during the Victorian era in Britain, with a role in gathering information in the school setting. The early tasks of school nurses arose out of the need to improve the health of children living in poverty and this coincided with a report from the British Army at the time which highlighted that young men joining the service were unfit for purpose (Webster & French 2002).

The report identified that nutrition was an important factor in the general health of populations and in particular that measuring the height and weights of children in school was a key indicator of their health and wellbeing. This remains true today in modern Britain: heights and weights are still measured at different stages of development. Many of the early aims of the school health service resonate today and Local Authorities are now key commissioners of school health services as they were when school health began. They have a remit to improve the health and wellbeing of young people, reduce child poverty and protect children and families (DH 2014).

Go to https://vimeo.com/116179180 to watch a short film on school nursing today.

'The early tasks of school nurses arose out of the need to improve the health of children living in poverty.'

School health today

The professional standing of the school nurse has changed dramatically since its inception in the Victorian era. Today, school nurses play a crucial role in the primary health care team and their key role lies within the public health (PH) arena. School Health Teams remain committed to promoting the health and wellbeing of children, young people and young adults (5-19) to give them the best start in life and sustain their optimum health status. You will need to be aware of the many different settings that children, young people and young adults occupy for example: home, school, college or university. It is also important to recognise the range of factors that will impact on their health such as: family circumstances, environment, health status or disability. You may also want to explore the different types of schools and colleges that exist in today's society (Free Schools, Academies, independent schools or Faith schools). A description of these can be found at: www.gov.uk/types-of-school/overview

You will need to be familiar with two key documents that guide school health practice.

1. The first is The Healthy Child Programme (5-19) (DH 2009). www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf
This document 'sets out the good practice framework for prevention and early intervention services for children and young people aged 5–19 and recommends how health, education and other partners working together across a range of settings can significantly enhance a child's or young person's life chances'. The Healthy Child Programme (5-19) aims to:

- Help parents develop and sustain a strong bond with children
- Encourage care that keeps children healthy and safe
- Protect children from serious disease, through screening and immunisation
- Reduce childhood obesity by promoting healthy eating and physical activity
- Identify health issues early, so support can be provided in a timely manner
- Make sure children are prepared for and supported in education settings
- Identify and help children, young people and families with problems that might affect their chances later in life.

Reference: DH (2009) The Healthy Child Programme (5-19) London DH

2. The second document is 'Getting it right for children, young people and their families: Maximising the school nursing team contribution: a call to action (DH 2012)'. This document guides school health practice and outlined in this document are the fundamental PH aims for school health teams:

1. Health promotion and prevention by the multi-disciplinary team
2. Defined support for children with additional and complex health needs
3. Additional or targeted school nursing support as identified in the Joint Strategic Needs Assessment.

This document is available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/216464/dh_133352.pdf

Discussion point: Have a look at these two documents and consider what skills and knowledge that you already have that will help you work with the SHT and identify what you will need to develop or learn. You can use the SWOT analysis template below and then discuss this with your mentor to help identify your learning needs.

Strengths	Weaknesses
Opportunities	**Threats**

The Key Roles and Responsibilities of the SHT:

There are some basic principles that guide school health practice that are framed in the two documents which are also based on Public Health approaches and the NMC guidelines for Specialist Community Public Health Nursing (NMC 2004):

The surveillance and assessment of the population's health and well-being: health screening.

A key role when you start to work in school health is the surveillance and assessment of children and young people's general health and wellbeing. You will encounter the phrase 'school readiness' while you are working with the SHT. Good liaison with health visitors helps to provide a seamless transition into the school setting. Please note that some children may not be in school and you will need to be aware of this in your area of work; you will also need to be aware of children with specific additional health needs. A school health questionnaire is normally done as children enter school to establish a baseline for general health and wellbeing and identify specific needs. The collection of this data is likely to form a part of your role as you join the SHT. The Healthy Child Programme (DH2009) also recommends gathering data in secondary school as well at different stages. This will vary in different areas; you will need to familiarise yourself with local policy and procedures and discuss with your mentor the service delivery model being used for school health. As well as the health questionnaire, the assessment will include the measurement of children's height and weight at different points in their school life. The National Child Measurement Programme (NCMP) measures the height and weight of children in Reception and in Year 6 to gather data on obesity. You will need to familiarise yourself with this initiative and learn how to measure children accurately using the correct Trust equipment. Some areas may also screen children for hearing or vision problems in schools. You will need to ensure that you are familiar with local policy about the sharing and storage of this Information. More about the NCMP can be found at: www.hscic.gov.uk/ncmp

Promoting and protecting the population's health and wellbeing.

Promoting healthy behaviours in children and young people and their families will be a key part of your role whether on a one to one basis or in groups. You will need to discuss with your mentor your responsibility in contributing to the delivery of any health education or health promotion initiatives in the practice area.

Protecting populations from harm is an important aspect of public health and immunisation and vaccination programmes are a very successful part of this agenda. Some school nurse teams will be involved in providing immunisations in schools but in other areas, specific immunisation teams are commissioned. If your area is involved in delivering this service, you will need to be familiar with the local policy and the immunisation schedules, which can be found in what is known as 'the Green Book'. As well as the childhood immunisation schedule, the Green Book gives guidance on the correct storage, transportation and administration of vaccines: www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book.

Any team immunising in schools or the community will need to be aware of the principles of consent and governance and further information can be found at: www.gov.uk/search?q=immunisation+training+for+professionals

'Promoting healthy behaviours in children, young people and their families will be a key part of your role.'

Immunisations undertaken by school nurses are normally administered under a Patient Group Directive (PGD):

'PGDs should be put together by a multi-disciplinary group including a doctor, a pharmacist and a representative of any professional group expected to supply the medicines under the PGD. It's good practice to involve local drug and therapeutics committees, area prescribing committees and similar advisory bodies. The PGD needs to be reviewed every two years and should include clinical governance arrangements and an assessment to see if a PGD is still the most effective way of providing patient care'.

Clinical governance refers to a framework through which NHS organisations are accountable for improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

Further information about PGD's is available at: www.gov.uk/government/publications/patient-group-directions-pgds

Immunisation training will be undertaken by local Trusts with regular updates. As with all nursing practices, individuals must be aware of their accountability for their actions as per the Nursing and Midwifery Code (NMC 2015) and must not undertake a procedure or intervention that they are not competent to perform. www.nmc-uk.org/Documents/NMC-Publications/NMC-Code-A5-FINAL.pdf

The links below will give you further information about the childhood flu campaign.

Information materials:
Public Health England (PHE) have updated the national communication material and supporting information for 2015/16 to include the following:

- A national consent form
- Template letters to invite children in Years 1 & 2 for flu vaccination (which includes Q&A for parents)
- The "Protecting your child against flu" leaflet
- Immunising primary school children against flu – Information for head teachers and other school staff.

The materials for 2015/16 will be available from the end of May and can be accessed via the annual flu programme website: www.gov.uk/government/collections/annual-flu-programme

Info and learning materials: www.e-bug.eu

- Digital Flu badges, a series of missions that children can take and earn Digital Badges: www.makewav.es/health

- Wired Young Carer's Group produced a song about getting a flu vaccination. It has been popular with children and is available for teams to use: https://vimeo.com/106076706

- Training materials: www.gov.uk/government/collections/annual-flu-programme

- An outline of potential Immunisation Training Requirements by role has been produced by the Royal College of Nursing /PHE. This can be found at: www.rcn.org.uk/__data/assets/pdf_file/0005/553748/004479.pdf

- The Royal College of Nursing statement on HCSWs administering live attenuated influenza vaccine can be found at: HCSW and Live Attenuated Influenza Vaccination [LAIV] for children and young people (March 2015) (PDF 360KB).

- A link to the School Nursing Service Planner is here: www.gov.uk/government/uploads/system/uploads/attachment_data/file/303769/Service_specifications.pdf

Individual skills

As a qualified nurse you will already have some important transferable skills but you may not have worked with children or young people before. Some of the skills you will need include:

- Communication skills
- Self-awareness
- Assertiveness
- Negotiation/conflict resolution
- Facilitating skills

Reflection point – think about these skills and when you have used them in the past. How might you need to use them within the SHT?

Communicating with children and young people and their families

Working with children and young people will require a number of different communication strategies, styles and approaches. You will be working with

young children as they enter the education system and communicating with parents and carers as appropriate. You may also be working with teenagers and young adults in a variety of different settings. The SHT may be communicating health messages in the classroom or other community settings as part of Personal Social Health and Economic Education (PSHE) although this will vary across different teams and across the country. Check this PSHE website for more information: www.pshe-association.org.uk .

It is useful to pay particular attention to talking to older children, adolescents or young adults and the skills you may need to communicate effectively.

Some of the key issues:

- Confidentiality
- Active Listening
- Showing empathy
- Being non-judgemental
- Ensuring privacy
- Body language
- Observation skills (for example assessing mood)

Discussion point: Consider what these terms mean to you and how you might apply them in your role. Think about your feelings about talking to groups of children or young people about sensitive issues such as sexual health.

Visiting schools or other educational environments

School nurses work within education (schools and other services) to improve outcomes for children and young people. The advantage of being a health professional is that you can be independent and are guided by your own professional standards and accountability when in the school setting (see The Code 2015). It often means that young people may talk to you more than they might a member of the school staff. This means that when working one to one with children and young people, you can maintain a confidential approach using child protection guidelines (see chapter 4 for more this). In the classroom, however, you are guests and you should normally be accompanied by a teacher when delivering health messages. This helps to manage behaviour issues in the classroom and protect you from accusations of inappropriate information being delivered. If it is part of your role to deliver health education, visiting schools for the first time can be a daunting prospect and it is important to have support and observe experienced practitioners in the first instance. Good lesson planning and sharing this with the school and your mentor in advance is good practice.

Visiting schools and raising the profile of the SHT is important to highlight the valuable contribution school nurses can make to improving health outcomes for children and young people. The British Youth Council has suggested that school nurses need to be present and visible in the school setting. See the link for more information: www.byc.org.uk/media/75447/byc_school_nurse_report_web.pdf

Also, the Department of Health has released documents urging students to get to know their school nurse: www.gov.uk/government/publications/students-starting-secondary-school-urged-to-get-to-know-their-school-nurse

Being visible in educational settings requires you to behave in a professional way at all times and you will need to be clear about the policies and protocols that guide you when working in the community and these settings.

The key skills for the SHT as a whole are summarised in Figure 1.

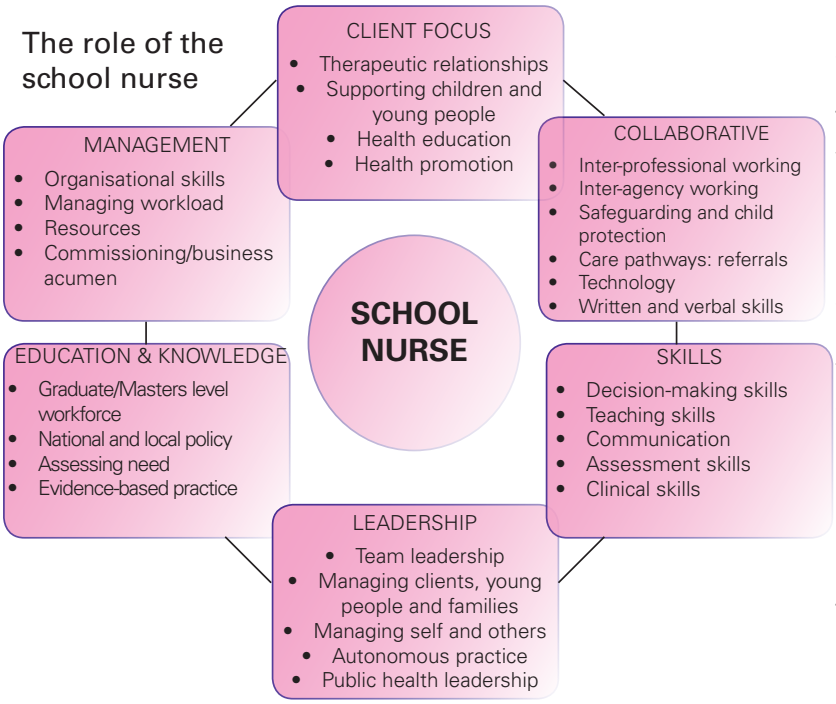
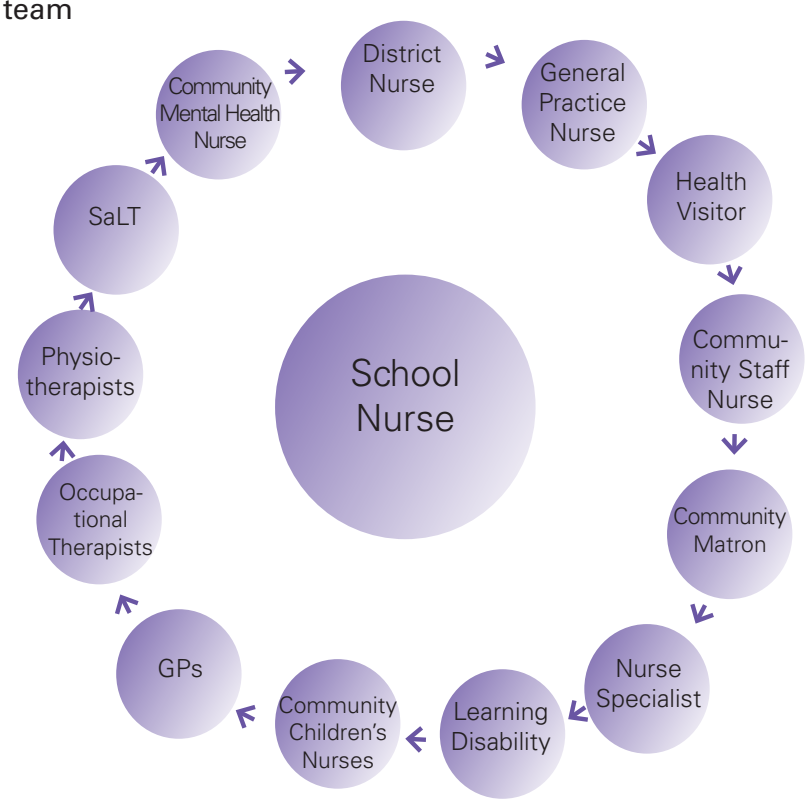


Figure 2
The multi-disciplinary team



Different roles in the community

Child and Adolescent Mental Health Services (CAMHS)

‘Children and young people and their families can be referred to CAMHS if children are finding it hard to cope with family life, school or the wider world. If these difficulties are too much for family, friends or GPs to help with, CAMHS may be able to assist.

Types of problems CAMHS can help with include violent or angry behaviour, depression, eating difficulties, low self-esteem, anxiety, obsessions or compulsions, sleep problems, self-harming and the effects of abuse or traumatic events. CAMHS can also diagnose and treat serious mental health problems such as bipolar disorder and schizophrenia’.
See: www.youngminds.org.uk/for_parents/services_children_young_people/camhs/what_are_cahms

Community Children’s Nurses

These provide holistic care to sick children by providing nursing care in the community setting, empowering and enabling the child, family/carers to become more competent in the management of the child’s condition, thereby reducing the need for hospital admissions or enabling early discharge. The Community Children’s Nurses provide nursing care to children and young people with a life limiting, life threatening condition, complex disability, long term conditions such as asthma, eczema or allergies as well as palliative and end of life care.

Community Mental Health Nurses

A Community Mental Health Nurse (CMHN), also sometimes known as a community psychiatric nurse, is a registered nurse with specialist training in mental health. Some CMHNs are attached to GP surgeries, or community mental health centres, while others work in psychiatric units. CMHNs have a wide range of expertise and offer advice and support to people with long-term mental health conditions, and administer medication. Some CMHNs specialise in treating certain people, such as children, older people, or people with a drug or alcohol addiction.

Community Paediatricians

Community Paediatricians are specialist children's doctors who have a particular expertise in looking after children with long term health problems which may have an impact on other areas of their life. These long terms problems may include complex health conditions requiring medical support, behavioural problems such as ADHD or other special educational needs.

District Nurses

District Nurses play a crucial role in the primary health care team. They visit people in their own homes or in residential care homes, providing care for patients and supporting family members. As well as providing direct patient care, district nurses also have a teaching role, working with patients to enable them to care for themselves or with family members teaching them how to give care to their relatives.

General Practitioners (GPs)

GPs provide a complete spectrum of care within the local community: dealing with problems that often combine physical, psychological and social components. Most GPs are independent contractors to the NHS. This independence means that in most cases, they are responsible for providing adequate premises from which to practice and for employing their own staff.

Health Care Assistants (HCAs)

HCAs work in hospital or community settings, such as GP surgeries, under the guidance of a qualified healthcare professional. The role can be varied depending upon the healthcare setting. In the community, they support the community school nurses with activities such as screening and immunisations. In the community, they support the community school nurses with activities such as screening and immunisations.

Health Visitors - also known as a specialist community public health nurse (SCPHN)

Health Visitors work with families with children under the age of 5 years of age. They support families and children in issues such as growth and development, post natal depression, breast feeding and weaning, domestic violence and bereavement. They also play a role in safeguarding and protecting children from harm.

Learning Disability Nurses

These nurses provide specialist healthcare to those with a range of learning disabilities. They also offer support to their families. Learning disability nursing is provided in settings such as adult education, residential and community centres, as well as in patients' homes, workplaces and schools.

Nursery Nurses

Nursery nurses provide care for children up to the age of five years. They work primarily with young patients, although some are employed in nurseries looking after children of NHS staff. The role can be varied depending upon the healthcare setting.

Occupational Therapists (OTs)

OTs work with people of all ages to help them overcome the effects of disability caused by physical or psychological illness, ageing or accident. The profession offers enormous opportunities for career development and endless variety. Paediatric OTs are specifically trained to help

children and young people with their individual needs.

Physiotherapists

A physiotherapist’s core skills include manual therapy, therapeutic exercise and the application of electro-physical modalities. They also have an appreciation of psychological, cultural and social factors influencing their clients. More physiotherapists work in the community and a growing number are employed by GPs. Treatment and advice for patients and carers take place in their own homes, nursing homes, day centres, schools and health centres.

Practice Nurses

Practice Nurses work within GP surgeries and assess, screen and treat patients of all ages. They run clinics for patients with long term conditions such as asthma, heart disease and diabetes. They also offer health promotion advice in areas such as contraception, weight loss, smoking cessation and travel Immunisations.

Speech and language therapists (SaLT)

SaLTs assess and treat speech, language and communication problems in children and young people to help them communicate better. Early referrals to SaLT are recommended as part of a multi-agency approach to supporting child development.

Chapter Summary

This Chapter has looked briefly at the history of school nursing in the UK. It has explored the key roles and responsibilities of the school health team with particular reference to the public health role. It has challenged you to consider if community nursing is for you and also to think about your own clinical skills and what additional skills you may need to work in school nursing.

References:

- DH (2014) School Nurse specification www.gov.uk/government/uploads/system/uploads/attachment_data/file/303769/Service_specifications.pdf
- NMC (2004) Standards for Specialist Public Health Nurses London NMC available online www.nmc.org.uk/globalassets/siteDocuments/Standards/nmcStandardsofProficiencyforSpecialistCommunityPublicHealthNurses.pdf
- NMC (2015) The Code Online: www.nmc.org.uk/standards/code/

Some useful web resources

- www.qni.org.uk The Queen’s Nursing Institute
- www.nhscareers.nhs.uk NHS Careers
- www.rcpch.ac.uk Royal College of Paediatrics and Child Health.www.chimat.org.uk/profiles
- www.gov.uk/government/organisations/public-health-england Public Health England Child Health Profiles
- www.gov.uk/government/uploads/system/uploads/attachment_data/file/216464/dh_133352.pdf Maximising the contribution of school nursing
- www.gov.uk/government/uploads/system/uploads/attachment_data/file/303769/Service_specifications.pdf Maximising the school nursing team contribution to the public health of school-aged children. Guidance to support the commissioning of public health provision for school aged children 5-19

The Queen's Nursing Institute

Transition to the School Nursing Service

Contents

Section A - Thinking about working in the school nursing setting

Chapter 2: Using reflection, identifying learning needs and getting support

Introduction

Whilst working through this resource it is advised that you identify a mentor who can support you whilst going through this online resource. Your mentor must be a qualified nurse and mentor who has had experience of working in school nursing. The main role of your mentor will be to assist with your development both in terms of making the transition to the community setting, working with the school health team (SHT) and identifying any additional support you may need. Ideally you should try and meet with your mentor weekly to reflect upon your weeks learning and to get an experienced school nurse's perspective on the challenges you may face. If you are doing a reflective e-journal it is also good to invite your mentor into your journal so that she can see how you are getting along. The NMC revalidation process (NMC 2015) will require nurses to provide evidence of their learning and we recommend that you use reflection as a tool to assist you.

This chapter will:

- Explore the use of a reflective journal
- Consider the use of reflection tools
- Help you consider your individual learning style
- Use examples from practice

Writing a Reflective Journal

To reflect means to evaluate, consider carefully, weigh up, ponder, contemplate or think purposefully about something. The effect of doing this is to heighten your awareness of what it is you are thinking about. This will also help you recognise the ways in which you learn. If you decide to hand write your journal then we suggest that you record your thoughts and feelings about the way you are using the learning gained from the resource in your daily professional practice. Consider using a hard backed notebook that you can take with you on a daily basis to record your experiences.

We would also like you to consider using an e-journal by clicking on the link below to create a more permanent professional journal that can be used beyond this resource as a way of recording your learning and development journey. https://exchange.bcuc.ac.uk/exchweb/bin/redir.asp?URL=https://sites.google.com/site/appstepbystepuserguide2011/creating-your-portfolio-using-google-sites

In both instances it will be crucial that you share your journal with your mentor so that the experience does not become a 'solitary' exercise and you gain from the reflective conversation and receive feedback form your colleagues and mentor.

Confidentiality

Confidentiality and data protection are important aspects of professional practice. It is very important that any written work concerning practice

‘It is crucial that you share your journal with your mentor so that the experience does not become a ‘solitary’ exercise.’

is anonymous. Real names of individuals and organisations must not be used. Please also access your own Trust’s policy on Confidentiality and be aware of the Department of Health and Professional bodies’ policies.

Department of Health (2003) NHS Code of Practice: Confidentiality. www.gov.uk/government/publications/confidentiality-nhs-code-of-practice

Nursing and Midwifery Council, (2015) The Code: Professional Standards of practice and behaviour for nurses and midwives. www.nmc.org.uk/standards/code

Reflection (guided dialogue)

In all professional roles it is important to reflect upon a situation whether it is deemed to be positive or negative. Reflection is seen as a theory of critical thinking and is a process of reviewing an experience of practice in order to describe, analyse, evaluate and so inform learning about practice (Boud et al 1985). Invariably it is human nature to reflect upon an occurrence when ‘something has gone wrong’ (Taylor, 2006). Reflective practice advocates that we should also reflect upon good practice as a way of enhancing and reinforcing this practice and also as a quality control mechanism.

As a novice in this role, being afforded the time to reflect on action with a mentor is crucial, embracing the recommendation by Thompson and Thompson (2008) that we maximise our ability for noticing. Moon’s (1999) proposal that reflection on action is more appropriate when values and beliefs are challenged reinforces the need for time to be taken. Reflective practice, when values are challenged, can be transformative and Mezirow (2003) argues that for learning to be transformative it must be accompanied by action.

Some reflective practice is deliberate; a planned activity following an action where it is important to review the activity, for example delivering training facilitating group work. Other reflections rise from a feeling generated before, during or after an event.

There are many models of reflection that can be used to assist in reflecting upon practice. Models may be viewed as academic exercises that at times are poorly implemented and poorly understood by practitioners (Quinn, 2008). The model that is used is not as important as long as a process occurs. Johns (1992) model of reflection is commonly applied, the basics of which are:

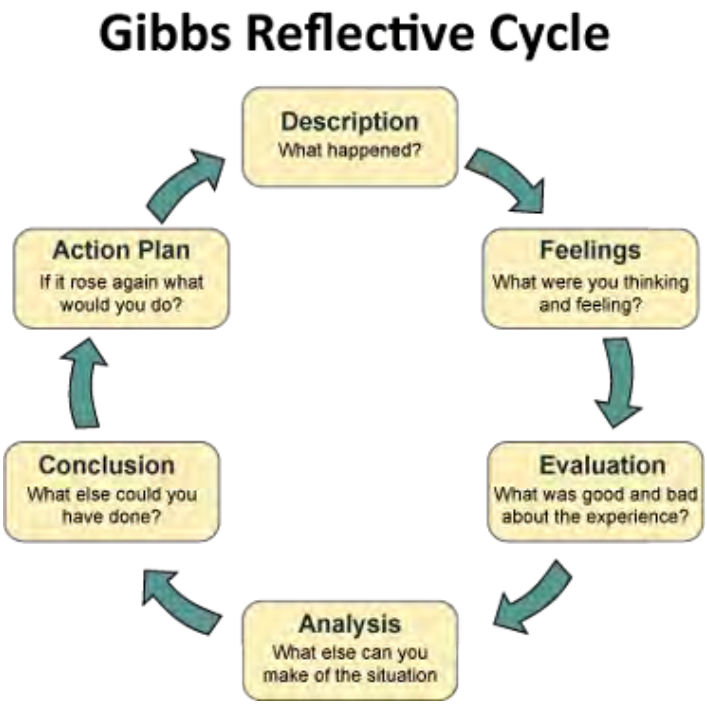
The process of reflection:

- Experience
- Perception
- Making Sense
- Principles
- Application

Reflection then becomes more than just a thoughtful practice; it becomes a process of turning thoughtful practice into a potential learning situation (Johns, 1996).

The learning that occurs must be in some way be utilised, and if it is viewed that practices or behaviours must be changed then how these changes occur need to be considered: “Reflection without action is wishful thinking” Freire (1972) cited in Ghaye (2011)

Here are some examples of reflective models that may assist you to reflect:



In the ‘reflective cycle’ (Graham Gibbs, 1992), there are six steps to aid reflective practice:

- Description: First you describe what happened in an event or situation

- Feelings: Then you identify your responses to the experience, for example, “What did I think and feel?”

- Evaluation: You can also identify what was good and bad about the event or situation.

- Analysis: The 'Feelings' and 'Evaluation' steps help you to make sense of the experience.

- Conclusions: With all this information you are now in a position to ask, "What have I learned from the experience?"

- Action plan: Finally, you can plan for the future, modifying your actions, on the basis of your reflections.

Here is a practice example of reflection using Gibbs:

- Description: First you describe what happened in an event or situation: 'I was doing an immunisation session in a local secondary school. A young girl was 'needle phobic' and appeared to be having a panic attack at the thought of the vaccination. She began to hyperventilate and looked like she was about to faint.'

- Feelings: Then you identify your responses to the experience, for example "What did I think and feel?" 'Initially I was really worried that she might faint or become hysterical in front of everyone. I was unsure at first what I should do to support her and calm her nerves.'

- Evaluation: You can also identify what was good and bad about the event or situation: 'The good aspect was that I identified the problem very early and was able to take her outside, away from the 'audience'. The worrying aspect was that I did not know the school well and was unsure where to take her as there appeared to be no room nearby. However, there were some seats out in the Hallway where we could sit and chat about her worries.'

- Analysis: The 'Feelings' and 'Evaluation' steps help you to make sense of the experience: 'I felt happy that I had the ability to rely on my early assessment and clinical nursing skills to see that the girl was nervous and her breathing was becoming rapid, suggesting anxiety. I needed to draw on my knowledge of phobias to needles and also my empathetic skills to be able to reassure her. Good communication skills are important in these situations.'

- Conclusions: With all this information you are now in a position to ask "What have I learned from the experience?" 'I have learnt to trust my clinical judgements and to realise that I can rely on my own ability in this type of situation. I have also learned to be prepared for unexpected or expected situations to occur in what may initially seem as a routine exercise.'

- Action plan: Finally, you can plan for the future, modifying your actions, on the basis of your reflections. 'In the future I would ensure that I know where to take pupils in the school if there is a problem like this again. I would also like to know if there is any history of anxiety or needle phobia in any of the young people attending immunisation sessions.'

‘It can be useful to get feedback on performance and increase self-awareness of your own practice.’

Johari Window

The Johari window model explores in depth parts of ourselves that we may not as yet have recognised. The challenge is to explore and understand a little bit more about ourselves through a window framework:

1. **Known self**- these are things that you know about yourself and that you may consciously present to others

2. **Hidden self**- these are things that you know about yourself but you choose to hide from others

3. **Blind self**- these are things about you that others can see but are unknown to you

4. **Unknown self**- these are feelings and abilities that you are not aware of and which others have not seen

By considering the four domains it should assist you to identify what is known by you, what is known by others and what is yet to be discovered. It can be useful to get feedback on performance and increase self- awareness of your own practice.

Here is the same practice example of reflection using the Johari Window:

‘I was doing an immunisation session in a local secondary school. A young girl was ‘needle phobic’ and appeared to be having a panic attack at the thought of the vaccination. She began to hyperventilate and looked like she was about to faint.’

1. **Known self** - these are things that you know about yourself and that you may consciously present to others: ‘I felt happy that I had the ability to rely on my knowledge of young people’s potential anxiety in receiving a vaccination. I was also comfortable in my understanding of ‘needle phobia’.

2. **Hidden self** - these are things that you know about yourself but you choose to hide from others: ‘I felt worried that I was unsure whether to remove her from the situation or remain in the hall. If she had fainted on the way out, she may have hurt herself. I was unsure if I was doing the right thing taking her out. ‘

3. **Blind self** - these are things about you that others can see but are unknown to you: ‘When reporting back to my team leader about the anxieties I had about this situation and how I acted, I was somewhat surprised at the amount of faith she had in my ability to cope. She stated that she could see how I had developed over previous months and knew that this type of situation ‘would not faze me’.

4. **Unknown self** - these are feelings and abilities that you are not aware of and which others have not seen: ‘Growing in experience and confidence is often unseen until compared to earlier situations.’

How to write reflectively

“It is often difficult for professionals to say or write about what they know and how they use their knowledge.” Fook J and Gardner F (2007) Practicing Critical Reflection McGraw Hill – Open University Press Berkshire.

Questions to use when writing reflectively:

- Where the event took place?
- Who was involved?
- What actually happened?
- How you were involved?
- What your feelings were at the time?
- What contribution did you make?
- What happened after the situation?
- What did you learn from this experience?
- New knowledge?
- New skills
- Professional development?
- Personal development?

Tips on how to maximise learning time:

- Think of every experience as a learning one - ‘talk as you go’, externalise all your thoughts sharing tacit knowledge.

- Capture all learning opportunities, however minor.

- Try to promote professional conversations with the mentor.
- Develop 'case studies' that maybe used to promote understanding.
- Try to have a short 'review' and evaluation session at the end of each day.

Example of a reflective account

'A thirteen year old boy (Sammi) was referred by the school because of suspected self-harm - cuts on his arms and wrists had been noted by his class teacher. I ran a drop-in in the school each week and saw pupils either by appointment or they were allowed to 'drop in' to see me. I first of all realised the importance of building a good relationship with Sammi and that he was initially reluctant to talk to me. His body language suggested that he was very unhappy and he did not want to make eye contact. I also noted the cuts on his wrists that he tried to conceal by pulling his sleeves over them. I talked firstly about the confidentiality issues: that I was not part of the school therefore, he could talk to me without fear but that if I was worried about him for any reason, I would need to share that information with appropriate people but we would not put him at further risk. I felt that really, that was all I could say in the first instance and that sometimes it is better to be quiet and not try to fill silences. So I sat quietly and allowed him to think about what I had said. Gradually, he began to relax and look up at me. I suggested that he tell me what he enjoyed doing at school and what he didn't. He said he liked maths and English but hated sport. He said that sometimes the other pupils picked on him because he felt so useless in games sessions. He also said that his father had left the family home and he was feeling very sad. We talked about his coping strategies when he felt stressed or sad. We agreed to meet again the following week and I talked to my team leader about possible referral routes to Child and Adolescent Mental Health Services (CAMH).
When discussing this with my team lead she confirmed to me I had done the right thing and that there was not much more we could have done at this stage.

I have learned more about issues around consent and confidentiality when talking to young people and that child protection must be foremost.

I am learning more about self-harming behaviour and what makes young people hurt themselves as a way of dealing with stress. The experience has made me think about bullying and that I need to talk to the school about their bullying policy.

It has also made me consider the importance of building up a relationship with young people and developing further understanding of adolescent development and that sometimes we don't have all the answers but that young people can benefit from a therapeutic, trusting relationship with an adult.

I feel more confident in myself as a result of this experience, that I made the right decisions and I am progressing in my decision-making skills. I am in no doubt that I will come across this type of situation again as self-harming behaviour is becoming more common.'

‘I am learning more about self-harming behaviour and what makes young people hurt themselves as a way of dealing with stress.’

School Nurses’ quotes

‘I had to learn to listen to young people and respect ‘silences’ sometimes.’

‘I need to understand when to refer to other agencies in case of the risk of significant harm.’

‘Recognise your own limitations and never be afraid to ask or seek advice if you are unsure.’

‘It can be lonely at first but you are not on your own, there is always a senior member of staff to help. This will be an exciting challenge in your professional life.’

Learning styles

It might be useful to discuss with your mentor your particular learning style. There are a number of tools that you could use. Here are two that you could share with your mentor. The first is the VARK questionnaire. This identifies whether you learn best using visual, audio, reading or kinaesthetic approaches. The second is the Honey and Mumford Learning styles questionnaire. This identifies whether you are an activist, a pragmatist, a theorist or a reflector. It can be useful to discover how you learn best to help you focus on the most productive way you can progress.

For more information, see below:
http://vark-learn.com/the-vark-questionnaire/

The Honey and Mumford: Learning Styles Questionnaire

There is no time limit to this questionnaire. It will probably take you 10-15 minutes. The accuracy of the results depends on how honest you can be. There are no right or wrong answers. If you agree more than you disagree with a statement put a tick. If you disagree more than you agree put a cross by it. Be sure to mark each item with either a tick or cross. When you have completed the questionnaire, continue this task by responding to the points that follow.

- ☐ 1. I have strong beliefs about what is right and wrong, good and bad.
- ☐ 2. I often act without considering the possible consequences.
- ☐ 3. I tend to solve problems using a step-by-step approach.
- ☐ 4. I believe that formal procedures and policies restrict people.
- ☐ 5. I have a reputation for saying what I think, simply and directly.
- ☐ 6. I often find that actions based on feelings are as sound as those based on careful thought and analysis.
- ☐ 7. I like the sort of work where I have time for thorough preparation and implementation.
- ☐ 8. I regularly question people about their basic assumptions.
- ☐ 9. What matters most is whether something works in practice.
- ☐ 10. I actively seek out new experiences.
- ☐ 11. When I hear about a new idea or approach I immediately start working out how to apply it in practice.
- ☐ 12. I am keen on self-discipline such as watching my diet, taking regular exercise, sticking to a fixed routine etc.
- ☐ 13. I take pride in doing a thorough job.
- ☐ 14. I get on best with logical, analytical people and less well with spontaneous, “irrational” people.
- ☐ 15. I take care over the interpretation of data available to me and avoid jumping to conclusions.
- ☐ 16. I like to reach a decision carefully after weighing up many alternatives.
- ☐ 17. I’m attracted more to novel, unusual ideas than to practical ones.
- ☐ 18. I don’t like disorganised things and prefer to fit things into a coherent pattern.
- ☐ 19. I accept and stick to laid down procedures and policies so long as I regard them as an efficient way of getting the job done.
- ☐ 20. I like to relate my actions to a general principle.
- ☐ 21. In discussions I like to get straight to the point.
- ☐ 22. I tend to have distant, rather formal relationships with people at work.
- ☐ 23. I thrive on the challenge of tackling something new and different.
- ☐ 24. I enjoy fun-loving, spontaneous people.
- ☐ 25. I pay meticulous attention to detail before coming to a conclusion.
- ☐ 26. I find it difficult to produce ideas on impulse.
- ☐ 27. I believe in coming to the point immediately.
- ☐ 28. I am careful not to jump to conclusions too quickly.
- ☐ 29. I prefer to have as many sources of information as possible -the more data to mull over the better.
- ☐ 30. Flippant people who don’t take things seriously enough usually irritate me.
- ☐ 31. I listen to other people’s point of view before putting my own forward.
- ☐ 32. I tend to be open about how I’m feeling.
- ☐ 33. In discussions I enjoy watching the manoeuvrings of the other participants.
- ☐ 34. I prefer to respond to events on a spontaneous,

flexible basis rather than plan things out in advance.

- ☐ 35. I tend to be attracted to techniques such as network analysis, flow charts, branching programmes, contingency planning, etc.
- ☐ 36. It worries me if I have to rush out a piece of work to meet a tight deadline.
- ☐ 37. I tend to judge people's ideas on their practical merits.
- ☐ 38. Quiet, thoughtful people tend to make me feel uneasy.
- ☐ 39. I often get irritated by people who want to rush things.
- ☐ 40. It is more important to enjoy the present moment than to think about the past or future.
- ☐ 41. I think that decisions based on a thorough analysis of all the information are sounder than those based on intuition.
- ☐ 42. I tend to be a perfectionist.
- ☐ 43. In discussions I usually produce lots of spontaneous ideas.
- ☐ 44. In meetings I put forward practical realistic ideas.
- ☐ 45. More often than not, rules are there to be broken.
- ☐ 46. I prefer to stand back from a situation and consider all the perspectives.
- ☐ 47. I can often see inconsistencies and weaknesses in other people's arguments.
- ☐ 48. On balance I talk more than I listen.
- ☐ 49. I can often see better, more practical ways to get things done.
- ☐ 50. I think written reports should be short and to the point.
- ☐ 51. I believe that rational, logical thinking should win the day.
- ☐ 52. I tend to discuss specific things with people rather than engaging in social discussion.
- ☐ 53. I like people who approach things realistically rather than theoretically.
- ☐ 54. In discussions I get impatient with irrelevancies and digressions.
- ☐ 55. If I have a report to write I tend to produce lots of drafts before settling on the final version.
- ☐ 56. I am keen to try things out to see if they work in practice.
- ☐ 57. I am keen to reach answers via a logical approach.
- ☐ 58. I enjoy being the one that talks a lot.
- ☐ 59. In discussions I often find I am the realist, keeping people to the point and avoiding wild speculations.
- ☐ 60. I like to ponder many alternatives before making up my mind.
- ☐ 61. In discussions with people I often find I am the most dispassionate and objective.
- ☐ 62. In discussions I'm more likely to adopt a "low profile" than to take the lead and do most of the talking.
- ☐ 63. I like to be able to relate current actions to a longer-term bigger picture.
- ☐ 64. When things go wrong I am happy to shrug it off and "put it down to experience".
- ☐ 65. I tend to reject wild, spontaneous ideas as being impractical.
- ☐ 66. It's best to think carefully before taking action.
- ☐ 67. On balance I do the listening rather than the talking.
- ☐ 68. I tend to be tough on people who find it difficult to adopt a logical approach.
- ☐ 69. Most times I believe the end justifies the means.
- ☐ 70. I don't mind hurting people's feelings so long as the job gets done.
- ☐ 71. I find the formality of having specific objectives and plans stifling.
- ☐ 72. I'm usually one of the people who puts life into a party.
- ☐ 73. I do whatever is expedient to get the job done.
- ☐ 74. I quickly get bored with methodical, detailed work.

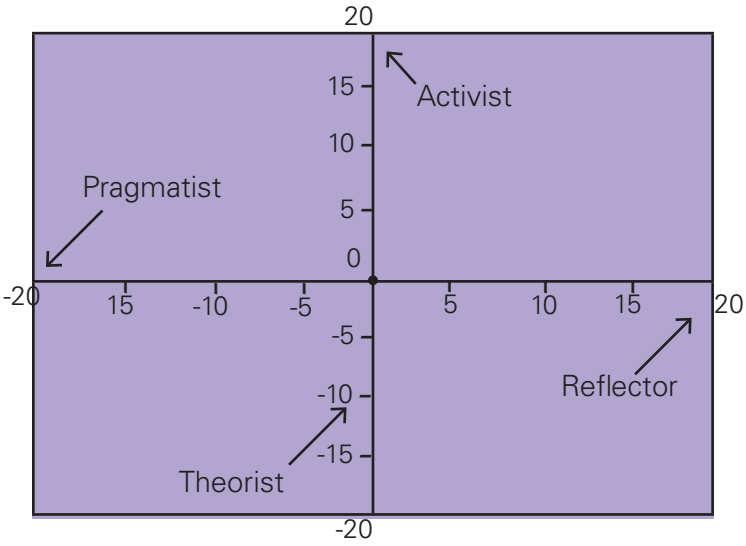
- ☐ 75. I am keen on exploring the basic assumptions, principles and theories underpinning things and events.
- ☐ 76. I'm always interested to find out what people think.
- ☐ 77. I like meetings to be run on methodical lines, sticking to laid down agenda, etc.
- ☐ 78. I steer clear of subjective or ambiguous topics.
- ☐ 79. I enjoy the drama and excitement of a crisis situation
- ☐ 80. People often find me insensitive to their feelings.

Scoring

You score one point for each item you ticked. There are no points for crossed items. Circle the questions you ticked on the list below:

2	7	1	5
4	13	3	9
6	15	8	11
10	16	12	19
17	25	14	21
23	28	18	27
24	29	20	35
32	31	22	37
34	33	26	44
38	36	30	49
40	39	42	50
43	41	47	53
45	46	51	54
48	52	57	56
58	55	61	59
64	60	63	65
71	62	68	69
72	66	75	70
74	67	77	73
79	76	78	80
Totals: ☐	☐	☐	☐
Activist	Reflector	Theorist	Pragmatist

Plot the scores on the arms of the cross below:



Your result may show that you have a particular learning style. It may be useful to bear this in mind as you approach tasks. Was the approach you adopted the best one in the circumstances? Would adopting another learning style have improved your performance?

At this point you may also find it helpful to read through Characteristics of the Four Learning Styles, which follows. This provides more detail and should help you clarify your sense of your own preferred style(s).

Characteristics of the four learning styles

(Sources: Learning Styles. FEDA, 1995; Honey & Mumford, The Manual of Learning Styles. 1992)

	ACTIVISTS	REFLECTORS	PRAGMATISTS	THEORISTS
STRENGTHS	- Doing things - Putting ideas into action - Enjoy change and variety - Flexibility - Acting quickly	- Collection of data from variety of sources - Looking at situations from various perspectives and grasping the big picture	- Practical application of ideas - Integrating theory and practice - Decision-making in organisations - Getting things done	- Creating theoretical models - Thoroughness - Industriousness - Verbal skills - Developing and working with systems
PREFERENCES	- New experiences - Taking risks - Getting involved in activities with people - Getting things done	- More interested in people (how they behave and how they feel) than in structures - To get involved directly and then reflect on the experience - More concerned with processes than outcomes	- More interested in structural aspects of situations than people - 'Hands On' experience	- Dealing with ideas - Solving problems - To know the experts' view - To work alone
CONCERNED ABOUT	- Personal relevance - Doing what interests them	- Personal meaning - The feelings of others - Maintaining wide ranging interests - Harmony	- Testing things out to get correct solution - Practical application of what they learn	- Details - Quality of information - Accuracy of facts - Personal effectiveness - Intellectual ability
PREFERRED WAY OF LEARNING AND WORKING	-Self-discovery, trial and error learning - Learning by doing - Flexible approaches to learning - Not worried about getting it wrong - Can work well with others - Likes attention, chairing meetings, leading discussions etc - More concerned with doing than thinking and feeling - Likes to get stuck in without wasting time	- Learning by listening and sharing ideas with others - Group work and discussions - Looking for meaning -Researching and reviewing - Thinking before doing - Bringing unity to diversity - Standing back from events and observing what happens	- Strong need to work on practical - To use skills and tinker with things - Test theories and apply common sense - Looking at information in a logical way, and then act on it immediately - Workshop and laboratory teaching methods - To solve problems - To reason deductively when focusing on specific problems - Making instinctive judgements based on practicality - Clear goals and adequate rewards	- Enjoy being taught in a didactic way - Prefer to work individually rather than in groups - Like to have access to a lot of information/ resources - Collecting data - Enjoy reading - To specialise - Planning organising work - Thinking things through - Reworking notes/essays to achieve best results - Make links b/w ideas - Examining info carefully - Critically evaluation information - Thinking sequentionally - Deductive reasoning

'Identify your sources of support early on so that the feeling of isolation can be minimised.'

	ACTIVISTS	REFLECTORS	PRAGMATISTS	THEORISTS
DISAD-VAN-TAGES	- Doing too many things at once - Lack of planning - Poor time management, leaving things to last minute - Lack of attention to detail - Not checking/testing things out - Jumping in too quickly and not thinking things through - Being too pushy at times - Giving insufficient consideration to alternative ways of doing things - Inability to stand back and allow others to take action	- Easily distracted - Waste too much time before getting started - Frustrated by action plans - Can be too easy going - Sometimes indecisive - Can forget important details - Tend to work in bursts of energy - Inability to act spontaneously	- Lack of patience with people's suggestions - Wanting to do everything their way - Lack of imagination - Poor presentation - Details can get in the way - Inability to consider alternatives - Intolerance to woolly ideas - Only doing what is perceived as directly relevant to a given task - Need to be in control and to do it alone - Not interested in concepts or theories	- Need a lot of information before starting work - Reluctant to try anything new - Like to do things in a set way - Get bogged down in theory - Don't trust feelings but rely on logic - Overcautious: don't take risks - Heavily reliant on expert opinion without considering other views - Uncomfortable in group work - May have difficulty understanding emotions and feelings

Getting support while you learn

Many nurses new to the community highlight the isolation they can experience as a lone worker, perhaps having come from a ward environment where there is always someone to talk to and to access for advice. It will be important that you identify your sources of support very early on so that the feeling of isolation can be minimised. Good practice would be to be able to identify a support contact person whilst working; this may be your mentor or another member of the school nurse team.

Preceptorship

If you are a newly qualified nurse the NMC strongly recommends that all 'new registrants' have a period of preceptorship on commencing employment NMC (2008).

The role of the 'preceptor' is to:

- Facilitate and support the transition of a new registrant.
- Facilitate the application of new knowledge and skills.
- Raise awareness of the standards and competencies set that the new registrant is required to achieve and support to achieve these.
- To providing constructive feedback on performance.

This is a crucial area of support as the first year in practice is often a stressful time. The learning that has occurred at university in order to develop a level of knowledge and proficient skills in nursing produces highly motivated and professional individuals. It is acknowledged that the realistic nature of practice with all its resource issues and other frustrations can lead to a demoralised nurse very quickly. A good preceptor will be someone who will support the consolidation of knowledge and skills, be a listening ear and be positive in their approach to ensure that there is a low attrition rate.

Clinical Supervision

You should have regular clinical supervision sessions. Clinical supervision in the workplace was introduced as a way of using reflective practice and shared experiences as a part of continuing professional development (CPD). It has the support of the NMC and fits well in the clinical governance framework, whilst helping to ensure better and improving nursing practice. You should also have specialist child protection supervision when you are involved in those cases.

The RCN have developed guidance on clinical supervision: www.rcn.org.uk/__data/assets/pdf_file/0007/78523/001549.pdf

www.cqc.org.uk/sites/default/files/documents/20130625_800734_v1_00_supporting_information-effective_clinical_supervision_for_publication.pdf

Chapter summary

This chapter has encouraged you to identify a mentor to support you in practice. We have suggested that you use a reflective journal and ideally, a professional one that you can use throughout your career. It has also identified ways in which you can think about your individual learning style to help you learn more effectively. Lastly, this chapter has given some advice about seeking help through preceptorship and clinical supervision.

References/website

NMC Revalidation www.nmc.org.uk/standards/revalidation/what-revalidation-is/

The Queen's Nursing Institute

Transition to the School Nursing Service

Contents

Section B - Working in the community

Chapter 3: Developing your role in the school health team.

Introduction

This chapter aims to help you develop your understanding of working in the community within school nursing practice and a School Health Team (SHT). You will need to develop your skills and knowledge of working with children, young people and their families and understand the factors that influence their health and wellbeing.

The aim of this Chapter is to:

- Consider issues around moving to public health nursing and assessing the needs of children, young people and their families
- Develop an understanding of the community setting as a work environment
- Extend your knowledge of the skills you need for working with families, children and young people.

When making the transition from another area of nursing practice to community or school nursing, there are many practical aspects that may need to be taken into consideration. You may be moving from the hospital setting into the community, from one community discipline to another or from one geographical area to another. One key factor will be to familiarise yourself with the emphasis on public health practice, which may be unfamiliar. The focus of public health is to increase healthy life expectancy and reduce the differences that exist in life expectancy between communities. A key to this is to establish a good start in life for children and help young people and their families to make healthy lifestyle choices.

Reflection point: Think about the term 'healthy life expectancy' and consider what this means to you. How different is public health practice from the one that you are familiar with?

There is much evidence to suggest that where you live is a key determinant of health and therefore, as an initial exercise, take some time to explore the area where you will be working and take note of:

The people in the area

- Is there an ethnic/cultural mix evident?
- Are there many young people/teenagers?
- Are there many older people?
- Can you identify different types of family?
- What type of housing is in the area?
- Is there a mix of accommodation types?
- What condition are the houses in?

What does the environment look like?

- Cleanliness of the streets
- Graffiti
- Parks and green spaces
- Children's playgrounds

The Facilities in the area such as:

- Primary Schools?
- Secondary Schools?
- Are there local shops?
- Is there a pharmacist?
- Is there a supermarket nearby?
- Post Office?
- Where is the nearest GP Surgery?
- Community Centre ?
- Children's Centres?
- Religious establishments/Places of worship?
- Youth clubs or other places for YP?
- Leisure Facilities?
- Police station?
- Library – you might find some useful information about the local area here.

Transport

- What public transport is available?
- Are there frequent bus services?
- What else can you tell about the area?
- Is it rural or urban?
- Are there any local businesses?
- Consider local employment opportunities e.g. are there large employers?
- Can you tell if there are any particular cultural or ethnic groups in the area – how do you know this?

Reflection point: What might this information tell you about your local practice area? How might this information help to you understand the local influences on the health and wellbeing of children, young people and their families?

Local health information can be found through Joint Strategic Needs Assessments (JSNA). These are developed through Health and Wellbeing Boards locally and aim to improve the health and wellbeing of local communities. They are intended to be a continuous process of assessment and planning to develop local priorities according to local need.

You can find out more about these strategies and discuss them with your mentor:
www.gov.uk/government/uploads/system/uploads/attachment_data/file/223842/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-2013.pdf

You will also need to be aware of other information that will help you to understand the particular health needs of the local population. The following list of resources may be helpful for you to access information to gain a greater understanding about the health needs of the children, young people and families you are working with.

Discuss these with your mentor to find out what data is kept by school health locally and how you might access them:

- Existing School Health Profiles
- Child and Maternal Health Observatory (Chimat) information
- Previous community Health Needs Assessments
- Existing School Health Records
- Local A and E attendance rates
- Trust health profiles
- Local Authority Data
- Local Public Health Reports
- Healthy Schools Data
- Information held by schools / clusters (local authority)
- Local Children and Young People's Plans
- Local crime statistics in your area

Public Health Issues

The key public issues today are well recognised both nationally and internationally and the burden of disease across the world is highlighted by the World Health Organisation (WHO). In high income countries such as the UK, particular public health problems include: cardio-vascular disorders, obesity, smoking, diabetes types 1 and 2, mental health problems and cancer.

See the fact sheet on the WHO website for an overview of world health: www.who.int/features/factfiles/global_burden/facts/en/index5.html.

Also see the link below for the Public Health Outcomes Framework:
www.gov.uk/government/uploads/system/uploads/attachment_data/file/216159/dh_132362.pdf

The key priorities for Public Health England are:

1. Helping people to live longer and more healthy lives by reducing preventable deaths and the burden of ill health associated with smoking, high blood pressure, obesity, poor diet, poor mental health, insufficient exercise, and alcohol.

2. Reducing the burden of disease and disability in life by focusing on preventing and recovering from the conditions with the greatest impact, including dementia, anxiety, depression and drug dependency.

3. Protecting the country from infectious diseases and environmental hazards, including the growing problem of infections that resist treatment with antibiotics.

4. Supporting families to give children and young people the best start in life, through working with health visiting and school nursing, family nurse partnerships and the Troubled Families programme.

5. Improving health in the workplace by encouraging employers to support their staff, and those moving into and out of the workforce, to lead healthier lives.

To underpin these outcome-focused priorities PHE plans to:

- Promote the development of place-based public health systems.
- Develop its own capacity and capability to provide professional, scientific and delivery expertise to our partners.

See the link below:
www.gov.uk/government/uploads/system/uploads/attachment_data/file/192676/Our_priorities_final.pdf

The causes of disease can be attributed to a number of factors including: the environment in which we live, the lifestyle choices that we make and the spread of infectious diseases. There are avoidable, non-communicable diseases, which begin in childhood; the SHT can contribute in many ways to influence the choices that young people make and support families to live healthier lives. This has to be balanced with broader political or social influences, which may be out of the control of the individual. It is important to take care not to make judgements about the way people live their lives.

There is also a responsibility for SHT's to contribute to the reduction in the spread of childhood infectious diseases. This is achieved through immunisation and vaccination programmes and also through health education in the community. For example, hygiene, hand washing advice or advice to parents about when to keep their child off school when they are ill.

More specifically, some of the ways that school nurses contribute to the public health agenda is to:

- Lead and deliver the Healthy Child Programme 5-19.

- Help to improve readiness for school by working in partnership with other agencies, such as health visitors, and screening children as they enter the school system.

- Build community capacity – for example working with schools to help create a healthy and safe educational environment.

- Contribute to the obesity agenda by tackling excess weight in 4-5 and 10-11 year olds through the NCMP and also through health education on nutrition and healthy eating.

- Support positive emotional health and wellbeing development throughout early childhood into young adulthood through education and providing one to one help and support where appropriate.

- Help young people make decisions about sexual health through

contributing to the sex and relationships education curriculum as well as providing sexual health services in schools or signposting to other community services if necessary.

- Contribute to reducing smoking, drugs and alcohol use in young people through early education and ongoing individual support as children and young people develop.

- Increase population vaccination cover through the childhood immunisation programmes.

- Provide good evidence to commissioners (JSNA) for services through assessing and determining individual and local needs. This will include evaluation of services already in place.

Discussion point: think about some of these public health issues and your local needs assessment. Discuss with members of the SHT and your mentor to identify what is being done in your local area and how success is measured and reported to commissioning bodies.

Working together

It has been recognised for some time that public health problems cannot be solved by one approach and there has also been a drive to increase the involvement of communities in addressing local issues. This approach has been termed different things by different governments such as: building community capacity, community engagement and building social capital.

The fundamental principles are:

- Using 'bottom up' approaches as well as top down policy. This is sometimes referred to as upstream and downstream strategies (see - The ambulance down in the valley: www.youtube.com/watch?v=qXNWWRFcrVE)

- Understanding (and respecting) the skills and knowledge of the population.

- Utilising the potential within a community (social capital).

- Building effective alliances/partnerships - this requires breaking down professional boundaries and working together.

You will work with a range of health professionals as well as education, social care and the voluntary sector and you will need to familiarise yourself with who you are likely to work with in the local area. There may also be individual differences between areas in the types of public health initiatives that are in place. Discuss with your mentor what is happening in your area and think about how local people are engaged in projects.

Working with families, children and young people

There is a diverse range of family types in the community, including those that may be experiencing hardship for a variety of reasons. Children and young people may be living with their biological parents, adoptive parents, grandparents or foster parents. They may be with a single parent, with same sex parents, living in an extended family or within a stepfamily. Understanding the individual circumstances of the families that you are working with is important for you to develop a good, trusting relationship with them.

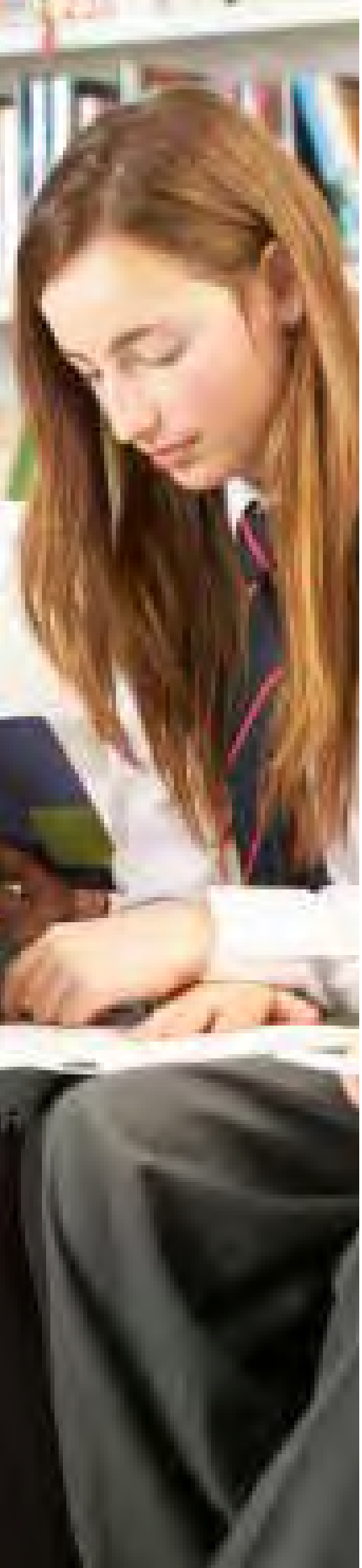
You are most likely to first encounter a family when a child enters the education system at five. Children with particular, additional health or social needs may already have been identified and care packages put in place, but there may be others where issues arise from health screening which requires you or the team to talk to the family.

Case scenario

You have measured Tom's (age five) height and weight on school entry as part of the NCMP. He falls into the overweight category and the school is also concerned that his older sister Hayley in year 6 is overweight and is finding it difficult to join in any physical exercise. This has been getting gradually worse over the last two years. Hayley is being teased by her classmates and Tom's class teacher is beginning to see the same thing happening to him.

- What would be your first step in this scenario?
- What might you need to find out?
- Who would you discuss this with?
- How would you approach Hayley and Tom's family?

You will need to discuss this scenario with your mentor and the school nurse team in the first instance. You could also discuss with the class teachers and any pastoral support workers in the school. You could also liaise with the health visitor to see if there have been any issues in the past.



It would be useful to establish the family circumstances and in particular if there have been any changes in the family circumstances that the school is aware of, as the problem for Hayley has been developing over the previous two years.

You or your mentor might meet with the Tom and Hayley's parents or carers to discuss this issue and offer support. This meeting needs to be sensitively approached for obvious reasons, but where children's physical health or mental wellbeing may be at risk as in this case, there may be a need to be assertive. Hayley will be moving up to secondary school and there is a risk of the teasing becoming more serious bullying. Being honest with parents/carers is very important and highlighting the risks will often help parents make positive changes. Knowing that you are there to help and support them and not judge their decisions will help to develop trust.

Case Scenario (talking to young children)

You have spoken to Tom and Hayley's mother (Anne) and although very defensive to begin with, she has become very grateful for any help that can be offered to her and the two young children. She also reveals that she has an older teenager at the local secondary school (Sasha) who is 14. Two years ago, their father (Stuart) left the family home and Anne has been finding it difficult to cope both emotionally and financially. Anne says she has times where she is feels very low in mood and she has been buying cheap, fast food, partly because she has lost the desire to cook and partly because she is struggling financially. She is particularly worried about Hayley and asks if you could talk to Hayley in school.

- Think about the problems for Anne, Tom, Hayley and Sasha, what would you do first?

In the first instance, you should talk to your mentor:

- It might be sensible for Anne to seek some help from her GP. She may be depressed and need extra support.

- As you have developed a good relationship with Anne and have here consent to see Hayley, it would be appropriate for you to talk to Hayley and assess the situation.

- You would need to find out the most appropriate time at school for you to talk to Hayley and make sure that she is happy to come and see you. Taking children out of lessons can highlight the issue to others, so think about this carefully.

- Talking to children at lunchtime can work quite well but, negotiate with the school and the class teacher.

- You will need to establish a relationship with Hayley where she will feel comfortable and safe to talk to you. You will need to be open and honest with her from the start and ensure that she understands that she can talk to you freely, but if she tells you anything that makes you worried about her, you would share it with appropriate people. Finding out about her and her interests is a good start: ask what she likes to do and what she doesn't like in school for example. She may open up to you, she may not. It is advisable not to rush a first contact but establish with her if she feels that she would like to talk to you further. You may be able to assess her

‘Being honest with parents/carers is very important and highlighting the risks will often help parents make positive changes.’

mood by her body language: does she make eye contact for example, is she chatty or very quiet, and is she nervous or confident? You will need all your observational skills in this first contact. You can then decide whether it is sensible to see Hayley again yourself or if someone else would be more appropriate. It is very important to abide by the Code of Professional Conduct (2015) and not undertake anything that you do not feel qualified to do.

- If you felt that she needed a referral to child and adolescent mental health services (CAMHS), for example, you would need to discuss this with the school nursing team.

Some of the issues for Hayley might be:

- Her weight
- Her father leaving the family home
- Her mother’s possible depression
- The teasing that she is experiencing in school

Case Scenario (talking to young people)

You have spoken to Hayley in school and established a good relationship with her; she is happy to come and talk to you and looks forward to seeing you. At the moment, it is not thought that she needs more input from CAMHS and you have discussed this with your mentor. Her main worry is about her mother and that she does not see her father very much now he has left the family home.

Anne (Hayley’s Mum) has been to the GP who has arranged some talking therapy sessions for her. She has found a part time job now that Tom is at school and is feeling much happier. You have given her some leaflets about cooking healthy meals and portion sizes and with the extra money from the job and more time, she is able to shop more sensibly and is beginning to enjoy cooking for the family again. You now have a good relationship with Anne as well as Hayley and she often calls to see you at the school when you are in.

On one of these visits she raises some concerns about Sasha, her 14 year old who is at the local secondary school and asks if you can help. Sasha is apparently becoming more withdrawn and although was also overweight like Tom and Hayley, she now seems to be losing weight very quickly and Anne has noticed that she is avoiding eating with the family.

- What do you think the issues might be?
- Who should you talk to first?
- What are the differences in talking to Hayley who is 11 and Sasha who is 14?
- Think about the key communication strategies for talking to teenagers and talk to your mentor about them.

Some of the issues for Sasha might be:

- The problems associated with puberty: physical changes/ ideal body image
- Worrying about her mother
- Her father leaving the family home
- School and exam pressures
- Peer influences (possible bullying)
- Perhaps the early signs of anorexia

If it is considered appropriate for you to talk to Sasha, you will need to carefully consider how you will do this. You will need to find out if she wants to talk to you in the first instance and if so, where would she like to do this? This approach may be made through Anne or through a trusted teacher at Sasha’s school. You could do a home visit, Sasha could come to your base or she may be happy to see you in school. She may want to communicate in a different way, for example through texting services if that is an option in your area of work.

Finding out what young people want from communication strategies is important. You will find that there are a range of issues that young people want to communicate about and you may become a trusted person for them. A flexible approach is important and an embracement of the technology that they use in the modern world. Text messaging for example has been used in many school nurse teams very successfully; this can provide good signposting to appropriate services and also can be used to answer sensitive questions when they don’t want a face to face encounter. Face to face contacts can draw attention to individuals and if they are worried about being bullied this may not be the most appropriate method of communication.

Some schools have also set up web pages for health issues and this also helps to make the school nurse more visible and accessible. Alternatively, there are some areas where school nurses are based in a secondary school with responsibility for the feeder schools. This means that young people may be more accustomed to this availability and may be more likely to access a face to face service.

One of the primary concerns for young people when talking to adults is confidentiality. While complete confidentiality should never be promised to young people, they need to be confident that you will act in their best interests and you must be clear from the outset about this if you talk to Sasha.

You will need to ensure that you explore local guidelines about talking to young people between the ages of 13-16 if you did not have consent from a parent/carer.

Fraser guidelines are often used to help form these policies around talking to young people. These guidelines originated to allow health professionals to provide sexual health services to young people under 16 and have been used to also allow health professionals to advise young people in other areas of their health without the consent of a parent/carer.

Discuss these guidelines with your mentor and look online for further information:
http://www.gpnotebook.co.uk/simplepage.cfm?ID=x20050425225930411760

http://www.nspcc.org.uk/preventing-abuse/child-protection-system/legal-definition-child-rights-law/gillick-competency-fraser-guidelines/

Some general tips when talking to young people (Wright 2012) :

- Consider position - This need to be comfortable for you and the young person. This may mean sitting to one side rather than directly in front. Avoid a barrier between you such as a desk or table.

- Body Language – You should be relaxed and open. Sitting forward slightly tends to demonstrate attentiveness. Crossed arms can be seen as defensive. You can also take the opportunity to observe the young person's body language. Are they agitated, worried, uncomfortable, restless, constantly looking at the door, reluctant to engage. These may mean that they are not really ready to talk to you or that they are nervous and may take time to settle down. As nurses we also make an assessment of their physical appearance; are they tired, pale, thin, overweight etc.

- Eye contact – be careful with eye contact, it is good to show that you are interested in the young person but they can find it threatening if you stare. In some cultures, eye contact is seen as disrespectful so judge each situation on its own merit.

- Privacy – Ensure that you have no interruptions when talking on a one to one basis. Turn off your phone and ensure no one is going to disturb you for the duration of the session.

- Listen carefully – active listening means that you need to ensure that you understand what is being said. This can be problematic with adolescents when they use language that you may not understand. Feedback and clarify as you go along but don't interrupt. Don't be tempted to fill silences, wait for the young person to speak and give them time to do so.

- Be non-judgemental - You may not like what the young person

‘One of the primary concerns for young people about talking to adults is around confidentiality.’

is telling you but in order to build trust, you must remain neutral in your expressions and body language. However, you must follow guidelines on confidentiality and child protection.

- **Show empathy** – No one can fully understand another person’s experience as this is unique to them, but you can show that you are sensitive to their situation.

- **Confidentiality** – you must establish from the start that you may have to disclose information to others if you are worried about the young person’s safety.

- **Consider clear ‘endings’** - agree timings and keep to time for the sessions; young people will respond better to a structure. They will begin to trust you if you do as you say you are going to do. Equally, agree how many times you need to talk and fix that at the first session if necessary.

Case scenario - summing up

The key issues in the scenario were the weight issues for the whole family and the potential impact of this on their mental health and wellbeing. There was also an issue around the father of the children leaving the family home and the effect of this loss on the family.

The school nurse team’s action in this case is to:

- Make contact with the family and establish a none-judgemental, supportive relationship to understand the situation.

- Offer nutritional advice about healthy eating, portion sizes and recommend eating together as a family. (In some cases, a referral to the GP or a dietician might be a useful option). Increasing physical exercise would also be important to highlight once a relationship is established. A discussion around sleep may also be useful as obesity in children and young people has been shown to be related to poor sleeping patterns.

See the leaflet on this from NHS choices: http://www.nhs.uk/Livewell/Childrenssleep/Pages/childrenssleephome.aspx

- Ongoing measurements of weight might be an option, but care has to be taken when deciding this. NICE guidelines suggest that there needs to be an individualised plan for children and young people and it is more important to establish healthy eating habits and increase physical exercise than to weigh too often which may be more emotionally damaging.

The NICE obesity guidelines for children and young people can be found at:
http://www.nice.org.uk/guidance/ng7/chapter/1-Recommendations#4-further-advice-for-parents-and-carers-of-children-and-young-people

- Offer support to Anne and give her a chance to talk - a referral to the GP might be advisable.

- Discuss some support for Hayley and Kate and ensure the most appropriate person or service is involved; this might be the qualified school nurse, a community staff nurse, a counsellor or it might be Child and Adult Mental Health Services (CAMHS).

Chapter Summary

This chapter began with an overview of the public health role of school nurses and the School Health Team (SHT). It has encouraged you to consider the skills and knowledge that you need in your role and how you might work with families, children and young people. It has given an example scenario of two key public health issues: obesity and emotional health and wellbeing and how you might develop your communication skills with a family.

References/ Web Resources

- Child and Maternal Health Observatory (Chimat) www.chimat.org.uk

- Childhood obesity http://www.noo.org.uk/uploads/doc/vid_11762_classifyingBMIinchildren.pdf

- Census data www.ons.gov.uk/ons/guide-method/census/2011/index.html

- Department of Health Website www.gov.uk

- Joseph Rowntree Foundation http://www.jrf.org.uk/search/site/young%20people

- Local Health Profiles http://www.apho.org.uk/

- National Children’s Bureau http://www.ncb.org.uk/

- NHS Health Information Centre for Health and Social Care http://www.hscic.gov.uk/

- NMC (2015) The Code Online: http://www.nmc.org.uk/standards/code/
- Office for National Statistics http://www.statistics.gov.uk/hub/index.html
- Public Health England https://www.gov.uk/government/organisations/public-health-england
- Public Health Outcomes Framework https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216159/dh_132362.pdf
- https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/377450/Framework_for_personalised_care_and_population_health_for_nurses.pdf
- Young Minds www.youngminds.org.uk
- Wright J (2012) School nurse survival guide: common questions and answers for the school nurse. London, Quay books.

The Queen's Nursing Institute

Transition to the School Nursing Service

Contents

Section B - Working in the community

Chapter 4: Supporting developmental needs across the lifespan

Introduction

In your role working with the School Nursing Team (SNT), developing an understanding of developmental milestones will help you with the key skills needed to deliver the Healthy Child Programme (HCP) 5-19 (DH, 2009). This will enable you to identify when children or young people need referrals to other agencies or when they will need more targeted support from the SNT. You will be involved in monitoring children and young people at transitional points in their lives: entering education, moving to secondary education, going through puberty or dealing with traumatic events in their lives.

The aim of this Chapter is to:

- Develop understanding of child and adolescent development
- Discuss what factors influence this development
- Explore the transition into adulthood
- Discuss the role of the school nurse in supporting developmental needs

It is important for school nurses to understand what 'normal' (sometimes termed typical) child development looks like and how to identify problems that may impact on children and young people achieving optimum health outcomes. This chapter explores the key areas of physical, cognitive, social and emotional development of children and young people and the factors that will impact on them. In particular the chapter will focus on:

- Developmental milestones
- Attachment theory and how this impacts on the development of relationships
- Understanding of adolescence
- Transitions: for example starting school or moving up to secondary school.

‘It is important for school nurses to understand what ‘normal’ child development looks like.’

A guide to some broad developmental milestones in the school years

Stage of development	Physical development	Cognitive development	Social and emotional development	Network of significant relationships	Coping strategies (adaptive qualities)
Early School Years KEY STAGE 1 (5-7)	-Growth - Approx: Girls - Weight: 12-32 kgs, Height: 100-134 cm Boys - 15-31 kgs, Height: 101-135cm -Gross and fine motor skills –e.g. hopping and writing. Able to walk heel to toe. -Bladder control - 85-90% 5-7 year olds dry by night	-Conversation developing clear to those outside usual contacts -Rate of vocabulary varies but may have 15,000 words, gaining 3000 per year -By 7 understands and uses conjunctions, tag questions, passive tense and infinitives. -Begins to see the world in terms of rules -Thinking generally related to specific experiences . -Beginning to use simple logic -By 7 able to categorise items, eg dinosaurs, football teams -Using number and learning to tell time -Has simple concepts of distance, time and speed.	-Gender identification – development of self -Early moral development -Peer play/making friends	-Family, culture, environment, school, friends.	-Development of inner processes such as reactions to crises - Resilience. -Developing a purpose and the courage to pursue personal goals
Middle childhood KEY STAGE 2 (7-11)	-Growth: Long bones and trunk lengthen. Start of puberty. -95% 10 years olds have bladder control but boys are over represented in those not dry by night	-Beginning to see and understand other’s points of view -Increasing complexity of language and number of words -Developing syntax (grammar), using and understanding conjunctions, tag questions, passive tenses and infinitives	-Friendships – peer influences -Skill learning -Self-evaluation -Team play	Family etc, school, wider environment, teachers, friends	-School rules and boundaries -Family beliefs etc -Self esteem -Developing understanding and competence - skills and knowledge
Adolescence KEY STAGE 3 (11-14) KEY STAGE 4 (14-16)	Adolescent brain development	-Able to think in abstract terms -Sees others points of views -Hold strong beliefs	-Emotional development -Membership of peer group, peer pressure	-Peers, family, school, teachers, environment	-Boundaries/respect for parents and society as a whole

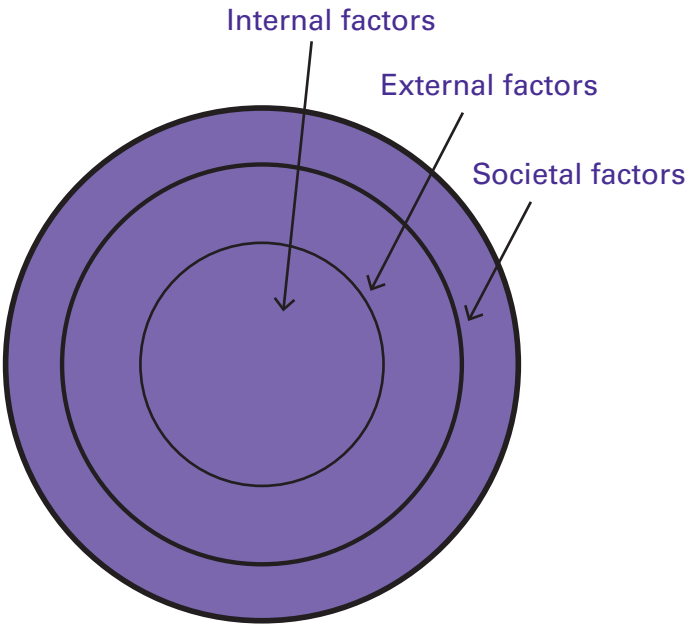
A guide to some broad developmental milestones in the school years

Stage of development	Physical development	Cognitive development	Social and emotional development	Network of significant relationships	Coping strategies (adaptive qualities)
Adolescence CONT. KEY STAGE 3 (11-14) KEY STAGE 4 (14-16)	Girls: -Commencement of Puberty: 8.5-12.5 years of age. -Oestrogen stimulates growth and development of reproductive organs -Breast development -Growth of pubic and axillary hair -Rapid growth in height -First menstruation approximately 2.5 years after start of puberty Boys: -Commencement of Puberty 10-14.5 years of age. -Androgens, largely testosterone, stimulate growth and development of the reproductive organs -Testicular enlargement and growth in length and girth of penis -Change in voice with lowering of pitch of voice -Growth in height later and more marked than in girls -Hair growth in pubic, axillary face and chest areas		-Romance and sexual relationships -Mood swings in evidence possibly as result of hormones or of different and changing expectations -Confidence develops and becoming more independent -Developing own identity separate from family - Friendship based on intimacy		-Developing drive and ambition, setting own goals -Developing relationships and loyalty to others
Young adulthood (18-24)	-Continued physical maturation -Brain development -Possible changes to sleeping patterns	-Able to think in abstract terms -Sees others' points of views -Hold strong beliefs	-Autonomy from parents -Gender identity -Internalised morality -Career choice	-Society, friends, work, college, culture, social class etc	Personality, personal experiences of, for example bullying. -Ability to find work etc -Develop own, individual values and beliefs, may or may not be related to parents/ family

Reference: Adapted from Thurtle and Wright (2008)

‘One of your key roles will be to help support the transition of children into school.’

Think about the factors that will affect these expected developmental milestones with your mentor and fill in the chart below:



Some internal factors:

- Genetic factors (for example the impact of disability)
- Congenital factors
- Personality
- Temperament
- Internal motivation

Some external factors:

- Family relationships
- Family structure
- Position in the family
- Family expectations and encouragement
- Cultural factors
- Domestic abuse (both direct and observed)
- Individual circumstances (for example living in poverty)
- Substance use/misuse
- Community networks

Some societal factors:

- National and local health, social and education policy
- Societal attitudes to children and young people
- Community cohesion

The transition into school

One of your key roles as part of the SHT will be to help support the transition of children into school. This is a huge transition for children as they become more independent from their family and develop their learning potential as well as how to socialise with others. Working with other professionals will be important for you to support children entering the education system. In particular, good liaison with health visitors will help to ensure a seamless transition into school and help with school readiness.

See the pathway for the transition from the early years to school: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216466/dh_133020.pdf

Many children now attend early years’ settings before school and so have developed some of their social skills. The education system at five however, does put more pressure on learning and achieving in a more structured way. Children are also expected to learn how to behave appropriately to be able to ‘fit in’. An awareness of factors that will impact on learning, social and emotional development is important.

One aspect of physical development that you may encounter in the primary school is continence (soiling and enuresis). Most children will be dry during the day when they enter school but some may be wetting at night and this will cause concern for some parents and they may ask you for help. You will need to be aware of local services and the SHT team may be involved in clinics or other models of treatment and care. Some general, initial advice that you could give (from ERIC (Education and Resources to Improving Childhood Continence) includes:

Take a history of the bed-wetting - for example is it a new problem/is the child unwell; if not:

- Talk to parents about fluid intake and bedtime routine. Fluid should be encouraged rather than reduced.
- Lifting a child to the toilet when they are asleep is not recommended: an alarm is needed to wake them up.
- Emphasise that bed-wetting is not the child’s fault and encourage parents/carers to avoid punishing the child
- A reward system could be tried with care.

If this advice is not sufficient then ERIC/NICE guidance suggests:

- An alarm
- Desmopressin
- Alarm and desmopressin.

You will need to explore the ERIC website for more information about enuresis and also about other continence issues such as constipation or soiling www.eric.org.uk.

NICE guidance: www.nice.org.uk/guidance/cg111

The importance of early attachment

Attachment can be defined as: 'an affectional tie that one person or animal forms between themselves and another specific one – a tie that binds them together in space and endures over time.' (Ainsworth 1969)

Evidence suggests that early attachment to a main carer has a positive long term effect on healthy adult relationships. This is sometimes referred to as social and emotional competence or emotional intelligence. Emotional intelligence enables individuals to understand their own emotions and those of others, which help them to develop empathy. This is important for socialisation – those who cannot display empathy are more likely to become socially isolated, find it difficult to make friends and later this may lead to violent crime. Attachment, along with other factors also impacts on the development of resilience. Resilience is associated with the ability to cope with change in our lives. Individuals who have good resilience are likely to cope with traumatic events better than those who don't.

Discussion point: discuss with your mentor/find out about the different types of attachment: secure, avoidant, ambivalent or disorganised.

The SHT should be made aware of children who may be displaying signs of poor attachment. The reasons for poor attachment may include:

- Mothers who have experienced post natal depression
- Neglectful relationships
- The 'toxic trio': domestic violence, substance misuse and mental ill health

It is very important to ensure that you don't make assumptions about perceived 'attachment disorders behaviours'. There may be other explanations for some of these behaviours such as Attention Deficit Hyperactivity Disorder, Autistic Spectrum disorders, parenting issues or a traumatic event in the child or young person's life. Behaviours identified by you, teachers or others should be carefully assessed by the most appropriate professional to ensure that parents do not feel 'blamed' for their child's behaviour. Discuss referral routes in your areas with your mentor.

Potential signs of poor/insecure attachment

Early signs - possibly at school entry or soon after:

- Being either very clingy or appearing distant and independent with adults
- Alienation/opposition to parents/carers
- A low self esteem
- Difficulty in making friends (may be antisocial behaviour)
- Lacking self-control (maybe becoming angry or aggressive)
- Some speech and language problems
- A lack of empathy
- Difficulty in concentrating/sitting still or learning

'Helping parents to think about how they manage their child's behaviour may be a part of your role.'

Possible later signs in childhood/adolescence or young adulthood:

- Antisocial behaviour/violence/crime
- Lack of empathy
- A lack of self-control
- Difficulty in dealing with stress or adversity
- Isolation
- Depression

The SHT will need to engage parents/carers in the process of intervention to gain their trust and ensure that the most appropriate plan is in place for the child or young person. It may be that parents/carers have their own concerns as well; one indicator of problems may be if the behaviour is the same in any setting that the child or young person is in. Sometimes, children and young people behave appropriately in school but not at home and parents/carers might seek your help.

Helping parents to think about how they manage their child's behaviour may be a part of your role. You may be involved in a number of ways: you could work one to one with a parent if appropriate, you could help run a parenting group or you might need to refer on to other services such as CAMHS. There may also be other support groups in the area for parents; find out what is available in your area and discuss your role with your mentor.

Attachment is an important area for you to think about and you can do more reading on this. Here are some good resources for you to access:

Why Love Matters: http://www.ecswe.net/downloads/publications/QOC-VII/Chapter3-Why-Love-Matters-How-Affection-Shapes-a-Babys-Brain-by-Sue-Gerhardt.pdf

Herbert M (2005) Developmental problems of childhood and adolescence; prevention, treatment and training Oxford, Blackwell

There are also some good novels which highlight some of the issues around attachment issues but also other behavioural problems in childhood and adolescence:

Haddon M (2003) The Curious Incident of the Dog in the Night Time London, Doubleday

Shriver L (2005) We Need To Talk About Kevin London, Serpents Tail

Filer N (2013) The Shock of the Fall London, Harper Collins

The table below summarises the key messages about attachment through the developmental stages:

Childhood stage	Social/ emotional compe-tence	Intellectual develop-ment	Behaviour-al compe-tence
Infancy	Trust/attach-ment	Alertness/ curiosity	Impulse and control
Toddler	Empathy	Communi-cation Motivation	Coping
Childhood	Social rela-tionships	Reasoning/ problem solving	Goal direct-ed learning
Adoles-cence	Supportive networks	Learn-ing abil-ity/achieve-ment	Social re-sponsability

Supporting the transition into adulthood

You may also be involved in supporting young people with their transition into secondary education from the primary sector and also into adulthood. Young people moving to secondary school aged 11 may be entering puberty, which may be a particularly difficult time for them physically and emotionally. They may be dealing with:

- Changing body shape/physical changes
- Mood changes
- Building relationships and exploring sexuality
- Becoming an adult/developing independence
- Preparing for life/career
- Developing a personal value system
- Forming a clear identity
- Achieving financial and social independence

Reflection point: Think back to when you were a teenager and what you were like. What things helped you cope, what support did you get, how did you behave, did you rebel, how did you dress?

The impact of these changes will be influenced by many things:

- Brain development
- Hormonal changes
- Peer pressure

- Family circumstances and expectations
- Cultural expectations
- Societal/educational expectations or pressure
- Particular circumstances such as additional health or social needs which may lead to vulnerability. For example young people with learning difficulties, physical disabilities, medical conditions, and young people looked after by the local authority or in other poor social circumstances.

These changes and influences to them may lead to particular behaviours in adolescence:

- Taking risks (smoking, alcohol and drugs)
- Low self esteem
- Being bullied or becoming a bully
- Self-harming behaviours
- Unhealthy sexual relationships (child sexual exploitation for example)
- Depression
- Eating disorders such as anorexia nervosa

Early identification and intervention is important for all those working with young people as they progress through to adulthood. Their needs to be an integrated, targeted approach which is built on a trusting relationship. You may have already worked with children in the primary school sector and identified that some need extra support. Many schools have transitional processes in place with their feeder schools and you may need to share information with others in order to best support the move to secondary education. Close working relationships between school staff and school nurses is the key to supporting young people. Discuss with your mentor and the SHT and identify what your role might be within the team in secondary school education.

Understanding some teenage behaviours

Recent research (NIMH 2015) suggests that much of the behaviour typically associated with teenagers can be explained by the ongoing development of the teenage brain; two examples of which are:

1. **Sleep** - Changing sleeping patterns are common in teenagers and there is some evidence to suggest that this is related to changes in the brain. It has been argued that the change is related to the release of melatonin which is needed to induce sleep. Studies of adolescents would suggest that melatonin starts to be released much later during adolescence (around 11pm) than previously and continues through the night, into the morning (The Sleep Foundation 2015). This might explain their sleepiness in the mornings and reluctance to get out of bed. The Sleep Foundations suggests that teenagers need between 8-10 hours of sleep each night but that only about 15% of them get that amount of sleep. Sleep is important for general health and wellbeing; it allows the body to regenerate and grow and it is also important in terms of your ability to learn, listen, concentrate and solve problems. Changing school timetables has been suggested to accommodate adolescents and their changing sleep patterns and brain development. You can find out more about sleep at: http://sleepfoundation.org/

2. **Risk taking** - Adolescents have a reputation for taking risks. This may be associated with smoking, drinking or taking drugs or it may be related to high adrenaline fuelled activities such as driving

too fast in the later adolescent years. It may be associated as well with more complex risk taking such as self-harming behaviours which may involve cutting or, it could be argued, eating disorders such as anorexia nervosa. These are difficult problems to cope with and may require specialised mental health services such as Child Adult Mental Health Services. You need to be aware of some of the signs of mental health problems such as these and they can begin with an overall change in behaviour noted in school or the home.

Some signs might be:

- A low self-esteem
- Becoming withdrawn or secretive
- A lack of interest in school where there was enthusiasm before
- Falling academic achievements
- Signs of clinical depression

It will be important for you to be familiar with the referral routes and the tier system within CAMHS. Talk to your mentor about what your role might be in this system:

Tier one

CAMHS at this level are provided by practitioners who are not mental health specialists working in universal services; this includes GPs, health visitors, school nurses, teachers, social workers, youth justice workers and voluntary agencies.
Practitioners will be able to offer general advice and treatment for less severe problems, contribute towards mental health promotion, identify problems early in their development, and refer to more specialist services.

Tier two

Practitioners at this level tend to be CAMHS specialists working in community and primary care settings in a uni-disciplinary way (although many will also work as part of Tier 3 services).
For example, this can include primary mental health workers, psychologists and counsellors working in GP practices, paediatric clinics, schools and youth services.

Practitioners offer consultation to families and other practitioners, outreach to identify severe or complex needs which require more specialist interventions, assessment (which may lead to treatment at a different tier), and training to practitioners at Tier 1.

Tier three

This is usually a multi-disciplinary team or service working in a community mental health clinic or child psychiatry outpatient service, providing a specialised service for children and young people with more severe, complex and persistent disorders.

Team members are likely to include child and adolescent psychiatrists, social workers, clinical psychologists, community psychiatric nurses, child psychotherapists, occupational therapists, art, music and drama therapists.

Tier four

These are essential tertiary level services for children and young people with the most serious problems, such as day units, highly specialised outpatient teams and in-patient units. These can include secure forensic adolescent units, eating disorders units, specialist neuro-psychiatric teams, and other specialist teams (e.g. for children who have been sexually abused), usually serving more than one district or region.

Self-harming behaviour may be considered as risky and the following guidance is from NICE:

1. Assess immediate risk of physical harm - refer to hospital if necessary/call an ambulance/police.
2. Consider the mental health and emotional state of the young person - Identify the main demographic and clinical features and psychological characteristics such as depression, hopelessness or ongoing suicidal tendencies.
3. Treat people with respect, care and privacy.
4. Show compassion and understanding.
5. Assessment needs to include an exploration of the individuals feeling and thoughts about the self-harming behaviour.
6. Explore other coping strategies.
7. Involve young people in any decisions that are made about their care.
8. A psychosocial assessment should be made - this includes background, family, friends, ambitions etc.
9. Support the family or friends if appropriate.
10. Effective collaboration with other services.
11. Staff should have regular clinical supervision.
12. Consider issues around consent and mental capacity.
13. Harm minimisation strategies: reduce the risks for young people if they continue to self-harm; clean equipment for example.

The following websites provide some helpful information for young people and school nurses:
www.nice.org.uk/guidance/cg16
www.thesite.org/mental-health/self-harm
www.youngminds.org.uk/for_children_young_people/whats_worrying_you/self-harm

One of the explanations of risk taking in adolescence is thought to be related to brain development. It is suggested by imaging techniques that the brain is still 'hard wiring' until late adolescence and that the last part of the brain to develop is the frontal lobe where the centres related to decision making are situated.

You can find out more about brain development at:
www.pbs.org/wgbh/pages/frontline/shows/teenbrain/interviews/giedd.html#ixzz1b1o577uc

Parents may access the SHT when they have teenagers that seem to change their behaviour overnight. Managing the anxieties of parents may be part of your role and helping them to understand what might be happening to their young adolescent will help them to cope more effectively. Maintaining good boundaries with teenagers and guiding them towards independence while continuing to keep them safe can be difficult: it can be a very traumatic time for a family. Your area may offer parenting groups for parents of teenagers and it would be helpful for you to be involved in these.

Scenarios for discussion - think about what you might do in the following situations, how they can be related to child and adolescent development theory and then discuss them with your mentor:

1. Karl is five years old and has just started school. He is a quiet child and often withdrawn. He rarely speaks to adults and seems to have little language but he does form relationships with the other children. When you are doing the routine screening on school entry, he is slightly small for his age and the school expresses some concerns about him. These concerns are mainly related to his social and emotional development as he is meeting the educational milestones expected at his age.

What information would you need to obtain about Karl? Who would you contact and what would you do next?

Discuss this with your mentor.

2. On a routine screening check, Madeline (Maddy) who is five and has just started school, fails the hearing check and is also difficult to understand in terms of her speech.

What would you do next?

3. Charlie is five and in Reception class. The class teacher tells you that she is worried that sometimes he has difficulty getting up from the floor and when they are doing PE he sometimes loses his balance.

What explanations could there by for Charlie's problems and what would you do next?

4. Emily is 11 years old. You have weighed and measured her as part of the National Child Measurement Programme. She has grown significantly taller in the last 6 months and she also tells you that she is bigger than most of her friends. She feels that she has put on weight as well but her BMI is within normal limits. Emily appears very worried about the changes in her body shape.

How would you support Emily and what might be the issues that could occur for her?

5. You are doing an immunisation session in a secondary school. You notice that Kylie (15) has cuts on her arms and you suspect that they are self-inflicted.

What would your first action be?
Who might you talk to?
What referrals might you make?

Chapter summary

This chapter has explored some of the child and adolescent development theory that will assist you in your role and explain some of the behaviours that you might encounter. It has explored the support that you might consider for children going through transitions into school or to secondary school. It has helped you reflect on what skills and knowledge you might need to develop to further enhance your role in the school nursing team.

References

Some useful resources for further reading on these topics are:

Go to the link below for more information on common child development theories and theorists: http://lrrpublic.cli.det.nsw.edu.au/lrrSecure/Sites/LRRView/7401/documents/theories_outline.pdf

Boushel M, Fawcett M, Selwyn J (2000) Focus on early Childhood: principles and realities. Oxford, Blackwell Science.

Gerhardt S(2004) Why Love Matters: How affection shapes a baby’s brain. Hove Brunner-Routledge.
Herbert M, (2003) Typical and Atypical Development: From Conception to Adolescence. Oxford, Blackwell publishers

Layard R, Dunn J (2009) A Good Childhood London, The Children’s Society/Penguin Books
National Institute of Mental Health (2015) Brain Under Construction http://www.nimh.nih.gov/health/publications/the-teen-brain-still-under-construction/index.shtml. Accessed March 2015

Thurtle V Wright J (eds) (2008) Promoting the Health of School Age Children London, Quay Books.

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Section B - Working in the community

Chapter 5: Integrated care of children with additional or complex health needs

This chapter will explore the needs of children, young people and families who are coping with additional or complex health needs. It will help to develop your understanding of the need for good, co-ordinated and integrated care. It will use a real life story to illustrate the thoughts and feelings from children, young people and their family about their specific circumstances: all names have been changed for confidentiality reasons. The role of the school health team (SHT) will be explored and the areas in which they can make a contribution to the health and wellbeing of the whole family.

The aim of this Chapter is to:

- Consider how coping with complex health needs can impact on the family
- Develop a general understanding of long term conditions
- Consider the role of the school nurse team in working with others to support children with additional needs in the community and the school setting
- Develop an understanding of the resources and networks available.

Introduction

Ideally, children with additional or complex health needs should be managed in the community using a partnership model to provide seamless, integrated care. Individualised plans need to be in place to address the specialised requirements for children with long term conditions or life limiting conditions. The whole family needs to be considered when providing care plans and their wishes respected. There are also other additional needs that may not be life-limiting or necessarily long term – there may be temporary acute illnesses that will impact on children or young people's education which SHT's will need to be aware of. Other additional needs may include children with learning or behavioural difficulties such Attention Deficit Hyperactivity Disorder (ADHD) or Autistic Spectrum Disorders (ASD).

There is an expectation that children with specific needs should, wherever possible attend a mainstream school. This is seen to be beneficial to children and young people's social and emotional as well as their cognitive development. However, there are cases where the individual needs of children and young people means that they may go to a special school. Some of these schools will have school nurses attached to them who may require particular nursing skills. Other schools are available for children or young people who have particular behavioural difficulties. Talk to your mentor about what is available in your area for children and young people with additional needs and think about referral routes to these schools.

Planning care for children with identified needs: developing pathways

The Healthy Child Programme (DH 2009) recommends a review of children and young people's health at key points in their lives. This is seen as the universal programme and targeted approaches will then focus on children and young people with particular needs. School nurses may be required to be the lead professional in coordinating care as per the Team Around the Child recommendations (TAC, 2012).

‘There is an expectation that children with specific needs should wherever possible attend a mainstream school .’

http://webarchive.nationalarchives.gov.uk/20130401151715/http://www.education.gov.uk/publications/eOrderingDownload/LeadPro_Managers-Guide.pdf

If they are not the named lead professional, it is important that any care planning is done with school health involvement to ensure that there is a co-ordinated pathway of care for the child or young person both in school and elsewhere. All children need a level of education and it is important to work together to provide the appropriate resources to enable this to happen.

Some examples of situations where the school nurse may be involved are:

- Asthma
- Epilepsy
- Anaphylaxis
- Diabetes Type 1 and Type 2
- Eczema
- Sickle Cell Disease and Thalassaemia

As well as these conditions, school nurses may consider other pathways for young people in their care, for example:

- Young people with alcohol problems
- Young people who are self-harming
- Young people not in school
- Looked after children
- Weight management

More complex needs include:

- Children who are ventilated
- Children with tracheostomies
- Children on enteral feeding
- Children with life limiting conditions such as cancer or degenerative disorders.

The following case study explores the life of a family coping with a child with a complex health need:

Case scenario - Holly’s story.

‘My name is Holly and I was born in Yorkshire on the 14th February 1994 my mum is called Heather and my dad’s called Jon. I have an older brother, Sammy, a younger brother Joe and a little sister Sarah. I don’t remember much about my start in life but mum and dad say that I was a healthy 8lbs 2oz. Over the first 4 weeks, I developed what looked like a birth mark apparently but this became worse and began to cover the whole of the right side of my face. Apparently, I was rushed to hospital when my breathing became difficult and it turned out that the birth mark was not just on my face but was going into my brain, my throat and my chest. I ended up with a tube to help my breathing and another one to help me eat. I don’t remember any of this.

My first real memory is when Joe was born when I was nearly two. He was amazing and I loved him on sight. Although my mum and dad sometimes seemed worried about me, I was mostly having a great time! I could not eat myself because of my tubes but I was very good at helping Joe to eat when he got on to solid food. He really liked yoghurt. Then Sarah was born and my life got even better! I do remember lots of people coming to the house to see me and help with all my tubes. I also remember going to the hospital as well quite a lot and everyone was very kind but I got very bored and just wanted to play. I had to have some operations which were not nice. A play lady used to come to the house sometimes and we used to get very messy playing with water and sand – mum sometimes looked a bit fed up about this! Mum and dad looked tired and got cross sometimes – they had to change me at night quite a lot – but mostly I remember laughing and having fun.

I did start at a local nursery but they said they couldn’t take me for some reason and I was really sad about that – but then I went to a really nice one where Joe went too. When I started school I found lots of friends there and most of them did not say anything about my face which still looked a bit funny. A nurse sometimes came to school to help with the tubes and another nurse also helped me settle into school - I didn’t really need that because I loved it although I found the maths and reading hard! When I went to secondary school, I had my good friends but there were some people who used to stare at me and I did get teased by some of the older children who did not know me. I went to talk to the nurse at the school sometimes – she was really nice and it was good to talk to someone about how I was feeling.

About this time I got to go riding and fell in love with horses, they helped me feel happy and improved my balance when I rode. I also struggled to talk when the tube in my throat was taken out and that is when we got Daz the dog. He was brilliant and I managed to talk to him all the time when no one else would listen or could understand me. I did get better at speaking though and a nice lady helped me talk better.

Sammy became my hero – as I got older, he used to look after me because I found school work really hard - mum said that my brain might have been hurt by the funny birthmark, she said that was why I had

some balance problems too. As I grew up, at 18, I even went to clubs with Sammy in London sometimes – I was the sensible one and just had two WKD's: my turn to look after him. When I was 16 I went to college – a special one that had horses and I got a diploma in horse care which I was very pleased about, I also got my own horse, Dobbs, a 15 hand coloured horse. I am now 21 and me, mum and Sarah took part in a triathlon to raise money for charity last year and I got a special award for my efforts. Life is great. '

Reflection point: Think about Holly's particular needs. What are the key issues for her as she has grown up? What are the positives in her life and what do you think has made her resilient?

Sammy's story

My name is Sammy. When Holly was born, I was three and I remember going to the Hospital to see her - she was beautiful and smelled nice. A few weeks after she came home though, there was a horrible night when an ambulance came and mum, dad and Holly went to the Hospital. Granny Jo came to look after me and we had hot chocolate and toast but I was worried about Holly. I did go and see her in the Hospital and that was a bit scary. When she came home, she had a tube in her neck and another one in her tummy. There was also a big red mark on her face that looked strange but underneath it she was still my little sister. I learned later that the mark on her face was like a tumour and that normally it is just on the skin but with Holly, it had gone into her throat and she had been struggling to breath. She also could not eat because it had blocked the eating tube. Later, it seemed to affect her growth because she was quite small.

It was really difficult at first because mum and dad seemed really stressed about Holly's tubes but we still all had fun and Holly was really cheerful most of the time. We couldn't go out much at first because sometimes Holly wasn't very well but she began to feel better and we had days out to the local farm. I didn't like it when people stared at her it made me feel really sad. Lots of people came to the house and Holly often had to go to the Hospital. Granny Jo used to come and look after me and we did lots of good things together – she used to give me Jelly Babies and make me fried bread for breakfast. When Joe was born and then Sarah it got really busy and noisy in our house, then Daz the dog came and he was great fun. Although he was really Holly's, I used to take him out for walks when I got older. That was a nice, quiet time for me and I talked to Daz a lot. We did not go on holiday for a long time - until I was nearly 8. Then we went to Brighton in a caravan and Granny Jo came too.

I sometimes felt left out with so much to do with Holly, Joe and Sarah but there was a nice nurse at the school who used to come and talk to me about how I was feeling. It was good to have someone just for me to talk to sometimes; I also got to spend some time at a special group for people with brothers or sisters like Holly. Most of the time though, I was really happy and liked to help out with Holly and we got to be really close. When she came to my school I used to watch out for her at playtime but she was usually with her friends. Holly struggled with learning at school and I liked to help her with the reading and maths - I was always good at school. Mum said that her brain might have been affected by the haemangioma.

As we both grew up, we used to go out together sometimes, my

friends were used to her being around but she could also be a pain just like little sisters can be. We did go to a club in London a couple of times which was good fun, Holly never seemed to worry about people looking at her but I did.'

Reflection point: How has Sammy been affected by Holly's condition. What has helped him cope?

Heather and Jon's story

Holly was born on Feb 14th 1994, she weighed 8lbs 2oz, it was a normal delivery and she appeared to be a really health baby. Over the next 4 weeks however, a growth appeared on the right side of her face. It was bright red and swollen, closing up her right eye. Initially, the health visitor said that it was a birth mark and that it would go down. We got more and more worried about her and eventually, her breathing became more difficult and one night we had to call the ambulance and we rushed to the hospital. She went to the paediatric intensive care unit and had to be ventilated for a short while. We were so scared; we had what felt like a tight band around our chests and mouths so dry that we could not drink anything, we both said afterwards that it was like having an out of body experience, but we knew that we had to keep calm to answer all the questions about Holly.

All the staff at the Hospital were amazing and the consultant who cared for Holly was fantastic. He explained that Holly had a Haemangioma which is the commonest kind of birth mark but that in some extreme circumstances, it can penetrate much deeper into the tissues. He said that the growth was invading into her throat, affecting her breathing and also that she was having difficulty in swallowing. He explained that were some treatments that would help to reduce the tumour but that this may take some time to work. In the meantime, she would need to have a tracheostomy to help her breathe and a tube into her stomach to feed her which made us even more scared. We thought it would be a temporary thing for a couple of weeks but the doctors said that the tubes might be there for up to four years.

The consultant was amazing, he asked another parent to come and talk to us who had a child with a tracheostomy and she was so reassuring that we felt more able to cope. She has remained a friend of ours ever since. We came home with Holly under the care of the community nursing team. We soon learned to care for Holly and all her tubes and dressings under the careful guidance of the community nurses, our GP and many others. At one point, there were 17 people outside the family involved in her care. We know that everyone was doing their very best but sometimes we wanted everyone to go away and let us get on with our lives and be a normal family.

We settled into family life with our older son Sammy and Holly and we had some real fun, able to keep our sense of humour most of the time. After a year, we discovered that we were pregnant again. This period of our lives was very difficult. The reaction to this news was very surprising from family and friends: what were we thinking, having another baby when we had Holly to look after? This really hurt and in addition to this, when we tried to get Holly into a nursery, they refused to take her saying they didn't take children like Holly. When Joe was born, Holly was fantastic, really pleased with her younger brother, loving him from the moment she saw him and the same happened two years later when we had Sarah. Our family was complete. There were some setbacks when Holly developed other health problems with her heart and her bowel and she has remained small for her age but she fought her way back from these with her usual resilience.

People sometimes stared at Holly when we were out and we often became very uncomfortable, we would have preferred people to come up and ask questions rather than simply staring, pointing or whispering about her. There were times in the early days when we just didn't want to go out. As time went on, the mark on Holly's face reduced in size and became less red and when she was nearly five, the swelling had reduced enough to have the tubes removed. It was such a relief but also rather scary, we had been caring for her for so long. As Holly developed we realised that she was slow to learn and it was thought that the tumour may have affected the frontal lobe of her brain making it harder for her to learn. She struggled to talk when the tubes came out but when Daz the rescue dog came, he made all the difference - Holly loved him and talked to him all the time and Sammy also fell in love with him, taking him out for walks often.

Today, Holly is 21 and she is amazing. She went to an equestrian college to work with horses that she loves. She graduated with a distinction in her course and we could not be more proud of her. She took part in a triathlon to raise money for charity and has become a spokesperson for others with haemangioma. We are so proud of all our family and grateful that we had such good support from so many different people. We would like to give some advice to professionals though, please don't assume

that parents always want to sit and talk about things, sometimes they just want to get on with their lives! Also, please try not to see children with complex needs as learning opportunities – it can get very wearing. Advice to other parents though, is to not be too proud to accept help, particular financial help through the benefit system which we found to be invaluable. Above all, laugh a lot and behave like a normal family.'

Reflection point - Think about Holly's story and consider who might have been involved in her care over the years. How were the family supported and what difficulties did they overcome. What do you think has made them resilient?

A number of terms have been applied to a care pathway but fundamentally, they describe the anticipated care for a specific condition, diagnosis or issue over a period of time and they form part of quality frameworks. The key points are:

- Care pathways should be locally developed.
- They should be prepared using the best available evidence.
- They involve agreement through a multi-disciplinary team.
- Pathways should be created with user involvement.
- The outcomes are measured through an audit process and reviewed regularly. An expected result should be measured against the actual result (variance analysis).
- Care pathways help to demonstrate the effectiveness of services.
- Benchmarks can be set in pathways. This is basically setting a standard of excellence which is achievable (SMART indicators can be applied here).

S – SPECIFIC
M – MEASURABLE
A – ACHIEVABLE
R – REALISTIC
T – TIMED

Activity - Find out in your local area what care pathways are in place for children with additional needs.

The Child and Families act (2014) includes a legal duty for schools to provide the right care and support to children with medical conditions in a way that is non stigmatising and inclusive. Supporting pupils at school with medical conditions provides statutory guidance for schools, governing bodies and healthcare providers.

www.gov.uk/government/uploads/system/uploads/attachment_data/file/306952/Statutory_guidance_on_supporting_pupils_at_school_with_medical_conditions.pdf

Children and Families Act 2014 :
www.legislation.gov.uk/ukpga/2014/6/contents/enacted/data.htm

Developing your knowledge and skills

It is important to assess your own current knowledge and abilities regarding certain conditions either as they appear on the caseload or if you have a particular interest in an illness or condition. Some local or national organisations may be a valuable source for this type of information, as they will be current and up to date on treatments and initiatives relating to the national guidelines and strategies. The following websites will help you develop your knowledge of a few of

'Advocacy is particularly important when working with children and families who may not feel they have a voice.'

the conditions that you will encounter as a school nurse:

- www.asthma.org.uk
- www.diabetes.org.uk/Children-and-diabetes
- www.epilepsyresearch.org.uk
- www.anaphylaxis.org.uk
- www.autism.org.uk
- www.disabilityrightsuk.org
- www.noo.org.uk/noo_about_obesity/child_obesity

Advocacy

Advocacy is particularly important when working with children and families who may not feel they have a voice. Many parents, carers and young people become experts in their particular condition and are perfectly capable of accessing appropriate services and care. Others however, may need help from professionals and as a school nurse, you may be in a good position to be advocate for your clients.

As a community nurse you will have to start to establish a personal authority and assertiveness in order to influence other health and social care professionals, colleagues and patients to promote care. Being assertive means respecting yourself and other people, seeing people as equal to you, not better or less important than you. The goal of this assertive behaviour in this context is to stand up for young people's rights and act as an advocate. Being assertive does not always mean you get what you want, but it can help you achieve a compromise. You will need to develop a deeper degree of self - awareness, self - belief in your ability to convey information with confidence and conviction. Remember, the child or young person's needs are paramount.

Activity - Think about some of the young people you may have on your caseload with an additional need in school. In what ways are they supported?

- Think about how you could help them learn about health related issues
- How could you direct them to more information and what would be the best source of information for them?
- Can you think of where you could access resources to help you to inform them better?
- What information is there for the school on managing children with medical needs?

Using technology

The use of technology to support young people with complex needs is becoming more common. This is both in terms of advanced mobile machinery that allows very sick children to be nursed at home and also in App technology that allows children with asthma, diabetes and epilepsy to monitor and manage their own condition. This is particularly helpful as a child grows into an adolescent and looks for more independence.

- Asthma App: https://itunes.apple.com/gb/app/myasthma-uk/id488576939?mt=8
- Diabetes App: www.diabetes.org.uk/How_we_help/Diabetes-UK-apps/Tracker-app/
- Epilepsy App: www.epilepsysociety.org.uk/how-download-iphone-app#.VGt0KDSsVHw

Reflection trigger point- what would you do if?

These reflection triggers are for you to get together with your mentor and if appropriate other team members to debate possible solutions. They could be used as a basis for a discussion or even a teaching session. We are aware that the solutions to these triggers may vary from Trust to Trust according to local policy and procedure. We are also aware that there may be no 'right or wrong' answers to how certain situations might be tackled and therefore it will be for you as a qualified nurse to apply your thinking within the parameters of your own professional practice.

- You are visiting a 14 year old girl in school who has type 1 Diabetes but who, according to teachers and her parents, is becoming very reluctant to take her medication?
- A primary school asks your advice about a boy of 6 who has severe eczema. The other children in his class are reluctant to play with him and he is becoming very withdrawn and unhappy. You are unsure if he has medications/creams and so

what would you do next?

- A 5 year old boy in one of your mainstream primary schools has been recently diagnosed with Muscular Dystrophy. His mother has asked to see you about how this information may be handled by the school and whether the other pupils should be made aware of his needs. What action might you take?

- A girl of 10 is going to a mainstream secondary school. She has Cerebral Palsy and you want to ensure a smooth transition into secondary education. Who should you liaise with and what action should you take?

- A boy of 13 is in mainstream school. He has Asperger's Syndrome and until recently has been managing well but recently he has become disruptive in class. He has started to develop physically and he seems to be going into puberty. How would you help him through this developmental stage?

Chapter Summary

This Chapter has raised some awareness of the vast topic of children with complex and additional needs. It has identified some definitions of the conditions that are considered to be complex needs and highlighted some cases for further discussion with your mentor. It has outlined a case scenario for you to consider the impact on a whole family coping with a child with an additional need.

Web Resources

Managing medicines in schools 2014:
www.gov.uk/government/uploads/system/uploads/attachment_data/file/306952/Statutory_guidance_on_supporting_pupils_at_school_with_medical_conditions.pdf

Supporting children with special educational needs in schools:
www.gov.uk/schools-colleges-childrens-services/special-educational-needs-disabilities

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Chapter 6: Working together to safeguard children, young people and their families

Introduction

Safeguarding children and young people is everyone's responsibility but the specific role that you play within that agenda will vary between different areas. Safeguarding is not just about child protection but describes an agenda which helps to identify vulnerable children, young people and families who are in need of extra help and support. They may not always ask for that help but you will be in contact with children, young people and families in a variety of different ways and settings and this means that they may disclose information to you that indicates that they are in need of help or that they are at risk of harm. You will need to know the processes that are in place for you to escalate any concerns that you have to the appropriate people and who the named child protection leads are in your area.

The aim of this Chapter is to:

- Encourage you to consider what your knowledge and skills are with regard to the safeguarding agenda
- Raise awareness of systems that protect vulnerable people and how to 'raise concerns'
- Discuss current issues that are impacting on children, young people and family's health and wellbeing.

Discussion point: Using this adapted SWOT analysis, identify your current knowledge about the safeguarding agenda and think about what your concerns are about this part of the school nursing role. Discuss this with your mentor.

STRENGTHS - what do I already know?	WEAKNESSES- What do I need to find out?
OPPORTUNITIES - where can I find out information?	THREATS - what are my main worries or concerns about safeguarding?

‘Safeguarding children and young people is everyone’s responsibility.’

The principles of safeguarding

Safeguarding is about promoting the welfare of children, young people and families and protecting vulnerable groups from harm. The underlying principles of safeguarding children, young people and their families are that professionals who come into contact them are alert to their needs and know how to act to help protect them from harm. The Working Together to Safeguard Children document (DH 2013) identifies safeguarding as:

1. Protecting children from maltreatment;
2. Preventing impairment of children’s health or development
3. Ensuring that children grow up in circumstances consistent with the provision of safe and effective care
4. Taking action to enable all children to have the best outcomes.

There is guidance for school nurses on safeguarding at the following website for you to get more information:

www.gov.uk/government/publications/working-together-to-safeguard-children--2

You may be aware of serious case reviews (SCR’s) that follow any tragic deaths of children or young people and there have been some high profile cases that have prompted attention on the child protection agenda. You can find some of these SCR’s on the following websites:

Serious case reviews at a glance: www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/2014/

SCR - Daniel Pelka: www.coventrylscb.org.uk/dpelka.html

SCR – Hamzah Khan: www.bradford-scb.org.uk/hamzah_khan_scr.htm

Discussion point: Think about any commonalities that exist across these SCR’s and how they may have informed your local child protection policies.

You will need to be aware of key documents in relation to safeguarding children, young people and their families as well as familiarising yourself with local policies and procedures. These are four of the key reports and documents:

1. **The Children Act (1989 and 2004)** www.legislation.gov.uk/ukpga/2004/31/contents

2. **Working Together to Safeguard Children (2013)** A guide to inter-agency working to safeguard and promote the welfare of children www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf

3. **The Children and Families Act** www.legislation.gov.uk/ukpga/2014/6/contents/enacted

4. **The Munro review on child protection** www.gov.uk/government/uploads/system/uploads/attachment_data/file/175391/Munro-Review.pdf

Working in the school nursing team (SNT) as a qualified nurse you will be governed by The Code: Professional standards of practice and behaviour for nurses and midwives (NMC (2015) which gives guidance on the key principles in protecting individuals at risk and harm.

Here is what the NMC says about safeguarding:

- Safeguarding = protecting people from abuse, neglect as well as actively promoting their welfare
- All members of health and social care teams are required to work together to take action to address actual or potential concerns

Reporting concerns

Your SHT will have procedures in place and there will be specialist child protection nurses in the organisation. The duty to investigate lies with social services and there will be a specific number to ring to the duty officer in children and families locally. See the NSPCC guidance below:

www.nspcc.org.uk/preventing-abuse/child-protection-system/england/reporting-your-concerns/

Vulnerability

Vulnerability can be defined in different ways but there is an acceptance that in terms of safeguarding, it refers to individuals who are susceptible to harm. It is linked to being dependent on others for care, security or support and this provides an opportunity for abusers to take advantage of the situation. Safeguarding is about acting in the best interest of the child or young person and putting them at the centre of decisions that are made about them. Children may be open to abusive situations either directly or indirectly.

For example, they may be witnessing domestic abuse or they may be being physically or sexually abused. There will be an emotional impact on children or young people from any type of abuse and this may have long term consequences. Early identification and intervention is very important therefore and there is a role for everyone in this respect.

What is Abuse?

It is important to have some understanding of how to recognise forms of abuse:

Safeguarding children is everyone's responsibility and to ensure that services are available to children in need or at risk of harm, every professional and organisation must be mindful of their responsibilities and process of appropriate referral (HM Govt 2013). Categories of abuse as defined by the National Society for the Prevention of Cruelty to Children (NSPCC) (2010) are listed as:

- Physical
- Sexual
- Emotional
- Neglect

It is important to consider what behaviours happening within a family could be seen to be causing or likely to cause significant harm to any child within that family.

Nice Guidelines 'When to Suspect Child Maltreatment' (NICE 2013) provides guidance for recognition of both physical and psychological symptoms. It is important to remember that the impact of abusive behaviours and neglect will be dependant on age, resilience and other support networks available.

It has been recognised that early intervention is extremely important to reduce the negative long term effects of child abuse (Munro 2011). This means that prompt referral to appropriate agencies is essential. Nurses are often concerned that by discussing clients they might be breaching confidentiality, but the safety of the child is paramount. You may have disclosures from older children and an understanding of confidential responsibilities is important here. Complete confidentiality can never be promised and any concerns that a young person is at risk of significant harm should be shared with the appropriate agencies.
http://cks.nice.org.uk/child-maltreatment-recognition-and-management#!topicsummary

‘Early intervention is extremely important to reduce the negative long term effects of child abuse.’

Assessing need

It might be helpful to look at levels or thresholds of need; how can you judge when a child is in need of extra help or in need of protection from significant harm. The four levels below will help to identify how you might assess this.

1. **No additional needs** – these are children or young person (YP) with no additional needs; all their health and developmental needs will be met by universal services. The majority of children living in each local authority area require support from universal services alone.

2. **Early help** – these are children or YP with additional needs who may be vulnerable and showing early signs of abuse and/or neglect; their needs are not clear, not known or not being met. This is the threshold for a multi- agency early help assessment to begin.

3. **Children in Need** – these are children or YP who are unlikely to achieve or maintain a satisfactory level of health or development, or their health and development will be significantly impaired, without the provision of services; or children who are disabled. They may require longer term intervention from statutory and specialist services. This is the threshold for an assessment led by children’s social care under s.17 Children Act 1989;

4. **Child Protection** - these children or YP are suffering or are likely to suffer significant harm. They will require intensive support under s.47 Children Act 1989. This is the threshold for child protection.

Reflection point - Think about the two case scenarios below and these levels of need. Where do you think Sam and Charli might be, based on these criteria? Discuss with your mentor.

1. Case study - Sam

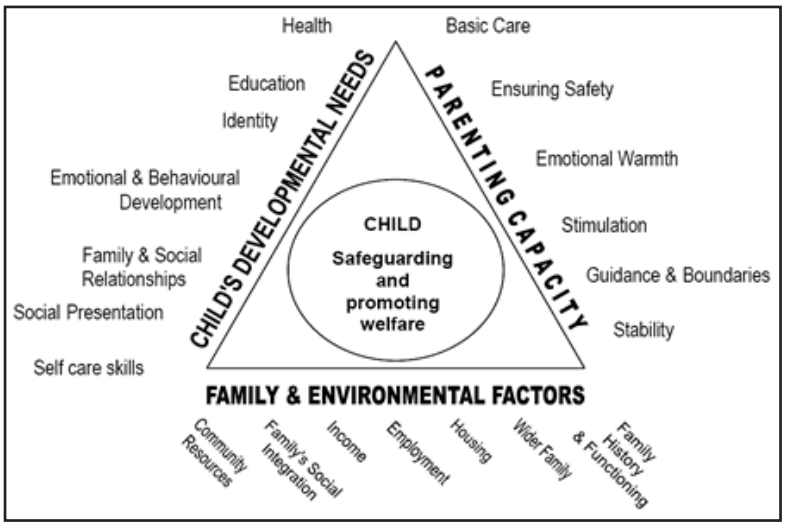
Sam is 7 years old and is an only child. He lives with his father (Rob) who is unemployed and is an alcoholic. Sam’s mother died two years ago of breast cancer. Rob has a sister, Hannah who lives nearby. She works full time and has three children of her own. Sam’s maternal grandparents live some distance away and his paternal grandparents have both died since the death of Sam’s mother. Sam had disclosed to a teacher that he was often waiting in the car in a car park for his father (Rob) while he was drinking in the local pub. When the concerns were first raised with this disclosure, the child protection thresholds were not met. New concerns were raised, shortly afterwards, by the school due to visible head lice on Sam’s head. There were also concerns about Sam’s school work and attitude in class which had gradually deteriorated since his mother had died. Sam had started school as a lively and enthusiastic student who made friends easily but he had become withdrawn and anxious and lacked concentration, often falling asleep in class. There had also been a social care referral due to Rob’s persistent lateness in picking him up from school.

2. Case study - Charli

Charli was 13 at the time of the referral to the school nurse drop in. She attended the local secondary school where the school nurse ran a drop- in. Charli lived at home with her mother (Emma) and two younger siblings, Freya aged 9 and Oscar aged 6. When Charli was 11, her parents separated and her father left the country to live in Australia with his new partner and so Charli rarely sees him. Charli attended the drop in at the time of the divorce for support from the school nurse and school counsellor as she was struggling to deal with her father not only leaving the home but also moving so far away. She had found the support at the drop- in very helpful. Charli’s mother (Emma) started a new relationship with Ryan six months after the divorce from Charli’s father, which Charli found very difficult to cope with. Ryan then moved into the family home about three months after the relationship began. Having established a good relationship with the school nurse, Charli continued to have regular contact and attended the drop in regularly for support. Charli began to come more frequently to the drop in and displayed signs of anxiety which gradually increased. At one of the drop-in sessions, Charli disclosed that when they are alone, Ryan made inappropriate comments to her and that he had tried to fondle her breasts. She was clearly very upset but did not want to tell her mother as they had been rowing frequently and Emma had called her a trouble maker who resented her being happy with Ryan. Emma had also just started working at the local supermarket in the evenings and left the children with Ryan. Charli was worried that both Oscar and Freya would be vulnerable if she went out and left them alone with Ryan.

Now think about Sam and Charli’s situations in relation to doing a more detailed assessment. Local assessment frameworks have evolved out of the idea of a Common Assessment Framework (CAF) that was developed to gather relevant information for children in need and children in need of protection.

This was to identify which relevant services would be needed to support vulnerable children, young people and their families. Although it may not be called a CAF in some areas, the principles are still applicable. Using the triangle below, consider the individual needs of Sam and Charli in relation to their developmental needs, the parenting capacity and their family and environmental circumstances. Discuss these with your mentor and think about what services would be appropriate and what is available in your local area.



Multi-agency approaches/working together

There is general agreement that there needs to be a team approach to address the needs of vulnerable children and young people. Criticisms of safeguarding processes in the past have highlighted that agencies don't always work together for the welfare of the child or young person in a co-ordinated way. Good integration hinges on good communication strategies between professionals as well as with the child, young person and their families. A team around the child approach should enable them to be placed at the centre with clearly identified needs and how those needs are going to be met.

Current issues relating to safeguarding

Domestic abuse and violence

See the school nurse pathway on domestic violence at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/211018/9576-TSO-Health_Visiting_Domestic_Violence_A3_Posters_WEB.pdf

When children and young people are witnessing or involved in abusive situations, their social, emotional and cognitive development may be affected. This may become evident in various ways, which could be identified in school or elsewhere and the SHT may be alerted to changes in children or young people's behaviours by education staff or other members of the community. A range of emotions and behaviours might be displayed; they may become anxious, withdrawn, nervous, sad, angry, aggressive or sexually inappropriate. They may also become less interested in school work or begin bullying others; they could be acting out behaviours that they are witnessing at home.

There is also growing evidence to suggest that abusive relationships can develop between young people themselves. You may be involved

'When children are witnessing or involved in abusive situations, their social, emotional and cognitive development may be affected.'

in contributing to sex and relationships education and also supporting individuals as part of Children in Need (CIN) or Child Protection (CP) plans. Guidance on developing healthy relationships which promote self-respect and a positive self-image are important in tackling the issues of sexual exploitation in the future. You will need to talk to your mentor about your responsibility and be aware of the policies and procedures in relation to these issues.

You can find some more information on the following websites: The last statutory guidance on Sex and Relationships Education (SRE) was in 2000: www.gov.uk/government/publications/sex-and-relationship-education

This is supplementary advice which came out in 2014: www.sexeducationforum.org.uk/media/17706/sreadvice.pdf

The Personal, Social Health and Economic Association provides this guidance: www.pshe-association.org.uk/content.aspx?CategoryID=1172

Improving the local response to young people experiencing relationship abuse www.caada.org.uk/Young_People/The_Young_Persons_Violence_Advocacy_Programme.html

Social Media

The internet has enabled young people to communicate in a wide variety of ways. While in many situations this is a positive development, it has also created a platform for abuse. This can be between young people where a different form of cyber bullying or sexual exploitation has grown or between adults and young people. Adults can portray themselves through the internet as anything they want to be without a child knowing who they really are. The internet also gives more opportunity to view inappropriate images such as pornography. Young people are also influenced by celebrities as role models that are not always positive on social media sites.

Here is some guidance about using digital technology: Guidance for nursing staff working with children and young people www.rcn.org.uk/__data/assets/pdf_file/0008/586988/004_534_web.pdf

Child Sexual Exploitation (CSE)

Your role in CSE, as with other safeguarding issues is to be aware of the risks, be alert to reports of any changing behaviours in young people, be confident in reporting your concerns and listen and believe what young people may tell you.

Types of child sexual exploitation include, but are not limited to:

Inappropriate relationships: often involving a sole perpetrator who has inappropriate power or control over a child or young person, and uses this to sexually exploit them. The victim may believe they are in a consensual loving relationship. The perpetrator may be known to the child and may be a family member.

'Boyfriend' model of exploitation: the perpetrator befriends and grooms a child or young person into a 'relationship'. Once trust is gained they may then coerce or force them to have sex with friends or associates. Often, the victim believes they are in a consensual, loving relationship.

Peer exploitation model: a child or young person is invited (often by same sex friends) or forced by peers or associates to engage in sexual activity. They may then be rewarded in many ways, including participating in the abuse of other victims.

Organised/networked sexual exploitation: victims (often connected) are passed through networks, possibly over geographical distances between towns and cities where they may be forced or coerced into sexual activity with multiple men and women, often at 'sex parties' involving drugs and alcohol before sexual abuse occurs. The victims may be used to recruit others into the network. This activity can entail serious organised crime involving the planned exchange of victims.

See 'If only someone had listened': Office of the Children's Commissioner's inquiry into child sexual exploitation in gangs and groups: Final report, Children's Commissioner, 2013 www.gov.uk/government/publications/helping-school-nurses-to-tackle-child-sexual-exploitation

As part of your role, you will need to have some understanding about consent and how the law can protect children and young people from sexual exploitation.

The Sexual Offences Act 2003, introduced a new series of laws to protect children under 16 from sexual abuse. However, the law is not intended to prosecute mutually agreed teenage sexual activity between two young people of a similar age, unless it involves abuse or exploitation. (FPA, 2011).

Specific laws protect children under 13, who cannot legally give their consent to any form of sexual activity. There is a maximum sentence of life imprisonment for rape, assault by penetration, and causing or inciting a child to engage in sexual activity. There is no defence of mistaken belief about the age of the child, as there is in cases involving 13–15 year olds. (FPA, 2011).

The following websites provide further information about child sexual exploitation

- Child Exploitation and online protection: www.ceop.police.uk
- Family Online Safety Institute: www.fosi.org
- The Anna Freud Institute: www.annafreud.org/corc.htm
- Preventing sexual exploitation: www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/child-sexual-exploitation/what-is-child-sexual-exploitation
- How to recognise sexual exploitation: www.nhs.uk/livewell/abuse/pages/child-sexual-exploitation-signs.aspx

Female Genital Mutilation

Female genital mutilation (sometimes referred to as female circumcision) refers to procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. The practice is illegal in the UK but it remains a cultural tradition in some communities. You may be working in multi-cultural communities, so talk to your mentor and others in the team about this and any particularly risky groups that might be in your area. It has been estimated that over 20,000 girls under the age of 15 are at risk of female genital mutilation (FGM) in the UK each year, and that 66,000 women in the UK are living with the consequences of FGM. However, the true extent is unknown, due to the "hidden" nature of the crime. Girls are often returned to their country of origin for the procedure but it is believed that it is also done in this country although it is illegal. Schools and SHT's need to be aware of young girls missing school, although it is often done during holiday time. Reporting procedures need to be in place and a multi-agency practice guideline is available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/380125/MultiAgencyPracticeGuidelinesNov14.pdf

Other information can be found at:

- www.gov.uk/government/publications/safeguarding-women-and-girls-at-risk-of-fgm
- www.gov.uk/government/publications/services-for-women-and-girls-with-fgm
- www.e-lfh.org.uk/programmes/female-genital-mutilation/
- www.hscic.gov.uk/isce/publication/scci2026.

Young carers as a vulnerable group

Young carers could be classified as a vulnerable group and in need of safeguarding, and they may be children in need of extra support. They may be at risk for a number of reasons:

- They be carrying out inappropriate caring and domestic duties in relation to their age and stage of development
- They may be missing school
- They may not be able to complete homework because of their caring responsibilities
- They often hide what is happening at home
- It may be difficult for them to sustain friendships.

‘Over 20,000 girls under the age of 15 are at risk of FGM in the UK each year.’

The number of young carers in the UK is growing and they may spend up to 50 hours a week caring for parents or other family members. The impact on their social life and educational achievement can be considerable. They will often be reluctant to relinquish their caring role or discuss with their teachers but they need help to access services and organisations who can provide them with appropriate support and respite.

Case scenario - Mary

Mary has multiple sclerosis and her condition has been gradually deteriorating since she was widowed 12 months ago. She has one child, Jack who is 7 years of age. Jack has been taking the odd day off school to look after Mary. Teachers are noting that Jack is falling asleep during class on occasions and his overall appearance has declined. For example Jack has been coming to school with a stained uniform for the past two weeks and his body odour is causing him to be excluded from group games at school. Jack’s class teacher speaks to you about Jack and asks for your help – in the first instance this is because of his unkempt appearance, falling asleep in class and he is being teased by his class mates.

What is your first action?

Possible actions:

- You would need to discuss this with the SHT
- A home visit may be arranged or Mary may be invited to the school for a meeting if she is well enough
- A joint visit would be useful with the integrated health and social care team at home if possible
- Both Jack and Mary will need an assessment. Mary to assess her health and social needs and Jack to assess his needs according to local assessment need guidelines
- A Referral to local MS Society might be useful
- A referral also to Young Carers for Jack http://qni.org.uk/supporting_carers/school_nurse_resources

Discussion point: What help and services would be available to Jack and Mary? Discuss with the SHT and also what your role might be.

Children in Care

A child who is being looked after by the local authority is known as a child in care (CIC) or a looked after child (LAC). In some cases, parents will have placed their children in care voluntarily but in other cases, children’s services will have intervened because of a risk of significant harm.

Children in care can be:

- living with foster parents
- at home with their parents under the supervision of social services
- in residential children’s homes
- Other residential settings like schools or secure units.

School nurses may play a part in assessing the health needs of looked after children. There may be specialist CIC nurses in your area. Find out what their responsibility is and what your involvement as part of the SHT is in undertaking health assessments. Children or young people (YP) in care have the same overall needs as other children and YP but they may also have additional needs, in particular, their emotional health and wellbeing. An accurate and up to date personal health record is important for children and YP to ensure that they understand their own health history as well as making sure that the right decisions are made. You may also be involved in supporting CIC as they leave the care system: discuss this with your mentor.

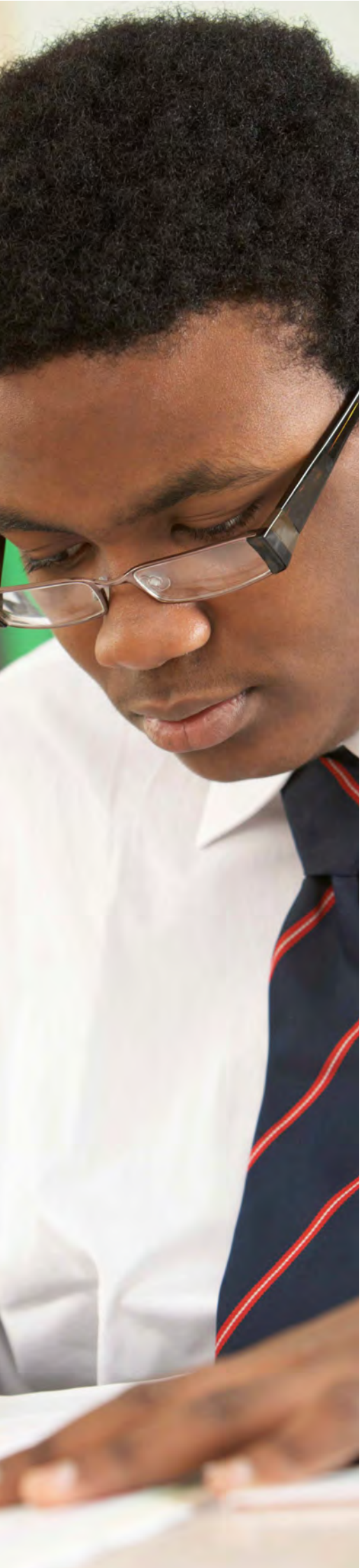
Reflection trigger point

These reflection triggers are for you to get together with your mentor and if appropriate other team members to debate possible solutions. They could be used as a basis for a discussion or even a teaching session. Consider these in relation to referral routes locally.

- A young girl (11 years old) comes to a drop in and appears thin and pale and seems to be cutting herself. There are marks on her arms and she also discloses that she is cutting herself. She says that she is very scared at home of her older brother Liam who is 17 and that her mum is often out, leaving Liam in charge. What would you do?

- You are doing a routine screening on school entry and a child has a large bruise on their eye. What would you do?

- You do a home visit to see a 9 year old boy who is not attending school. The house is untidy and chaotic but he is happily playing with his young sister who is 3. Mum also has a new baby and looks very tired. What would you do?



- You are made aware by a primary school that a young African girl who is about to go to secondary school has been taken out of school for two weeks in term time without permission from the school. There are concerns by the school that there may be an issue of Female Genital Mutilation. They are unsure whether she left the country or not during this time. What are your responsibilities in this case? And what action would you take?

Below is a list of common Acronyms used in safeguarding. Although it can be confusing using acronyms and they are not recommended, they do exist. They will vary and change but here are some common ones in use:

- **CIN** – Child/Ren in need
- **DV/A** - Domestic Violence/abuse
- **EOTAS** - Education Other Than At School
- **ICS** Integrated Children's Services
- **MASH** Multi-Agency Safeguarding Hub
- **TAC** Team Around the Child TAF Team Around the Funds
- **CP** review – Child Protection Review
- **CSC** – Children's Social Care
- **CSE** – Child Sexual Exploitation
- **SEN** – Special Educational Needs
- **SW** – Social Worker
- **CIC** – Child in Care
- **LAC** – Looked After Child
- **LADO** – Local Authority Designated Officer
- **MAPPA** – Multi Agency Public Protection Arrangements
- **LASCB** – Local Area safeguarding Children's Board
- **MARAC** – Multi Agency Risk Assessment Conferencing

Chapter summary

This chapter has given an overview of the safeguarding agenda and what your role may be within that. It has encouraged you to reflect on any gaps in your knowledge and also to think about the concerns that you may have when you come into contact with child protection issues. It has highlighted some of the current issues in safeguarding such as FGM and CSE. You have also had the opportunity to look at some case scenario's to help assess the needs of children, young people and their families.

References/resources

www.chimat.org.uk/schoolhealth/safeguarding

Her Majesty's Government (2013) Working Together to Safeguard Children. A guide to inter-agency working to safeguard and promote the welfare of children. London. Stationery Office.

National Institute for Health and Clinical Excellence (2013) When to suspect child maltreatment. NICE Clinical Guideline 89. London. NICE. NSPCC Inform (2010) Child Protection Fact Sheet. The definitions and signs of child abuse. London. NSPCC.

Munro, E (2011) The Munro Review of Child protection: A child-centred system. London. Department for Education.

‘The number of young carers in the UK is growing and they may spend up to 50 hours a week caring for parents or other family members.’

Royal College of Nursing and the Royal College of Paediatrics and Child Health (2012) Looked after children: Knowledge, skills and competence of health care staff. Intercollegiate framework. London. RCN and RCPCH.

www.rcpch.ac.uk/child-health/standards-care/child-protection/updates/child-protection-updates

The Queen's Nursing Institute

Transition to the School Nursing Service

Contents

Section B - Working in the community

Chapter 7: Mid-point reflection and progress check on identified skills development

Introduction

This chapter will enable you to reflect on the previous chapters and start to apply what you have learned so far. It is made up mainly of some case scenarios for you to reflect on and discuss with your mentor.

The aim of this Chapter is to:

- Reflect upon the experience of the on-line resource so far
- Review completion of reflective diary
- Re-visit additional skills that you may need to achieve in order to work in the community setting

At this point, think again about your SWOT analysis and compare it with the one that you did earlier. What has changed? What have you learned in practice? What have you learned through using this resource and what can you identify as your ongoing learning needs?

STRENGTHS - what do I already know?	WEAKNESSES- What do I need to find out?
OPPORTUNITIES - where can I find out information?	THREATS - what are my main worries or concerns about safeguarding?

Working in the community requires practitioners at all levels to be resourceful, flexible and adaptable to the various situations you may be confronted with. You will be working within different teams within your role, for example: the school nurse team, the broader school health team, education teams or social care teams. The school nurse team itself may be made up of a number of different practitioners such as: Qualified Specialist Community Public Health Nurses, Community Staff Nurses, Nursery Nurses and Health Care Assistants. In many instances there will be limited resources and so it is important to have the ability to prioritise work and this will depend upon the needs of the children young people and families in the local area. School nursing works best when the individual skills of each practitioner are acknowledged and recognised and utilised effectively.

'Working in the community requires practitioners at all levels to be resourceful, flexible and adaptable.'

Reflection point: how do you prioritise your work? Think about the scenario below and discuss with your mentor.

Case study: Aleem

You are in a high school, it is 2pm and you have an initial child protection conference at 3pm. A teacher comes to talk to you about a pupil who is afraid to go home. Aleem is 17 and she tells you that her mother has found a condom in her bedroom and has told her father and they are furious with her; she is afraid to go home. What are your priorities in this situation? What skills will you need and who could you utilise? Crucially, you will need to think about your competency in making decisions and the decisions that you make may be helped by considering the steps you might need to take.

Facione (2007 p23) suggests that there are six steps to effective thinking and problem solving. Consider Aleem's case and apply these steps to help you decide the best course of action:

Ideals	Five Whats and a Why	Aleem's case
Identify the problem	**What** is the real problem we are facing here?	
Define the context	**What** are the facts and circumstances that frame this problem?	
Enumerate choices	**What** are our most plausible three or four options?	
Analyse options	**What** is our best course of action, all things considered?	
List reasons explicitly - let's be clear	**Why** are we making this particular choice?	
Self-correct OK, let's look at it again	**What** did we miss?	

You can now look at the scenarios below and apply this decision making model as well as other information that you have learned so far to help you.

Scenario 1

You are doing a routine school entry screening at a primary school. You discover a child who is overweight for their height. You also notice that they are rather breathless on exertion.

- What would you do and in which order?
- Would you talk to the class teacher – what questions might you ask?
- Would you ring the parent/carer – and what would you say?
- Would you contact the GP?
- Would you talk to your team leader?
- Would you discuss with the child what their eating habits are?
- Would you check the child's lunch box?

Possible actions:

- Talk to the child as you are doing the screening in a casual way – not drawing too much attention to food.
- Talk to the class teacher about how active the child is in sports activities: ask if they have concerns. Are there any bullying issues?
- Talk to your team leader about speaking to parents/carers. This needs to be done very sensitively and the team leader may be the most appropriate to do this if you are inexperienced with you being present as well.
- If needed, you may want to see the parent/carer to discuss this further, this gives a good opportunity to establish a relationship and possible reasons for the overweight issue and you can give advice.

Scenario 2

You are working in a secondary school drop in and a 15 year old girl comes and discloses that she might be pregnant. What would do?

- Would you establish whether she could be pregnant?
- Would you talk about the partner and when they last had sex or a period.
- Do a pregnancy test
- Talk about how they could talk to a parent/carer/boyfriend about this
- Discuss with your team leader/manager
- Talk to the parent or carer as they are under 16?

Possible action:

- Establishing understanding of why this young

person thinks they are pregnant is really important. This will help you decide if they are Fraser competent (see Chapter 4 for more on Fraser Guidelines).

- You also need to be sure that there is not an abusive situation. How old is the partner, how long have they been together, is she prepared to name the father?

- A pregnancy test will be vital if not already done. You may also need to talk about possible options. If the young person is within 72 hours of sex, then they could have emergency contraception if appropriate. Or if within 5 days referral to GP/Sexual Health clinic for alternative EC such as a coil or 5 day emergency contraceptive pill (Ella One)

Scenario 3

You are undertaking routine immunisations for the school leavers' boosters in a secondary school. You notice that a boy has scars along his forearms and he appears very withdrawn without making eye contact. What would you do?

- Would you ignore it and give him the immunisation?
- Would you leave it at that moment and talk to your team leader about it with a view to returning later?
- Would you try to engage him in conversation and ask if he is unhappy?
- Would ask him directly about the scarring?
- Would you give him information about contacting the school nurse services?
- Would you tell the school about what you have observed?
- Would you inform a parent?

Possible actions:

- Opening up a means of communication is important here. The assessment of immediate risk of harm is crucial. Is he likely to go and harm himself more severely for example? Is he Fraser competent?

- You might need to spend some time talking to him and it would be important for him to know that there is help available and also that you have recognised the injuries. You might need to say that you would like to see him again and make an appointment to do that to give you time to talk to your team leader.

- The school might need to be informed if there is bullying involved. Parents/carers may also be informed too, depending on assessed risk.

Additional scenarios

Look at the additional quotes below and think of what you would do in each situation. What will you do to gain the required knowledge or skills? Where could you find out the information?

'I am unsure what to do if a child/young person refuses an immunisation.'

'I am unsure what to do if a 14 year old wants an immunisation but there is no parental consent.'

‘Learning how to react calmly and non-judgementally is vital in order to contain potentially volatile situations.’

‘A child fails a hearing check but I think it is more a lack of understanding about the test rather than a hearing problem.’

‘A school asks me to do a puberty talk but I have never done it before.’

‘A parent complains that a school nurse has withheld information about the sexual activity of their 15 year old teenager.’

‘I have been seeing a 13 year old who is self-harming for 6 weeks. They refuse to talk to anyone else as I have built a rapport with them. I don’t know how to move this forward.’

‘I have been asked by a parent if they should send their child to school with chicken pox.’

‘A 6 year old girl has severe eczema and I don’t think that her mother is applying the prescribed creams and the school is also reluctant to put the creams on in school.’

The school nurse role is varied and you may be: immunising children and young people, screening for health needs, working with families, supporting emotional needs or identifying more serious mental health problems. The ability to recognise your limitations, know the referral routes and work collaboratively is imperative to ensure safe practice.

Whilst it is very important to be able to recognise your limitations, it is even more important to be confident enough to express them to your colleagues or manager/mentor in an appropriate manner.

The quality of a community service is based on the effective decision making skills of practitioners working in the community. The role of the school nurse also requires sound knowledge of child protection as well the clinical assessment skills needed for managing issues such as self-harming behaviours. Situations can be unpredictable in the community and children and young people could display behaviours that may challenge you.

Being aware of how and why children or teenagers might be behaving in particular ways is important and learning how to react calmly and non-judgementally is vital in order to contain potentially volatile situations. Decisions may have to be made promptly without discussion with other staff that may not be immediately available. Acting in the best interests of the child or young person must remain at the forefront of your practice at all times and this will be about assessing the level of risk and acting accordingly. It is the duty of all health professionals to be accountable in demonstrating sound judgement and decision making (Standing, 2010).

Chapter Summary

The overall aim of this chapter is to revisit some of the skills that are required for school nursing practice. Whilst it is acknowledged that the skills required for working in the community are multifaceted, it is hoped that this chapter has helped you recognise that not everyone will have all the required skills all of the time. Therefore, it is essential that community teams work together to recognise the various scope and level of expertise within their teams, (and on occasions beyond their teams) and to reach out and utilise those people who have the right skills for the task in hand. In highlighting the importance of this you are encouraged to reflect on those people within your team and other agencies and look at whether the skills each individual has are being used effectively.

Further Reading

Facione, P.A. (2007) Critical Thinking: What it is and why it counts., California Academic Press, California

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Section B - Working in the community

Chapter 8: Team working and working with other professionals

Introduction

Strong leadership and management are key to the success of the NHS and integrated working is an important aspect of the school nursing service. You will be involved in a number of different ways: as a member of a team; managing yourself, perhaps leading a team, managing individuals and groups of children young people and supporting health promotion activities. We have seen in previous chapters that you will be working with others to safeguard children and young people and also working with different agencies to support children, young people and their families with additional health and social needs. Good health and social outcomes for all children, young people and young adults cannot be achieved unless all agencies work together effectively. This means thinking about where this works well and what barriers there may be to effective working.

The aim of this Chapter is to explore how teams work together and what your role is within those teams it will:

- Explore the benefits of working as a team member
- Recognise the importance of working with other professionals in the community
- Understand the need for the right staff, with the right skills in the right place at the right time

Discussion point: You may belong to a number of different teams in your personal life as well as your professional one. Are they successful teams? What makes them successful and what qualities or skills do you bring to them?

Exercise:

What makes a good team?	Reflect on these in relation to the school nurse team that you are working in
Having a clear goal, aim and direction	
Appropriate leadership	
Recognising and utilising the relevant skills within the team	
Developing mutual trust and respect between members of the team	
A unified commitment	
Good communication	
Flexibility	
Having a supportive climate	
Any others?	

‘Without a written record of events there is no evidence to support a decision made.’

Team roles

Your role within any professional team will vary depending on the model of school nursing practice that is in your area. Developing an awareness of your qualities as a team member is important as well as thinking about the other members of your team or teams. It will also help you to think about what leadership skills you have and where they are appropriately applied. It is argued that for a team to be successful, you will need a mix of people: those who create the ideas, those who move things forward, those who organise and co-ordinate work and those who get on and do the work. Belbin’s team role theory is perhaps the most famous and you can have a look at the chart to see if you can identify yourself and others within your team.

You can also explore this further on the following website: www.belbin.com

			Team Role Contribution	Allowable Weakness
Thinking	Plant	PL	Creative, Original, Unorthodox Solves difficult problems	Absent-minded Ignores details
	Monitor Evaluator	ME	Objective, Strategic, Discerning Judges all options	Uninspiring, Critical
	Specialist	SP	Deep Knowledge, Single-minded, Self-starting	Limited contribution
Action	Shaper	SH	Hard Driving, Influencer, Dynamic Challenges, Puts on the Pressure	Abrasive, Insensitive Easily provoked
	Implementer	IMP	Organizing, Disciplined, Reliable Turns ideas into practical actions	Inflexible Reluctant to change
	Completer Finisher	CF	Meticulous, Conscientious, On time Searches out errors and omissions	Worrier, Nit-Picks Reluctant to delegate
People	Team Worker	TW	Diplomatic, Cooperative, Perceptive Listens, Averts friction	Indecisive
	Resource Investigator	RI	Outgoing, Enthusiastic, Networker Recognizes Opportunities	Over-optimistic Easily Bored
	Coordinator	CO	Motivator, Orchestrator, Facilitator Clarifies goals & decision-making.	Manipulative Over-delegates

Exercise: How does it feel to be a member of your team? Do you feel valued? Apart from your team who else do you collaborate with to benefit the children, young people and families that you work with?

Here are some of the professionals that you may work with:

- Clinical Psychologist
- Dietician
- Educational Psychologist
- General Practitioners
- Health and Wellbeing Manager in school
- Health Visitors
- Other community nurses such as Learning Disability Nurses or Community Children’s Nurses.
- School Nurse/community staff nurses/nursery nurses/health care assistant
- Social Worker
- Speech and Language Therapist
- TaMHS worker Targeted mental health in schools
- Teachers/learning support workers/SENCO’s/ classroom assistants

Can you look at the team that you are working with and identify who you collaborate with on a regular basis?

What impact does this collaboration have on you as part of the team?

Spend a few moments to think of the various ways that you collaborate/communicate with others in the workplace:

- Verbal communication
- Telephone
- Written records
- Emails
- Texts
- Letters
- Agile (flexible) working

New technology has also opened up new ways of communicating both with colleagues and others, for example ‘social media’. Here is the NMC’s guidance for nurses on social media: Use of digital technology guidance for nursing staff working with children and young people www.rcn.org.uk/__data/assets/pdf_file/0008/586988/004_534_web.pdf

Sharing information

Working within the School Nurse Team and the collaborations that you have identified will require good sharing of appropriate information across disciplines and different agencies. You will need to have a look at the local policies and procedures about what information is shared and with whom. Accurate record keeping and documentation is important in professional practice and is a means of communicating with all those involved in the welfare of children or young people being seen by the school nurse. Once something is written down, it is a permanent account of what has happened and also what has been said. Remember, if it is not written down there is a sense that somehow ‘it didn’t happen’. Without a written record of events there is no evidence to support a decision made or an audit trail from which to follow a sequence of events. It

is therefore crucial that accurate consistent and contemporaneous records are kept at all times. Ensure you are familiar with records that may be kept on a child or young person and where those records are stored. The Guidelines for Records and Record Keeping (NMC, 2009 p2), state clearly that:

'The quality of your record keeping is also a reflection of the standard of your professional practice. Good record keeping is a mark of the skilled and safe practitioner, whilst careless or incomplete record keeping often highlights wider problems with the individual's practice.'

The above statement makes it clear that professionally, nurses are accountable for keeping accurate and consistent records. When it comes to making good quality records they should be:

- Clear and accurate
- Factual, consistent, and relevant
- Comprehensive and useful
- Contemporaneous (made at the time).

The other element of accurate record keeping relates closely to investigations and serious untoward incidents (SUI) (DH, 2006b). The principle definition of an SUI is:

'.. something out of the ordinary or unexpected, with the potential to cause serious harm, that is likely to attract public and media interest that occurs on NHS premises or in the provision of an NHS or a commissioned service. SUIs are not exclusively clinical issues, for example, an electrical failure may have consequences that make it an SUI.' (NHS, 2009).

There is also the issue of 'never events' which are inexcusable actions in a health care setting. More information can be found at: www.idsc-uk.co.uk/docs-2012/never-events-policy-framework-update-to-policy.pdf

This reinforces the importance of accurate record keeping by all health professionals.

Case scenario - Jennifer

Jennifer is a 14 year old girl who has spoken to you as she is worried about her mother (Joyce). Her mother has been falling over a lot at home and has also had difficulty holding onto objects. She dropped a saucepan of boiling water yesterday but fortunately no one was injured. Jennifer lives with her mother and 10 year old brother James. Jennifer is frightened that if they involve the doctor he might put mum in hospital and she and her brother might be taken into care.

- What would you envisage your role to be in this situation?
- What immediate action would you take?
- Who will need to be involved in this case?
- What areas of care can be provided by other members of the multi-disciplinary team?
- Is there the potential for overlap of services?
- What can be done to prevent this happening?
- How could Jennifer's concerns be dealt with?

‘The NHS continues to evolve and change and this can cause conflict within teams and between professionals.’

Possible action

- Jennifer to be informed that her mother’s welfare is of great importance
- The GP to be contacted
- Are there any other relatives that could support the family in the short term
- Identify who the key coordinator would be
- The welfare of Jennifer and James to be high priority

Barriers to multi-disciplinary working

Working together in a seamless way is the most effective way of providing effective services. However, there may be barriers to this, particularly when working across different professional boundaries. In the above scenario, health, education and social care will need to co-operate to ensure that Jennifer, James and their mother are safe and supported. Communication can be a barrier to this, as well as clear understanding of each other’s roles in the process.

There may be other barriers such as:

- Separate or different paperwork within the different agencies - One set of documentation is helpful using a ‘key worker’ or ‘lead professional’ model. This means identifying the right lead person to co-ordinate the process. This will avoid overlapping of roles and duplication of services.

- Language/terminology differences between professionals - the use of acronyms can also cause confusion here.

- Reluctance to share information - this might be a lack of understanding about the principles of confidentiality, for example the GP might be worried about sharing information about Joyce. This may be related to poor information sharing protocols.

- Poor working relationships - there might be a historical problem where communication has broken down between professionals which has not been resolved

- Lack of awareness, appreciation or trust of the roles and responsibilities of others

- Limited time and resources, increased workloads or constant re-organisation

- Lack of appropriately trained staff

Reflection point: Consider these barriers and think about any examples of this in your work or are there good examples of collaboration that you can identify.

Managing change within teams

The NHS continues to evolve and change and this can cause conflict within teams and between professionals. There is frequent re-structuring of services and employing organisations and you may experience frustrations yourself about this or you may see that frustration in others. Often, the resistance to change relates to poor communication strategies and you may need to be aware of this if you progress in the school nursing profession, as you may be leading changes.

An example of where you might become involved is if there is a change to a local protocol/procedure or guideline. Most areas will have consultations or committees that look at updating documents and it is a useful group to become involved in if you can. There are also local applications of broader political drivers that you could be involved in such as developing school nurse pathways of care: epilepsy, diabetes or asthma for example. Find out from your mentor what there is locally. You will then experience how changes are implemented and consider communication strategies.

These are some considerations that you may want to think about if you are experiencing or implementing change in your environment.

- Why are there good reasons for the change that you can see?
- Who is involved and needs to be consulted about the change?
- How will the change affect the workforce and what/who are the anticipated challenges/ limitations and restrictions?
- How soon is the change likely to happen?
- What will the communication strategy be?
- Who will lead the change?
- How will the change be implemented?
- Will there be a pilot phase?
- How will the change be evaluated?

Reflection trigger point – what would you do if?

These reflection triggers are for you to get together with your mentor and if appropriate other team members to debate possible solutions. They could be used as a basis for a discussion or even a teaching

session. We are aware that the solutions to these triggers may vary from Trust to Trust/Local Authority according to local policy and procedure. We are also aware that there may be no 'right or wrong' answers to how certain situations might be tackled and therefore it will be for you as a qualified nurse to apply your thinking within the parameters of your own professional practice.

Reflection

- You are working with another school nurse who always seems to be offloading her work onto you, saying she is too busy and she doesn't really know how to deal with some of the issues that have arisen. What would you do?

- You are working with a colleague who communicates with the children on face book and offers to see them informally to discuss any problems they may have. She seems to get very heavily involved with the children and young people that she cares for and does not appear to appreciate any professional boundaries. What would you do?

- A parent has spoken to you about some anger issues that his son Peter is having. He asks you to keep this confidential and let him know if you hear of any problems at school. What action would you take?

Consider you are a staff nurse new to working in the school nursing team and you notice one of the team is not documenting the records as she is seeing children in a clinic

- Would you question her?
- Would you inform your mentor?
- Would you take no action because you think she might write the notes up later?

Possible action

- You could challenge your colleague
- You could say that you are new to the school nursing team and part of your role is to work with your mentor, so you must inform your mentor of what you have been witnessing
- You could ignore the situation

Think of the impact your decision will have on the children being seen in the clinic. Have you collaborated effectively with the correct person in the team? Have you compromised the children's care on any of the above statements?

Chapter Summary

This chapter has looked at the importance of team work and collaborative ways of working within a multi-disciplinary team. It stresses that all members of the multi-disciplinary team have a responsibility and all members of the team should be invited to participate in discussions regarding the children they see.

If a multi-disciplinary team is going to be effective there must be respect across all of the disciplines which will foster a positive environment. The overall aim of collaboration is to encourage health professionals to work together in the most effective and efficient way to produce the best health outcomes for children, young people and their families. This chapter has also highlighted the importance of accurate record keeping;

‘There might be no ‘right or wrong’ answers to how certain situations might be tackled.’

verbal statements unsupported by documentary evidence carry less weight in a court of law.

References

Nursing & Midwifery Council, (2009), Record Keeping: Guidance for nurses and midwives, NMC, London

Web-links

- www.nmc.uk.org
- www.gov.uk
- www.comfirst.org.uk
- www.charity-commission.gov.uk
- www.eicp.ca/en
- www.cochrane.org
- www.eoecph.nhs.uk
- www.england.nhs.uk
- http://www.idsc-uk.co.uk/docs-2012/never-events-policy-framework-update-to-policy.pdf
- www.rcn.org
- www.nursetogether.com
- www.schoolnurse.com
- www.nmc-uk.org/Documents/NMC-Publications/revised-new-NMC-Code.pdf

The Queen's Nursing Institute

Transition to the School Nursing Service

Contents

Section C - Policy

Chapter 9: Working safely in the community

Introduction

This chapter will explore some general issues around working safely whilst working within the school nursing team (SNT). Employers have a responsibility to ensure their employees are safe and all local areas will have guidelines and policies around working in the community. There is legislation that exists to support and protect you in this environment and your employers need to ensure that measures are in place to prevent or minimise risk. You will be working in a variety of different settings within the community including: education environments, health clinics, homes, community centres, youth centres and Children's Centres.

The aim of this Chapter is to:

- Explore some of the legislation that protects nurses working in the community
- Consider your own personal safety when working in the community
- Consider how risk is assessed in education settings and elsewhere in the community

Thinking about your move to working in the SNT, what situations have you encountered where a risk assessment may have been needed? What local policies and procedures are there are in your area about safe working practices?

The concept of risk can be defined in many ways and you may have considered the risks related to your working practices as being either personal to you as a practitioner, or it may relate to the risk to others. This may be risk to children, young people and their families or it may be the risk to other members of the team that you are working with or the wider teams that you are working with. The safeguarding of children and young people has been discussed in Chapter 6, but there other safety concerns that you will need to be aware of, which include issues such as infection control or safe handling of medicines or vaccines.

Personal safety, health and wellbeing

School nursing practice is about supporting others to be as healthy as they can be in order to enjoy and achieve. It is important that you consider your own health, wellbeing and safety as well as others when working in the community. Make sure that you are fit to work and look after your physical health and emotional wellbeing (consider your work/life balance for example!). Stress at work can be a very real problem and in the community setting it can be particularly stressful when you are working with limited resources and dealing with difficult situations. You will be able to contribute to the well-being of others more effectively if you are healthy yourself.

Personal reflection and thinking point: think about what you do to stay healthy? Do you eat well? Do you do regular exercise? What do you do to relax? Are there things that you could change to enable you to be a role model for those that you are in contact with?

School nurses can be classed as 'mobile workers working away from their fixed base' (HSE, 2009 p 2). There are two main pieces of legislation

‘Visiting homes is a very different experience to seeing children or young people in an educational setting or clinic.’

that should protect workers in this situation:

The Health and Safety at Work Act 1974: Section 2 sets out a duty of care on employers to ensure the health, safety and welfare of their employees whilst they are at work.

The Management of Health and Safety at work Regulations 1999: Regulation 3 states that every employer shall make a suitable and sufficient assessment of:

- the risks to the health and safety of his employees to which they are exposed whilst they are at work; and
- the risks to the health and safety of persons not in his employment arising out of or in connection with the conduct by him of his undertaking.

A lone worker is someone who works by themselves without direct or close supervision. When working with the school nurses, you may find yourself in situations of working alone in a clinic after school, or working at weekends and accessing clinic buildings etc. It is important that you become familiar with and know how to access your Trust’s lone worker policy and adhere to it, in order to assist with your own personal safety. As part of your learning for this Chapter it is recommended that you read your Trust policy on Lone Working. This is essential as it may vary from trust to trust and also there is a great deal of hearsay around this subject, so new employees need to read and refer to it regularly.

Driving while at work

When using your own car for work please consider the following:

1. You need a full driving licence - obvious we know - but you must have one!
2. Be aware of the type of vehicle insurance that is required whilst employed. Also your employer’s insurance responsibilities
3. Have an understanding of the procedure if you have a road traffic accident whilst working
4. Have knowledge of the rules around taking passengers eg students or colleagues when driving whilst employed during working hours
5. Be aware of the rules around traffic offences including the accumulation of points - disqualification, speed, alcohol, using a mobile phone, dangerous driving whilst employed and how to report any incident.
6. What are the rules in your Trust about getting parking tickets whilst on duty?
7. It is not advisable to give children, young people or members of their family a lift in your car.
8. As part of your learning for this Chapter it is recommended that you read your Trust policy on Insurances and also policies around Traffic offences
9. Also read your employers’ policy on the use of your own car for work purposes. This will be within the Trust policy on Insurances which will vary from Trust to Trust. You will also need to check your own insurance policy.

Visiting children, young people and families at home

There are occasions when you may visit children or young people at home, this may be joint visits with other agencies or you may be on your own. Visits are made to the home for a number of reasons:

- An assessment for a Looked After Child (children in care)
- As part of a child protection plan
- A child who is refusing to go to school
- A child who is not attending school for other reasons
- A home schooled child.

Visiting homes is a very different experience to seeing children or young people in an educational setting or clinic. You will need to be aware of both yours and the family’s rights in this situation. The ‘home’ that you may visit may not be as you would expect it to be, for example you may visit a Travellers’ site where the home is a caravan. The home itself may be not what you are used to, people have very different standards of cleanliness for example. Remember you are a guest in their environment and you need to respect that while maintaining your own safety.

Preparing to visit

Here are some practicalities to think about when preparing to visit a child and their family in the home. Remember at all times to do as much homework as possible about the child and family background before visiting. For example the medical history of the child or young person, who do they live with, does anyone living in the house have a history of violence or aggression or are there dangerous dogs in the house (or other pets). A thorough risk assessment is important and so aim to speak to anyone who has involvement with the family. It may be that in your role you will be accompanying another member of

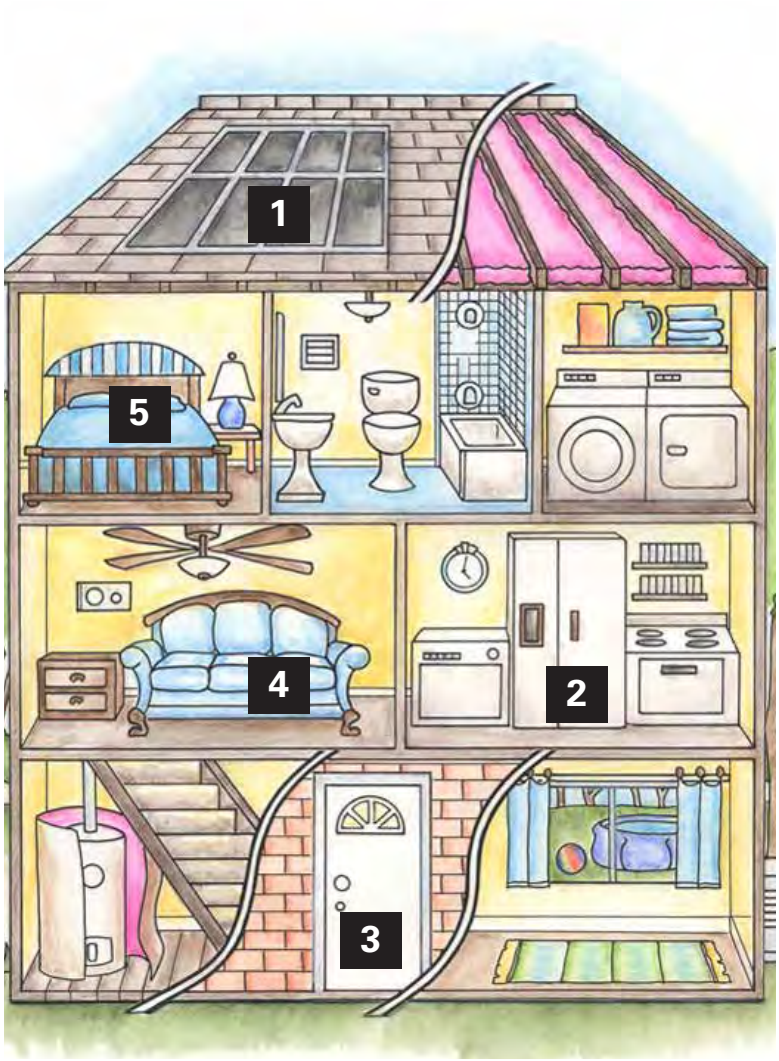
the team, particularly in the first instance.

You should run through a personal checklist:

- Make sure that you inform others of your whereabouts at all times
- Ensure that you have a charged mobile phone with you
- Have a separate work mobile if possible
- Have your car keys in an accessible place
- Plan your access and exit route to the property
- Inside the property, ensure you have a clear route to the exit if you need to move quickly
- Do not visit known 'risk' people or areas alone
- Adhere to your Trust policy on Home Visiting
- Trust your own 'instinctive' feelings if you do not feel safe
- Removing shoes when asked by clients' parents for example may leave you vulnerable, be vigilant at all times

Here are some other considerations when visiting people's homes:

Entry rights for Community Nurses



1. Who is the occupier? - The occupier is either the person who owns the property or the person who is in control of the premises.

2. Occupier's Liability - There is both a statutory duty (this relates to property law that landlords must obey) and a common law duty (this relates to law developed through judges and decisions made on similar cases in courts) to take care of premises, so that visitors

to those premises do not suffer injury. It follows that if a community nurse is injured because of the dangerous conditions of the premises she is visiting, she may be able to sue the occupier who has a duty under the Occupiers Act (1957) – as well as common law to keep the premises safe.

3. Entering the premises - asked for permission or implied permission apply here. Normally a community nurse will be a lawful visitor even when visiting a new family uninvited. But that does not mean she has the right of entry to a client's house. A community nurse has the right of entry in an emergency, in order to save life. E.g. if you arrived at a house and could see the child through the window lying unconscious on the floor. In other situations it would be advisable to call the police who can force entry legally. As part of your learning for this chapter it is recommended that you read your Trust policy on 'Entry'.

4. Trespass - Once a community nurse enters the property of a client, she/he does so with implied consent of the occupier. If the occupier withdraws consent and asks you to leave, if you do not leave you are trespassing!

5. Vulnerable groups - There are special provisions for mental health and learning disabilities under the Mental Health Act (2007) around access and also around the safeguarding of a child.

Violence, Aggression or Harassment

There are personal risks as a professional in any setting and there will always be the potential to be hurt in any situation. It can be particularly problematic in the community because school nurses may be dealing with difficult situations such as child protection, domestic violence and confidential information. Anger, fear, anxiety and frustration can lead normally rational people to behave in an unpredictable way. This may include aggressive behaviour. Understanding how to defuse situations is a key skill and the ability to read the early verbal and non-verbal cues that alert one to problems is important. In the community, these skills need to be particularly developed as well as the ability to negotiate and manage conflict important.

Reflection: think about a situation where you have had to defuse a volatile situation or you have witnessed someone else doing so. How was the situation resolved and what skills were needed?

In most situations children, young people and their families will be pleased to have your support and help. However, in some cases there maybe situations where the child or family are unhappy with you or what you represent.

Please be mindful of the following:

- The potential for an outburst is a very real one
- Try to avoid vulnerable or volatile situations at all times
- Be aware that individuals can be unpredictable at times
- Have a clear understanding of your Trust policy on Violence , Aggression or Harassment
- Employers must take steps to keep staff safe at all times
- DO NOT suffer in silence – communicate and document any fears you may have to your manager immediately. This may ensure the safety of colleagues or the wider healthcare team so timely reporting is invaluable
- Know where exits and fire extinguishers are when working in unfamiliar surroundings, such as evening clinics
- When working in a school be aware of their health and safety policy procedures
- In some instances you may find it safer to visit a child or young person at home in pairs.

Healthy Schools

As well as your own safety needs and visiting homes or other community settings, you will need to consider how schools maintain a healthy environment and you may well be asked for advice and support to achieve this. This may range from health and safety issues, advice on infection control and the safe administration of medicines and vaccinations. Although you may not have expertise in assessing health and safety risks, you can use your noticing skills to identify any hazards in the school setting. It is good practice to keep your eyes and ears alert for any health issues that may arise in your day to day work and to raise concerns appropriately.

Infection control

Increasingly, infection control is highlighted in many public areas including schools where there may be notices asking people to use antiseptic hand cleansers. All nurses need to be aware of the principles of infection control. Standard infection control precautions need to be applied to all work that school nurses do and in particular, in clinical work such as immunisations. Local areas have guidelines on infection control and the fundamental issues for school nurses include:

- Hand hygiene – alcohol based hand rub should be available for staff in the absence of effective hand washing facilities.

- The use of personal protective equipment. There should be clear local guidelines on the use of protective equipment such as wearing gloves at immunisation sessions. This should be based on a risk assessment.

- The safe use and disposal of sharps – no immunisations should be given without correctly assembled sharps boxes.

- Education of healthcare personnel and also other staff including school staff. Schools may seek advice from the school nurse about infection control.

- School nurses may be consulted about childhood infectious diseases by schools or parents and there should be clarity about whether children should be excluded from school. It is important to maintain currency about this as from time to time, recommendations change. Fundamentally, if a child or young person is acutely unwell, one should question whether they should be in school.

- The spread of communicable/notifiable diseases. School nurses may be involved when there is an outbreak of a communicable disease such as tuberculosis. They may be required to screen populations for the disease and implement immunisation programmes if needed.

Public Health England provides information about infection control in schools and other settings:
www.gov.uk/government/uploads/system/uploads/attachment_data/file/353953/Guidance_on_infection_control_in_schools_11_Sept.pdf

There is also guidance about keeping children away from school on NHS choices:
www.nhs.uk/Livewell/Yourchildatschool/Pages/Illness.aspx

Immunisation in schools

There are some safety issues about immunising in an education setting. You are likely to be involved in immunising children and young people and the Green Book has already been discussed earlier in this resource. You will also need to revisit local protocols RCN Guidelines regarding safe immunisation (2015).

Nurse-led immunisation for school-aged children may be undertaken via NHS-directed school immunisation teams or by nurses employed by educational establishments working alongside a local general practice.

Successful immunisation depends on the:

- Production of a safe and effective vaccine
- Maintenance of the cold chain during vaccine transportation and storage
- Injection into the correct anatomical site and an appropriate recipient
- Correct injection technique.

The nurse/s will work in partnership with an identified link person from the location at which the vaccination is to be administered. Together you will assess and plan the environment in which the immunisation

'There might be no 'right or wrong' answers to how certain situations might be tackled.'

session will be carried out. In doing this you should consider:

- Access to a telephone
- Access to hand washing facilities
- Privacy
- First aid and emergency support
- Local health and safety policy.

You should also look at the management of:

- Adverse reactions
- Adverse incident handling
- Needlestick injury issues
- Safe disposal of sharps and clinical waste
- Updating patient records.

Have a look at the full guidelines at: www.rcn.org.uk/__data/assets/pdf_file/0010/585838/RCNguidance_immunisation_school-age_WEB.pdf

The links below will give you further information about the childhood flu campaign:

Information materials:
PHE has updated the national communication material and supporting information for 2015/16 to include the following:

- A national consent form
- Template letters to invite children in Years 1 and 2 for flu vaccination (which includes Q&A for parents)
- The "Protecting your child against flu" leaflet
- Immunising primary school children against flu – Information for head teachers and other school staff

The materials for 2015/16 can be accessed via the annual flu programme website www.gov.uk/government/collections/annual-flu-programme

Info and learning materials www.e-bug.eu

- Digital Flu badges, a series of missions that children can take and earn Digital Badges (www.makewav.es/health)

- WiredYoung Carer's Group produced a song about getting a flu vaccination. It has been popular with children and is available for teams to use: https://vimeo.com/106076706

- Training materials: www.gov.uk/government/collections/annual-flu-programme

- An outline of potential Immunisation Training Requirements by role has been produced by the Royal College of Nursing /PHE. This can be found at www.rcn.org.uk/__data/assets/pdf_file/0005/553748/004479.pdf

- The Royal College of Nursing statement on HCSWs administering live attenuated influenza vaccine can be found at: HCSW and Live Attenuated Influenza Vaccination [LAIV] for children and young people (March 2015) (PDF 360KB).

- A link to the School Nursing Service Planner is here. www.gov.uk/government/uploads/system/uploads/attachment_data/file/303769/Service_specifications.pdf

Medicines Management

You may not be directly involved in the management of medicines in schools, but the school health team may be asked to advise schools about managing medicines in the school setting. Part of your responsibilities may relate to training staff, for example on the use of emergency medications such as: asthma inhalers, Epipens (or other auto-injectors of Epinephrine), diabetic or epilepsy drugs. Make sure that you are competent to do training sessions in schools. You will need to observe more experienced staff first and be observed by your mentor before you undertake this role.

There is guidance on supporting pupils at school with a medical condition that you need to be aware of: www.gov.uk/government/publications/supporting-pupils-at-school-with-medical-conditions--3

Duty to report incidents

It is your professional duty to act to identify and minimise risk to patients NMC (2015) and to report any incident if you consider the health or safety of an individual has been or is likely to be endangered.

Safe Working Activity
• Think about your own day to day practice • When have you felt at risk? • Have you ever performed a risk assessment? • A risk assessment is simply a careful examination of what, in your work, could cause harm to people, so that you can weigh up whether you have taken enough precautions or should do more to prevent harm. Workers and others have a right to be protected from harm caused by a failure to take reasonable control measures. • Whose responsibility is it to risk assess? • The management of risk is considered one of the fundamental duties of every member of staff and it will be part of your role to familiarise yourself with the risk factor • Do you have a policy of safe practice e.g. when finishing at the end of the shift, working off site or evening shifts - how do colleagues know you are safe?

Case scenario - Safe working

You are giving a talk on contraception to a group of 14 year olds. The talk is being given between 5 and 6 in the evening and you say that you are happy to discuss any issues with individual students should they require this. You use an office in the school where you can meet the students individually to maintain confidentiality. One student asks to speak to you and he closes the door of the office and stands in front of the door. He is verbally inappropriate, asking questions about your sex life and what contraception techniques you use.

You are not aware of any mental health issues and you had not been alerted to this student by any of the teaching staff.

- What would you do in a situation like this?
- What are your Trust's policies around such incidents?
- What legislation if any could protect you as a worker from this situation?

Possible action:

- Ask the student to take a seat to move him away from the door
- Challenge the student if you feel able and inform him that his behaviour is not appropriate
- Inform the student of the possible implications of his behaviour
- Most definitely inform your mentor and manager and document the incident
- Ensure that you feel supported before carrying out one to one meetings with students
- Adhere to your Trust policy on this type of behaviour

‘The management of risk is considered one of the fundamental duties of every member of staff.’

Chapter Summary

This Chapter has introduced some of the key issues of safe working in the community setting. It has explored the key legislation that protects community nurses and discussed ‘rights of entry’ when going to people’s homes. In particular it has highlighted some of the personal safety issues that need to be taken into consideration when working in the community setting as a lone worker.

Web resources

www.rcn.org.uk

Health & Safety at work Act (1974)
www.legislation.gov.uk/ukpga/1974/37

Management of Health & Safety at Work Regulations. (1999)
www.legislation.gov.uk/uksi/1999/3242/contents/made

Manual handling Operations Regulations (1992)
www.legislation.gov.uk/uksi/1992/2793/contents/made

Control of Substances Hazardous to Health Regulations (2002)
www.legislation.gov.uk/uksi/2002/2677/contents/made

Personal Protective Equipment at Work Regulations (1992)
www.legislation.gov.uk/uksi/1992/2966/contents/made

Occupiers’ Liability Act (1957)
www.legislation.gov.uk/ukpga/Eliz2/5-6/31/contents

Health and safety Executive
www.hse.gov.uk

The Code Professional standards of practice and behaviour for nurses and midwives
www.nmc-uk.org/Documents/NMC-Publications/revised-new-NMC-Code.pdf

Lone working
www.hse.gov.uk/pubns/indg73.pdf

Transition to the School Nursing Service

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Section C - Policy

Chapter 10: The policy context and keeping up to date

Introduction

In today's NHS there are so many changes that will impact on the way in which community nursing is delivered and as a school nurse you will need a working knowledge of what these changes will mean to you in your role.

The aim of this Chapter is to:

- Raise awareness of the political climate in which the NHS now exists
- Consider the Department of Health strategy for the future of school nursing
- Highlight the principles of the Healthy Child Programme (5-19).
- Consider how you keep up to date?

We will now look in turn at the Department of Health (DH), The Queen's Nursing Institute (QNI) and the Community Practitioners and Health Visitors Association (CPHVA) and their interpretation of some of the changes:

The Department of Health

The NHS Five Year Forward View published in 2014 suggested that: 'the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health' (DH 2014, p4). The idea that prevention is better than cure has been evident for many years. Derek Wanless warned in his report for the King's Fund 12 years ago that the country would face a huge burden unless preventative work was taken more seriously (Wanless, 2005). Many public health issues facing the developed world are now non-communicable conditions related to obesity, smoking and alcohol. The Five Year Forward View (DH, 2014) advocates more 'hard hitting action' on these health issues and there will be a drive for more community services with changing roles that promote better health outcomes across the whole lifespan (DH 2014).

The Equity and Excellence white paper outlined significant changes in the NHS with a commissioning agenda that has changed the way services are delivered (DH 2010). The commissioning framework focuses on the productivity of services; productivity may be defined as the 'measure of the efficiency of the production'. The 'product' in the NHS, it could be argued, is improved health outcomes for individuals. In 2011, the Department of Health initiated a review of the contribution that school nurses make to this agenda, The Healthy Child Programme (HCP). A new model of school nursing practice was developed which focussed on the valuable contribution school nurses make to improving health outcomes for children and young people (DH, 2012a). Key knowledge and skills were identified and highlighted as crucial to the 'unique selling point' for school nurses. This was vital given the commissioning agenda and the changes to health and social care that were happening.

The public health outcomes framework published in 2012 (DH, 2012b) also mirror the overall aims for the NHS and Public Health England, which are to increase healthy life expectancy and reduce the differences in healthy life expectancy across communities. These changes are not

'Many public health issues facing the developed world are now non-communicable diseases related to obesity, smoking and alcohol.'

new public health aims, school nurses have been contributing to this agenda for many years. The difference is that they will now need to be able to demonstrate the effectiveness of what they do.

The nursing profession overall has had to evolve in line with patient need, new therapies and different models of service delivery. There has been a need to develop new knowledge and skills and return to the fundamentals of nursing which have been characterised within the DH Strategy for Nursing 6 C's care, compassion, competence, communication, courage and commitment. The 6 C's provide a framework of practice for all nurses including school nurses.
http://www.england.nhs.uk/wp-content/uploads/2012/12/6c-a5-leaflet.pdf

There are various ways to get involved in 6C's Live.
Twitter accounts to follow:

- @6CsLive
- @nhsb
- @JaneMCummings
- @VivJBennett
- @JulietBeal
- @PHE

Hashtags to follow:

- #6Cs
- #weschoolnurses

Getting it right for children, young people and families:

Maximising the contribution of the school nursing team: Vision and Call to Action (DH 2012).
The 'Call to Action' 2012 outlined the 'offer' from the school nursing service based on The Healthy Child programme (DH 2009) and outlined what could be expected from the service in the form of a model for practice.

You can explore this document at:
www.gov.uk/government/uploads/system/uploads/attachment_data/file/216464/dh_133352.pdf

The School Nurse Development Model

The Offer

Your Community has a range of health services (including GP and community services) for children and young people and their families. School nurses develop and provide these and make sure you know about them.

Universal services from your school nurse team provide the Healthy Child Programme to ensure a healthy start for every child (e.g., immunisations, health checks). They support children and parents to ensure access to a range of community services.

Universal plus delivers a swift response from your School Nurse Service when you need specific expert help (e.g., with sexual health, mental health concerns, long-term conditions and additional health needs.

Universal partnership plus delivers ongoing support by your SN team from a range of local services working together and with you, to deal with more complex issues over a period of time (e.g. with charities and your local authority).

The Healthy Child Programme (5-19)

The Healthy Child Programme (5-19) (DH 2009) has also guided school nursing practice in recent years. This programme was initiated by the Labour party Government in 2009 and the principles have been maintained to provide a framework for supporting children and young people from 5-19. This follows on from The Healthy Child Programme (pregnancy and the first 5 years of life): www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf

The principles here include a core public health offer for school-aged children: Public health; Health promotion and prevention by the multi-disciplinary team; Defined support for children with additional and complex health needs; Additional or targeted school nursing support as identified in the Joint Strategic Needs Assessment (see below about commissioning school nursing services).

'Delivery of the universal elements of the Healthy Child Programme should be underpinned by a robust Joint Strategic Needs Assessment, which will need to identify vulnerable and at risk groups,

including young carers, Children in Care, young offenders, those not in education, employment or training (NEET) and children with disabilities. At an individual or family level, services should be developed to meet individual need and tailored to ensure individuals are supported'.The Healthy Child Programme document can be found at:

www.thelancastermodel.co.uk/programs/Healthy%20Child%20Programme%202009.pdf

Commissioning services

School nursing is now commissioned through public health in local authorities and information can be found here about this process: www.gov.uk/government/uploads/system/uploads/attachment_data/file/303769/Service_specifications.pdf

It is clear that school nurses will have to promote their services to Commissioning Groups and their contribution to public health locally. School nurses will have to prove and provide evidence that they are able to improve health outcomes for children and young people and their families. Sometimes there is clear quantitative evidence that can be utilised such as the National Child Weight Measurement Programme or the Immunisations programmes. Other evidence is less easily measured such as health promotion work and Personal, Social, Health Education. Health Questionnaires are also being utilised in different areas to help measure local needs.

The Queen's Nursing Institute (QNI)

The Queen's Nursing Institute is a registered charity, founded in 1887, with the original purpose of organising the training and supply of District Nurses on a national basis. It operates in England, Wales and Northern Ireland, while a separate charity, QNI Scotland, carries out similar activities there.

Today the QNI supports all nurses working in the community and primary care to improve healthcare for people in their own homes and communities. It works with nurses and decision-makers to make sure that good quality nursing is available for everyone where and when they need it.

The QNI does this by:

- Funding nurses' own ideas to improve patient care and helping them develop their skills through leadership and training programmes.

- Through a national network of Queen's Nurses who are committed to the highest standards of care and who lead and inspire others.

- By influencing government, policy makers, and health service planners, and campaigning for resources and investment in high quality community nursing services.

To find out more about The QNI, go to www.qni.org.uk.

CPHVA

'Modern school nurses work in the community as well as in schools so that all children can benefit whether or not they attend school. The main aim is to campaign for one full time, year round, qualified school nurse

'Anger, fear, anxiety and frustration can lead normally rational people to behave in an unpredictable way.'

to one secondary school area. This would ensure that each child and young person would be able to discuss health issues and receive support on a one to one basis.

School nurses are unique, as they work at the interface between education and health, understanding the culture of both. They bring about effective partnership working to improve the health outcomes of young people.

There is no doubt that school nurses' knowledge and intervention can make a tremendous difference to the public health problems of obesity, smoking, poor mental health, drug and alcohol abuse and teenage pregnancy. However, this needs to be strongly advocated on a local level' (CPHVA).

To find out more about CPHVA, go to: www.unitetheunion.org/how-we-help/list-of-sectors/healthsector/healthsectoryourprofession/cphva/schoolnurses

See below for information and a video on school nursing practice: www.nhscareers.nhs.uk/explore-by-career/nursing/careers-in-nursing/school-nursing

School and Public Health Nursing Association (SAPHNA)

SAPHNA is a professional organisation representing the voice of school and public health nurses across the UK. To see the latest SAPHNA news, views, events and resources for go to :
www.jfhc.co.uk/saphna/home.aspx

How do I keep up to date?

Keeping up to date is a requirement of the NMC registration. You are required to maintain currency in your field of practice to ensure that best evidence based practice is maintained and therefore, the public protected (NMC, 2011b). It is also crucial given the rapidly changing NHS that all nurses monitor changing policy and respond appropriately.

One method of keeping updated is to perform a literature search of a particular topic of interest related to your practice. It is a way of broadening knowledge of a topic and it can increase both general and specialist knowledge. It will improve your research skills and allows for critical appraisal of research, it can also assist with developing confidence and vocabulary of a subject, contributing to the ability to be assertive.

The purpose of a Literature Search

- It broadens your knowledge on a topic
- Increases your general knowledge, specialist knowledge, vocabulary and confidence
- Shows your skill in finding relevant information
- Allows for critical appraisal of research.

Contributing to consultation documents should also be an important aspect of the community nurse role. This means signing up to relevant professional forums such as the RCN or QNI, and ensuring that you are on relevant e-mailing lists. Your managers will be on circulation lists from different organisations, such as government departments. Make sure that anything is forwarded to you that is of interest. Anyone can contribute to policy consultation documents, either as individuals or groups and this is crucial in raising the profile of community nursing.

@WeSchoolNurses

@WeSchoolNurses is a Twitter account for connecting, driving and supporting the school nursing community through fortnightly twitter chats and nurse social media resources. @WeSchoolNurses is part of the larger @WeNurses community, founded by Teresa Chinn MBE. The chats, usually on a Tuesday evening at 8pm, focus on topical school and public health nursing issues. Twitter has fast become one of the best vehicles to drive contemporary school nursing practice and is a great way of connecting school nurses who need additional guidance, information and ideas. Sharing of practice enables nurses to explore innovative ideas and improve practice delivery nationally. Peer support is in abundance, helping to give confidence and maintain the passion of a small dedicated workforce.

Chat details can be found here: www.wecommunities.org/tweet-chats/chat-calendar

Archived chats can be found here: www.wecommunities.org/tweet-chats/chat-archive

Activity 1

- What impact do you think commissioning will have on outcomes for children?
- Consider the advantages and disadvantages

Activity 2

- Choose a topic that interests you or a topic that you know very little about (your choice must relate to school nursing)

- Search on the DH, QNI, RCN ,King's Fund or any other related website for information
- Look at any resources you may have in your clinic or local surgeries
- Access all the related websites that are attached to this resource that may assist your search
- Start to compile an information file of your topic

Chapter Summary

This Chapter has introduced the importance of understanding the government NHS reforms and other related literature and their impact on school nursing. The emphasis will be on community nurses to sell their service, in order to do this they will need to be up to date and politically aware of how the changes will affect the delivery of the school nursing service.

Web Resources

- www.evidence.nhs.uk NHS Evidence database
- www.kingsfund.org.uk The King's Fund
- www.nice.gov.uk

The Queen's Nursing Institute

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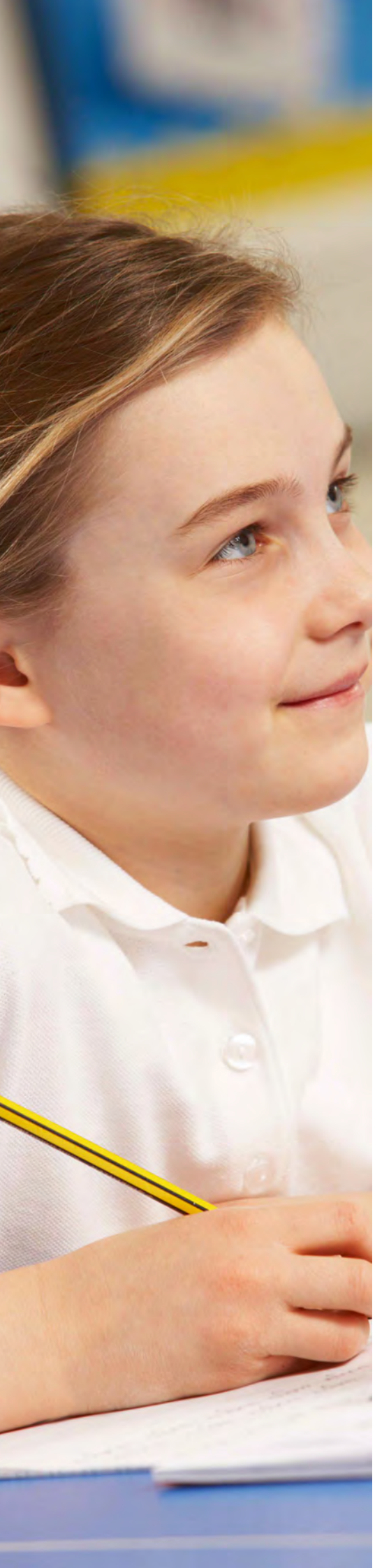

Section C - Policy

Chapter 11: Developing your career in school nursing

Introduction

The aim of this Chapter is to:
- Consider your confidence and competence in school nursing
- Start to contemplate your own personal development plan
- Begin to consider career planning

Importance of CPD

The overall aim of CPD is to give all those working with patients/clients/children and young people the opportunity to update their knowledge and skills in their area of work. For those that are qualified nurses it is a NMC requirement that at least 35 hours of learning activity relevant to their practice is carried out over a three year period. All qualified nurses must currently keep a portfolio which is updated on a regular basis, and at least every time a new learning activity has taken place (PREP). There is no point just putting together a portfolio of handouts, power points, leaflets and certificates of attendance. This will of course prove that you have attended an update, but it will not demonstrate what you have actually learnt. It is therefore recommended that a reflective account is written following each study day that you attend. Attending study days is also an opportunity for you to look at various career paths that you might like to follow in the community setting. The NMC is updating the way in which practitioners will need to demonstrate that they are up to date and have maintained contact with the evidence base for their practice.

Revalidation will replace the current PREP process in December 2015. For further information on this please visit the website: www.nmc-uk.org/Nurses-and-midwives/Revalidation

In 2004 the NMC created a third part of the professional nurse register for all Specialist Community Public Health Nurses that included school nurses, health visitors and occupational health nurses. An obvious career path for a staff nurse working in the community is to apply for the Specialist Community Public Health Nursing programme. However, others choose to remain as community staff nurses working in the school health team. You will need to apply in the first instance to a Trust to be sponsored to do the course and you will be allocated a qualified practice teacher to support you in practice. Should you decide to follow the Specialist Practice route; the standards for SCPHN are on the NMC website: www.nmc-uk.org/Educators/Standards-for-education/Standards-of-proficiency-for-specialist-community-public-health-nurses

The standards for SCPHN's are based on the four principles of practice:
- The Search for Health Needs
- The Stimulation of Awareness of Health Needs
- The Influence on policies affecting health
- The Facilitation of health enhancing activities

‘It is imperative to know what your level of knowledge is if you are to work within your competence.’

If you contemplate doing the SCPHN qualification you can do this at degree or Post Graduate level (PG Dip). The programmes at universities have to be approved by the NMC and successful completion of the programme will enable you to be recorded on the third part of the NMC register as well having an academic qualification. The programme is 50% practice and 50% theory. A portfolio of evidence demonstrating your competency will be required and the academic learning is applied directly to your practice. Some of the key topics covered on the course are:

- Leadership and management knowledge and skills
- Public health and health promotion
- The determinants of health and well being
- Safeguarding and child protection
- Research skills and the importance of evidence based practice
- Emotional health and well-being
- Engaging communities to improve health: assessing need
- Communication with children and young people
- The political agenda.

Values-based recruitment to Higher Education Institutes is now in place and you will need to be aware of these values if you are offered an interview to do the SCPHN course. You will be asked questions around the following:

- **Working together for clients** (children, young people and their families)
- **Respect and dignity** - valuing everyone as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits
- **Commitment to quality of care** - insist on high quality, safety and effectiveness of services
- **Compassion** - ensuring that compassion is central to everything you do
- **Everyone counts** - maximising resources for the benefit of the whole community, and make sure nobody is excluded, discriminated against or left behind
- **Improving Lives** - strive to improve health and well-being and people’s experiences of the NHS.

If you are accepted on the course and qualify as a SCPHN you can then think about further learning opportunities such as the practice teacher course or, if you have done a PG diploma, you may want to complete the Masters programme.

The following website, www.nhscareers.uk, will highlight the various nursing opportunities that are available. Whether it be working as a member of a primary care team, working as part of a social enterprise or working with a specialist team of health workers; you will know what your specific interests are, so spend time working through this site.

A number of Health Care Assistants also work as part of a school nurse team and they also should be involved in continuing professional development. Whilst they are not accountable to a professional body, they still have their own individual integrity and individual responsibility to ensure that they are working as a safe practitioner.

It is imperative to know what your level of knowledge is if you are to work within your competence. Look at the diagram below. Where would you place yourself on the ladder of competence?

Level1 – Unconscious Incompetence – You don’t know that you don’t know

Level 2 – Conscious Incompetence – You know that you don’t know

Level 3 – Conscious Competence – You know that you know

Level 4 – Unconscious Competence – You don’t know that you know – it just seems easy !

Using this ladder as a tool will assist you in identifying where more learning needs to take place, but it will also give reassurance when you are competent.

The web page, www.mind.tools.com/pages/article/newISS-96htm introduces you to a number of leadership and management strategies which you might find useful when you identify which level

on the above ladder you sit. Please remember that leadership and management not only happens in senior management positions, but every member of a team will have some leadership role to play.

Reflection point - Having identified where you are on the ladder, what action are you going to take to change your position on the ladder?
Also acknowledge that you may be at different levels of competence depending on what skill or subject matter is being addressed. You may find the exercise uncomfortable because it displays areas where you possibly thought you were more competent than you actually are. This is not a problem as long as you are aware of this and demonstrate an emotional intelligence that is resilient and will assist you to develop/ strengthen in these areas www.mind.tools.com

www.emotionaliq.org/EI.htm This website will introduce you to emotional intelligence and the different models used. Emotional intelligence is the ability to perceive emotions in you and in others. Having recognised this it then enables you to identify strategies that will help you to reflectively regulate emotions to promote emotional and intellectual growth (Mayer & Salovey, 1997).

Personal Development Plan

What is required of a personal development plan? A development plan is designed to help you to reflect on your career to date and for you to put together a SMART (Specific, Measured, Achievable, Realistic, Timely) action plan to assist you to reach your next goal. There are three key stages in working on a personal development plan:

1. Identify what is required of your current role
2. Carry out a SWOT analysis – look at the strengths, weaknesses, opportunities and threats that have assisted/prevented you from working effectively in your current role and also when considering future roles
3. Develop a SMART action plan to assist you to move forward in the direction of your chosen career.

Reflection point - Have you considered any other community career paths you may want to follow? What steps/actions do you need to take to follow your chosen career pathway
This website may help you to develop your plan: www.worldwork.biz/legacy/www/downloads/Personal_Development_Plan.pdf

Having devised this personal development plan it will pave the path for you when you attend interviews and will also assist you when writing your CV, as it will have outlined clear objectives in the form of your SMART action plan.

Applying for jobs

Firstly, find out background information about the company: whether it is a NHS Trust or a Social Enterprise, charity or private company. Information can be found on the website. Find out what their vision and strategy for the future is. What skill sets are they looking for – do you have the skills they are looking for? It is essential that the job description is scrutinised and that you look at the essential skills and desirable skills that are required for the position that you are applying

‘Leadership not only happens in senior management positions, every member of a team will have some leadership role to play.’

for. When you compile your CV ensure that it meets the criteria in the job description. Be as succinct as possible when you answer questions on the application form and do not add unnecessary information that has no bearing on the job application.

www.monster.co.uk This website will give you a lot of valuable information regarding the format of CV writing and the way to use specific words that will enhance your CV.

If you are invited for an interview it is a good idea to have a practise interview with someone who has an understanding of the role you are applying for. Make sure you are up to date with government and Department of Health policies that potentially will impact on your practice. Be enthusiastic and remember to let the interview panel know what specific skills you will be bringing to the role. If you are asked to present at interview it is likely that you will have ten minutes to present. Prepare your power point slides. Keep these to a minimum (not more than 10 slides) and only write headers or bullet points so that you can talk around the slides and remember to speak slowly and articulate your words. It is also a good idea to bring your portfolio of personal development which will demonstrate how you have been updating yourself and what you have learnt from the updates. https://nationalcareersservice.direct.gov.uk/advice/getajob/interviews

Should you be unsuccessful at interview it is always a good idea to ask for feedback from the panel – this will help you when you apply for further jobs.

Reflection point - Now that you have completed this on line resource, what do you plan to do? Has working through the various chapters assisted you in challenging your practice? Do you feel more confident now? Are you going to pursue your studies further?

Chapter Summary

This chapter has looked at the importance of recognising your individual competence in the role you are currently working in. It has given some ways in which you can recognise your level of competence. This can really only occur if the individual concerned has a self awareness that will enable them to act on the areas where they feel less competent and put a strategy in place to deal with this.

The career pathway for working in the community was looked at, recognising that not all staff nurses will want to study for the Specialist Community Public Health Nursing programme. The importance of having a personal development plan was discussed and also it was stressed that preparation in the form of CV writing, interview skills and application processes were important when applying for any new role in the community setting.

Further Web Resources

- www.nhscareers.uk
- www.jobs.nhs.uk
- www.changemodel.nhs.uk
- www.kingsfund.org.uk
- www.cno.dh.gov.uk
- www.nmc.uk.org
- www.rcn.org.uk
- www.businessballs.com

Evaluation

We would be grateful if you would complete a short evaluation on this resource. To take part, please go to https://www.surveymonkey.com/r/SXF8TXW. Thank you.

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