Position Description

Date: February 2017

Job Title : Gerontology Nurse Specialist, Community R.A.C.I.P and Interim Care Scheme

Department : Specialty Medicine and Health of Older People

Location : Rodney/North Shore/ Waitakere Community but mobile across the DHB

Reporting To :
- Operations Manager Older Adults and Home Health for performance objectives and contribution at Senior nurse level
- Clinical Nurse Director (community & specialty practice) for achievement of quality standards (client safety, effectiveness and client experience) maintenance of advanced practice, professional practice standards, the development of professional practice and the development of the professional workforce.

Direct Reports : None

Functional Relationships : Internal
- Gerontology Nurse Practitioner/ Clinical Leader R.A.C.I.P.
- Geriatricians
- Gerontology Nurse Practitioners and Clinical Specialists
- CNS Interim Care Scheme
- CNS MHSOA
- CNS Dementia
- Pharmacist (RACIP)
- Interim care scheme social worker
- Director of Nursing and Midwifery
- HODN MedHops
- Charge Nurse Managers (acute services and AT&R)
- MHSOA community clinicians
- District nurses
- Palliative Care clinical nurse specialists
- NASC
- MHSOA

External
- Social worker
- Dietitians and other allied health staff
- Other clinical nurse specialists
- Funding Team
- Maori Health Services
- Asian/pacific health services
- Consumers, consumer advocates
- and families
- General practitioners
- Practice nurses
- Residential aged care providers
- Home based care providers
- Private cultural providers
- Age Concern
- Tertiary institutions
Position Description

**Gerontology Nurse Specialist – Community Residential Aged Care Integration Programme [RACIP] and Interim Care Scheme**

**DHB Purpose, Values and Standards**

At the heart of Waitemata DHB is our promise of ‘better care for everyone’. This promise statement is the articulation of our three-fold purpose to:

1. promote wellness,
2. prevent, cure and ameliorate ill health and
3. relieve the suffering of those entrusted to our care.

At the heart of our values is the need for all of us to reflect on the intrinsic dignity of every single person that enters our care. It is a privilege to be able to care for patients, whānau and our community, a privilege that is sometimes overlooked in our day to day work.

Our standards and behaviours serve as a reminder to us all about how we are with our patients and with each other.

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| **Purpose of the role** | This is an advanced practice role using expertise in comprehensive gerontology nursing assessment and diagnostic reasoning skills to assess health needs; set goals; provide advice at a level of advanced gerontological nursing practice based on best practice guidelines; promote functional independence; promote optimal wellness and prevent health crises. This will be undertaken in partnership with older people; their families/whanau; secondary specialist services; the residential care sector (where appropriate) and their primary care provider. This includes:
|---|---|
|  | • Providing advanced gerontology assessment and advanced clinical decision making in the assessment and management of older people in the community and in residential aged care facilities.  
|  | • Ensuring the most effective of use of resources for the individual person  
|  | • Identification of and monitoring through acute episodes of care  
|  | • Preventing unnecessary acute hospitalisation  
|  | • Facilitating discharge to home environment and on-going care  
|  | • Participation in skill development of the nursing workforce in residential care settings, and the development of educational resources for these settings, is also key to the purpose of this role.  
|  | --- |
# Gerontology Nurse Specialist – Community Residential Aged Care Integration Programme (RACIP) and Interim Care Scheme

## Position Description

### KEY ACCOUNTABILITIES

<table>
<thead>
<tr>
<th>Domain One</th>
<th>Professional responsibility</th>
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<tbody>
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<td><strong>Domain One</strong></td>
<td>Professional responsibility</td>
</tr>
<tr>
<td>Includes accountabilities for professional, legal, ethical and culturally safe practice. This includes being able to demonstrate advanced critical thinking, judgement and accountability for own actions and decisions</td>
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- Meets all registered nurse PDRP competencies at minimum of RN Level 4 requirements – refer generic RN competencies
- Perceived as highly effective, progressive and knowledgeable in area of practice, according to legal, ethical, cultural safety/sensitivity and professional standards
- Is up to date with professional issues in order to challenge scope of practice and professional standards

#### Professional Leadership and Expertise

- Applies critical reasoning and professional judgement to nursing practice issues and decisions for older people at risk
- Provides advanced gerontology assessment and advanced clinical decision making in the assessment and management of older people in the community and residential aged care facilities.
- Coordinates the assessment, planning and nursing care of older people with complex needs in direct care delivery, contributing to the development of integrated service delivery across the continuum of care – one to one client management and impact on practices/processes of care on populations at local and system level
- Role models excellence in clinical professional practice when working alongside staff to reinforce learning and to provide assistance as required.
- Actively assists in care coordination of frail older people with complex needs
- Problem solves and offers guidance to other clinicians and providers
- Ensures clinical knowledge of frail older people at risk is continually reassessed and families, community or residential aged care staff are supported to meet the complex and /or changing needs
- Maintains and develops clinical expertise in advanced gerontological nursing and demonstrates this in practice.
- Acts as a resource person for nursing, medical and other health professionals
- Applies critical reasoning and professional judgment to nursing practice issues and decisions for older people at risk
- Enhances advanced nursing practice and contributes to the profession locally, regionally and nationally
- Documentation of caseload statistics is maintained and reviewed e.g. databases

#### Professional Development of specialty practice

- Participates in regular interdisciplinary case review processes, clinical and professional supervision
- Self-directed in achieving learning and development plan, including PDRP responsibilities
- Actively participates in professional nursing groups, maintains effective local, regional, national and international networks. Attends educational opportunities, conferences and regional gerontology nursing forums
- Develops educational resources, and provides structured education and other training for a particular purpose, as well as providing other support for WDHB Residential Care facilities and primary care staff
- Exhibits experiential leadership.

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Position Description: Gerontology Nurse Specialist Community, RACIP & Interim Care Scheme. Approved by Director Nursing & Midwifery 6/02/2017
Gerontology Nurse Specialist – Community Residential Aged Care Integration Programme [RACIP] and Interim Care Scheme

**Position Description**

<table>
<thead>
<tr>
<th>Leading Nursing care and management</th>
<th>Community and R.A.C.I.P role</th>
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<tbody>
<tr>
<td><strong>Assessment</strong></td>
<td><strong>Diagnostic and monitoring function</strong></td>
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<tr>
<td>Completes a skilled comprehensive gerontology nursing assessment, using advanced diagnostic reasoning skills.</td>
<td>Provides an interpretation of the client’s condition and communicates, clarifies and teaches this as required to other members of the health care team including practice nurses, GPs, allied health and any other health care professionals working with the client/family.</td>
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<tr>
<td>Recognises changing clinical relevance, clinical grasp and response-based practice; practices in an anticipatory, proactive manner using sound accurate clinical judgment.</td>
<td>Ensures that the care plan identifies, and reduces significantly, the four shared risk factors associated with the five most common geriatric syndromes.</td>
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<tr>
<td>Anticipates the complex needs of a frail older person, understanding the particular demands and experiences of illness, clinical forethought about risks and vulnerabilities.</td>
<td>Demonstrates clinical forethought by anticipating and preventing potential problems, anticipates breakdown and deterioration prior to explicit diagnostic signs; diagnoses and manages emergent situations; provides prompt interventions to maintain optimal health and well-being in older people.</td>
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<tr>
<td>Clinical knowledge of the older person is continually reassessed to meet complex and/or changing clinical needs: Significant changes in a patient’s condition are detected and documented.</td>
<td>Recognises and communicates transitions in care phases and responds appropriately.</td>
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<tr>
<td>Documentation is professional, accurate and transparent.</td>
<td>Facilitates and coordinates, collaborates with multidisciplinary teams to ensure appropriate care coordination.</td>
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**Administration and monitoring of therapeutic interventions and regimens**

- Monitors the outcome of care, or arranges same and takes appropriate action as required.
- Assists clinical team in a variety of settings, to manage multiple therapeutic interventions.
- Limits the impact of long term interventions and movement between care settings.
- Assists the staff working across the continuum of primary care, acute care and residential aged care to provide consistent care for the patient according to the care pathway.
- Involves specialist input/referral at appropriate times.
- Assists the staff working in other areas (primary care; residential aged care facilities; acute care and community care) to provide consistent care for the older person at risk. Involves specialist input/referral at appropriate times.
- Uses health promotion to integrate the implications of illness and recovery rehabilitation or long term functional impairment into their clients’ lifestyles.
### Position Description

**Organises, in conjunction with the appropriate personnel depending on the care setting, the team and orchestrates their actions**

#### Development of a strong customer-focused service
- Exhibits characteristics of a Servant Leader: Listening, empathy, healing, awareness, stewardship, commitment to the growth of people and building community
- Develops a trusting relationship and rapport with older people and their families/whanau, caregivers and other health professionals across the continuum of care
- Develops positive and functional working relationships with primary care and residential aged care providers to optimise the ability to maintain the client safely in the community or residential aged care environment.
- Proactive in supporting residential care and home care staff to develop confidence in the care and management of frail older people with complex needs
- Participates in case review and debriefing activities for other providers as required
- Older people are guaranteed continuous access to services which are appropriate to their circumstance. Backup care is provided and clinical requirements are met
- Uses health promotion, education and self-care approaches to reduce health problems
- Assistance is provided to older people and their families/whanau to integrate the implications of illness and recovery, rehabilitation or long term functional impairment into their lifestyles
- Provides support and guidance for the family

#### Interim Care Scheme role
- Provides specialist nursing care and expertise both in direct care delivery and in support to other staff in the management of clients on the Interim Care Scheme
- To see and assess patients within their own allocated ARRC facilities, on the Interim Care Scheme, at least every two weeks
- To work with the facility RNs to ensure appropriate care plans are in place taking into consideration their individual needs such as non-weight bearing, or partial weight bearing in addition to their gerontology needs.
- To liaise with orthopaedics charge nurses and CNS Interim care to ensure information about client needs with regards equipment, braces, wound and limb care is handed over.
- To arrange transfer back to hospital in the event the patient deteriorates medically.
- To liaise with the Interim Care Social Worker and the CNS Interim Care to ensure good communication about potential and actual Interim Care clients. Provide feedback to the teams about any clients found to be unsuitable so that criteria can be refined over time.
- To seek advice, support and supervision from the Gerontology Nurse Practitioner and geriatricians
Gerontology Nurse Specialist – Community Residential Aged Care Integration Programme [RACIP] and Interim Care Scheme

**Position Description**

- Interim Care Team, ARC facilities and GPs are well supported in terms of the provision of timely and relevant gerontology nurse specialist clinical advice in relation to the Interim Care Service aims and objectives as laid out in the Service Specification
- Clinical advice is provided in accordance with best practice, medical prescription, relevant legislation, professional ethics and standards
- Interim Care Team assisted to finalise and refine (as necessary) clinical systems and processes such as identification of suitable clients, transfers, handover, care planning and other processes to be used by the ARC facilities
- Effective liaison with stakeholders and Interim Care Team members is developed and maintained
- Residential Aged Care facility staff are assisted with care planning as agreed, including assistance accessing hospital handover, facilitating integration/linkages between primary and secondary care
- Models advance practice skills leading case review, educating staff, older people and their family/whanau
- Role models and maintains own clinical expertise in gerontological nursing. Role models expert clinical practice, excellent communication
- GNS approach based on the consultative model used by the WDHB Residential Aged Care Integration Programme GNSs and supports General Practice Team
- ARRC staff assisted with care planning as agreed, including assistance accessing hospital handover, facilitating integration/linkages between primary and secondary care
- Developing and maintaining collegial support from other GNSs and geriatricians
- Develop and implement an agreed consultative GNS intervention approach to ARC facilities and General Practice Teams
- GNS approach based on the consultative model used by the WDHB Residential Aged Care Integration Programme GNSs and supports General Practice Team
- ARRC staff assisted with care planning as agreed, including assistance accessing hospital handover, facilitating integration/linkages between primary and secondary care
- Developing and maintaining collegial support from other GNSs and geriatricians skills and a variety of effective project management/leadership skills
- Develop and implement an agreed consultative GNS intervention approach to ARC facilities and General Practice Teams
- GNS approach based on the consultative model used by the WDHB Residential Aged Care Integration Programme GNSs and supports General Practice Team
- ARRC staff assisted with care planning as agreed, including assistance accessing hospital handover, facilitating integration/linkages between primary and secondary care
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Gerontology Nurse Specialist – Community Residential Aged Care Integration Programme [RACIP] and Interim Care Scheme

Position Description

Education and clinical teaching
- Role models excellence in clinical professional practice when working alongside staff to reinforce learning and to provide assistance when required
- Coaches family and/or staff as required: Captures the concept of readiness to learn and maximises these opportunities
- Teaches and supervises less experienced clinicians and care givers, facilitating the clinical development of others, coaching others in interpreting, forecasting and responding to client transitions. Acts as a clinical resource for all clinical staff
- Fosters inquiry, critical thinking and research skill among the nursing workforce to advance nursing practice and client care.
- Develops appropriate educational resources
- Work with other services/health providers to enhance the skill and knowledge of nurses caring for frail older people with complex needs across the hospital-community interface

Domain Three  Interpersonal relationships and enhancing the patient experience
Includes accountability for interpersonal and therapeutic communication with clients/patients and members of the health care team.

- Close working relationship with geriatricians; primary care; interim care scheme and residential aged care clinicians.
- Demonstrates effective interpersonal skills and commitment to patient and family centred care
- Ensures cultural beliefs, practices and support of individuals, their family and carers is central to all interventions
- Engaged with gerontology nurse specialists and nurse practitioners regionally and nationally. Demonstrates clinical and professional leadership through effective teamwork and collaborative relationships
- Role models advanced therapeutic communication, engages client and family in care planning for self-care, improving knowledge of disease/illness, self-management, prevention of complications and promotion of recovery

Domain Four  Interprofessional healthcare and quality improvement to deliver organisational objectives
Includes accountability for evaluating the effectiveness of care and promotion of nursing perspective within the health care team

Supports Professional Activity
- Provides teaching – nursing and medical education; participates in clinical governance activities including audit and research; Administration – organisational requirement; contribution to service planning and policy development; professional development
- Assists in the implementation of nursing practice and models of care appropriate to care of older people with complex needs

Quality Improvement: Guideline and policy development
- Leads the development/review of best practice pathways, protocols and guidelines in gerontology nursing practice.
- Supports the development of best practice resources for residential aged care.
- Change agent/leader
- Leads/contributes/collaborates in quality & care improvement processes, risk management and resource utilisation review, including trending and auditing and developing appropriate responses – educational, policy, advisory at client, nurse and system level
- Identifies efficiencies through new and innovative ways of working, improve quality of care and client experience

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Position Description

Service Development

- Participates in service development and strategic leadership to enhance the patient experience, application of values in practice.
- Undertakes/leads specific or organizational portfolio responsibilities. Includes assisting Maori GNS in implementation and management of initiatives to address differential access to healthcare services for Maori.

Research & Audit; Evidence based practice

- Researches, evaluates, develops and implements standards of nursing practice in care of older people with complex needs and supports practice improvements. Works to ensure recommended best practice guidelines/policies are research based and relevant across Waitemata DHB
- Confident use of technology. Critiques and uses research findings in practice. Participates in research.

Statutory & Treaty of Waitangi obligations

- Ensures the professional and political integrity of WDHB by carrying out all functions in compliance of the Treaty of Waitangi and by demonstrating a serious commitment to keeping the treaty alive.
- Shows sensitivity to cultural complexity in the workforce and patient population

To recognise individual responsibility for workplace Health & Safety under the Health and Safety at Work Act 2015

Contribute to a safe and healthy workplace at WDHB by:

All Employees

- Following & complying with H&S policies & processes & applying them to their own work activities, including using/wearing Personal Protective Equipment as required.
- Participating in activities directed at preventing harm & promoting well-being in the workplace
- Identifying, reporting & self-managing hazards where appropriate
- Early and accurate reporting of incidents at work and raising issues of concern when identified.

VERIFICATON

Employee: ____________________________

Manager: ____________________________ Date: ____________________________

Note: This job description forms part of an individual’s contract of employment and must be attached to that contract.
**PERSON SPECIFICATION**

**POSITION TITLE:** Gerontology Nurse Specialist Community, R.A.C.I.P, ICS

| Education and Qualifications | • Registered Nurse (RGON, RCpN, RPN, BHSc) with current New Zealand annual practising certificate  
|                             | • Post Graduate Diploma in gerontology or medical nursing  
|                             | • Working to achieve Masters in advanced nursing practice, gerontology related, includes prescribing practicum  
|                             | • Current NZ Drivers Licence  

| Experience | • At least five years post registration practice in care of older people  
|            | • Achieved RN Level 4 or equivalent in specialty with current portfolio  
|            | • Reputation for excellence in specialty practice  
|            | • Demonstrated prior leadership ability within the health sector  
|            | • Experience of results based accountability and managing for outcomes  
|            | • Understanding of inequalities intervention frameworks  
|            | • Experience working with community providers (General practice, NGOs) and communities  

| Skills, Knowledge & Behaviour | • Advanced physical assessment, history taking, diagnostic reasoning and pharmacology knowledge  
|                             | • Knowledge and ability to provide direction for patients with long term conditions. Able to show clinical leadership in situations.  
|                             | • Committed to person-centred care  
|                             | • Ability to work with minimal direction and coordinate with the multi-disciplinary team to provide advanced assessment, and clinical reasoning skills in the care of older people with complex needs  
|                             | • Is aware of contemporary standards and has reputation of providing good nursing care. Demonstrated confident collaborative approach in team practice  
|                             | • Demonstrated operational management/care coordination skills  
|                             | • Clinical professional leadership  
|                             | • Is able to make presentations to expert clinical audiences using technological resources available. Ability to effectively share clinical knowledge with others  
|                             | • Project management and quality improvement processes  
|                             | • Demonstrated confidence in quality improvement to improve service delivery  

| Personal Attributes | Leadership  
|                    | People management  
|                    | Teamwork  
|                    | Cultural safety  
|                    | Self-management  
|                    | Patient focused  
|                    | Communication / interpersonal skills  
|                    | Innovation  
|                    | Flexibility  
|                    | Planning and monitoring  
| • Proactive attitude | • Excellent communicator  
| • Articulate, good presentation skills | • Self-directed and motivated  
| • Strong teamwork reputation, confident collaboration | • Resilience  
| • Positive professionally mature | • Able to influence without conflict, accepts constructive feedback  
| • Culturally safe practice |