The day provides a variety of challenges at school and in pupils' homes as the school nurse responds to the needs of those in her care and communicates with others involved in pupils' health and well-being.

Yvonne Maunder

Yvonne Maunder is a school nurse in Devon.

All names in the article have been changed to protect identities.

My day as a school nurse

Unpredictable, busy and satisfying - a typical day in the life of a nurse working with primary and secondary school children.

I work full time and provide school nurse care to six primary schools and one secondary school.

My working day begins at 8 am as I drive to the administration department of my local NHS Trust. On arrival, I read and sign the typed letters for posting and collect today's mail before battling with the traffic to arrive at my base in a secondary school.

"Mornin' Miss"

The school has approximately 700 pupils and the catchment area is a nearby council estate with significant deprivation. Several pupils meet me on the way to my room with a "Mornin' Miss."

Selina shows me her tattoo, tells me that it didn't hurt and only cost £30. Simon asks when he will be having his BCG. David says he has stopped smoking again - a story I have heard for over a year. Two girls catch me in the corridor and ask if they can make an appointment. Pupils never come alone, they always come in twos, threes, fours or more. They seem to be quite happy discussing personal issues with their friends present. I make an appointment for them to return at 10 am and write out slips for them to show to their teacher.

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At 8.50 am, I call into the staff room to collect post and have a quick word with the teaching assistants about staffing and timing of the forthcoming BCG immunisation sessions. The first aider asks about anaphylaxis and I briefly answer her questions.

Messages

Back in my room at 9 am I pick up answerphone messages and I am aware that post has to be read and answered, the two pupils are coming at 10 am and I am going to one of my primary school by 10.30 am.

There are four messages that require a fairly quick response. One is from a parent asking about BCG, another call is from a social worker who needs to update me on a child who has been removed from his home on a police protection order. The third call is from a health visitor who needs me to call back, and the last call from the Joint Agency Team asking if I will call them.

I reply to the first call and reassure the parent that her son will be able to have the BCG immunisation despite him taking antibiotics. The second call to the Social Worker pleases me as he is at his desk and we can have a conversation without having to keep leaving messages. He tells me about Ricky, age 7, who has been removed from his home and is now living with a foster carer. I record the date, time and venue for the child protection meeting and also manage to speak to the Health Visitor who tells me about a family she is visiting. There is a school age child of 8 years old and parents are concerned about his bedwetting, and would like me to contact them. I feel happier to make contact sooner rather than later as telephone messages can get forgotten, or mislaid if not acted upon immediately. Also, some people can be at crisis point before they ask for help and a delay of several days, before they hear anything, can seem an eternity.

Bandages and first aid

At 9.20am, I am about to contact the mother concerned about her son's bedwetting, when there is a knock at the door and two Year 8 boys come in with stories about playing football. One boy clearly has bruising to his leg but the other boy has no evidence of injury and tries hard to convince me that he really needs a bandage like his friend. A small bandage works a treat and they go back to class as I write up the injury in the accident book.

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Repeated visits

I find it difficult to turn students away when they require first aid as it has been my experience that repeated visits can often be the lead in to something they want to discuss. Sally, for example, was a frequent visitor complaining of headaches, sore throats and minor injuries. On one visit she started to cry and disclosed information about serious abuse that happened when she was 8 years old. She told nobody about this not even her parents or best friend. Following the disclosure, I made a referral for therapy and contacted Social Services.

At 9.30 am, I contact the mother and discuss her son's bedwetting, and make an appointment to carry out a home visit. Also finally manage to contact the Joint Agency Team, agree to visit a family and telephone the family to make an appointment for a home visit. Once all calls have been made I open and read the post.

Contraception

The two pupils come for their appointment at 10 am. They tell me they are both taking the pill and now want to stop. They want an alternative method of contraception and are considering having an implant. They have a leaflet given by the GP, and have highlighted text they don't understand. I answer their questions and can explain the procedure as, only a few days previously, I accompanied another pupil to a family planning clinic and observed an implant being inserted. I am impressed that the girls have thought this through carefully, and have discussed it with their mothers.

Primary school visit

I leave the secondary school at 10.20 am and arrive at one of my primary schools by 10.30 am. There is no available room and I am given a small area to one side of the main office. Fortunately there is a sliding door which offers some privacy, but it is noisy trying to carry out hearing tests. A noisy environment is far from ideal but quiet areas in schools are hard to find. It would be impossible to use the room for discussions with a parent as our conversation would easily be overheard.

I carry out three hearing tests and have to be opportunistic and use the gaps in conversation and the gaps between the telephone ringing to operate the audiometer. The first child passes the hearing test and I will write to the parent about the result, and also contact the GP as he requested the test.

Edward

The second child also passes the hearing test, and I will also write to his parents. The third child is Edward, a little boy in the reception class aged 5 whom I have not met before. When I collect him from the classroom I explain who I am and that we are going to play a short listening game. I show Edward the audiometer, the headphones and tapping stick and explain what I want him to do. I start, but he does not respond so I try again and again and again.

Edward is unable to tap the stick in response to hearing the noise from the audiometer so I give up. He can hear what I am saying, even when I speak quietly, because he answers me if I ask a question. This is fairly unusual as most children quite like tapping the stick and will usually comply. Although Edward can tell me what he is supposed to do ie. tap the stick in response to the noise, he cannot do it. I begin to wonder if there is some difficulty in understanding and communication.

Back in the classroom I ask Edward if he can stand on one leg, but he cannot unless he holds onto a door frame. We try again in an area without anything to hold onto but he cannot stand on one leg, and neither can he hop. At one point I ask if Edward can leave one foot on the floor and pick the other leg up. Edward bends down, grabs his ankle and tries to pick his other leg off the floor. I become more convinced that there is some difficulty in understanding and communication. I speak to the teacher who is very worried about him. I note to attempt a hearing test again in 6 weeks time, just to rule out misunderstanding or shyness. I will write to mum explaining I will try again in 6 weeks and I make a note to telephone mum on my return to the office.

At 11 am I go into Year 1 classroom to talk to the children about 'medicines', emphasising that we must only take medicines that are meant for us alone, and only if a parent/guardian gives it to us.

Jack

On coming from the classroom the Special Educational Needs Co-ordinator (SENCO) catches me and talks about a little boy who is to start school in September. Jack is in the school nursery and is incontinent of faeces several times a day and has to wear a nappy. Mum is very anxious about the prospect of him starting school as he smells and needs two or three baths a day. Mum is worried that he will be teased by the other children and that the teachers will not be able to cope. Mum is hoping that she can delay his entry into school.

I contact Jack's mother and make an appointment to visit at home the following week. Mum sounds very friendly but distressed. My heart sinks a little when she tells me that she has seen a consultant paediatrician who is 'no help at all' and 'the health visitor hasn't been able to help either'. I tell mum that I do not have a magic wand but I'm happy to visit and listen and offer some advice.

A&E slips

I return to the secondary school by 12 noon, pick up more messages and catch up with administration including the casualty slips that I collected from the NHS Trust office. The slips are sent to the school nurse whenever a child visits A&E. I always look to see if there is a child I know and look at the number of attendances and the nature of the injury.

One slip catches my eye. Its for a girl in the school who I see on occasions. She attended A&E with a stab wound. I highlight this slip and make an appointment for the girl to come and see me so that I can check that all is OK.

The last lesson of the morning, before the lunch break, begins at 12.20 pm. Lunch starts at 1.20 pm in the secondary school, far too late for those pupils who do not have breakfast -

from what I can gather that is almost all of them.

Hygiene box

For the last lesson, I have two girls with special needs with their learning support assistant. The lesson today is around personal hygiene and periods. One of the girls has recently started her periods and was distraught when it happened. There are concerns as she is quite thin, and frequently very smelly. She is incontinent of urine at night so has to wear a pad. We spend the lesson discussing periods and personal hygiene. We look at different sanitary protection and the contents of the 'hygiene box' and spray ourselves with body spray.

My anxieties about this girl do not lessen; I ask her if she has been cleaning her teeth, she says 'no' as she has no toothpaste and has not used the sample I gave her a few weeks ago - her mum threw it out. I ask if she washes morning and night, she says 'no', having a bath three times a week. I ask about 'smellies' like body spray or deodorant and she says 'no'. I suggest she could ask her mum to buy 'smellies' but she says 'no', she is too frightened of her mum to ask. I ask if she could ask for 'smellies' for her forthcoming birthday, but she shakes her head and says she is too scared to ask.

I make a mental note to document what has been said as I feel unhappy about her fear of her mother. I feel slightly relieved that I have already made an appointment to visit this family. It has taken 18 months to get this mother to engage with me by listening to her complaints about her daughter and almost empathising with her. I feel this is the only way that I can have access to the family. Unbeknown to mum I have discussed the situation with the Child Protection lead nurse and Social Services, and I am in the process of gathering information.

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Lunch time

Lunch time arrives at 1.20 pm and I eat sandwiches and continue with paperwork but pupils come in and out of my room. Girls want sanitary towels, one wants a leaflet on how to stop smoking, another tells me that under no circumstances is she having her BCG next week, and others pay a 'social call'. These visits can be quite enlightening as I learn who got drunk at the weekend, who got arrested, who's smoking cannabis (or worse) and who may be pregnant.

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James

At 1.50 pm one of my regular visitors, James, calls in. He has been 'rugby tackled' on the field and hurt his back. I ask the other pupils to leave the room and I offer James a seat but he finds it difficult to sit, he also finds it difficult to stand. Amidst moans and groans he lies down on two chairs pushed together and feels a little more comfortable. I know James well, and know that he is a bit 'dramatic.' I also know that he has immense social problems and I feel that I cannot ignore his injury. He asks me to look at his back but I can see no marks or bruising.

James says his pain is at number 9 on a scale of 0 - 10, he cannot move freely and would not be able to walk comfortably. I tell him that I will ring his parents and ask them to collect him and go to the GP.

James has been living with a neighbour for about six months as his parents did not want him, and he has only returned home in the last few days. I ring home and speak to his step dad first and then his real mum. Mum informs me that she cannot collect James from school as she has to go to a meeting, step dad cannot collect him as he will probably be taking her to the meeting, and there is nobody else. She reminds me that there is only an hour and a quarter of the school day left and then James will have to walk home. I tell her that I'm not sure that he can walk home. Mum reports that she is going to her meeting and was just going out of the door when I rang. I say that I may have to ring for an ambulance in that case and mum says 'fine'.

By 2.10 pm, James is still complaining of pain and is unable sit up. I make the decision to call for an ambulance based on clinical findings.

Paramedics arrive at 2.20 pm and are really kind to James. They explain that he will have to go to A&E on a board and wearing a collar and that he must not move. I telephone James' parents, speak to mum (who still hasn't gone out of the door) and inform her that James will be going to A&E and will be there at about 2.45 pm. Mum sounds disinterested. James then goes to A&E with a teaching assistant and I try to contact James' Social Worker but have to leave a message asking for him to ring me. For the next fifty minutes or so I make more telephone calls to parents, and read medical letters.

Home visit

I leave school to make a home visit to a family with two children, a girl in Year 8 and a boy in Year 6. Arriving at the home by 4 pm, I listen to mum as she talks about her children. I learn that the children's father had died two years earlier and mum thinks they would all benefit from counselling. With the children's agreement I will arrange it. Mum continues talking and tells me that her husband died at the age of 38 years old from a heart attack. I then learnt that his father died at age 60, his grandfather died at age 30 and an uncle also died at age 30 - all from heart attacks. This information concerned me for several reasons. I was picking up a picture of possibly a familial hypercholesterolaemia. Both children were already overweight, mum was obese and had a history of gestational diabetes which required insulin.

I offer to write to the GP to ask if the children could be screened for familial hypercholesterolaemia, and I offer health promotion input as this family are at risk of weight related morbidity. Mum agreed for me doing both. I make notes in my diary to write to the GP re screening and for me to follow up the family in 4 weeks time.

I leave for home at 5.10 pm and mull over the days events. Every day as a school nurse is unpredictable, sometimes it can be quite exhausting both physically and mentally, but it is never boring.