

**Nursing Services in
New Zealand
Secondary Schools**

A Summary

Citation: Ministry of Health. 2009.
Nursing Services in New Zealand Secondary Schools: A summary.
Wellington: Ministry of Health.

Published in February 2009 by the
Ministry of Health
PO Box 5013, Wellington, New Zealand

ISBN 978-0-478-31909-5 (Print)
ISBN 978-0-478-31910-1 (Online)
HP 4755

This document is available on the Ministry of Health's website:
<http://www.moh.govt.nz>



MANATŪ HAUORA

Foreword

Nursing services have long been provided in New Zealand secondary schools. However, over the years there have been changes in the types of services provided, how they are funded and by whom.

In recent times, policies generally have become more child-focused and there has been more emphasis on the participation of, and consultation with, children and young people around providing services or developing policies that will affect them. There is also increasing awareness of the links between children and young people's health needs and their educational achievements. At the same time, changes within the wider health sector have led to an increased focus on primary health care and, in particular, to a focus on the critical role of the primary health care nurse.

School nursing services are potential sites for the development of primary health care services as envisaged in the Primary Health Care Strategy (Minister of Health 2001), and in many schools such services are currently being provided. However, little is known about the nature and extent of these services.

Clearly nursing has a significant role to play in helping our young people get the most from their educational experience.

This document begins to point the way towards the future of a comprehensive school nursing strategy for New Zealand.

Mark Jones
Chief Nurse
New Zealand

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The Research

A report by the Health Services Research Centre: *Nursing Services in New Zealand Secondary Schools* (Buckley et al 2009) aimed to explore the range of nursing services in New Zealand schools, seeking to answer the questions.

- Which nursing services are provided in secondary schools?
- How are these services funded?
- How do they link to other health services?
- What are the professional issues for nurses working in schools?

The report had three main data sources:

- a literature review exploring New Zealand school health services, adolescent health and health needs, barriers to youth accessing health care and models of youth health care (see section 3, pg 6 of the full report)
- qualitative interviews with 16 nurses working in secondary schools or youth centres and one interview with a school counsellor
- two surveys: a short web-based survey of 154 secondary school principals and a survey of 235 nurses who work in secondary schools.

This document summarises the findings in *Nursing Services in New Zealand Secondary Schools*, generally focusing on the answers to the questions above.

To view the full report *Nursing Services in New Zealand Secondary Schools* go to www.moh.govt.nz

Key Points

- Three-quarters of secondary schools had a nursing service but there was considerable variation in the types of health services provided in schools across the country and in their funding. But the types of services available did not depend on the ‘type’ of nurse (that is, school-employed nurse¹, public health nurse, PHO-employed nurse), nor did it depend on school decile² level.
- About half the nurses were employed by schools. Most others were employed by District Health Boards (DHBs); about half of these through Public Health Units (PHUs). Approximately (2 percent) were employed by Primary Health Organisations (PHOs).
- The broad range of services available included personal health services, first aid, health assessments, health education and promotion, home visits, referrals to other health providers and assistance with the development of school health plans.
- While there was some variation in what they did in individual schools across the decile range there is no consistent trend and nurses in low decile schools were offering the same sorts of services as those in middle and high decile schools. For nurses who were employed by an organisation outside the school, their scopes of service were decided most often by the employer in consultation with the school, and then by the employer alone.
- Fifty percent of the nurses (118 of respondents) undertook fewer than 20 consultations a week, but 16 percent (37 respondents) saw more than 120 students a week. Some nurses, particularly public health nurses, worked in more than one school, with some working in up to 12 schools.
- Almost all schools also had counsellors and some had physiotherapists, General Practitioner (GP) clinics, dental services, and vision and hearing checks. Nurses linked students to a range of other health providers both in and out of the school, including GPs, family planning clinics, counsellors, social workers, and Resource Teachers: Learning and Behaviour (RTLBs).
- Most nurses had access to a clinic area within the school, but some used the school hall or unoccupied offices. Many nurses did not have access to a computer and those who did were using a variety of databases to record consultations.
- Most school principals felt the health services in their schools met students’ needs. Those who expressed some doubt were usually seeking more hours rather than commenting on the quality of services provided.
- Most nurses were not available at the school clinic during school holidays.
- A third of nurses, mostly school-employed nurses, did not receive clinical supervision.
- Most nurse respondents were older than 30 and most had broad professional experience.
- Although most received professional development support of some kind, almost all nurses wanted to undertake further training.

1 The term ‘school-employed nurse’ used in this document refers to nurses working in schools, who are employed by the school. Almost all the nurses working in schools but employed by DHBs called themselves ‘public health nurses’.

2 New Zealand schools are allocated a decile rating related to the socioeconomic characteristics of their students. Decile 1 schools are the 10 percent of schools with the highest proportion of students from low socioeconomic communities, and decile 10 schools are the 10 percent of schools with the lowest proportion of these students. But note this is the direct opposite of ratings used by the New Zealand Index of Deprivation (NZDep Index). The Index measures socioeconomic deprivation over geographical units as defined by Statistics New Zealand. Using this index, 1 represents the areas with the least deprived scores and 10 the areas with the most.

Conclusions/Recommendations

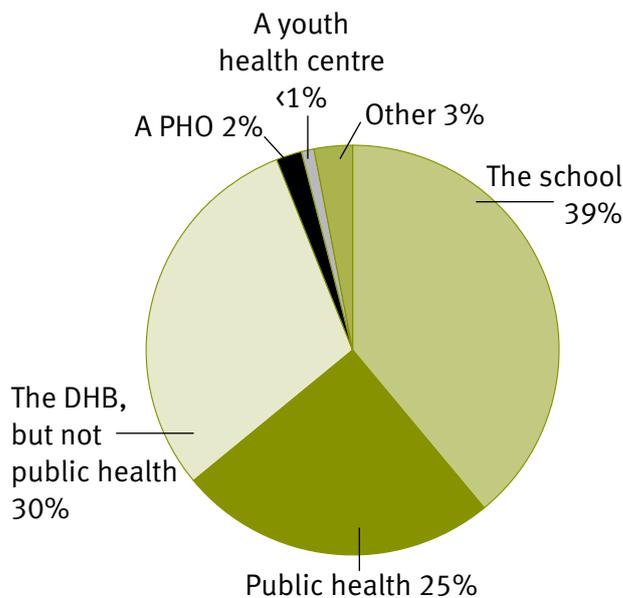
- School nurses provide health services but within an education context. The role is a health role but as nurses are supporting students' education generally as well as providing health education, the role needs to be supported within both health and education.
- There is a need to develop a policy concerning school-based health services; this would be best undertaken by the Ministry of Health in consultation with the Ministry of Education.
- Both principals and nurses would like to see the availability of school nursing services extended both in hours and range (of services). There was also a desire for GP services, more counselling services and other services such as physiotherapy and dental services.
- The professional isolation of many nurses employed by schools needs to be addressed.
- The preponderance of nurses in the upper age ranges, 40–59 years, has implications for future workforce planning.
- The role of the school nurse needs to be clarified. There is a perception held by some, particularly in schools, of the 'school nurse' as providing 'Panadol and band aids' and who can also assist with some of the administration tasks.
- There is a need for the development of adolescent health career pathways for nurses in schools.
- DHBs could take responsibility for health services in schools, and be equitably funded for this.
- The perspective of school students should be taken into account when deciding the appropriate models of school health services.

Findings

Employers of nurses in schools

The figure below shows the largest number of nurses in schools were employed directly by schools (39%). However, PHUs and other DHB nurses together were the greater number of nurses. Two percent of nurses were employed by a PHO.

Figure 1: 'Who is your employer?' (Nurses' survey)



The category 'Other' chosen by the nurse respondents was commonly made up of DHBs, sometimes in partnership with a PHO or youth health service and community trusts.

Funding for school nursing services

Funding comes from a variety of sources:

- schools' operations grants, sometimes backed up by funding received from international students' fees and in some cases funded by community or other grants
- other school funds
- DHBs – including Public Health and Achievement in Multi Cultural High School (AIMHI)³ schools, with funding from Healthy Community Schools (HCS) (the Ministry of Health has funded school nursing in nine AIMHI schools since 2007)
- PHOs.

Nurses can also become registered providers of Accident Compensation Corporation (ACC) services which provides extra funding – anything from \$6,000 to \$10,000 a year. This funding covers all consultations that are a result of accidents or injuries.

³ The AIMHI schooling improvement programme includes nine decile one urban secondary schools, eight in Auckland and one in Wellington, with high proportions of Pasifika and Māori students. The AIMHI group of schools was established in late 1995 and from 2002 onwards the AIMHI Healthy Community Schools initiative was established to co-locate community health and other services on school sites

Extra income that nurses can access if necessary includes:

- funding for extra staff to undertake HEADSS⁴ assessments
- Services to Improve Access (SIA) funding⁵

Nurses described working around systems, such as sometimes using the health centre's funds for students who could not afford the GP's fee.

Some nurses raised the issue of problems arising from students' health funding. For some schools, there was only one PHO in an area, so all the students in that area were enrolled in that PHO. But in other areas where there were a number of PHOs, students may be enrolled in any one of them. Nurses could therefore find themselves referring students to a GP outside the student's own PHO.

For that GP/PHO to be funded, the consultation required some 'claw back' of funding from the PHO the students were enrolled with. It appears that in most cases, these GPs were not using 'claw back'. Instead funding for payment was regularly sought through alternative sources such as SIA or ACC. Nurses used these sources of funding for referrals to other health providers as much as possible.

In some cases the GPs were seeing the students 'out of the goodness of [their] hearts'. Both GPs and nurses were in some instances providing services without payment.

'I find it really hard when it's not a sexual health thing, like a chest infection that's just not going away, and mum and dad won't take them to the doctor. I find that really hard, because then it comes to the cost thing. And I've been . . . taking it out of the health clinic budget and not getting any of it back.'

Nurses also had to budget for supplies, as one nurse described.

'The budget is like \$2000 a year. The facilities are part of the school, it's more for any equipment, or dressings and medications and things like that. [It's] just [enough]. I worked out last year that it costs about \$8.50 to run the clinic a day, which isn't much, but at the same time I tend to be quite thrifty and try and get things donated and stuff. . .'

Nurses would prefer to receive funding from both Health and Education for school health services, since they saw themselves as part of the school community. They felt they were making a contribution to education, expressed in the idea that a 'healthy student' was better able to learn. As well, teachers were better able to teach, when students' health, behaviour and welfare needs were being met.

Need for school nursing services

Although prioritisation of health services was usually decile-based, many nurses felt the need for adolescent health services was not entirely related to the (low) socioeconomic background of the school. They thought there were a number of reasons why some adolescents might have had a greater need for school-based services than others. These included access to services and/or access to transport, for rural students in particular, but also for students in cities who were unable to pay for transport; time lost from school; and privacy and confidentiality. These accessibility

4 HEADSS is a youth health assessment tool referring to Home, Education, Activities, Drugs, Sexuality and Suicide.

5 Services to Improve Access (SIA) funding is available for all PHOs to reduce inequalities among those populations that are known to have the worst health status: Māori, Pacific people and those living in NZDep index 9–10 decile areas. The funding is for new services or improved access. Examples of the successful use of SIA funding are: the provision of clinics at work sites, marae, church groups and schools; transport services to help people get to clinics.

issues applied across socioeconomic boundaries. Moreover, nurses described how adolescent health issues also crossed socioeconomic boundaries:

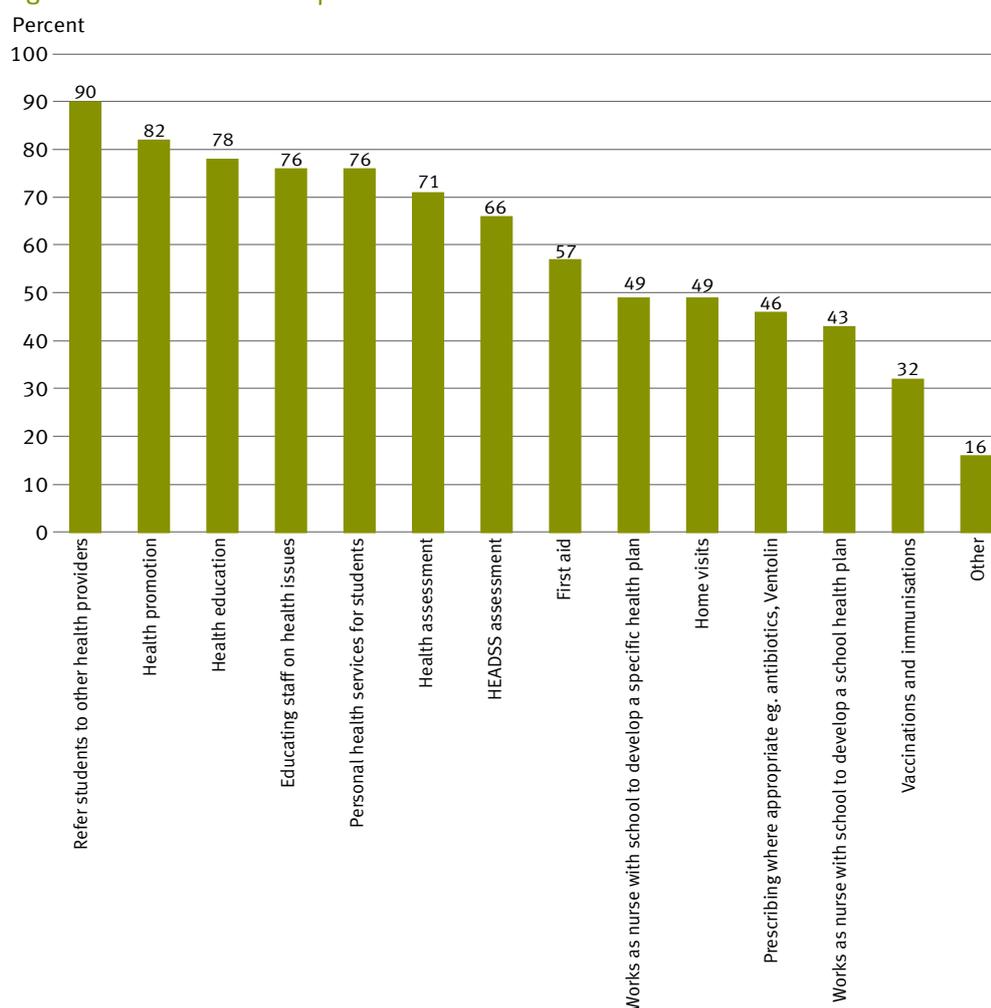
‘. . . kids at [high decile city school] are taking as many risks around sex, drugs, alcohol, mental health, all that kind of thing as the kids in [city area with low decile schools]. And so our kids become marginalised in the same category as Māori and Pasifika . . . And nurses out in the 10 decile school areas will tell you they have as many problems. They just manifest in a different way.’

Range of nursing services

Nurses were asked to indicate the range of services they provided. Slightly more than three quarters provided personal health services and a similar number undertook HEADSS or other health assessments. Almost half were involved in administering medication where appropriate (for example, the emergency contraceptive pill, antibiotics, Ventolin) and undertaking home visits. Many also provided first aid services and worked with the school on development of the school or other specific health plans. Almost all referred students to other health providers and undertook health education and health promotion activities. Just over a third indicated they provided advice to teachers on health classes.

‘I’m seeing an average of about 31 students a day. And that can be anything; headaches, injuries, dressings, medical stuff like coughs, colds, generally being unwell. Lots of sexual health, there’s the mental health side of things, drug and alcohol, period pains . . . And sometimes it’s just questions as well: “I’m thinking about having sex but I don’t know”, things like that . . . I get referrals from teachers to talk to students about hygiene. There are students that come in just for their medication each day.’

Figure 2: Health services provided



The ‘other’ tasks described by nurses included liaising and/or attending meetings with counsellors, Child, Youth and Family services (CYF), paediatric care, and RTLBs, running health and peer support programmes, and research.

Many more school-employed nurses provided first aid than nurses employed by other agencies, in part because these nurses were more likely to be on-hand during the week. School-employed nurses were less likely to be undertaking health assessments or personal health services or to be involved in providing vaccinations or administering medications, than DHB-employed or public health nurses. They were also much less likely to undertake home visits than both public health nurses and DHB-employed nurses.

While public health nurses had job descriptions and scopes of practice decided by their employer, for other nurses the role was not always clear. One school-employed nurse commented:

‘I really don’t think that they really thought too hard and in-depth as to what a nurse does ... they needed a registered nurse to deal with the ongoing issues that are in the school ... I don’t think they gave it any really in-depth thought because they don’t know, they are not medical people.’

In some school clinics, the emphasis was on assessment and referral, with very minimal hands-on care for such things as dressings or tests. Nurses indicated that decisions regarding the level or type of care depended on a number of factors; sometimes on who the service provider was, their scope of practice or available resources.

Hours worked by nurses

Although many nurses (50 percent) were seeing fewer than 20 students a week, about a fifth were seeing more than 100. These were most often school-employed nurses who were available for more than 25 hours a week. By contrast, the majority of public health and DHB-employed nurses were available for consultation for fewer than five hours each week and generally seeing fewer than 20 students per week. They tended to hold brief clinics at schools, often one or two lunch-hour visits per week.

Students’ reasons for using school nursing services

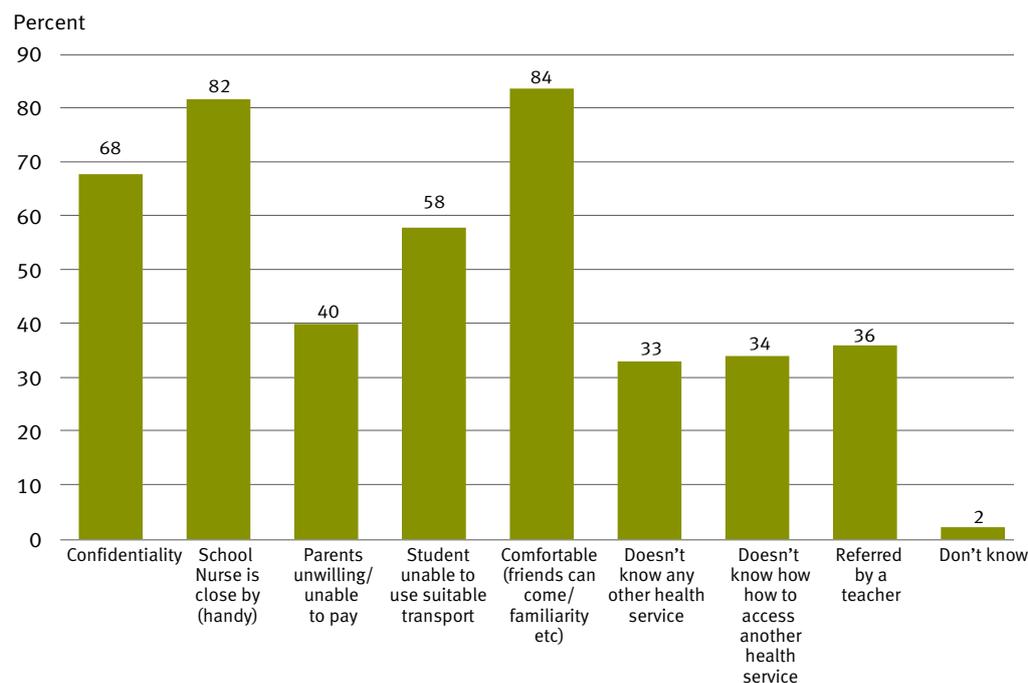
Nurses believed that the common reasons why students used school health services were because of proximity and because students found it ‘comfortable’ as they could bring friends and it was familiar. The next most common reason was for confidentiality, particularly when students wanted to use health services independently of their families.

Other reasons were not having access to transport to other health services, parents unwilling or unable to pay for other health services and students not knowing about other health services or how to use them.

‘... often these young people don’t want to be seen in the doctor’s waiting room, because an aunt or something might see them and then say, what’s your daughter doing, I saw her at the doctor’s ...’

It may be that there are two distinct classes of medical needs that determine which health services students use. For example, students may prefer to access school-based services (or youth health centres) for sexual health needs, possibly for bullying/violence issues, alcohol and drugs, and so on, for reasons of privacy and confidentiality. They may happily access their local family GP for other health issues such as injuries and general health. However, for some students, the advantages of proximity and accessibility (in terms of cost and transport, and ‘comfort’) mean school-based clinics are preferable for all their health needs.

Figure 3: Reasons for using school health clinics



Eighty-one percent of nurses indicated that teachers referred students, 80 percent indicated that counsellors or other health professionals referred students and just under 60 percent indicated that parents made referrals; many students also made their own appointments or just ‘queued up’.

Nurses emphasised their role in encouraging students to take responsibility for their own health and to use health providers outside the school. Students would not always be at school, clinics were not open in school holidays and it was important that young people learned to be aware of, and attend to, their own health needs. The nurses also talked about the advantages of students visiting their family GP because the GP had the student’s medical and health history.

Most common reasons for consultations (Nurses’ survey)

Nurses were asked to indicate the most common reasons why students attended their clinics.

The most common reason students sought consultations was for advice on sexual health/contraception, followed by treatment of injuries and general sickness. Only about 30 percent of nurses indicated that students sought help from them for mental health issues or family problems. Twenty percent indicated students were likely to see them because of bullying issues.

Table 1: Most common reasons for consultations (Nurses' survey)

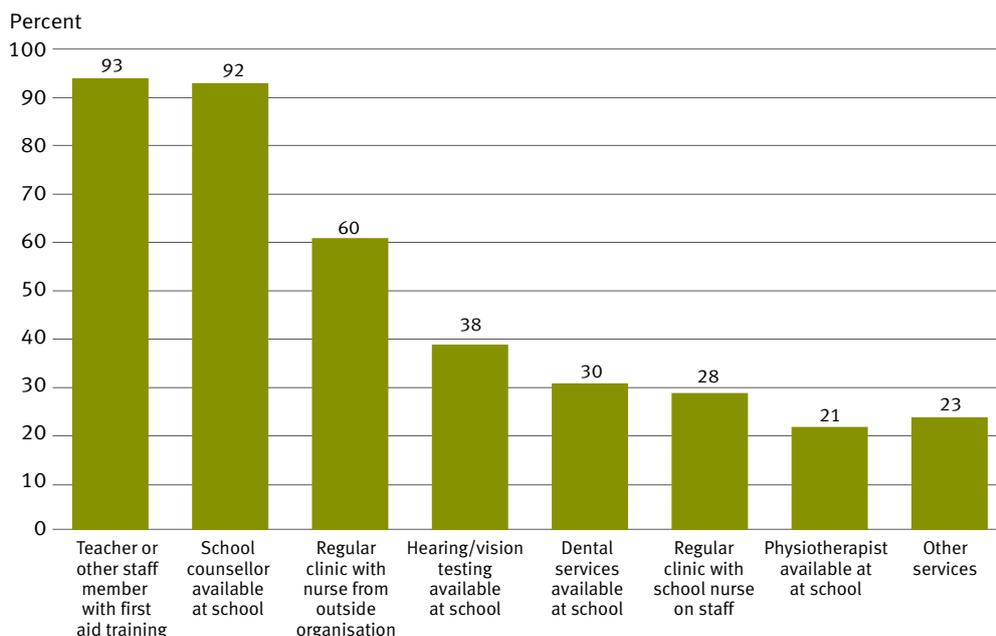
Reason	'Often' or 'Sometimes'	
	Frequency	Percent
Sexual matters	168	72
Injuries and general sickness	149	63
Mental health issues	79	34
Coping with family problems	75	32
Bullying/violence issues	47	20
Healthy eating etc	44	19
Alcohol or drugs	32	14
Weight loss or body shape	31	13
Fitness, physical activity etc	25	11
Smoking cessation	14	6

Other reasons students sought consultations with the nurse included help with school projects, hearing/vision testing, just wanting to talk to someone or wanting information on health issues, and for health assessments.

Other health services available in schools (Principals' survey)

Most schools had a first-aid trained staff member and a counsellor and many had a regular clinic with a nurse from outside the school. In addition to the hearing and vision, and dental and physiotherapy services, a number of principals also indicated the availability of doctors, a family planning service, sexual health services, Māori providers of health and social services, social workers, mental health services or psychologists and health support workers.

Figure 4: Health services available at the school (Principals' survey)

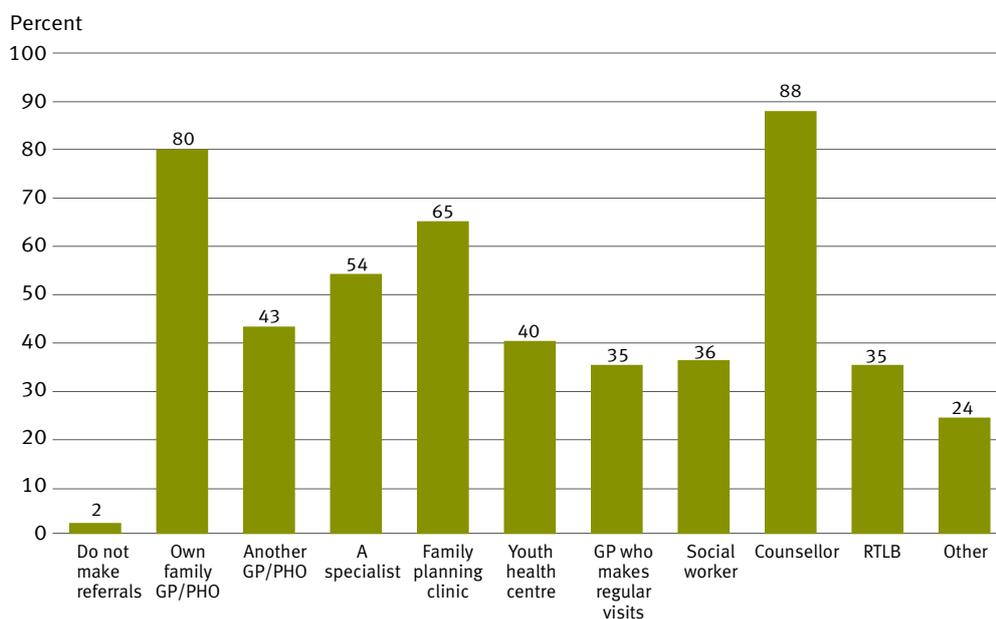


Schools with one or more nurses were more likely to have other health services such as counsellors, doctors and Māori service providers, than schools that had no nurse. This may have been a reflection of the higher needs of students in these schools, but it is also very likely a reflection of the fact that the nurses at these schools were active in linking students to these other services.

Referrals to other health or social service providers

Nurses were asked about other health or social service providers to which they referred students. High numbers of nurses referred students to counsellors and GPs, and referrals to family planning clinics and medical specialists were also commonly made. These types of referrals reflect the reasons nurses gave for students visiting them. As in Table 1, the majority wanted advice on sexual matters and a third wanted consultations to talk about mental health and family issues.

Figure 5: Referrals to other health or social service providers



The ‘other’ providers listed by nurses included mental health providers, CYF workers, other nurses, sexual health services, dentists or other dental services, physiotherapists, hearing and vision therapists, GPs, a youth health centre, asthma educators; ‘quit smoking’, alcohol and drug services, and other school staff.

School-employed nurses were more likely than others to refer students to GPs other than family GPs. (This appears to be because school-employed nurses often have a GP with whom they have built a good working relationship and who is in close proximity to the school.) School-employed nurses were also more likely than DHB-employed or public health nurses, to refer students to counsellors, and less likely to refer students to specialists, youth health centres or social workers.

Most nurses described having close links or good relationships with local health centres, youth health centres, GPs or PHOs.

Sometimes nurses mentioned the advantage of proximity to other health services to which students might be referred. Not only did this eliminate transport problems but students did not have to be absent long from school in order to attend.

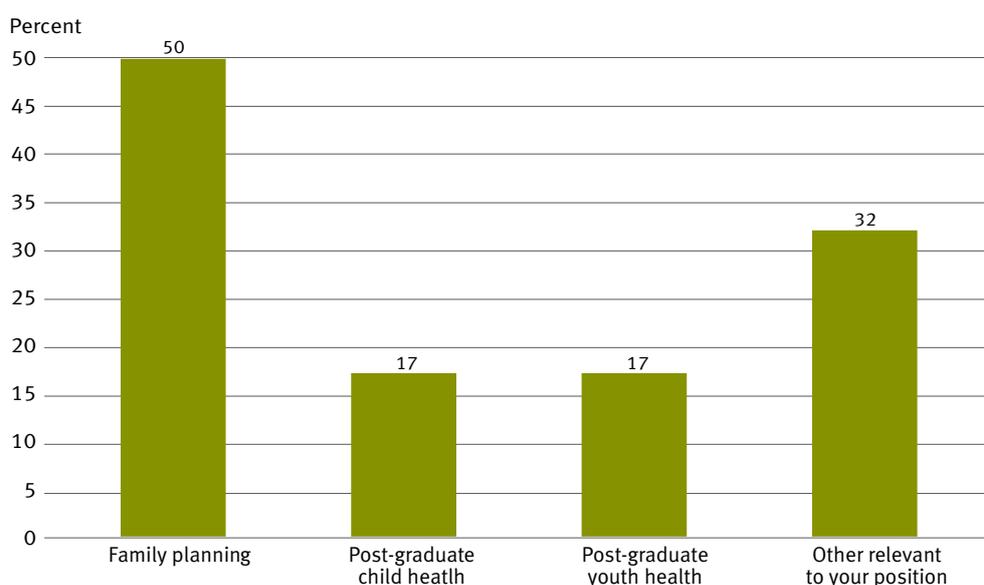
The most common referral made by nurses was to counsellors (see Figure 5 above) and almost all nurses spoke of the good working relations they had with counselling staff at their schools. In most cases nurses were located in offices near counsellors and worked collegially with them, seeing themselves as part of a ‘pastoral care team’. Often students were using both nursing and counselling services.

Qualifications

Most of the nurse respondents were registered nurses (93 percent). There were a small number of enrolled nurses and a number of other school staff who were trained in first aid.

‘We all basically need to be a registered nurse, but two years post basic would be a really important experience really, focusing on children and adolescent issues. All of our public health nurses that go into high schools have got a family planning, sexual health and contraception certificate, they’ve done that extra training and we encourage people to do a basic counselling course.’

Figure 6: Further relevant qualifications



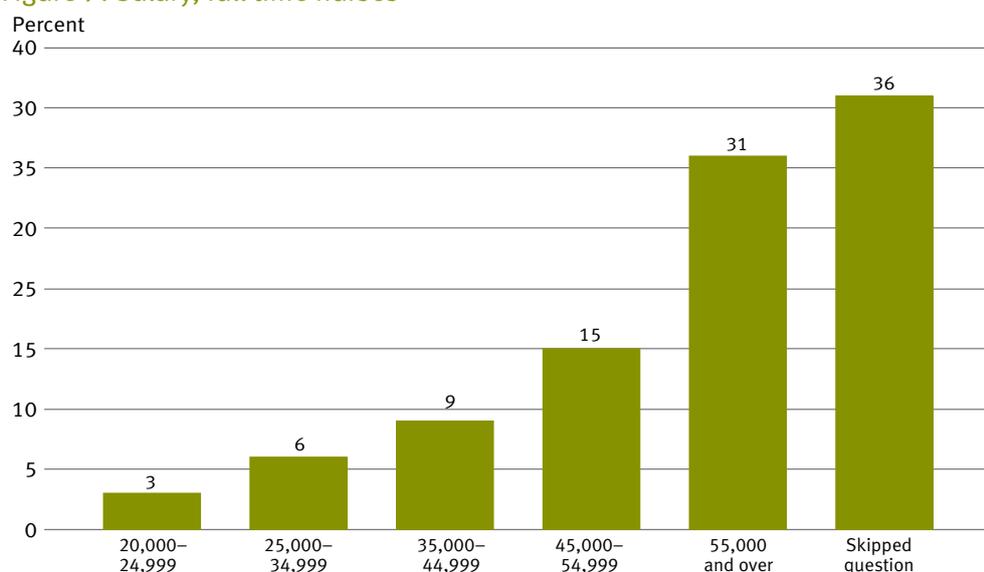
‘Other’ relevant qualifications that nurses described included:

- post-graduate rural health certificates and diplomas
- sexual and reproductive health certificate
- HEADSS training
- emergency contraceptive pill training
- child and youth health papers
- certificates in counselling, mental health, health education and promotion
- asthma education diploma
- teaching diploma.

Remuneration

Nurses were asked to indicate their salary level, or hourly rate if they worked part-time. Seventy-three nurses, or 31 percent, indicated a salary range of over \$55,000 but high numbers skipped the question.

Figure 7: Salary, full time nurses



Nurses in the higher salary ranges, over \$50,000, were most likely to be public health or DHB-employed nurses and very few in these groups earned salaries in the lower ranges. School-employed nurses’ salaries tended to be more evenly spread over the whole range of salaries, with most in the middle ranges, \$30,000 to \$45,000.⁶ Some caution should be used in interpreting the difference in salaries between school-employed and other nurses. Public health nurses in particular worked only part of their time in school clinics and were also undertaking other nursing activities. The differences in salary may be based (at least partly) on their roles rather than the simple fact that they were employed by schools or by public health.

Nurses employed by schools and working part-time received the lowest hourly rates (most earning between \$20 and \$24 an hour) compared with nurses employed by all other agencies. Public health nurses were more likely to be earning between \$25 and \$29 an hour and nurses employed by DHBs were most likely to be earning \$30–\$34 an hour.

⁶ These figures are from the survey of nurses; however, more than a third of full-time nurses and nearly half of part-time nurses did not answer the questions on salary/wages.

Nurses in the highest salary range, \$55,000 and over, were more likely to have additional qualifications, the most common being family planning qualifications. Post-graduate child and youth health qualifications were held by some nurses within all salary ranges, although those receiving more than \$50,000 were more likely to have a post-graduate child health qualification than those on lower salaries.

Some of the more poorly paid nurses, when explaining why they stayed in their positions, described how the working hours fitted in with their families, or that they were unable to work in a hospital for health or other reasons. Most nurses, regardless of employer, also expressed strong commitment to the needs of young people and the importance of the job.

'I love my job, I love the kids, I love what I do and you've got someone now who's taking on the job because she's passionate and sees the vision, but you know it's at the expense of . . . it's your own financial expense.'

Reporting and clinical supervision

Nurses were asked whether they reported to someone in their professional capacity as a nurse. Of those who responded positively, more than half reported to a senior nurse and over a third to another professional in the organisation that employed them. Sixteen percent indicated they did not report to anyone in a professional capacity. Most of these were school-employed nurses. Twenty-six percent of public health nurses and 29 percent of non-public health DHB nurses reported in a professional capacity.

Table 2: Nurses' professional reporting by employer type

Type of Employer	Reports in a professional capacity	Does not report in a professional capacity
The school	22	14
Public health	26	1
The DHB, but not public health	29	3
A PHO	2	1
A youth health centre	1	0
Another organisation	3	0

One third of nurses indicated they did not receive clinical supervision⁷; almost all of this group were employed by schools. Although most nurses described supervisors as senior nurses, managers, doctors, trained supervisors or senior colleagues, quite a number of nurses indicated they received clinical supervision from colleagues. Some indicated counsellors or social workers as their clinical supervisors and some mentioned a local 'cluster group' which made its own arrangements to meet competency requirements.

Most principals indicated they received regular reports about clinical activities undertaken by nurses and more than half indicated that these reports also went to Boards of Trustees. Eighty percent of nurses also indicated they reported to senior staff within the school and about a third

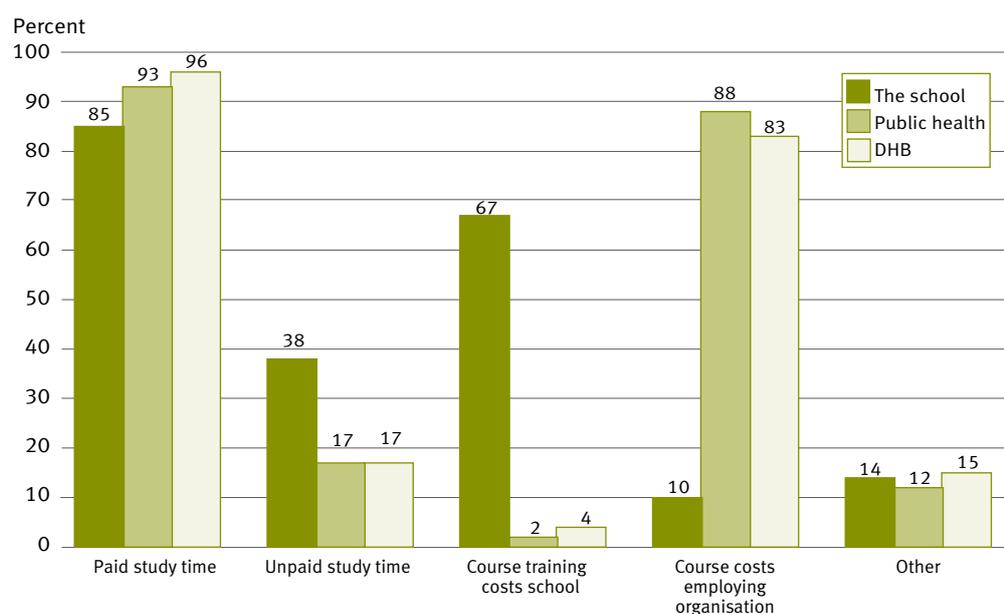
⁷ Reporting in a 'professional capacity as a nurse' refers to nurses' reporting lines within their employing organisation, while 'clinical supervision' refers to having a supervisor within health who is available for supervisory sessions concerning de-briefing on the work, professional development and so on.

indicated they reported to Boards of Trustees. Of those nurses who indicated that reports went to the Boards of Trustees, 38 percent reported via the principal and 17 percent reported directly.

Professional development

Most nurses indicated they were able to take paid study days or time, and a further quarter of respondents were able to take unpaid study days or time. School-employed nurses were slightly less likely to have paid study time than others, and more likely than other nurses to indicate that they had unpaid study time. About two thirds of school-employed nurses indicated that their school met course training costs and most (more than 80 percent) of DHB and public health nurses indicated that their employers met course training costs.

Figure 8: Professional support available (by employer)



Funding for study was an issue for many of the nurses, and even those who did obtain Clinical Training Agency (CTA) or other funding, often found it difficult to do papers on top of full-time work, or to organise to be away from work. Another issue, for rural nurses in particular, was time for travelling to training institutes.

Nurses who spoke strongly of the need for professional development envisaged an expanding role for the school nurse, away from being a dispenser of Panadol and band aids to being an ‘adolescent health nurse’.

Despite the fact there were also nurses who said they were in the job because it was comfortable, and had no any wish to further their career, almost all were keen to see a career pathway for school nurses or adolescent health nurses with relevant and accessible training.

Nurses in public health were also concerned there should be competencies within public health nursing for adolescent health.

‘They need to be recognising specialist nursing fields. There needs to be an adoption of competencies nationwide and Ministry-recognised. The Ministry [of Health] needs to work with the Ministry of Education to say, this is a public health nursing service and this is what it does. There needs to be a further specification for public health nursing, there is not one.’

Age range of nurses

Most nurses were over 30 years of age, with the largest group in the 40 to 49 years age range. Some nurses over 40 had worked in schools for more than 11 years – some up to 20 years – indicating that they had made careers within school nursing.

Table 3: Years of working in schools by nurses' age range

Age range	Years working as a nurse in schools				
	0–5 years	6–10 years	11–15 years	16–20 years	over 21 years
20–29 years	4	0	0	0	0
30–39 years	10	3	0	0	0
40–49 years	24	9	5	1	0
50–59 years	13	12	7	3	1
over 60 years	2	0	0	1	2

Coverage during school holidays

Almost a third of nurses indicated that no special arrangements were made for students for the school holidays. Some nurses could be contacted by students during the holidays, mainly public health and DHB-employed nurses, and some nurses indicated they advised students about other services they could use.

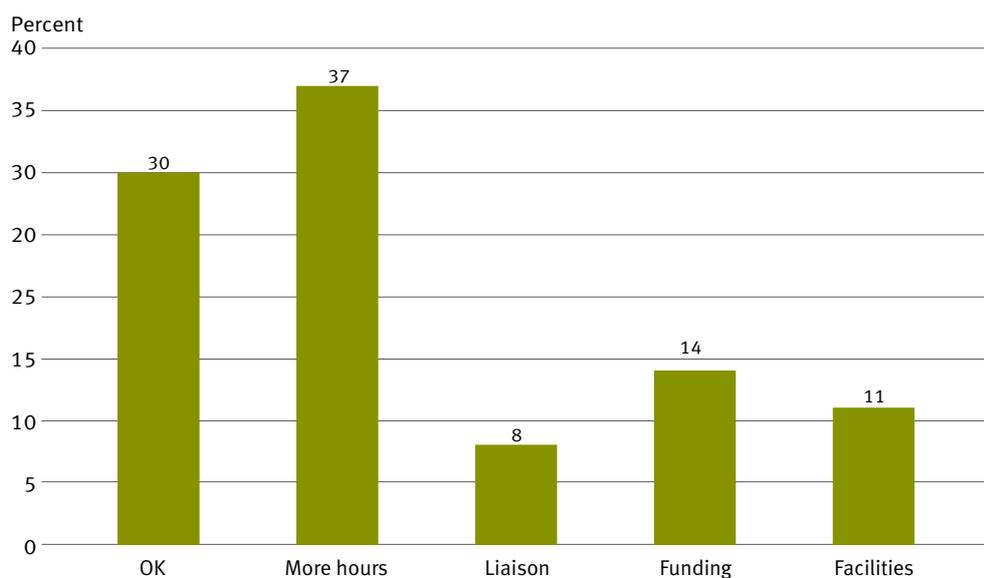
School-employed nurses were likely to be employed for only a 40-week year, although some asked for their pay to be spread over 52 weeks so they received income all through the year.

Possible improvements to school nursing services

Principals' responses

The principals' survey asked an open-ended question: What do you think needs to be done to improve the nurse services at your school? Seventy percent of the comments made by principals concerned funding, more hours, facilities and liaison but none expressed concerns about the quality of the nursing service or the general desirability of having school nurses.

Figure 9: Main issues mentioned by principals



‘Better facilities. At present, small room and the office and the actual sick bay are one room – makes confidential enquiries quite difficult.’

‘We struggle to fund one nurse full-time but the demand sometimes exceeds her ability to respond in a timely fashion. The nurse could also be doing more teaching of health and nutrition if she had more time so we could be more proactive rather than reactive.’

Some principals also commented on the ‘limited’ school funds available and said they would like the funding to come from Health to support improvement to school health services.

‘Have the government recognise that this is an essential service and provide for it properly within the operations grant. Then we could offer better pay scales and keep the fine people we recruit, who sometimes leave.’

‘More funding to allow more qualified nurses to be employed to concentrate solely on nursing activities.’

The principals’ comments also showed concerns about the availability of services.

‘Concern about access to mental health services for students who are seriously at risk of self harm. Currently, when there is a crisis situation, the family has to drive the student to obtain services, nearly a two-hour drive across a mountain pass.’

‘Funding of health services is appalling! Our school of 900 students has one hour from a visiting doctor and one hour of a visiting sexual health nurse. And nothing else! We have arranged for a physiotherapist to visit – he funds himself (ACC).’

But a substantial proportion of the comments made by principals, 30 percent, were that services were adequate.

‘Every Wednesday lunch time we have a doctor or nurse that spends up to an hour in our clinic seeing students. If there are students that want to see a doctor outside this time, I make an appointment in town and there is no cost.’

‘They are excellent.’

Need for other health services

The principals' survey indicated that 92 percent of schools had counsellors. However, almost 30 percent of nurses indicated that more access to them was needed. More than 50 percent of the nurses also considered their schools needed better access to social workers, psychologists and drug and alcohol counsellors, and about 40 percent also considered there was less than adequate access to sexual health nurses, fitness advisors and family advisors.

In other areas, some principals saw a need for additional sexual health/family planning services, mental health/counselling services, and for the nurse to take part in health education and health promotion activities. There were also some who wanted extended hearing, vision and dental services.

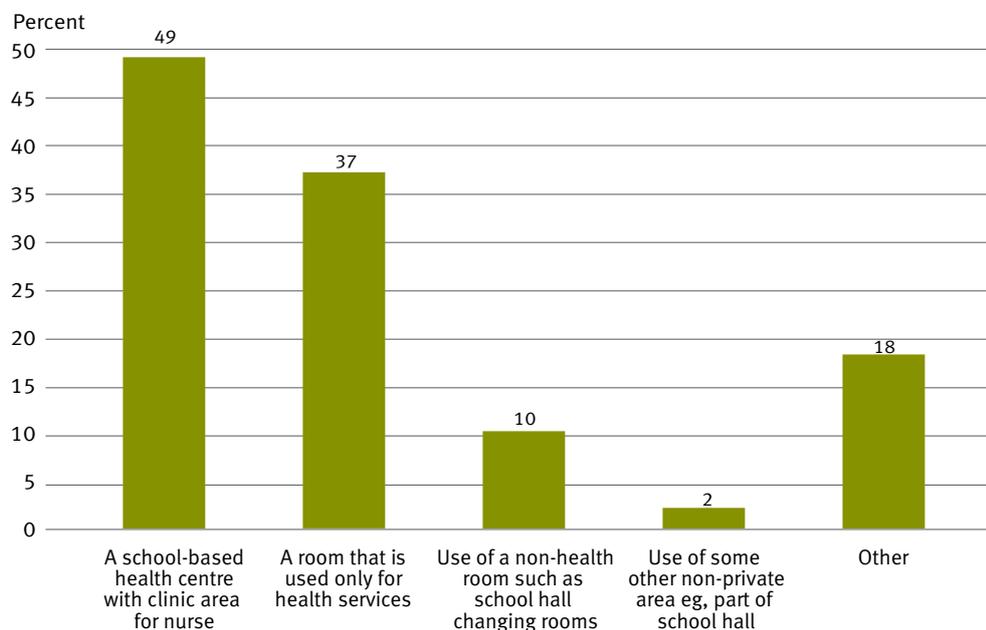
Other principals stated they would like the services of a doctor at their schools, or would like these services extended if they were already available.

Availability of clinic facilities at schools (nurses' survey)

Forty-nine percent of nurses had a clinic area, and a further 37 percent had use of a room that was used only for health services. Ten percent of respondents used another room at the school, such as the school hall changing room and 2 percent stated they used a 'non-private' area such as part of the school hall.

There was a sizable proportion of respondents who selected 'other' and were using spaces such as the sick bay if no students were there; whichever room was available at that time; careers room, any empty office available or store room.

Figure 10: Clinic facilities



Some of the difficulties nurses described concerning non-dedicated rooms included the lack of privacy, having to share with other health staff so clinic time was limited and having inadequate treatment facilities in the non-dedicated room. Nurses also preferred to be situated near other health staff, particularly school counsellors, as they liked to work as a team.

Nurses talked about the importance of school staff consulting with the school health team when developing facilities so that appropriate facilities could be provided. These included such things as an adequate treatment room but also the need to situate toilets where students could come and go privately, and the need for a private waiting area which was screened off from the view of the rest of the school.

Storage of information

Many nurses kept their clinical notes as paper files, locked in a cabinet either at the school or, if they were public health nurses, at their office. Others had access to computers but were using a variety of different databases.

Public health nurses in particular were concerned that there was inadequate sharing of information concerning children's and young people's health status.

'Even if the paediatrician could see, oh, the public health nurse saw them yesterday, I'll give her a call, I mean we're in the home, when you go into a home and glance around, you get so much information from just those things . . . So ideally it would be that every nurse has a laptop and records that are electronic, that are linked into a central child health database.'

Perceived gaps in the service

Nurses interviewed could see gaps in services and student health needs that were not being met. In some cases they considered extra staff were needed, in others more frequent clinics and extended hours. The need for longer hours of nursing service was also the issue mentioned most often by principals (see figure 9). The nurses also talked about problems trying to refer students to other health services and the difficulties in getting outside help, whether from overstretched mental health services or from CYF. They talked about the difficulties finding the funding that would enable students to use other services.

Most of the nurses would expand services if they could, but were inhibited by funding availability.

'We need more of us. You'd hear that from everybody. Some of the nurses are very busy and some of the cases that we have are very complex and not just a one-off thing and need ongoing support, some young people are not well identified with their family and feel as though the world's against them and if you can help them make better choices then we'd love to be able to do that.'

'There is a huge resource issue really. Especially . . . seeing 60 kids a day. You know, how do you do all this other stuff? It's a difficulty getting all this done when there's no down time, the only down time is after work and . . . while it needs to be done you're constantly doing a 55 hour week as I do.'

Conclusions and Recommendations for the Development of the School Nurse Position

The report *Nursing Services in New Zealand Secondary Schools* included the following conclusions and recommendations.

- The need for health services in schools is not strongly related to the school decile level (socioeconomic area). Students in schools of all decile level are engaging in high risk activities.
- School nurses provide health services but within an education context. Approximately 35 percent are funded through education sources and provide the vast majority of hours. There is an argument for more equitable funding to come from both health and education and many nurses favour funding from health sources.
- There is a need to develop a policy concerning school-based health services possibly by the Ministry of Health in consultation with the Ministry of Education. Allowing ad hoc development of school-based health services might lead to discrepancies in availability and access.
- Both principals and nurses would like to see the availability of school nurse- provided health services in schools extended both in hours and range (of services). There is also a desire for GP services, more counselling services and other services such as physiotherapy and dental services.
- Most nurses were not available at the school clinic during school holidays. This could be an issue for students who were unable to access other health care, for reasons of cost, transport or confidentiality.
- The professional isolation of many nurses employed by schools needs to be addressed. A third of nurses, mostly school-employed nurses, do not receive clinical supervision. There is a need for the provision of professional support and oversight for these nurses whichever model for school health services develops.
- Public health nurses have job descriptions and scopes of practice decided by their employer (the DHB), but other nurses' job descriptions are not always clear and not necessarily appropriate.
- The preponderance of nurses in the upper age ranges, 40-59 years, has implications for future workforce planning; there needs to be growth in the numbers of those in lower age ranges so there are experienced nurses to replace those who will retire in the next two decades.
- The role of the school nurse needs to be clarified. Although most DHB and PHO nurses have clear scopes of practice there is a perception held by some, particularly in schools, of the 'school nurse' as providing 'Panadol and band aids' and who can also assist with some of the administration tasks. This has contributed to low levels of professional support, lack of clinical oversight and relatively low levels of pay for some nurses.
- There is a need for the development of adolescent health career pathways for nurses in schools. On-going support from employers is needed if nurses are to undertake further training, particularly towards an adolescent nurse career pathway. Currently this is more likely to occur if nurses are employed within the health sector rather than in the education sector. However, nurses are working on school sites, supporting students' education through their contribution to students' health and wellbeing. They need the support of school staff to do this effectively. In view of this there needs to be a partnership with the education sector.

- On-line courses are one possible solution to the problem of nurses, particularly rural nurses, finding the time to travel to training institutes.
- One way forward might be for DHBs to take responsibility for health services in schools, and to be equitably funded for this. They would need to come to arrangements with schools, so that existing structures are not disrupted. Ideally PHOs would be involved, as part of linking to the wider health system. Links need to be made in particular to youth health centres, as not all students or young people are in school. There is a demand for extended GP services that are more accessible to students, as well as other health services, and links with PHOs might also enable nurses in schools to more easily link their students to these other health services.
- This report did not seek the perspective of school pupils which is likely to be important in deciding the appropriate models of school nursing (and other) health services. This would be a valuable research exercise.

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