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**Document Control**

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<th>Author</th>
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<td>August 2019</td>
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1. Introduction

1.1 Purpose

The Community Nursing (CN) tool has been designed by Community Nurses (CNs) in partnership with the Healthcare Staffing Programme (HSP). It is set up to enable CN's to record information about all aspects of their work. This includes the direct intervention they have with children and families, as well as the associated workload they carry out as part of their wider role. It also allows them to report exceptional circumstances which are occasions when an unusual work event has happened that is not captured within the direct intervention and associated workload sections or has interfered with this work e.g fire evacuation.

The tool uses the information inputted by the practitioner to measure this workload, based on the intensity of work and time taken. It then collates this information into a report that can be used by the practitioner and managers to plan the allocation of resources to effectively meet the service or health board’s priorities and to identify any risks that may exist in the service.

It is important to remember the report is only one part of the triangulation approach to workload planning and should be considered in conjunction with:

- Funded establishment
- The findings from the Professional Judgement tool
- Quality indicators and local context

This document will provide detailed information from how to log in to how to finalise and submit data. It will not provide information about the methodologies used to develop the tool or how best to use the reports obtained from the tool. That information can be accessed via the learning resources available on the HSP (programme previously known as NMWWPP) webpages:

http://www.isdscotland.org/Health-Topics/Workforce/Nursing-and-Midwifery/NMWWP/

1.2 Background

Nursing & Midwifery workload tools are an essential part of the Health and Care (Staffing) Act 2019 aimed at ensuring health & social care staffing is at the level required to deliver safe, quality focused care to people using the services. The tools are designed to give staff the platform on which to record information about the actual work they do. This is to collate the activities in a manner that supports decisions about staffing, resource allocation and service design as part of a triangulated process of planning.

1 Please note, the CN tool should be completed in conjunction with a Professional Judgement Tool and Quality Tool. Each of these tools can be accessed in the same way as detailed below, however please refer to each tools individual user guides for direction about how and when to complete.
To find out more about this, please refer to the HSP website and learning resources: https://www.isdscotland.org/Health-Topics/Workforce/Nursing-and-Midwifery/NMWWP

The political commitment in Scotland is that, through application of a common staffing method (Figure 1) health services will be staffed to the level required to provide safe, high quality care. To ensure this, each NHS Scotland Board and the services therein, are responsible for having effective planning processes, informed by the activities captured through the mandated use of workload tools. The CN tool is one of national workload tools available for this purpose.

**Figure 1 – The common staffing method**

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2 The Professional Judgement tool (and all other tools) can be accessed in the same way as detailed below. However please refer to each tools’ individual user guides for direction about how and when to complete.
2. Logging In

2.1 Accessing the tools

To gain access to the workload planning tool you will require access to the local SSTSS platform. Please speak to your line manager about local processes to obtain this.

Once you have been issued with your username and password (via your local SSTSS manager) you should use the link provided to go to the login page.

⚠️ The tools should be accessed via Internet Explorer 11 or Internet Explorer 8. Firefox, Google Chrome or any other browsers are not supported and should not be used.

Enter your username and password as they were provided to you and select ‘Login’:

Passwords are case-sensitive and you will be prompted to change your password the first time you log in.
Click ‘Confirm’ to proceed:

And then select ‘SSTS’:

2.2 **Screen Display Issues**

Some boards have reported issues with the workload tool screens not displaying correctly, for example save buttons being hidden or data entry boxes being misaligned. This is due to compatibility issues following an SSTS update. If you experience display problems, you should first check that you are using either Internet Explorer 8 or Internet Explorer 11. If you are still having problems, please contact your local SSTS Manager, who can advise on local settings and solutions.

Firefox, Google Chrome or any browsers apart from Internet Explorer 8 or 11 are not supported and should not be used.
2.3 Changing Working Location

Once you have logged in to the tool you will be presented with the following screen:

Check the Current Location at the top of the screen.
If this is incorrect, select ‘My Account’ and then ‘Change Working Location’:

A screen will then appear containing the ward and clinical areas you have access to:

The ward/area can be searched for by roster location, staff bank, local area or employer.
To choose a ward/area of interest, select it from the available list and then click ‘Select’:
The below screen will then appear, select ‘OK’ to proceed:

The location will then update on the toolbar:
3. Creating/Editing Entries in Tool

3.1 Opening the tool

To open the Community Nursing Workload tool, select ‘Workload Tools’ and then ‘Community Nursing’:

A screen similar to the below will then appear:
3.2 Entering Data

To add data simply select the date of interest:

And the below screen will appear:

This screen will have all the details as contained within the SSTS system. User's can update certain details within this section at anytime.

Your SSTS manager will have helped to set this up.

Once details have been changed the user should click on the Save button. When the user visits this screen in the future, the updated details will be shown.
The daily working start/end time can be completed by entering the relevant times for the given shift:

<table>
<thead>
<tr>
<th>Work Day Start Time:</th>
<th>08:30</th>
<th>Clear</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work Day End Time:</td>
<td>16:30</td>
<td>Clear</td>
</tr>
</tbody>
</table>

To clear the times simply click on the Clear button.

The hours recorded in this section should be the ACTUAL start time and end time of work. If a user worked more / less than their core hours e.g. normal working hours 08.30 to 16.30 but they worked 08:30 to 18:00, then end time should be updated to 18:00 to reflect this.

### 3.2.1 Additional Time

Work day start time and end time capture the actual hours worked (contracted hours are already recorded).

The additional time field should **only** be used when you have returned to or come early to work for a planned activity e.g. you have returned to work for an evening support group / called out / telephone calls.

In these circumstances the user can tick the additional time box and then enter the ‘**Additional Start Time**’ and ‘**Additional End Time**’:

<table>
<thead>
<tr>
<th>Additional Start Time:</th>
<th>Clear</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional End Time:</td>
<td>Clear</td>
</tr>
</tbody>
</table>

Once the user has selected the Save button a message will appear highlighting the save has been successful. Click ‘**OK**’ to move on:
Selecting Exit will take the user back to the initial screen where they can access dates previously entered OR select a new workload date.
4. Adding a Direct Intervention

To add a ‘Direct Intervention’ the user should select from the tab at the top of the screen. Once selected the below screen will appear:

The Direct Intervention screen, shown above, will initially contain no details when the user accesses this screen for the selected date for the first time. Therefore, to add a direct intervention, the user should select ‘Add Direct Intervention’. The below screen will then appear:
The screen is set up ready to record both ‘Face to Face’ and ‘Non Face to Face’ contact. If the user clicks the ‘No Face to Face Contact’ option, then all details in this section will be greyed out:

This option should be selected when no “face to face contact” for the relevant patient took place.

Similarly, if the user selects the ‘No Non Face to Face Contact’ option then all details will be greyed out:

This option should be selected when no “non face to face contact” for the relevant patient took place.

If both ‘face to face’ and ‘non face to face’ contact has taken place, no box should be ticked. Information about what is referred to as face to face and non face to face activities can be located by clicking the information icon on the tool.

The recording of telephone calls with patients, parents/carers as face to face contact has been a recent update and the information icons within the tool will not reflect this change. All calls directly with the patient, parent or carer should be recorded as face to face contact. All other calls should remain as non-face to face contact.

For ease, users should consider face to face contact as when they are directly communicating with a child or family member and non face to face when a child or their family member is not present e.g. when they are record keeping or speaking with another professional about the child’s care etc.
The ‘Duration’ default will be shown as ‘Not Set’:

![Duration drop-down menu with 'Not Set']

If '90 + mins' is selected from the duration drop down, the exact number of mins should be entered in the ‘Exact minutes if 90 or over’ text box:

![Duration drop-down menu with '90 + mins' selected]

By clicking on the blue information icon a popup window will appear providing guidance:

![Face to Face Contact Choice]

This is particularly helpful if the user wants to access examples associated with the levels of intervention.

Location refers to the location of where the direct intervention took place. Within ‘Location’ the following options are available: *Care Home, Health Centre, Patient/Client’s Home, Residential Home, School and Other*. If ‘Other’ within ‘Location’ is selected, then the user should enter relevant details in to the “Other” free text box to better define the location:

![Location drop-down menu with 'Other' selected]

This option should be selected when no “non face to face contact” for the relevant patient took place.

If you have had direct telephone contact with a child, young person or direct carer, you should record this as a face to face contact. The location should be recorded by selecting ‘other’ and inserting ‘telephone’ in the box provided.

There are three options once the user has entered information for the direct intervention:

- Click **Save** to save the information and return to the Direct Interventions Summary screen (see screen below).
Click **Save and add another** to save the information and be presented with a blank "Direct Intervention" screen to enter the next direct intervention.

Clicking **Cancel** will **NOT** save any information that is on the ‘Direct Intervention’ screen and will return the user to the summary screen.

Once Direct Interventions have been added the screen will look like that shown below:

Within the above screen the user can access those patients that have already been entered for the given date.

Select **Edit** to edit previously entered patients for the related ‘Face to Face’ or ‘Non Face to Face’ contact.

The **Delete** button will delete the relevant record and the following message will appear:

The user should select **Yes** if they want to delete the record and **No** to abandon the action.

As more interventions are added, they will be shown on the above screen.

Selecting **Exit** on the screen will take the user back to the initial screen where they can access records previously entered or a new workload date.
5. **Clinics**

To add a clinic the user should select **Clinic/Sessions/ Drop in** from the tab at the top of the screen.

The clinics/session tab should be used for times when no direct intervention of varying level is undertaken with a child or family member. An example would be a general education session regarding a specific condition.

Once selected the below screen will appear:

![Clinic屏幕](image)

The Clinics screen, shown above, will initially contain no details when the user accesses this date and screen for the first time.

Therefore to add a clinic; users should select **Add Clinic/Sessions/ Drop in**. The following screen will appear:

![Clinic屏幕](image)
Within the ‘Type’ menu the following options are available:

![Type menu]

Users can enter:

- **Clinic Description** – details of the clinic that took place
- **Start / End Time** - the start and end time of the clinic
- **Number of Patients/clients/child/young person** - the number of patients/clients/children/young persons who attended the clinic

When selecting a clinic, each member of staff involved in the clinic will record his/her own individual workload activity in their own record.

There are three options once the user has entered information for the clinic:

- **Save** - To save the information and return to the Clinic Summary screen (see screen below).
- **Save and add another** - To save the information and be presented with a blank screen to enter the next clinic.
- **Cancel** - will NOT save any information that is on the ‘Clinics’ screen and will return the user to the summary screen.

Once Clinics have been added the screen will look like that shown below.

![Clinic summary screen]

Within the above screen the user can access those patients that have already been entered for the given date.

Select **Edit** to edit previously entered patients for the related ‘Clinic’.

The **Delete** button will delete the relevant record and the following message will appear:
The user should select **Yes** if they want to delete the record and **No** to abandon the action.

As more clinics are added, they will be shown on the above screen.

Selecting **Exit** on the above screen will take the user back to the initial screen where they can access dates previously entered OR a new workload date.
6. **Associated Workload and Travel**

6.1 **Associated Workload**

To add ‘Associated Workload’ the user should select from the tab at the top of the screen.

Once selected the below screen will appear:

![Associated Workload Screen](image)

Associated Workload should be entered for the whole shift and not per patient.

These sections appear as above and are made up of drop-down boxes and text boxes:
If the user selects 90+ minutes from the drop-down they should fill in the exact number of minutes in the text box next to the drop down:

| 90 + mins | Exact minutes if 90 mins or over |

Clicking on the blue information icon provides guidance on that section.

There are two options once the user has entered information for the clinic:

- Click the **Save** button to save the information on this screen where the following message will appear “Successfully saved Associated Workload Details”.
- Selecting the **Exit** button on the above screen will take the user back to the initial screen where they can access dates previously entered OR a new workload date.

### 6.2 Travel

To add travel the user should select from the tab at the top of the screen.

Once selected the below screen will appear:

Travel should be entered for the **WHOLE** shift and not per patient. Time should be entered in minutes.
‘Travel Miles’ should be rounded to the nearest mile.

All relevant “Modes” of travel should be selected from walking to car etc, note it is possible to select multiple options.

There are two options once the user has entered information for travel:

- Click `Save` to save the information on this screen where the following message will appear “Successfully saved Travel Details”.

- Selecting `Exit` on the above screen will take the user back to the initial screen where they can access dates previously entered OR a new workload date.
7. Exceptions

To add “Exceptions” the user should select the **Exceptions** tab from the top of the screen.

Once selected the below screen will appear:

The Exceptions screen, shown above, will initially contain no details.

To add an Exception, the user should select **Add Exception** and the below screen will appear:

The Unique identifier box is a mandatory field and requires completion.

⚠️ When entering non patient related exceptions, “N/A” should be entered into the Unique Identifier box.
A list of pre-defined “Reasons” relating to exceptions is already available within the “Reasons” drop down menu:

![Reasons Drop Down Menu](image)

The number of staff relates to the total number of staff associated with the detailed exception.

There are three options once the user has entered information for the exception:

- Click **Save** to save the information and return to the ‘Exceptions’ screen.
- Click **Save and add another** to save the information and be presented with a blank ‘Exceptions’ screen to enter the next exception.
- Clicking **Cancel** will not save any information that is on the ‘Exceptions’ screen and will return the user to the summary screen.

Once exceptions have been added the screen will look like that shown below:

![Exception Screen](image)

By clicking on the blue information icon you will get a popup window showing the guidance for exception reporting.

Within the above screen the user can access those exceptions that have already been entered for the given date.

Select **Edit** to edit a previously entered ‘Exception’.

The **Delete** button will delete the relevant exception and the following message will appear:
The user should select **Yes** if they want to delete the record and **No** to abandon the action.

As more exceptions are added they will be shown on the above screen.

Selecting **Exit** on the above screen will take the user back to the initial screen where they can access dates previously entered OR a new workload date.
8. Summary

The summary screen enables users to check the workload time of the data they entered, compare this against their actual working hours (recorded in the ‘Workload Details’ tab) and record how much time they spent completing the workload that day.

To access the ‘Summary’ screen select from the tab at the top of the screen.

Time taken to complete the workload tool should always be recorded here and not in the ‘Associated Workload’ tab.

![Summary Screen](image-url)
9. Business Objects

After CN data entry into SSTS is complete, please use one of the Professional Judgement standard reports developed in Business Objects (BOXI) to view and extract information for a selected period of time.

These reports were created by the national team and have a series of built-in prompts to generate customised outputs locally, for example:

<table>
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<tr>
<th>Prompts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reply to prompts before running the query.</td>
</tr>
<tr>
<td>Select START DATE:</td>
</tr>
<tr>
<td>Select END DATE:</td>
</tr>
<tr>
<td>Select EMPLOYER:</td>
</tr>
<tr>
<td>Select SPECIALTY:</td>
</tr>
</tbody>
</table>

Access to BOXI reports requires a login and password, which can be granted by your local SSTS Manager.

⚠️ You will require your Line Manager’s permission and authorisation before contacting your local SSTS Manager.
10. Frequently asked questions and answers

Q1 How often should the CN tool be completed?
The programme recommendation is that the tool should be completed for a minimum of two consecutive weeks once a year.
However, the tool can be used as often as an individual/team or health board wish.
The national team would recommend checking with your local workforce team for detail about when the tool has been scheduled for the local area.

Q2 How many days/weeks should the tool run for?
It is recommended to run the tool for at least two consecutive weeks.

Q3 How is the tool accessed?
The Community Nursing tool is accessed via the SSTS platform. Local processes about gaining access to the platform will be in place in every board. A common process adopted is that access permission is given by the local SSTS team on receipt of a line manager authorisation form. After they receive this you will be issued with a username and password. Follow the directions in Section 2.1 of this user guide to access the tool once your username and password is in place.
Occasionally screen issues arise with the tool on local board systems. If this happens, please refer to Section 2.2 of the user guide or contact your local IT team for assistance.

Q4 Should other tools be completed at the same time as the Community Nursing tool?
Yes. The Community Nursing tool has been designed for use in conjunction with the Quality Tool and the Professional Judgement Tool as detailed below. Like the CN tool, both of these tools can be accessed via the SSTS platform. User guides on how to input data is available for each tool. Please refer to this during the run.
The Professional Judgement tool is completed for two full weeks during the run of the CN tool. The tool is set up to record data for two weeks. It is recommended that the two weeks begin on a Monday.
One tool is normally completed by a team leader or designated person on behalf of the team. Local arrangements should be established so information from the whole team is collated to inform completion of the Professional Judgement tool.
The Quality Tool is completed weekly during the run. It is recommended that one tool per week is completed by the team leader or designated person on behalf of the team during the month run. For example, at the end of a two week run, approximately two quality tools would be completed. Local arrangements should be established so information from the whole team is collated to inform completion of the Quality Tool.
Q5 How does the tool work?
The tool is designed so community nurses can record the overall time they have worked; the time they have taken with work activities; and the level of complexity each activity is categorised as. Guidance about the level of complexity can be accessed by clicking on the information icon in the tool.

The activities are recorded under several headings which include: direct interventions, clinics/sessions/drop-in, associated workload, travel and exceptions. The tool collates this data in a report for use to inform local planning processes. This report is accessed via Business Objects (BOXI)

Q6 What if the hours I have worked vary, how do I record this?
The top section of the tools front page is pre populated with each individual staff members contracted hours. When first using the tool, check that this information is correct.

As detailed in Section 3.2 of this user guide, it is recognised that on occasion staff work varying hours on a daily bases. Therefore there is a section lower on the tools front page that allows you to record your ACTUAL start and end time of a rostered shift.

The normal default for the tool is that the core shift hours are 7.5 hours per day which excludes a 30 minute break. For the purpose of this example we will consider the core hours as 08.30 – 16.30 hours = 8 hours. If you have managed to work your core hours, you would record these and the tool will take 30 minutes off for breaks automatically, recording 7.5 hours. The start and finish times in services will be different and can be changed to whatever you work.

It is known that some services operate a shift pattern of 7.5 hours but the hours worked are 08.30 – 17.00 with a one hour break. As the break period is automatically set as 30 minutes, it is recommended that you adjust your actual work time by 30 minutes so the shift is still recorded as 7.5 hours. In this example you would adjust your hours to 08.30 – 16.30.

If your work hours are under or over your core hours you would use the actual hours worked section to record the different shift pattern of the day. For example, if due to your workload you were required to work 9 hours (excluding breaks) from 08.30 – 18.00 hours then this is the hours you would record.

Another example is if you had reduced hours one day due to annual leave or arranged time off in lieu. Here you would record the actual hours worked maybe as 08.30 – 12.30 hours to reflect this reduction in time.

It is important that the actual time worked is changed on this front page so the activity times recorded on the tool are similar. If not changed, the final report will record that you have inserted either additional or less activity time than the recorded hours worked e.g. you recorded 9 hours of activity but only recorded a core 7.5 shift pattern on the front page. The report would highlight longer activity time than hours worked and the data may not appear accurate.

Please note, changing the tool to record your actual hours worked WILL NOT change your contracted hours or notify HR/Payroll departments.

Normal local processes should be followed to notify managers or payroll about any changes in work pattern.
Q7 When would I tick the ‘additional time’ box on the front page?

The additional time box on the front page is only ticked if you have left work and have returned to carry out planned work. An example of this would be if you left work at 16.30 and returned to carry out a scheduled health education session from 19.00 – 21.00 hours. Another example is if you had a scheduled telephone clinic in the evening from 18.00 – 19.00 hours. Even if this took place at home, this would be categorised as you leaving and returning to work for additional time to carry out a work activity.

On ticking the additional time box, start and end times will appear. Here you would record the actual start and finish time of the additional time worked.

If the work activity was not planned and was a result of working longer hours to meet your caseload requirement, please refer to Q5 for guidance.

Q8 What type of work is recorded in the direct interventions tab?

The direct interventions tab is used to record work activities relating to a specific child or young person using the services or aligned to your caseload. To record this data you would first start by inputting in the persons unique identifier. This is normally the CHI. If the CHI is not available, initials and date of birth can be used but the CHI is preferable.

The direct interventions tab is separated into two sections.

- The one on the left hand side of the screen as you face it is used to record ‘face to face’ contact.
- The one on the right hand side of the screen as you face it is used to record ‘non face to face’ contact.

For guidance about what to record on each section, the information icon can be selected.

The recording of telephone calls with patients, parents/carers as face to face contact has been a recent update and the information icons within the tool will not reflect this change. All calls directly with the patient, parent or carer should be recorded as face to face contact. All other calls should remain as non-face to face contact.

Below are some general principles and examples about what can be recorded.

**Face to Face**

To record items in this section, you would leave the box at the top of the section un-ticked. The box at the top is only ticked if you have not had direct contact with a child, young person or direct carer.

To determine whether it is face to face, the basic question to ask yourself for this section of the tool is - have you directly communicated or interacted with a child, young person or direct carer? If the answer is yes, then you would record this in the face to face section.

The location recorded as where the child, young person or direct carer is during the time of contact e.g. home, clinic, education establishment i.e. nursery/school.

If you have had direct telephone contact with a child, young person or direct carer, you can record this as a face to face contact. The location would be recorded by selecting ‘other’ and inserting ‘telephone’ in the box provided.
Communicating with the child, young person or direct carer via text or email is **NOT** recorded as face to face contact. This would instead be recorded in ‘non face to face’.

**Non Face to Face**

To record items in this section, you would leave the box at the top of the section un-ticked. The box at the top is only ticked if you have not undertaken any activities relating to a child or young person without direct communication with them.

To determine whether it is ‘non face to face’, the basic question to ask yourself for this section of the tool is - have you directly communicated about or undertook an activity relating to a child or young person but without them present? If the answer is yes, then you would record this in the face to face section.

General examples for this are:

- Recording interactions that have taken place with the child, young person or direct carer (basic record keeping in line with NMC and organisational guidelines)
- Communicating with other professionals about the child or young person, sending texts or emails to the child, young person or direct carer or other professionals.

You would also record here any teaching that you carry out about the specific child or young person’s condition or needs with school personnel, as an example.

When selecting a location at this point, it is where you are during the non face to face activity e.g. office, school, car.

**Please note that due to the age of children or the cognitive capacity of some young people engaged with the CN team, it is necessary to consider the direct carer when thinking about face to face and non face to face contact.** To clarify, the term direct carer is being used to refer to those with responsibility for the child when in their care which could include parents and guardians, carers in school setting or residential care including respite, hospice etc.

**Q9 When would I use the clinic/session/drop in tab?**

This tab would only be used when the clinic/session/drop has been routine. This means that each person receives the same service with the same level of intervention. If so then the start and end time of the session and number of people attending would be recorded. An example could be a phlebotomy session.

If the clinic was focused on delivering one to one interventions of varying complexity and for varying time periods, then it is recommended that the direct intervention tab would be used. Here the ‘face to face’ and ‘non face to face’ sections would be used as directed in Q7 above and [Section 4](#) of this user guide.

**Q10 When will I use the associated workload tab?**

When designing the tool, community nurse practitioners recognised that to meet the professional requirements of their role, they were often asked to undertake some general activities. Dependent on their role and level of responsibility it was acknowledged that this would vary per day. Therefore the associated workload tab was created to enable practitioners to record some additional activities, including such things as general teaching of students and other professionals, team meetings, general admin e.g. emails and stock orders etc.
Guidelines for what can be included here can be accessed by clicking on the information icons at each section in the tool.

It is important that any admin, ordering or emailing that directly relates to a child or young person is recorded in the direct intervention tab in the ‘non face to face’ section. The admin section in the associated workload tab is for general administration only.

Please note, in the personal development section of this tab learning and education can be recorded. This is referring to educational sessions that happen during the time you are on shift e.g. taking 2 hours from patient facing contact to attend a face to face or complete an online learning session.

Full day learning sessions are NOT recorded in this section. Full day learning activities are already considered as part of a predicted absence allowance built into the tool calculator. Only learning activities that influence a rostered patient facing shift should be recorded.

**Q11 What is viewed as an exception?**

The exception tab is used to record data about a rare event that has happened during a shift that has interfered or impacted on the normal duties of the individual or service. Examples are fire evacuation or unplanned ward cover.

Situations involving unplanned sick leave, annual leave or unplanned complex work is not viewed as exceptional. Complex work situations involving people would be recorded in the direct intervention tab. If the service has been impacted significantly by leave, this would be recorded on the quality tool and/or professional judgement tool.

**Q12 What travel should I record?**

The travel tab gives you the opportunity to record the collective amount of travel you have undertaken in one day in time (minutes) and distance (miles). Recording travel would commence from leaving your office/base. Each mode of travel taken over the day should be selected e.g. walking to travelling via car or public transport.

**Q12 Should senior students and bank/agency staff record their work activities?**

Ideally yes they would. If staff are working regularly with the team during the run and have responsibility to carry out activities, then they should be issued with a username and password. Local processes would be followed as guided by Q3. Giving tool access to all staff will enable the community nursing team to record the full team activity for planning and resource allocation purposes.

Some staff members may have two roles in a health board. If this is the case, they may need two usernames for the SSTS platform to complete tools for each job. Please consult your SSTS lead for advice and support with this.

**Q13 Where can I get support when completing this tool?**

Information about tool completion can be obtained on the SSTS platform and by clicking on the information icons positioned throughout the tool. Further details on how to complete the tool can be found within our video demonstration, accessed by clicking here.

If additional support is required, please contact your local workforce lead.