#### Form JE 5



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| 1. JOB IDENTIFICATION | |
| |  |  | | --- | --- | |  |  | | Job Title: | District Nurse Clinical Team Leader | | Responsible to (insert job title): | Senior Nurse Primary Care | | Department(s): | Community Nursing | | Directorate: | Angus HSCP | | Operating Division: |  | | Job Reference: | **Sc06-1203(rev24)** | | No of Job Holders: | 6 | | |
| 2. JOB PURPOSE | |
| Responsible and accountable for the delivery of nursing care at home/community over the 24-hour period to the practice/geographical population (and wider locality at weekends). Work in collaboration with the Primary Health Care Team, wider District Nursing Team, NHS24, Out of Hours Nursing Service and other agencies involved in the delivery of care in the Community.  Plan, manage and organise a defined caseload providing leadership and clinical supervision to the District Nursing Team as well as case supervision to junior members of the District Nursing Team.  Engage in assessment of individual and/or family care needs in conjunction with the clients and within available resources plan, implement and evaluate health care programmes conducive with meeting their needs, referring to other team members and agencies when appropriate.  Support Public Health Agenda.  Providing expert and specialist nursing care and when appropriate take on role of lead assessor  The postholder is responsible for the planning and implementation of practice-based learning for Specialist Practitioner Qualification (SPQ) students. | |
| **3. DIMENSIONS** | |
| The District Nursing (DN) Service is embedded in our local communities, within Angus we have 9 District Nursing teams, and they are pivotal in caring for patients in their own home or homely setting and preventing unnecessary admission to hospital.  The Aims of the District Nursing Service are to:   * Ensure referrals to the service are appropriate for admission to a DN caseload; where referrals are assessed as inappropriate for the DN service, timely sign posting is given to the referrer * Support individuals to understand their healthcare needs and encourage them to participate in decision making regarding the treatment options available, goal setting and agreed health outcomes including contributing to multidisciplinary anticipatory care planning * Reduce duplication of assessments wherever possible by sharing relevant information with other members of the health and social care team in line with GDPR guidance * Allocate and deploy resources appropriately, ensuring people are seen by the right person at the right time in the right place | |
| 4. ORGANISATIONAL POSITION | |
| |  | | --- | | Senior Nurse Service Manager  (Primary Care) (Primary Care )    Clinical Nurse Educator  **/) District Nurse Clinical team leader- (this post)**  District Nurse  Community Staff Nurse  Nursing Team | | |
| 5. ROLE OF DEPARTMENT | |
| * To provide 24-hour nursing care in the community across 7 days a week * To provide a high quality, comprehensive and accessible nursing service to individuals, and who have been assessed as requiring care from the District Nursing service in their own home or homely setting * Provision of person-centred, safe and culturally sensitive assessment, treatment, planning and delivery of ongoing nursing care * To work with individuals to enable them to remain safely in their own homes, to maximise their independence and to achieve their health goals and improve their quality of life * Work in an integrated way within locality teams to support the provision of multidisciplinary/multi-agency, seamless care which is delivered within a person’s home or as close to a person’s home as possible, thereby reducing avoidable admissions and re-admissions to hospital and facilitating safe and timely discharges * Work with the multi-disciplinary/multi-agency team in providing a person-centred approach in order to reduce duplication and improve continuity of care * Support people in fulfilling their choice of dying in their preferred place of care and enabling choice in End of Life (EOL) care. Using appropriate EOL care pathways to support choice options and by extending support and enablement to the families and carers of these individuals * Listen to individuals, their family and carers to ensure they feel their concerns are listened to and acknowledged and ensure that lessons are learnt when things do not go as planned and shared to improve the care we deliver and achieve service outcomes * Promote health and wellbeing and reduce health inequalities by offering pertinent advice and information to individuals, carers and other professionals * Promote equitable access to the service based on assessed need, irrespective of any physical, functional, sensory or cognitive difficulties * Provide a care coordinator role for those individuals with complex care needs to support them to navigate health and social care pathways * To regularly review the care plan of all people on the district nurse caseload. The frequency of this will depend on the level of assessed need or as indicated by local policy or protocols | |
| 6. KEY RESULT AREAS | |
| Responsible and accountable for the ongoing assessment, development, implementation and monitoring of health care ensuring that the highest standard of service and care is delivered in a consistent and safe manner, primarily within the home and a wide range of community and clinical settings.  Maintain accurate up to date clinical records including electronic records and care plans in accordance with local policy, GP practice requirements, legislation, good practice and patient confidentiality.  Undertake a range of clinical duties ensuring all protocols and policies, are implemented and adhered to, and that equipment is maintained to the appropriate standards.  Participating in development of guidelines and protocols.  Support and educate patients, relatives and carer’s in order to achieve optimum health and independence.  Develop and participate in the Health Improvement plan, promotion of healthy lifestyles, prevention of disease to support the Public Health Agenda. Participate in work related to the General medical contract for housebound patients with chronic disease.  Initiate, establish and maintain good working relationships with patients, carers and members of the Primary Health Care Team to support multidisciplinary working.  In line with clinical governance to audit agreed standards of care, measure clinical outcome and implement any required change. Participate in and support research and development projects.  Establish and maintain effective communications and relationships with statutory and voluntary agencies, which promotes collaborative working and effective co-ordination of services for individuals and groups.  This may require participation in effective discharge planning procedures and development of care packages. Attends and/or organises case conferences appropriately.  The post holder is required to comply with all Statutory Policies and Procedures of NHS Tayside the Board and the Nursing Midwifery Council Code of Professional Practice, Guidelines and Standards.  The post holder is required to take responsibility for his or her own professional development in discussion with and with the agreement of the Service Manager.  Provide management, leadership and mentorship to the District Nurse team. Participate in the teaching and clinical supervision of staff, and students.  To participate in the recruitment and selection of new staff within the service and take an active role in their induction/orientation programme  By personal example ensure that the highest standard of professional conduct is maintained.  To assist in the investigation and resolution of complaints in line with local policies.  Responsible for the ordering and maintenance of stock supplies at base and within patients homes e.g. dressings.  To maximise all available physical and human resources to meet continuing patient need  Planning and organisational skills for effective caseload management and appropriate delegation and deployment of District Nurse team members.  Develops specialised individual patient programmes of care/care packages including risk assessment.  Liaison and co-ordination of services to deliver complex care packages in line with the joint future agenda.  To teach, mentor, assess and develop SPQ student to equip them for safe practice.  Act as a counsellor and guide to the student and be able to identify with them their stresses at an early stage and support them to resolve these stressors in partnership and if required with the HIE’s.  *To support NHS Tayside values of quality, teamwork, care and compassion, dignity and respect, and openness, honesty and responsibility through the application of appropriate behaviors and attitudes.* | |
| 7a. EQUIPMENTAND MACHINERY | |
| * Responsible for the safe use of patient related equipment e.g. hoists, therapeutic mattresses, syringe drivers, Doppler machines. * Responsible for the **initial** instruction in the use of equipment to those carers currently involved with the patient * Responsible for the ordering of appropriate equipment to meet patient need e.g. hospital beds, recliner chairs * Ensure that all relevant equipment is regularly checked. In accordance with local policy | |
| **7b. SYSTEMS** | |
| * Personally generated clinical notes both paper and electronic * Inputs personally generated data into electronic system * Patient-held records. * Organises team workload, staff meetings, rotas and adjusts as necessary * Consideration given to deployment of staff in relation to travel costs * Efficient use of mobile telephones and laptops issued for the service * Overall responsibility for stock control both at base and in patients’ homes   **Responsibility for Records Management –**  All records created in the course of the business of NHS Tayside are corporate records and are public records under the terms of the Public Records (Scotland) Act 2011. This includes email messages and other electronic records. It is your responsibility to ensure that you keep appropriate records of your work in NHS Tayside and manage those records in keeping with the NHS Tayside Records Management Policy and with any guidance produced by NHS Tayside specific to your employment. | |
| 8. ASSIGNMENT AND REVIEW OF WORK | |
| Staff Management, including staffing levels  Supervisory responsibilities for the team including annual appraisal of junior members  The postholder has oversight of the service financial budget for district nursing team, staffing, prescribing, stock control and ordering equipment  Providing service to patients within home/community settings to patients and carers registered with the GP Practices/Health Centre/geographical area. Provides a wide range of healthcare options to the practice population, to ensure the highest standard of care is given, which complies with current clinical guidelines and legislation. Public Health/Health education is essential, and every opportunity should be taken to promote a healthy lifestyle.  Assess, plan, implement and evaluate the care requirements of the practice/geographical population using a variety of sources to meet the patient’s needs.  Liaison and collaboration with other agencies both voluntary and statutory to provide a seamless service to patients and their carers being cognisant of local and national health policies including joint futures.  Responsibility for assessing and providing care to a diverse client group with complex health and social care needs.  Provide specialist advice and consultation on community nursing issues to other professionals and service users.  Clinical Team Leader has the additional responsibility of supporting the SPQ students throughout their academic year, enabling them to fulfil the required competencies.  This is achieved by: -  • developing learning contracts.  • providing time for reflection whilst on practice.  • teaching how best practice is informed and facilitated by theory and research.  • introducing students to the community, giving them an awareness of communication and networking channels vital for community practice.  • frequent collaboration with the university, providing input and influencing course development. | |
| **9. DECISIONS AND JUDGEMENTS** | |
| Working as an autonomous practitioner workload will be self-generated and referrals may come from other sources e.g. via GP’s, Hospital Team, Patients and Carer, Social Work, other Healthcare professionals.  Work will be carried out and reviewed in accordance with NHS Tayside’s policies and procedures.  The line Manager will undertake an annual performance review and appraisal in accordance with Personal development policy.  Assessing and interpreting a wide range of acute/chronic conditions, whilst making relevant changes to patient care/ management and completes episodes of care as required.  To make independent decisions in relation to prescribing as part of holistic care and in line with legislation.  Prioritise and decide when to refer to other healthcare professionals and statutory and voluntary services.  Management and coordination of other team members. Taking action as required resolving staff disputes/ problems within own team and wider zone.  Take a proactive part in the recruitment, interview and selection process for new staff within community teams.  The manager can be contacted for support and advice when necessary. | |
| 10. MOST CHALLENGING/DIFFICULT PARTS OF THE JOB | |
| Being able to manage the organisation of the district nursing role within the GP practices, while maintaining continuity of care and improving quality of patient care within the home and other community settings.  Being able to meet the clinical needs of a diverse client group and demands from other agencies and professionals whilst balancing conflicting priorities in addressing the health challenges within NHS Tayside.  Self-development and contributing to service developments by participation in working groups /committees self plus DN Team to support above.  Meeting clinical and managerial responsibilities ensuring that high standards are maintained. This includes responding promptly to informal complaints, reporting incidents appropriately and participating in adverse incidents reviews when called.  Balancing the needs of the student without any reduction in caseload responsibilities.  The need to keep up to date with emerging educational and political trends, reflected in a constantly changing student curriculum. | |
| **11. COMMUNICATIONS AND RELATIONSHIPS** | |
| The District Nurse will regularly communicate confidential, complex and sensitive information with various people through face-to-face, on the telephone or in written correspondence maintaining confidentiality at all times (daily basis).  The ability to establish and maintain good relationships between the nursing team and wider multidisciplinary team is essential and includes communications with public health care team and other health, welfare, social services and voluntary agencies (daily basis).  The ability to work effectively with clients, carers and relatives either individually, as a family unit or as a community in order to promote positive relationships.  Essential communication skills would include tactful persuasion, motivation, negotiation and empathy as well as diplomacy leading to informed patient choice.  A very high level of interpersonal skill is required when communicating in an emotive or hostile atmosphere with various patient groups e.g. those with substance misuse problems, mental illness or whilst caring for those in the terminal stage of their illness (daily basis).  **KEY CONTACTS**:   * GPs and Primary Care and Community Staff, * Minor injuries units, out of hours nursing and medical staff and Community Hospital Staff * Senior Nurses with management responsibility * Practice Nursing Staff and Marie curie staff * Community and Practice Administration Staff * Support services in the area e.g. dieticians and or podiatrists and those allied health professionals in relation to patient condition/care. * Prevention of admission and intermediate care services including intensive home care services. * Pharmacists – practice based and community pharmacists * Local Authority specifically Social Work * Patients/Relatives and Carers/ persons with Power of Attorney * Other NHS Boards/NHS 24 * Other Statutory and Voluntary Agencies * Patient participation and public involvement groups * Institutes of higher education | |
| **12. PHYSICAL, MENTAL, EMOTIONAL AND ENVIRONMENTAL DEMANDS OF THE JOB** | |
| **Physical**:   * Initial set up of heavy equipment in patients’ homes e.g. mattress variator, Air mattress. * Working in, cramped awkward positions often kneeling and bending. * Carrying equipment daily, bag, scales, etc. * Patient movement with use of mechanical aides, manoeuvre patients daily or more often, in confined spaces. * Kneeling/stand/walking for the majority of shift. * Requirement to travel on a daily basis between patients’ homes and maintain service provision during adverse weather conditions –this may necessitate walking to patient’s homes.   **Mental**:   * Responsible for high level decision making and judgments in relation to all aspects of patient care. * Concentration required when checking documents/patient notes, drug dosages (including times of being single nurse giving controlled drugs), scheduling visits, writing prescriptions, complex care planning. * Requirement to prioritise own work and that of others including co-ordination of the off-duty rota * Unpredictable workload and work pattern. * Utilising resources efficiently. * Requirement to deal with urgent situations and respond to those patients contacting thru the rapid response system during terminal illness.   **Emotional**:   * Communicating with distressed/anxious/aggressive patients/relatives. * Caring for the terminally ill/palliative care patients includes children. * Caring for patients following receipt of prognosis/breaking bad news. Regular and ongoing. * Support of staff involved in distressing situations/general support. * Bereavement support. * Management of conflict within the team. * Clinical Supervision   **Environmental**:   * Exposure to body fluids, several times each shift. * Exposure to poor social circumstances (daily). * Requirement to work in confined spaces (patients’ homes). * Lone working daily. * Isolated communities daily. * Working in vulnerable situations daily. * Adverse weather unpredictable. * Verbal/physical aggression at least weekly but can be daily depending on patients that day. * Exposure to passive smoking, exposure to animals for example aggressive domestic pets. * Stress of travelling between calls when under pressure. * Occurrence variable. | |
| 13. KNOWLEDGE, TRAINING AND EXPERIENCE REQUIRED TO DO THE JOB | |
| * Registered General Nurse * Recognised qualification in District Nursing (Specialist Practitioner Qualification Community Nursing in the Home or District Nursing Certificate or Diploma.) * Evidence of Continuous professional development * Nurse Prescriber / Non-medical prescribing * Clinical History taking and examination module * Highly developed critical thinking and analytical skills   **Competencies:**   * Specialist holistic assessment skills * Highly developed communication, interpersonal skills, and Problem-Solving Skills * Time Management Skills * Leadership skills with ability to work well under pressure and be adaptable * Ability to work on own initiative and delegate determining priorities and making efficient use of resources * IT skills * Ability to introduce and manage change within the practice nursing team * Maintaining mandatory training requirements * Sound clinical skills including experience in delivering palliative care in a home setting the management of chronic disease assessment /management of acute and chronic wounds. * Teaching and mentorship skills | |
| **14. JOB DESCRIPTION AGREEMENT** | |
| A separate job description will need to be signed off by each job holder to whom the job description applies.  Job Holder’s Signature:  Head of Department Signature:  **(I confirm this Job Description accurately reflects the duties and**  **responsibilities of the postholder and does not impact upon any other**  **postholders role)** | Date:  Date: |