### CNS Workload Tool Guidance Notes

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>GUIDELINES</th>
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<tbody>
<tr>
<td>Face-to-face Patient Related Contact</td>
<td>Everything you do to or with a patient present (includes record keeping where the patient is actively involved in the process)</td>
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<tr>
<td>a) Family Assessment</td>
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<tr>
<td>b) Interventions</td>
<td>Specific clinical interventions demonstrating specialist/advanced skills</td>
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</table>
| | - Management of acute/chronic/long term conditions (e.g. asthma, oxygen, cystic fibrosis, home ventilation diabetes, renal, cardiac, oncology)  
  - ‘Hospital at home’ and/or care of the acutely ill adult  
  - Continence Care e.g. stoma, bladder and bowel management  
  - Pain assessment and management  
  - Clinical investigations (e.g. venepuncture, monitoring and interpretation of results)  
  - Administration of medicines  
  - Medication management / Supplementary and independent prescribing and administration of Intravenous therapy (e.g. chemotherapy, antibiotics, TPN)  
  - Nutritional support including enteral feeding  
  - Wound Management |
| Levels of Intervention 1 | Straightforward |
| Level 1 Examples |  |
| | - Provide face to face advice and/or information with no other input required at that point  
  - Straightforward assessment of a situation that requires advice/information but no other input / assessment of a situation which results in advice/information given directly to parent/carer/client but no other input  
  - Simple post-operative wound that requires removal of suture or a straightforward assessment requiring no further intervention  
  - Home / clinic contact with parent /carer/client following e.g. A/E attendance, hospital |
| Levels of Intervention 2 | Minimal |
| Level 2 Examples |  |
| | - Provide face to face advice and/or information but further support or wider explanation is required  
  - Provide face to face advice in a situation which requires recipient specific understanding i.e. where there are cognitive / sensory impairment  
  - Assessment of situation results in the need for uncomplicated direct clinical intervention in one or two aspects of care at that point but once completed no further intervention required  
  - Assessment of a situation which results in the need for minimal |
| Levels of Intervention 3 | Moderate |
| Level 3 Examples |  |
| | - Provide face to face detailed information and provide support and advice to parent/carer/client for a complicated situation  
  - Direct face to face assessment of a complicated situation requiring moderate intervention on more than one or two aspects of care and will require further monitoring and intervention. e.g.  
  - Post-operative wound, with, general concern of possibility of deterioration. Requires referral for appropriate assessment and treatment. Support and reassurance required  
  - Assessment resulting in further monitoring / intervention |
| Levels of Intervention 4 | Complex |
| Level 4 Examples |  |
| | - Complex situation requiring the coordination/ case management of multiple avenues of advice and information. Demand for personal support to family/carer increasing  
  - Regular re-assessment of situation required with multiple interventions required. Long-term situation  
  - Post-operative wound open, discharging, patient generally unwell parent/carer upset and anxious. May require re-admission  
  - Assuming the role of Lead Professional in a given situation  
  - Direct contact with a family in crisis requiring immediate and high level intervention |
| c) Clinical Consultation | • Communication with MDT other professionals & families  
| | • Information sharing  
| | • Multidisciplinary and multiagency working  
| | • Assessment of capacity to consent  
| d) Discharge Coordination | • Multidisciplinary discharge planning meetings  
| | • Coordination of supplies and equipment (patient specific)  
| e) Child Protection Activity | • Referral  
| | • Meetings  
| | • Training  
| | • Reports/documentation  
| | • Reviewing  
| f) Supporting / Advising / Counselling Skills | • Knowledge of needs of patient and dynamics of family situation  
| | • Developing and establishing a relationship  
| | • Skilled listening  
| | • Enabling/empowering  
| | • Planning  
| | • Providing diagnosis  
| | • Counselling skills  
| | • Bereavement support  
| | • Care coordination  
| | • Key worker role  
| g) Palliative / Terminal Care / Breaking Bad News | • Providing diagnosis  
| | • Counselling skills  
| | • Bereavement support  
| | • Care coordination  
| | • Key worker role  

| Palliative and Bereavement care  
| Intravenous access devices (e.g. portacath, central lines)  
| Pre – post operative assessment and care (e.g. orthopaedic)  
| Neurological (e.g. epilepsy, complex health care needs, learning disability)  
| • Discharge, DNA, follow up on a previous call  
| • Accessible record and documentation of intervention  
| • Intervention e.g. discuss the management of constipation through dietary advice. Assessment of the situation at this stage deems no further intervention required beyond discussion and advice to with parent/carer/client  
| • Direct Communication with carer / families / wider PCT, multi agency colleagues  
| • Unplanned meeting with parent/carer/client requiring minimal intervention/ advice/ discussion and client understanding assured  
| • Post-operative wound inflamed requiring observation but not intervention and information provided to carer/patient about signs to look for and how to access intervention should that be required  

| c) Communication face to face with Ward / Community Nurses to inform assessment and ongoing intervention  
| d) Management of a diabetic patient where there is need for regular titration of dosage and or regular contact with secondary services due to instability of blood sugars.  
| • Deterioration of a client situation which involves direct contact and intervention e.g. referral to other NHS services, social services etc…”  
| • Intensive family support
| h) Clinical Documentation / Patient Held Records | • Clinical case records / written communication (e.g. letters, reports)  
• Assistance with applications for benefits (e.g. Disability Living Allowance)  
• Risk assessment (e.g. home ventilation, moving & handling)  
• DNAR / Anticipatory care plans  
• Development of protocols/policies for individual health needs | • Advice to family / carer re patient condition |
| i) Training and Education | • Identification of best practice  
• Delivery to children, young people, families and carers  
• Evaluation of patient care/understanding. (Patient involvement)  
• Multidisciplinary and multiagency training  
• Delivery of appropriate face to face education to under and post graduate students | |
| j) Research / Audit | • Patient/family audit  
• Consultation with children and young people  
• Research governance  
• Service evaluation  
• Supporting clinical trials | |
<table>
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<tr>
<th>Professional Communication involving clinical advice utilising knowledge and skills</th>
<th>Level 1 Examples</th>
<th>Level 2 Examples</th>
<th>Level 3 Examples</th>
<th>Level 4 Examples</th>
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</table>
| • Receiving and making telephone calls, e-mails and faxes to MDT / other professionals, parents/carers, patients  
• Receiving and making telephone calls to other professionals, parents/carers, patients  
• Referrals to other services  
• Prescription writing / ordering  
• Patient handover – updating colleagues when requiring cover for annual leave  
• Discussion/liaison with colleagues and partner agencies  
  o Relating to arranging or discussing care or management of a patient  
  o Arranging for the patient to attend A&E or for admission to the ward  
  o Opportunistic discussions with other professionals (internal / external) regarding a patient  
  o Ward liaison (discharges and admissions)  
• Letters/reports/dictation  
  o Minutes of individual patients meetings, reports for meetings (case conference) to whom it may concern letters  
• Education/ Training of staff / carers in relation to a specific patient  
  o Training to a support worker, nursing assistant looking after a patient with i.e. gastrostomy, tracheotomy, diabetes or cystic fibrosis etc (if the patient was present then this would be a direct contact) | • Provide advice and/or information with no other input required at that point  
• Simple assessment of a situation that requires advice/information but no other input  
• Cancer CNS responding to telephone call from District Nurse, about a patient with cancer, seeking advice about appropriateness of vaccination whilst on treatment  
• CNS responding to telephone call from another Healthcare Professional seeking advice re patient care | • Provide advice and/or information but further support or wider explanation is required  
• Provide advice and/or information in a situation which requires recipient specific understanding i.e. where there are cognitive / sensory impairment  
• Assessment of situation results in the need for uncomplicated intervention in one or two aspects of care at that point but once completed no further intervention required  
• Assessment of a situation which results in the need for minimal intervention e.g. Dietary advice re constipation. Assessment of the situation at this stage deems no further intervention required beyond advice/information | • Provide detailed information and provide support and advice for a complicated situation  
• Assessment of a complicated situation (case management) requiring intervention on more than one or two aspects of care and will require further monitoring and intervention e.g. the need for face to face contact, home visit, GP/clinic visit - the omission of which would be detrimental to the health and wellbeing of the client/family/carer  
• Assessment resulting in further monitoring / intervention  
• CNS contributing to Case Conferences and complex case discussion | • Complex situation requiring the coordination of multiple avenues of advice and information. And increasing demand for personal support to families and carers. Demand for personal support to family/carer increasing  
• Regular re-assessment of complex situation required with multiple interventions required. Long-term situation  
• Diabetes CNS liaising with staff nurse in ward to support the nurse in monitoring the patient’s blood sugar level, providing dietary advice and providing support for the family |
<table>
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<tr>
<th>Admission /Discharge Coordination</th>
<th>Arranging venues, invitations to external agencies, minute taking, taking forward outcomes arising from meetings such as liaising with social work</th>
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<tbody>
<tr>
<td><strong>Admission /Discharge Coordination</strong></td>
<td>Discussion between GP &amp; CNS re medication management which involves CNS having to access and refer to patient’s case notes</td>
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<tr>
<td><strong>Research/Audit</strong></td>
<td>Accessible record and documentation of intervention</td>
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<tr>
<td><strong>Clinical Documentation / Patient Held</strong></td>
<td>Communication with carer / families / wider PCT, multi agency colleagues</td>
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<tr>
<td><strong>Clinical Documentation / Patient Held</strong></td>
<td>Advice to family / carer re patient condition</td>
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<td>Record not accessible, arrange access to record Documentation - Input of intervention information into client record e.g. telephone liaison advice/information</td>
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<td>The case requires Case Management for patients with complex needs related to long term conditions, palliative care or end of life care. Examples – Advanced assessment, high levels of decision making, formulation and co-ordination of management plans in partnership other agencies adopting a patient centred approach</td>
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<td>Plan deliver and evaluate complex packages of care through continuous audit and monitoring of appropriate data</td>
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<td>Proactively managing and facilitating effective complex discharge planning</td>
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<td>Providing clinical and professional expertise to patients, carers and members of the multi disciplinary team as appropriate</td>
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<tr>
<td><strong>Admission /Discharge Coordination</strong></td>
<td>Coordination / participation in multidisciplinary admission / discharge planning meetings to arrange effective admission / discharge planning</td>
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<tr>
<td><strong>Research/Audit</strong></td>
<td>Ensuring that appropriate care packages are in place to support patients and carers within the community</td>
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<tr>
<td><strong>Clinical Documentation / Patient Held</strong></td>
<td>Coordination of supplies and equipment (patient specific)</td>
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<tr>
<td><strong>Clinical Documentation / Patient Held</strong></td>
<td>Development of protocols/policies for individual health needs</td>
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- E-mail/fax relating to a patient:
  - Fax to enteral feeding company re change of regime or GP regarding a prescription
  - Or a new referral being sent
  - E-mail to other professionals, social work or psychology
- Writing up notes following record keeping/phone calls and entering information onto computer
  - Patients notes (written)
  - Patients notes (electronic)
- Preparing notes/results for clinics/consultation (clinic preparation)
  - Record keeping including IT based
  - Prescription writing / ordering
  - Lab results (filing)
  - Tracking / filing records
  - Ordering equipment
  - Multi-agency team meetings/ case discussions and case conferences
- Attending critical incident meetings
- Risk assessment and management

**Admission /Discharge Coordination**

**Research/Audit**

**Clinical Documentation / Patient Held**
<table>
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<th>Records</th>
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- Assuming the role of Lead Professional
- Call from a family in crisis requiring immediate and high level intervention
- Gathering information and preparing complex reports
- Deterioration of a complex client situation
## Venue of Intervention
- Clinic
- Community
- Other
- Ward

## Group Clinics
### Group clinic (sessions):
If you run a group clinic (i.e. with a number of patients at one time), e.g. Cardiac Rehabilitation / Bereavement Support Group, please use the specific Clinic section recording start and finish, type of clinic and number of people seen. Any additional workload over and above the group purpose should be reported under the Direct Intervention screen including level of intervention.

If appropriate if you carry out Health Promotion/Education Sessions e.g. Breast Awareness / Talks to Public Groups record start and finish, type of session and number of people seen. Any additional workload over and above the session purpose should be reported under the Direct Intervention screen including level of intervention.

## Associated Workload
Record total time in minutes and total time PER DAY, NOT PER PATIENT

## Specialist Clinical Consultation
- Advice to professionals (internal/external)
- Advice to external agencies
- Communication with MDT other professionals & families
- Information sharing, e.g. Ward rounds / case discussion
- Attending incident meetings
- Adverse event management (e.g. clinical incidents in blood transfusion settings)
- Compiling reports
- Co-ordinating programmed activity in the Boards, hospitals, primary care (e.g. vaccination services)

## Management / HR
- Off duty
- Staff salary data / SSTS
- Recruitment
- Sickness/absence reporting and return to work meetings
- Disciplinary/ performance management
- Project work

## Administration
- Emails
- General phone calls
- Travel forms E Expenses
- Database (non patient related)
- Monthly reports/statistics
- Supplies/ordering (general)
<table>
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<tr>
<th>Topic</th>
<th>Description</th>
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| Co-ordination of equipment (general) | Lab results (filing)  
Mileage / timesheets paperwork  
Incident reporting |
| Meetings (non patient specific) | Senior Nurse meeting / Team meetings  
Representing Team leader/line manager at meetings  
Managed clinical networks  
National forums  
Attending steering group meetings  
Professional meetings foraums |
| Delivery of Staff Teaching / Education / Practice Development | Providing  
Clinical supervision / clinical support  
Personal Development Review/Personal Development Plan  
Developing education resources (e.g. Cleanliness champions, model policies safer blood s,)  
Multi-agency teaching  
Contributing to programme and curricula development  
Drafting guidance for consultation  
Student related activities  
Mentorship preregistration |
| Personal Professional Development | Mandatory training  
Continuing Professional Development, e.g., Conferences, study days, self-directed learning  
Eksf/Personal Development Review/Personal Development Plan  
Clinical supervision  
Team development  
Shadowing opportunities to enhance skills |
<p>| Travel Time | Travel time recorded should include walking, waiting and parking time |</p>
<table>
<thead>
<tr>
<th>Travel Mode</th>
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<tbody>
<tr>
<td>Foot – F</td>
</tr>
<tr>
<td>Car – C</td>
</tr>
<tr>
<td>Public Transport – PT</td>
</tr>
<tr>
<td>Boat – B</td>
</tr>
<tr>
<td>Plane – P</td>
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</tbody>
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An option of choosing more than one mode of transport per journey is available e.g.:

- Walking from your work base to collect your car; the car journey; and walking to the location.
- Walking from one end of the Hospital / Health Centre / building to the other

*Developed by the Community Children’s and Specialist Nurses Sub Group. A Sub Group of the Paediatric & Neonatal Nursing Subgroup. These are Sub Groups of the Nursing and Midwifery Workload and Work Force Planning Project. Adapted for Adult use by NMWWPP CNS SLWG Aug 2010. Updated December 2011, November 2013 and April 2017*