Gerontology Nurse Specialist Maori Community and Residential Aged Care Integration Programme

Position Description

Date: February 2017

Job Title: Gerontology Nurse Specialist - Maori Community and R.A.C.I.P.

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.
- Clinical Nurse Director Maori for cultural supervision

Direct Reports: None

Functional Relationships:
- Internal
  - Director of Nursing and Midwifery
  - Head of Division Nursing, Medicine
  - NP/Team Leader RACIP
  - Gerontology Nurse Practitioners and specialists
  - Geriatricians
  - WDHB Diabetes and Respiratory Maori clinical nurse specialists
  - Dementia and MHSOA Clinical Nurse Specialists
  - All other clinical nurse Specialists
  - Maori NASC
  - Nursing staff
  - Medical staff
  - Social workers
  - Dieticians
  - Other allied health staff
  - Maori Nurses Group
  - Maori Services and Kaumatua
  - Funding & Planning
- External
  - Dietitians and other allied health staff
  - Other clinical nurse specialists
  - Funding Team
  - Maori Health Services
  - Asian/pacific health services
  - Consumers, their whanau, and significant others
  - Waipareira Whanau House, Henderson
  - Other Primary Care Providers-GP’s and Practice nurses
  - Residential Aged Care providers
  - Other Maori Health Providers
  - Other DHB providers
  - Medical specialists
  - Age Concern
  - External Service providers
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.

Purpose of the role

This is an advanced practice role using expertise in comprehensive gerontology nursing assessment using 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 in Maori (and at times other) older people.

This will be undertaken in partnership with Maori older people; their whānau; secondary specialist services; the residential care sector (where appropriate) their primary care provider and Maori health care providers as appropriate.

This includes:

- Co-ordinating the multidisciplinary services in community and residential care settings to meet the needs of a defined caseload of Maori older people with complex health care needs with the intent of promoting functional independence, optimal wellness and preventing health crisis. This care co-ordination will take place across the continuum of care and through different service settings including residential care.
- Ensuring the most effective use of resources for the individual Maori older person, including preventing unnecessary acute hospitalization, identification and monitoring through acute episodes of care, facilitating discharge to a home environment or ongoing care, and working closely with Primary Care and Maori Health providers to promote wellbeing in a community setting.
- Providing advanced gerontology assessment and advanced clinical decision making in the assessment and management of older people who are Maori.
- 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.
- Supporting the Gerontology Nurse Practitioners and Nurse Specialists in...
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understanding Maori values and concepts (Tikanga) guidelines, and the Maori Health Model Te Whare Tapa Wha

KEY ACCOUNTABILITIES

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

<table>
<thead>
<tr>
<th>Domain One</th>
<th>Professional responsibility</th>
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| Professional Leadership and Expertise | • 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  
• Establishes and maintains effective local, regional, national and international networks with other Maori specialists in the care of older people to ensure culturally safe practice  
• Assists in initiatives developed to reduce inequalities and improve Maori access to healthcare services to impact on Maori health status  
• Provides clinical and professional nursing leadership engaging with primary care, NGOs and iwi so that older Maori people receive the best care possible.  
• Care is culturally appropriate and sensitive and ensures the wairua (spiritual), Hinengaro (psychological) and Tinana (physical) wellbeing of tangata mauiui (Maori consumers/ clients/ patients) and their whanau (family and extended family group).  
• Facilitates client centred care at all times as outlined in WDHB foundation documents and ensures that clients and whanau are involved with decision making around care planning in a continuous manner.  
• Provides support and guidance for the whanau, ensuring that they receive consistent information from the interdisciplinary team.  
• Provides support and assistance to senior nurses, district nurses, geriatricians, allied health teams, and the NASC team as regards professional practice standards for older Maori people and their whanau, and introduction of change.  
• Provides advice to interdisciplinary team members that is consistent with best practice interventions for Maori older people  
• Applies critical reasoning and professional judgement to nursing practice issues and decisions for older Maori people at risk  
• Provides advanced gerontology assessment and advanced clinical decision making in the assessment and management of older Maori people in the community and residential aged care facilities  
• Coordinates the assessment, planning and nursing care of Maori 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 health professionals and other staff to reinforce learning and to provide assistance as required  
• Actively assists in care coordination of frail older Maori people with complex needs  
• Problem solves and offers guidance to other clinicians and providers |
**Position Description**

**Key Accountabilities**

- Ensures clinical knowledge of frail older people at risk is continually reassessed and whānau, community or residential aged care staff are supported to meet the complex and/or changing needs of the Maori person to keep them physically and culturally safe.

- 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 judgement to nursing practice issues for older Maori and their whānau and decisions for older Maori 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, cultural and professional supervision.

- Self-directed in achieving learning and development plan, including PDRP responsibilities.

- Actively participates in professional nursing and Maori groups, maintains effective local, regional, national and international networks.

- Develops educational resources, and provides structured education and other training for a particular purpose that supports the health of Maori older people as well as providing other support for WDHB Residential Care facilities; primary care staff and particular Maori Health providers.

- Exhibits experiential leadership.

**Domain Two Management of Nursing Care at Advanced Practice Level**

*Includes accountability related to service user/care recipient/assessments and management of advanced nursing care that is supported by evidence*

**Nursing Care and Management**

**Assessment**

- Completes a skilled comprehensive gerontology nursing assessment, using advanced diagnostic reasoning skills.

- Recognises changing clinical relevance, clinical grasp and response-based practice; practices in an anticipatory, proactive manner using sound accurate clinical judgment.

- Anticipates the complex needs of a frail older Maori person, understanding the particular demands and experiences of illness, clinical forethought about risks and vulnerabilities and cultural safety.

- Clinical knowledge of the Maori older person is continually reassessed to meet complex and/or changing clinical needs: Significant changes in a patient’s condition are detected and documented.

- Documentation is professional, accurate and transparent.

**Diagnostic and Monitoring Function**

- 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, Maori provider staff, GPs, allied health and any other health care professionals working with the client/whānau.

- Ensures that the care plan identifies, and reduces significantly, the four shared risk factors associated with the five most common geriatric syndromes and issues related to cultural safety.

- 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 Maori older people.
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**Nursing care and management, contd**

- Recognises and communicates transitions in care phases and responds appropriately
- Facilitates and coordinates, collaborates with multidisciplinary teams to ensure appropriate care coordination

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

### Case management function

- Co-ordinates the interdisciplinary services in community and residential care settings to meet the needs of a defined caseload of Maori older people with complex health care needs with the intent of promoting functional independence, optimal wellness and preventing health crisis. This care co-ordination will take place across the continuum of care and through different service settings including residential aged care.
- Ensures the most effective use of resources for the individual Maori older person, including preventing unnecessary acute hospitalization, identification and monitoring through acute episodes of care, facilitating discharge to a home environment or ongoing care, and working closely with Primary Care and/or Maori Health providers to promote wellbeing in a community setting.

### Development of a strong culturally appropriate customer-focused service for Maori people

- Including whanau in care planning, decision-making and treatment is a key principle that Waitemata DHB has adopted. Accordingly tangata mauiui and their whanau will be actively encouraged to be involved in and/or invited to contribute and participate in all aspects of care and decision-making. This includes care plans, discharge planning and multi-disciplinary team meetings. A copy of the care plan may be shared with each tangata mauiui and whanau after permission has been gained from the tangata mauiui/patient.
- As a member of the gerontology Nursing 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 Maori older people and their whanau, caregivers and other health professionals and Maori health providers across the continuum of care
- Develops positive and functional working relationships with primary care, residential aged care providers and Maori Health providers to optimise the ability to maintain the older Maori client safely in the community or residential aged care environment.
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- Proactive in supporting residential care and home care staff to develop confidence in the care and management of Maori older people with complex needs and to support their whanau
- Participates in case review and debriefing activities for other providers as required
- Maori 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 Maori older people and their whanau to integrate the implications of illness and recovery, rehabilitation or long term functional impairment into their lifestyles
- Provides support and guidance for whanau

Develop and implement an agreed consultative GNS intervention approach to ARC facilities, General Practice Teams, and Maori Health providers

- GNS approach based on the consultative model used by the WDHB Residential Aged Care Integration Programme GNSs and supports the General Practice Teams and Maori Health providers
- 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 GNPs, GNSs and geriatricians

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 whanau 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 cultural safety into the clinical development of others, coaching others in interpreting, forecasting and responding to client transitions. Acts as a clinical, and Maori values and concepts resource for all clinical staff
- Fosters inquiry, critical thinking, research skill and cultural safety among the nursing workforce to advance nursing practice and client/whanau centred care.
- Develops appropriate educational resources that ensures cultural safety for older Maori people and supports the rest of the NPs and GNSs to develop general resources
- Work with other services/health providers to enhance the skill and knowledge of nurses caring for older Maori 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; residential aged care clinicians and Maori Health providers
- Demonstrates effective interpersonal skills and commitment to patient and whanau centred care
- Ensures Tikanga best practice and support of individuals, their whanau and carers, is central to all interventions
  - Tika: Straight like the walls of a whare, able to withstand scrutiny
  - Pono: Honest, open work that shows integrity
  - Aroha: Desire to work responsibly with/for each other
  - Whakai: Humble oneself so that the message can be heard
  - Humarie: Be sensitive, calm, reliable
  - Manaaki: Take generous care of each other, anticipate each other’s concerns and situation
  - Whanaungatanga: Build the working relationships necessary, to truly honour others
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- Engages 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 whanau 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.

**Service Development**

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

**Research & Audit; Evidence based practice**

- Researches, evaluates, develops and implements standards of nursing practice in care of Maori 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.

**Workplace Health & Safety 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.

VERIFICATION

Employee: ________________________________ Date: ________________________________

Manager: ________________________________

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

Position Description: Gerontology Nurse Specialist Maori Community & RACIP. Approved by Director of Nursing & Midwifery 27/02/2017
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#### 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
- Preferred 5 years experience in community care of the older adult and/or experience in advanced practice roles in the community supporting Maori
- Strong cultural engagement and application of Tikanga Maori. Te Reo Maori preferred
- 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 providers (General practice, NGOS, Residential Aged Care) 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 client 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 Maori older people with complex needs
- Understanding of and commitment to the principles of the Treaty of Waitangi
- 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: Has demonstrated effective teaching skills
- Project management and quality improvement processes
- Demonstrated confidence in quality improvement to improve service delivery

#### Skills/Knowledge/Behaviour / Personal Attributes

#### Leadership
- Mature, positive, proactive and enthusiastic attitude
- Possesses a good sense of humour
- Strong and self-reliant

#### People management
- Awareness of how Health and Safety impacts on an organisation
- Seeks advice and guidance from colleagues and other disciplines as required
- Self-directed and motivated

#### Teamwork
- Innovative, takes initiative in patient focused approach to practice
- Displays drive and energy and persists in overcoming obstacles
- Articulate, good presentation skills

#### Cultural safety
- 1. Personal Attributes
- Patient focused
- Communication /
Position Description:

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<th>Innovation</th>
<th>Flexibility</th>
<th>Planning &amp; monitoring</th>
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<tr>
<td>Committed to own professional and personal development</td>
<td>Receives and processes constructive feedback related to own performance</td>
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2. Teamwork
- Sensitive and constructive to others
- Seeks out opportunities to support others in achieving goals
- Strong teamwork reputation, confident collaboration and Inclusive of colleagues
- Resilience, flexible and willing to work across a range of clinical settings
- Is able to manage conflict constructively

3. Self-Management
- Recognises and respects individual differences
- Develops positive working relationships with patients, whanau, staff and managers
- Upholds confidentiality, behaves with integrity and discretion
- Positive professionally mature

4. Communication skills
- Demonstrated strong written and verbal communication skills
- Sets high standards and strives to achieve challenging goals
- Copes well under pressure, is resilient to change and understands personal limitations
- Is able to communicate effectively on the phone and via computer and face to face with a variety of people
- Is able to communicate without engendering conflict
- Excellent communicator
- Articulate, good presentation skills

5. Learning
- Makes effective decisions within appropriate timeframes and levels of responsibility
- Escalates issues appropriately
- Knows where to go and when to ask for help
- Accepts constructive feedback