**NHS Greater Glasgow and Clyde Job Description**

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| 1. **JOB IDENTIFICATION** | |
| **Job Title:**  **Responsible to:**  **Department:**  **Directorate:** | **Community Staff Nurse - Focussed Intervention Team**  **Team Lead Focussed Intervention Team**  **Health & Community Care**  **West Dunbartonshire Health and Social Care Partnership (HSCP)** |
| **2. JOB PURPOSE** | |
| This post is part of an extended hours Integrated Health and Community Care Team within West Dunbartonshire HSCP providing rapid access to Focussed Interventions and/or Advanced Care Planning for a defined period of time. It offers the opportunity to work as a community staff nurse with all adult care groups and provide direct clinical care, which encompasses holistic nursing assessment and management of patients within their own homes or homely setting*.* Encompassed within this team is also a Care Home Liaison Nurse service & COPD Nurse service and as a Community Staff Nurse you will support these roles – providing an excellent development opportunity.  The post holder will   * Participate in Anticipatory Care Planning as required with the aim to minimise avoidable hospital admissions and maximise individual’s ability to remain safely at home. * Provide an accessible, appropriate, high quality, culturally sensitive and effective nursing service to all age groups in the community, by working in partnership with service users, care providers and other agencies. * Function as an independent autonomous practitioner by virtue of in-depth knowledge, expertise, proficiency and experience to enable the Focussed Intervention Team to provide a quality multidisciplinary service. * Be a registered nurse who will support the Focussed Intervention Team in delivering care to patients within the caseload. * Be responsible for providing skilled nursing interventions for patients within the caseload. * Deliver relevant core generic assessment? appropriate to the multidisciplinary component of this team. * Manage delegated activity within the caseload, and provide support to other members of the Focussed Intervention team. * Provide professional advice and direction to other professional colleagues and team members. * Supervise less experienced staff as well as Support Workers and students on clinical placement. | |
| **3. ROLE OF DEPARTMENT** | |
| West Dunbartonshire has a diverse population of approximately 90,000 and covers two distinct localities. West Dunbartonshire HSCP employs approximately 2,083 staff and manages services of various client groupings. The HSCP has established links with the acute sector, the third sector and a number of independent contractors. The Health & Community Care Services within West Dunbartonshire HSCP offers a service to individuals and their carers through a co-ordinated approach by all health and social care staff.  The Focussed Intervention Team (FIT) will build on current good practice on frailty, COPD management in the community and anticipatory care planning and will enhance service provision to people with frailty and complex care needs. The team remit will encompass multi-morbidity and long term conditions across adulthood. There is approximately 18 staff in the Focussed Intervention Team that operates over 7 days including public holidays. | |
| **4. ORGANISATIONAL CHART**  **(shows levels directly above and below this post)**  Integrated Operations Manager  Team Lead      Senior Nurse / Nurse Team leaders  MDT staff (inclusive of RN’s)  **Community Staff Nurse (This post)**  Band 5    **--------Professional Guidance**  **\_\_\_\_\_\_Management**  FIT Support Workers | |
| **5. SCOPE AND RANGE** | |
| The Focussed Intervention Team is available 365-days a year. Care needs are prioritised to be able to respond to both planned and unplanned care. This includes the ability to respond timeously to unscheduled care requests for those patients who require urgent Focussed Interventions, to prevent admission to hospital or respond to a changing level of frailty. The caseload compromises of patients with a range of complex needs requiring high-level multidisciplinary interventions, those requiring nursing care in relation to chronic disease management and the provision of skilled multidisciplinary interventions, and also potentially technical interventions, e.g. subcutaneous infusions, enteral feeding and tracheostomy management. The caseload population will be derived from a defined geographical population (residents of West Dunbartonshire) and a defined client group (Frail and / or those at risk of admission to hospital).  The caseload also supports those with COPD in the community (with a defined set of criteria) and also manages nurse led beds within West Dunbartonshire Local Authority residential care homes.  The post holder   * Will participate in the late shift, weekend and public holiday rota. * Where staffing levels are reduced it may be necessary to reallocate staff to provide support to another team within the HSCP. * Be responsible for delivering care to patients as delegated by senior team members (RN, Occupational Therapists and Physiotherapists). * Will be professionally responsible and accountable for all aspects of your own professional practice. * Will act to assess, plan, implement, evaluate, treat and progress programmes of patient/client care to maximise their rehabilitation potential and minimise the risk of hospital admission, under the line management and direction of senior team members. * Make an initial assessment of patients/clients requiring health and social care services using a standardised assessment tool and agreed professional assessment tools. * Continually reassess patients/clients in order to progress treatments effectively and advice patients/clients, members of the MDT, GPs, carers, and other health and social services professionals. * Co-ordinate interventions which may include other disciplines; advise and educate patient/client/carers/relatives/other health professionals. * Be responsible for maintenance of accurate written records and information recorded electronically, use of computerised diary and records including comprehensive progress and discharge reports. | |
| **6. MAIN TASKS, DUTIES AND RESPONSIBILITIES** | |
| The post holder is responsible and accountable for assessing, planning and implementation of programmes of care as directed by the line managers within the team. These will be developed in partnership with Patients, Family, Carers and Significant others, and will be evidence based taking into consideration the lifestyle, race, gender and cultural background, and factors which impact on physical, mental or emotional health.  The post holder will -   * Assume the responsibility of the caseload holder during short periods of sickness, absence and annual leave, seeking support as required from other senior members of the FIT Team. * Be responsible for the utilisation of various clinical and environmental risk assessment tools in order to identify actual and potential risks and ensure implementation of appropriate interventions. * Be responsible for reporting and participating in the critical appraisal of incidents to reduce any recurrences and participate in further investigation as required. * Be able to support patients, families and carers in order to achieve optimum health and independence. * Plan and prioritise workload as required, delegate work using available resources and make decisions to ensure that patients’ needs are being met. * Have knowledge and skills to manage those with COPD in their home /homely setting. * Have knowledge of Technology Enhanced Care to support patients to self manage their long term conditions. * Work within systems to ensure continuation of a quality 24-hour multidisciplinary service * Be required to provide nursing care to patients within West Dunbartonshire HSCP Residential Care Home setting in Nurse led beds, working effectively with Care Home staff. * Use a systematic, flexible and innovative approach to problem-solving where there is either barrier to understanding or financial constraints within the patient’s home, in order to provide a safe and effective care package. * Participate in clinical audit and research that will ensure continuing improvements in practice and enhance individual and team performance for the improvement of patient care. * Participate in the implementation of evidence-based nurse interventions to meet the individual needs of patients using national guidance and standards developed by NHS Quality Improvement Scotland, Scottish Intercollegiate Guidelines Network and Best Practice Statements * Be familiar with and ensure implementation of local, regional and national policies, procedures and guidelines pertinent to their area in the pursuit of the highest standard of care. * Provide clinical leadership and be a role model for junior members of the team by representing the values and beliefs of the nursing profession as well as that of the organisation. * Participate in systems of practice support, caseload supervision and personal development plans. * Attend staff meetings and clinical and mandatory training. * Have the skills to respond to emergency situations e.g. anaphylaxis and cardiac arrest, by providing basic life support. * The post holder is responsible for ensuring that they practice within the Policies and Procedures of NHSGGC; the Legal & Ethical framework established by Nursing & Midwifery Council (NMC) – The Code – Professional Standards of Practice and Behaviours for Nurses and Midwifes (2015) and National Legislation to ensure the patients’ interests and wellbeing are met. * Maintain accurate up-to-date clinical records and care plans in accordance with NMC standards for records and record keeping, ensuring compliance with the Data Protection Act, GDPR, and the Freedom of Information Act. * As a mentor (underpinned by theoretical and experiential knowledge) the post holder will ensure that systems are in place to supervise and support pre-registration nursing students. Accommodate other multi-disciplinary and multi-agency personnel who require to gain an overview of the team. * Participate in any audits relating to clinical placements in partnership with Higher Education Institutions and implement any changes as required, working in collaboration with the Division’s Practice Education Facilitators. * Participate in the delivery of preceptorship programmes for newly qualified nursing staff as delegated by line manager and senior members of the team.  . Would induction not me management?Be responsible for own professional development and encourage and support the continuing professional development of junior team members.  * Be responsible for establishing and maintaining effective communications and working relationships with primary, secondary and tertiary care colleagues, and collaborate with statutory and voluntary agencies to ensure effective co-ordination of services for individuals and groups. This will include effective discharge planning procedure and development of care packages. * To have knowledge of the determinants of ill health and participate in health needs assessment to support health improvement activity, thus enabling patients to improve and maintain their health and wellbeing. | |
| **7. SYSTEMS, EQUIPMENT AND MACHINERY** | |
| **The post holder will utilise the following resources on a regular basis:**  **SYSTEMS**   * Electronic clinical and management systems e.g. CNIS, EMIS, Care First, Clinical Portal, MS Office, Team Databases, EQUIPU, DATIX, e-ESS/SSTS, TURAS, profession specific tools. * To assist in ensuring adequate stock levels of equipment, as agreed by the team, is available for use by the team. * To provide statistical information for reporting purposes  EQUIPMENT AND MACHINERY: **Clinical Equipment e.g.**   * Height adjustable and electrically operated hospital beds. * Full range of transfer equipment, including hoists, stand aids, bed levers, transfer boards, sliding sheets, monkey poles * Pressure reducing equipment including cushions and mattresses * Activities of daily living equipment * Mobility aids * Wheelchairs including toilet/commode and shower chairs * Bathing equipment * Oxygen cylinders * Nebulisers * Equipment to support effective use of inhalers * Ear syringing equipment * Enteral pumps * Phlebotomy apparatus * Injection apparatus Pump * Syringe pump equipment * Suction equipment * Clinical observation equipment * IT equipment * Mobile phone | |
| **8. DECISIONS AND JUDGEMENTS** | |
| * To be accountable for his/her own professional actions and justify decisions based on the assessment of the client, family/carer and environment. * To be aware of his/her own scope of practice and work mainly without direct supervision whilst regularly reporting back to the caseload holder.   To identify their own learning and development needs.. | |

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| **9. COMMUNICATIONS AND RELATIONSHIPS** |
| |  |  |  | | --- | --- | --- | | **The post holder communicates with:** | **What the communication is about** | **Any difficulties encountered** | | Patients & Staff | * To be able to motivate and persuade others through advanced communication skills, with the benefit of verbal and non-verbal skills, using written and electronic information where needed * To demonstrate the ability to communicate complex and sensitive information to patient/clients, carers and other staff, where there may be barriers to communication i.e. non-English speaking patients; use of interpreters; excess noise or lack of privacy and ensure all members of the team do likewise * To maintain close links, communication and liaison between all staff and people involved in patient/client care, student education, research or policy development as appropriate and promote good working relationships at all times * To liaise with and advise occupational therapists, physiotherapists, nursing staff, relevant medical staff, social workers and other health care professionals who may be in direct contact with the post holder with regard to patient/client care * To communicate effectively with all other disciplines involved in the patient's care both in the Acute and in the community thus ensuring a multidisciplinary approach * To attend meetings and case conferences as appropriate, and to liaise with and advise other disciplines, as appropriate, to achieve comprehensive, effective and confidential patient/client management through admission to discharge | Patients/clients who are aggressive or under the influence of alcohol.  Poor adherence - e.g. patient/client with dementia.  Unable to obtain informed consent.  Patients/clients with learning difficulties.  Patients/clients who are abusive.  Treating patients/clients within the home setting who may have dogs that are not under the appropriate control.  Patient/client with communication difficulties  Managing families emotions in times of crisis | |
| **10. PHYSICAL, MENTAL, EMOTIONAL AND ENVIRONMENTAL DEMANDS OF THE JOB** |
| |  |  |  | | --- | --- | --- | | **Physical skills**  Parenteral administration of medicines  Enteral feeding  Intricate wound care  Insertion of male and female and supra-pubic catheters  Removal of sutures/clips  Leg Ulcer Care  Bowel and Bladder Care  Manoeuvre and move patients with and without the use of mechanical aids | **Physical demands**  Manoeuvre and move patients with and without the use of mechanical aids  Push wheelchairs/shower chairs/hoists – with and without patients in them  Carry nursing bag/equipment to patients’ homes  Stand or walk for majority of shift  Drive within city/countryside environments  VDU exposure  Bending and kneeling  Climbing/descending stairs | **Emotional demands**  To deal with patients/clients suffering from painful, terminal conditions, patients/clients under the influence of alcohol which may lead to anxiety and aggressive behaviour.  Dealing with difficult family circumstances.  To be able to manage potentially stressful, upsetting or emotional situations in an empathetic manner.  To sensitively deal with distressing or emotional circumstances regarding patient/client care e.g. imparting news of poor prognoses such as chronic pain management or lifelong disability. | | **Mental demands**  To work in an unpredictable environment where the work patterns may be disrupted by frequent demands from patients, clinical staff, carers, rehab assistants and administrative support staff  To support junior staff and other team members when indicated in the management of challenging patients | **Working conditions**  Lone working, eg domiciliary visits.  Dealing with difficult working conditions, eg exposure to unpleasant or hazardous circumstances such as poorly controlled temperatures, smells.  Needlestick Injuries  Exposure to pets |  | |
| **11. MOST CHALLENGING/DIFFICULT PARTS OF THE JOB** |
| The intensity of dealing with high volume of acutely unwell patients/clients and the need to make recommendations about their ongoing interventions / care.  Service provides cover to a wide geographical area which may involve driving for long distances and long periods of time. There is a requirement to drive to all community referrals.  There are frequent interruptions involving new referrals being made which means ongoing prioritising of planned caseloads. Rapid Response referrals must be dealt within 2 hours of referral.  This job may involve frequent exposure to highly unpleasant working conditions e.g. body fluids including sputum, faeces, urine, vomit and lice, unpleasant smells, alcohol and drug abuse.  Occasional exposure to verbal and physical aggression. |
| **12. KNOWLEDGE, TRAINING AND EXPERIENCE REQUIRED TO DO THE JOB** |
| See attached Person Specification |

PERSON SPECIFICATION

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| Job Title: | FIT Practitioner – Band 5 Registered Nurse | |
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| Requirements | **Attribute** | Essential **(E)**  Desirable **(D)** |
| **QUALIFICATIONS** | First level Registered Nurse with currently valid registration with the Nursing and Midwifery Council  Educated to degree level in Adult Nursing or equivalent | E **E** |
|  | Non Medical Prescribing (V100 or V300) qualification (or willing to work towards this)  Advanced Assessment and Clinical Decision making module (or willing to work towards this). | D **D** |
| **EXPERIENCE** | Minimum of 2 years’ post-registration NHS experience | **E** |
|  | Working in a multi-disciplinary team | **D** |
|  | Experience in community nursing | **D** |
| **KNOWLEDGE** | Evidence of ongoing CPD in a variety of specialities | E |
|  | Evidence of Statutory & Mandatory Training  Post registration experience in COPD | E **D** |
|  | Ability to fulfil criteria outlined in the Job description | **E** |
| **SKILLS** | Demonstrable ability to process and use complex information to improve patient outcomes. | E |
|  | Demonstrable ability to use clinical reasoning and judgement | E |
|  | IT skills to utilise clinical information systems, databases and other software to improve patient care. | E |
|  | Excellent written and verbal communication and negotiation skills to communicate effectively with health and social care professionals, patients and carers. | E |
|  | Excellent organisational skills. | E |
| **ABILITY** | Demonstrable ability to prioritise workload. | E |
|  | Ability to apply logic and analytical skills to manage clinical risk. | E |
|  | Ability to work autonomously and evaluate own work. | E |
|  | Demonstrable ability to work quickly, accurately and to deadlines. | E |
|  | Demonstrable ability to work as part of a team | E |
|  | Valid full UK driving licence | E |