

APPENDIX E Position description with related competencies

Key Task		Expected Outcome	Competencies required	
COMMUNITY/POPULATION AND PUBLIC HEALTH			Knowledge (K), Skills (S), Attributes (A)	
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>	a) Translates the principles set out in the following key commitments to health into her/his practice activities: <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. b) Participates in 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. 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.	K	<ul style="list-style-type: none"> ❑ Familiar with primary/public/population health care concepts, including those outlined in the key national and international primary health care documents listed, and also with WCDHB public/primary health priorities, <ul style="list-style-type: none"> ❑ including WCDHB Maori Health Plan/Te Kaupapa Hauora Maori. ❑ Familiar with resource people and linkages in relation to above. ❑ Familiar with community development and consultation concepts and able to participate in related planning and processes. ❑ Aware of other agencies (government-funded and other) operating in the community; able to build and maintain relationships with them and work with them in a partnership model. ❑ Familiar with the local community, the groups and people within it, including their cultural and spiritual beliefs and values.
			S	<ul style="list-style-type: none"> ❑ Able to run community activities, projects and programmes, in partnership with colleagues and other providers.
			A	
2	<i>Support public health programmes that ensure notifiable diseases are identified, investigated and measures put in place to minimise risk.</i>	a) Confirmed and/or suspected cases of communicable diseases are referred for investigation by Community and Public Health. b) Specified cases of notifiable diseases are investigated, contacts traced and effective education and treatment initiated or provided. c) Education about vaccine preventable diseases and immunisation (for notifiable diseases) is provided for target groups, families and individuals.	K	<ul style="list-style-type: none"> ❑ Knows aetiology of communicable diseases (in NZ), notification and compliance requirements and treatment regimes. ❑ Aware of at risk groups for communicable diseases. ❑ Familiar with immunisation schedules. ❑ Familiar with requirements for maintaining an immunisation register. ❑ Familiar with concerns about immunisation and able to provide appropriate information that helps parents/caregivers make informed decisions.
			S	<ul style="list-style-type: none"> ❑ Able to investigate cases and trace contacts, followup and implement appropriate education and treatment.
			A	

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HEALTH PROMOTION AND ILLNESS PREVENTION			Knowledge (K), Skills (S), Attributes (A)	
3	<i>Contribute to the achievement of optimum health outcomes for the designated population by providing health promotion /protection services.</i>	<p>a) Participates in the 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"> ▪ completing 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>	K	<ul style="list-style-type: none"> ❑ Familiar with health promotion concepts and goals. ❑ Aware of Strengthening Families process and able to support client involvement. ❑ Familiar with childhood development and milestones, and age related health problems. ❑ Familiar with the service delivery requirements for Well Child/Tamariki Ora and able to complete core and additional Well Child schedules. ❑ Familiar with and able to advocate and support the Health Promoting Schools framework. ❑ Familiar with the range of international and national promotions and able to select those most appropriate for school/community needs.
			S	<ul style="list-style-type: none"> ❑ Able to assess and promote client's readiness to discuss health issues (motivational interviewing/effective brief intervention). ❑ Able to assess the resources and motivation for self-management within an individual or family/whanau; support and supplement, and when to involve other agencies as appropriate. ❑ Able to assess the information and learning needs of clients and families/ whanau about their clinical conditions/health problems. ❑ Able to recognise and respect the client's definition of a healthy lifestyle according to their circumstances, also their goals and strategies. ❑ Able to recognise when a client's right to exercise their autonomy is putting them at risk, and an intervention based on safety must be implemented. ❑ Able to initiate, promote and provide self-referral clinics in school. ❑ Able to set systems in place for immunisation screening in schools.

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PERSONAL HEALTH/DISEASE MANAGEMENT SERVICES			Knowledge (K), Skills (S), Attributes (A)	
4	<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>a) Individuals and families/whanau are assessed on the basis of presenting problems.</p> <p>b) Diagnostic tests from an agreed range are ordered and interpreted either independently or in collaboration with a medical practitioner.</p> <p>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.</p> <p>d) The plan of action and interventions</p> <ul style="list-style-type: none"> ▪ are based on best practice guidelines ▪ utilise relevant Standing Orders/clinical guidelines ▪ observe WCDHB protocols and policies. <p>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.</p> <p>f) Individual and family/whanau response 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.</p> <p>g) An appropriate formulary is maintained.</p> <p>h) Self-referral health clinics and health promotions are scheduled on a regular basis at times and places appropriate to the neighbourhood.</p> <p>i) The nurse is available for self-referrals as appropriate to the neighbourhood.</p> <p>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.</p> <p>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.</p>	K	
			S	<ul style="list-style-type: none"> ❑ Familiar with and practised in using a range of health assessment tools. ❑ Able to assess maternal/parental and family health. ❑ Able to assess infant/child health. ❑ Able to assess the school environs and students in terms of health-related needs or issues. ❑ Able to assess adult health. ❑ Familiar with the indications for diagnostic tests and able to interpret the results and identify when referral is required. ❑ Familiar with a range of resources and able to determine and access those most suited to the client. ❑ Able to identify when to request advice or a consultation, or refer a case on to an appropriate agency. ❑ Able to formulate, deliver and revise a plan of care. ❑ Able to evaluate client progress and the effectiveness of care. ❑ Able to act effectively and appropriately in an advocacy role. ❑ Able to access and apply best practice guidelines for clinical conditions and palliative care.
			A	<ul style="list-style-type: none"> ❑ Acknowledges the importance of client/family involvement in directing and choosing care/treatment.

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RELATIONSHIPS, SYSTEMS AND NETWORKS			Knowledge (K), Skills (S), Attributes (A)	
5	<i>Develop and maintain the relationships and referral networks necessary to coordinate care across services and organisations.</i>	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.	K	<input type="checkbox"/> Familiar with Tikanga Maori.
			S	<input type="checkbox"/> Able to work in partnership with clients and families/whanau/groups.
			A	<input type="checkbox"/> Skilled in listening, and dealing patiently with different cultural/ethnic groups.
6	<i>Ensure that accurate and complete records of care/intervention are kept.</i>	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.	K	<input type="checkbox"/> Familiar with the concepts and requirements associated with a client held file.
			S	<input type="checkbox"/> Able to use the available record keeping system (whether paper based or electronic). <input type="checkbox"/> Able to write clearly and concisely, and manage own timeliness of record keeping. <input type="checkbox"/> Able to locate or design (or access expertise to design) client tools and resources. <input type="checkbox"/> Aware of and able to complete contractually required reporting.
			A	<input type="checkbox"/> Committed to client involvement and rights in relation to their records.

Key Task		Expected Outcome	Competencies required	
PROFESSIONAL ROLE OBLIGATIONS			Knowledge (K), Skills (S), Attributes (A)	
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. 	K	<ul style="list-style-type: none"> □ Aware of CCR and DHB requirements for keeping a record of professional practice. □ Familiar with ethical and legal requirements relevant to the role. □ Familiar with requirements for and issues around gaining consent.
			S	<ul style="list-style-type: none"> □ Able to articulate own beliefs and principles of professionalism, and carry them through in relationships with clients and colleagues. □ Able to identify own learning needs to keep current in practice. □ Understands own limitations and professional accountability and applies this in decision-making. □ Able to assess own practice, and seek, receive and respond to feedback. □ Able to preceptor, orientate, educate and support other staff. □ Able to develop and critique practice and procedures. □ Able to identify those professional organisations and groups which are a good match to own interests, development needs and situation.
			A	

Key Task		Expected Outcome	Competencies required	
WORK ROLE OBLIGATIONS			Knowledge (K), Skills (S), Attributes (A)	
8	<i>Fulfil professional, organisational and statutory requirements for safety, accountability and quality in practice.</i>	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.	K	<input type="checkbox"/> Familiar with WCDHB general policies and the Health & Safety plan. <input type="checkbox"/> Familiar with the quality process and able to instigate and implement it, and aware of the WCDHB quality programme. <input type="checkbox"/> Familiar with relevant Standing Orders and WCDHB protocols and policies. <input type="checkbox"/> Understands the nurse's role and responsibilities in relation to prescribing, Standing Orders, and controlled drugs. <input type="checkbox"/> Knows how to access pharmacological information, and is able to identify what action to take on any concerns. <input type="checkbox"/> Familiar with accident/incident reporting procedures. <input type="checkbox"/> Familiar with professional and DHB Codes of Conduct. <input type="checkbox"/> Knows organisational channels of communication. <input type="checkbox"/> Aware of DHB policy, privacy requirements and medico-legal aspects of documentation.
			S	<input type="checkbox"/> Able to identify hazards and minimise or eliminate them.
			A	
9	<i>Function as a constructive team member.</i>	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.	K	
			S	<input type="checkbox"/> Able to work autonomously, but also as a reliable team member. <input type="checkbox"/> Able to prioritise workload - individual and team. <input type="checkbox"/> Able to manage own time efficiently and flexibly.
			A	<input type="checkbox"/> Committed to contributing to an effective team process