



**Department of Education and Early
Childhood Development**

**Review of the Secondary
School Nursing program
Final report - Executive Summary**

Government
March 2009
This report contains 28 pages
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Inherent Limitations – full report

The report on the Review of the Secondary School Nursing Program was been prepared as outlined in the methodology of that report. The procedures outlined in section one of that report do not constitute a comprehensive review of operations.

The findings in that report are based on a qualitative study and the reported results reflect the perception of the stakeholders consulted but only to the extent of the sample interviewed. No warranty of completeness, accuracy or reliability is given in relation to the statements and representations made by, and the information and documentation provided by, stakeholders consulted as part of the process.

KPMG have indicated within this report the sources of the information provided. We have not sought to independently verify those sources unless otherwise noted within that report. KPMG is under no obligation in any circumstance to update that report, in either oral or written form, for events occurring after the report has been issued in final form. The findings in this report have been formed on the above basis.

Inherent limitations – executive summary

This document is the executive summary of the report on the Review of the Secondary School Nursing Program.

The limitations of the full report also apply to this executive summary. In addition the contents of this executive summary are not warranted to provide a complete report of all findings, discussions, perceptions, or any other information provided in the full report.

Third Party Reliance

This executive summary has been prepared at the request of the Department of Education and Early Childhood Development in accordance with the terms of KPMG's contract. Other than our responsibility to the Department of Education and Early Childhood Development, neither KPMG nor any member or employee of KPMG undertakes responsibility arising in any way from reliance placed by a third party on this executive summary. Any reliance placed is that party's sole responsibility.

1 Executive summary

1.1 Introduction

The Office for Children in the Department of Education and Early Childhood Development (DEECD) engaged KPMG in September 2008 to undertake a review of the Secondary School Nursing Program (SSNP). This report presents the findings of the review.

Program overview

The SSNP was implemented in 1999 and there are currently 100 nurses employed across vulnerable schools throughout Victoria. Secondary School Nurses (SSNs or nurses) are allocated to schools on a 0.5 equivalent full time (EFT) basis, with approximately 60 per cent of SSNs employed on a full time basis, working across two separate schools.

Under the 0.5 EFT model, SSNs are allocated to schools two and a half days per week. In most DEECD regions, SSNs have an administration or office day whereby they spend a day per week at the regional office in order to participate in peer support and professional development opportunities, and complete administrative tasks. These days also provide an opportunity for clinical supervision to occur.

SSNs are employed at a senior level and are independent practitioners. They report to a regional nurse manager responsible for regional administration and coordination of the program. Responsibilities of the regional nurse manager include: managing the SSNs, coordinating professional development, providing SSNs with information and resources, and overseeing planning, evaluation and regional liaison with stakeholders.

Whilst the line management of nurses is through the regional nurse managers, nurses also operate within school structures. In particular, school principals are central to the success of the SSNP and in supporting nurses to become integrated into school communities and student wellbeing teams. This relationship is central to:

- nurses being well oriented to the school;
- nurses having access to basic office supplies and a safe workplace;
- direct involvement by relevant school staff in annual action planning;
- the school community being aware of the role of the nurse and the benefits the role brings to the school; and
- ongoing planning in relation to the health and welfare of students at the school.¹

¹ Secondary School Nursing Program Guidelines, Rural and Regional Health and Aged Care Division, Victoria Government Department of Human Services. 2002.

Whilst not directly accountable in a line management sense, SSNs are required to report to school principals on a quarterly basis. Within the school structure, SSNs are typically part of student wellbeing teams and work within any existing welfare structures. Ideally, nurses participate in regular team meetings with the student wellbeing team and work collaboratively with them in relation to student health and welfare issues.

The role of the secondary school nurse (SSN or nurse) has three broad objectives:

- health promotion and primary prevention;
- early intervention; and
- interventions with students (may include short term counselling or referral and facilitation of access to community services).²

A range of materials have been developed to support the program including SSNP guidelines that were developed in 2002 and program and professional practice standards developed in 2006.

Program direction is consistent with a range of government policies including:

- *A Fairer Victoria*;³
- *Future Directions: An action agenda for young people*;⁴
- *The Victorian Child and Adolescent Outcomes Framework*;⁵
- *The Blueprint for Early Childhood Development and school reform*;⁶ and
- *The Vulnerable Youth Framework*.⁷

² Ibid, p 8

³ A Fairer Victoria. Viewed at [http://www.dpc.vic.gov.au/CA256D800027B102/Lookup/SocialPolicyActionPlan/\\$file/fairer%20vic.pdf](http://www.dpc.vic.gov.au/CA256D800027B102/Lookup/SocialPolicyActionPlan/$file/fairer%20vic.pdf) Accessed January 2009.

⁴ Future Directions: An action agenda for young people. Viewed at [http://www.youth.vic.gov.au/Web21/ofy/rwpgslib.nsf/GraphicFiles/Future+Directions+07/\\$file/DVC_FutureDB_web.pdf](http://www.youth.vic.gov.au/Web21/ofy/rwpgslib.nsf/GraphicFiles/Future+Directions+07/$file/DVC_FutureDB_web.pdf) Accessed January 2009.

⁵ The Victorian Child and Adolescent Outcomes Framework. Viewed at <http://www.eduweb.vic.gov.au/edulibrary/public/govrel/Policy/children/childoutcomes-issue1.pdf> Accessed January 2009-01-29

⁶ The Blueprint for Early Childhood Development and school reform. Viewed at <http://www.education.vic.gov.au/about/directions/blueprint2008/thepaper.htm> Accessed January 2009.

⁷ The Vulnerable Youth Framework Viewed at http://www.cyf.vic.gov.au/_data/assets/pdf_file/0003/251733/vyfdiscussionpaperweb_smaller.pdf Accessed January 2009.

Review approach

DEECD undertook a review of the SSNP to focus on the model of service, methods to strengthen the SSNP within the context of a changing policy environment, options for the allocation of nurses to schools, and mechanisms for monitoring and measuring program outcomes.⁸

A framework was developed to review program progress against the following domains:

- effective health promotion to reduce negative health outcomes and risk taking in young people (health promotion);
- delivering primary health care services that have a focus on appropriate assessment, care, referral and support, including supporting primary to secondary transitions (service delivery); and
- supporting school communities in addressing contemporary health and social issues through ensuring coordination between schools and community based services to prevent ill health and problem behaviours (supporting school communities).

Project activities informing the review were as follows:

- a brief examination of literature on school nurse programs, nationally and internationally, to identify critical success factors that may be relevant to the operation of the SSNP in the Victorian context;
- face to face consultation with stakeholders from five DEECD regions (North, South, East, Loddon Mallee and Barwon South West) that included meetings with DEECD regional management, SSNs and school and community stakeholders;
- meetings with staff from six schools from around Victoria (five of these schools had a nurse and the other school did not). These meetings included consultations with the principal (or nominee), the student wellbeing team, the nurse and students (where possible);
- one two hour meeting was held with all of the regional nurse managers; and
- three on-line surveys for completion by SSNs, school staff and community based stakeholders.

⁸ Department of Education and Early Childhood Development 2008, *Evaluation of the Secondary School Nursing Program*, DEECD Request for Quote, Victoria.

1.2 Overall conclusions

Results of the review indicate that the SSNP is highly valued by school and community stakeholders for the contribution the program makes to the health and wellbeing of students in vulnerable schools. Nurses are well regarded by students and student wellbeing staff and have integrated reasonably well into school structures and in particular, student wellbeing teams. Students identify the importance of the nurse in providing an independent and impartial adult that they can talk to in confidence. Nurses are planning and delivering health promotion activities that align with state government adolescent health priorities.

It is not possible, in the absence of effective data collection systems and robust evaluations of health promotion activities, to determine the effectiveness of the program in improving health outcomes for students.

A summary of findings from the review are presented below.

1.3 Health promotion

A key objective of the SSNP is to reduce negative health outcome and risk taking behaviours among young people through the implementation of health promotion activities to support the health and wellbeing of young people in schools. The planning, development and delivery of health promotion materials to students are considered below.

Local planning and consultation

The SSNP aims to support schools and local communities to plan health and wellbeing interventions to address issues identified through the examination of local data and research.⁹ Nurses are required to develop an annual action plan identifying health promotion and other targets for the school year, and these plans should link in with broader student wellbeing and whole of school plans. All planning should be underpinned by consultation with relevant school and community stakeholders.¹⁰ Regional nurse managers are responsible for overseeing the development and implementation of annual action plans.¹¹

There is some variability in relation to how nurses develop their school annual action plans with student wellbeing teams and SSN peers being the primary partners in their development. This variability may be a product of how well the nurse is integrated with the student wellbeing team and supported by the school in general. Principals and teachers in rural schools are more likely to be actively involved in the development of annual action plans. Principals, however, are involved in planning with 56 per cent of nurses in metropolitan schools.

A small number of nurses indicated that the annual action plans are not documents that are formalised by the school and to which they are held accountable however this varied from school to school.

⁹ SSNP guidelines, p 3

¹⁰ SSNP standards, p 7

¹¹ SSNP guidelines, p 13

The planning process is primarily based on input from stakeholders rather than any data available to schools or nurses. Nine per cent of SSNs identified that the School Nurse Information System (SNIS) provides relevant information to support the planning process although the majority indicated that the system does not generate meaningful data.

Delivery of health promotion in schools

Health promotion activity is intended to reduce negative health outcomes for young people with an emphasis on drug and alcohol misuse, tobacco smoking, eating disorders, obesity, depression, suicide and injuries'.¹² Health promotion is achieved through engaging students via multiple channels including through the school curriculum. Nurses advised that historical SSNP guidance recommends that 70 per cent of their time be targeted towards health promotion with the other 30 per cent focused on clinical interventions (clinical interventions are discussed in the next section).

Nurses deliver health promotion activities most frequently in relation to sexual health, drug and alcohol use and mental health. Community and school stakeholders identify that mental health, drug and alcohol use and family issues are the biggest health issues facing young people with sexual health being a relatively low priority.

Mental health promotion occurs in schools to a lesser degree than either drug and alcohol or sexual health programs (despite this being identified as a key priority area for students by both SSNs and school stakeholders). This may be linked to the familiarity or confidence of nurses with the subject matter. For example, 21 per cent of nurses that completed the SSN survey identified a mental health, psychiatric or adolescent health background.

The majority of nurses deliver formal health promotion messages in classroom based settings with this most frequently occurring on a weekly basis. Much health promotion activity that is planned does not eventuate as school events on a daily basis often overrides this.

Development of health promotion materials

The SSNP standards advocate the use and creation of health promotion materials to assist students' understanding of health related issues. These materials should reflect the diversity of the student population.¹³ There is also an expectation that SSNs will liaise and network with local agencies in the development and provision of materials.¹⁴

A portion of nurse time (17 per cent) is spent in service planning and preparation to support health promotion activities (or curriculum development). Whilst a number of nurses reported developing and sharing resources with colleagues, this appears to occur on an ad hoc basis and most often occurs within regions. This is likely to create significant duplication of effort across the program as materials are developed at various sites.

¹² SSNP guidelines, p 3

¹³ SSNP standards, p 9

¹⁴ Ibid, p 6

SSN expertise and understanding

SSNs should be appropriately qualified and have expertise in health promotion and a sound understanding of adolescent health issues.¹⁵

Nurses employed in the SSNP come from diverse professional backgrounds. Twenty per cent of SSN survey respondents have a community nursing background. Other nursing backgrounds included midwifery (16.5 per cent), paediatrics (13.9 per cent), community health (10 per cent), mental health (7.8 per cent) and adolescent health (4.3 per cent). Four per cent of respondents described their background as being health promotion as distinct to an area of nursing. That said it is recognised that most areas of nursing will incorporate some focus on health promotion, even if this is subsidiary to the main focus of that nursing type.

Evidence based health promotion activities

Health promotion activities must be underpinned by current information that ensures the program will address health issues relevant to young people.¹⁶

Thirty-nine per cent of nurses always use an evidence base to guide their activities and almost 60 per cent of nurses frequently rely on an evidence base. The sources cited as an evidence base included peak bodies, government supported information, peer review journals and experts in the field of adolescent health. The main source of evidence accessed by nurses is through professional development activities, and information sourced through colleagues.

Health promotion activities that are evaluated

Evaluation is defined as the process used to determine whether a program has achieved its goals and objectives.¹⁷ It is used to ensure that the decisions made and approaches taken are contemporary and appropriate to needs, and are considered to be ‘good practice’ in health promotion.¹⁸

Nurses indicate that 95 per cent of health promotion programs are evaluated to some degree to determine whether they are effective and well targeted. Methods used to evaluate programs include feedback from students (94.1 per cent), feedback from colleagues (73.9 per cent) and health networks (58 per cent), and the use of data and health indicators (57.1 per cent).

Forty per cent of nurses are confident that the health promotion information they are delivering is meeting the needs of students, however this assumption cannot be validated. Fifty-nine per cent of SSNs indicated that they were ‘somewhat confident’ about whether health promotion activities were meeting the needs of students.

¹⁵ SSNP guidelines, p 18

¹⁶ SSNP standards, p 7

¹⁷ SSNP guidelines, p 68

¹⁸ VicHealth. Viewed at http://www.health.vic.gov.au/healthpromotion/hp_practice/index.htm. Accessed January 2009

Collaborative community partnerships in health promotion

The SSNP guidelines call for the program to establish linkages and to work collaboratively with schools and other health partners.¹⁹

Most nurses identified that they have established partnerships with community stakeholders linked to adolescent health service delivery. Schools also presented as being very supportive of the role of the nurse and the importance of establishing strong community networks.

Formal and informal health networks at a local level support an exchange of information and resources for health promotion activities, and eighty-one per cent of community stakeholders who participated in the survey revealed that they had partnered with nurses in developing or delivering health promotion activities for students.

Conclusions

There is evidence that in SSNP schools planning in relation to health promotion occurs at a school level. This joint planning occurs more frequently in metropolitan regions (as opposed to rural regions) and in larger schools. Planning partners primarily include student wellbeing staff, with some evidence of principals and year level coordinator involvement. Less than half of the nurses base planning on any analysis of local data.

Health promotion activities in schools focus on a range of topics but include sexual health, drug and alcohol use, mental health and bullying. These topics are consistent with those outlined in state government policy to improve the health and wellbeing of young people in Victoria. There is also a well established evidence base, independent of SSNP, that suggests that health promotion on these topics do improve outcomes for young people (particularly mental health and drug and alcohol use).

Health promotion activities are delivered by nurses in a number of ways varying from in the classroom by the nurse, in the classroom by the teacher, outside the classroom, through promotional displays or the distribution of materials. The approach adopted by the nurse may be a product of the nurse's level of comfort with the medium rather than driven by other factors.

The duplication of effort in the development of health promotion materials is of particular concern. Nurses appear to be developing health promotion materials at a school and regional level across the state with little to no attention on coordinating these development activities. Ideally, regions or central office would take responsibility for developing a suite of health promotion activities that are evidence based and that are then made available to all nurses (and tailored as necessary) to meet the needs of their particular school community.

In order to work effectively in school communities, nurses ideally would have a background in adolescent health or adolescent mental health. In reality, the nurses come from a range of backgrounds including midwifery and accident and emergency. There is no current need for nurses to be qualified in adolescent health, adolescent mental health or in health promotion.

¹⁹ Ibid, p 7

There is minimal evidence that health promotion activities are effectively evaluated to ensure that they are meeting program objectives or improving outcomes for young people involved in them. There is a need to develop tools to support the design, delivery and evaluation of health promotion programs to ensure their efficacy.

1.4 Service delivery

One of the goals of the SSNP is to provide appropriate primary health care through clinical nursing including assessment, care, referral and support.

Clinical responses and issues

Clinical responses are those that promote and improve the health and wellbeing of individual students.

Nurses estimated that up to 24 per cent of their time is spent in the provision of direct clinical care and support to students in their school. Clinical services include responding to minor accidents and ailments (31.1 per cent), first aid (27.7 per cent), health counselling (89.9 per cent) and referrals (96.6 per cent). 38.7 per cent of nurses indicated that they also conduct 'other' clinical duties including assessment, following up referrals, support for students, transporting young people to specialists, developing care plans or safety plans with students, conflict resolution, secondary consultation, and liaison with parents. Nurses prioritise their responsibilities differently, with 26.1 per cent prioritising health promotion over other activities, and 28.9 per cent prioritising direct student care over all else.

Assessment

A key clinical role of the nurse when working with students is to undertake assessments in relation to the presenting problem. The secondary school nursing professional practice standards adopt the American Nurses Association of School Nurses (2003) definition of assessment. For the purpose of the SSNP, assessment is defined as 'the collection and documentation of data / information about or from individuals, students, families, health care providers, organisations or communities in a systematic, continuous manner using appropriate techniques'.²⁰ The SSNP standards recommend that nurses use the risk and resilience assessment framework to support assessment with young people.

Nurses undertake regular assessments of young people, particularly in relation to sexual health, mental health, and general health issues. While some nurses indicated that they use assessment tools to support this, such as the HEADSS (Home, Education/Employment, Activities, Drugs, Sexuality and Suicide), most nurses indicated that assessment is based on conversations with the young person. Nurses do not appear, to any large degree, to use the *Risk and Resilience Assessment Framework* outlined in the SSNP guidelines to support clinical assessments.

²⁰ SSN professional practice standards, 2006. Department of Human Services. p.17.

Referrals

Nurses are often the first point of contact for young people within the broader health system, and one of the key aspects of the nursing role is to establish and maintain appropriate community networks to promote and support the health and wellbeing of students.²¹

Nurses use a range of community based services to support their work with young people and to address issues revealed post assessment, including community health services, youth services, general practitioners and family services. Nearly half (45.4 per cent) of nurses surveyed indicated they sometimes had trouble making referrals for students, mainly due to the capacity of community agencies to accept the referrals or excessive wait times. This often resulted in nurses supporting young people with complex problems until more specialised help becomes available.

Health counselling and support

The SSNP standards describe an expectation that nurses will provide health counselling to support the health and wellbeing of young people.²² This counselling may be initiated by students, by the nurse or through referral to student wellbeing teams. The purpose of counselling is to identify and plan to address 'mental, social and emotional health (issues) as well as physical health issues that may require further investigation'.²³ This type of work with students should be underpinned by good communication and empathy.

The SSNP guidelines note that 'nurses employed in the program are not expected to have the skills or expertise to conduct therapeutic counselling'. Rather, the nurse's role in health counselling is to assess, and listen, and be the first point of contact for the student to access primary health care.²⁴

The type of issues responded to by nurses through health counselling interventions include peer and family relationships, conflict with teachers, sexuality (same sex attracted youth), and risk taking behaviours (e.g. drug and alcohol use, safe sex etc.). Nurses appear to provide short term counselling support to students and seek to refer them externally to access longer term counselling and support.

Care planning

Care planning occurs with students once issues have been identified that require intervention or support. Care planning should occur in consultation with students and outline how planned interventions will occur. Care plans should be evaluated and monitored over time to ensure that they are meeting student needs.

Nearly two thirds of nurses (61 per cent) nominated that they participated in care planning or acted as a case manager to students. Different ways of managing student issues were apparent

²¹ Ibid, p 44

²² SSNP guidelines, p 8

²³ Ibid, p 8

²⁴ Ibid, p 43

in different school settings. This may be reflective of the capacity of external providers to accept referrals, the number of services available to students, the capacity of students to access services (most relevant in rural communities) and the orientation of the nurse and student wellbeing team. The scope of care planning appears to be dependent on the complexity of the needs of the student and their capacity to manage their own care. Wherever possible, nurses advised that they act to empower students to identify issues and implement solutions in order to build student resilience.

Transitions

Supporting students to manage transition phases is also a particular focus of the SSNP. The SSNP guidelines describe the need for nurses to support transitions at two key stages:

- 1 Primary school transitions – working with primary school students to provide information and explain the role of the SSN. This may involve the provision of information to year six or seven students, or developing and delivering a presentation to these groups.
- 2 Secondary school transitions – nurses should be involved in the development and delivery of programs to support young people as they prepare to leave secondary school.²⁵

The majority of nurses (81 per cent) indicated that they engage in some activities towards the end of the school year to support students to make the transition from primary to secondary school (19 per cent of nurses indicated that they do not). Nurses identified that children with special needs, those identified by the primary school nurse and those identified by parents were often given priority attention. Information about new students is transferred to nurses from primary schools most often via face to face meetings (established between the primary and secondary school nurses) and via telephone.

Fifty per cent of nurses indicated that they ‘sometimes’ support transitions of young people from secondary school to alternative education or employment.

Confidentiality

Quite explicit guidance about student confidentiality is provided to nurses in the SSNP guidelines.²⁶ Nurses must keep conversations with students confidential if the nurse is satisfied that:

- the student is legally capable of making decisions on their own behalf; and
- the student is fully able to understand key issues relating to protection of their information.

The guidelines provide further advice to nurses about what information can be shared with other school staff (information about general health issues, where referrals have been made to, and

²⁵ SSNP guidelines, p 35

²⁶ SSNP guidelines, p 30

that the nurse has an appointment with the student).²⁷ No information can be provided to schools which identifies the young person (unless student consent is provided).

Students identified that they were aware of the confidentiality requirements of the nurse, and this made them more likely to seek assistance as they would be confident that any information they shared would not be reported to teachers or parents (in all but exceptional circumstances). Students also reported that the SSN explained clearly the rules of confidentiality that they adhere to and it made it easier to 'open up' and discuss the problems they were having. Students reported that this heightened level of confidentiality meant that the SSN was seen as a good person to speak to if students were in conflict with teachers.

Some school stakeholders identified concerns whereby the nurse would be counselling or supporting a particular student in relation to an issue, and no information about this would be available to the school. This caused problems when the nurse was not available and the student required assistance.

Record keeping

Records of conversations with students should be recorded in the 'student's health record'.²⁸ The program standards indicate that SNIS contains student health records and should be the primary mechanism through which information is recorded. Records should also be kept in accordance with the Health Records Act, 2001.

Just over 65 per cent of nurses indicated that SNIS is the only data recording system available to them for recording clinical and health promotion activities, while 31.1 per cent indicated that they also relied on other methods. These other methods include annual action plans, personal diaries (many nurses cited this method of record keeping), and personally developed data and record collection system. Many nurses commented on the failure of SNIS to adequately capture information about what they do or how they do it.

Conclusions

In the context of the current review, service delivery includes nurse clinical responses to individuals or student groups on a range of issues impacting on their health and wellbeing. Such service delivery generally occurs as part of the student wellbeing team.

The majority of nurses define clinical responses in relation to counselling or referral of students. A minority of nurses provide a clinical response in relation to minor injuries or ailments. Nurses also identified various priorities, with some nurses indicating that clinical care takes priority over health promotion and others indicating the opposite.

These variations in service delivery may be a product of the different needs of schools, and this is appropriate as long as the approach of the nurse is underpinned by local planning and is responsive to the health needs of the student population. There is some evidence to suggest that

²⁷ Ibid, p 31

²⁸ SSNP guidelines, p 30

schools require further information or support in the best and most beneficial ways of using their nurse.

A range of student clinical issues are identified by nurses, with mental health, sexual health and family issues being the most predominant. A focus on health promotion and clinical intervention in these areas would seem appropriate and consistent with government policy direction.

Nurses work with individual students is based on assessment and planning to determine the appropriate intervention. Nurses appear to be undertaking assessments that rely on clinical judgement, and there is a need for a more structured and evidence based approach to this activity. Case and care planning occurs in conjunction with student wellbeing teams and community service providers, and there is evidence of good cooperation between these partners in providing a response to young people. Community referrals are generally made in relation to mental health, family issues and sexual health (this is consistent with stakeholder views about the issues that face young people).

While the SSNP guidelines provide clarity about the role of the nurse in supporting primary to secondary transitions, it appears that a small number of nurses have no involvement in this activity. Given supporting transitions is a key component of DEECD's *Blueprint for Early Childhood Development and School Reform*, it would seem appropriate that this anomaly is addressed. Nurses also support transitions from secondary school in varying degrees.

The requirement by nurses to maintain strict student confidentiality is seen as a positive aspect of the role by both students and nurses. It does, however, create a range of challenges for school staff, particularly when they feel they have a right to know what is going on in a student's life. Of particular concern to school staff is knowing how to respond to students in the absence of the nurse (who holds all of the information).

A majority of nurses indicated that the current SNIS program is inadequate to their data recording needs and, as a result, they are maintaining confidential client records or activities in personal diaries. This approach would seem inadequate for a number of reasons including confidentiality of records, and the capacity of the program as a whole to generate accurate data about nurse activities.

1.5 Supporting school communities

Nurses are expected to become well integrated within the schools they are allocated to, and to 'work within the protocols, policies, management structures and processes' of that school. They are also expected to have 'knowledge of relevant points of referral for students and be aware of services, activities and events that are happening in the local area.'

The culture of the school

The culture of the school community will often guide the health promotion and intervention needs of the school. It is important that nurses are able to become familiar with, and work within, the school culture to promote effective service delivery.

It is a challenge for nurses to work within a school environment given the difference in cultures between school and most health settings. The challenge most frequently cited by nurses was a sense of isolation and not feeling like an integral part of the school community.

A number of principals identified that the practice of nurses being assigned to schools (with schools unable to contribute to their selection) limits the opportunities for assimilation into the school culture and the development of effective working relationships.

Nurses expressed the view that if the school leadership understood and supported the program's objectives they are able to be more effective in their roles. Challenges arose when SSNP nurses were viewed as 'sick bay attendants' rather than having a broader role in promoting the health and wellbeing of all students.

The role of the principal

The principal 'is fundamental to the success of the SSNP within the school'.²⁹ Their role includes:

- supporting the aims and objectives of the program;
- providing support to the nurse to ensure programs and services can be delivered efficiently; and
- ensuring that the whole school supports the nurse and the role of the nurse.³⁰

The involvement of principals with nurses in the program appeared to be varied. Nurses reported that the involvement of some principals tended to be more administrative, whereby the principal would 'sign off' plans or activities that had been developed with other school stakeholders (which may indicate that the principal has delegated this task). Feedback from nurses also suggests that some principals do not have a clear grasp of the purpose and objectives of the program and therefore do not enable the nurse to become fully utilised by the school.

Schools tend to promote the presence of the nurse at their school through a variety of mechanisms, with the most common being the school newsletter (90.4 per cent). Other mechanisms included the school handbook, internet, meetings, assemblies and in class teaching.

The role of the nurse

Nurses are expected to work with school communities to achieve the goals of the program. This may mean that the nurse's role will vary at different schools, depending on the cultural and health needs of the school at the time.³¹ The key role of nurses is health promotion and primary prevention, as well as individual student support. Nurses undertake these roles within the school community to promote the health of the student body.

²⁹ Ibid, p 15

³⁰ Ibid

³¹ SSNP guidelines, p 7

The capacity of nurses to work effectively within schools was found to be dependent on the ability of schools and nurses to develop and sustain productive working relationships that support the work of the nurse and promote student access to the program.

One example of program failure in the school setting related to nurses' inability to engage positively with staff. For example, one principal noted that the lack of flexibility and responsiveness of the previous nurse (or program) meant that the needs of the students or the school were not being met.

Nurses also reported challenges whereby they felt unsupported by school staff to become an integral part of school functioning and were unable to easily gain access to students for health promotion purposes.

School stakeholders and nurses identified the following factors seen to impact most on the effectiveness of the SSNP:

- nurse part-time status;
- nurse workload; and
- nurses operating across multiple or split campuses.

Orientation, resources and accommodation

School principals are responsible for ensuring that nurses are fully informed about the policies and procedures operating in the school, and for the provision of appropriate resources and a safe and supportive working environment.³²

Orientation for nurses occurs at both the regional and school levels. At a regional level, orientation to the SSNP was thought to be comprehensive and included an introduction to the goals of the program, meeting program colleagues, and an overview of program functions and administrative requirements. Many concerns were raised however, in relation to training offered to support the use of the SNIS database.

Orientation at a school level was reported to be ad hoc, contributing to the feelings of isolation that many nurses report. This sense of isolation was identified by 37 per cent of nurses to be a factor impacting on the effectiveness of their service delivery. The majority of nurses indicated, however, that they are located in suitable accommodation that enables students to access them and that they have appropriate levels of privacy to undertake their role.

Partnerships with students

Nurses should seek to integrate 'the views and ideas of students... into discussion about the role and direction of the school nurse'.³³ Nurses should also be developing and delivering programs and services that meet the needs of students.

³² Ibid, p 15

Interviews with students revealed that the characteristics of school nurses valued by students include:

- they are seen to be approachable;
- a perception that nurses are different from teachers;
- nurses are seen as having expertise in particular areas; and
- students trust that information shared with the nurse will remain confidential.

Partnerships with communities

Nurses are required to have knowledge of local services that can assist in supporting the health and wellbeing of young people.³⁴ This should be done through participation on local health based networks and partnerships.³⁵

One of the ways nurses maintain links with community services is through participation on local networks with the vast majority of nurses (82.4 per cent) indicating that they participate on community health networks. Nurses also indicated that they relied on their colleagues and peer contacts to maintain community connections, and many advised that the weekly SSNP team meetings supported this also. Nurses maintain community connections through attendance at conferences and in service days. These activities potentially take up a substantial component of the two and a half days a week nurses are in schools but are an important element of the role. Community stakeholders identified benefits for them in networking with school nurses, including better access to the student population.

Nurse integration into the student wellbeing team

Nurses are expected to function as an active member of the school's student wellbeing teams. Within this team, nurses have a number of responsibilities, including:

- identifying and working within current school welfare and health promotion policies;
- working collaboratively with the team about issues relating to the health and wellbeing of students;
- maintaining current information and connections with community based services that may assist student wellbeing teams to support students;
- attending regular student wellbeing team meetings; and
- liaising with staff associated with primary transitions.³⁶

³³ Ibid, p 17

³⁴ Ibid, p 9

³⁵ SSNP guidelines, p 7

Throughout the review, a clear message was received that all stakeholders see the student wellbeing team as the appropriate structure in which nurses should be located. Predominately effective relationships between nurses and student wellbeing team were reported with a majority of nursing staff indicated that they worked in a coordinated way with student wellbeing teams. A small number of nurses (5.1 per cent) were identified as working independently of the student wellbeing team.

Some practical challenges to nurses operating within student wellbeing teams were noted by school stakeholders, including:

- other staff members having to pick up working with students when the nurse is not at school and may have limited information about the issues;
- students often having to wait until they can see the nurse again (particularly where the nurse is stretched over multiple campuses);
- difficulties for students in understanding different roles of the student wellbeing team when the nurse is providing counselling and support;
- members of the student wellbeing team and the nurse can all be part time so coordination can be a challenge;
- where the nurse is seen to work independently, there are communication gaps as student wellbeing staff are not sure what the nurse is doing;
- tension between the advice the school nurse receives from SSNP management and the needs of the school (for example, the role of the nurse in relation to anaphylaxis training); and
- the student wellbeing team needing to ‘take on whatever comes through the door’ but nurse activities being more targeted.

Barriers noted by school stakeholders regarding collaborative working arrangements between nurses and wellbeing teams include the part time status of the nurses and the perception that there were frequent, professional development activities taking the nurse away from the school. Conversely, some nurses reported being excluded from wellbeing team meetings despite requesting involvement and frequently being unaware of current school events and student issues due to a lack of a coordinated approach.

There is a need for greater integration of the SSNP and student wellbeing teams at the school, network, regional and statewide levels. This integration should include consideration of the practice of student wellbeing teams and SSNs and of the policy that underpins both program areas.

³⁶ SSNP Guidelines, p 16

Communication between the principal and regional nurse manager

One of the roles of the regional nurse manager is to 'liaise with school principals and student wellbeing teams as required'.³⁷ This function is considered important because it is a mechanism through which any issues associated with the SSNP can be addressed and rectified.

Consultation with principals determined that there was very little interaction between regional management and senior school staff. It may be argued that this lack of interaction is appropriate given the 0.5 EFT status of SSNs in the wider context of a range of other school issues. Frustrations identified by principals regarding the SSNP include:

- the inability of schools to routinely participate in the selection of nurses;
- a lack of clarity regarding activities undertaken by the nurse (e.g. whether the nurse had a role in implementing school wide health initiatives, for example, anaphylaxis training); and
- limited awareness of when nurses are present on campus.

On a number of occasions throughout forums held as part of this review, principals or their delegates indicated that a regular forum for communication should be established at a regional level so that information could be shared about the program and issues raised and addressed.

Conclusions

The role of the school nurse does not appear to be clearly understood by some school principals and school communities. This has resulted in nurses undertaking different activities across school campuses. This is not necessarily a concern as long as the activities that are undertaken are underpinned by a solid evidence base and robust planning at a local level and are within the guidelines provided to support the SSNP.

School communities identify the part time status of the nurse as having the biggest impact on nurses' ability to work effectively within schools. This impact is felt more so if the nurse is unable to broker effective partnerships or relationships with staff within schools. Nurse flexibility is identified as a key factor in the success of the program. However, the current operating model (two days per school and one office day) does not currently support flexibility. Operating across schools with a split campus is also an impediment to effective service delivery.

Nurse flexibility and availability limits their capacity to work as an integrated member of the student wellbeing team. Nurses appear to approach integration with the team somewhat differently with many becoming fully integrated, while others continue to work independently of the team.

The role of the principal is vitally important in supporting nurses to become integrated into school communities. Principals are responsible for ensuring that nurses receive appropriate orientation into schools and are aware of the necessary school policies and procedures. Nurses

³⁷ SSNP guidelines, p 13

indicate that, while they feel sufficiently oriented at a regional level, this is not occurring consistently at a school level.

Schools appear to be supporting the role of nurses within schools through the promotion of the role through newsletters and in class. Teachers and nurses tend to work well together in conducting joint health promotion activities in classroom settings.

Nurses are responsible for establishing appropriate partnerships with community service providers relevant to the health and wellbeing needs of young people at their school. This currently occurs through participation on a limited number of community health networks. Identification of networks or services should form a component of annual planning given the limited amount of time nurses have to focus on this aspect of their role.

There is an opportunity to more effectively integrate the SSNP with other student wellbeing services. Such integration should occur at a school, network, regional and statewide levels and include consideration of practice approaches and policy direction.

1.6 Program administration and management

Program administration and management occurs at the following two levels:

- central office; and
- regional office.

Central office

The SSNP is centrally directed from within the Operations Division of DEECD. The program has two program staff: a Manager, Operations and a Senior Program and Policy Advisor who are accountable to the General Manager, Operations Division. In each case, the SSNP is only one area of that employee's responsibilities.

Central office is able to provide limited support to the regions and school nurses due to lean staffing structures. Such support currently involves the facilitation of the regional nurse managers' forum and some guidance in relation to policy. The SNIS system also appears to facilitate inadequate data collection and reporting therefore accountability of the program is limited.

Regional office

In each of the DEECD regions, a regional nurse manager is responsible for supervision and management of the nurses and general program management.

The role of the regional nurse manager is currently the primary mechanism through which nurses receive supervision and support. The majority of regions implement this through the use

of an office or administration day. This model significantly restricts the scope of nurses to provide a flexible and responsive service to vulnerable schools.

Formal clinical supervision of the nurses appears to occur on an ad hoc basis with most nurses receiving one on one supervision on a term or semester basis. Given the amount of clinical work nurses are engaging in, this level of formal supervision would appear to be inadequate.

There is a current opportunity to change this approach through encouraging regional nurse managers to have a more hands on role in relation to visiting nurses within their schools and establishing an expectation that nurses undertake administration tasks outside of the school day or in school holiday time.

1.7 Program model

The current model to allocate nurses to schools across Victoria appears to be successful in identifying the most appropriate placements. The following changes are recommended:

- the SLN index has been superseded by the Student Family Occupation (SFO) index. To be consistent with other decision making processes within government, the SSNP should consider replacing the SLN with the SFO (or other appropriate data); and
- the Survey of Risk and Protective Factors by the Centre for Adolescent Health is now 10 years old and has not been renewed. This criterion should no longer be used in recognition that some of the ratings are now likely to be inaccurate.

An undefined, but assumed to be small, number of schools have received nurses independent of the current allocation model. These exceptions occurred when the program was initially piloted, with pilot schools being chosen through a nomination process (rather than on an as needs basis). The closure or merger of a number of schools throughout the state has also resulted in changes to nurse allocations.

Future options for re-allocation of nurses across Victoria include:

- re-running the model using updated criteria (identified above); or
- allowing regions to allocate nurses to vulnerable schools based on local knowledge.

This approach may also allow for increased flexibility in regional allocations whereby nurses could be allocated to high needs schools on an enhanced basis (for example, schools with multiple campuses and high student numbers could be provided with a nurse on a full time basis).

A problematic aspect of the current program model is the inherent inflexibility when nurses are assigned to schools on set days, have a regular weekly day in the regional office and are struggling to find places in school curricula (which are also inflexible).

A number of options are presented to address this including:

- fixing the days a nurse is in each school *after* the school timetable is published would enable nurses to be in schools on days that most suit health promotion delivery;
- where nurses are full time employees (i.e. working in two schools), the fixing of days could also be varied so that, to further promote flexibility, the nurse could vary the balance of days in a week spent at a particular school across the term/year;
- in regions where nurses attend a weekly office day, that day could be removed or made less frequent; and
- SSNs could work more as teams to visit schools for specific health promotion activities on an as needs basis (removing the need for nurses to always be allocated to individual schools).

1.8 Recommendations

A number of areas for improvement have been identified that, if addressed, will improve the capacity of the SSNP to provide a more effective service to students, including:

- stronger program administration and management from both a central office and regional office perspective including changes to the program model to allow nurses greater opportunities to engage with schools and students;
- greater clarity about the role of nurses, and in particular, engaging schools more effectively to understand the purpose and objectives of the SSNP;
- enhanced accountability, supervision and support structures for nurses including the development of a practice framework to guide service delivery;
- more emphasis on evidence based and collaborative planning by SSNs (that is supported regionally);
- the development of a professional development framework for nurses that supports them to develop specific expertise in the areas of adolescent health and health promotion;
- greater support for nurses to deliver health promotion activities that are evidence based and evaluated;
- stronger emphasis on information management; and
- future considerations for a new allocation model.

Twenty-eight recommendations are made as follows:

Program administration and management

- 1. Central office should establish a statewide SSNP reference group. This group could consist of a range of stakeholders including school principals, teachers, student wellbeing teams, students, parents, academics and adolescent health experts. This group could be time limited and with a specific purpose (for example to oversee recommendations made in this report) or ongoing, and play a role in governing the SSNP). A regional nurse manager should be part of this reference group and provide feedback in relation to regional nursing activities.**
- 2. The SSNP reference group should give early consideration as to how the SSNP can be more effectively integrated with existing student welfare structures at a school, network, regional and statewide level. This consideration should include integration at a service delivery, program management and policy level.**
- 3. Regional nurse managers to examine alternative methods of providing supervision and professional development opportunities for nurses that does not require them spending one day per week in the regional office. Consideration should be given to when and how nurses complete administrative tasks.**
- 4. The regional nurse manager group should take a more active role in the coordination of the program across regions, as well as within regions, to enhance the efficiency of the SSNP. This may include the establishment of local SSNP working groups or participation in school networks.**
- 5. Regional nurse managers to develop a regional communication strategy that includes school networks, school principals and local stakeholders. They should also assume responsibility for strategic networking activities and develop, at state-wide and regional levels, a coordinated approach to identify and engage key partners.**

The role of SSNs

- 6. Guidance materials should be developed to clarify the SSNP focus and the scope. Roles and responsibilities can then be customised at a school level. Guidance materials should be developed in consultation with key stakeholders. Regional nurse managers should play a more active role in engaging school principals in relation to the focus of the program.**
- 7. Further guidance should be provided to schools and nurses in relation to nurse obligations to maintain the confidentiality of students. Processes should be put in place to address circumstances when the nurse may not be available to ensure that essential information is available to school staff (the role of the regional nurse manager should be considered in relation to this issue). A range of stakeholders should contribute to the development of such guidelines including principals, teachers, student wellbeing teams, adolescent health experts, nurses and students.**
- 8. The differences in the SSNP across different settings should be acknowledged. Nurses in rural settings should be awarded enhanced flexibility to respond to the priorities of the**

school, network and regional nurse manager. All service delivery in rural settings must, however, be based on collaborative planning.

9. A school or network representative should be included in the selection panel for SSNs to enhance opportunities for strong matching of nurses to schools.

10. A comprehensive school induction program should be developed by DEECD in consultation with schools, for use by schools when SSNs are placed in their setting.

Accountability, supervision and support

11. SSNP program outcome measures should be identified so that the success of the program can be more formally evaluated. Outcome measures should be linked at a high level to the Statewide Outcomes Framework for Children and Adolescents.

12. A series of key performance indicators should be established that demonstrate the efficacy of the SSNP in relation to meeting core program outcomes (as determined above). These indicators should be reported on regularly at a regional and central office level. The frameworks recommended above should provide specific information about program outputs and anticipated program outcomes against which nurse and program performance can be measured.

13. A standardised, externally validated, adolescent specific assessment and planning tool should be developed for use by all SSNs to underpin all assessments and planning for vulnerable young people (or the risk and resilience assessment framework should be re-implemented).

14. A clinical framework should be developed to provide guidance to nurses in relation to assessment, planning and counselling of students. This framework should ensure that appropriate supervision arrangements are in place for nurses involved in significant amounts of clinical assessment and case management work (e.g. for nurses in rural regions).

15. A clear clinical supervision framework be developed to guide regional nurse manager supervision of nurses. The framework should be evidence based and consider the provision of regular supervision via a range of options including in schools, via telephone or email or face-to-face with individuals or groups on a regular basis.

Evidence based and collaborative planning

16. SSNP planning at the school level should be more fully integrated into student wellbeing team planning and include input from school principals, local school networks and regions. Planning should be informed by locally available and statewide data and reflect the health promotion priorities of all stakeholders (including the school network, local community and state government).

17. SSNP data requirements for planning should be determined and an appropriate data base developed to support collection and analysis of this.

18. The annual action planning system should be redeveloped, or replaced, to allow the recording of health promotion activity and outcomes against planned and unplanned activity. The system design should allow local and program wide reporting of progress against plans and outcomes / outputs achieved.

Professional development

19. The SSNP should actively recruit nurses with formalised training or experience in health promotion, adolescent health and adolescent mental health.

20. A comprehensive skills audit of SSNP staff be undertaken to identify the expertise of staff and opportunities for professional development.

21. All nurses without training and experience in the areas of adolescent health, adolescent mental health and health promotion should undergo mandatory training in this area within a twelve month period of employment.

22. All nurses recruited to the SSNP should undergo professional development regarding adolescent health, adolescent mental health and health promotion within the first year of their employment (this may involve participation in relevant short courses attended out of school time).

23. A comprehensive professional development framework be developed that identifies the range of competencies needed by nurses employed in the SSNP. This framework should detail ongoing professional development opportunities for nurses.

Evidence based health promotion

24. Evidenced based health promotion materials with integrated evaluation mechanism should be developed in a regionally coordinated manner and shared statewide. The development of these materials should be:

- **informed by statewide health promotion policy directions and liaison with Victoria Health, DHS and the Victorian Curriculum and Assessment Authority; and**
- **made available to nurses through an information storage and sharing tool (like those used within DHS) be used to enable the sharing of resources across all regions.**

The use of evidence based health promotion materials could be linked to a key performance indicator developed for the program (as per recommendation 11).

Information management

25. Nurses should be provided with guidance and training to assist them to understand their obligations under current program guidelines and the *Health Records Act 2001* and the importance of recording contemporaneous notes (within 24 hours) of student interactions and interventions. The regional nurse manager to actively oversees SSN documentation through supervision and regular audits to ensure timeliness of recording of information in the SNIS database, the quality of information documented, and the storage of documentation. Orientation of nurses into the program should include a focus on information management policy and practice.

26. The SNIS system should be updated or replaced to provide reliable reporting functionality that accurately reflects underlying SSNP activity (this review did not examine the SNIS system in detail and as a result is not able to identify which components are deficient).

The allocation model

27. The SSNP allocation model should be modified to incorporate the *Student Family Occupation (SFO)* index (or other relevant index). Consideration should be given to replacing the Student Learning Needs and the *Survey of Risk and Protective Factors*. A revised model should be re-run with the latest available data from each index. The outcomes of the re-run model should be:

- used by central office if the program receives additional funding to expand the program (see contingent recommendation below); or
- provided to DEECD regional management to inform any regional allocations of released resources.

28. The current regional allocation process should be retained for allocating the occasional released resource. It is further recommended that a more formalised process for approving the allocation is adopted, where the regional management recommend a particular reallocation and central office approve it. Regional management may consider reallocating nurses to schools according to additional criteria such as size of school and number of campuses (see recommendation 27).

The recommendation and approval process should kept as simple as possible where:

- regional management makes a simple recommendation that the released resource be allocated to the school identified as being most at need by the latest re-run of the model; or
- regional management present a case for an alternate school over the school identified in the model. Any case presented should set out how the proposed allocation furthers the objectives of the program compared to a model based allocation. Based on the regional managements' observations during the evaluation that they can clearly identify priority schools this case should be relatively simple and not exceed two pages.

Contingent recommendation

Based on the above assumptions, the following contingent recommendation is made:

- **Any additional resources should be allocated to ensure there is a state funded nurse in each secondary school throughout Victoria (at present this would mean 0.5 EFT per school, but this could vary subject to the adoption of Recommendation 27);**
- **If additional resourcing is received that exceeds the requirement to place a nurse in each school, any excess resourcing should be allocated to schools in order of decreasing school size across the state. This allocation should be made by the regions either by:**
 - **allocating additional resources directly to identified large schools; or**
 - **retaining the resourcing centrally or regionally to create non-school-allocated nurses to undertake health promotion work on a visiting team basis. The use of this approach is likely to be dependent on the degree to which the region has adopted network based approaches.**
- **If additional resources are received the SSNP may also adopt a separate allocation for Koori schools and English language schools where specially employed nurses may be tasked to serve these schools specifically. The central program would need to examine what would be the appropriate level of allocation for these schools, any specific skill / expertise needed by nurses to work in these schools, and whether nurses should work in teams across all schools or are linked to schools as is the case at present.**