

#### **JOB DESCRIPTION TEMPLATE**

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| JOB IDENTIFICATION |
| Job Title: Community Assessment & Rehabilitation Nurse  Responsible to (insert job title): Intermediate Care Team Leader  Department(s): Intermediate Care & Rehabilitation Services  Directorate: Health and Community Care  Operating Division: Health and Social care Partnership  Job Reference:  No of Job Holders: 4  Last Update (insert date): 19/07/2023 |

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| 2. JOB PURPOSE |
| Community Assessment and Rehabilitation Nurse providing alternative to hospital admission and facilitate early hospital discharge by assessing, planning, implementing care and managing patients from hospital, community and other settings. Patients will be vulnerable, have complex multi- factorial health and social issues.  Complete a multi- factorial assessment and maintain associated documents to aid diagnosis, carry out treatment, rehabilitation, return independent living skills and manage complex plans with multiple agencies providing services. |

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| **3. DIMENSIONS** |
| Service provided to adults with multi-factorial pathologies across the vast geographical area which incorporates areas of social depravation and geographical isolation. Community Rehab Nurse will be based in South Ayrshire providing enhanced level of support to maintain patients within their own home. They will provide cover across areas as necessary to ensure availability at all times.  Provides a wide and varied range of healthcare options to a diverse range of clinical conditions and patients with physical, psychological, mental and social needs in a community setting, ensuring the highest standards of patient care which complies with current clinical guidelines and legislation whilst working within the remit of the professional governing body, Nursing & Midwifery Council (NMC).  Patient throughput is impossible to quantify. Referrals are continuously taken with no upper limit and pattern can be unpredictable. Assessments/treatments can take varying amounts of time depending on the complexity of the presenting condition/circumstances and the differing clinical, social and psychological needs of the patient. Timeous discharge from the service is important to maintain throughput and allow others to access the specialist skills.  Participate in service development for the team within the Health & Social Care Partnership as we head towards an enhanced level of support for patients in our care.  The Post Holder will be required to co-ordinate day to day work and allocation of work to others. Deal with operational issues as they arise. Allocation of work will be to multi-disciplinary staff of differing banding and enablement care staff. This could vary from 1 to 20 staff. |

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| 4. ORGANISATIONAL POSITION |
| HSCP Senior Manager  Professional Lead  HSCP Service Manager    This post  Team Leader  MDT Staff and Enablement Care staff |

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| 5. ROLE OF DEPARTMENT |
| Planning, designing, developing and delivering the Service in collaboration with South, North & East Partnerships to meet the needs of patients by delivering an enhanced level of care in their own homes or homely environment. To support early discharges from our Acute hospitals and prevent inappropriate admission.  To plan, design, develop and manage Community Health Partnership Services to meet patient needs in line with local and national strategies and priorities, involving patients, carers and the community in general in the development and delivery of integrated quality services.  To develop Independent Contractors in accordance with appropriate contractual arrangements.  To ensure there is a robust, Corporate, Clinical and Staff Governance Framework across all services.  Ensuring local needs are reflected in Community Plans and Local Health Plans.  Implementing plans developed by Community Health Partnership’s in response to local and corporate priorities.  Delivering health improvement and services which meet the needs of individuals and local communities.  Enhancing integration within health services and in health improvement activity.  Reducing inequalities within and between local communities.  Working well and engaging with others.  Having agreed, shared goals and plans.  Being flexible and continuously developing to meet changing requirements. |

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| 6. KEY RESULT AREAS |

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| Work in an inter-agency, inter-disciplinary team i.e. Medical Staff, Allied Health Professionals, ACE Practitioners, Technical Instructors, Social Work colleagues and carers etc., also working jointly and be the link with the consultant geriatricians with formal access to them and day hospital to develop role blurring skills whilst maintaining professional autonomy to achieve satisfactory outcomes for patient care.,  **Clinical Responsibilities - Complex Case Management**  Using highly developed consultation skills to undertake advanced comprehensive specialised assessment of health and psycho-social care needs of patients with complex presentations and multi-factorial pathologies including those with chronic disease, gathering and interpreting information; performing tests and analysing the results, providing direct clinical care that encompasses advanced specialist nursing assessment, treatment, management and rehabilitation of patients within the multidisciplinary team, working autonomously within the settings of A&E when required, hospital wards, care homes and community, giving expert advice and alternative management options. Ensuring consent is obtained and documented.  Work with patients to support compliance with and adherence to prescribed treatments improving clinical outcomes by enabling them to function independently and increasing their choice to remain in their own home/community, reducing the need for, or providing alternatives to hospital admission/support early discharge.  Use highly developed communication skills to negotiate and make recommendations to all relevant disciplines of staff to maximise patient care and promote multi-disciplinary working, where expert opinions between different agencies can differ and conflict. Provide and receive complex information and communicate complicated clinical matters to achieve maximum comprehension of the issues involved and facilitate informed decision making...  Communicate effectively with patients or carers using highly developed interpersonal/communication skills, utilising where necessary alternative methods of communication to overcome different levels of understanding dependant on knowledge base, cultural backgrounds or preferred ways of communicating to achieve desired outcomes.  Development of evidence based holistic personal care programmes in collaboration with individuals, families and their carers, planning and organising a broad range of complex programmes of rehabilitation, requiring a high degree of organisation/care management skills, based on a full assessment of medical, nursing and social care needs, some of which will be ongoing and require the formulation of continual adjustment strategies to obtain best results for patient recovery.  Carry out comprehensive specialist assessment of patients which include those with diverse, complex presentations/multiple pathologies, using advanced clinical reasoning skills to provide in-depth, accurate information which aids diagnosis, often in a highly complex situation where some information eg medical history, is unavailable.  Responsible for a robust mechanism of monitoring, evaluating and reporting the implementation/delivery of the services within the team, carried out through audit and analysis of questionnaires, evaluating patients’ response to health care provision and the effectiveness of care and rehabilitation. This is carried out on an ongoing basis.  Commit funding from an allocated budget to provide flexible packages of care to meet the individuals assessed need taking into account best value for money and clinical risk. This can include negotiating contracted hours with Private Providers to ensure effective service delivery.  Proactively monitor patients on the caseload, providing highly specialised advice concerning the care and treatment of rehabilitation/enablement patients, identifying the early symptoms of disease exacerbation, acute illness and injuries. Prioritise individuals for assessment and management according to their health status and needs, refer to other professionals/specialism as required for appropriate support/diagnostic tests and contributing to diagnosis to ensure optimum outcomes.  Work proactively with patients and their families to plan for and improve end of life care, ensuring that choices are reflected in personalised care plans and communicate with others involved in their care, providing leadership for partner organisations to co-ordinate inputs from all other agencies, ensuring that care is integrated throughout all parts of the health and social system.  Plan, organise and chair case conferences in order to ensure quality of care and delivery of service to patients and their families.  Responsible for own professional development, participate in continuing education and health promotion programmes, develop and update clinical knowledge.  Maintain patient documentation, records and accurate statistical information to reflect care provided, meet professional standards, including computerised systems.  **Managerial**  Responsible for day to day management of any issues i.e. emergency referral of individual with complex care needs requiring inter agency cooperation and consequent reorganisation of previously scheduled team domiciliary visits etc. Plan and organise staff workload on a daily basis to ensure efficient service delivery, allocating cases to appropriate members of staff and re-allocating work as required to ensure optimal outcome for patients.  Authorised signatory for payment of invoices from private care providers and for purchase of stock/stationery/supplies on a regular basis.  Manage performance and behavioural issues in line with local policies and guidelines, minimising and managing interpersonal conflict, maintaining trust and support of the team. Deal with performance issues using highly developed communication skills and be able to demonstrate sensitivity and understanding using a problem solving approach to deal with for example staff personal problems or illness, reporting to line manager if required.  Responsible for the allocation or placement and subsequent supervision of qualified staff or students from multi-disciplinary professions in line with Ayrshire and Arran induction programmes.  Plan and organise own workload taking into account current caseload & competing/complex demands of new/emergency referrals to the service.  Conduct staff appraisal processes (PDP) to allocated staff of any discipline, Technical Instructors and care staff. to facilitate staff development and ensure that organisational objectives are met.  Actively participate in selection and recruitment of staff, serving on interview panels as appropriate and participating in the decision making process.  **Education, Research and Audit**  Lead on research and audit relevant to nursing and specialised area, disseminating findings at a local and national level. Also undertaking research and lead on clinical audit in assessment and rehabilitation of adult and older people allowing service evaluation and development.  Lead specialist in own area for community rehabilitation nursing within multi-disciplinary team, providing support to colleagues with their ongoing clinical development by appraisal, clinical supervision and co-ordinating and participating in training to promote an environment of continuous knowledge within own clinical area.  Responsible for the development and implementation of changes to protocols, clinical guidelines and policies i.e. admission, discharge, rehabilitation pathways in relation to quality, risk management and development of quality care, which will impact on other services including Health, Social services, Voluntary and private sectors, to ensure best practice and consistency of approach.  Critically evaluate newly generated research findings and adapt them for practice using advanced knowledge and skills and disseminate findings internally to influence best practice within the rehabilitation team, this will impact on other disciplines through the cascaded need for them to change their practices in line with the new findings.  Provide specialist education and training in advanced assessment and rehabilitation to multi-disciplinary team members, other health and social care staff, in the hospital, community and voluntary/private care sectors, through in-service, competencies, training events promoting knowledge of specialist role of assessment and rehabilitation training numbers can vary from one to one to groups of 20+. . |

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| 7a. EQUIPMENT AND MACHINERY |
| Use and provide a wide range of equipment during therapeutic interventions, a sample of which is noted below. Interventions will be carried out in a home setting.  **Activities of Daily Living Equipment;**  Dressing – stocking aids, helping hands, button hooks.  Feeding – adapted cutlery, specialised crockery.  Toileting – raised toilet seat, toilet frames, commode.  Kitchen – kitchen trolley, perching stool, tap turners, kettle tippers.  Transfers – bed sticks, high chairs, cushions, mattress elevators, chair raisers.  Bathing – bath boards, bath seats, shower stools, electrical bathing equipment.  **Mobility;**  Mobilators, zimmer frames, trolleys, delta frames, wheelchairs, elbow crutches, walking sticks, quadrapods.  **Manual Handling Equipment;**  Mechanical hoists, sliding boards, sliding sheets, transfer boards, profiling beds.  **Treatment/Rehabilitation;**  Tens units, exercise bicycle, weights, hot/ice packs for pain management/healing process.  **Clinical;**  Glucometer – for blood glucose monitoring  Digital thermometer – for temperature monitoring  Scales – for determining and monitoring weight  Stethescope & Sphygmomanometer – for blood pressure monitoring  Needles and Blood bottles – for venepuncture  Tape measure  Urine testing strips – for urinalysis  Pulse oximeter/saturation monitor  ECG machine  **Other Equipment/Machinery used;**  Personal Computer, Office Equipment, Printer, Digital Sender, Photocopier, Telephone- fixed line and mobile, Fax Machine, Car User. |
| **7b. SYSTEMS** |
| Working within agreed parameters and protocols the team generate and contribute information to databases, ensuring compliance with Data Protection Act and Government legislation. These systems include:  **Manual;**  Personally generated clinical notes  Produce and maintain patient care plans.  Patient Held Record of Care.  Discharge letters/reports – sent to GP and referrer on completion of intervention/treatment.  Referral to other disciplines e.g. podiatry, dietetics, written & telephone.  Stock Ordering  Monthly returns/Stats, Single Shared assessment, Referral log data.  Access medical notes for patient information  NMC Professional Codes of Practice  Ayrshire & Arran Community Health Division Nursing Guidelines & Protocols.  **Computer;**  Service Database.  South Ayrshire Council Systems (SWIS).  Electronic Data Systems e.g. Word, Excel.  Datix incident reporting system.  Travel and timesheets.  E-mail.  SSTS  Turas  Hospital Information System for results access. |

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| 8. ASSIGNMENT AND REVIEW OF WORK |
| Act independently upon referrals from Hospital/Medical Staff, GP, other primary care professionals, social services, care homes and individuals, their carers and families. Patients are referred to the team from 53 GP practices, primary, secondary care staff and social care staff across three local authorities. Referrals are made directly to the team office by telephone or by face to face contact with referring source and may come with very limited information and without access to medical notes prior to the assessment being carried out.  New referrals from accident and emergency must be responded to within 2 hours and before the end of the working day for community referrals where appropriate.  Workload is delegated daily by the post-holder to fellow team members following discussion with them regarding each client’s treatment plan. Post-holder manages and prioritises own caseload on a daily basis with the constant need to reprioritise and reallocate workload throughout the day to accommodate new referrals.  Professionally and legally accountable for all aspects of own work including the management of patients in your care.  Clinical caseload will be generated by the specific service needs through new policies and procedures introduced by NHS Ayrshire and Arran and taking cognisance of any relevant policies and procedures introduced or developed by Ayrshire Councils.  Some work will be self-generated and the post holder should be comfortable with independent working. Daily working independently without direct support of professional colleagues. Lone working for a large proportion of working day.  Work independently as an autonomous professional on a day-to-day basis, responsible for planning and organising own workload and that of delegated staff.  Prioritise work, using highly developed organisational skills, to meet the needs of the practice population and service.  The post holder will be responsible to and report to the team manager in relation to agreed objectives.  The post holder will prepare and participate in peer supervision, 1 to 1 updates with line manager and a minimum of yearly performance review. |

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| **9. DECISIONS AND JUDGEMENTS** |
| In line with NMC code of conduct post holder responsible for making autonomous clinical judgements to decide whether an individual is safe to return home or remain at home taking into account clinical condition, support available, and environment. The post holder will be able to combine high level assessment to aid diagnosis, co-ordinate and monitor treatment and lead the co-ordination of care working with partner agencies and key stakeholders. Consultants, GPs & senior professionals will rely on the post holders’ decisions and judgements to determine whether patient can safely be supported at home (medically & socially).  Assessment of patient’s complex needs (physical, psychological, social & spiritual) to establish change in condition, inform clinical decision-making and care plan, making complex clinical and professional autonomous decisions on a daily basis regarding the care & management of patients. Justify these decisions through stringent monitoring of the patient’s condition & acting on clinical judgement/interpretation.  As a Community and Rehabilitation Nurse, the post holder will work autonomously without direct supervision and act with their own discretion to interpret policies in relation to their caseload, determining whether a patient should be admitted to hospital or be treated in their own home. Also planning, organising and chairing case conferences in order to ensure quality of care and delivery of service to patients and their families.  Assess and manage own, staff and patient risk, both in a hospital and community setting, determining when to delegate appropriate tasks to other team members, taking into account clinical risk, available skill mix, existing workload and any specialist interests ensuring adequate review/supervision arrangements, identifying any training needs.  Undertake investigation of complaints, developing a response and action plan to improve service care and/or delivery. |

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| 10. MOST CHALLENGING/DIFFICULT PARTS OF THE JOB |
| Challenge the opinion of medical/senior staff in relation to the decision over whether a patient can be safely supported at home or discharged home. Challenge any complacency or actions that are not in the interest of the patient/public.  Working independently and adapting to the variable and unpredictable demands of multiple referrals, education and training responsibilities from multiple sources. Responding daily to crisis situations, often with very limited information and access to medical notes.  Planning, organising and managing complex care/treatment packages, having to co-ordinate different multi – agency services with constant monitoring, evaluating and adjustment to patient care plans, while working with patients who may have complex and challenging needs. Using highly developed communication and clinical skills which will have an impact on patients with challenging behaviour, risk management issues, ill health or terminal illness.  Implementing multi – agency policies and proposing change to services to provide alternatives to hospital admission and facilitate early discharge in the face of differing and sometimes conflicting processes and consistent challenge from other staff both hospital and community, requiring highly developed communication skills to negotiate and persuade on an ongoing basis where there are opposing views and objectives.  Lone working, working in areas of social depravation, geographical isolation, with no immediate support available. |

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| **11. COMMUNICATIONS AND RELATIONSHIPS** |
| **This list is neither exclusive nor exhaustive.**  **Internal;** NHS Ayrshire and Arran, South, North and East Ayrshire Community Health Partnerships.  **External;** South, North and East Ayrshire Councils, Private Sector Organisations, Voluntary Organisations, Other NHS Services out with Ayrshire and Arran, Community Pharmacists, University tutors/students, NMC.  **Patients;**  Provide and receive information regarding assessment, diagnosis and treatment and use persuasive/negotiating skills to encourage compliance.  Highly complex communication skills are required to motivate, negotiate with and persuade to achieve optimum outcomes for patients where there are often conflicting views/opinions or barriers to understanding.  Continually demonstrate a high level of empathy, sensitivity, support and reassurance when communicating with patients, relatives and staff, particularly in relation to breaking bad news and dealing with emotionally challenging situations where patients do not easily understand their care/treatment due to cultural, language, physical or cognitive disabilities or where there is denial or anger.  Use highly developed verbal and written communication skills to investigate and report on verbal and written complaints.  Utilise highly developed communication techniques/skills to facilitate rehabilitation in a home setting. Overcome barriers to communication such as frailty, environment or cognitive impairment and be able to demonstrate empathy with the patient.  **Relatives/Carers;**  Provide and receive information regarding complex and sensitive issues where relevant consent has been obtained.  Use highly developed communication skills to educate and negotiate with carers in relation to patient care needs, taking account of how and what to convey in terms of sensitive information regarding the patient.  Teach a range of patient management strategies using highly developed communication skills where there may be opposing views and the need for persuasion and re-assurance.  **Multi-disciplinary Team;**  Working in partnership with other professional/statutory and voluntary agencies, using highly developed communication skills to break down cultural and communication barriers, ensuring excellent communications and working relationships resulting in the provision of a high quality service. Using developed discretionary skills to determine the extent of complex/sensitive information to be imparted.  Use highly developed communication skills to negotiate with multi-disciplinary team regarding service needs consistently throughout the day, where there may be opposing views or opinions.  Liase with and advise medical staff using highly developed communication skills to convey complex/sensitive information and to increase knowledge relating to individual patients, ensuring patient management is maximised.  Promote multi-disciplinary working through arranging, attending and contributing to appropriate multi-disciplinary/multi-agency team meetings and case conferences, frequently, taking a lead role in this process and presenting complex information using highly developed skills, to a large group. |

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

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| **Physical (Skills):**  Dexterity and accuracy required for e.g. venepuncture, ear examination, removal of sutures/clips  Operating blood glucose monitors, using lancets to draw blood for analysis.  Administering injections as clinically required e.g. insulin.  Driving – frequent moving between multiple locations on the same day on a daily basis over a wide geographical area.  Daily application of manual handling techniques and therapeutic rehabilitation skills, frequent use of moving hoist, wheelchairs, walking aids and other manual handling equipment.  A high degree of dexterity, accuracy and sensory activity is required to ensure effective assessment & management of patients’ in confined home environments. Co-ordination and precision are essential when mobilising patients and implementing rehabilitation programmes.  Keyboard –on a daily basis  **Physical (Demands):**  Frequent requirement to exert moderate physical effort for several short periods during a shift. Equipment, which can be, irregular in shape, is lifted in/out of the car and carried into patients homes on a daily basis and throughout the day as required. Equipment weight can vary from 1Kg to >20Kgs per item. Items often have to be carried some distance and up stairs depending on geographical location of patients home.  Frequently working in confined spaces, kneeling bending or crouching for long periods of time.  Daily therapeutic handling.  Assisting or facilitating patients with positioning in a bed/chair, move from lying to sitting position, sit to standing, transfer bed/chair and when mobilising. This includes the use of mechanical aids on a daily basis.  The unpredictability of patients can result in a sudden effort being required e.g. to prevent loss of balance/fall. This may include assisting patients with significant physical, cognitive or behavioural impairment who may be reluctant to co-operate, immobile or obese.  Frequent physical effort required with several different patients in varying home environments e.g. cramped cluttered spaces.  Re-arranging an environment to optimise patient assessment and treatment outcomes within the confines of a patients home  **Mental (Demands):**  Frequent requirement for concentration where the work pattern is unpredictable. Working on an on demand basis the post holder is obliged to respond to crisis situations and to respond to third party requests for intervention with no prior notice. These interruptions can involve re-arranging a caseload to respond to urgent referrals on a daily basis, requiring the post holder to change planned activities with no prior knowledge.  The post holder must be continually able to cope with unpredictable workloads and act timeously to deal with crisis situations, responding to constant interruptions throughout the day from mobile phone/pager.  Frequently deal with competing demands from patients, colleagues, patients families and members of the multi-disciplinary team where there may be conflicting views.  Using highly developed skills to prevent situations from becoming volatile.  Balancing clinical v non-clinical priorities.  Constant awareness of risk, continuously risk assessing.  Intense concentration required when assessing and treating patients as incorrectly applied techniques can endanger the patient.  Making quick accurate judgements/decisions, the outcome of which can affect the safety of self, patient and others.  Being aware of NHS and Local Authority regulations when assessing patients/inputting care/rehabilitation services.  In depth mental awareness to carry out interpretation of clinical assessment.  Managing a caseload while adhering to budgetary restrictions.  Supporting other members of staff on a daily basis.  **Emotional (Demands):**  The post involves working with critically or terminally ill patients, those with chronic degenerative disorders or those who exhibit challenging behaviour/anger, depression. These patients can be from any adult age group.  Frequently working and communicating with patients/relatives who may be distressed/anxious/worried.  Frequent exposure to emotional circumstances, in particular care of patients and their carers at the end of life.  Need to encourage, motivate and counsel a patient on a daily basis is emotionally draining.  Working with bereaved individuals.  There are times when skills are required to diffuse explosive situations with family conflict within a patient’s home.  At times it will be necessary to break unwelcome news e.g. telling a patient/carer of limited expectations from rehabilitation therapy or need for admission to hospital/respite.  Working in a multidisciplinary team can lead to an increase in stress due to challenging professional boundaries.  Undertaking distressing treatments modalities e.g. venepuncture, ear examinations, suture/clip removal, wound dressings, bowel and catheter care.  **Environmental Demands:**  Frequent exposure to uncontained body fluids, faeces, lice, vermin and blood.  Frequent exposure to transmittable diseases and infections e.g. Hepatitis, C Diff.  Frequent exposure to contaminated linen, floors, work surfaces and equipment.  Occasional exposure to contaminated sharp objects e.g. needles, suture cutters. Use of sharp safe boxes.  Occasional exposure to containable hazards eg need for personal alarms, lone worker system.  Occasional exposure to verbal/physical abuse, with no immediate support.  Frequently working in areas of social depravation and geographical isolation often in inclement weather.  Working in isolation within patients homes with no quick access to support, many rural areas have no mobile phone contact. Lone working is a key component of the post.  Visiting patients’ homes with no risk assessment carried out prior to visit. Frequently necessary to visit homes where there is unavoidable risk/no prior knowledge of potential hazards.  Contact with domestic animals whose behaviour can be unpredictable.  Working in high risk areas e.g. dealing with patients with drug/alcohol dependency in their own homes. |

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| 13. KNOWLEDGE, TRAINING AND EXPERIENCE REQUIRED TO DO THE JOB |
| **The post holder will be an expert, advanced practitioner within the field of Rehabilitation Nursing, with a highly developed specialist knowledge gained by:**  **Essential**  **Qualifications**  First level Registered Nurse with current NMC registration.  Educated to degree level  Relevant post-graduate registration qualification or experience in assessment/ community/ rehabilitation.  **Training and Experience - Essential**  Significant comprehensive post registration experience  Experience in rehabilitation and/or care management.  Experience in multi-disciplinary, multi-agency working.  Ability to work independently without direct clinical/professional supervision.  Ability to direct and coordinate programmes of care working collaboratively and autonomously.  **Desirable**  Experience, knowledge and understanding of service improvement and redesign.  Experience, knowledge and understanding of patient and public involvement.  Evidence of relevant on-going professional development and a commitment to lifelong learning.  Experience in change management.  **Knowledge and skills - Essential**  Knowledge and skills to work in a collaborative manner with key stakeholders.  Self-motivating.  Advanced communication and interpersonal skills.  Advanced problem solving and time management skills.  High level decision making prioritisation.  Knowledge, understanding and experience of service improvement and redesign and managing change.  Evidence of continued professional development and a commitment to lifelong learning.  Ability to work well under pressure to competing demands, using own initiative.  Excellent team working skills.  Extended nurse role – venepuncture, ear syringing, and care of syringe driver.  Driving licence.  Undertake extended nurse role to include – intra venous therapy (antibiotics) and electrocardiograph (ECG)  Ability to lead/develop clinical audit, protocols, guidelines.  Teaching, supervising, mentoring and supporting staff.  **Desirable**  IT skills |

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| **14. JOB DESCRIPTION AGREEMENT** | |
| A separate job description will need to be signed off by each jobholder to whom the job description applies.  Job Holder’s Signature:  Head of Department Signature: | Date:  Date: |