AGENDA FOR CHANGE
NHS JOB EVALUATION SCHEME

NHS Highland

1. JOB IDENTIFICATION

Job Title:	**Advanced Practice Community Nurse/Team Lead - Diabetes**
Reports to (insert job title):	**District Manager**
Accountable to**:**	**Director of Operations**
Department, Ward or Section**:**	**Diabetes Service**
CHP, Directorate or Corporate Department:	**North West and South and Mid operational units**
Job Reference:	**GENNHSHNURSDIAB01**
No of Job Holders:	**1**
Last Update (insert date):	**Revised Feb 13**

2. JOB PURPOSE

To lead the ongoing development and maintenance of the roles of Diabetes Nursing within the operational unit in conjunction with colleagues across NHS Highland practising at Advanced Practice level (*as defined within Careers Framework*) leading the clinical care of the nursing caseload of adult patients and managing the Senior Practitioner Nurse – Diabetes Nurse post.

Take a leading nursing role, in conjunction with medical colleagues, in the promotion of best practice in diabetes care supporting Primary Care colleagues to deliver “shared and practice based” care as described in the Local Enhanced Services SLA, through the provision of training, advice and support to enhance their knowledge and skills promoting the Shifting of the Balance of Care from Secondary to Primary Care settings.

3. DIMENSIONS

Service Dimensions

Description of Unit area including; South and Mid including Invernesshire, Nairn County, Badenoch & Strathspey, East and Mid Ross

Population size: circa 123, 000

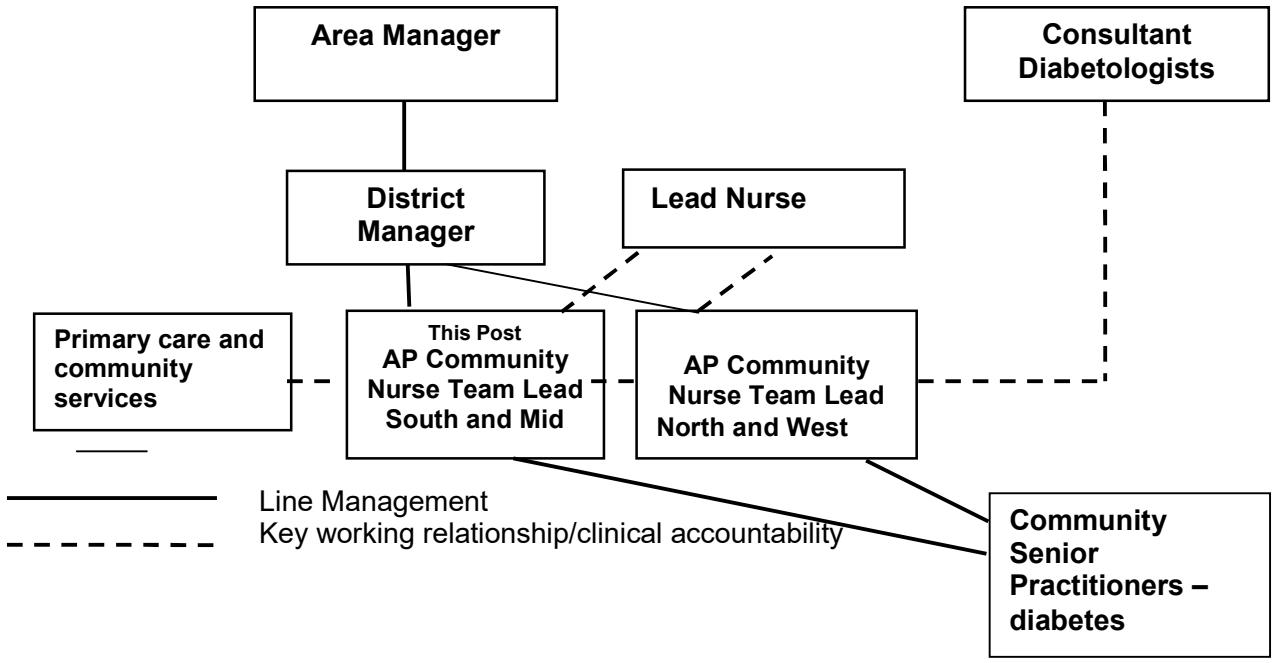
Hospitals: 5 Community Hospitals, New Craigs Psychiatric Hospital

GP practices 28 Practices

District Health and Social Care Teams 7 Teams

Care homes, patients own homes, and other institutional settings e.g. Prison.

4. ORGANISATIONAL POSITION



5. ROLE OF DEPARTMENT

The role of Primary, Secondary and Community care services in relation to the management of patients with diabetes is to practice within agreed clinical pathways promoting self management, minimising disease related complications and working toward shifting the balance of care; providing care as close to the patient's home as possible.

6. MAIN TASKS, DUTIES AND RESPONSIBILITIES

Advanced Clinical Practice

1. Act as a role model, practicing person centred, evidence based care as described (currently) within the Scottish Diabetes Framework, SIGN guidelines and the local Managed Clinical Network for Diabetes and Highland Diabetes Guidelines, providing individualised care and support to people who require complex diabetes management.
2. Deliver diabetes care in conjunction with relevant generic standards of care and policies e.g. NHS Scotland Standards for Older People, Dementia Standards and Admission, Transfer and Discharge Policy.
3. Utilise critical thinking and analytical skills, incorporating critical reflection, drawing on a diverse range of associated knowledge disciplines, higher level clinical judgement and problem solving in decision-making to determine person centred, evidence-based therapeutic interventions including, physical examination, ordering and interpreting diagnostic tests, assessment of the clinical effectiveness of medication regimes; prescribe and titrate medications.
4. Assist patients to achieve optimum health and well being, taking account of patient choice, implications of lifestyle preferences, employment, driving, manual dexterity, vision and intellectual ability; promote self care disease management including diet, exercise, knowledge and recognition of signs of hypoglycaemia / ketoacidosis and diabetic complications advising on appropriate use of routine professional care / advice and emergency services.
5. Fulfil the role of clinical case manager and Lead Professional as appropriate; develop, implement and evaluate clinical care of patients including the identification of patients who fulfil the criteria for Anticipatory Care Alerts and complete / update Alerts informing relevant members of the multi disciplinary care team.
6. Assess and manage risk within the clinical environment using professional judgement in managing complex and unpredictable care events ensuring appropriate place of patient care; capture the learning from these experiences to improve patient care and service delivery
7. Provide telephone advice to patients and multi disciplinary colleagues in the absence of diabetes nursing colleagues within North Highland.
8. Act as advocate for patients for example those who may be experiencing discrimination in the workplace.

Clinical /Professional Leadership

1. Promote the implementation of the agreed model of Diabetes care facilitating the patients journey between Secondary and Primary / Community Care management through the delivery of diabetes management education and support to colleagues in primary and community care.
2. In conjunction with colleagues in GP practices, assist practices to assess current diabetic care against the SLA and achieve agreed clinical and service standards establishing professional working relationships encouraging effective multi disciplinary team working across care sectors.
3. Provide advice to own and other professions on complex diabetes management supporting the care of patients with co morbidities and care interventions e.g. infections, post operative care, renal dialysis, renal or cardiac failure, PEG feeding etc,.

4. Represent diabetes nursing at strategic and operational planning groups and participate in multi-disciplinary meetings, promoting the contribution, impact and boundaries of advanced level nursing practice within the healthcare team and wider health and social care sector regarding developments in diabetes care and services to enhance safe, effective and cost efficient care.

5. Utilising negotiating and influencing skills, proactively develop and sustain new partnerships and networks engaging professional colleagues and wider relevant organisation stakeholders to influence and improve health outcomes and achieve service quality as described within NHS Scotland Quality Strategy.

6. Lead the development and line manage the Senior Practitioners – Diabetes Nurse posts and associated budget.

7. Give and receive feedback in a constructive, open and honest manner.

Facilitating Learning

1. Provide patient / carer diabetes medication management education, i.e. oral hypoglycaemic agents, GLP1 and insulin administration including blood and urine glucose monitoring. Assess injection technique, injection site problems; provide information and advice on insulin delivery devices and safe disposal of injection equipment.

2. Delivery patient education in groups and one-to-one sessions enabling patients / carers to appropriately practice self care, through the application of adult learning theories, designing and coordinating the implementation of education appropriate to individuals preferred approaches to learning, motivation, cognitive ability and developmental stage.

3. In partnership with specialist dietician, deliver peer reviewed structured education programme to patients who have Type 1 diabetes.

4. Contribute to the implementation of the NHS Highland Diabetes Education strategy providing mentorship and coaching to multi disciplinary colleagues, promoting a learning environment, evidence-based practice, succession planning and building capability and capacity.

5. Seek opportunities to work with and provide education to patient support groups and wider public raising awareness of diabetes as a public health issue.

6. The post holder is accountable for own professional actions demonstrating resilience, determination and leadership in contexts that may be unfamiliar, complex and unpredictable

7. Continuously assess and update own professional education needs utilising the education framework within the Advanced Practice Toolkit, maintaining a current PDP.

Improving quality and developing practice

1. Strive continuously to improve practice and health outcomes to ensure consistence with or better than national and international standards through initiating, facilitating and leading change at individual, team, organisational and system levels

2. Identify need for change taking cognisance of the implications of epidemiological, health inequalities, demographic, social, political and professional trends and developments; developing case for change, leading innovation and managing change.

3. In conjunction with multi disciplinary colleagues, audit and evaluate clinical practice at individual and systems levels, selecting and applying valid and reliable approaches and methods which are appropriate to needs and context, acting on findings.

4. Develop robust governance systems by critically appraising and synthesising the outcomes of relevant research, evaluations and audits applying findings to improve practice contributing to the development and implementation of evidence-based protocols, documentation processes standards, policies and clinical guidelines.

5. Alert appropriate individuals and organisations to gaps in evidence and / or practice knowledge and, as either a principal investigator or in collaboration with others, support and conduct research to enhance practice

6. Publish and disseminate service and care delivery developments through presentations at conferences and articles in the professional press.

7. Develop systems to collate clinical caseload activity data; utilise data in the evaluation of the development of the service.

8. Participate in clinical supervision and seek networking opportunities to further own professional knowledge and development.

7a. EQUIPMENT AND MACHINERY

Utilise technical clinical equipment, calibrating when required, checking for faults and ensuring regular maintenance. Internal and external quality assurance checks and reporting back to Biochemistry.
DCA machine; Near patient testing equipment used to measure HbA1c levels.
Blood Glucose meters; Near patient testing equipment to monitor blood glucose levels.
Blood Ketone meters. Near patient testing to monitor blood ketone levels
Insulin pen devices; for insulin delivery.
Butterfly devices, syringes and needles
Resuscitation equipment including defibrillator.
Computers and lap top/ Maintenance of patient records, Printers, Phone systems

7b. SYSTEMS

1. Works as a practitioner within the Guidelines and Standards of the Nursing and Midwifery Council and NHS Highland

2. Utilise computerised systems to support practice e.g. PAS, SCI-Clinical, Email, results reporting.

3. Provides service activity reports to Line Manager

4. Participates and acts upon relevant statistics such as audit, to enhance delivery and quality of patient care

5. Assist GP practices in the implementation and maintenance of auditing processes

8. ASSIGNMENT AND REVIEW OF WORK

1. Works autonomously managing referrals from Consultant Diabetologists and Teams, Ward Staff (Hospitals), Clinics, General Practitioners, District Nurses, Patients and Carers, Midwives, Care Home Staff, School Nurses, CPN's, Podiatrists etc, delegating suitable patients to Senior Practitioner Diabetes Nurses.

2. Education, learning and development needs are identified via e-KSF and PDP&R process.

2. Works within the statutes and guidelines of the NMC, National, Highland and locally agreed policies, protocols and procedures.

3. Anticipate and develop strategies to resolve service challenges / needs, involving appropriate colleagues such as; peers, Lead Nurse, General Manager, Accountant, and Consultants / Clinical Director.

4. Attends and participates in speciality meetings, staff meetings, and nurse development meetings.

9. DECISIONS AND JUDGEMENTS

1. Makes autonomous clinical decisions, identifying, analysing and synthising relevant information, utilising knowledge, skills and experience of diabetes management taking account of the guidance and standards of the NMC and National, NHSS Highland and local policies, procedures and protocols.

2. Recognises own limitations in the provision of clinical care and urgency of patient needs referring to other health care professionals accordingly.

10. MOST CHALLENGING/DIFFICULT PARTS OF THE JOB

1. Developing and embedding a new model of service provision and levels (Advanced and Senior Practitioner) of nursing practice, across primary, community and secondary care, managing increasing incidence of diabetes within limited resources.

2. Risk of professional isolation due to specialist nature of the role.

3. Developing and sustaining the service and nursing practice while responding to and meeting the varying needs of the patients, relatives and staff.

4. Dealing with problems that have a high degree of complexity, providing advice to other health care professionals in the management of acute situations, using information delivered over the phone.

5. Challenges associated with non-concordance of patients with prescribed treatment

6. Prioritising a varied and demanding workload across a wide geographical area

7. Driving alone, often in inclement weather and in remote areas.

11. COMMUNICATIONS AND RELATIONSHIPS

1. Establish and maintain professional relationships with a wide range of health care professionals, third sector agencies, Hospital, Care Home and other care institutions to provide a planned, co-ordinated seamless service for patients.

2. Identify potential and existing challenges in care options for patients, carers and staff, using negotiation and counselling skills to achieve reconciliation and the best outcomes for patients.

3. Participate in clinical meetings with nursing colleagues, Consultants, Podiatrists, Dieticians etc.

4. Communicate with patients / relatives / carers face to face, by telephone and by email.

5. Participates in regular meetings with colleagues such as Consultants, Podiatrists, Dietician, Nurses, AHPs, for the purpose of; planning, managing, evaluating and developing diabetes services and improving patient care.

12. PHYSICAL, MENTAL, EMOTIONAL AND ENVIRONMENTAL DEMANDS OF THE JOB

1. Concentration, decision-making and organisational skills to cope with competing demands (emergency situations, answering constant telephone enquiries). Daily.

2. Teaching and clinically supervising multidisciplinary staff, patients and carers. - Daily.

3. Dealing with the emotional effects of care for acutely and chronically ill patients and their families. - Daily.

4. Ability to accurately assess patient insulin requirements and calculate appropriate doses. - Daily.

5. Managing verbal abuse and challenging behaviour. - Rarely.

6. Breaking bad news to patients, relatives and staff. Diabetes is a chronic disease that affects not only the patient but the whole family. For a patient with poor diabetic control changing treatment to improve control can result in them no longer being able to continue with their employment. The reality of diabetic complications can be devastating for patients and families.

Environmental

1. Geographical distances involved in delivering care necessitate driving alone in urban and rural environments and occasionally in adverse weather conditions

2. Working within a range of NHS and non NHS settings.

3. Exposure to bodily fluids.

13. KNOWLEDGE, TRAINING AND EXPERIENCE REQUIRED TO DO THE JOB

1. First level Registered Nurse
2. A minimum of 4 years relevant post registration experience.
3. Professional knowledge, skill and clinical expertise of diabetes nursing attained through experience for a minimum of 4 years in a relevant post
4. Evidence of Post Registration Diabetes education and training equivalent to SCQF level11.
5. Evidence of relevant ongoing professional development PDP&R.
6. Team Leadership / Line Management / Service development skills
7. Specific training / skills:
   Lead Professional Training, Long Term Condition Management, Case Management, Health Behaviour Change, Motivational Interviewing, Alcohol Brief Interventions, Smoking Cessation
8. Independent and Supplementary Non Medical Prescribing or willingness to undertake training
9. Experience in working in the community or out patients department.
10. IT Skills – e.g. e-mail, word processing, accessing results reports, SCI-DC, caseload / workload data inputting

14. JOB DESCRIPTION AGREEMENT

I agree that the above Job Description is an accurate reflection of my duties and responsibilities at the date of signing.	
Job Holder's Signature:	Date:
Manager's Signature:	Date: