

APPENDIX D Annotated position descriptions



West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

POSITION DESCRIPTION

'Neighbourhood Nurse' Primary Health Care

Revised in Neighbourhood Nurse workshop 19/10/06. Notated to show alterations from 'working document' provisional position description developed in Reefton.

Department:	Community/Primary Health Care Services
Location:	
Hours of Work:	According to letter of appointment
Employment Agreement:	Nursing MECA
Department Head:	Nurse Manager, Community/Primary Health Care Services
General Manager:	Community and Primary Health Services

Purpose

To provide nursing care that addresses the health needs of a caseload of individuals, families/whanau, schools and groups in a specific community. Care is provided across the lifespan, on a continuum encompassing health promotion, disease prevention and disease management.

Context

This new primary health care nursing role has been developed from what was learned in a pilot funded by the Ministry in a Primary Healthcare Nursing Innovation. The role is seen as one of a number of primary healthcare nursing roles available to meet the needs of local communities.

Nature & Scope

Functional Relationships

- Primary care services including medical and health services and specialist nurses
- Secondary services
- Community representatives including Maori
- Professional Practice Coordinator
- Clinical Nurse Leaders, West Coast
- Community and Public Health
- Workforce and Practice Development Coordinator, Primary Health Care

Achievement of Objectives

Depends... on next steps?

The position description has been developed and refined in the course of the Neighbourhood Nurse project, and further modified on the basis of submissions received after wide consultation. It effectively integrates a generalist level of public health, health promotion and personal healthcare responsibilities without replacing specialties in those areas. The appointee will bring considerable primary health care expertise to the new role, and be supported in developing the competencies that enable them to fulfil the expected outcomes.

Key Task	Expected Outcome
COMMUNITY/POPULATION AND PUBLIC HEALTH	
<p>1 <i>Support local communities, including the Maori community and other ethnic groups, in achieving their own vision of health by supporting community development and undertaking population based public health activities with groups, families/whanau and individuals.</i></p> <div data-bbox="416 909 568 1099" style="border: 1px solid black; padding: 5px; margin-top: 20px;"> <p>Assumes that local provider team undertakes this process</p> </div>	<p>a) Translates the principles set out in the following key commitments to health into her/his practice activities:</p> <ul style="list-style-type: none"> ▪ WCDHB Primary Health Care Annual Plan ▪ WCDHB Maori Health Plan/Te Kaupapa Hauora Maori ▪ New Zealand Primary Health Care Strategy ▪ New Zealand Maori Health Strategy/He Korowai Oranga ▪ Treaty of Waitangi principles and partnership ▪ Ottawa Charter. <p>b) Plans and implements <i>Participates in</i> community and health promotion activities according to the above principles and WCDHB public/primary health priorities (including WCDHB Maori Health Plan/Te Kaupapa Hauora Maori), in consultation and partnership with community agencies and other initiatives.</p> <p>c) Participates in a process to develop or update annually a community profile that includes information that may impact on service provision or strategic planning, in consultation with the community.</p>
<p>2 Ensure that <i>Support public health programmes that ensure notifiable diseases are identified, investigated and measures put in place to minimise risk.</i></p> <div data-bbox="584 1458 751 1603" style="border: 1px solid black; padding: 5px; margin-top: 20px;"> <p>Assumes that public health programmes are driven by specialist</p> </div>	<p>a) Confirmed and/or suspected cases of communicable diseases are referred for investigation by Community and Public Health.</p> <p>b) Specified cases of notifiable diseases are investigated, contacts traced and effective education and treatment initiated or provided.</p> <p>c) Education about vaccine preventable diseases and immunisation (for notifiable diseases) is provided for target groups, families and individuals.</p>

HEALTH PROMOTION AND ILLNESS PREVENTION		
3	<p><i>Contribute to the achievement of optimum health outcomes for the designated population by providing health promotion/protection services.</i></p> <div style="border: 1px solid black; padding: 5px; margin: 10px 0;">Assumes that public health programmes are driven by specialist</div> <div style="border: 1px solid black; padding: 5px; margin: 10px 0;">The nurse needs to be registered or approved to visit school. Immunisation stays with Practice Nurse. Immigrants need to be assessed for immunisation status according to disease-profile. Well-child programme remains with PHN depending on team mix.</div> <div style="border: 1px solid black; padding: 5px; margin: 10px 0;">Involvement in services delivered in schools is dependent on the requirements of the role related to the community and allocation of responsibilities within the team.</div>	<p>a) <u>Participates in the</u> planning, implementation and evaluation of community and group-focused health promotion/protection activities, projects and programmes in conjunction with Community and Public Health, Rata Te Awhina Trust and other agencies or personnel.</p> <p>b) Opportunities are created in the course of professional interaction with families/whanau and individuals to discuss their health needs and priorities, according to their readiness and interest.</p> <p>c) Families/whanau and individuals exploring their health priorities and problems are supported in</p> <ul style="list-style-type: none"> ▪ defining what a healthy lifestyle would mean for them according their circumstances ▪ developing objectives and strategies which will help them meet their own health goals and whanau ora ▪ meeting their learning needs and accessing appropriate resources ▪ their participation in Strengthening Families process. <p>d) Support Well Child/Tamariki Ora Service in</p> <ul style="list-style-type: none"> ▪ completion of a schedule of well child visits (core and additional) that fulfils health protection and clinical assessment requirements ▪ a programme of health education and promotion activities including completion of immunisation schedule and education which enables caregivers to make informed choices around immunization ▪ support of family/whanau e.g. promotion of breastfeeding/feeding, maternal health, response to needs and referrals. <p>e) Liaise with and support Early Childhood Services offered in the nurse's neighbourhood.</p> <p>f) A School Service offered in the nurse's neighbourhood evidences</p> <ul style="list-style-type: none"> ▪ screening of new entrants and new students as to their immunisation status ▪ new entrant examination undertaken within 6 months of entry ▪ identification of health-related needs or issues in the school environs and the students ▪ receiving and initiating referrals of children/tamariki to and from appropriate agencies ▪ gaining student and/or parent/caregiver consent for referral where required ▪ partnering/supporting School communities in the development and implementation the Health Promoting Schools framework ▪ involvement in inter/national promotions ▪ supporting the school in maintaining an immunisation register ▪ self-referral clinics at schools where appropriate. <p>g) Immunisation of hard-to-reach children/tamariki is undertaken in consultation with the Immunisation Coordinator.</p>

PERSONAL HEALTH/DISEASE MANAGEMENT SERVICES		
4	<p><i>Provide personal health and disease management services to individuals and families/whanau from first point of contact (brief encounter) and emergency/acute care to case management, rehabilitation and palliative care (extended involvement).</i></p>	<ul style="list-style-type: none"> a) Individuals and families/whanau are assessed on the basis of presenting problems. b) Diagnostic tests from an agreed range are ordered and interpreted either independently or in collaboration with a medical practitioner. c) A plan of action is formulated with the individual or family/whanau according to the assessment and clinical findings, their informed choices and circumstances, the degree of self-management appropriate and the services available. d) The plan of action and interventions <ul style="list-style-type: none"> ▪ are based on best practice guidelines ▪ utilise relevant Standing Orders/clinical guidelines ▪ observe WCDHB protocols and policies. e) Referrals and consultations within the PHC nursing team and with health and other colleagues are made to provide the best available information and timely care to the individual and family/whanau. f) Individual and family/whanau responses to interventions are reviewed in terms of appropriate progress, independence and quality of life with the nurse at each interaction; adjustments are made to the plan as required. g) An appropriate formulary is maintained. h) Self-referral health clinics and health promotions are scheduled on a regular basis at times and places appropriate to the neighbourhood. i) The nurse is available for self-referrals as appropriate to the neighbourhood. j) The Home Hospice philosophy is observed in caring for the terminally ill and the bereaved, as are requirements for the administration, supervision and storage of controlled drugs prescribed for terminally ill patients. k) The nurse acts as an advocate for clients and/or families/whanau, at their request, recognising differences, with particular attention to cultural aspects and recommended tikanga best practice.

RELATIONSHIPS, SYSTEMS AND NETWORKS		
5	<i>Develop and maintain the relationships and referral networks necessary to coordinate care across services and organisations.</i>	<ul style="list-style-type: none"> a) Works in a partnership model with individuals, families/whanau, groups and the community in a manner they determine as being culturally and spiritually safe. b) Works with the Maori community <ul style="list-style-type: none"> ▪ according to Treaty of Waitangi principles (i.e. protection, participation and partnership) ▪ in a way which is consistent with Tikanga Maori principles ▪ towards fulfilling the goals of the New Zealand Maori Health Strategy/He Korowai Oranga. c) Maintains a professional manner in relationships. d) Develops and maintains referral and resource networks in order to be able access expertise, equipment and other resources for clients.
6	<i>Ensure that accurate and complete records of care/intervention are kept.</i>	<ul style="list-style-type: none"> a) Initiates and maintains written and electronic records that include initial and ongoing <ul style="list-style-type: none"> ▪ assessment findings ▪ planning, implementation and evaluation of care ▪ client response and progress in a clear, concise and timely manner. b) Manages the records in a way that allows other team members appropriate access in a timely manner. c) Observes privacy and confidentiality requirements, and facilitates client choices around the recording and access of sensitive information. d) Educates and supports clients in the keeping of their own record, accesses and/or develops suitable patient tools.
PROFESSIONAL ROLE OBLIGATIONS		
7	<i>Conduct oneself as a professional.</i>	<ul style="list-style-type: none"> a) Maintains a professional portfolio that meets Nursing Council's continuing competence requirements. b) Takes specific steps to ensure that own knowledge is current in clinical management and nursing practice, and is accountable for own practice. c) Assesses own learning needs, and implements a plan to meet them in accordance with WCDHB policies and support. d) Reflects on own practice in order to maintain an awareness of own limitations in complex or new situations. e) Seeks peer feedback through case review and other methods. f) Undertakes regular clinical supervision with an approved provider. g) Seeks support and/or refers to appropriate colleagues in challenging or unfamiliar situations. h) Undertakes self-assessment in preparation for annual appraisal and works through the process constructively with immediate manager and appropriate others. i) Is familiar with and observes ethical and legal requirements relevant to the role and upholds client rights and interest and acknowledge the client's individuality, abilities, culture and choice. j) Contributes to the development of nursing practice and the profession by <ul style="list-style-type: none"> ▪ supporting students and other learners ▪ reviewing and developing practice and procedures ▪ initiating or being involved in appropriate quality improvement initiatives ▪ participating in professional interest groups or networks.

WORK ROLE OBLIGATIONS		
8	<i>Fulfil professional, organisational and statutory requirements for safety, accountability and quality in practice.</i>	<ul style="list-style-type: none"> a) Observes WCDHB policies. b) Submits timely and accurate completion of daily patient contact statistical data, monthly returns and reports as required by contracts and employer. c) Takes all practicable steps to identify, minimise or eliminate/isolate potential hazards/harm/injury to self and clients. d) Completes reporting process for accidents, injuries or near misses. e) Notifies appropriate manager or professional if, despite all attempts to eliminate, isolate or minimise them, hazards and potential harm to staff and clients persist. f) Abides by WCDHB's Health and Safety Plan; participates in planning and Health and Safety Training as appropriate. g) Participates in the WCDHB Quality Assurance programme as directed and abides by clinical protocols and procedures. h) Conforms with requirements for the use of WCDHB equipment and resources. i) Attends mandatory training sessions as provided and/or required by WCDHB.
9	<i>Function as a constructive team member.</i>	<ul style="list-style-type: none"> a) Raises work and team concerns and issues in a timely and constructive manner with the appropriate personnel and managers. b) Prioritises own workload and works as efficiently and flexibly as possible. c) Considers the needs and priorities of others/across the team and works as flexibly as possible to ensure that needs and commitments are met across all caseloads. d) Contributes to the development and review of documentation, resources, policies and processes that support the effective functioning of the team.

Qualifications, Competencies, Experience and Personal Qualities

	Minimum	Preferred
Qualifications	RGON or RCpN.	Enrolment in or achievement of relevant post-graduate qualifications/certification.
Specific competencies	Refer separate document.	
Experience	In any one of the following areas: <ul style="list-style-type: none"> ▶ primary health care nursing ▶ community nursing ▶ rural nursing. 	In a number of the following areas: <ul style="list-style-type: none"> ▶ primary health care nursing ▶ community nursing ▶ rural nursing.
Personal Qualities	In a changing health service environment, they remain focussed on improving health outcomes. They are comfortable in a rural environment and smaller isolated community. They can work both autonomously, and as effective team participants. They have integrity, good communication skills, maturity and adaptability; they are proactive and positive.	

Signed on behalf of West Coast District Health Board

I accept the terms and conditions as outlined in this Position Description

Date _____

Date _____

Name

Name

Position

Job Title

West Coast District Health Board

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Te Poari Hauora a Rohe o Tai Poutini

POSITION DESCRIPTION

'Whanau Nurse' Primary Health Care

Department:	Community/Primary Health Care Services
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Hours of Work:	According to letter of appointment
Employment Agreement:	Nursing MECA
Department Head:	Nurse Manager, Community/Primary Health Care Services
General Manager:	Community and Primary Health Services
General Manager:	*Maori Health

Dual reporting for Whanau Nurse discussed with GM Maori Health July/August 2006.

Incorporates revisions made in Neighbourhood Nurse workshop 19/10/06. Notated to show alterations from 'working document' provisional position description developed in Reefton.

Variations from Neighbourhood Nurse document are asterisked.

Purpose

To provide nursing care that addresses the health needs of a caseload of individuals, families/whanau, schools and groups in a specific community, *working in the Neighbourhood Nurse model. Care is provided across the lifespan, on a continuum encompassing health promotion, disease prevention and disease management.

Context

This new primary health care nursing role has been developed from what was learned in a pilot funded by the Ministry in a Primary Healthcare Nursing Innovation. The role is seen as one of a number of primary healthcare nursing roles available to meet the needs of local communities.

Nature & Scope

Functional Relationships

- Primary care services including medical and health services and specialist nurses
- Secondary services
- Community representatives including Maori
- Professional Practice Coordinator
- Clinical Nurse Leaders, West Coast
- Community and Public Health
- *Rata Te Awhina Trust, Kaiawhina, Nga Iwi, Hapu and whanau
- *Maori Mental Health Team
- Workforce and Practice Development Coordinator, Primary Health Care

*Performance expectations are the same as for the 'Neighbourhood Nurse' except under (8), add as 8a: 'Maintains an organisational relationship with the Kaiarahi/GM Maori Health, which includes regular reporting and participation and networks with other Maori staff'.