Enabling school staff to undertake clean intermittent catheterisation

Children with bladder problems may need help with catheterisation at school. Health professionals must know local and national policies to deliver this safely.

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Successful clean intermittent catheterisation depends on the ability of the child, parents and carers to undertake the procedure and effectively integrate it into both home and school life. Paediatric continence nurses need to support this process by addressing the concerns and anxieties of school staff. Inconsistencies in practice and the absence of local policy can exacerbate concerns and anxiety. This article highlights the main issues surrounding use of CIC in schools and discusses them in the light of current legislation and guidance.

Clean intermittent catheterisation (CIC) is a simple, quick and effective procedure to manage neuropathic bladder, intractable urinary incontinence, urinary retention or incomplete bladder emptying in children.

Legislation in the UK over the past 20 years has promoted inclusive education so that children with special needs, including those with disabilities or complex health needs, have the right to be educated in mainstream schools (Department for Education and Skills, 2001). Government policies, including Managing Medicines in Schools (DfES and DH, 2000) and Including Me (Carlin, 2005), offer guidance for schools about roles, responsibilities, entitlement and the provision of support for those with complex healthcare needs.

Where there are no local policies for CIC, school staff, parents and health professionals can experience heightened feelings of inadequacy, anxiety and concern, which can lead to conflict. This can also prevent children from participating fully in school activities and affect attendance, achievement and socialisation (Fishwick and Gormley, 2004).

School staff do not understand bladder problems as well as other long term conditions such as diabetes, asthma and epilepsy, which is a major reason for anxiety and concern (Fishwick and Gormley, 2004). The intimate and perceived medical nature of CIC can raise issues about child protection, the risk of harm to the child and debate about who should be responsible for it. Head teachers may be concerned about the provision of appropriate facilities and adequate funding to support the child.

Developing a local policy for CIC is vital to decrease anxiety and confusion for parents, school staff and health professionals, and will ensure commitment and promote shared governance and ownership (Carlin, 2005; Fishwick and Gormley, 2004). The guiding principle during planning and training must be to safeguard the child and the employees who agree to undertake the procedure.

PROTECTION AND PREVENTING HARM

Health professionals need to reassure carers that CIC is a normal everyday procedure that, if painful, would be unacceptable to the child and would result in non-compliance. Extensive research has demonstrated the efficacy of the procedure and shown that carers performing CIC pose no more risk than an individual performing self catheterisation (Moore et al, 2007).

CIC ensures complete bladder emptying, thereby preventing infection, preserving renal function and promoting continence. This in turn increases self esteem, self worth, positive body image and the confidence to enjoy and participate in normal everyday activities. This helps to secure the child’s physical, psychological, emotional and social wellbeing (DfES and DH, 2004; DH, 2003). Failing to carry out CIC in school puts children with continence problems at significant risk of harm and is detrimental to their overall health and safety.

The Children Act 2004 requires organisations employing staff in childcare positions to ensure these staff have regular checks by the Criminal Investigations Bureau. Satisfactory checks allow them to provide intimate care without needing a second person present (Carlin, 2005).

Written consent from the parents and head teacher is essential to protect everyone involved in CIC (Carlin, 2005; DH, 2001).

WHO CAN PERFORM CIC?

There is no contractual obligation for teachers and non-teaching staff to manage pupils’ medical needs, and staff do so voluntarily.

To ensure safety and protection, CIC must be delivered reliably and consistently during the school day by someone familiar and acceptable to the child. Privacy and dignity dictate that the number of people present during the procedure should be kept to a minimum and there must be cover for absence and sickness.

It is practical for CIC to be undertaken by school staff (DH, 2000) as they have a common law duty of care to behave as a responsible, careful parent would to...
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promote the welfare, health and safety of children (DFES, 2001). Carlin (2005) suggests that CIC can be safely taught to unqualified personnel and in school the classroom assistant is the logical choice. Office staff, dinner ladies and other school staff may also be considered as suitable carers. In the absence of any volunteers, schools may have to advertise and employ someone specifically for this purpose.

In some areas parents are expected to come into school to perform CIC or to change a continence product; this does not foster independence or promote social normality for the child and contravenes the Equality Act 2010. It is also inappropriate to leave a child in soiled or wet clothes until a parent is able to attend (Carlin, 2005).

FACILITIES AND EQUIPMENT

According to The Education (Schools Premises) Regulations 1999, the local education authority has a responsibility to provide an appropriate room for medical treatment with suitable handwashing and toiletfacilities/tinyurl.com/school-premises. Funds are available for schools via the LEA annual school action initiative fund to improve the physical environment so that children with disabilities can access mainstream education. Facilities must take account of the need for privacy and dignity.

Staff must take effective handwashing techniques and schools should ensure adequate provision of soap and water. Care staff should use protective non-sterile gloves (NICE, 2010); it is the employer’s responsibility to provide protective equipment (Health and Safety Executive, 1999) and waste disposal facilities (DH, 2002). Hygiene disposal units are a cost effective way for schools to dispose of catheters. Further information about facilities or equipment in schools for CIC is outlined in Good Practice in Continence Services (DH, 2000).

Catheter manufacturers also provide information and booklets on catheterisation in schools.

LITIGATION

A robust governance framework is essential for training and preparing carers. Training must be undertaken by primary care trusts or NHS trusts and carried out by suitably qualified health professionals who are experienced and competent in catheterising children (Carlin, 2005). Health professionals are legally accountable for any task they delegate even if they are not present when it is undertaken (Nursing and Midwifery Council, 2008).

It is essential that the procedure taught follows evidence based guidelines and the carer’s competency is assessed and documented. Staff who follow documented procedures given by the health professional will have full support of the LEA and are fully covered by their employer’s liability insurance in the event of a complaint (DFES and DH, 2005).

The head teacher has a contractual duty to ensure staff receive training and the PCT has discretion to make resources available for that. Parents may play an important part in training but it is not appropriate for them to be responsible for organising and delivering training to schools; this will affect liability insurance. To validate insurance, education authority risk assessors will require written evidence of comprehensive training undertaken by a suitably qualified health professional, competency and consent of all relevant parties. It is also necessary to ensure staff have regular updates and reassessment of competency (Carlin, 2005). Individual authorities may require extra information.

Catheterisation should be included in carers’ job descriptions and in the child’s school healthcare plan. Individual healthcare plans should be drawn up by the school nurse and the person teaching CIC in collaboration with parents, school staff and the child where appropriate. Including Me (Carlin, 2005) offers in-depth guidance on compiling healthcare plans.

Comprehensive and legally robust documentation is vital to minimise litigation risk and ensure employee safety is not compromised. Examples of documentation are available in Including Me (Carlin, 2005) and Managing Bladder and Bowel in Schools and Early Years Setting (PromoCon, 2006).

FUNDING OF SUPPORT

CIC generally requires less than three full hours of support per week (approximately 15 minutes per catheterisation) and this is usually funded from within the school special needs budget.

Some children requiring CIC have other needs, such as hydrocephalus, and may need assessment for an educational statement. Schools with a number of children requiring CIC may choose to approach the LEA for additional support. Clarification of local funding arrangements is invaluable and may be obtained from the LEA.

CONCLUSION

Providing CIC in school is fundamental to the overall safety and wellbeing of the child who requires it. Effective communication, negotiation and collaboration between health and education services are vital to ensure it is performed safely and effectively.

Health professionals involved in paediatric continence care should seek to influence the development of local policies to include the specific needs of children with continence issues for the benefit of children, parents, and health and education services.

REFERENCES


