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The CNS group felt they should examine their steps need to occur. After this discussion, the to be performed, a number of administrative failed to see that for the clinical intervention their activity as predominantly clinical and reflection CNSs indicated that they coded dictating, typing and faxing letters. On checking emails and making calls to patients ensuring correct results were available, tasks consisted of coordinating clinical notes, in 15-30 minutes, a small number took over two hours. The majority of administrative taken up by administrative tasks (Fig 4).

While many of these tasks were completed research and audit (1%) (Fig 3).

Educational/professional development (4%), consultancy (2%), administrative activity (30%), with less time spent undertaking clinical (63%) and administrative activity (30%), where 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 no uniformity 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 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 and 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”.

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 role.

CNS narratives gave examples of their “rescue work”, describing situations where 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. Arguably 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;
- Psychological support work that CNSs were providing for this patient group.

One narrative describes how the CNS...