Using a database to demonstrate the clinical nurse specialist’s contribution to patient care

The benefits of the clinical nurse specialist role to patient care are not always clear. A trust developed a database to analyse their workload and contribution.

INTRODUCTION

The cancer reform strategy (Department of Health, 2007a) set out a commitment to establish a new NHS cancer patient experience survey programme to monitor national progress and to use the findings to drive quality improvements locally. This is in line with the government’s vision, outlined in the NHS next stage review (DH, 2008a), which stated that patient experience should be one of the NHS’s guiding principles.

Tackling variations in the quality of care and giving patients more information and choice were key themes in this report. Implicit within this is the contribution of the clinical nurse specialist (CNS) to delivering this vision. The DH (2007a) said CNSs have a valuable role across different elements of patient management and support, carrying out a range of functions including technical aspects of care, information provision, emotional support and care coordination.

Many policy documents argue that personalising care is essential to ensure patients receive care that is tailored to them (DH, 2007a; 2007b). The first annual report on the cancer reform strategy (DH, 2008b) explored new models of care and focused on:

- Testing new ideas to reduce length of stay;
- Avoiding emergency admissions;
- Considering care delivery in the most appropriate setting;
- Developing models of care that improve quality and value patients’ time.

Many of these strands are common components of the CNS role. The evidence of how valuable this role can be to patient outcomes is well understood and documented, highlighted in the chapter on survivorship in the cancer reform strategy (DH, 2007a). This discusses living with and beyond cancer, a theme further developed in the National Cancer Survivorship Initiative’s vision (DH et al, 2010). However, specialist nurse roles appear to be under threat due to financial pressures in the NHS (Tarrant et al, 2008). The CNS role has been subject to scrutiny within clinical areas as it appears...
The CNS role in the UK has evolved over the last 30 years and debate still continues over its definition. However, the Nursing and Midwifery Council (2007) said there are four main themes: advanced clinical/professional practice; facilitating learning; leadership/management; and research practice. These appear to be common in the literature, which generally report the key elements of the CNS role as clinical practice, education, management/consultation and research (Ball, 2005; Hamric and Spross, 1989). While these components are prescriptive, they are considered to be approximately representative of most roles.

The Pandora research also showed hidden elements connecting the impact of CNS work to patient and organisational outcomes (Leary et al, 2008) (Box 1). Pandora was initially piloted at the trust in 2007 among a group of volunteer CNSs and after a successful phase, it was agreed that its use should be part of all CNS roles.

INTRODUCING PANDORA AT THE TRUST

To facilitate the rollout of Pandora, an e-learning tool was developed (Fig 1). All CNSs at the trust had to complete this to access Pandora. E-learning was considered to be the most convenient and accessible method of training, allowing CNSs to complete it when it was most suitable for them. A unique training log in was emailed from the information, communications and technology team to each CNS and training took about 20 minutes to complete.

The training helped CNSs to navigate their way around the database using scenarios to show how an event could be coded under the key dimensions. On completion, each CNS emailed Pandora and received a unique password and username. The database could be accessed via the internet so activity could be subjected to content analysis, for example (Leary, 2007).

The Pandora research also showed hidden elements connecting the impact of CNS work to patient and organisational outcomes (Leary et al, 2008) (Box 1). Pandora was initially piloted at the trust in 2007 among a group of volunteer CNSs and after a successful phase, it was agreed that its use should be part of all CNS roles.

WHAT IS PANDORA?

Pandora is a database designed to articulate the complexity of the CNS role (Leary et al, 2008). It does this by collecting data in various forms including narratives that may be subjected to content analysis, for example (Leary, 2007).

The trust guideline. for Clinical Nurse Specialists, an unpublished UCLH guideline.

CNS WORK IN CANCER AND SURGERY

Data was collected from a group of 18 CNSs working in cancer and surgery at the trust over five months. They collected different weekdays to reflect their workload accurately. The report was collected over a short period, the aim being to generate a report to feed back to this group of CNSs. The data presented below describes this activity, which was validated and further explained by the CNSs themselves at a nursing meeting in December 2009. This allowed for validation and further explanation of the data through discussion and reflection with the group.

FIG 2. TIME FRAME WITH CLINICAL INTERVENTIONS

Unsurprisingly the majority of CNSs’ time was coded under clinical activity. Much of this was physical and psychological assessments, which took about one hour to complete (Fig 2).

Physical work encompassed: physical, general and specialist symptom control, performing specialist and routine procedures and making recommendations to other multidisciplinary teams. This was expected due to the multiprofessional nature of these roles.

Quantitative Workload

Unsurprisingly the majority of CNSs’ time was coded under clinical activity. Much of this was physical and psychological assessments, which took about one hour to complete (Fig 2).

Physical work encompassed: physical, general and specialist symptom control, performing specialist and routine procedures and making recommendations to other multidisciplinary teams. This was expected due to the multiprofessional nature of these roles.

Unsurprisingly the majority of CNSs’ time was coded under clinical activity. Much of this was physical and psychological assessments, which took about one hour to complete (Fig 2).

Physical work encompassed: physical, general and specialist symptom control, performing specialist and routine procedures and making recommendations to other multidisciplinary teams. This was expected due to the multiprofessional nature of these roles.

Unsurprisingly the majority of CNSs’ time was coded under clinical activity. Much of this was physical and psychological assessments, which took about one hour to complete (Fig 2).

Physical work encompassed: physical, general and specialist symptom control, performing specialist and routine procedures and making recommendations to other multidisciplinary teams. This was expected due to the multiprofessional nature of these roles.
of cancer and the importance of multidisciplinary working, guided by the *Manual of Cancer Services Standards* (DH, 2001). These assessments were completed in outpatient and inpatient departments as well as over the telephone, and were coded low to medium on the emotional effort scale.

When examining the drop down elements selected during psychological assessment, CNSs coded that most of their time was spent managing anxiety, supporting patients and families with clinical choices and dealing with distressed patients and relatives. Communicating significant news to patients and relatives was coded as a smaller percentage of time. While activity was coded in all interventions, the majority of time was spent undertaking clinical (63%) and administrative activity (30%), with less time coded under educational and professional development (4%), consultancy (2%), research and audit (1%) (Fig 3).

**Administrative tasks**

A significant amount of overall time was taken up by administrative tasks (Fig 4). While many of these tasks were completed in 15-30 minutes, a small number took over two hours. The majority of administrative tasks consisted of coordinating clinical notes, ensuring correct results were available, checking emails and making calls to patients and other multidisciplinary team members. Less administrative time was coded under dictating, typing and faxing letters. On reflection CNSs indicated that they coded their activity as predominantly clinical and failed to see that for the clinical intervention to be performed, a number of administrative steps need to occur. After this discussion, the CNS group felt they should examine their workload more closely and code every step/event in the future.

There appeared to be differences with the breadth and depth of the CNS role: some practitioners managed and completed a ward round where they reviewed and dressed wounds, while others were involved in completing a Macmillan grant application or acting as advisers on the North London cancer network. The majority of workload associated with this group of CNSs involved following up on telephone calls and reviewing patients in outpatient and inpatient settings.

**Rescue and brokering work**

Evident in the data with this group was that a significant amount of time was spent organising patient pathways – chasing medical notes, and ensuring blood results and biopsy results were present along with other completed investigations. CNSs were anticipating the pathway of care before patients’ attendance, usually in the outpatient setting, by coordinating a particular procedure or liaising and coordinating with the necessary multidisciplinary team before, during and after patient review. It appeared that many were spending a significant amount of their time “brokering” and doing “rescue work” (Leary, 2008).

These terms describe how a CNS may negotiate a particular pathway for a patient, ensuring the best possible outcome at a particular time. “Rescue work” is based on Silber et al’s (1992) work, which explored what would happen if a situation was not rescued. While many practitioners did not code their activity as “rescue work”, there are clear examples of this and it is an important element of the CNS work (Leary, 2008).

CNS narratives gave examples of their “rescue work”, describing situations where there was prevention of unscheduled care, as admissions were prevented by coordinating a pathway of appropriate care in a home setting. This ensured patients could be seen locally, by their GP, providing a shared protocol of care and best possible outcome. Understandably, emotional effort under the psychological dimension was significantly higher than in others, with many events coded as medium to exceptionally high. This is a subjective scale but it seemed to be reflected in the qualitative narratives (Fig 5).

**QUALITATIVE WORKLOAD DATA**

While the quantitative data demonstrates the percentage of time CNSs were spending on a key dimension, the qualitative data gives enormous insight into the level of “intimacy” they have with patients and relatives at a traumatic time in their lives. There were five pages of narratives and these were pooled and analysed to identify some common themes (Box 2). The strongest themes were:

- Communication/health promotion;
- Brokering;
- Rescue work;
- Advocacy work;
- Helping patients with clinical choices at...
time of diagnosis:

- Psychological support work that CNSs were providing for this patient group.

One narrative describes how the CNS “spent time with a patient whose mother is dying while he is undergoing chemotherapy. Explored his feelings of anger towards her for abandoning him when he needs her most”. Another CNS described how they “talked through the choices that had been made by the team and acknowledged difficulties in dealing with an unknown outcome for the family”. Yet another described their role with a “complex discharge” in a “patient with high anxiety and distress” where there was discussion with the patient regarding the “palliative phase of disease”.

Many of these themes concur with Tarrant et al’s (2008) work, which found patients with prostate cancer valued input from a specialist nurse. Equally, the evidence of the value of the CNS role to patient outcomes is highlighted in the cancer reform strategy (DH, 2007a) and the National Cancer Survivorship Initiative’s vision (DH et al, 2010).

Interestingly, research by the Picker Institute Europe (Coulter, 2005) identified the main aspects of healthcare that patients consider important:

- Fast access to reliable health advice;
- Effective treatment delivered by trusted professionals;
- Involvement in decisions and respect for preferences;
- Clear, comprehensible information and support for self care;
- Continuity of care;
- Emotional support and support for family and carers.

Many of these aspects appear to overlap with the aspects coded by CNSs in their qualitative narratives in caring for this group.

CONCLUSION

The Pandora database has demonstrated the complexity and multiplicity of components of the CNS role and its impact on care.

To access further information or a demonstration of Pandora contact NHS Innovations London at www.nhsinnovationslondon.com/contact-us/

REFERENCES


