Royal Cornwall Hospitals
NHS Trust

Dermatology Skin Cancer Clinical Nurse Specialist Nurse-Led Clinics Protocol

V2.0

July 2024

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The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

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1. Introduction

1.1. On 21st May 2020 a new nursing role was established within the Dermatology Unit at Royal Cornwall Hospital for the assessment and management of patients being referred into the Dermatology service for skin lesions. The role title is Dermatology Skin Cancer Clinical Nurse Specialist (CNS). The role also includes review and management of specific patients for the purpose of follow up and surveillance.

1.2. Non-melanoma skin cancer is the most common type of cancer in the UK, with 147,000 people being diagnosed in the UK each year (CRUK, 2019). Melanoma incidence in Britain has risen sharply in recent decades, rising faster than any other of the top 10 cancers (CRUK, 2018). Melanoma is now the fifth most common cancer in the UK with approximately 15,400 people diagnosed each year. Rates of melanoma within the southwest are 41% higher than the rest of the UK for the male population and 27% higher in females (CRUK, 2018 and ONS, 2019). Skin cancer rates rose faster than any of the other top ten cancers in 2011. These rates are forecast to rise by over 50% by 2030 which will put significant pressure on skin cancer services (ONS, 2019 and Melanoma Taskforce 2018).

1.3. According to the Melanoma Taskforce (2018) there is lack of clarity over the role of the Skin Cancer Clinical Nurse Specialist, as they tend to fulfil many roles across the pathway.

1.4. The Clinical Nurse Specialist (CNS) role is constantly being developed to fit in with the needs of the patient as well as the organisation (Bousfield, 1997). The UKCC (1992) stressed that these roles should be developed to improve the “nursing care” of the client group in question and not simply to fill a shortfall in medical services by undertaking some of the tasks of junior doctors, however in reality the clinical nurse specialist does need to bridge this gap to ensure that patients do receive timely, equitable and ultimately good quality care. With expert skills and knowledge in this area the CNS is well placed to deliver this care as an integral part of the multi-disciplinary team (MDT) (Department of Health, 2010). The Improving Outcomes Guidance (IOG) for people with Skin Tumours including Melanoma (NICE 2006) concurred that observational studies of the skin cancer surveillance role of appropriately trained nurses demonstrate high recognition rates for suspicious skin lesions. The CNS should value and promote advanced nursing practice driven by patient need for care that doctors are unable to provide (Rolfe, 2014).

1.5. Benefits to the patients

- Patients receive timely assessment, treatment, and continuity of care.
- Reduction in waiting times for consultant clinics enabling more new patients to be seen.
- More timely symptoms assessment and management, aided by non-medical prescribing.
- Timelier referral for appropriate investigations, aided by non-medical imaging referral protocol.

1.6. This version supersedes any previous versions of this document.

2. Purpose of this Standard Operating Procedure

This document is to support the clinics undertaken by the post holder in terms of best practice and to ensure good clinical governance in line with consultant led skin lesion/surveillance clinics.

3. Ownership and Responsibilities

3.1. Regarding CNS led clinics the Associate Specialist and Consultant Dermatologists are responsible for:

- Supervising the clinical practice of the Dermatology Skin Cancer Clinical Nurse Specialist within the agreed parameters as indicated within the individual's development plan.

- Holding overall responsibility for imaging/investigations requested in their name.

3.2. Role of Individual CNS

All CNSs are responsible for:

3.2.1. A registered nurse is bound by a code of professional conduct (Nursing and Midwifery Council, 2020).

3.2.2. The CNS will be able to take a relevant history and undertake a thorough clinical assessment to develop a management plan and evaluate the progress of that plan within the limitations of their knowledge and skills while being supported by medical and other members of the multi-disciplinary team. They will demonstrate clinical judgement and critical decision-making skills based upon established guidelines.

3.2.3. The CNS who is legally permitted and qualified to prescribe takes the responsibility for the clinical assessment of the patient, establishing a diagnosis and the clinical management required, as well as the responsibility for prescribing, and the appropriateness of that prescribing (Nursing and Midwifery Council, 2006). The CNS should also adhere to regulations issued by their employers regarding legal and ethical issues for practice.

3.2.4. The CNS will work under the supervision of the Associate Specialist and Consultant Dermatologists and have a named clinical supervisor.

4. Standards and Practice

4.1. Nurse-Led Clinics

As part of the multi-disciplinary team, and under the supervision of Associate Specialist and Consultant Dermatologists, the Dermatology Skin Cancer Clinical

Nurse Specialist will utilise their specialist knowledge and skills to see and manage a cohort of new and follow up patients. They will:

4.1.1. Assess, diagnose, plan, implement and evaluate treatments and interventions for patients with skin lesions, within the parameters of local protocols.

4.1.2. Under-take relevant clinical examination including dermoscopy, as indicated by the patient's condition; analysing clinical signs and investigating results to support diagnosis and initiating treatment as required.

4.1.3. Obtain consent for and perform clinical interventions against specialty protocol, including punch biopsy, curettage and cautery and shave excision, after an appropriate period of training as per department policy.

4.1.4. Request investigations such as blood, urine and other laboratory tests, ultrasound, CT and MRI scans and x-rays in accordance with IR(ME)R regulations and as local policy allows.

4.1.5. To undertake the role of Independent Nurse Prescriber within the clinical setting of Dermatology and Oncology and in line with Trust policy/national guidance.

4.1.6. Integrate both pharmacological and non-pharmacological treatment in patient care/management plans.

4.1.7. Produce accurate and complete documentation and patient records consistent with legislation, policies, and procedures.

4.1.8. Receive, process, and communicate highly complex information requiring persuasive, motivational, reassuring, and empathetic communication skills to maximise co-operation with care and treatment programmes, often about complex, sensitive and potentially distressing information, including cancer diagnosis.

4.1.9. Anticipate barriers to communication and establish methods of overcoming these, ensuring patients and significant others are kept fully informed and consent to treatment is maintained.

4.1.10. Act as a resource for staff advising on local, Trust and national policy, procedures and guidelines ensuring patient safety and clinical governance.

4.1.11. Understand and apply the legal safeguarding framework that supports the identification of vulnerable and abused adults/children and be aware of statutory vulnerable patients' health procedures and Trust guidance. Ensure appropriate referral if required.

4.1.12. Work autonomously within local and national policies and codes of conduct. Independently plan and prioritise own workload, liaising with relevant multi-disciplinary team members within the Trust and wider health community.

4.1.13. Autonomously assess patients; receive and make referrals; assess, order, interpret and act upon investigative tests; support diagnosis; evaluate, treat, plan, refer and discharge patients within the Trust.

4.1.14. Recognise and work within own competence and professional code of conduct as regulated by the Nursing and Midwifery Council (NMC, 2020).

4.2. Patient Criteria

Inclusion - The skin cancer nursing team will see the following patients:

4.3. New referred '2 week wait' skin lesion patients.

4.3.1. New referred 'urgent' skin lesion patients.

4.3.2. New referred 'routine' skin lesion patients.

4.3.3. Any newly organ transplant patient on immunosuppression for education and skin review.

4.3.4. All skin cancer patients in active surveillance under the care of the Dermatology speciality, regardless of stage of cancer, for routine follow up.

4.3.5. Exclusion:

4.3.6. Patients under 16 years of age.

4.4. Frequency of Nurse-Led Follow-Up Care

4.4.1. Newly referred lesion clinics will be held on weeks days with a supervisor identified per session.

4.4.2. Organ transplant education clinics will take place quarterly, as needed.

4.4.3. Surveillance process will be governed by local and national guidelines (BAD, 2010; NICE, 2015; RCHT, 2020).

4.4.4. Clinics will be weekly.

4.5. Acquiring and Maintaining Competency

4.5.1. The Clinical Nurse Specialist should have or be working towards a degree and be a highly experienced nurse who uses specialist knowledge and skills to support diagnosis and treatment of patients referred with skin cancer.

4.5.2. Recommended training and competency:

4.5.3. Dermoscopy course.

4.5.4. Non-medical prescribers' qualification.

4.5.5. Radiation Protection - Referrer Training.

4.5.6. MRI safety training.

4.5.7. Highly specialised knowledge and skills/university qualification in dermatology and skin cancer.

4.5.8. Clinical leadership experience.

4.6. Theoretical Understanding

It is important that the skin cancer nurse has sound theoretical knowledge to ensure practice is evidence based. As with all clinical practice the practitioner needs to update this knowledge by attending relevant conferences, meetings and reviewing research articles. Evidence of continuing professional development within this area should be available within their practice portfolio.

4.7. Clinical Skills

(Further definitions can be found in appendix 3).

The following competencies are essential and should be achieved by the Clinical Nurse Specialist (CNS) prior to undertaking nurse-led clinics.

4.7.1. Examination of the skin – to detect recurrent or possible new malignant lesions.

4.7.2. Recognition of the following skin lesions: Benign pigmented naevi, atypical naevi, basal cell papilloma, angioma/vascular lesions, chondrodermatitis, basal cell carcinoma, dermatofibroma, actinic keratosis, squamous cell carcinoma, Bowens disease/intraepithelial carcinoma, keratoacanthoma, melanoma: nodular/ superficial – spreading/acral lentiginous/lentigo maligna.

4.7.3. An understanding of the principles and use of the dermatoscope – including recognition of features that might indicate a diagnosis of skin cancer.

4.7.4. Checking of lymph nodes for signs of recurrent/metastatic disease.

4.7.5. Aetiology, epidemiology, treatment, and prevention of skin cancer.

4.7.6. Communication skills.

4.7.7. Record keeping/documentation.

4.7.8. Cancer Immunotherapy/chemotherapy/biologics management and drug monitoring.

4.7.9. Symptoms and side effect management.

4.8. **Competency Assessment**

4.8.1. The CNS should work under the supervision of the Associate Specialist and Consultant Dermatologists and have a named clinical supervisor.

4.8.2. The CNS and supervisor should have a robust assessment and development process that is embedded in clinical practice and encompasses theoretical and practical competencies.

4.8.3. Competency should be reviewed annually via audit.

4.9. **Record Keeping/ Documentation**

The Code (NMC, 2015) highlights the importance of accurate, timely and appropriate documentation and recordkeeping. The purpose of accurate records is to provide current, comprehensive, and concise information concerning the condition and care of the patient or client and associated observations. Records support standard setting, quality assessment and audit and provide a baseline against which improvement or deterioration may be judged. The following should be documented:

4.9.1. Any problems that arise and the action taken in response to them.

4.9.2. Evidence of care required intervention by the practitioner and patient response.

4.9.3. Any factors physical, psychological, or social that appear to affect the patient.

4.9.4. A record of the chronology of events and the reasons for any decisions made.

4.9.5. Any records should be signed and dated by the practitioner.

4.10. **Monitoring and *A*udit**

The CNS will be responsible for monitoring clinical practice and performance. This will be undertaken using an agreed development plan and practice logbook which will be regularly reviewed at specified intervals with the supervisor. Annual performance audits will be presented at appropriate departmental/speciality meetings.

5. Dissemination and Implementation

This document will be disseminated to all relevant Dermatology Staff and will be stored in Department Guidelines in the Dermatology shared folder. It will also be available in the RCHT Document Library.

6. Monitoring Compliance and Effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Performance.
Lead	Clinical Supervisor.
Tool	Annual performance audits on a word or Excel template.
Frequency	Annually.
Reporting arrangements	The annual performance audit will be presented at the appropriate departmental and specialty meetings.
Acting on recommendations and Lead(s)	Any recommendations or actions will have an action owner identified at the departmental or specialty meeting.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned as needed guided by the action importance level. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

7. Updating and Review

This document will be reviewed no less than every three years but sooner if any amendments to the standard operating procedure of the CNS led clinics are needed.

8. Equality and Diversity

8.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

8.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Dermatology Skin Cancer Clinical Nurse Specialist Nurse Led Clinics Protocol V2.0.
This document replaces (exact title of previous version):	Dermatology Skin Cancer Clinical Nurse Specialist Nurse Led Clinics Protocol V1.0.
Date Issued/Approved:	12 February 2024.
Date Valid From:	July 2024.
Date Valid To:	July 2027.
Author/Owner:	Sarah Carswell, Dermatology Skin Cancer, Clinical, Nurse Specialist.
Contact details:	01872 252481
Brief summary of contents:	Procedure for Skin Cancer Clinical Nurse Specialist nurse led clinics.
Suggested Keywords:	Nurse led clinics, skin cancer.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer.
Approval route for consultation and ratification:	Dermatology Business and Governance Meeting.
Manager confirming approval processes:	Roz Davies.
Name of Governance Lead confirming consultation and ratification:	Maria Lane.
Links to key external standards:	None required.
Related Documents:	Please see the reference/reading section in appendix 3.
Training Need Identified:	No.

Information Category	Detailed Information
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet.
Document Library Folder/Sub Folder:	Clinical/Dermatology.

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
June 202	V1.0.	Version 1.0.	Sarah Carswell, Dermatology Skin Cancer Clinical Nurse Specialist.
July 2024	V2.0.	References and links to relevant policies updated.	Sarah Carswell, Dermatology Skin Cancer Clinical Nurse Specialist.

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team. rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy/policy/proposal/service function to be assessed:	Dermatology Skin Cancer Clinical Nurse Specialist Nurse-Led Clinics Standard Operating Procedure V2.0.
Department and Service Area:	Specialist Services and Surgery (SSS).
Is this a new or existing document?	Existing.
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Sarah Carswell, Dermatology Skin Cancer Clinical Nurse Specialist.
Contact details:	01872 252481.

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	Clinical Nurse Specialists who carry out Dermatology Skin Cancer nurse led clinics.
2. Policy Objectives	This document is to support the clinics undertaken by the post holder in terms of best practice and to ensure good clinical governance in line with consultant led skin lesion/surveillance clinics.
3. Policy Intended Outcomes	• Patients receive timely assessment, treatment, and continuity of care. • Reduction in waiting times for consultant clinics enabling more new patients to be seen. • More timely symptoms assessment and management, aided by non-medical prescribing. • Timelier referral for appropriate investigations, aided by non-medical imaging referral protocol.

Information Category	Detailed Information
4. How will you measure each outcome?	Annual performance audit.
5. Who is intended to benefit from the policy?	Patients.
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/visitors: No • Local groups/system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	Dermatology Business and Governance Meeting.
6c. What was the outcome of the consultation?	Approved.
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:** No

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	

Protected Characteristic	(Yes or No)	Rationale
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Sarah Carswell, Dermatology Skin Cancer Clinical Nurse Specialist.

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

Appendix 3. References/reading list

- Bousfield, C. (1997) A Phenomenological Investigation into The Role of The Clinical Nurse Specialist. Journal of Advanced Nursing. 25, pp 245–256.

- British Association of Dermatologists (2009) Multi-professional guidelines for the management of the patient with primary cutaneous squamous cell carcinoma [online]. Available from:

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- Cancer Research UK (2018) Melanoma skin cancer. [online]. London: CRUK. Available from\;

  https://www.cancerresearchuk.org/about-cancer/melanoma/about [Accessed 26 May 2020].

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- Department of Health (2010) Quality in Nursing Excellence in Cancer Care: The Contribution of the Clinical Nurse Specialist [online]. Available from:

  https://www.macmillan.org.uk/documents/aboutus/commissioners/excellenceincancercarethecontributionoftheclinicalnursespecialist.pdf [Accessed 26 May 2020].

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- Office for National Statistics (2019) Cancer Registration Statistics, England: 2017 Cancer diagnoses and age-standardised incidence rates for all types of cancer by age, sex and region including breast, prostate, lung and colorectal cancer. [online]. Newport: ONS Available from:

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- Rolfe, G. (2014) Advanced nursing practice 1: understanding advanced nursing practice. Nursing Times; 110: 27, pp. 20-23.

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  http://doclibrary-rcht-intranet.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/HealthInformatics/CorporateAndHealthRecords/PolicyToManageInformationAndRecords.pdf [Accessed 26 May 2020].

- Royal Cornwall Hospital Trust (2018b) Positive Patient Identification Policy and Procedures. [online] Cornwall: RCHT. Available from:

  http://doclibrary-rcht-intranet.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Clinical/Surgery/PositivePatientIdentificationPolicyAndProcedures.pdf [Accessed 26 May 2020].

- Royal Cornwall Hospital Trust (2019a) Clinical Imaging - non medical referrer protocol for Skin Cancer Clinical Nurse Specialists. [online] Cornwall: RCHT. Available from:

  http://doclibrary-rcht-intranet.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/Clinical/ClinicalImaging/ClinicalImagingReferralProtocolForSkinCancerCNSClinicalGuideline.pdf [Accessed 26 May 2020].

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- United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1992) The scope of professional practice. London:UKCC.

- United Kingdom Oncology Nursing Society (2018) Acute oncology initial management guidelines. [online] London: UKONS. Available from:

  https://www.ukons.org/resources/#1223 [Accessed 26 May 2020].

Appendix 4. Definitions

The practical procedures above will now be defined:

Examination of the skin

Examination of the skin involves visual inspection of the patient's skin aided by good light, magnifying glass and by touch to identify abnormal lesions. The examination should also include examination of the scar line for signs of recurrence. The patient should have privacy and be treated with sensitivity as this procedure necessitates them being undressed.

Recognition of Skin Lesions

Benign Pigmented Naevi

These comprise of a group of pigmented lesions made up of melanocytes (pigment cells) at the basal layer of the skin.

Atypical Naevi

These are pigmented lesions as above but tend to be > 0.5cm in diameter with variegation in pigment and/or irregular outlines. They are often multiple distinguishing them from malignant melanoma.

Basal Cell Papilloma

These are warty, waxy lesions with a characteristic ‘stuck on’ appearance, occurring commonly in the elderly. On the face they may appear flat.

Angioma/ Vascular Lesions

These comprise of a group of lesions found commonly in babies: strawberry naevus, port wine stain; in puberty and pregnancy: spider naevi; the elderly: Campbell de Morgan spots or due to trauma: pyogenic granuloma.

Chondrodermatitis Helica

A condition found on the ears, most commonly in elderly males who have worked outdoors. The lesions are scaling and inflammatory with ulceration and tethering of the epidermis to the underlying cartilage.

Dermatofibroma

These are common lesions and harmless mainly found on exposed areas of the arms and legs of women. They are thought to be the result of an insect bite. They are solitary, flesh to very dark brown in colour, smooth, round and slightly raised in appearance but may be indented and can have central scale.

Actinic Keratosis

Is an area of epidermal dysplasia giving rise to scaling on light exposed pale skin.

Keratoacanthoma

A normally self-limiting, rapidly growing, hyperkeratotic papule found mostly on sun exposed sites.

Basal Cell Carcinoma

Often called a rodent ulcer, occasionally pigmented, typically have a pearly appearance with rolled edges and form a central crust. These are the most common type of skin cancer usually found on the elderly in sun-exposed sites and rarely metastasise.

Bowens Disease

This is a superficial intra epidermal carcinoma derived from the epidermal Keratinocytes found most on the legs and is associated with a history of exposure to ultra-violet light or previous ingestion of arsenic.

Squamous Cell Carcinoma

This is a malignant skin condition derived from epidermal keratinocytes with the potential to metastasise. The lesions are found on sun-exposed parts of the body especially in the elderly, in people who are immuno-compromised, in association with chronic inflammation and after contact with tar.

Melanoma

These are malignant pigmented (although occasionally may be amelanotic) lesions arising in existing mole or de-novo and have the capacity to metastasise. There are four types of melanomas.

- Lentigo maligna melanoma typically found on sun exposed sites in the elderly and has a history of a slowly expanding in-situ or radial growth phase.

- Superficial Spreading melanoma the most common variety presenting as irregular shaped pigmented areas most often found on men's backs and women's' legs.

- Nodular Melanomas have a rapid vertical growth phase resulting in a raised nodule and may be associated with the breakdown of the overlying epidermis and ulceration.

- Acral lentiginous melanoma are found on the palms and soles of the feet and may initially present as a pigmented macular area but in time nodular areas develop in the macular area. Another type in this group is the subungual malignant melanoma presenting as a pigmented streak in the nail (although some may be amelanotic) and pigment on the nail fold proximal to the nail bed (Hutchinson's sign).

Dermatoscopy

Dermatoscopy involves the use of an incident light magnifying system to examine the pigment network of melanocytic lesions, usually with immersion oil at the skin-microscope interface. This procedure permits a detailed examination of the pigmented structures of the epidermis and dermo-epidermal junction.

Checking of lymph nodes

The draining lymph node basin should be examined when indicated at each initial and follow up visit for signs of palpable lymph nodes indicating recurrent disease e.g. if the primary melanoma is on the right leg, then the nodes in the right groin should be felt (the nodes should be felt in the left groin for comparison). If the primary lesion is on the torso it is important that to check not only the draining lymph node basin but the contra-lateral nodal basin as well (occasionally this is the draining lymph node basin). If nodes are felt then arrangements should be made for further assessment, this would usually require ultrasound guided fine needle aspiration/core biopsy to identify if malignant cells are present.

Aetiology, epidemiology, treatment, and prevention of skin cancer/melanoma

Knowledge of the cause, incidence, treatment and prevention of skin cancer is vital so that the CNS can provide the patient with health education thus facilitating early recognition of new or recurrent lesions as well as information about safe behaviour in the sun.

Communication Skills

Communication is a complex two-way process involving both verbal and nonverbal components.

Clinical Assessment Skills

The CNS should undertake and successfully complete an Advanced Assessment Skills Course. The course will provide baseline practical and theoretical knowledge and skills with regards to detecting the normal from the abnormal. Completion of the above course provides evidence of:

- Comprehensive understanding of the four key assessment skills of inspection, palpation, percussion, and auscultation.
- The ability to demonstrate and critically evaluate the role of history taking as a key component in client assessment.
- Knowledge of the relevant applied anatomy pertaining to the following systems: Respiratory, Cardiovascular, Gastrointestinal, Neuro, Breast, Skin and Lymph, Musculo-Skeletal, Head and Neck. Including, variations across life span.
- Developed, demonstrated, and critically appraised the use of history taking skills and the four key assessment skills in undertaking a comprehensive client assessment.
- Identification and articulation of ‘normal’ and ‘deviation from normal’ in the physical assessment of clients, including variations in normal across the lifespan.
- Demonstration of the importance of sensitivity to peers, professional colleagues, and patients in undertaking physical examination, respecting privacy, dignity, and confidentiality.
- Demonstration of the effective documentation of findings from the history taking and physical assessment process in an understandable format.
- Recognition and critical analysis of the legal, ethical, and professional issues pertaining to nurses undertaking expanded roles in the arena of physical assessment and the application of these roles to professional practice.