Integrated Care Programme for the Prevention and Management of Chronic Disease

Integrated Model of Care for the Prevention and Management of Chronic Disease

Implementation Guide

Seirbhís Sláinte Níos Fearr á Forbairt | Building a Better Health Service

Table of Contents

Integrated Model of Care for the Prevention and Management of Chronic Disease - Implementation Guide

Introduction

The Integrated Care Programme for the Prevention and Management of Chronic Disease (ICPCD) focuses on improving the standard of care for four major chronic diseases that affect over one million people in Ireland: cardiovascular disease, type 2 diabetes, chronic obstructive pulmonary disease (COPD) and asthma. The ICPCD is leading out on the development and implementation of a model of care for the Integrated Prevention and Management of Chronic Disease in Ireland.

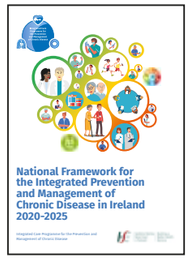
We know that the risk factors for chronic disease and the levels of chronic disease across Ireland's population are increasing. Our health service as it is currently structured with an overly hospital-centric focus, struggles to meet the needs of our population. Sláintecare, Ireland's ten-year plan for delivering a health and social care service that meets population need, has provided the impetus for developing and implementing a chronic disease framework that is person-centred, holistic, proactive and preventive in its approach and delivered in the community.

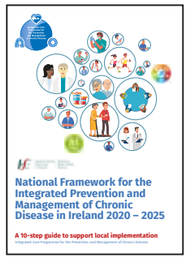
Our recent experience of learning to live with COVID-19 lends further weight to the need for reform of our health services: it is now essential that congregated settings, such as the hospital setting, for older people or people with chronic disease are avoided as much as possible and that these individuals be cared for within the community setting. Implementation of the 'end-to-end' model for the integrated prevention and management of chronic disease will support health and social care professionals to provide holistic patient-centred care as close to home as possible.

'Integrated Care' for chronic disease is defined as healthcare provided at the lowest appropriate level of complexity, with responsive, connected services built around patient need, to support and empower individuals to optimise their health, actively address and minimise their risk factors for chronic disease and to live well with chronic disease.

The '*National Framework for the Integrated Prevention and Management of Chronic Disease*' and accompanying '*National Framework for the Integrated Prevention and Management of Chronic Disease: a ten-step guide to support local implementation*', outlines an 'end-to-end' model for the prevention and management of chronic disease. It describes a new, integrated way of working for Health and Social Care Professionals (HSCP) that is designed to improve the healthcare experience and health outcomes for individuals living with chronic disease in Ireland.

Core ingredients of Integrated Care for Chronic Disease





The '*National Framework for the Integrated Prevention and Management of Chronic Disease*' outlines the steps that are being taken at a national level to support the integration of care for the prevention and management of chronic disease. It describes a continuum of health promotion, disease prevention, diagnosis, treatment, disease-management and rehabilitation services that are coordinated across different healthcare providers and healthcare settings and describes a new way of working together across the health continuum. It should be read in conjunction with its companion document '*National Framework for the Integrated Prevention and Management of Chronic Disease: a ten-step guide to support local implementation*' which provides a local guide for the development of integrated care at the local level.

Integrated care requires us to adopt new ways of working across boundaries at community, Community Health Network, Ambulatory Care Hub, hospital and Regional Health Area levels, with HSCPs working to the top of their licence. A shift from an over-reliance on acute sector services to the provision of person-centred care provided as close to home as possible is required. This 'ten-step guide' is based on evidence of "what works" in the delivery of integrated care. This evidence is drawn from international literature but also from our experience of implementing integrated care here in Ireland.

Resources Included in this pack

This pack has been developed to support each local site on their own journey towards achieving end-to-end care for individuals with chronic disease in their area. The pack contains the following:

- A brief overview of the integrated model of care for the prevention and management of chronic disease and the services required to support implementation of the model of care in each local area. Further detail on the model of care and local implementation can be found in the '*National Framework for the Integrated Prevention and Management of Chronic Disease*' and the '*National Framework for the Integrated Prevention and Management of Chronic Disease: a ten-step guide to support local implementation*' which are also included in this pack; **https://www.hse.ie/eng/about/who/cspd/icp/chronic-disease**
- Guidance on the establishment of a specialist ambulatory care hub;
- The ICPCD suite of metrics;
- Guidance on the establishment of local governance structures;
- A suite of job descriptions that covers each member of the Chronic Disease Specialist Team who will work across the specialist ambulatory care hub and the acute hospital setting; and,
- A suite of National Clinical Programme resources **(appendix 1)**

The roll-out of this Integrated Model of Care for the Integrated Prevention and Management of Chronic Disease builds on the hard work, experience and learning of existing integrated care team members working throughout Ireland. Despite the challenging landscape of the COVID-19 healthcare setting at this time, we will work together to integrate the various strands of Ireland's health service and this scale-up of integrated care services provides an exciting opportunity to achieve real changes in how we deliver healthcare with the ultimate goal of providing a person-centred service by ensuring that individuals receive "the right care, at the right time, by the right team and in the right place".

Dr Orlaith O'Reilly
NCAGL Chronic Disease

Ms Geraldine Crowley
AND Chronic Disease Strategy and Planning

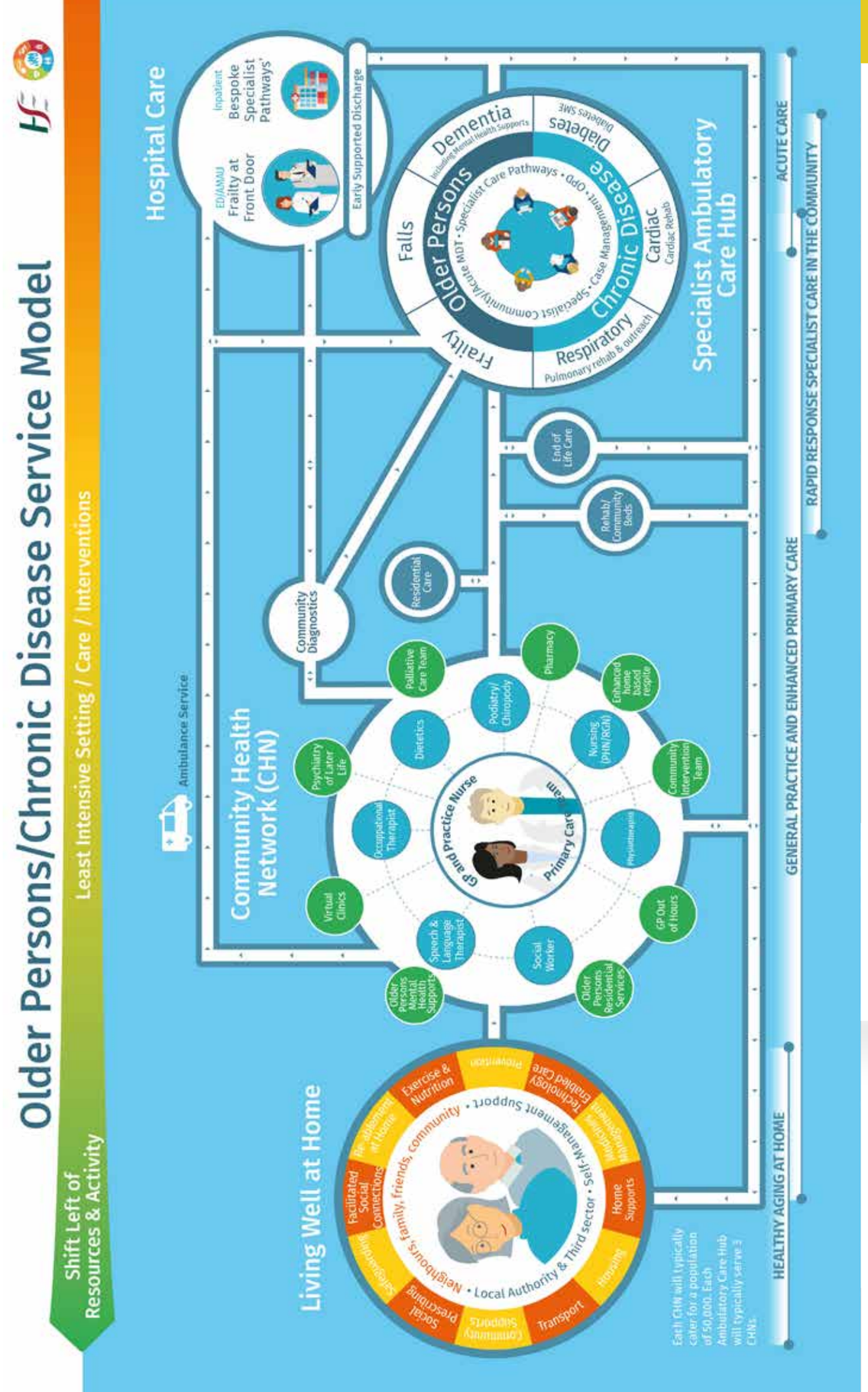


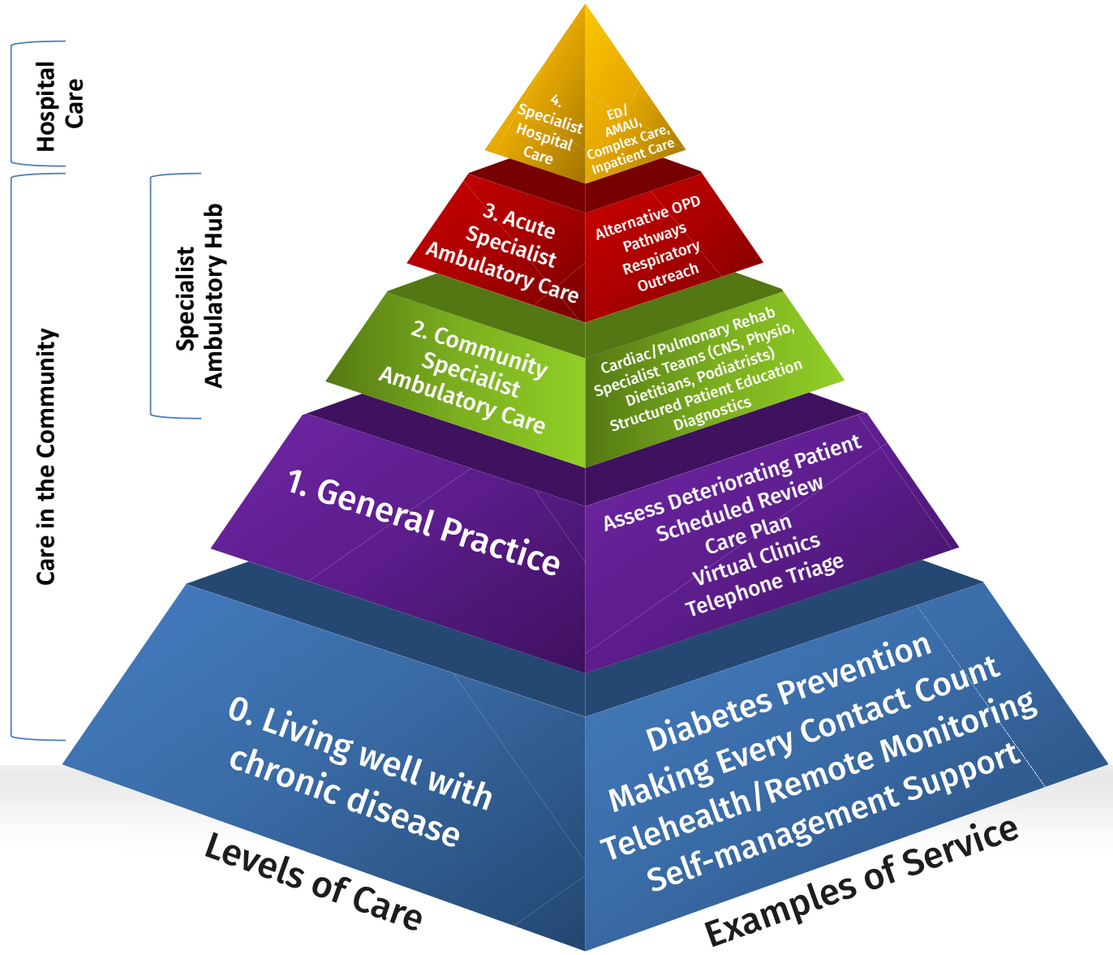
Figure 1. Older persons/chronic disease service model

The Integrated Model of Care for the Prevention and Management of Chronic Disease

The '*Integrated Model of Care for the Prevention and Management of Chronic Disease*' is at the heart of the '*National Framework for the Integrated Prevention and Management of Chronic Disease*' and demonstrates how "end-to-end" care can be provided within the Irish health services.

The Model of Care (Figure2) describes the five levels of service, and examples of each service, that need to be provided for a population in order to deliver integrated end-to-end care for chronic disease. These are the five levels of service that local areas need to strengthen and provide in an equitable manner to their population.

Figure 2. Model of care for the Integrated Prevention and Management of Chronic Disease



This model of care supports people to live well within the community, with ready and equitable access to General Practitioner (GP) review, diagnostics, HSCP input and specialist opinion, as required. The focus is on keeping people well and on providing care as close to home as possible.

Level 0: Living well with chronic disease. The Integrated Care Programme for the Prevention and Management of Chronic Disease is working to develop services to support and empower individuals living in the community to prevent and/or manage their chronic disease and associated complications. Such services include education sessions, goal-setting and the development of action plans to support chronic disease management at home.

Level 1: General Practice care is provided at Community Health Network (CHN) level. The new Chronic Disease Management Programme in General Practice will provide additional supports to GPs in caring for individuals living with chronic disease in the community.

Level 2: Community specialist ambulatory care will provide a further layer of support to the GP to care for patients in the community through ready access to diagnostics, pulmonary and cardiac rehabilitation and diabetes structured patient education services which will be based in the ambulatory care hub in the community.

Level 3: Acute specialist ambulatory care will offer acute specialist services such as outpatient services and respiratory outreach which will be delivered from the ambulatory care hub.

Level 4: Specialist hospital care may be required for the management of complex issues requiring hospital resources. However, an emphasis on early supported discharge home, with the appropriate supports in place in the community, will be a priority for the health services.

Core elements of integrated care for people with chronic disease include primary and secondary prevention, early detection and intervention, efficient access to community diagnostics, patient-centred assessment and on-going comprehensive medical treatment, all to be provided in the most appropriate setting. Figure 3 shows the full spectrum of services required to provide end-to-end care in Ireland and the settings where they should occur. Each local area must ensure that the full spectrum of services is available to their population in order to support full implementation of the model of care.

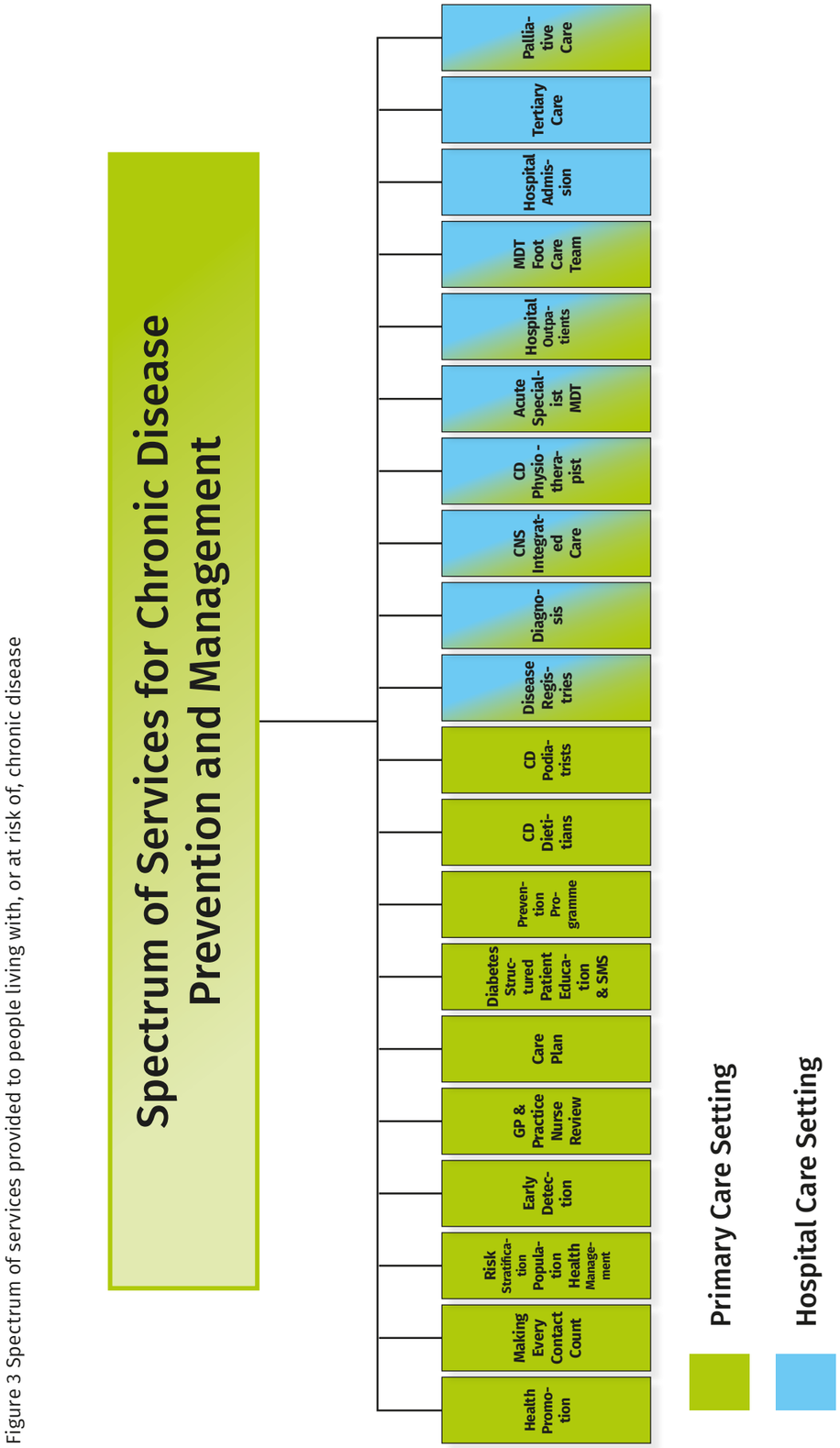
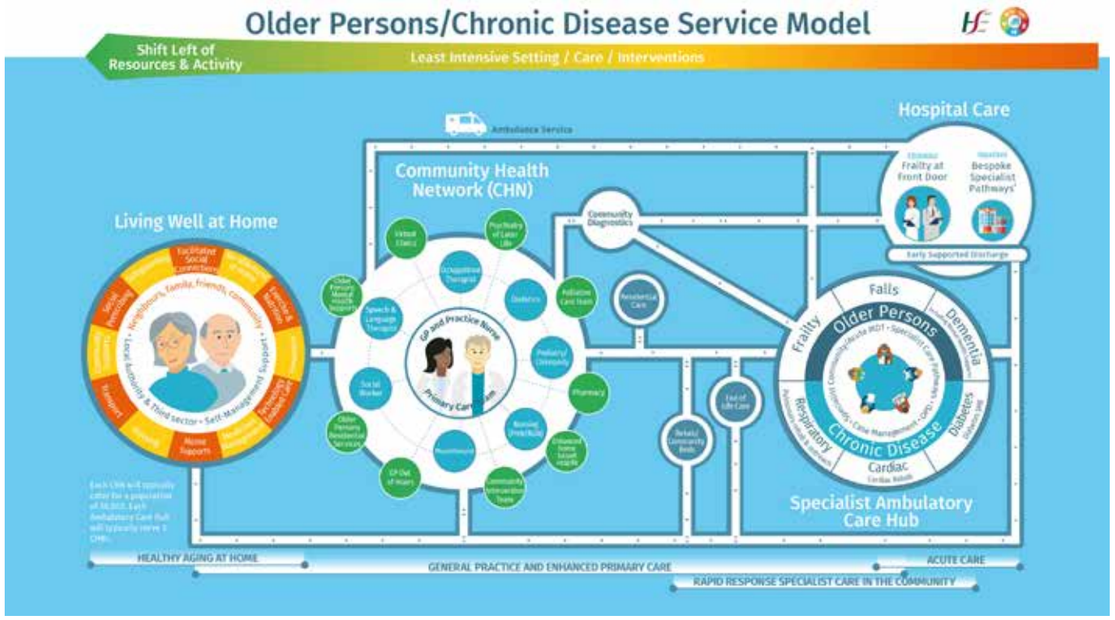


Figure 3 Spectrum of services provided to people living with, or at risk of, chronic disease

Specialist Ambulatory Care Hub - Chronic Disease

Figure 1 Older persons/chronic disease service model



The specialist ambulatory care hub offers access to specialist services in the community for individuals living with more complex chronic disease and/or multi-morbidity who may require specialist input. It will provide a centre in the community where a multidisciplinary chronic disease specialist team will work together in order to provide an integrated, holistic assessment and service and will act as a single point of access to a wider host of services within the community for individuals with more complex needs. The specialist ambulatory care hub for chronic disease will also provide access to diagnostics such as spirometry, echo and X-ray to GPs and the Chronic Disease Specialist Team working within the community. GPs who refer their patients in to the specialist ambulatory care hub for chronic disease will work closely with the specialist team in managing care for their patients. The Integrated Care Consultants will be based in the specialist ambulatory care hub for half of their working week, with the other half to be spent working in the hospital affiliated with their hub. This will support continuity of care across the community and acute settings.

Self-management support services e.g. cardiac rehab, pulmonary rehab, diabetes prevention, weight management, and diabetes self-management education will be provided in the hubs.

It is important to note that the specialist ambulatory care hubs for chronic disease are entirely separate from the COVID assessment hubs. These two types of hubs will be situated in different locations and will work towards different objectives.

Community Chronic Disease Specialist Teams (per hub)

Diabetes:

- CNS Diabetes 3.0 WTE
- Clinical Specialist Podiatrist 1.0 WTE
- Senior Grade Podiatrist 1.0 WTE
- Basic Grade Podiatrist 1.0 WTE
- Senior Dietitian 3.0 WTE
- Staff Grade Dietitian (Weight Management/DPP) 3.0 WTE

Cardiology

- CNS Cardiovascular Disease 3.0 WTE
- Senior Physiotherapist (Cardiology) 1.0 WTE
- Cardiac Rehabilitation Coordinator 1.0 WTE
- Staff Nurse Cardiac Rehabilitation 1.0 WTE
- Admin Assistant (IV) Cardiac Rehabilitation team 0.5 WTE
- Clinical Psychologist 0.2 WTE

Respiratory

- CNS Respiratory 3.0 WTE
- Senior Physiotherapist 3.0 WTE
- CS Physio Rehab coordinator 1.0 WTE
- CNS Rehab 1.0 WTE
- Staff Grade Physio rehab 1.0 WTE
- Pulmonary Rehab admin 0.5 WTE

GP Lead with Specialist Interest

- GP Lead with Specialist Interest 0.2 WTE *(aligned to hub with 16 specialist consultants)*

Admin/management

- Service Improvement Lead 1.0 WTE
- Project Officer 1.0 WTE
- Administration Staff 2.0 WTE

Critical gaps resourced in Acute Ambulatory Care Specialist Teams:

There will be 18 Ambulatory Care Hubs associated with these 11 prioritised hospitals

1. Cork University Hospital
2. University Hospital Limerick
3. University Hospital Galway
4. Mater Misericordiae University Hospital
5. Beaumont Hospital
6. Connolly Hospital
7. Tallaght University Hospital
8. St. James's Hospital
9. St. Vincent's University Hospital
10. St. Luke's Hospital, Kilkenny
11. University Hospital Waterford

Critical gaps in acute services for the hospitals concerned have been identified by the National Clinical Programmes. Initial resources have been secured to fill these critical gaps. Hospital acute specialist teams will support the delivery of specialist ambulatory care, and COPD outreach teams will provide hospital avoidance and early supported discharge programmes in their locality.

Key critical acute staffing gaps have been identified in these areas. 68.2 WTE will be recruited to support the Specialist Ambulatory Care hub. These staff consists of:

- Consultant 16.0 WTE
- Acute Team ANP Diabetes 11.0 WTE
- Senior Dietitian 10.0 WTE
- Staff Grade Dietician 3.0 WTE
- Acute Respiratory Team CNS 7.0 WTE
- Acute Respiratory Team Physio 4.0 WTE
- COPD Outreach CNS 5.0 WTE
- COPD Outreach CS Physio 4.0 WTE
- Acute CNS Cardiovascular Disease 8.2 WTE

While some additional resources for acute ambulatory care teams are being made available immediately, existing hospital consultant teams will be required to support these services, additional acute resources will be made available as the hubs develop.

Governance

1. Clinical governance

Community Specialist Teams

The function of the Community Specialist Team is to support GP's to care for people with chronic disease in the community. They provide services i.e. specialist nursing, physiotherapy, dietetics, podiatry and structured patient education, to patients on referral from their GP. The clinical governance of the patient remains under the GP.

Pulmonary and Cardiac Rehabilitation

Pulmonary and cardiac rehabilitation services are provided in the hub. These services are under the clinical governance of the local consultant respiratory physician or cardiologist. Each hospital associated with the hub will nominate a relevant consultant to oversee these services and integrate the hospital and community delivery of their rehabilitation service.

Acute Specialist Teams

Hospital specialist teams for cardiology, endocrinology, respiratory medicine and pulmonary outreach have been resourced to fill critical gaps, to allow them to support ambulatory care in association with the community specialist teams in the hubs. Patients referred by their GP to acute specialist services will be under the clinical governance of the relevant consultant for the acute services.

Clinical Leadership

Each hospital has been resourced with at least one Integrated Care Consultant. This is a new position created for cardiology, respiratory medicine and endocrinology and will be based 50% in the community and 50% in the hospital. The Integrated Care Consultant will be part of the hospital acute specialty specific team and will engage with other consultant colleagues in the hospital to provide ambulatory services to and within the hub as locally agreed. Initially each hospital will have at least one Integrated Care Consultant. Integrated Care Consultants will sit on the Local Governance Group for Chronic Disease, to ensure collaboration and integration between hospital and community services. Additional Integrated Care Consultants for each chronic disease specialty (cardiology, respiratory medicine, and endocrinology) will be sought for each hospital as the hubs develop, and identified critical acute gaps resourced.

The Integrated Care Consultants will have a specific role to support clinical service design, implementation and clinical governance of their hub, whilst also ensuring service design in key pathways is aligned with deliverables. Each hospital associated with a hub will nominate a consultant in each chronic disease specialties to work with the integrated care consultant (s) in their hospital to ensure this role is delivered.

2. Professional Governance

Professional Governance for each disciplinary group will be through their existing community or acute clinical line managers.

3. Operational Governance

The Operational Governance of the ambulatory care hub is under the Chief Officer of the CHO, via the head of Primary Care. The Head of Primary Care is the Chair of the Local Chronic Disease Governance Group. The Service Improvement Lead for Chronic Disease reports to the Head of Primary Care in each CHO.

The local Service Improvement Lead will, with the local Project Officer to support the delivery of key enablers including workforce recruitment, data to drive service improvement, operational function and reporting back to relevant heads of care in their area. The Service Improvement Lead will also be tasked with overseeing the operational function of the Local Governance Group (LGG) for Chronic Disease. The Service Improvement Lead will ensure an interdisciplinary approach, whilst also monitoring case load and will have a reporting function to the Primary Care Service Manager in the Community.

Key functions of Specialist Ambulatory Care Hub

- Support GP's in the local networks to manage chronic disease patients in the community
- Liaison with Primary Care-Community Health Network to support continuity of care in the community and to reduce duplication of work
- Deliver chronic disease-specific pathways of care
- Provide linkages with the chronic disease services in the affiliated hospital to support continuity of care
- Co-location of Integrated Care Consultants and HSCPs to support multidisciplinary approach to care
- Provide community access to diagnostics
- Provide access to self-management support services including cardiac rehabilitation, pulmonary rehabilitation, foot protection services, diabetes structured patient education, diabetes prevention and weight management programmes

Functions of the Chronic Disease Specialist Ambulatory Care Team

The specialist ambulatory care hub for chronic disease will provide additional services for individuals with more complex chronic disease needs within the community. The key functions of the team are as follows:

- Single point of access for Consultant +/- HSCP assessment for patients referred by GPs
- Deliver appropriate interventions for patients with complicated chronic disease
- Specialist care planning including case management function
- Co-ordination with GPs, primary care and community supports
- Deliver alternative outpatient pathways
- Promote and support population health initiatives within Primary Care

Key Linkages

In order to deliver integrated patient-centred care with a focus on hospital avoidance, the Integrated Care Consultants and HSCPs may need to change the way they work. Close linkages across CHO, local authority, community, primary care, the specialist ambulatory care hub and secondary care will need to be strengthened to deliver 'end-to-end' care. These linkages will need to be supported through the delivery of key enablers such as establishment of local integrated governance structures, progression of ICT infrastructure and funding.

Measures & outcomes for Community Specialist Teams for Chronic Disease

The evidence base indicates that a well-designed model of care for the prevention and management of chronic disease that sits within an integrated health service, is associated with positive outcomes including improved patient satisfaction, improved accessibility of health and social services and reduction in waiting times, levels of utilisation of hospital services and costs secondary to a reduction in hospital admissions.

Phase One will see the specialist ambulatory care hubs for chronic disease primarily impacting the 11 acute hospitals with the following measures and outcomes proposed when teams are fully implemented and with the model of care embedded and operating at optimal level:

Process indicators:

- 60% of hubs have begun to develop appropriate governance structures by the end of Q2 of first year of implementation and 100% hubs have appropriate governance structures in place by end of 2021.
- 60% of hubs have commenced development process of a multidisciplinary team by end of Q2 of first year of implementation with 100% hubs engaging in regular multidisciplinary team meetings by end of 2021.
- 60% of hubs have commenced development of Local Integrated Care Working Groups for the chronic diseases by end of Q2 of first year of implementation and 100% hubs have Local Integrated Care Working Groups for the chronic diseases and regular team meetings by end of Q2 of 2021.

Acute sector indicators – for patients with the four major chronic diseases in the relevant groups and areas:

- A 20% reduction in non-elective admissions for COPD, asthma, heart failure and diabetes by end of 2022 due to increased availability and accessibility of resources within the community.
- A reduction of 20% in bed days used for patients with COPD, asthma, diabetes and heart failure who are in the Chronic Disease Programme by end of 2022.
- 10% of eligible patients with multimorbidity will have a chronic disease care plan in place at end of 2021, rising to 20% by end of 2022.

Access indicators:

- A 40% reduction in urgent outpatient waiting times by end of 2022 due to increased access to diagnostics, specialist opinion and specialist support for the GP within the community.
- 30% of referrals for individuals with complex chronic disease/multimorbidity to the Chronic Disease Ambulatory Care Hub will receive input from the Specialist Team/be reviewed in the Ambulatory Clinic within 2 weeks by end of 2021, increasing to 50% by end of 2022.
- At least 40% of referred patients offered a standard cardiac rehabilitation programme by end of 2022.
- At least 40% of referred patients offered standard pulmonary rehabilitation programme by end of 2022.
- At least 60% of newly diagnosed type 2 diabetics are referred to an evidence-based, standardised diabetes structured patient education programme within three months of diagnosis by end of 2022.

Improved staff perception of quality of care they provide

- Bespoke Staff Survey across CDM Community Hubs to be undertaken.

Patient satisfaction

- National Patient Experience Survey to be expanded to include community services if appropriate or alternatively bespoke Patient Experience Survey to be undertaken in CDM Community Hub areas.

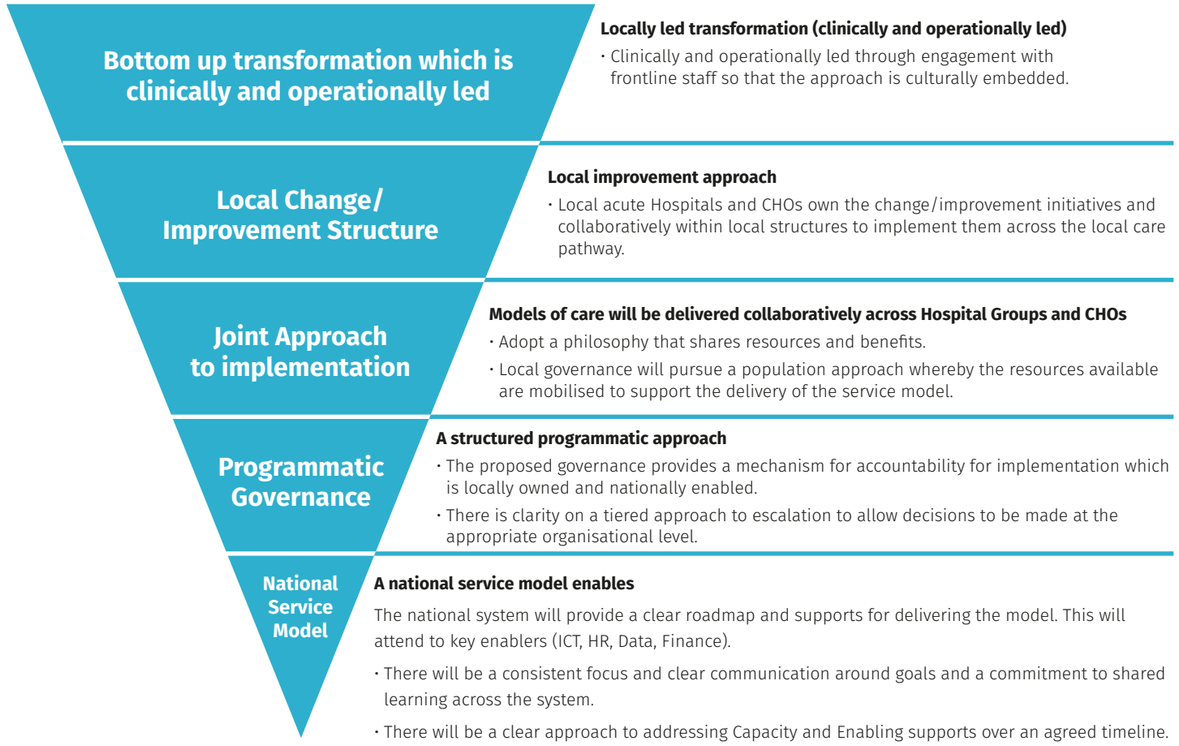
COPD Outreach-specific measures

- Number of patients discharged under COPD Outreach as % of ALL discharged for COPD
- Mean Average Length of Stay (ALOS) for COPD Outreach Discharges
- Difference in mean ALOS for COPD Outreach Discharge compared with COPD Discharge-ALL ALOS
- Number of patients referred to COPD Outreach as % of COPD Discharge
- Number of patients accepted on to Outreach Programme
- Average number of visits per patient accepted into COPD Outreach Service
- % re-admission to same acute hospitals of patients with COPD within 30 and 90 days
- Number of admissions avoided

Guidance on local governance structures to support implementation of the integrated service model

Practical experience of the implementation of integrated care to date has taught us that a local governance structure which involves CHO, hospital, primary care and community senior decision-makers, as well as clinicians, is an essential factor in enabling implementation and embedding integrated care in the health service. Sláintecare and the Integrated Care Programme for Older People (ICPOP) advocate for the creation of an enabling environment to address implementation (Figure 4).

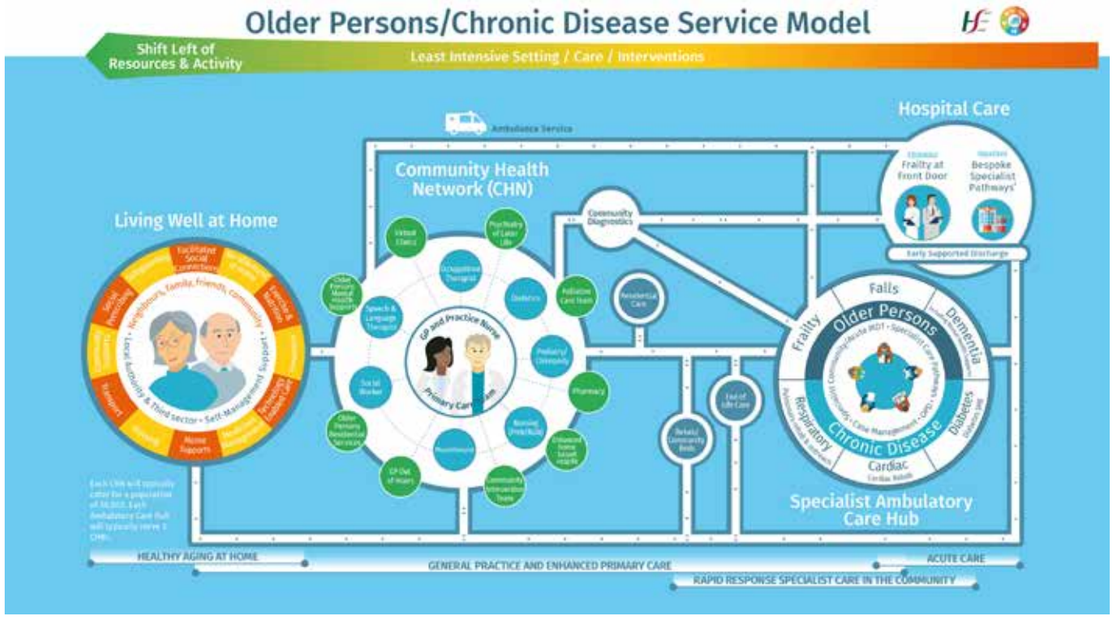
Figure 4 Change approach



In many areas there are disease-specific LGGs already in existence and it is anticipated that local areas will build on existing governance arrangements, where possible. The key function of the local governance group will be to implement integrated pathways of care for individuals with chronic disease, as per the model of care for the Integrated Prevention and Management of Chronic Disease.

The local governance group will focus on five key areas:

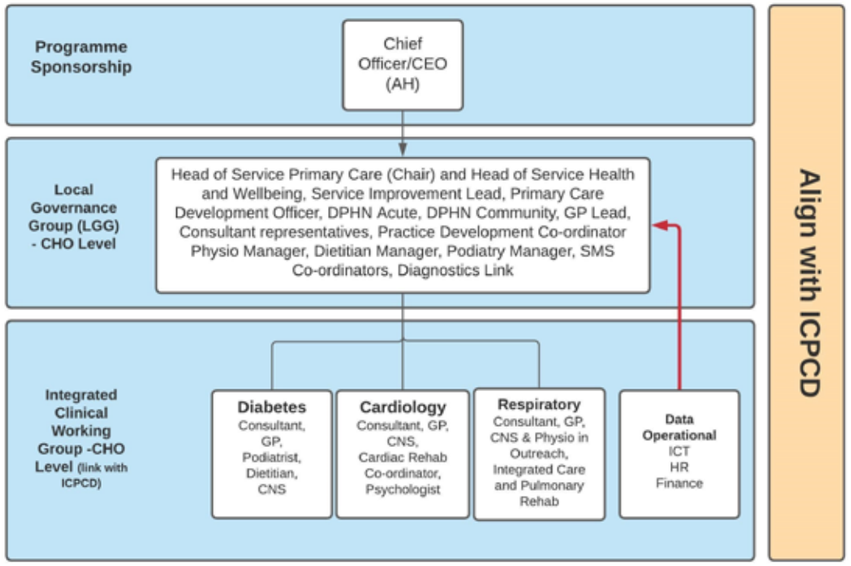
1. Provide operational oversight to the service as it transitions
2. Integrate service developments and existing services into one coherent model locally (reflecting Fig 1)
3. Provide senior leadership on servicing integrated pathways (exemplified by shared resources and personnel)
4. Support clinical and operational leadership in implementation of discrete service elements (e.g. specialist ambulatory care hub)
5. Facilitate the delivery of enablers, particularly data collection in order to drive service improvement



Example of local governance leadership structure

The leadership of the change process is critically important. The leadership group are primarily representative of and attend to key service developments. Professional requirements (e.g. WTE resource is addressed as part of the HR/Project Management component). The 'appointment' of a clinical lead and service improvement lead in each local health economy (CHO/Acute Hospitals (AH)) is essential.

Example of tasks for local group/working group



Living well with support 	• Asset mapping of resources • Communications and awareness • Promote COPD and Asthma Advice line • Promote the implementation of MECC • Promote the use of Self-Management Support (SMS) directories • Support delivery of SMS Education courses • Promote referral to cardiac and pulmonary rehab, diabetes prevention, weight management and self-management services	• Referrals to preventative interventions • Evaluate uptake on COPD Asthma Advice line • Staff trained in MECC • The number of MECC interventions delivered • Number of individuals who have completed an SMS course
	• Implement the modified GP Contract for Chronic Disease	• As per nationally agreed dataset
Ambulatory Care Pathways 	• Demand and capacity planning (Profiling population by CHN) • Profiling services (directory) • Develop liaison linkages between Specialist Chronic Disease Team, GPs, primary care and acute hospitals • Define and develop priority care pathways in line with Models of Care (MOC) • Develop and implement a communications strategy for the specialist team targeted at HCP and public • Support a CPD and Practice Development for team members	• Activity data for members of the Specialist Chronic Disease Team
Inpatient pathways 	• Adopt a 'Home First' focus • Implement Inpatient Pathways as per Chronic Disease national models of care • Address early supported discharge component between care settings –utilising Specialist Hub teams	Hospital discharges, LOS, and pulmonary outreach data.

The scope of the LGG would also address the following:

- To ensure the project remains aligned with the national service model and 10-step framework.
- To ensure the project remains within the scope is implemented within the agreed timelines and within the allocated budget.
- Set up working group teams as required managing elements of the project work.
- To oversee the development and delivery of the Specialist Chronic Disease Teams and to ensure that dependencies between individual work streams are managed and their work remains aligned with the model of integration described in the Chronic Disease Model of Care.
- To ensure the project makes the most of existing resources.
- To escalate emerging issues which need to be addressed by the governance group.
- To ensure that national education programmes relevant to the care of patients with chronic disease are offered to key staff locally.

Activity Targets

Chronic Disease Management Hub					
Roles	**WTE per Hub**	**Client Profile/ Threshold of Clients**	**Number / % of hub population (150,000) that will be targeted**	**Activity per WTE/No. of patients seen annually**	**Total activity for CDM hub team**
CDM Community Specialist Team					
Clinical nurse Specialist for Cardiovascular Disease (CVD)	3.0	Individuals with heart failure and multimorbid individuals with CVD	5,880 patients per hub	1,000	3,000
Clinical Nurse Specialist for Respiratory Disease	3.0	Approximately 30% of individuals with COPD and Asthma have complicated disease	6,702 patients per hub	1,000	3,000
Clinical Nurse Specialist for Diabetes	3.0	Individuals with either Type 1 diabetes or Type 2 Diabetes with complicated disease	2,964 patients per hub	1,000	3,000
Diabetes Dietitian	3.0	Individuals with newly diagnosed diabetes and individuals with established diabetes who have not yet participated in the Diabetes Structured Patient Education programme	300 patients with newly diagnosed diabetes per hub per annum 7,800 existing patients	285 patient educations sessions 720 clinic appointments annually	855 patient education sessions 2,160 clinic appointments annually
Respiratory physiotherapist	3.0	Individuals with diagnosis of COPD and asthma who have complicated disease	6,702 patients per hub	1,350	4,050
Podiatrist	3.0	Patients with diabetes at moderate/high risk of foot disease. Also 3% of diabetic patients at any time have active foot disease	7,800 patient visits annually	1,800	5,400
Diabetes Prevention/ dietitian or Nurse	1.5	The diabetes prevention programme is to be supplied to people with HbA1c in the pre-diabetes range	8,370 people per hub with pre-diabetes	560 patient education sessions 400 clinic appointments	840 patient education sessions 600 clinic appointments
Weight Management Dietitian	1.5	The weight management programme will be supplied to individuals with obesity and 2 or more co-morbidities	13,500 individuals with obesity and multimorbidity per hub	560 patient education sessions 400 clinic appointments	840 patient education sessions 600 clinic appointments
Pulmonary Rehabilitation Team					
Pulmonary Physician oversight, Programme coordinator (Physiotherapist), Respiratory Nurse Specialist, Physiotherapy Assistant or additional Physiotherapist or additional Respiratory Nurse Specialist & Administration support	3.7	Patients who have been discharged following acute exacerbation of COPD	370 patients per hub		675 sessions per annum
Cardiac Rehabilitation hub Team					
Clinical director Oversight, Programme Coordinator (Cardiac Nurse Specialist, Physiotherapist, Cardiac Nurse, Clinical Psychologist & administration support	3.9	Patients who have been discharged following a myocardial infarct or a revascularisation event together with those with heart failure	290 patient per hub		675 sessions per annum

Activities undertaken and throughput on the various roles in the network team

APPENDIX 1
List of programme specific resources to support chronic disease specialist teams:

Respiratory

COPD

https://www.hse.ie/eng/about/who/cspd/ncps/copd/resources/programme-documents-resources.html

These include the following documents

- **A guidance document for setting up COPD Outreach for healthcare professionals**
  https://www.hse.ie/eng/about/who/cspd/ncps/copd/resources/national-clinical-programme-for-respiratory.pdf
- **A guidance document for setting up Pulmonary rehabilitation for healthcare professionals**
  https://www.hse.ie/eng/about/who/cspd/ncps/copd/resources/hse-guidance-document-on-pulmonary-rehabilitation.pdf
- **End to End COPD Model of care**
  https://www.hse.ie/eng/about/who/cspd/ncps/copd/moc/end-to-end-copd-model-of-care-december-2019.pdf
- **COPD Acute management Bundle**
  https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/copd-acute-management-bundle.pdf
- **COPD Discharge Bundle**
  https://www.hse.ie/eng/about/who/cspd/ncps/copd/resources/copd-discharge-bundle-nccp-2018.pdf
- **COPD Communication card**
  https://www.hse.ie/eng/about/who/cspd/ncps/copd/resources/copd-communication-card.pdf
- **COPD Self Care Plan**
  https://www.hse.ie/eng/about/who/cspd/ncps/copd/resources/copd-self-care-plan.pdf
- **Guidance for setting up Virtual Supported Discharge**
  https://www.hse.ie/eng/about/who/cspd/ncps/copd/resources/guidance-for-setting-up-a-virtual-supported-discharge-service-for-covid-19.pdf
- **Guidance for setting up Virtual Pulmonary rehabilitation**
  https://www.hse.ie/eng/about/who/cspd/ncps/copd/resources/ncp-respiratory-guidance-on-setting-up-virtual-pulmonary-rehabilitation-for-asthma-and-copd.pdf
- **Spirometry Performance and Interpretation for HCP**
  https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/spirometry-performance-and-interpretation-for-healthcare-professionals-2015.pdf
- **Guidance for the clinical management of COVID-19 in COPD and Asthma** (CD 19-021 002/14.04.20)
  https://hse.drsteevenslibrary.ie/c.php?g=679077&p=4866795

- **Guidance for setting up a Virtual Pulmonary Rehabilitation Service for patients following Covid 19**
  https://hse.drsteevenslibrary.ie/ld.php?content_id=32965401
- **Guidance for the process of incorporating Virtual Teleheath into existing Oxygen Clinics**
  https://hse.drsteevenslibrary.ie/ld.php?content_id=32939412

Asthma

https://www.hse.ie/eng/about/who/cspd/ncps/asthma/resources/

- **My asthma Action Plan**
  https://www.hse.ie/eng/about/who/cspd/ncps/asthma/resources/my-asthma-action-plan-asthma-society-of-ireland.pdf
- **Asthma check**
  https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/asthma-check-chronic-disease-watch.pdf
- **Guideline for the management of an acute asthma attack (NCEC)**
  https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/guidelines-for-the-management-of-an-acute-asthma-attack-in-adults-2015-.pdf

Diabetes

- **Model of Integrated Care for Patients with Type 2 Diabetes**
  (Link to: https://www.hse.ie/eng/about/who/cspd/ncps/diabetes/moc/)
- **Diabetic Foot Model of Care**
  (Link to: https://www.hse.ie/eng/about/who/cspd/ncps/diabetes/moc/). Update due Q1 2021
- **Dietetic Resource Pack**
  https://www.hse.ie/eng/about/who/cspd/ncps/diabetes/resources/programme- documents-resources.html
- **Clinical Nurse Specialist (Diabetes Integrated Care) Guidelines for Attending Diabetes Clinics in General Practice**
  https://www.hse.ie/eng/about/who/cspd/ncps/diabetes/resources/programme-documents-resources.html
- **National Insulin Titration Guideline for Nurses working with People with Diabetes who require Subcutaneous Insulin Injections**
  (https://www.hse.ie/eng/about/who/cspd/ncps/diabetes/resources/national-insulin-titration-guideline-for-nurses.pdf)
- **Guidance on Blood Sugar Testing**
  (Link to: https://www.hse.ie/eng/about/who/cspd/ncps/diabetes/blood-sugar-testing/)
- **Diagnosis and Management of uncomplicated Type 2 Diabetes (T2DM) A succinct practical guide for Irish General Practice**
  (Link to: https://www.icgp.ie/speck/properties/asset/asset.=LibraryAsset&id=6756F105%2DFAF4%2D490B%2D95B34119585EA460&property=asset&revision=tip&disposition=inline&app=icgp&filename=T2DM%5FQRG%2Epdf)
- **Guidance for resumption of Diabetes Services during the COVID-19 pandemic**
  (Link to: https://hse.drsteevenslibrary.ie/ld.php?content_id=33127678)

Cardiovascular Disease

Acute Coronary Syndrome

- **Procedures for Myocardial Infarction in the Community (2015)**
  https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/gp-information-acs.pdf
- **Optimal Reperfusion Service Protocol**
  https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/optimal-reperfusion-service.pdf
- **Acute Coronary Syndrome Model of Care (2012)**
  https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/acute-coronary-syndrome-prog-moc.pdf
- **Guidance on Management of STEMI patients NSTEMI patients during the Covid-19 pandemic**
  (CD 19-054 001/21.04.20)
  https://hse.drsteevenslibrary.ie/c.php?g=679077&p=4865641

Heart Failure

- **Heart Failure Model of Care (2012)***
  https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/heart-failure-model-of-care-jan-2012.pdf
- **Heart Failure in General Practice, Quality and Safety in Practice Committee, ICGP (2019)**
  https://www.icgp.ie/speck/properties/asset/asset. ibraryAsset&id=03F612C8%2DFEC4%2D4C97%2DBAB-021C20EB7A200&property=asset&revision=tip&disposition=inline&app=icgp&filename=Heart%5FFail-ure%5Fin%5FGeneral%5FPractice%2Epdf
- **Heart Failure in General Practice, Appendices**
  https://www.icgp.ie/speck/properties/asset/asset.cfm?type=LibraryAsset&id=979AC0B4%2DAACE%2D4D25%2DB9D39EE7DC038979&property=asset&revision=tip&disposi-tion=inline&app=icgp&filename=Heart%5FFailure%5FAppendices%2Epdf
- **Webinar: Heart Failure in General Practice: Tips and Tricks**
  Dr Joe Gallagher, HSE/ ICGP Lead Cardiovascular Disease
  https://primarycaretrials.ie/resources/webinar-heart-failure-general-practice/
- **Guidance for Heart Failure Management during Covid-19 pandemic**
  (CD 19-057 001/28.04.20)
  https://hse.drsteevenslibrary.ie/c.php?g=679077&p=4865643
- **How to manage Heart Failure Outpatient Workload within new Chronic Disease Model of Care: Virtual Consultation Service**
  https://www.hse.ie/eng/about/who/cspd/ncps/heart-failure/resources/

General cardiovascular COVID related Information:

- **What is the evidence on additional risk of COVID 19 for people >65 with cardiovascular disease? Summary of the Evidence**
  https://hselibrary.ie/what-is-the-evidence-on-additional-risk-for-people-65-with-cardiovascular-disease/

Suite of generic role descriptors for Acute ICP CD Teams September 2020

Diabetes

Integrated Care Consultant (summary of job description)

Acute Team ANP

Acute Team CNS

Senior Dietitian

Staff Grade Dietitian

Respiratory

Integrated Care Consultant (summary of job description)

Acute Respiratory Team CNS

Acute Respiratory Team Physio

Outreach Team CNS

Outreach Team Physio

Cardiology

Integrated Care Consultant (summary of job description)

Acute Team CNS Cardiovascular Disease

Consultant Lead in Integrated Care

Job Specification & Terms and Conditions

Summary of job description for Integrated Care Consultant Post for Cardiology/Respiratory/Endocrinology

- The Integrated Care Consultant post for Cardiology, Respiratory and Endocrinology are new posts created to support a shift in health care provision, which is now required to focus on integrated, person centered care based as close to home as possible. The commitment for this post is 39 hours per week, 50% of which will be committed to hospital based services and 50% committed to work within the associated community ambulatory care hubs. This is a new full-time post, designed to support the development and implementation of cardiology/respiratory/endocrinology medicine as part of integrated care.

- The Integrated Care Consultant will provide leadership in the provision of chronic disease ambulatory care within the specialist ambulatory care hub and support the development of integrated services across the wider region served by the ambulatory care hub.

- The Integrated Care Consultant will promote and aid co-ordination and integration of chronic disease care between primary and secondary health care and relevant social care agencies. This will include functions such as participation in the Local Governance Group for Integrated Care in Chronic Disease, participation in multidisciplinary meetings and case management activities to manage complex cases.

- The Integrated Care Consultant will engage with other consultant colleagues in the hospital to provide ambulatory care services to and within the hub as locally agreed, and will link with consultants in other chronic disease specialties within their hospital to facilitate hospital and community integration.

- The Consultant, in partnership with the chronic disease specialist team, will lead out on the development and implementation of clear pathways, referral modes, alternative outpatient pathways and will work across the hospital and hub environments to support continuity of care, early discharge and hospital avoidance, where possible.

- The Consultant will work closely with the chronic disease specialist team to provide holistic patient-centered care with a focus on treating patients as close to home as possible. To that end, the consultant will also liaise with patients' GPs or other Health and Social Care Professionals within the community to support the provision of this care.

- The Consultant will lead the development and implementation of the alternative outpatient pathways at hospital and ambulatory care level.

- The Consultant will be required to lead out on the development of an educational programme across the hub and hospital setting that supports the integrated care agenda.

- The Consultant will work with the National Clinical Programmes, the chronic disease programmes, the Integrated Care Programme for the Prevention and Management of Chronic Disease and the National Clinical Advisor and Group Lead for Chronic Disease to develop integrated care.

- The Consultant will assess and manage patients with complex symptoms in the community, liaising where appropriate, with the other medical specialty services within the hub.

- The Consultant will provide oversight and drive implementation of self-management support services for chronic disease.

- The Consultant will provide improved integration of early discharge, outreach and admission avoidance programmes.

- The Consultant will visit regularly and be responsible for the medical care and treatment of patients under his/her charge in the hospital.

- The Consultant will contribute to general hospital on-call services.

- The Consultant will promote and further develop disease prevention measures in their respective medical specialty.

- The Consultant will act as an advisor on case finding mechanisms for individuals with undiagnosed chronic disease.

- The Consultant will act as a resource and provider of specialist expertise in area of cardiology/respiratory/endocrinology on public health initiatives for the local population.

- The Consultant will embrace service redesign as appropriate.

Advanced Nurse Practitioner Candidate (cANP) Diabetes

Job Specification & Terms and Conditions

Job Title and Grade	**Advanced Nurse Practitioner (cANP) Diabetes** *(Grade Code:2272)* The candidate ANP is required to progress to registration with Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) (NMBI) as a Registered Advanced Nurse Practitioner (RcANP) within **3 years** of commencement of this post and appointment to post as RcANP.
Purpose of the Post	**Background to the Post** The need to reform the healthcare services in Ireland in order to provide a more sustainable, integrated and patient-centred approach has come to the fore in recent health policies and strategies. Integrated care requires health and social care services to work together across different levels and sites in order to provide end-to-end care that meets patient need. As described in the Sláintecare report (2017), integrated care involves: • Ensuring appropriate care pathways are developed with a focus on person-centred service planning to ensure services are built around patients; • Supporting timely access to all health and social care services according to • medical need; and, • Patients accessing care at the most appropriate, cost effective service level with a strong emphasis on prevention and public health. The cANP Diabetes will develop and lead a service for patients / service users with diabetes, with an emphasis on providing care across the acute hospital and community setting. The registered advanced practice service is provided by nurses who practice at a higher level of capability, autonomy and provide expert advanced decision making The overall purpose of the cANP Diabetes service is to provide safe, timely, evidenced based nurse-led care to patients at an advanced nursing level .This involves undertaking and documenting complete episodes of patient care, which includes comprehensively assessing, diagnosing, planning, treating and discharging patients in accordance with collaboratively agreed local policies, procedures, protocols and guidelines and/or service level agreements/ memoranda of understanding. The cANP (Diabetes) demonstrates advanced clinical and theoretical knowledge, critical thinking, clinical leadership and complex decision-making abilities. The cANP (Diabetes) practices in accordance with the Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives (NMBI 2014), the Scope of Nursing and Midwifery Practice Framework (NMBI 2015), Advanced Practice (Nursing) Standards and Requirements (NMBI 2017), and the Values for Nurses and Midwives in Ireland (Department of Health 2016). The cANP (Diabetes) service provides clinical leadership and professional scholarship in the delivery of optimal nursing services and informs the development of evidence based health policy at local, regional and national levels. The cANP (Diabetes) contributes to nursing research that shapes and advances nursing practice, education and health care policy at local, national and international levels. The post requires a cANP (Diabetes) with the scope of practice that represents the diverse inpatient population of the hospital; reflecting diabetes care across age groups and diabetes types In collaboration with dietetic colleagues, the cANP (Diabetes) will take a lead role in the co-ordination, delivery and reporting of diabetes self-management education for individuals with Type 1 diabetes within the hospital and associated networks.
Principle Duties and Responsibilities	The cANP (Diabetes) practices to a higher level of capability across six domains of competence as defined by Bord Altranais agus Cnáimhseachais na hÉireann Advanced Practice (Nursing) Standards and Requirements (NMBI 2017). The six domains of competence are as follows: • Professional Values and Conduct • Clinical-Decision Making • Knowledge and Cognitive Competences • Communication and Interpersonal Competences • Management and Team Competences • Leadership and Professional Scholarship Competences Each of the six domains specifies the standard which the cANP (Diabetes) has a duty and responsibility to develop and demonstrate at registration. **Domain 1: Professional Values and Conduct** Standard 1 The cANP (Diabetes) will apply ethically sound solutions to complex issues related to individuals and populations by: • Demonstrating accountability and responsibility for professional practice as a lead healthcare professional for a diverse client age diabetes care need

- Articulating safe boundaries and engaging in timely referral and collaboration for those areas outside his/her scope of practice, experience, and competence using established referral pathways as per locally agreed policies, procedures, protocols and guidelines

- Demonstrating leadership by practising compassionately to facilitate, optimise, promote and support the health, comfort, quality of life and wellbeing of persons whose lives are affected by altered health, chronic disorders, disability, distress or life-limiting conditions. The cANP practices according to a professional practice model that provides him/her latitude to control his/her own practice, focusing on person centred care, interpersonal interactions and the promotion of healing environments

  The chosen professional practice model for nursing should reflect the individual needs of a diverse client group which emphasises a caring therapeutic relationship between the cANP and his/her patients, recognising that cANPs work in partnership with their multidisciplinary colleagues[2]

1 The caseload and scope of practice for the Registered Advanced Nurse Practitioner service will evolve to reflect changing service needs

2 Slatyer S., Coventry L.L., Twigg DI., & Davis S. (2016) Professional practice models for nursing: a review of the literature and synthesis of key components. *Journal of Nursing Management* ***24***, 139-150

- Articulating and promoting the cANP role in clinical, political and professional contexts by (for example presenting key performance outcomes locally and nationally; contributing to the service's annual report; participating in local and national committees to ensure best practice as per the relevant national clinical and integrated care programme).

Domain 2: Clinical-Decision Making Competences

Standard 2

The cANP (Diabetes) will utilise advanced knowledge, skills, and abilities to engage in senior clinical decision making by:

- Conducting a comprehensive holistic health assessment using evidenced based frameworks, policies, procedures, protocols and guidelines to determine diagnoses and inform autonomous advanced nursing care

- Synthesising and interpreting assessment information particularly history including prior treatment outcomes, physical findings and diagnostic data to identify normal, at risk and subnormal states of health

- Demonstrating timely use of diagnostic investigations / additional evidence-based advanced assessments to inform clinical-decision making

- Exhibiting comprehensive knowledge of therapeutic interventions including pharmacological and non-pharmacological advanced nursing interventions, supported by evidence-based policies, procedures, protocols, and guidelines, relevant legislation, and relevant professional regulatory standards and requirements

- Initiating and implementing health promotion activities and self-management plans in accordance with the wider public health agenda

- Discharging patients from the service as per an agreed supporting policy, procedure, protocols, guidelines and referral pathways

Domain 3: Knowledge and Cognitive Competences

Standard 3

The cANP (Diabetes) will actively contribute to the professional body of knowledge related to his/her area of advanced practice by:

- Providing leadership in the translation of new knowledge to clinical practice by for example, teaching sessions; journal clubs; case reviews; facilitating clinical supervision to other members of the team

- Educating others using an advanced expert knowledge base derived from clinical experience, on-going reflection, clinical supervision and engagement in continuous professional development

- Demonstrating a vision for advanced practice nursing based on service need and a competent expert knowledge base that is developed through research, critical thinking, and experiential learning

- Demonstrating accountability in considering access, cost and clinical effectiveness when planning, delivering and evaluating care (for example key performance areas, key performance indicators, and metrics).

Domain 4: Communication and Interpersonal Competences

Standard 4

The cANP (Diabetes) will negotiate and advocate with other health professionals to ensure the beliefs, rights and wishes of the person are respected by:

- Communicating effectively with the healthcare team through sharing of information in accordance with legal, professional and regulatory requirements as per established referral pathways

- Demonstrating leadership in professional practice by using professional language (verbally and in writing) that represents the plan of care, which is developed in collaboration with the person and shared with the other members of the inter-professional team as per the organisation's policies, procedures, protocols and guidelines
- Facilitating clinical supervision and mentorship through utilising one's expert knowledge and clinical competences
- Utilising information technology, in accordance with legislation and organisational policies, procedures, protocols and guidelines to record all aspects of advanced nursing care.

Domain 5: Management and Team Competences

Standard 5

The cANP (Diabetes) will manage risk to those who access the service through collaborative risk assessments and promotion of a safe environment by:

- Promoting a culture of quality care
- Proactively seeking quantitative and qualitative feedback from persons receiving care, families and members of the multidisciplinary team on their experiences of the service, analysing same and making suggestions for improvement
- Implementing practice changes using negotiation and consensus building, in collaboration with the multidisciplinary team and persons receiving care.

Domain 6: Leadership and Professional Scholarship Competences

Standard 6

The cANP (Diabetes) will lead in multidisciplinary team planning for transitions across the continuum of care by:

- Demonstrating clinical leadership in the design and evaluation of services by for example, findings from research, audit, metrics, new evidence)
- Engaging in health policy development, implementation, and evaluation by for example, key performance indicators from national clinical and integrated care programme/HSE national service plan/ local service need to influence and shape the future development and direction of advanced practice in diabetes care

- Identifying gaps in the provision of care and services pertaining to his/her area of advanced practice and expand the service to enhance the quality, effectiveness and safety of the service in response to emerging healthcare needs
- Leading in managing and implementing change.

Education and Training

The cANP **Diabetes** will:

- Contribute to service development through appropriate continuous education, research initiatives, keeping up to date with nursing literature, recent nursing research and new developments in nursing practice, education and management.
- Provide support and advice to those engaging in continuous professional development in his/her area of advanced nursing practice.

KPI's

- The identification and development of Key Performance Indicators (KPIs) which are congruent with the Hospital's service plan targets.
- The development of Action Plans to address KPI targets.
- Driving and promoting a Performance Management culture.
- In conjunction with line manager assist in the development of a Performance Management system for your profession.
- The management and delivery of KPIs as a routine and core business objective.

PLEASE NOTE THE FOLLOWING GENERAL CONDITIONS:

- Employees must attend fire lectures periodically and must observe fire orders.
- All accidents within the Department must be reported immediately.
- Infection Control Policies must be adhered to.
- In line with the Safety, Health and Welfare at Work Acts 2005 and 2010 all staff must comply with all safety regulations and audits.
- In line with the Public Health (Tobacco) (Amendment) Act 2004, smoking within the Hospital Buildings is not permitted.
- Hospital uniform code must be adhered to.
- Provide information that meets the need of Senior Management.
- To support, promote and actively participate in sustainable energy, water and waste initiatives to create a more sustainable, low carbon and efficient health service.

Risk Management, Infection Control, Hygiene Services and Health & Safety

- The management of Risk, Infection Control, Hygiene Services and Health & Safety is the responsibility of everyone and will be achieved within a progressive, honest and open environment.
- The post holder must be familiar with the necessary education, training and support to enable them to meet this responsibility.
- The post holder has a duty to familiarise themselves with the relevant Organisational Policies, Procedures & Standards and attend training as appropriate in the following areas:
    - Continuous Quality Improvement Initiatives

	○ Document Control Information Management Systems ○ Risk Management Strategy and Policies ○ Hygiene Related Policies, Procedures and Standards ○ Decontamination Code of Practice ○ Infection Control Policies ○ Safety Statement, Health & Safety Policies and Fire Procedure ○ Data Protection and confidentiality Policies • The post holder is responsible for ensuring that they become familiar with the requirements stated within the Risk Management Strategy and that they comply with the Group's Risk Management Incident/Near miss reporting Policies and Procedures. • The post holder is responsible for ensuring that they comply with hygiene services requirements in your area of responsibility. Hygiene Services incorporates environment and facilities, hand hygiene, catering, cleaning, the management of laundry, waste, sharps and equipment. • The post holder must foster and support a quality improvement culture through-out your area of responsibility in relation to hygiene services. • The post holders' responsibility for Quality & Risk Management, Hygiene Services and Health & Safety will be clarified to you in the induction process and by your line manager. • The post holder must take reasonable care for his or her own actions and the effect that these may have upon the safety of others. • The post holder must cooperate with management, attend Health & Safety related training and not undertake any task for which they have not been authorised and adequately trained. • The post holder is required to bring to the attention of a responsible person any perceived shortcoming in our safety arrangements or any defects in work equipment. • It is the post holder's responsibility to be aware of and comply with the HSE Health Care Records Management/Integrated Discharge Planning (HCRM / IDP) Code of Practice.

Clinical Nurse Specialist (Diabetes – Integrated Care)

Job Specification & Terms and Conditions

Job Title and Grade	**Clinical Nurse Specialist (Diabetes – Integrated Care)** *(Grade Code: 2632)*
Purpose of the Post	The purpose of this Clinical Nurse Specialist (Diabetes – Integrated Care) post is to: Deliver care in line with the five core concepts of the role set out in the Framework for the Establishment of Clinical Nurse Specialist Posts, 4th edition, National Council for the Professional Development of Nursing and Midwifery (NCNM) 2008. The CNS will work as part of a multidisciplinary team who will be responsible for implementing the delivery of the Model of Integrated Care for Patients Type 2 Diabetes (2018) within the community healthcare network and community healthcare organisation. In line with the Model of Care, 80% of the CNS role will involve working with General Practitioners (GP's) and MDT's in Primary Care and 20% of CNS role will involve working in Secondary Care. There will be a strong focus on service integration and team-working. This post will also involve the core elements of the CNS post to include clinical audit and research.
Principal Duties and Responsibilities	The post holder's practice is based on the five core concepts of Clinical Nurse Specialist (Diabetes – Integrated Care) role as defined by the NCNM 4th edition (2008) in order to fulfil the role. The concepts are: • Clinical Focus • Patient/Client Advocate • Education and Training • Audit and Research • Consultant **<u>Clinical Focus</u>** Clinical Nurse Specialist (Diabetes – Integrated Care) will have a strong patient focus whereby the specialty defines itself as Nursing and subscribes to the overall purpose, functions and ethical standards of Nursing. The clinical practice role may be divided into direct and indirect care. Direct care comprises the assessment, planning, delivery and evaluation of care to the patient, family and/or carer. Indirect care relates to activities that influence and support the provision of direct care. **<u>Direct Care</u>** *Clinical Nurse Specialist (Diabetes – Integrated Care) will:* • Provide a specialist nursing service for patients with a diagnosis of Diabetes who require support and treatment through the continuum of care. • Undertake comprehensive patient assessment to include physical, psychological, social and spiritual elements of care using best evidence based practice in Diabetes care. • Use the outcomes of patient assessment to develop and implement plans of care/case management in conjunction with the multi-disciplinary team (MDT) and the patient, family and/or carer as appropriate.

- Monitor and evaluate the patient's response to treatment and amend the plan of care accordingly in conjunction with the MDT and patient, family and/or carer as appropriate.
- Make alterations in the management of patient's condition in collaboration with the MDT and the patient in line with agreed pathways and policies, procedures, protocols and guidelines (PPPG's).
- Accept appropriate referrals from MDT colleagues.
- Co-ordinate investigations, treatment therapies and patient follow-up.
- Communicate with patients, family and /or carer as appropriate, to assess patient's needs and provide relevant support, information, education, advice and counselling as required.
- Where appropriate work collaboratively with MDT colleagues across Primary and Secondary Care to provide a seamless service delivery to the patient, family and/or carer as appropriate.
- Participate in medication reconciliation taking cognisance of poly-pharmacy and support medical and pharmacy staff with medication reviews and medication management.
- Identify and promote specific symptom management strategies as well as the identification of triggers which may cause exacerbation of symptoms. Provide patients with appropriate self-management strategies and escalation pathways.
- Identify health promotion priorities for the patient, family and/or carer and support patient self-care in line with best evidence. This will include the provision of educational and health promotion material which is comprehensive, easy to understand and meets patient's needs.
- Support the initiation and continuing care of patients with Type 2 Diabetes who have been commenced on insulin/injectable therapy.
- Fast track emergency referrals e.g. patients with urinary ketones or foot ulcerations to the appropriate member of the MDT for review and collaborative management planning.

Indirect Care

Clinical Nurse Specialist (Diabetes – Integrated Care) will:

- Identify and agree appropriate referral pathways for patients with Diabetes.
- Participate in case review with MDT colleagues.
- Use a case management approach to patients with complex needs in collaboration with MDT in both Primary and Secondary Care as appropriate.
- Take a proactive role in the formulation and provision of evidence based PPPGs relating to Diabetes care.
- Take a lead role in ensuring the service for patients with Diabetes is in line with best practice guidelines and the Safer Better Healthcare Standards (HIQA, 2012).

Patient/Client Advocate

Clinical Nurse Specialist (Diabetes – Integrated Care) will:

- Communicate, negotiate and represent patient's family and/or carer values and decisions in relation to their condition in collaboration with MDT colleagues in both Primary and Secondary Care as appropriate.
- Develop and support the concept of advocacy, particularly in relation to patient participation in decision making, thereby enabling informed choice of treatment options
- Respect and maintain the privacy, dignity and confidentiality of the patient, family and/or carer.
- Establish, maintain and improve procedures for collaboration and cooperation between Acute Services, Primary Care and Voluntary Organisations as appropriate.
- Proactively challenge any interaction which fails to deliver a quality service to patients.

Education & Training:

*Clinical Nurse Specialist (*Diabetes – Integrated Care*) will:*

- Maintain clinical competence in patient management within Diabetes Nursing, keeping up-to-date with relevant research to ensure the implementation of evidence based practice.
- Provide the patient, family and/or carer with appropriate information and other supportive interventions to increase their knowledge, skill and confidence in managing their Diabetes.
- Contribute to the design, development and implementation of education programmes and resources for the patient, family and/or carer in relation to Diabetes thus empowering them to self-manage their condition.
- Provide mentorship and preceptorship for nursing colleagues as appropriate.
- Participate in training programmes for Nursing, MDT colleagues and key stakeholders as appropriate.
- Create exchange of learning opportunities within the MDT in relation to evidence based Diabetes care delivery through journal clubs, conferences, etc.
- Develop and maintain links with Regional Centres for Nursing & Midwifery Education (RCNMEs), the Nursing and Midwifery Planning and Development Units (NMPDUs) and relevant third level Higher Education Institutes (HEIs) in the design, development and delivery of educational programmes in Diabetes care.
- Be responsible for addressing own continuing professional development needs

Audit & Research:

Clinical Nurse Specialist (Diabetes – Integrated Care) will:

- Establish and maintain a register of patients with Diabetes within Clinical Nurse Specialist Caseload.
- Maintain a record of clinically relevant data aligned to National Key Performance Indicators (KPI's) as directed and advised by the, DPHN, National Clinical Programme and senior management.
- Identify, initiate and conduct Nursing and MDT audit and research projects relevant to the area of practice.
- Identify, critically analyse, disseminate and integrate best evidence relating to Diabetes care into practice.
- Contribute to nursing research on all aspects of Diabetes care.
- Use the outcomes of audit to improve service provision.
- Contribute to service planning and budgetary processes through use of audit data and specialist knowledge.
- Monitor, access, utilise and disseminate current relevant research to advise and ensure the provision of informed evidence based practice.

Audit expected outcomes including:

- Collate data on agreed KPIs and outcome measures which will provide evidence of the effectiveness of Clinical Nurse Specialist (Diabetes-Integrated Care). Refer to the National Council for the Professional Development of Nursing and Nursing final report - *Evaluation of Clinical Nurse and Midwife Specialist and Advanced Nurse and Midwife Practitioner roles in Ireland* (SCAPE Report, 2010) and refer to the National KPIs associated with the speciality. They should have a clinical Nursing focus as well as a breakdown of activity - patients seen and treated.
- Evaluate audit results and research findings to identify areas for quality improvement in collaboration with nursing management and MDT colleagues (Primary and Secondary Care).

Consultant:

Clinical Nurse Specialist (Diabetes – Integrated Care) will:

- Provide leadership in clinical practice and act as a resource and role model for Diabetes practice.
- Generate and contribute to the development of clinical standards and guidelines and support implementation.
- Use specialist knowledge to support and enhance generalist nursing practice.
- Develop collaborative working relationships with local Diabetes Clinical Nurse Specialist /Registered Advanced Nurse Practitioner/MDT colleagues as appropriate, developing person centred care pathways to promote the integrated model of care delivery.
- With the support of the Director of Nursing, attend integrated care planning meetings as required.
- Where appropriate develop and maintain relationships with specialist services in voluntary organisations which support patients in the community.
- Liaise with other health service providers in the development and on-going delivery of the National Clinical Programme model of care.
- Network with other Clinical Nurse Specialist in Diabetes **and** in related professional associations.

Health & Safety:

These duties must be performed in accordance with local organisational and the HSE health and safety polices. In carrying out these duties the employee must ensure that effective safety procedures are in place to comply with the Health, Safety and Welfare at Work Act (2005). Staff must carry out their duties in a safe and responsible manner in line with the local policy documents and as set out in the local safety statement, which must be read and understood.

Quality, Risk and Safety Responsibilities

It is the responsibility of all staff to:

- Participate and cooperate with legislative and regulatory requirements with regard to quality, risk and safety.
- Participate and cooperate with local quality, risk and safety initiatives as required.
- Participate and cooperate with internal and external evaluations of the organisation's structures, services and processes as required, including but not limited to, The National Hygiene Audit, National Decontamination Audit, Health and Safety Audits and other audits specified by the HSE or other regulatory authorities.
- Initiate, support and implement quality improvement initiatives in their area which are in keeping with local organisational quality, risk and safety requirements.
- Contribute to the development of PPPGs and safe professional practice and adhere to relevant legislation, regulations and standards.
- Comply with Health Service Executive (HSE) Complaints Policy.
- Ensure completion of incident/near miss forms and clinical risk reporting.
- Adhere to department policies in relation to the care and safety of any equipment supplied and used to carry out the responsibilities of the role of Clinical Nurse Specialist in Diabetes care.

Specific Responsibility for Best Practice in Hygiene
Hygiene is defined as: "The practice that serves to keep people and environments clean and prevent infection. It involves the study of preserving one's health, preventing the spread of disease, and recognising, evaluating and controlling health hazards. In the healthcare setting it incorporates the following key areas: environment and facilities, hand hygiene, catering, management of laundry, waste and sharps, and equipment" (HIQA, 2008; P2). It is the responsibility of all staff to ensure compliance with local organisational hygiene standards, guidelines and practices.

Management/Administration:

Clinical Nurse Specialist (Diabetes - Integrated Care) will:

- Provide an efficient, effective and high quality service, respecting the needs of each patient, family and/or carer.
- Effectively manage time and caseload in order to meet changing and developing service needs.
- Continually monitor the service to ensure it reflects current needs.
- Implement and manage identified changes.
- Ensure that confidentiality in relation to patient records is maintained.
- Represent the specialist service at local, national and international fore as required.
- Maintain accurate and contemporaneous records and data on all matters pertaining to the planning, management, delivery and evaluation of care and ensure that this service is in line with HSE requirements.
- Contribute to the service planning process as appropriate and as directed by the DPHN
- Have a working knowledge of the Health Information and Quality Authority (HIQA) Standards as they apply to the role for example, Standards for Healthcare, National Standards for the Prevention and Control of Healthcare Associated Infections, Hygiene Standards etc and comply with associated HSE protocols for implementing and maintaining these standards as appropriate to the role.
- To support, promote and actively participate in sustainable energy, water and waste initiatives to create a more sustainable, low carbon and efficient health service.

The above Job Specification is not intended to be a comprehensive list of all duties involved and consequently, the post holder may be required to perform other duties as appropriate to the post which may be assigned to him/her from time to time and to contribute to the development of the post while in office.

Senior Dietitian – Acute services

Job Title and Grade	*Senior Dietitian (Integrated Care Diabetes)*
Principal Duties and Responsibilities	**<u>Professional /Clinical</u>** • Support the organisation, provision and evaluation of the Nutrition & Dietetic Services to people with diabetes in the secondary care setting and through specialist outreach clinics as required enhancing integrated care service delivery. • Provide a reformed service that utilises telehealth and other ICT measures to facilitate more effective and efficient delivery of care. • Contribute to the strategic planning of regional diabetes services. • In collaboration with MDT colleagues, take a lead role in the co-ordination, delivery and reporting of diabetes self-management education for individuals with Type 1 diabetes within the hospital and associated networks. • Contribute to research activities within their specialist area as required. • Liaise with the medical / nursing teams, allied health professionals and other members of primary and secondary care teams in planning and delivering the diabetes care of service users. • Liaise with dietetic colleagues in primary care services in planning the nutritional care of people with diabetes across the integrated care pathway. • Contribute to development, implementation and evaluation of diabetes related standards and policies within the Department of Nutrition and Dietetics and relevant care pathways. • Assist in the development of diabetes related diet sheets, nutrition education material and structured education materials in collaboration with colleagues locally and nationally. • Maintain professional competence through continual update. • Provide expertise and training in the area of diabetes related nutrition to staff /colleagues as appropriate. • Participate in training of student dietitians in association with Dietetic colleagues. • Maintain appropriate patient records and statistics in line with the department policy and for national metrics. • Be actively involved in continuously improving the quality of the service, use audit and quality improvement methods to facilitate integrated care. • Comply with policies, procedures and standards of care of the Department of Nutrition and Dietetics. • Work as part of a national team of educators- attending necessary updates, contributing to the development of national care plans, educator and client materials. Contribute to the ongoing training and development of educators as required. • Work within own scope of professional competence in line with principles of best practice, professional conduct and clinical governance.
	• Promote a culture that values equality, diversity and respect in the work place. • Participate in quality assurance initiatives. • Actively participate in National Structured Education and Diabetes working groups to ensure optimum delivery of service. • Maintain professional standards with regard to patent and data confidentiality. • Carry out any other duties and responsibilities appropriate to the post that may be assigned by the Dietitian Manager or another nominated person. • Develop, implement and monitor a plan of care, based on assessment of the patients' nutritional needs.. • Ensure appropriate discharge planning in conjunction with patient's families/carers and the multidisciplinary team. • Actively participate in multidisciplinary team meetings. • Liaise with catering staff regarding the provision of therapeutic diets. • Prioritise and manage their patient caseload according to the needs of the department and service. • Recognise the need for effective self-management of workload, available time and resources. • Work in a manner that maintains patient/client confidentiality and that upholds the client's and families/carers trust. • To provide cover for colleagues during periods of absence and to take lead in the provision of service during cover/ leave. • Develop and implement policies, protocols, guidelines and care plans, as required for the provision of best nutrition practice to the patient therefore, abiding by the national and international strategies and policies in order to maintain best practice in their assigned area. • Assist in the development of diet sheets and nutrition education material in collaboration with colleagues. • Provide evidence-based nutrition training to health care professionals/colleagues as appropriate. • Contribute to development, implementation and evaluation of standards and policies within the hospital and the Department of Nutrition and Dietetics. • Comply with professional, CORU, hospital and department policies, procedures and standards of care. • Initiate and/or participate in initiatives within their specialist area or the department in general that enhance the standard of care to clients. • Maintain professional standards with regard to patient and data confidentiality. • Promote a high standard of service, which respects the role of other health professionals and works in accordance with relevant codes of practice and clinical governance. • Know the limits of their practice and when to seek advice or refer to another health professional. • Contribute to the development and implementation of database, information and audit systems and shared care arrangements. • Provide leadership to staff grade dietitians and where appropriate other senior dietitians through the process of professional supervision, mentoring and tutoring with a view to enabling the dietitian to identify areas for skill development.

- Represent the clinical nutrition & dietetic service at meetings committees and project work.
- Promote a culture that values equality, diversity and respect in the work place.
- Comply with the Dietitian's Registration Board Code of Professional Conduct and Ethics

Ongoing Professional Education

- Maintain professional knowledge on relevant scientific research and practice development.
- Read evaluate and translate new literature into practice
- Maintain standards of practice and levels of clinical knowledge by participating in continuous professional development initiatives and attendance at relevant courses as appropriate in line with CORU requirements
- Act as a resource by participating in the education and training of dietetic colleagues, other health professionals and service user groups as required.
- Participate in the development and evaluation of nutrition education resource material.
- Attend mandatory training programmes ensuring it is up to date at all times. (Child First /Manual Handling / Fire safety).
- Supervise the work of staff grade dietitians when required.
- Provide induction and mentoring to professional colleagues.
- Manage, participate and play a key role in the practice education of student Dietitians.
- Engage in career and personal development planning in collaboration with the Dietitian Manager or another nominated person.
- Engage in professional supervision and reflective practice.
- Engage in career and personal development planning in collaboration with the Dietitian Manager or designated other person.

Health & Safety

- Comply with and contribute to the development of policies, procedures and safe professional practice and adhere to relevant legislation, regulations and standards.
- Work in a safe manner with due care and attention to the safety of self and others.
- Be aware of risk management issues, identify risks and take appropriate action.
- Report any adverse incidents or near misses.
- Adhere to HSE policies in relation to the procurement, care and safety of any equipment supplied for the fulfilment of duty.
- Participate and cooperate with legislative and regulatory requirements with regard to quality, risk and safety.
- Participate and co-operate with the Hospital Quality, Risk and Safety initiatives as required.
- Participate and co-operate with internal and external evaluations of hospital structures, services and processes as required, including but not limited to, the National Hygiene Audit, National Decontamination Audit, Health and Safety Audits and other audits specified by the HSE or other regulatory authorities.
- To initiate, support and implement quality improvement initiatives in their area which are in keeping with the hospitals quality, risk and safety requirements.

- Have a working knowledge of the Health Information and Quality Authority (HIQA) Standards as they apply to the role for example, Standards for Healthcare, National Standards for the Prevention and Control of Healthcare Associated Infections, Hygiene Standards etc and comply with associated HSE protocols for implementing and maintaining these standards as appropriate to the role.
- To support, promote and actively participate in sustainable energy, water and waste initiatives to create a more sustainable, low carbon and efficient health service.

Administrative

- Provide line management supervision to assigned Staff Grade Dietitians/appropriate others and co-ordinate service delivery.
- Contribute to policy development, performance monitoring, business planning and budgetary control as advised by the Dietitian Manager or designated other person.
- Prepare progress reports/statistics as required and in line with agreed templates/business plans.
- Work towards and deliver on key performance indicators.
- Ensure the maintenance of appropriate patient records in accordance with hospital and departmental guidelines and systems such as the Maternal Neonatal Clinical Management System (MNCMS) and GDPR.
- Contribute to the development and oversee the implementation of information sharing protocols, audit systems, referral pathways, and share care arrangements.
- Maintain professional standards with regard to patient and data confidentiality.
- Keep up to date with organisational developments within the Irish Health Service.
- Carry out other duties appropriate to the post as required by the Dietitian Manager or designated other person.
- To deputise for the Dietitian Manager if required.

The above Job Specification is not intended to be a comprehensive list of all duties involved and consequently, the post holder may be required to perform other duties as appropriate to the post which may be assigned to him/her from time to time and to contribute to the development of the post while in office.

Staff Grade dietitian

Job Title and Grade	Staff Grade dietitian
Principal Duties and Responsibilities	The basic grade dietitian will ; • Be a CORU registered dietitian with knowledge and training in client assessment diagnosis and treatment, nutrition, physical activity, behaviour change, diabetes prevention, weight management, lifestyle modification and group facilitation skills. • Enable the implementation of the National Framework for the Integrated Prevention and Management of Chronic Disease, Model of Integrated Care for patients with Type 2 Diabetes and Model of Care for the Management of Overweight and Obesity providing an enhanced diabetes prevention / weight management service in primary care. • Deliver evidence based HSE diabetes prevention programmes and weight management interventions within the network through a variety of platforms as appropriate. • Support individuals to manage their weight to prevent progression of obesity, improve obesity related complications, and prevent additional complications. • Provide a service in line with the model of care for individuals for whom a group programme is not appropriate using face to face or technology enabled solutions. • Coordinate, communicate and report on HSE diabetes prevention and obesity management programme activities within the network. • Work with the integrated care teams, SMS co-ordinators, health and wellbeing, mental health, disability, older persons groups and social prescribing processes and the public to embed referral pathways in line with models of care and ensure integration across the services. • Ensure a specific focus on service provision for areas of deprivation, ethnic minorities and hard to reach groups. • Ensure robust systems to receive and process all referrals in a timely manner and deliver a model of care for diabetes prevention and obesity management. • Compile, sort, and organise data for entry onto the national self-management education database to support program evaluation and improvement and reporting as required locally and nationally. • Collect and analyse data to identify community needs prior to planning, • Serve as a resource to assist individuals, other healthcare workers, or the community in relation to diabetes prevention and obesity initiatives. • Work as part of a national team of educators – attending necessary updates, contributing to the development of national care plans, educator and client materials as required. Contribute to ongoing training and development of educators as required. • Develop, strengthen and maintain partnerships with local, regional and national organisations involved in provision of related services. • Be a proactive communicator, prepared to enhance the service using new technologies, social media and advertising and HSE communications • Devise and implement appropriate care plans so that service users are assessed and advised appropriately • Refer the service user to more specialist services as required and develop and maintain close liaison with hospital staff and specialist services as appropriate • Manage clinical and non-clinical caseloads appropriate to the post • Monitor and evaluate all clinical intervention outcomes • Actively participate in multidisciplinary team meetings and case conferences • Actively participate in the development and implementation of nutrition and dietetic services in liaison with the Senior Dietitian/Clinical Specialist Dietitian or Dietitian Manager as appropriate • Work within own scope of professional competence in line with principles of best practice, professional conduct and clinical governance • Seek the advice of relevant personnel when appropriate/as required • Promote a culture that values equality, diversity and respect in the workplace **Education & Training** The Staff Grade Dietitian will: • Attend mandatory training programmes • Maintain professional knowledge on relevant areas of scientific research and practice development • Maintain standards of practice and levels of clinical knowledge by participating in continuous professional development initiatives and attendance at relevant courses as appropriate • Engage in career and personal development planning in collaboration with the Senior Dietitian, Clinical Specialist Dietitian or Dietitian Manager as appropriate. • Participate in induction and mentoring with professional colleagues. S/he will be open to reflective practice • Act as a resource by participating in the education and training of dietetic colleagues, other health professionals and service users as required • Participate and play a role in the practice education of student Dietitians • Participate in the development and evaluation of nutrition education resource material relevant to the role. **Health & Safety** The Staff Grade Dietitian will: • Comply with and contribute to the development of policies, procedures and safe professional practice and adhere to relevant legislation, regulations and standards • Work in a safe manner with due care and attention to the safety of self and others • Be aware of risk management issues, identify risks and take appropriate action

	• Report any adverse incidents or near misses • Adhere to HSE policies in relation to the procurement, care and safety of any equipment supplied • Have a working knowledge of HIQA Standards as they apply to the role for example, Standards for Healthcare, National Standards for the Prevention and Control of Healthcare Associated Infections, Hygiene Standards etc **Administration** The Staff Grade Dietitian will: • Maintain appropriate service user records, reports and statistics in accordance with local guidelines and national requirements, the Freedom of Information Act and professional standards • Contribute to the preparation of work plans for the service to include specific objectives, strategies, activities, budget and relevant evaluation methods based on best practice • Use audit and quality improvement methods to facilitate integrated care • Contribute to the development and implementation of information sharing protocols, audit systems, referral pathways, and shared care arrangements • Assist in ensuring that the nutrition and dietetic service makes the most efficient and effective use of developments in IT • Maintain professional standards with regard to patient and data confidentiality • Keep up to date with organisational developments within the Irish Health Service • Carry out other duties appropriate to the post as required from time to time by the Senior Dietitian/Dietitian Manager **KPI's (Key Performance Indicators)** • The development of Action Plans to address KPI targets. • In conjunction with line manager assist in the development of a Performance Management system for your profession. • The management and delivery of KPIs as a routine and core business objective. **PLEASE NOTE THE FOLLOWING GENERAL CONDITIONS:** • Employees must attend fire lectures periodically and must observe fire orders. • All accidents within the Department must be reported immediately. • Infection Control Policies must be adhered to. • In line with the Safety, Health and Welfare at Work Act, 2005 all staff must comply with all safety regulations and audits. • In line with the Public Health (Tobacco) (Amendment) Act 2004, smoking within the workplace is not permitted. • Provide information that meets the need of Senior Management.

Job Title and Grade	**Clinical Nurse Specialist Respiratory – Acute**
Purpose of the Post	The role of the CNSp will differ according to the needs and configuration of established respiratory services at each site. The purpose of this Clinical Nurse Specialist Respiratory – Acute Integrated Care post was developed to: provide expertise and specialist nursing services to patients with a respiratory condition both in the ward, hospital outpatient settings and in primary care. The post holder will liaise between acute respiratory services and integrated respiratory services in the community along with other agencies to deliver effective evidenced based care. They will use resources efficiently to achieve the best possible outcomes in keeping with the NCP Programme model of care and HIQA standards. The person appointed to this post will work in the overall integrated respiratory service. This post is 50% acute based and 50% community based to work with the Consultant in Respiratory Medicine, Lead in Integrated Respiratory Care and General Internal Medicine in further development of integrated care services. The post holder will work as part of a multidisciplinary team delivering coordinated evidence based care for respiratory patients. Please note a portion of the appointees work will be carried out "offsite". This means that the appointee will travel to the hubs to perform duties related to the role. They will work with colleagues across the integrated care services to develop and implement ambulatory care pathways to improve the transition of patients between primary and secondary care. The post holder will work as part of a multidisciplinary team and in close liaison with their associated Consultant Respiratory Physician to deliver coordinated evidence based care for patients. In order to ensure continuity of service to patients the CNSp may be required to rotate/cover other parts of the integrated respiratory service such as Respiratory Integrated Care and Outreach. This will also promote service integration and enhance skillset development. It will be dependent on identified service needs at each site. If deemed appropriate, site rotation should occur within the first 3-6 months of taking up the post. The Clinical Nurse Specialist's caseload will focus initially on the following patient groups. • COPD • Asthma • General acute respiratory
Principal Duties and Responsibilities	The CNSp will deliver care in line with the five core concepts of the role set out in the Framework for the Establishment of Clinical Nurse/Midwife Specialist Post, 4th ed. National Council for the Professional Development of Nursing and Midwifery (NCNM) 2008. The concepts are: • Clinical Focus • Patient/Client Advocate • Education and Training

- Audit and Research
- Consultant

Whereby the CNSp is required to rotate into Outreach or Respiratory Integrated Care, some aspects of their primary role under these headings may alter to include additional duties such as home visits, primary care centre visits, oxygen assessments and nurse led spirometry clinics.

Clinical Focus

The CNSp. will have a strong patient focus whereby the specialty defines itself as nursing and subscribes to the overall purpose, functions and ethical standards of nursing. The clinical practice role may be divided into direct and indirect care. Direct care comprises the assessment, planning, delivery and evaluation of care to the patient, family and/or carer. Indirect care relates to activities that influence others in their provision of direct care. The CNSp will work in conjunction with other team members in co-ordinating and developing the Integrated Care service to meet the needs of the population it serves in line with the objectives of the organisation.

Direct Care:

- Provide a specialist nursing service for patients with respiratory disease that incorporates evidence based knowledge, investigative and analytical skills and specialist assessment techniques to triage comprehensibly assess and manage a range of complex presentations.
- Use the outcomes of patient assessment to develop and implement plans of care in conjunction with MDT colleagues, the patient and /or carer providing and receiving complex sensitive information, taking into account physical, psychological and social care needs when taking a clinical history and assessing patients.
- Monitor and ensure maintenance of adequate and effective discharge planning for patients with respiratory disease to include devising pathways to link patients with other integrated respiratory services.
- Work in collaboration with other members of the multidisciplinary team to assess, plan, implement and evaluate care for patients within the respiratory service in a person centred manner. This will include:
- Titration of prescribed medicines within agreed protocols
- Provide spirometry service to confirm differential diagnosis and staging of disease if not previously undertaken.
- Review and assess patients inhaler treatments make adjustments / recommendations on treatment plans and facilitate onward referral as appropriate.
- If a Registered Nurse Prescriber (RNP) the nurse must work within the scope of their practice and adhere to the regulations set down by NMBI pertaining to this role and, local policy requirements.
- Monitor and evaluate the patient's response to treatment and amend the plan of care accordingly in conjunction with the GP/Consultant/MDT and patient, family and/or carer as appropriate.
- Evaluate clinical problems using objective measurement tools e.g. Spirometry, Arterial Blood Gases (ABG) in conjunction with other team members, co-ordinate investigations, therapies and patient follow-up in secondary or primary care as appropriate.
- Provide specialist interventions including, sputum clearance, relaxation, breathing control, exercise and breathlessness management
- Identify and promote specific symptom management strategies as well as the identification of triggers which may cause exacerbation of symptoms. Provide patients with appropriate self-management strategies and escalation/de-escalation plans.
- Use agreed direct pathway for patients who may present/become clinically unwell at time of attending/engaging with the service
- Identify health promotion priorities for the patient, family and/or carer and support patient self-care in line with best evidence and utilising principles laid out by MECC (Make Every Contact Count). This will include the provision of educational and health promotion material which is comprehensive, easy to understand and meets patients' needs.
- Assess patient understanding of treatment proposals, gain informed consent and have the capacity to work within a legal framework with patients who lack capacity to consent to treatment.
- Provide psychological support for patients and their families.
- Communicate with patients, families and friends, assess needs and provide relevant support, information, education, advice and counselling when and where necessary.

Indirect Care:

- Manage, develop and evaluate admission avoidance pathways with GPs, Consultant and integrated teams.
- Participate in case reviews with MDT colleagues as required.
- Use a case management approach to patients with complex needs in collaboration with MDT in both Primary and Secondary Care
- Take a proactive role in the formulation and provision of evidence based PPPGs relating to Integrated and Acute Care. Contribute to the development and implementation of information sharing protocols, audit systems, referral pathways, individual care plans and shared care arrangements through regular collaboration/meetings with respiratory nurses locally and nationally.
- Manage clinical risk within own clinical caseload, to have up to date knowledge of indications, contraindications and precautions for any treatment skills and techniques selected and applied throughout an individual course of treatment.
- Arrange referrals to other appropriate specialist services as deemed necessary
- Refer for further clinical psychological evaluation if felt necessary or requested by the patient and/or their family.

- Effectively manage time and caseload in order to meet the needs of an evolving service
- Work closely with colleagues across services in order to provide a seamless integrated service for the patient
- Identify and utilise professional and voluntary resources and facilities at local and national level by direct and indirect referral
- Refer to relevant services to assist with procurement of domiciliary equipment and respiratory therapies that may be required by the patient such as oxygen
- Participate in the Departmental Clinical Governance processes, working in partnership with the Head of Departments, CNM3/ADON, and Clinical Governance lead and local respiratory governance groups.
- Ensure that effective clinical governance procedures are maintained and evolve according to defined needs and demands in Respiratory care.
- Maintain professional standards including patient and data confidentiality in line with HSE policy
- Develop and implement strategies as part of the Integrated Care team for delivering effective care within a changing environment using IT and alternative delivery strategies as needed.

Patient Advocate

Clinical Nurse Specialist, Respiratory – Acute Integrated Care will:

- Communicate, negotiate and represent patient's family and/or carer values and decisions in relation to their condition in collaboration with MDT colleagues in both Primary and Secondary Care as appropriate
- Develop and support the concept of advocacy particularly in relation to patients' participation in decision making thereby enabling informed choice of treatment options.
- Respect and maintain the privacy, dignity and confidentiality of the patient, family and/or carer
- Establish, maintain and improve procedures for collaboration and cooperation between acute services, Community services, Primary Care and voluntary organisations as appropriate.
- Proactively challenge any interaction which fails to deliver a quality service to patients.
- Take appropriate action on any matter identified as being detrimental to staff and/or service user care or wellbeing which may inhibit the effective provision of effective care.
- Participate in meetings as a patient and service representative when requested to advocate and support the development of services/staff in respiratory care
- Support the development of local patient advocacy groups pertinent to specialty
- Contribute to case conferencing meetings with supporting consultant and other members of the MDT
- Provide and advocate for appropriate assessments, supports and strategies for patients with disease related changes and difficulties.

Education and Training

Clinical Nurse Specialist, Respiratory – Acute Care will:

- Maintain clinical competence in patient management within respiratory nursing, keeping up-to-date with relevant research to ensure the implementation of evidence based practice.
- Provide the patient, family and/or carer with appropriate information and other supportive interventions to increase their knowledge, skill and confidence in managing their respiratory conditions.
- Contribute to the design, development and implementation of education programmes and resources for the patient, family and/or carer in relation to Asthma and/or COPD thus empowering them to manage their own condition independently and autonomously.
- Provide mentorship and preceptorship for nursing colleagues as appropriate.
- Participate in training programmes for nursing, MDT colleagues and key stakeholders as appropriate.
- Address the educational needs of nursing and other professionals by participating in or facilitating training programmes for all members of the MDT.
- Create exchange of learning opportunities within the MDT in relation to evidence based respiratory care delivery through journal clubs, conferences etc.
- Develop and maintain links with Regional Centres for Nursing & Midwifery Education (RCNMEs), the Nursing and Midwifery Planning and Development Units (NMPDUs) and relevant third level Higher Education Institutes (HEIs) in the design, development and delivery of educational programmes in respiratory care
- Be responsible for addressing own continuing professional development needs.
- Develop and deliver education and training programmes for the wider primary and secondary care MDTs as requested or deemed necessary
- Seek advice and assistance with assigned cases which prove to be beyond the scope of their professional competence

Audit and Research

Clinical Nurse Specialist, Respiratory – Acute Care will*:*

- Collect and maintain a record of clinically relevant data aligned to the business intelligence unit (BIU) and National KPI's as directed and advised by the Director of Nursing, the National Clinical Programmes and senior management.
- Provide annual reports/updates on patient numbers and activity levels as required for service planning.
- Identify, initiate and conduct nursing and collaborative MDT audit and research projects relevant to the area of practice.

	• Identify, critically analyse, disseminate and integrate best evidence relating to respiratory care into practice. • Contribute to nursing research on all aspects of Integrated and respiratory care. • Use the outcomes of audit to inform service provision and the need for change • Contribute to service/business planning and budgetary processes through use of audit data and specialist knowledge • Monitor, access, utilise and disseminate current relevant research to advise and ensure the provision of informed evidence based practice. • Contribute to the examination of patients and staff's experiences when engaging with Integrated and acute respiratory services. • Assures all patient evaluations are performed and results communicated to the appropriate stakeholders. • Represent the department / team at local, national and international meetings and conferences as appropriate. Clinical Nurse Specialist, Respiratory – Acute Care will: • Provide leadership in clinical practice and act as resource in providing specialist knowledge, expertise and care in liaison with the MDT. • Generate and contribute to the development of clinical standards and guidelines and support implementation. • Use specialist knowledge in Respiratory Care to support and enhance generalist nursing/midwifery practice. • Develop collaborative working relationships with local respiratory CNSp's/Registered and Candidate Advanced Nurse Practitioner GP/Consultant/MDT colleagues as appropriate, developing person centred care pathways to promote the integrated model of care delivery. • With the support of the DON, attend integrated care planning meetings as required. • Develop and maintain relationships with specialist services in Voluntary Organisations which support patients in the community. • Represent Integrated services at local, national and international meetings as required • Promote the role of the services amongst all health care staff. • Work with, support, advise and help build up the knowledge and expertise of the other healthcare professionals involved in providing care for patients through regular formal and informal education. • Liaise with other chronic disease specialist teams (such as diabetes/heart failure) to discuss joint management/assessment needs of patients as necessary.

Senior Physiotherapist Respiratory Acute

Job Specification,

Job Title & Grade	**Senior Physiotherapist** *(Grade Code 3158)*
Purpose of the Post	The Respiratory Service will support: • the development of an integrated respiratory model with the consultant and community teams • A holistic, multidisciplinary approach to the care of individuals with acute and chronic respiratory disease; • Provision of a reformed inpatient & outpatient service that utilises telehealth and other ICT measures to facilitate more effective and efficient delivery of care; • Timely access to specialist services and specialist opinion for patients with respiratory disease; • Early intervention pathways/ rapid access clinics for acute, chronic or newly presenting respiratory conditions; • Development of pathways for the management of chronic conditions. • To be responsible for the provision of a high quality Physiotherapy service in accordance with standards of professional practice • To carry out clinical and educational duties as required • To work with Physiotherapy Manager in ensuring the co-ordination, development and delivery of a quality, client centred physiotherapy service across and between networks in the geographical area.
Principal Duties and Responsibilities	**<u>Professional / Clinical</u>** The Senior Physiotherapist will: • Be a lead clinician in the Physiotherapy Profession and carry a clinical caseload appropriate to the post • Be responsible for client assessment, development and implementation of individualised treatment plans that are client centred and in line with best practice • Be responsible for goal setting in partnership with client, family and other team members as appropriate • Be responsible for standards of practice of self and staff appointed to clinical / designated area(s) • Be a clinical resource for other Physiotherapists • Communicate and work in co-operation with the Physiotherapy Manager and other team members in providing an integrated quality service, taking the lead role as required • Communicate effectively with and provide instruction, guidance and support to, staff clients, family, carers etc. • Document client records in accordance with professional standards and departmental policies • Provide a service in varied locations in line with local policy / guidelines and within appropriate time allocation (e.g. clinic, home visits)

- Participate and be a lead clinician as appropriate in review meetings, case conferences etc.
- Develop and promote professional standards of practice
- Work within own scope of professional competence in line with principles of best practice, professional conduct and clinical governance
- Seek advice of relevant personnel when appropriate / as required
- Operate within the scope of practice of the Irish Society of Chartered Physiotherapists
- Provide weekend and on call service where it is a requirement of the post

Communication

- To provide specialist respiratory physiotherapy advice and support to multidisciplinary colleagues
- Develop strong links with the respiratory multidisciplinary team in both the hospital and community setting.
- Effective communication with patients, their carers and relevant stakeholders to promote patient self-management in the community

Education & Training

The Senior Physiotherapist will:

- Participate in mandatory training programmes
- Take responsibility for, and keep up to date with Physiotherapy practice by participating in continuing professional development such as reflective practice, in service, self-directed learning, research, clinical audit etc.
- Be responsible for the induction and clinical supervision of staff in the designated area(s)
- Co-ordinate and deliver clinical placements in partnership with universities and clinical educators
- Manage, participate and play a key role in the practice education of student therapists. Take part in teaching / training / supervision / evaluation of staff / students and attend practice educator courses as relevant to role and needs
- Engage in personal development planning and performance review for self and others as required

Quality, Safety & Risk

The Senior Physiotherapist will:

- Be responsible for the on-going co-ordination, delivery and development of a quality service in line with best practice
- Develop and monitor implementation of agreed policies, procedures and safe professional practice by adhering to relevant legislation, regulations and standards
- Ensure the safety of self and others, and the maintenance of safe environments and equipment used in Physiotherapy in accordance with legislation
- Assess and manage risk in their assigned area(s) of responsibility
- Take the appropriate timely action to manage any incidents or near misses within their assigned area(s)
- Report any deficiency/danger in any aspect of the service to the team or Physiotherapy Manager as appropriate
- Be responsible for the safe and competent use of all equipment, aids and appliances both by clients and staff under their supervision
- Develop and promote quality standards of work and co-operate with quality assurance programmes
- Oversee and monitor the standards of best practice within their Physiotherapy team
- Have a working knowledge of HIQA Standards as they apply to the role, for example, Standards for Healthcare, National Standards for the Prevention and Control of Healthcare Associated Infections, Hygiene Standards etc. and comply with associated HSE protocols for implementing and maintaining these standards.

Administrative

The Senior Physiotherapist will:

- Contribute to the service planning process
- Assist the Physiotherapy Manager and relevant others in service development encompassing policy development and implementation
- Review and evaluate the Physiotherapy service regularly, identifying changing needs and opportunities to improve services
- Collect and evaluate data about the service area as identified in service plans and demonstrate the achievement of the objectives of the service
- Oversee the upkeep of accurate records in line with best practice
- Collate and maintain accurate statistics and render reports as required
- Represent the department / team at meetings and conferences as appropriate
- Inform the Physiotherapy Manager of staff issues (needs, interests, views) as appropriate
- Promote a culture that values diversity and respect in the workplace
- Participate in the control and ordering of Physiotherapy stock and equipment in conjunction with the Physiotherapy Manager
- Be accountable for the budget, where relevant
- Keep up to date with organisational developments within the Irish Health Service
- Engage in IT developments as they apply to clients and service administration
- Perform such other duties appropriate to the role as may be assigned by the Physiotherapy Manager

The above Job Specification is not intended to be a comprehensive list of all duties involved and consequently, the post holder may be required to perform other duties as appropriate to the post which may be assigned to him/her from time to time and to contribute to the development of the post while in office.

Clinical Specialist Physiotherapist (COPD Outreach Programme)

Job Specification, Terms & Conditions

Job Title & Grade	**Clinical Specialist Physiotherapist (COPD Outreach Programme)** *(Grade Code 3707)*
Purpose of the Post	As outlined above, the need to reform the healthcare services in Ireland in order to provide a more sustainable, integrated and patient-centred approach has come to the fore in recent health policies and strategies. Integrated care requires health and social care services to work together across different levels and sites in order to provide end-to-end care that meets patient need. As described in the Sláintecare report (2017), integrated care involves: • Ensuring appropriate care pathways are developed with a focus on person-centred service planning to ensure services are built around patients; • Supporting timely access to all health and social care services according to medical need; and, • Patients accessing care at the most appropriate, cost effective service level with a strong emphasis on prevention and public health • To work in conjunction with other team members in co-ordinating and developing the service to meet the needs of the population it serves in line with the objectives of the organisation • To be responsible for the provision of a high quality Physiotherapy service in accordance with standards of professional practice • To carry out clinical and educational duties as required • To work with Physiotherapy Manager in ensuring the co-ordination, development and delivery of a quality, client centred physiotherapy service across and between networks in the geographical area. • To develop COPD Outreach services in line with the COPD National Clinical Programme Model of Care document and associated guidance (HSE 2011). More specifically, the Clinical Specialist Physiotherapist, as part of the COPD Outreach Team will: • Manage, develop and evaluate an early supported discharge programme • Manage, develop and evaluate and admission avoidance programme with GP and Consultant • Plan and implement a care package from hospital to home • Contribute to business planning and business cases • Develop and maintain guidelines and protocols relating to COPD outreach • Develop and implement strategies as part of the COPD Outreach team for delivering effective COPD care within a changing environment. • Engage in projects to raise the profile of the specialist service and team members. • Develop evidence based oxygen assessment and review clinics for respiratory patients • Refer to Community Pulmonary rehabilitation team where appropriate • Act as a point of contact for clinical queries from GPs and the Chronic Disease Specialist Team members and see patients in the ambulatory care hub as appropriate • Participate in multidisciplinary team meetings and case management activities to manage complex cases • Embrace service redesign as appropriate for the respiratory services

Principal Duties and Responsibilities	**<u>Professional / Clinical</u>** The Clinical Specialist Physiotherapist (COPD Outreach) will: • Be a lead clinician in the Physiotherapy Profession and carry a clinical caseload appropriate to the post • Be responsible for client assessment, development and implementation of individualised treatment plans that are client centred and in line with best practice • Be responsible for goal setting in partnership with client, family and other team members as appropriate • Be responsible for standards of practice of self and staff appointed to clinical / designated area(s) • Be a clinical resource for other Physiotherapists • Communicate and work in co-operation with the Physiotherapy Manager and other team members in providing an integrated quality service, taking the lead role as required • Communicate effectively with and provide instruction, guidance and support to, staff_clients, family, carers etc. • Document client records in accordance with professional standards and departmental policies • Provide a service in varied locations in line with local policy / guidelines and within appropriate time allocation (e.g. clinic, home visits) • Participate and be a lead clinician as appropriate in review meetings, case conferences etc. • Develop and promote professional standards of practice • Work within own scope of professional competence in line with principles of best practice, professional conduct and clinical governance • Seek advice of relevant personnel when appropriate / as required • Operate within the scope of practice of the Irish Society of Chartered Physiotherapists • Provide weekend and on call service where it is a requirement of the post • Develop advanced skills as relevant to respiratory such as taking and interpreting Arterial blood gases **<u>Education & Training</u>** The Clinical Specialist Physiotherapist will: • Participate in mandatory training programmes • Take responsibility for, and keep up to date with Physiotherapy practice by participating in continuing professional development such as reflective practice, in service, self-directed learning, research, clinical audit etc. • Be responsible for the induction and clinical supervision of staff in the designated area(s) • Co-ordinate and deliver clinical placements in partnership with universities and clinical educators • Manage, participate and play a key role in the practice education of student therapists. Take part in teaching / training / supervision / evaluation of staff / students and attend practice educator courses as relevant to role and needs • Engage in personal development planning and performance review for self and others as required

	Quality, Safety & Risk The Clinical Specialist Physiotherapist will: • Be responsible for the co-ordination and delivery of a quality service in line with best practice • Develop and monitor implementation of agreed policies, procedures and safe professional practice by adhering to relevant legislation, regulations and standards • Ensure the safety of self and others, and the maintenance of safe environments and equipment used in Physiotherapy in accordance with legislation • Assess and manage risk in their assigned area(s) of responsibility • Take the appropriate timely action to manage any incidents or near misses within their assigned area(s) • Report any deficiency/danger in any aspect of the service to the team or Physiotherapy Manager as appropriate • Be responsible for the safe and competent use of all equipment, aids and appliances both by clients and staff under their supervision • Develop and promote quality standards of work and co-operate with quality assurance programmes • Oversee and monitor the standards of best practice within their Physiotherapy team • Have a working knowledge of HIQA Standards as they apply to the role, for example, Standards for Healthcare, National Standards for the Prevention and Control of Healthcare Associated Infections, Hygiene Standards etc. and comply with associated HSE protocols for implementing and maintaining these standards. **Administrative** The Clinical Specialist Physiotherapist will: • Contribute to the service planning process • Assist the Physiotherapy Manager and relevant others in service development encompassing policy development and implementation • Review and evaluate the Physiotherapy service regularly, identifying changing needs and opportunities to improve services • Collect and evaluate data about the service area as identified in service plans and demonstrate the achievement of the objectives of the service • Oversee the upkeep of accurate records in line with best practice • Collate and maintain accurate statistics and render reports as required • Represent the department / team at meetings and conferences as appropriate • Inform the Physiotherapy Manager of staff issues (needs, interests, views) as appropriate • Promote a culture that values diversity and respect in the workplace • Participate in the control and ordering of Physiotherapy stock and equipment in conjunction with the Physiotherapy Manager • Be accountable for the budget, where relevant • Keep up to date with organisational developments within the Irish Health Service • Engage in IT developments as they apply to clients and service administration

	• Perform such other duties appropriate to the role as may be assigned by the Physiotherapy Manager The areas of specific interest for this post include leading and delivering COPD Outreach as part of a respiratory integrated care in a community setting. . The Clinical Specialist Physiotherapist will have responsibility for service provision, education and training, service development and quality improvement. The Clinical Specialist Physiotherapist should have abilities in management and be capable of assuming lead responsibilities in the future. The post will contribute to on-going progress in the delivery of decision making at the point of access to the hospital and redirection of patients presenting acutely to the hospital back to community care with acute management plans or redirection to appropriate specialist outpatient assessment. **The above Job Specification is not intended to be a comprehensive list of all duties involved and consequently, the post holder may be required to perform other duties as appropriate to the post which may be assigned to him/her from time to time and to contribute to the development of the post while in office.**

Clinical Nurse Specialist (CNSp) Respiratory

Chronic Obstructive Pulmonary Disease (COPD) Outreach

Job Specification,

Job Title and Grade	**Clinical Nurse Specialist Respiratory – COPD Outreach**
Purpose of the Post	The role of the COPD Outreach team will differ according to the needs and configuration of established respiratory services at each site. The successful candidate will lead COPD Outreach and integrate this service with ambulatory care between the hospital and community services. They will work with colleagues across these services to develop and implement ambulatory care pathways and to manage respiratory disease, and associated co-morbidities, within the community setting, where appropriate. The post holder will develop COPD Outreach services in line with the National Clinical Programme Respiratory Model of Care documents and associated guidance. The person appointed to this post will work in the COPD Outreach Service within the assigned hospital and will be closely aligned with the associated integrated respiratory services. COPD Outreach is a four pronged service offering early supported discharge, assisted discharge, and admission prevention and case management to COPD patients. The post holder will work as part of a multidisciplinary team delivering coordinated evidence based care for patients with COPD. The role of the CNSp Respiratory in COPD Outreach is to provide initial post discharge, person centred care and on-going management of patients with COPD in the home/normal place of residence. The post holder will be a key member of the multidisciplinary team, required to provide a specialist nursing resource within the governance structure created for the programme. They will provide physical, psychological and emotional support to an agreed caseload of COPD Outreach patients and their families throughout their COPD trajectory. In order to ensure continuity of service to patients the CNSp may be required to rotate/cover other parts of the integrated respiratory service such as Respiratory Integrated Care and the Acute service. This will also promote service integration and enhance skillset development. It will be dependent on identified service needs at each site. If deemed appropriate, site rotation should occur within the first 3-6 months of taking up the post. The Clinical Nurse Specialists caseload will focus initially on patients with COPD meeting the inclusion criteria for outreach
Principal Duties and Responsibilities	The CNSp will deliver care in line with the five core concepts of the role set out in the Framework for the Establishment of Clinical Nurse/Midwife Specialist Post, 4th ed. National Council for the Professional Development of Nursing and Midwifery (NCNM) 2008. The concepts are: • Clinical Focus • Patient/Client Advocate • Education and Training • Audit and Research • Consultant Whereby the CNSp is required to rotate into Acute services or Respiratory Integrated Care, some aspects of their primary role under these headings may alter to include additional duties such as running clinics in the ambulatory care hub or primary care centre, oxygen assessments and nurse led spirometry clinics. **Clinical Focus** The CNSp. will have a strong patient focus whereby the specialty defines itself as nursing and subscribes to the overall purpose, functions and ethical standards of nursing. The clinical practice role may be divided into direct and indirect care. Direct care comprises the assessment, planning, delivery and evaluation of care to the patient, family and/or carer. Indirect care relates to activities that influence others in their provision of direct care. The CNSp will work in conjunction with other team members in co-ordinating and developing the COPD Outreach service to meet the needs of the population it serves in line with the objectives of the organisation. **Direct Care:** • Provide a specialist nursing service for patients with COPD that incorporates evidence based knowledge, investigative and analytical skills and specialist assessment techniques to triage comprehensibly assess and manage a range of complex presentations. • Use the outcomes of patient assessment to develop and implement plans of care in conjunction with MDT colleagues, the patient and /or carer providing and receiving complex sensitive information, taking into account physical, psychological and social care needs when taking a clinical history and assessing patients. • Monitor and ensure maintenance of adequate and effective discharge planning for patients with COPD returning to their own homes after an admission with an exacerbation. • Admit patients to COPD Outreach service ensuring pre-agreed inclusion/exclusion criteria are adhered too • Work in collaboration with other members of the multidisciplinary team to assess, plan, implement and evaluate care for patients within the COPD Outreach service in a person centred manner. This will include: • Titration of prescribed medicines within agreed protocols • Review and assess patients inhaler treatments make adjustments / recommendations on treatment plans and facilitate onward referral as appropriate. • If a Registered Nurse Prescriber (RNP) the nurse must work within the scope of their practice and adhere to the regulations set down by NMBI pertaining to this role and, local policy requirements. • Monitor and evaluate the patient's response to treatment and amend the plan of care accordingly in conjunction with the GP/Consultant/MDT and patient, family and/or carer as appropriate.

	• Evaluate clinical problems using objective measurement tools e.g. Spirometry, Arterial Blood Gases (ABG) in conjunction with other team members, co-ordinate investigations, therapies and patient follow-up in secondary or primary care as appropriate. • Provide specialist interventions including, sputum clearance, relaxation, breathing control, exercise and breathlessness management • Identify and promote specific symptom management strategies as well as the identification of triggers which may cause exacerbation of symptoms. Provide patients with appropriate self-management strategies and escalation/de-escalation plans. • Use agreed direct pathway for patients who may present/become clinically unwell at time of attending/engaging with the service • Provide spirometry service to confirm differential diagnosis and staging of disease if not previously undertaken. • Identify health promotion priorities for the patient, family and/or carer and support patient self-care in line with best evidence and utilising principles laid out by MECC (Make Every Contact Count). This will include the provision of educational and health promotion material which is comprehensive, easy to understand and meets patients' needs. • Assess patient understanding of treatment proposals, gain informed consent and have the capacity to work within a legal framework with patients who lack capacity to consent to treatment. • Provide psychological support for patients and their families. • Communicate with patients, families and friends, assess needs and provide relevant support, information, education, advice and counselling when and where necessary. **Indirect Care:** • Manage, develop and evaluate admission avoidance pathways with GPs, Consultant and integrated teams. • Participate in case reviews with MDT colleagues as required. • Use a case management approach to patients with complex needs in collaboration with MDT in both Primary and Secondary Care • Take a proactive role in the formulation and provision of evidence based PPPGs relating to COPD Outreach and Integrated Care. Contribute to the development and implementation of information sharing protocols, audit systems, referral pathways, individual care plans and shared care arrangements through regular collaboration/meetings with respiratory nurses locally and nationally. • Manage clinical risk within own clinical caseload, to have up to date knowledge of indications, contraindications and precautions for any treatment skills and techniques selected and applied throughout an individual course of treatment. • Arrange referrals to other appropriate specialist services as deemed necessary

	• Refer for further clinical psychological evaluation if felt necessary or requested by the patient and/or their family. • Effectively manage time and caseload in order to meet the needs of an evolving service • Work closely with colleagues across services in order to provide a seamless integrated service for the patient • Identify and utilise professional and voluntary resources and facilities at local and national level by direct and indirect referral • Refer to relevant services to assist with procurement of domiciliary equipment and respiratory therapies that may be required by the patient such as oxygen • Participate in the Departmental Clinical Governance processes, working in partnership with the Head of Departments, CNM3/ADON, and Clinical Governance lead and local respiratory governance groups. • Ensure that effective clinical governance procedures are maintained and evolve according to defined needs and demands in COPD Outreach. • Maintain professional standards including patient and data confidentiality in line with HSE policy • Develop and implement strategies as part of the Integrated Care team for delivering effective care within a changing environment using IT and alternative delivery strategies as needed. **Patient Advocate** Clinical Nurse Specialist Respiratory – COPD Outreach will: • Communicate, negotiate and represent patient's family and/or carer values and decisions in relation to their condition in collaboration with MDT colleagues in both Primary and Secondary Care as appropriate • Develop and support the concept of advocacy particularly in relation to patients' participation in decision making thereby enabling informed choice of treatment options. • Respect and maintain the privacy, dignity and confidentiality of the patient, family and/or carer • Establish, maintain and improve procedures for collaboration and cooperation between acute services, Community services, Primary Care and voluntary organisations as appropriate. • Proactively challenge any interaction which fails to deliver a quality service to patients. • Take appropriate action on any matter identified as being detrimental to staff and/or service user care or wellbeing which may inhibit the effective provision of effective care. • Participate in meetings as a patient and service representative when requested to advocate and support the development of services/staff in respiratory care

- Support the development of local patient advocacy groups pertinent to specialty
- Contribute to case conferencing meetings with supporting consultant and other members of the MDT
- Provide and advocate for appropriate assessments, supports and strategies for patients with disease related changes and difficulties.

Education and Training

Clinical Nurse Specialist Respiratory – COPD Outreach will:

- Maintain clinical competence in patient management within respiratory nursing, keeping up-to-date with relevant research to ensure the implementation of evidence based practice.
- Provide the patient, family and/or carer with appropriate information and other supportive interventions to increase their knowledge, skill and confidence in managing their respiratory conditions.
- Contribute to the design, development and implementation of education programmes and resources for the patient, family and/or carer in relation to Asthma and/or COPD thus empowering them to manage their own condition independently and autonomously.
- Provide mentorship and preceptorship for nursing colleagues as appropriate.
- Participate in training programmes for nursing, MDT colleagues and key stakeholders as appropriate.
- Address the educational needs of nursing and other professionals by participating in or facilitating training programmes for all members of the MDT.
- Create exchange of learning opportunities within the MDT in relation to evidence based respiratory care delivery through journal clubs, conferences etc.
- Develop and maintain links with Regional Centres for Nursing & Midwifery Education (RCNMEs), the Nursing and Midwifery Planning and Development Units (NMPDUs) and relevant third level Higher Education Institutes (HEIs) in the design, development and delivery of educational programmes in respiratory care
- Be responsible for addressing own continuing professional development needs.
- Develop and deliver education and training programmes for the wider primary and secondary care MDTs as requested or deemed necessary
- Seek advice and assistance with assigned cases which prove to be beyond the scope of their professional competence.

Audit and Research

Clinical Nurse Specialist Respiratory – COPD Outreach will:

- Collect and maintain a record of clinically relevant data aligned to the business intelligence unit (BIU) and National KPI's as directed and advised by the Director of Nursing, the National Clinical Programmes and senior management.
- Provide annual reports/updates on patient numbers and activity levels as required for service planning.
- Identify, initiate and conduct nursing and collaborative MDT audit and research projects relevant to the area of practice.
- Identify, critically analyse, disseminate and integrate best evidence relating to COPD Outreach into practice.
- Contribute to nursing research on all aspects of Integrated and COPD care.
- Use the outcomes of audit to inform service provision and the need for change
- Contribute to service/business planning and budgetary processes through use of audit data and specialist knowledge
- Monitor, access, utilise and disseminate current relevant research to advise and ensure the provision of informed evidence based practice.
- Contribute to the examination of patients and staff's experiences when engaging with COPD Outreach services.
- Assures all patient evaluations are performed and results communicated to the appropriate stakeholders.
- Represent the department / team at local, national and international meetings and conferences as appropriate.

Consultant

Clinical Nurse Specialist Respiratory – COPD Outreach will:

- Provide leadership in clinical practice and act as resource in providing specialist knowledge, expertise and care in liaison with the MDT.
- Generate and contribute to the development of clinical standards and guidelines and support implementation.
- Use specialist knowledge in COPD Care to support and enhance generalist nursing practice.
- Develop collaborative working relationships with local respiratory CNSp's/Registered and Candidate Advanced Nurse Practitioner GP/Consultant/MDT colleagues as appropriate, developing person centred care pathways to promote the integrated model of care delivery.
- With the support of the DON, attend integrated care planning meetings as required.

	• Develop and maintain relationships with specialist services in Voluntary Organisations which support patients in the community. • Represent Integrated services at local, national and international meetings as required • Promote the role of the service amongst all health care staff in particular in the emergency department and medical admissions unit as appropriate. • Work with, support, advise and help build up the knowledge and expertise of the other healthcare professionals involved in providing care for patients through regular formal and informal education. • Liaise with other chronic disease specialist teams (such as diabetes/heart failure) to discuss joint management/assessment needs of patients as necessary.

Job Title and Grade	Clinical Nurse Specialist - Cardiovascular Disease (CNSp. CVD)
Purpose of the Post	The role of the CNSp. CVD was developed to: provide expertise and specialist nursing services to patients with a cardiovascular condition both in the ward, hospital outpatient settings and in primary care. The role of the CNSp CVD will differ according to the needs and configuration of established cardiovascular services at each site. The post holder will act as a liaison between acute cardiology services and integrated cardiology services in the community and other agencies, to deliver effective evidenced based care, using resources efficiently to achieve the best possible outcomes for patients with cardiovascular disease in keeping with agreed models of care and HIQA standards. The post holder will work with colleagues across the acute cardiology services and integrated care services to develop and implement ambulatory care pathways for cardiovascular disease and associated co-morbidities, to improve the transition of patients between primary and secondary care. The post holder will work as part of a MDT and in close liaison with their associated Consultant Cardiologist to deliver coordinated evidence based care for patients. The CNSp CVD will support the implementation of a model of integrated care which is focused on enhancing the management of care for patients between Primary (General Practice) and Secondary (Hospital) Care, thus optimising the patient's quality of life and contributing to an integrated health service. The role supports the implementation of Slaintecare through the provision of community diagnostics and shifting treatment from the acute sector to the community. The primary focus of the post holder will be to ensure that patients with cardiovascular disease receive timely and appropriate care through assessment, planning, implementation and evaluation of care delivery. The person appointed to this post will work in the overall integrated cardiology service. This post is 50% acute based and 50% community based to work with the Integrated Care Consultant Cardiologist to develop integrated care services. Please note a portion of the appointees work will be carried out "offsite". This means that the appointee will travel to the hubs to perform duties related to the role. The CNSp. CVD caseload will focus initially on the following patient groups: • Chronic Cardiovascular Disease • Atrial Fibrillations • Ischaemic Heart Disease The CNSp. CVD plays a vital role in ensuring patients are empowered with skills and knowledge necessary for them to achieve optimal health and wellbeing.
Principal Duties and Responsibilities	**<u>Professional Responsibilities</u>** *The Clinical Nurse Specialist will:* • Practice in accordance with relevant legislation and with regard to The Scope of Nursing & Midwifery Practice Framework (Nursing and Midwifery Board of Ireland, 2015) and the Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives (Nursing and Midwifery Board of Ireland, 2014).

- Adhere to national, regional and local HSE guidelines, policies, protocols and legislation.
- Be aware of ethical policies and procedures which pertain to their area of practice.
- Respect and maintain the privacy, dignity and confidentiality of the patient.
- Maintain a high standard of professional behaviour and be professionally accountable for actions/omissions. Take measures to develop and maintain the competences required for professional practice.
- Adhere to the Nursing & Midwifery values of Care, Compassion and Commitment (DoH, 2016).
- Adhere to appropriate lines of authority within the midwife management structure.

The CNSp. CVD will deliver care in line with the five core concepts of the role set out in the Framework for the Establishment of Clinical Nurse/Midwife Specialist Posts, 4th ed National Council for the Professional Development of Nursing and Midwifery (NCNM) 2008.

The concepts are:
- Clinical Focus
- Patient/Client Advocate
- Education and Training
- Audit and Research
- Consultant

Clinical Focus

The CNSp. CVD will have a strong patient focus whereby the specialty defines itself as nursing and subscribes to the overall purpose, functions and ethical standards of nursing. The clinical practice role may be divided into direct and indirect care. Direct care comprises of the assessment, planning, delivery and evaluation of care to patients, their families and/or carer. Indirect care relates to activities that influence others in their provision of direct care.

Direct Care

- Provide a specialist nursing service for patients with a diagnosis of cardiovascular disease who require support and treatment through the continuum of care.
- Undertake comprehensive patient assessment to include physical, psychological, social and spiritual elements of care using latest evidence based practice in cardiovascular care.
- Use the outcomes of patient assessment to develop and implement plans of care in conjunction with MDT colleagues, the patient, family and/or carer.
- Monitor and evaluate the patient's response to treatment and review the plan of care accordingly in liaison with the MDT and the patient, family and/or carer as appropriate.
- Make alterations in the management of patient's conditions in collaboration with the MDT and the patient in line with agreed pathways and policies, procedures, protocols and guidelines (PPPGs).
- Accept appropriate referrals from colleagues within the MDT.
- Co-ordinate investigations, treatment, therapies and patient follow-up.
- Communicate with patient, family and/or carer as appropriate, to assess the patient's needs and provide relevant support, information, education, advice and counselling as required.
- Work collaboratively with the patient's GP and other MDT colleagues in Primary and Secondary Care, to provide a seamless service delivery to the patients, family and/or carer as appropriate.
- Participate in medication reconciliation taking cognisance of poly-pharmacy and support medical and pharmacy staff with medication reviews and medication management.
- Provide a nurse led cardiology assessment clinic with GP/ Consultant Specialist input regarding drug titration.
- Identify health promotion priorities for the patient, family and/ or carer and support patient self-care in line with best evidence. This will include the provision of educational and health promotion material which is comprehensive, easy to understand and meets patients' needs.
- Identify and promote specific symptom management strategies as well as the identification of triggers which may cause exacerbation of symptoms. Provide patients with appropriate self-management strategies and escalation pathways.

Indirect Care

- Identify and agree appropriate referral pathways for patients with cardiovascular disease.
- Participate in case reviews with MDT colleagues.
- Take a proactive role in the formulation and provision of evidence based PPPGs relating to cardiology care.
- Take a lead role in ensuring the service for patients with cardiovascular disease is in line with best practice guidelines and the Standards for Safer Better Healthcare (HIQA).
- Use a case management approach to patients with complex needs in collaboration with the MDT in Primary and Secondary Care.

Patient/Client Advocate:

- Communicate, negotiate and represent patient's values and decisions in relation to their condition in collaboration with MDT colleagues in both Primary and Secondary Care.
- Develop and support the concept of advocacy particularly in relation to patient participation in decision making thereby enabling informed choice of treatment options.
- Respect and maintain the privacy, dignity and confidentiality of the patient, family and/or carer.
- Establish, maintain and improve procedures for collaboration and cooperation between Acute Services, Primary Care and Voluntary Organisations.
- Proactively challenge any interaction which fails to deliver a quality service to patients.
- Comply with HSE Complaints Policy.

Education & Training:

- Maintain clinical competence in patient management within cardiovascular nursing, keeping up-to-date with relevant research to ensure the implementation of evidence based practice.
- Provide patients and their families and/or carers with appropriate information and other supportive interventions to increase their knowledge, skill and confidence in managing their condition and their optimal quality of life.
- Contribute to the design, development and implementation of education programmes and resources for patients, family and/or carers in relation to chronic cardiovascular disease thus empowering them to self-manage their condition.
- Participate in training programmes for nursing, MDT colleagues and key stakeholders as appropriate
- Create exchange of learning opportunities within the MDT in relation to evidence based cardiovascular care delivery through journal clubs, conferences etc.
- Develop and maintain links with Regional Centres for Nursing & Midwifery Education (RCNMEs), the Nursing and Midwifery Planning and Development Units (NMPDUs) and relevant third level Higher Education Institutes (HEIs) in the design, development and delivery of educational programmes in relation to cardiovascular care.

Audit and Research:

- Establish and maintain a register of patients with chronic cardiovascular disease within the CNSp. CVD caseload.
- Collect and maintain a record of clinically relevant data aligned to National KPI's as directed and advised by the DON, the National Heart Programme and senior management.
- Identify, initiate and conduct nursing and MDT audit and research projects relevant to the area of practice.
- Identify, critically analyse, disseminate and integrate best evidence relating to cardiovascular care into practice.
- Evaluate audit results and research findings to identify areas for quality improvement in collaboration with nursing management and MDT members (Primary and Secondary Care).
- Contribute to nursing research on all aspects of cardiovascular disease care.

Consultant:

	• Provide leadership in clinical practice and act as a resource and role model for specialist practice. • Generate and contribute to the development of clinical standards and guidelines and support implementation. • Use specialist knowledge to support and enhance generalist nursing/ midwifery practice. • Develop collaborative working relationships with local cardiovascular CNS's/ Registered Advanced Nurse Practitioners/ MDT colleagues as appropriate, developing person centred care pathways to promote the integrated model of care delivery. • With the support of the DON, attend integrated care planning meetings as required. • Develop and maintain relationships with specialist services in voluntary organisations which support patients in the community. • Liaise with other health service providers in the development and on-going delivery of appropriate models of care. • Network with other CNSp. CVD's and related professional associations. **Health & Safety** These duties must be performed in accordance with local organisational & the HSE health and safety polices. In carrying out these duties the employee must ensure that effective safety procedures are in place to comply with the Health, Safety and Welfare at Work Act (2005). Staff must carry out their duties in a safe and responsible manner in line with the local policy documents and as set out in the local safety statement, which must be read and understood. **Quality, Risk and Safety Responsibilities** It is the responsibility of all staff to: • Participate and cooperate with legislative and regulatory requirements with regard to quality, risk and safety. • Participate and cooperate with local quality, risk and safety initiatives as required. • Participate and cooperate with internal and external evaluations of the organisation's structures, services and processes as required, including but not limited to, The National Hygiene Audit, National Decontamination Audit, Health and Safety Audits and other audits specified by the HSE or other regulatory authorities • To initiate, support and implement quality improvement initiatives in their area which are in keeping with local organisational quality, risk and safety requirements. • Contribute to the development of PPPGs and safe professional practice and adhere to relevant legislation, regulations and standards. • Ensure completion of incident/near miss forms and clinical risk reporting. • Adhere to department policies in relation to the care and safety of any equipment supplied and used to carry out the responsibilities of the role of CNSp. CVD. **Specific Responsibility for Best Practice in Hygiene** Hygiene is defined as: "The practice that serves to keep people and environments clean and prevent infection. It involves the study of preserving one's health, preventing the spread of disease, and recognising, evaluating and controlling health hazards. In the healthcare setting it incorporates the following key areas: environment and facilities, hand hygiene, catering, management of laundry, waste and sharps, and equipment" (HIQA, 2008; P2). It is the responsibility of all staff to ensure compliance with local organisational hygiene standards, guidelines and practices. **Management/Administration** • Provide an efficient, effective and high quality service, respecting the needs of each patient, family and/or carer. • Effectively manage time and caseload in order to meet changing and developing service needs. • Continually monitor the service to ensure it reflects current needs. • Implement and manage identified changes. • Ensure that confidentiality in relation to patient records is maintained.

	• Represent the specialist service at local, national and international fora as required. • Maintain accurate and contemporaneous records and data on all matters pertaining to the planning, management, delivery and evaluation of care and ensure that this service is in line with HSE requirements. • Contribute to the service planning process as appropriate and as directed by A/DON • Have a working knowledge of the Health Information and Quality Authority (HIQA) Standards as they apply to the role for example, Standards for Healthcare, National Standards for the Prevention and Control of Healthcare Associated Infections, Hygiene Standards etc. and comply with associated HSE protocols for implementing and maintaining these standards as appropriate to the role. • To support, promote and actively participate in sustainable energy, water and waste initiatives to create a more sustainable, low carbon and efficient health service. **The above Job Specification is not intended to be a comprehensive list of all duties involved and consequently, the post holder may be required to perform other duties as appropriate to the post which may be assigned to him/ her from time to time and to contribute to the development of the post while in office.**

Suite of generic Role Descriptors for Community ICP CD Teams September 2020

Diabetes

CNS Diabetes

Clinical Specialist Podiatrist

Senior Grade Podiatrist

Basic Grade Podiatrist

Senior Dietitian

Staff Grade Dietitian (Weight Mgt/Diabetes Prevention)

Cardiology

CNS Cardiovascular Disease – Integrated Care

Senior Cardiology Physiotherapist

Cardiac Rehab Co-ordinator - Draft

Staff Nurse Cardiac Rehabilitation – Draft

Cardiac Rehab Admin

Clinical Cardiology Psychologist - Draft

Respiratory

CNS Respiratory

Senior Physiotherapist Respiratory

Clinical Specialist Physio Rehab Co-ordinator

CNS Rehab

Staff Grade Physio Rehab

Pulmonary Rehab Admin

Others

GP Lead with Specialist interest (Respiratory sample enclosed)

Service Improvement Lead

Project Officer

Clinical Nurse Specialist (Diabetes – Integrated Care)

Job Specification & Terms and Conditions

Job Title and Grade	**Clinical Nurse Specialist (Diabetes – Integrated Care)** *(Grade Code: 2632)*
Purpose of the Post	The purpose of this Clinical Nurse Specialist (Diabetes – Integrated Care) post is to: Deliver care in line with the five core concepts of the role set out in the Framework for the Establishment of Clinical Nurse Specialist Posts, 4th edition, National Council for the Professional Development of Nursing and Midwifery (NCNM) 2008. The CNS will work as part of a multidisciplinary team who will be responsible for implementing the delivery of the Model of Integrated Care for Patients Type 2 Diabetes (2018) within the community healthcare network and community healthcare organisation. In line with the Model of Care, 80% of the CNS role will involve working with General Practitioners (GP's) and MDT's in Primary Care and 20% of CNS role will involve working in Secondary Care. There will be a strong focus on service integration and team-working. This post will also involve the core elements of the CNS post to include clinical audit and research.
Principal Duties and Responsibilities	The post holder's practice is based on the five core concepts of Clinical Nurse Specialist (Diabetes – Integrated Care) role as defined by the NCNM 4th edition (2008) in order to fulfil the role. The concepts are: • Clinical Focus • Patient/Client Advocate • Education and Training • Audit and Research • Consultant **Clinical Focus** Clinical Nurse Specialist (Diabetes – Integrated Care) will have a strong patient focus whereby the specialty defines itself as Nursing and subscribes to the overall purpose, functions and ethical standards of Nursing. The clinical practice role may be divided into direct and indirect care. Direct care comprises the assessment, planning, delivery and evaluation of care to the patient, family and/or carer. Indirect care relates to activities that influence and support the provision of direct care. **Direct Care** *Clinical Nurse Specialist (Diabetes – Integrated Care) will:* • Provide a specialist nursing service for patients with a diagnosis of Diabetes who require support and treatment through the continuum of care.

- Undertake comprehensive patient assessment to include physical, psychological, social and spiritual elements of care using best evidence based practice in Diabetes care.
- Use the outcomes of patient assessment to develop and implement plans of care/case management in conjunction with the multi-disciplinary team (MDT) and the patient, family and/or carer as appropriate.
- Monitor and evaluate the patient's response to treatment and amend the plan of care accordingly in conjunction with the MDT and patient, family and/or carer as appropriate.
- Make alterations in the management of patient's condition in collaboration with the MDT and the patient in line with agreed pathways and policies, procedures, protocols and guidelines (PPPG's).
- Accept appropriate referrals from MDT colleagues.
- Co-ordinate investigations, treatment therapies and patient follow-up.
- Communicate with patients, family and /or carer as appropriate, to assess patient's needs and provide relevant support, information, education, advice and counselling as required.
- Where appropriate work collaboratively with MDT colleagues across Primary and Secondary Care to provide a seamless service delivery to the patient, family and/or carer as appropriate.
- Participate in medication reconciliation taking cognisance of poly-pharmacy and support medical and pharmacy staff with medication reviews and medication management.
- Identify and promote specific symptom management strategies as well as the identification of triggers which may cause exacerbation of symptoms. Provide patients with appropriate self-management strategies and escalation pathways.
- Identify health promotion priorities for the patient, family and/or carer and support patient self-care in line with best evidence. This will include the provision of educational and health promotion material which is comprehensive, easy to understand and meets patient's needs.
- Support the initiation and continuing care of patients with Type 2 Diabetes who have been commenced on insulin/injectable therapy.
- Fast track emergency referrals e.g. patients with urinary ketones or foot ulcerations to the appropriate member of the MDT for review and collaborative management planning.

Indirect Care

Clinical Nurse Specialist (Diabetes – Integrated Care) will:

- Identify and agree appropriate referral pathways for patients with Diabetes.
- Participate in case review with MDT colleagues.
- Use a case management approach to patients with complex needs in collaboration with MDT in both Primary and Secondary Care as appropriate.
- Take a proactive role in the formulation and provision of evidence based PPPGs relating to Diabetes care.
- Take a lead role in ensuring the service for patients with Diabetes is in line with best practice guidelines and the Safer Better Healthcare Standards (HIQA, 2012).

Patient/Client Advocate

Clinical Nurse Specialist (Diabetes – Integrated Care) will:

- Communicate, negotiate and represent patient's family and/or carer values and decisions in relation to their condition in collaboration with MDT colleagues in both Primary and Secondary Care as appropriate.
- Develop and support the concept of advocacy, particularly in relation to patient participation in decision making, thereby enabling informed choice of treatment options
- Respect and maintain the privacy, dignity and confidentiality of the patient, family and/or carer.
- Establish, maintain and improve procedures for collaboration and cooperation between Acute Services, Primary Care and Voluntary Organisations as appropriate.
- Proactively challenge any interaction which fails to deliver a quality service to patients.

Education & Training:

*Clinical Nurse Specialist (*Diabetes – Integrated Care*) will:*

- Maintain clinical competence in patient management within Diabetes Nursing, keeping up-to-date with relevant research to ensure the implementation of evidence based practice.
- Provide the patient, family and/or carer with appropriate information and other supportive interventions to increase their knowledge, skill and confidence in managing their Diabetes.
- Contribute to the design, development and implementation of education programmes and resources for the patient, family and/or carer in relation to Diabetes thus empowering them to self-manage their condition.
- Provide mentorship and preceptorship for nursing colleagues as appropriate.
- Participate in training programmes for Nursing, MDT colleagues and key stakeholders as appropriate.
- Create exchange of learning opportunities within the MDT in relation to evidence based Diabetes care delivery through journal clubs, conferences, etc.
- Develop and maintain links with Regional Centres for Nursing & Midwifery Education (RCNMEs), the Nursing and Midwifery Planning and Development Units (NMPDUs) and relevant third level Higher Education Institutes (HEIs) in the design, development and delivery of educational programmes in Diabetes care.
- Be responsible for addressing own continuing professional development needs

Audit & Research:

Clinical Nurse Specialist (Diabetes – Integrated Care) will:

- Establish and maintain a register of patients with Diabetes within Clinical Nurse Specialist Caseload.
- Maintain a record of clinically relevant data aligned to National Key Performance Indicators (KPI's) as directed and advised by the, DPHN, National Clinical Programme and senior management.
- Identify, initiate and conduct Nursing and MDT audit and research projects relevant to the area of practice.
- Identify, critically analyse, disseminate and integrate best evidence relating to Diabetes care into practice.

- Contribute to nursing research on all aspects of Diabetes care.
- Use the outcomes of audit to improve service provision.
- Contribute to service planning and budgetary processes through use of audit data and specialist knowledge.
- Monitor, access, utilise and disseminate current relevant research to advise and ensure the provision of informed evidence based practice.

Audit expected outcomes including:

- Collate data on agreed KPIs and outcome measures which will provide evidence of the effectiveness of Clinical Nurse Specialist (Diabetes-Integrated Care). Refer to the National Council for the Professional Development of Nursing and Nursing final report - *Evaluation of Clinical Nurse and Midwife Specialist and Advanced Nurse and Midwife Practitioner roles in Ireland* (SCAPE Report, 2010) and refer to the National KPIs associated with the speciality. They should have a clinical Nursing focus as well as a breakdown of activity - patients seen and treated.
- Evaluate audit results and research findings to identify areas for quality improvement in collaboration with nursing management and MDT colleagues (Primary and Secondary Care).

Consultant:

Clinical Nurse Specialist (Diabetes – Integrated Care) will:

- Provide leadership in clinical practice and act as a resource and role model for Diabetes practice.
- Generate and contribute to the development of clinical standards and guidelines and support implementation.
- Use specialist knowledge to support and enhance generalist nursing practice.
- Develop collaborative working relationships with local Diabetes Clinical Nurse Specialist /Registered Advanced Nurse Practitioner/MDT colleagues as appropriate, developing person centred care pathways to promote the integrated model of care delivery.
- With the support of the Director of Nursing, attend integrated care planning meetings as required.
- Where appropriate develop and maintain relationships with specialist services in voluntary organisations which support patients in the community.
- Liaise with other health service providers in the development and on-going delivery of the National Clinical Programme model of care.
- Network with other Clinical Nurse Specialist in Diabetes **and** in related professional associations.

Health & Safety:

These duties must be performed in accordance with local organisational and the HSE health and safety polices. In carrying out these duties the employee must ensure that effective safety procedures are in place to comply with the Health, Safety and Welfare at Work Act (2005). Staff must carry out their duties in a safe and responsible manner in line with the local policy documents and as set out in the local safety statement, which must be read and understood.

Quality, Risk and Safety Responsibilities

It is the responsibility of all staff to:

- Participate and cooperate with legislative and regulatory requirements with regard to quality, risk and safety.
- Participate and cooperate with local quality, risk and safety initiatives as required.
- Participate and cooperate with internal and external evaluations of the organisation's structures, services and processes as required, including but not limited to, The National Hygiene Audit, National Decontamination Audit, Health and Safety Audits and other audits specified by the HSE or other regulatory authorities.
- Initiate, support and implement quality improvement initiatives in their area which are in keeping with local organisational quality, risk and safety requirements.
- Contribute to the development of PPPGs and safe professional practice and adhere to relevant legislation, regulations and standards.
- Comply with Health Service Executive (HSE) Complaints Policy.
- Ensure completion of incident/near miss forms and clinical risk reporting.
- Adhere to department policies in relation to the care and safety of any equipment supplied and used to carry out the responsibilities of the role of Clinical Nurse Specialist in Diabetes care.

  Specific Responsibility for Best Practice in Hygiene
  Hygiene is defined as: "The practice that serves to keep people and environments clean and prevent infection. It involves the study of preserving one's health, preventing the spread of disease, and recognising, evaluating and controlling health hazards. In the healthcare setting it incorporates the following key areas: environment and facilities, hand hygiene, catering, management of laundry, waste and sharps, and equipment" (HIQA, 2008; P2). It is the responsibility of all staff to ensure compliance with local organisational hygiene standards, guidelines and practices.

Management/Administration:

Clinical Nurse Specialist (Diabetes - Integrated Care) will:

- Provide an efficient, effective and high quality service, respecting the needs of each patient, family and/or carer.
- Effectively manage time and caseload in order to meet changing and developing service needs.
- Continually monitor the service to ensure it reflects current needs.
- Implement and manage identified changes.
- Ensure that confidentiality in relation to patient records is maintained.
- Represent the specialist service at local, national and international fore as required.
- Maintain accurate and contemporaneous records and data on all matters pertaining to the planning, management, delivery and evaluation of care and ensure that this service is in line with HSE requirements.
- Contribute to the service planning process as appropriate and as directed by the DPHN
- Have a working knowledge of the Health Information and Quality Authority (HIQA) Standards as they apply to the role for example, Standards for Healthcare, National Standards for the Prevention and Control of Healthcare Associated Infections, Hygiene Standards etc and comply with associated HSE protocols for implementing and maintaining these standards as appropriate to the role.

	• To support, promote and actively participate in sustainable energy, water and waste initiatives to create a more sustainable, low carbon and efficient health service. **The above Job Specification is not intended to be a comprehensive list of all duties involved and consequently, the post holder may be required to perform other duties as appropriate to the post which may be assigned to him/her from time to time and to contribute to the development of the post while in office.**

Podiatrist, Clinical Specialist (Diabetes)

Job Specification & Terms and Conditions

Job Title and Grade	**Podiatrist, Clinical Specialist Diabetes)** *(Grade Code: 3654)*
Purpose of the Post	As a Podiatrist, Clinical Specialist in Diabetes the post holder will have the vision and drive to bring professionals in the Regional referral area from different areas of healthcare together to provide optimal diagnoses and treatment and to improve outcomes for those with diabetes foot complications. The Podiatrist, Clinical Specialist will be responsible for leading the development and provision of a high quality service to diabetes patients at risk of DFU and those patients who are in-remission from DFU. They will work closely with Senior Podiatrist (Diabetes) and the Staff Grade Podiatrist (Diabetes) as well as Foot Protection Team. It will be necessary to connect and work closely with the multidisciplinary foot team podiatrist to promote integrated working within the podiatry profession; to enable integrated working between the foot protection team and multidisciplinary foot team, and, to help coordinate the management of the diabetic foot in the local region. This will also facilitate and assist with CPD and learning. In this role the Clinical Specialist Podiatrist, will be responsible for the co-ordination of strategic planning and development of specialist diabetes foot services in the community setting, participation in clinical research, and collaboration in multi-centre studies on the various aspects of managing and treating the foot in diabetes. To work as part of multi-disciplinary teams in providing a quality, person-centred, evidence-based podiatry service to meet the needs of service users in the community setting.
Principal Duties and Responsibilities	*The Podiatrist, Clinical Specialist (Diabetes) will:* **Clinical Practice** • Act as a recognised expert podiatric resource for specialised clinical advice to patients, peers and other medical staff including GPs.

	• Ensure professional standards are maintained in accordance with The College of Podiatry (UK) Guidelines on Minimum Standards of Clinical Practice for Podiatry. • Responsibility for own clinical and administrative practices in line with HSE policies procedures and guidelines as well as national models of care and national podiatric best practice. • Treat and manage a specialist clinical caseload within your regional area for those with diabetes foot disease. • Undertake specialist podiatry treatments and interventions as appropriate to your grade, skills and competencies in the community setting. • Provide standardised high-quality diabetes foot management to patients at risk of developing foot complications and those in remission from DFU. There may be requirement to provide continued care to those patients with active foot disease, in line with the care plan developed by the multi-disciplinary foot team, providing care closer to the patient's home in the community. • Adhere to national and international guidelines on diabetes foot management. • Develop specialised, tailored management plans following an in-depth accurate assessment and diagnosis of the patient, using highly advanced and specialist skills in patient management. • Ensure timely referral to other services in the foot protection team or other as required. • Identify the need for change in own clinical practice, and that of colleagues, within the context of changing demographics, economic and legislative needs. • Provide clinical leadership that will influence and assist in the development of quality improvements in diabetes foot management. **Quality, Safety and Risk Management** • Work in a safe manner with due care and attention to the safety of self and others • Implement internationally developed standards in care for the diabetes foot and avail of evidence based interventions to achieve these standards as agreed locally. • Develop and review appropriate clinical care pathways for patients with diabetes and facilitate these with other specialists within the team and wider networks. • Ensure that every patient is to be treated as an individual and provided with a high quality service in terms of dignity courtesy, kindness, interest and efficiency. • Lead and collaborate on the development and implementation of local and national standards of practice, clinical protocols and clinical pathways for diabetes foot management.

	• Actively participate in relevant Special Interest Groups including local governance and implementation groups on a regular basis as agreed with Podiatry manager. • Support and stimulate and partake in research in your specialist area • Participate in local and national audit, benchmarking and quality assurance measures in own specialist area and facilitate these in the National Diabetes Programme. • Participate in the development, co-ordination and implementation of strategy relevant to the National Clinical Programme for Diabetes or other HSE developed programmes for the diabetic foot • In conjunction with the National Diabetes Working Group and the Podiatry Manager, plan, co-ordinate and facilitate research and development activities within diabetes foot management. • Provide clinical and non-clinical risk management, set standards and measure clinical effectiveness in own specialist area. **Research, Audit, Evaluation and Development.** • Implement research and audit tools to improve clinical practice and patient outcomes • Use work items provided by the Health Service Executive in accordance with training and instructions, including personal protective equipment. • Develop and review policies, procedures, protocols and guidelines for managing diabetes patient care within the community setting. • Plan, develop and review innovative service developments across own specialist services within the team in conjunction with the Podiatry Manager and keeping National Clinical Programme informed and up-to-date on developments. • Have a working knowledge of the Health Information and Quality Authority (HIQA) Standards as they apply to the role and your woking environment for example, Standards for Healthcare, National Standards for the Prevention and Control of Healthcare Associated Infections, Hygiene Standards etc and comply with associated HSE protocols for implementing and maintaining these standards as appropriate to the role. • To support, promote and actively participate in sustainable energy, water and waste initiatives to create a more sustainable, low carbon and efficient health service. **Work Practice** • Provide a specialist podiatry service for those at risk of or in remission from DFU, and as required for those with Active foot disease within community setting. • Liaise with other members of the foot protection team, patients, carers and others, on matters relating to the management and treatment of diabetes patients at risk of or in remission from DFU.

	• Provide clinical support to the foot protection team members and networks by maintaining an effective range of communication skills to instruct, inform, and negotiate in order to achieve active patient participation, a cohesive approach to treatment and successful case management. • Be responsible for collating and monitoring data relating to the specialist area and to prepare activity reports on this area for the Podiatry Manager and the HSE. • Participate in collaborative interdisciplinary research. • Inform the Podiatry Manager of changes or trends within service provision to diabetes patients and provide recommendations on implementing changes. • Implement agreed policies, procedures and safe professional practice by adhering to relevant legislation, regulations and standards. • Participate in the business planning aspect of the diabetes specialist team and contribute to the business planning process for the community Podiatry Department in conjunction with the Podiatry Manager. • Participating in business planning aspect of diabetes foot protection service in relation to biomechanical services, aids and appliances and orthoses. • Partake in the allocation of work amongst staff within the clinical area so as to ensure a high standard of service to patients and a good staff morale. **Education and Development** • Provide case supervision to less experienced Podiatrists in own specialist clinical area. • Remain up to date with all HSE service agreed mandatory training, complete HSE induction training. • Maintain a personal development plan with the relevant podiatry clinical grade and Podiatry management • Be committed to personal development and acquisition of further skills and knowledge in own specialist clinical area in order to maintain and further develop a high level of clinical expertise. • Plan, develop and provide specialist training/teaching for podiatry staff within the HSE to facilitate others in the setting up of new and the further development of clinical services for diabetes foot management. • In collaboration with all members of the FPT, the Clinical Specialist Podiatrist (Diabetes) will lead on providing diabetic foot education to HSE community healthcare workers. They will also work together with multidisciplinary foot team podiatrists to develop and deliver diabetic foot education to General Practitioners and Practice Nurses. • Once enacted, register and maintain professional registration with the Podiatrists Registration Board in CORU.

	• Facilitate clinical practice placements for podiatry undergraduate students and other health care professionals as appropriate agreed with the podiatry manager.. • Supervise, mentor and provide peer support of less experienced members of staff within the team and advise the Podiatry Manager of needs required. • Liaise with relevant outside agencies such as universities and professional bodies in order to promote the profession. **The above Job Specification is not intended to be a comprehensive list of all duties involved and consequently, the post holder may be required to perform other duties as appropriate to the post which may be assigned to him/her from time to time and to contribute to the development of the post while in office.**

Podiatrist, Senior, (Diabetes)

Job Specification, Terms and Conditions

Job Title and Grade	**Podiatrist, Senior, (Diabetes)** *(Grade Code: 3346)*
Purpose of the Post	The person appointed to this post of Senior Podiatrist will work as part of the foot protection team in an Integrated Care structure with particular relevance to the Diabetes Model of Integrated Care. The Senior Podiatrist (Diabetes) will provide a quality, person-centred, evidence-based podiatry service to adult service users who present with at-risk foot and those in remission from Diabetic Foot Ulcers. They will work closely with Clinical Specialist Podiatrist (Diabetes) and the Staff Grade Podiatrist (Diabetes) as well as Foot Protection Team. In conjunction and in-line with the leadership of the Clinical Specialist Podiatrist (Diabetes) it will be necessary to connect and work closely with the multidisciplinary foot team podiatrist to promote integrated working within the podiatry profession; to enable integrated working between the foot protection team and multidisciplinary foot team, and, to help coordinate the management of the diabetic foot in the local region. This will also facilitate and assist with CPD and learning. To work as part of foot protection team in providing a quality, person-centred, evidence-based podiatry service to meet the needs of service users in the community setting.
Principal Duties and Responsibilities	**Professional / Clinical** *The Senior Podiatrist will:* • Adhere to the HSE Diabetic Foot Model of Care. • Ensure professional standards are maintained in accordance with The College of Podiatry (UK) “Guidelines on Minimum Standards of Clinical Practice” for Podiatry. • Ensure professional standards are maintained in accordance with HSE and local policies Procedures Protocols and Guidelines including agreed Standard Operating Procedures • Ensure Professional and Clinical responsibility is adhered to at all times.

	• Provide standardised high-quality diabetes foot management to patients at risk of developing foot complications and those in remission from DFU. There may be requirement to provide continued care to those patients with active foot disease, in line with the care plan developed by the multi-disciplinary foot team, providing care closer to the patient’s home in the community. • Work as part of a team or independently to ensure effective day-to-day co-ordination and prioritisation of the podiatry service within the designated work / activity areas. • Co-ordinate clinic appointments, organise time and ensure deadlines are met. • Communicate with senior and/or junior staff, write reports, present data as required and specifically collect required access data of foot protection service that will facilitate audit. • Provide data reports to the National Diabetes Programme, Working Group and Regional Co-ordinator of Clinical Programmes and RDO Offices as required. • Be directly responsible for the assessment and treatment of patients referred, including those with a complex presentation using investigative analytical skills. • Interpret and analyse clinical and non-clinical facts to form an accurate diagnosis and prognosis for a wide range of complex conditions. • Monitor and evaluate outcomes of treatment for individual patients. • Be responsible for the recording and updating of clinical records following assessment and treatment of patients. • Develop and present Health Promotion packages for service stakeholders. • Work as part of foot protection team and to liaise with other staff and disciplines, attend case conferences and meetings as appropriate. • Engage in team building and change management initiatives. • Develop and maintain good working relationships with foot protection team members, and specialist services to ensure an integrated service for clients. • Work independently as well as part of a wider healthcare team. • Participate in community needs assessment and ongoing community involvement. **Education and Training**

The Senior Podiatrist will:

- Act at all times as an effective role model by demonstrating skilled Podiatry practice within the clinical situation
- Maintain and develop podiatry skills in the clinical area through personal study, attending lectures, courses, in-house training, and to act as a resource for other members of staff as agreed with Podiatry management
- Act as a mentor, providing advice and support to junior staff, sharing knowledge to maintain professional standards and good work practice
- Partake in induction and clinical supervision of staff grade podiatrists as requested.
- Discuss and partake in podiatry service development needs with Clinical Specialist and/or Podiatry Manager as appropriate.
- Participate in continuous improvement and other quality initiatives
- Actively seek opportunities to improve client care within resources available
- Work effectively using common computer software and engage in Information Technology development as they apply to client and service administration
- Be responsible for keeping up to date with organisational development within the Health Service Executive
- Once enacted, register and maintain professional registration with the Podiatrists Registration Board in CORU.

Health & Safety

The Senior Podiatrist will:

- Work in a safe manner with due care and attention to the safety of self and others.
- Implement agreed policies, procedures and safe professional practice by adhering to relevant legislation, regulations and standards, maintaining up to date knowledge.
- Be responsible for risk minimisation and management of own area of work and report any potential hazards of any aspect of the service to the line manager.
- Document appropriately and report any near misses, hazards and accidents and bring them to the attention of the relevant person(s).
- Have a working knowledge of the Health Information and Quality Authority (HIQA) Standards as they apply to the role and environment for example, Standards for Healthcare, National Standards for the Prevention and Control of Healthcare Associated Infections, Hygiene Standards etc and comply with associated HSE protocols for implementing and maintaining these standards.
- Support, promote and actively participate in sustainable energy, water and waste initiatives to create a more sustainable, low carbon and efficient health service.

Administration

The Senior Podiatrist will:

- Participate in relevant planning activities to ensure that the podiatry services provided are adequate, equitable and developed according to patients needs in consultation and agreement with podiatry manager.
- Contribute to the development and implementation of information sharing protocols, audit systems, referral pathways, individual care plans and shared care arrangements.
- Understand and adhere to the policies, procedures and protocols of the Service and participate in the development of such policies as appropriate.
- Carry out clinical/administrative audit to ensure standards are met, and co-operate with any audit processes undertaken by the podiatry manager.
- Be responsible and accountable for the care and maintenance of equipment and stock control and other such duties that may be assigned by the Podiatry Manager, e.g. to be responsible and accountable for the economical use of resources of the Service.
- Prepare, store and maintain patient records / data as required by GDPR Legislation.
- Be aware of the implications of the Freedom of Information legislation.
- Notify the Podiatry Manager of all leave in accordance with local policies and procedures.

The above job specification is not intended to be a comprehensive list of all duties involved and consequently, the post holder may be required to perform other duties as appropriate to the post which may be assigned to him/her from time to time and to contribute to the development of the post while in office

Podiatrist Staff Grade (Diabetes)

Job Specification & Terms and Conditions

Job Title and Grade	**Podiatrist Staff Grade (Diabetes)** *(Grade Code 3352)*
Purpose of the Post	The person appointed to this post of Staff Grade Podiatrist will work as part of the foot protection team in an Integrated Care structure with particular relevance to the Diabetes Model of Integrated Care. The Staff Grade Podiatrist (Diabetes) will provide a quality, person-centred, evidence-based podiatry service to adult service users who present with at-risk foot and those in remission from Diabetic Foot Ulcers. They will work closely with Clinical Specialist Podiatrist (Diabetes) and the Staff Grade Podiatrist (Diabetes) as well as Foot Protection Team. In conjunction and in-line with the leadership of the Clinical Specialist Podiatrist (Diabetes) it will be necessary to connect and work closely with the multidisciplinary foot team podiatrist to promote integrated working within the podiatry profession; to enable integrated working between the foot protection team and multidisciplinary foot team, and, to help coordinate the management of the diabetic foot in the local region. This will also facilitate and assist with CPD and learning. To work as part of foot protection team in providing a quality, person-centred, evidence-based podiatry service to meet the needs of service users in the community setting.
Principal Duties and Responsibilities	*The Podiatrist Staff Grade will:* **Professional / Clinical** • Adhere to the HSE Diabetic Foot Model of Care • Ensure professional standards are maintained in accordance with The College of Podiatry (UK) Guidelines on Minimum Standards of Clinical Practice for Podiatry. • Ensure Professional and Clinical responsibility is adhered to at all times. • Provide standardised high-quality diabetes foot management to patients at risk of developing foot complications and those in remission from DFU. In collaboration with Clinical Specialist (Diabetes) and Senior Podiatrist (Diabetes), there may be requirement to provide continued care to those patients with active foot disease, in line with the care plan developed by the multi-disciplinary foot team, providing care closer to the patient's home in the community.
	• Work as part of the podiatry team and assist in the day to day running, co-ordination and prioritisation of the podiatry service within the designated work / activity areas. • Communicate with senior staff and write reports and present data as required and specifically collect required access data of foot protection service that will facilitate clinical audit. • Provide activity data reports to Podiatry Manager using nationally agreed metric templates or to the National Diabetes Programme, Working Group and Regional Co-ordinator of Clinical Programmes • Be directly responsible for the assessment and treatment of patients referred • Inform and facilitate clients in assessing other appropriate healthcare and support services, including referral to more specialist services if required • Be responsible for the recording and updating of clinical records following assessment and treatment of patients • Monitor and evaluate outcomes of treatment for individual patients • Work as part of a foot protection team and liaise with other staff and disciplines, attend case conferences, and meetings as appropriate • Engage in team building and change management initiatives • Participate in community needs assessment and ongoing community involvement • Participate in the development and presentation of Health Promotion packages for service stakeholders • Develop and maintain good working relationships with foot protection team members, and specialist services to ensure an integrated service for clients. • Coordinate clinical appointments, manage time efficiently and ensure that deadlines are met • Participate in specialised clinics under supervision • Work independently or as part of a team • Understand and adhere to the policies, procedures and protocols of the Service and to participate in the development of such policies as appropriate **Education & Training** • Act at all times as an effective role model by demonstrating skilled podiatry practice within the clinical situation • Maintain mandatory training as agreed with podiatry manager • Maintain and develop personal podiatry skills in the clinical area through personal study, attending lectures, courses, in-house training, and to act as a resource for other members of staff agreed with Podiatry management. • Participate in continuous improvement and other quality initiatives supervised by a designated mentor/Podiatry Manager / Senior Podiatrist • Provide training and supervision to other staff as required, sharing knowledge to maintain professional standards and good work practice • Discuss present performance and future development needs with the Podiatry Manager / Senior/specialist Podiatrist or designated mentor • Actively seek opportunities to improve client care within resources available

	• Work effectively using common computer software and engage in Information Technology development as it applies to client and service administration • Be responsible for keeping up to date with organisational development within the Health Service Executive • To participate in the practice education of student Podiatrists • Once enacted, register and maintain professional registration with the Podiatrists Registration Board in CORU. **Health & Safety** • Work in a safe manner with due care and attention to the safety of self and others • Implement agreed policies, procedures and safe professional practice by adhering to relevant legislation, regulations and standards maintaining up to date knowledge. • Be responsible for risk minimisation and management of own area of work and report any potential hazards of any aspect of the service to the line manager • Document appropriately and report any near misses, hazards and accidents and bring them to the attention of the relevant person(s) • Have a working knowledge of the Health Information and Quality Authority (HIQA) Standards as they apply to the role and environment for example, Standards for Healthcare, National Standards for the Prevention and Control of Healthcare Associated Infections, Hygiene Standards etc and comply with associated HSE protocols for implementing and maintaining these standards as appropriate to the role **Administration** • Participate in relevant planning activities, to ensure that the podiatry services provided are adequate and equitable developed according to patients needs in consultation and agreement with the Senior /Specialist Podiatrist/Podiatry Manager. • Contribute to the development and implementation of information sharing protocols, audit systems, referral pathways, individual care plans and shared care arrangements. • Be responsible and accountable for the care and maintenance of equipment and stock control and other such duties that may be assigned by the Senior Podiatrist, e.g. to be responsible and accountable for the economical use of resources of the Service. • Communicate with senior and/ junior staff and write reports and present data as required • Collate and submit activity data / prepare and maintain such records as are required by the Senior/specialist Podiatrist /Podiatry Manager • Prepare store and maintain patient records /data as required by GDPR • Be aware of the implications of the Freedom of Information legislation • Notify the Podiatry Manager of all leave in accordance with local policies and procedures • To support, promote and actively participate in sustainable energy, water and waste initiatives to create a more sustainable, low carbon and efficient health service. **The above Job Specification is not intended to be a comprehensive list of all duties involved and consequently, the post holder may be required to perform other duties as appropriate to the post which may be assigned to him/her from time to time and to contribute to the development of the post while in office.**

Senior dietitian – Diabetes Integrated Care

Job Specification & Terms and Conditions

Job Title and Grade	**Senior dietitian – Diabetes Integrated Care**
Principal Duties and Responsibilities	**Professional/Clinical** *The Senior Dietitian will:* • Lead the organisation, provision and evaluation of the Nutrition & Dietetic Services to patients with diabetes in the primary care setting, linking with other health care professionals and patient advocacy groups. • Provide a reformed service that utilises telehealth and other ICT measures to facilitate more effective and efficient delivery of care. • Contribute to the strategic planning of regional diabetes services. • Coordinate and contribute to the provision of regional diabetes structured patient education (SPE) and individual diabetes nutrition education in line with National policy and international best practice and standards. • Be responsible for on-going updating of regional SPE information on the national SPE data base. • Supervise the collection and return of regional data relating to National KPIs for (SPE) and other areas of metrics as required. • Contribute to research activities within their specialist area as required. • Liaise with the medical / nursing teams, allied health professionals and other members of primary care teams in planning and delivering the diabetes care of service users. • Liaise with dietetic colleagues in acute services in planning the nutritional care of people with diabetes across the integrated care pathway. • Contribute to development, implementation and evaluation of diabetes related standards and policies within the Department of Nutrition and Dietetics and relevant care pathways. • Work as part of a national team of educators- attending necessary updates, contributing to the development of national care plans, educator and client materials. Contribute to the ongoing training and development of educators as required. • Maintain professional competence through continual update. • Provide expertise and training in the area of diabetes related nutrition to staff /colleagues as appropriate. • Participate in training of student dietitians in association with Dietetic colleagues. • Maintain appropriate patient records and statistics in line with the department policy and for national metrics. • Be actively involved in continuously improving the quality of the service, use audit and quality improvement methods to facilitate integrated care.

	• Comply with policies, procedures and standards of care of the Department of Nutrition and Dietetics. • Ensure the ongoing review of existing resources, develop and evaluate new resources to support and meet the needs of the target audience in line with National policy. • Work within own scope of professional competence in line with principles of best practice, professional conduct and clinical governance. • Promote a culture that values equality, diversity and respect in the work place. • Participate in quality assurance initiatives. • Actively participate in National Structured Education working groups to ensure optimum delivery of service. • Maintain professional standards with regard to patent and data confidentiality. • Carry out any other duties and responsibilities appropriate to the post that may be assigned by the Dietitian Manager or another nominated person. **Education & Training** *The Senior Dietitian will:* • Attend mandatory training programmes. • Maintain professional knowledge on relevant scientific research and practice development. • Maintain standards of practice and levels of clinical knowledge by participating in continuous professional development initiatives and attendance at relevant courses as appropriate. • Engage in career and personal development planning in collaboration with the Dietitian Manager or another nominated person. • Provide induction and mentoring to professional colleagues. S/he will be open to reflective practice. • Act as a resource by participating in the education and training of dietetic colleagues, other health professionals and service user groups as required. • Manage, participate and play a key role in the practice education of student Dietitians. • Participate in the development and evaluation of nutrition education resource materials for structured patient education and individual consultations. **Health & Safety** *The Senior Dietitian will:* • Comply with and contribute to the development of policies, procedures and safe professional practice and adhere to relevant legislation, regulations and standards. • Work in a safe manner with due care and attention to the safety of self and others. • Be aware of risk management issues, identify risks and take appropriate action. • Report any adverse incidents or near misses.

	• Adhere to HSE policies in relation to the procurement, care and safety of any equipment supplied for the fulfilment of duty. • Have a working knowledge of the Health Information and Quality Authority (HIQA) Standards as they apply to the role for example, Standards for Healthcare, National Standards for the Prevention and Control of Healthcare Associated Infections, Hygiene Standards etc. • Support, promote and actively participate in sustainable energy, water and waste initiatives to create a more sustainable, low carbon and efficient health service.

Staff Grade Dietitian (Diabetes)

Job Specification & Terms and Conditions

Job Title and Grade	*Staff Grade Dietitian*
Principal Duties and Responsibilities	**Professional / Clinical Practice** • Provide a dedicated dietetic service to individuals with diabetes and their families that is integrated with services provided in Primary Care. • Contribute to the ongoing reform of service that utilises telehealth and other ICT measures to facilitate more effective and efficient delivery of care. • Contribute to the provision of regional diabetes structured patient education (SPE) diabetes services and individual diabetes nutrition education in line with national policy and international best practice, as per Model of Integrated Care. • Report on all SPE activity to national office. • Collection and return relevant data relating to National KPIs for (SPE) and other areas of metrics as required. • Contribute to research activities within the area of diabetes and pre-diabetes care as required. • Liaise with the medical / nursing teams, allied health professionals and other members of primary and secondary care teams in delivering the diabetes care of service users. • Liaise with dietetic colleagues in primary care in planning the nutritional care of people with diabetes across the integrated care pathway. • Contribute to development, implementation and evaluation of diabetes related standards and policies within the Department of Nutrition and Dietetics and relevant care pathways. • Assist in the development of diabetes related diet sheets, nutrition education material and structured education materials in collaboration with colleagues locally and nationally. • Work as part of a national team of educators – attending necessary updates, contributing to the development of national care plans, educator and client materials as required. Contribute to educator training as required. • Maintain professional competence through continual update. • Provide expertise and training in the area of diabetes related nutrition to staff /colleagues as appropriate. • Participate in training of student dietitians in association with Dietetic colleagues if required. • Maintain appropriate patient records and statistics in line with the department policy and for national metrics.

	• Assess, review and monitor patients and adjust their diet and/or nutrition support regimen (in conjunction with the MDT) based on changes in the patient's state of health and condition • Maintain accurate records of each consultation as per the agreed department standard (currently NCPM format) about the patient in dietetic notes and medical notes • Operate within the department care plans and provide a dietetic service that is evidence based, including specific objectives, strategies, and relevant evaluation. • Prioritise and manage a patient caseload according to the needs of the department or service. • Recognise the need for effective Self-Management of workload, available time and resources. • Instigate the Malnutrition Universal Screening Tool (M.U.S.T.) and relevant other adapted screening tools or patient resources for patient groups. • Liaise and contribute effectively with multidisciplinary teams, staff colleagues and Dietitians in acute settings and in Primary Care including Residential Services using a collaborative, multidisciplinary team approach. • Actively participate in multidisciplinary team meetings and case conferences. • To participate in clinical audit and research. • Know the limits of their practice and when to seek advice or refer to another health professional. **Education & Training** • Strive to maintain standards of practice and levels of clinical knowledge by participating in continuous professional development initiatives and attend relevant courses as appropriate. • Be a member of professional groups and participate in relevant forums pertaining to clinical nutrition and dietetics. • Produce and evaluate nutrition education materials for patients and multidisciplinary teams. • Engage in career and personal development. • Participate in clinical supervision, and mentoring. • Attend and present at journal club and clinical meetings within the department. • Engage in the education of colleagues, student dietitians and other health professionals. • Update department resources and develop new teaching materials, lecture notes and other educational materials. **Quality and Risk, Health and Safety Management**

	• To participate in quality improvements in delivery of care through quality assurance projects, clinical audit and research • Become familiar with and work in accordance with relevant HSE Policies, legislation and professional policies, guidelines and requirements to ensure safe practice and high standards of service delivery. • Participate in and ensure mandatory training is up to date • Work in a safe manner with due care and attention to the safety of self and others. • Maintain appropriate patient record details and statistics in accordance with hospital and departmental guidelines, along with the Freedom of Information Act. • Be aware of risk management issues, identify risks and take appropriate action, report all adverse incidents and near misses. • Have a working knowledge of the Health Information and Quality Authority (HIQA) Standards as they apply to the role for example, Standards for Healthcare, National Standards for the Prevention and Control of Healthcare Associated Infections, Hygiene Standards etc. • Support, promote and actively participate in sustainable energy, water and waste initiatives to create a more sustainable, low carbon and efficient health service. **<u>Administrative</u>** • Prepare patient progress reports, performance indicators or statistics as required. • Contribute to service planning and development in their area of assignment and has the ability to prepare and present relevant information that will aid operational and strategic planning for future service development. • Maintain appropriate records in accordance with legal and local requirements. • Make efficient use of developments in Information Technology. • Maintain professional standards with regard to patient and data confidentiality. • Keep up to date with organisational developments within the Irish Health Service.

Senior Physiotherapist (Respiratory - Integrated Care)

Job Specification,

Job Title & Grade	Senior Physiotherapist (Respiratory - Integrated Care)
Purpose of the Post	As outlined above, the need to reform the healthcare services in Ireland in order to provide a more sustainable, integrated and patient-centred approach has come to the fore in recent health policies and strategies. Integrated care requires health and social care services to work together across different levels and sites in order to provide end-to-end care that meets patient need. The senior integrated care physiotherapist will • To work in conjunction with other team members in co-ordinating and developing the service to meet the needs of the population it serves in line with the objectives of the organisation • To be responsible for the provision of a high quality Physiotherapy service in accordance with standards of professional practice • To carry out clinical and educational duties as required • To work with Physiotherapy Manager in ensuring the co-ordination, development and delivery of a quality, client centred physiotherapy service across and between networks in the geographical area. More specifically, the Senior Physiotherapist, as part of the Integrated Care Team will: • Manage, develop and evaluate an Integrated Care Respiratory service in the community setting; • Plan and implement oxygen assessment and review clinics for patients meeting the criteria • Refer to Community Pulmonary rehabilitation team where appropriate • Manage, develop and evaluate and admission avoidance programme with GP and Consultant • Be an expert resource in respiratory care to physiotherapists working in primary care • Contribute to business planning and business cases • Develop and maintain guidelines and protocols relating to Respiratory Integrated Care develop and implement strategies as part of the Integrated Care team for delivering effective care of chronic respiratory conditions within a changing environment 80% of the role will involve working with GP's in Primary Care, and 20% of role will involve working with Secondary Care Consultants & their respiratory teams

Principal Duties and Responsibilities	**<u>Professional / Clinical</u>** The Senior Physiotherapist will: • Be a lead clinician in the area of respiratory Physiotherapy and carry a clinical caseload appropriate to the post • Be responsible for client assessment, development and implementation of individualised plans and oxygen assessment and review clinics in line with best practice • Be responsible for goal setting in partnership with client, family and other team members as appropriate • Be responsible for standards of practice of self and staff appointed to clinical / designated area(s) • Be a clinical resource for other Physiotherapists • Communicate and work in co-operation with the Physiotherapy Manager and other team members in providing an integrated quality service, taking the lead role as required • Communicate effectively with and provide instruction, guidance and support to, staff clients, family, carers • Document client records in accordance with professional standards and departmental policies • Provide a service in varied locations in line with local policy / guidelines and within appropriate time allocation (e.g. GP practice, health / primary care centres, clinic) • Participate and be a lead clinician as appropriate in review meetings, case conferences etc. • Develop and promote professional standards of practice • Work within own scope of professional competence in line with principles of best practice, professional conduct and clinical governance • Seek advice of relevant personnel when appropriate / as required • Operate within the scope of practice of the Irish Society of Chartered Physiotherapists • Provide weekend and on call service where it is a requirement of the post **<u>Education & Training</u>** The Senior Physiotherapist will: • Participate in mandatory training programmes including CPR and anaphylaxis training • Take responsibility for, and keep up to date with Physiotherapy practice by participating in continuing professional development such as reflective practice, in service, self-directed learning, research, clinical audit etc. • Be responsible for the induction and clinical supervision of staff in the integrated care services(s) • Provide clinical supervision / evaluation to undergraduate physiotherapists as directed by the Physiotherapy Manager. Take part in teaching / training / supervision / evaluation of staff / students and attend practice educator courses as relevant to role and needs • Develop or maintain competencies in performing spirometry, if a requirement of your role, having first undertaken or be willing to undertake a minimum of the IARS module of education "CPD Certificate in Spirometry for Healthcare Professionals" further details on: www.iars.ie/spirometry-course • Engage in personal development planning and performance review for self and others as required within the integrated care team

	• Develop advanced skills as relevant to respiratory such as taking and interpreting Arterial blood gases **<u>Quality, Safety & Risk</u>** The Senior Physiotherapist will: • Be responsible for the co-ordination and delivery of a quality service in line with best practice; • Develop and monitor implementation of agreed policies, procedures and safe professional practice by adhering to relevant legislation, regulations and standards; • Ensure the safety of self and others, and the maintenance of safe environments and equipment used in Physiotherapy in accordance with legislation; • Assess and manage risk in their assigned area(s) of responsibility; • Take the appropriate timely action to manage any incidents or near misses within their assigned area(s); • Report any deficiency/danger in any aspect of the service to the team or Physiotherapy Manager as appropriate; • Be responsible for the safe and competent use of all equipment, aids and appliances both by clients and staff under their supervision; • Develop and promote quality standards of work and co-operate with quality assurance programmes; • Oversee and monitor the standards of best practice within their Physiotherapy team; • Have a working knowledge of HIQA Standards as they apply to the role, for example, National Standards for Safer Better Healthcare, National Standards for the Prevention and Control of Healthcare Associated Infections, Hygiene Standards etc. and comply with associated HSE protocols for implementing and maintaining these standards. **<u>Administrative</u>** The Senior Physiotherapist will: • Contribute to the service planning process • Assist the Physiotherapy Manager and relevant others in service development encompassing policy development and implementation • Review and evaluate the Physiotherapy service regularly, identifying changing needs and opportunities to improve services in conjunction with MDT (demonstrator project) • Collect and evaluate data about the service area as identified in service plans and demonstrate the achievement of the objectives of the demonstrator project and there after the service • Oversee the upkeep of accurate records in line with best practice • Collate and maintain accurate statistics and render reports as required • Represent the department / team at meetings and conferences as appropriate • Inform the Physiotherapy Manager of staff issues (needs, interests, views) as appropriate • Promote a culture that values diversity and respect in the workplace

	• Participate in the control and ordering of Physiotherapy stock and equipment in conjunction with the Physiotherapy Manager • Be accountable for the budget, where relevant • Keep up to date with organisational developments within the Irish Health Service • Engage in IT developments as they apply to clients and service administration • Perform such other duties appropriate to the role as may be assigned by the Physiotherapy Manager **The above Job Specification is not intended to be a comprehensive list of all duties involved and consequently, the post holder may be required to perform other duties as appropriate to the post which may be assigned to him/her from time to time and to contribute to the development of the post while in office.**

Job Title, Grade, Grade Code	**Clinical Nurse Specialist (CNSp), Respiratory – Integrated Care** *Grade Code: 2632*
Purpose of the Post	The role of the CNSp will differ according to the needs and configuration of established respiratory services at each site. The purpose of this Clinical Nurse Specialist, Respiratory Integrated Care post is to: provide expertise and specialist nursing services to patients with a respiratory condition both in the hospital outpatient settings and in primary care. The post holder will liaise between acute respiratory services and integrated respiratory services in the community along with other agencies to deliver effective evidenced based care. They will use resources efficiently to achieve the best possible outcomes in keeping with the NCP Programme model of care and HIQA standards. The person appointed to this post will work in newly formed Respiratory Integrated Care services. The post holder will work as part of a multidisciplinary team delivering coordinated evidence based care for patients in primary care whilst liaising closely with secondary care. The CNS RIC will deliver nurse-led clinics to provide support to patients and their GPs in creating management plans, assessing inhaler treatments, assisting with diagnosis development and will provide education to patients and staff. This post is 80% working with GP's in Primary Care, and 20% of CNSp role will involve working with Secondary Care respiratory teams. In order to ensure continuity of service to patients the CNSp may be required to rotate/cover other parts of the integrated respiratory service such as Pulmonary Rehabilitation and Outreach. This will also promote service integration and enhance skillset development. It will be dependent on identified service needs at each site. If deemed appropriate, site rotation should occur within the first 3-6 months of taking up the post. The Clinical Nurse Specialist (RIC) caseload will focus initially on the following patient groups. • COPD • Asthma
Principle Duties and Responsibilities	The CNSp will deliver care in line with the five core concepts of the role set out in the Framework for the Establishment of Clinical Nurse/Midwife Specialist Post, 4th ed. National Council for the Professional Development of Nursing and Midwifery (NCNM) 2008. The concepts are:

- Clinical Focus
- Patient/Client Advocate
- Education and Training
- Audit and Research
- Consultant

Whereby the CNSp is required to rotate into Outreach or Pulmonary Rehabilitation, some aspects of their primary role under these headings may alter to include additional duties such as home visits, delivering pulmonary rehabilitation, oxygen assessments and nurse led spirometry clinics.

Clinical Focus

The CNSp. will have a strong patient focus whereby the specialty defines itself as nursing and subscribes to the overall purpose, functions and ethical standards of nursing. The clinical practice role may be divided into direct and indirect care. Direct care comprises the assessment, planning, delivery and evaluation of care to the patient, family and/or carer. Indirect care relates to activities that influence others in their provision of direct care. The CNSp will work in conjunction with other team members in co-ordinating and developing the Integrated Care service to meet the needs of the population it serves in line with the objectives of the organisation.

Direct Care

The Clinical Nurse Specialist Respiratory-Integrated Care will:

- Provide a specialist nursing service for patients with COPD/Asthma that incorporates evidence based knowledge, investigative and analytical skills and specialist assessment techniques to triage comprehensibly assess and manage a range of complex presentations.
- Use the outcomes of patient assessment to develop and implement plans of care/case management in conjunction with the GP/Consultant/MDT and the patient, family and/or carer as appropriate.
- Monitor and evaluate the patient's response to treatment and amend the plan of care accordingly in conjunction with the GP/Consultant/MDT and patient, family and/or carer as appropriate.
- Make alterations in the management of patient's condition in collaboration with the GP/Consultant/MDT and the patient in line with agreed pathways, policies, protocols and guidelines (PPPG's).
- Manage nurse led asthma and COPD Clinics with GP/Specialist input
- Evaluate clinical problems using objective measurement tools e.g. Spirometry, Arterial Blood Gases (ABG) in conjunction with other team members, co-ordinate investigations, therapies and patient follow-up in secondary or primary care as appropriate.
- Provide spirometry service to confirm differential diagnosis and staging of disease where appropriate.
- Use a case management approach to patients with complex needs
- If a Registered Nurse Prescriber (RNP) the nurse must work within the scope of their practice and adhere to the regulations set down by NMBI pertaining to this role and, local policy requirements.
- Use agreed direct pathway for patients who may present/become clinically unwell at time of attending/engaging with the service.
- In collaboration with the GP and Consultant, co-ordinate investigations, treatment therapies and patient follow-up and referrals as required.
- Communicate with patients, family and /or carer as appropriate, to assess patient's needs and provide relevant support, information, education, advice and counselling as required.
- Work collaboratively with MDT colleagues across Primary and Secondary Care to provide a seamless service delivery to the patient, family and/or carer as appropriate.
- Participate in medication reconciliation taking cognisance of poly-pharmacy and support medical and pharmacy staff with medication reviews and medication management.
- Provide specialist interventions including, sputum clearance, and relaxation, breathing control, exercise and breathlessness management.
- Identify and promote specific symptom management strategies as well as the identification of triggers which may cause exacerbation of symptoms. Provide patients with appropriate self-management strategies and escalation/de-escalation plans.
- Identify health promotion priorities for the patient, family and/or carer and support patient self-care in line with best evidence and using the principles laid out by MECC (Make Every Contact Count). This will include the provision educational and health promotion material which is comprehensive, easy to understand and meets patients' needs
- Assess patient understanding of treatment proposals, gain informed consent and have the capacity to work within a legal framework with patients who lack capacity to consent to treatment.

- Communicate with patients, families and friends, assess needs and provide relevant support, information, education, advice and counselling when and where necessary.

Indirect Care

- Identify and agree appropriate referral pathways for patients with Asthma or COPD, or both COPD and Asthma
- Participate in case review with MDT colleagues
- Use a case management approach to patients with complex needs in collaboration with MDT in both Primary and Secondary Care
- Take a proactive role in the formulation and provision of evidence based PPPGs relating to Integrated Care. Contribute to the development and implementation of information sharing protocols, audit systems, referral pathways, individual care plans and shared care arrangements through regular collaboration/meetings with respiratory nurses locally and nationally.
- Manage clinical risk within own clinical caseload, to have up to date knowledge of indications, contraindications and precautions for any treatment skills and techniques selected and applied throughout an individual course of treatment.
- Arrange referrals to other appropriate specialist services as deemed necessary
- Refer for further clinical psychological evaluation if felt necessary or requested by the patient and/or their family.
- Effectively manage time and caseload in order to meet the needs of an evolving service
- Work closely with colleagues across services in order to provide a seamless integrated service for the patient
- Identify and utilise professional and voluntary resources and facilities at local and national level by direct and indirect referral
- Refer to relevant services to assist with procurement of domiciliary equipment and respiratory therapies that may be required by the patient such as oxygen
- Participate in the Departmental Clinical Governance processes, working in partnership with the Head of Departments, CNM3/ADPHN, and Clinical Governance lead and local respiratory governance groups.
- Ensure that effective clinical governance procedures are maintained and evolve according to defined needs and demands in Respiratory care.
- Maintain professional standards including patient and data confidentiality in line with HSE policy

- Develop and implement strategies as part of the Integrated Care team for delivering effective care within a changing environment using IT and alternative delivery strategies as needed.

Patient/Client Advocate

Clinical Nurse Specialist Respiratory – Integrated Care will:

- Communicate, negotiate and represent patient's family and /or carer values and decisions in relation to their condition in collaboration with GP/Consultant/MDT colleagues in both Primary and Secondary Care as appropriate
- Develop and support the concept of advocacy, particularly in relation to patient participation in decision making, thereby enabling informed choice of treatment options
- Respect and maintain the privacy, dignity and confidentiality of the patient, family and/or carer
- Establish, maintain and improve procedures for collaboration and cooperation between Acute Services, Primary Care and Voluntary Organisations
- Proactively challenge any interaction which fails to deliver a quality service to patients.
- Participate in meetings as a patient and service representative when requested to advocate and support the development of services/staff in respiratory care
- Support the development of local patient advocacy groups pertinent to specialty
- Contribute to case conferencing meetings with supporting consultant and other members of the MDT
- Provide and advocate for appropriate assessments, supports and strategies for patients with disease related changes and difficulties.

<u>Education & Training:</u>

Clinical Nurse Specialist Respiratory – Integrated Care will:

- Maintain clinical competence in patient management within respiratory nursing, keeping up-to-date with relevant research to ensure the implementation of evidence based practice.
- Provide the patient, family and/or carer with appropriate information and other supportive interventions to increase their knowledge, skill and confidence in managing their respiratory conditions.
- Contribute to the design, development and implementation of education programmes and resources for the patient, family and/or carer in relation to Asthma and/or COPD thus empowering them to manage their own condition independently and autonomously.

- Provide mentorship and preceptorship for nursing colleagues as appropriate.
- Participate in training programmes for nursing, MDT colleagues and key stakeholders as appropriate.
- Address the educational needs of nursing and other professionals by participating in or facilitating training programmes for all members of the MDT.
- Create exchange of learning opportunities within the MDT in relation to evidence based respiratory care delivery through journal clubs, conferences etc.
- Develop and maintain links with Regional Centres for Nursing & Midwifery Education (RCNMEs), the Nursing and Midwifery Planning and Development Units (NMPDUs) and relevant third level Higher Education Institutes (HEIs) in the design, development and delivery of educational programmes in respiratory care
- Be responsible for addressing own continuing professional development needs.
- Develop and deliver education and training programmes for the wider primary and secondary care MDTs as requested or deemed necessary
- Seek advice and assistance with assigned cases which prove to be beyond the scope of their professional competence.

Audit & Research:

Clinical Nurse Specialist Respiratory – Integrated Care will:

- Collect and maintain a record of clinically relevant data aligned to the business intelligence unit (BIU) and National KPI's as directed and advised by the PR coordinator, the National Clinical Programmes and senior management.
- Provide annual reports/updates on patient numbers and activity levels as required for service planning.
- Identify, initiate and conduct nursing and collaborative MDT audit and research projects relevant to the area of practice.
- Identify, critically analyse, disseminate and integrate best evidence relating to respiratory care into practice.
- Contribute to nursing research on all aspects of Asthma and COPD nursing care
- Use the outcomes of audit to inform service provision and the need for change
- Contribute to service planning and budgetary processes through use of audit data and specialist knowledge.
- Monitor, access, utilise and disseminate current relevant research to advise and ensure the provision of informed evidence based practice.
- Contribute to the examination of patients and staffs experiences when engaging with Pulmonary Rehabilitation and Integrated services
- Assures all patient evaluations are performed and results communicated to the appropriate stakeholders.
- Represent the department / team at local, national and international meetings and conferences as appropriate.

Consultant:

Clinical Nurse Specialist Respiratory – Integrated Care will:

- Provide leadership in clinical practice and act as a resource and role model to primary care staff in the area of asthma/COPD/respiratory practice.
- Generate and contribute to the development of clinical standards and guidelines and support implementation.
- Use specialist knowledge in Respiratory Care to support and enhance generalist nursing/midwifery practice.
- Develop collaborative working relationships with local respiratory CNSp's/Registered and Candidate Advanced Nurse Practitioner/ GP/ Consultant/ MDT colleagues as appropriate, developing person centred care pathways to promote the integrated model of care delivery.
- With the support of the DPHN, attend integrated care planning meetings as required.
- Develop and maintain relationships with specialist services in Voluntary Organisations which support patients in the community.
- Liaise with other health service providers in the development and on-going delivery of the National Clinical Programme model of care.
- Network with other Clinical Nurse Specialist's in respiratory care and in related professional associations.
- Support the development of local disease specific patient support groups by acting as a specialist resource and point of contact for educational elements as needed.
- Liaise with other chronic disease specialist teams (such as diabetes/heart failure) to discuss joint management/assessment needs of patients as necessary.

Pulmonary Rehabilitation Coordinator

Job Specification, Terms & Conditions

Job Title & Grade	Clinical Specialist Physiotherapist Pulmonary Rehabilitation Coordinator *(Grade Code 3707)*
Purpose of the Post	As outlined above, the need to reform the healthcare services in Ireland in order to provide a more sustainable, integrated and patient-centred approach has come to the fore in recent health policies and strategies. Integrated care requires health and social care services to work together across different levels and sites in order to provide end-to-end care that meets patient need. The Pulmonary rehabilitation coordinator will offer dynamic leadership to promote and develop a high quality evidenced based pulmonary rehabilitation service championing innovation to improve and support service delivery. They will act as the representative clinical lead at local and national strategic development meetings disseminating information and acting on initiatives and improvements within the resources available. The post holder will coordinate resources and services for the Pulmonary Rehabilitation Program. The post holder will also act as an expert clinical resource offering supervision, education and on-going support to staff and teams managing complex respiratory patients. The Pulmonary Rehabilitation coordinator will be a highly competent, visible and experienced autonomous practitioner who uses specialist knowledge and advanced skills to support Pulmonary Rehabilitation services. They will have a good understanding of the vision of the HSE and Sláintecare and to be able to translate this into a local context for operational implementation within their team and locality area. They will demonstrate advanced clinical judgement and critical decision-making skills based upon evidence based practice.
	The post-holder will utilise their advanced level knowledge and skills to: • Triage referrals and identify complex cases and optimise treatment with the Respiratory Consultant and GP before commencing Pulmonary rehabilitation • Accurately undertake specialist clinical skills including airway clearance techniques, breathlessness management, interpreting and analysing clinical and non-clinical tests to form an accurate assessment and decide suitability for pulmonary rehabilitation. • Demonstrate a strong working knowledge of guidelines for best practice, competence in physical assessment skills and treatment of complex respiratory patients for pulmonary rehabilitation • Assess, diagnose, plan, implement and evaluate treatments and interventions of Pulmonary rehabilitation • Integrate both pharmacological and non-pharmacological aspects of Pulmonary rehabilitation into patient care/management plans • Be a competent autonomous practitioner, leading innovation and demonstrating respiratory clinical expertise and acting as a role model for others. • Lead, support and develop the team of health care professionals delivering Pulmonary Rehabilitation and respiratory care to a wide range of patients. • Liaise with and give specialist advice to other members of the Multidisciplinary team (MDT) regarding the medical management of patients with respiratory problems, have knowledge of disease management pathways within secondary and primary care and be able to signpost and refer on where appropriate • Carry out risk assessment within the service, equipment and environment and to minimise risk within the team. • Continuously evaluate patient progress and outcomes. • Develop operational pathways, protocols and procedures to ensure the delivery of safe pulmonary rehabilitation in accordance with local and national clinical standards. • Effectively manage capacity within the team and performance including waiting list management

	• Work with the multidisciplinary respiratory team and the service lead to strategically develop and operationally manage the Pulmonary Rehabilitation service. • Undertake the evaluation of current practices through the use of evidence based practice, audit and outcome measures and act upon results through making recommendations and implementing change. • Supporting staff during the process of change within the team and organisation.
Principal Duties and Responsibilities	***Communication and Working Relationships*** • To provide specialist exercise advice and support to multidisciplinary colleagues in the Respiratory Service and other professionals countywide involved in the delivery of pulmonary rehabilitation. • Develop strong links with Peer Support Groups and promote patient self-management in the community working in partnership with COPD Support Ireland and other relevant agencies. • Communicates with colleagues in the Respiratory Service and wider MDT's, service users, carers, stakeholders, the public and their representatives, ensuring effective and accurate information is delivered. • To actively engage with, listen to and seek views of team members, patients/ carers and key stakeholders to influence, enhance and improve accessibility and inclusiveness of future service development. • To communicate with all team members and other relevant health, social care and education professionals e.g. social workers, specialist practitioners, GPs and practice staff, consultants, and any other statutory, voluntary and independent sector professionals. • To be responsible for the initiation of communication links with patients/ carers in highly stressful/complex situations to seek resolution, agreement regarding future treatment/ care and gain co-operation. ***Managing a service*** • To take personal responsibility for maximising opportunities to improve the use of resources and the quality of services that you are accountable for and to ensure that your line manager is engaged in the plans particularly where support is required to make the change happen effectively. • To implement clinical governance and risk management and act upon aspects of service delivery that is identified as requiring attention. • To participate in and supervise all aspects of the pulmonary rehabilitation service including triage, assessment, reviewing and initiating treatment in the home or clinic setting. • To network with other pulmonary rehabilitation services locally, regionally and nationally, benchmarking the service against advances in respiratory care/ services ensure sharing and implementation of good practice • To facilitate the sharing of information across disciplines and agencies as appropriate acting as a resource for specialist knowledge and advice in relation to the management of complex respiratory patients • To develop and sustain dynamic and responsive multidisciplinary/multi agency community services delivering best practice.

	• To work with the Locality Clinical Lead and other team leaders/managers to proactively support the development and redesign of care pathways embracing the concept of care closer to home and expanding/enhancing multi-disciplinary/multi agency working, community services and community hospitals. • To coordinate the MDT rota, annual leave, study leave. • To develop appropriate support, teaching, mentorship mechanisms for all team members and facilitate the sharing of information across disciplines and agencies. • To adhere to professional codes of physiotherapy conduct and standards of competence relevant to team members and to provide specialist and expert clinical advice. • To use technology as an aid for data capture in order to plan, implement, monitor and report upon outcomes and information. • To offer innovative clinical leadership and management solutions to enable most effective use of resources for the benefit of patients. • To ensure referral, assessment, planning, review and closure/discharge procedures within the team are consistent with expectations. • To continuously review and integrate new developments and practice into the team to enhance service delivery. • To audit, monitor and research service delivery, in order to continuously improve and develop the service. • To assist the Locality Clinical Lead in producing reports to inform management groups, clinical forums, business development/planning and performance management monitoring. • To be accountable for the planning of evidenced based, proactive specialist interventions requiring a high level of expertise in clinical skills. • To promote health and wellbeing, the prevention of ill health and foster independence at every opportunity, whilst respecting the patient right to choose. • To offer creative and dynamic leadership and management solutions to enable the delivery of effective change and subsequent service improvement. • Responsible for the policy implementation and policy or service development within your team. • To initiate and encourage evidence based practice and research within team and service to drive improvements. • Chair meetings related to service delivery or case management where appropriate ***Team and People Development*** • To ensure the skills and talents are actively recognised and developed within your team and the wider organisation. • To take active steps to encourage, support and promote a culture of development, improvement and learning within the team. • To encourage a proactive culture of 2 way communication and the sharing of information within the team and across disciplines that supports the philosophy of a well informed and positively engaged workforce. • To promote and publicise your team/service within the organisation. ***Management and Personal Development***

	• To provide leadership to junior staff and support staff through supervision, training and appraisal. • Provide supervision and appraisal for junior staff and students within the team. • Participates in in-service training with the respiratory team. • To manage and undertake audit and research in specific areas of clinical practice and service delivery using a range of research methodologies as part of a wider multidisciplinary team (MDT). • Take responsibility for own learning and performance including participation in clinical supervision and maintaining awareness of relevant research evidence. • Act as a constant source of clinical and theoretical knowledge for members of MDT as well as patients and their significant others, providing support and clinical advice. • Responsible for initiating and developing R&D programmes or activities. **Clinical Activities** • As an autonomous practitioner, undertake advanced assessments of patients with diverse or complex physical, psychological, cognitive and behavioural conditions in order to formulate a diagnosis and deliver appropriate treatment plans including exercise therapy e.g. Advanced COPD with co-morbidities and several anxiety related issues. • To undertake all aspects of clinical duties as an autonomous practitioner, including professional and legal accountability and managing clinical risk for all aspects of own work. • Aspects of work will include delivery of treatment as an individual practitioner or as part of a multi-disciplinary team. • To be responsible for the safe and competent assessment and treatment of patients with a complex history of respiratory conditions and co-morbidities within national and service guidelines and policies. • As an autonomous practitioner, undertake advanced assessment of patients with diverse or complex physical, psychological, cognitive or behavioural conditions in order to deliver appropriate exercise therapy. • Develop education in collaboration with the multi-disciplinary team ensuring that all patient care is based on current research and best practice. **Strategic Development, Planning and Organising** • To participate in service development and innovative ways of delivering exercise prescription for vulnerable people in the community with complex respiratory conditions, e.g. investigating and implementing the use of technology to support the delivery of pulmonary rehabilitation programmes to people at home. • Collation and interpretation of statistical data collected to measure outcomes and impact of pulmonary rehabilitation programmes. • Responsibility for planning and coordinating safe delivery of Pulmonary Rehabilitation. Includes access to groups and ensuring correct staff : patient ratio (National Guidelines) • To participate in the development of team policies as required. • Demonstrates clinical leadership in the effective and efficient use of resources, e.g. ordering stock, travel.

	Administrative • Maintain waiting list and appropriate KPIs in line with NCP Respiratory • Ensure that all accidents, incidents and hazards are reported and dealt with according to organisational requirements. • Maintains accurate documentation in line with professional and organisational policies and procedures. • Complies with the Data Protection Act and GDPR recommendations. • Compliance with organisational policy in reporting any untoward accident or incident using the appropriate recording system. • To comply with organisational Health and Safety policies The above Job Specification is not intended to be a comprehensive list of all duties involved and consequently, the post holder may be required to perform other duties as appropriate to the post which may be assigned to him/her from time to time and to contribute to the development of the post while in office.

Clinical Nurse Specialist, Respiratory - Pulmonary Rehabilitation

Job Specification,

Job Title & Grade	**Clinical Nurse Specialist (CNSp), Respiratory - Pulmonary Rehabilitation (PR)**
Purpose of the Post	The role of the CNSp will differ according to the needs and configuration of established respiratory services at each site. The successful candidate will work within the Community PR service and integrate with other ambulatory care services between the hospital and community. They will work with colleagues across these services to develop and implement ambulatory care pathways to manage patients with respiratory disease and associated co-morbidities, within the community setting. The post holder will work as part of a multidisciplinary team delivering coordinated evidence based care for patients. Pulmonary Rehabilitation (PR) has been proven to increase exercise capacity and health status in people with respiratory disease who have significant self-reported exercise limitation. It can improve exercise capacity in people with a variety of respiratory diseases that affect activities of daily living. The role of the CNSp in PR is to be responsible for the safe and competent assessment and supervision of patients with respiratory disease undertaking PR programmes. The CNSp is required to provide a specialist nursing resource within the governance structure created for the programme. They will provide physical, psychological and emotional support to PR participants and their families as needed throughout the programme. They will provide physical, psychological and emotional support to an agreed caseload of patients participating in the Pulmonary Rehabilitation programme. The post holder will have a close working relationship with the PR coordinator and their physiotherapy team members. They will also liaise closely between the PR team and other integrated respiratory care teams in the community and secondary care to deliver effective evidenced based care, using resources efficiently to achieve the best possible outcomes in keeping with the National Clinical Programmes-Respiratory guidance documents In order to ensure continuity of service to patients the CNSp may be required to rotate/cover other parts of the integrated respiratory service such as Respiratory Integrated Care and Outreach along with their senior physiotherapy colleagues. This will also promote service integration and enhance skillset development. It will be dependent on identified service needs at each site. If deemed appropriate, site rotation should occur within the first 3-6 months of taking up the post. This post will be 100% community based
Principal Duties and Responsibilities	The CNSp will deliver care in line with the five core concepts of the role set out in the Framework for the Establishment of Clinical Nurse/Midwife Specialist Post, 4th ed. National Council for the Professional Development of Nursing and Midwifery (NCNM) 2008. The concepts are: • Clinical Focus • Patient/Client Advocate • Education and Training • Audit and Research • Consultant Whereby the CNSp is required to rotate into Outreach or Respiratory Integrated Care, some aspects of their primary role under these headings may alter to include additional duties such as home/hospital visits, oxygen assessment and nurse led spirometry clinics. **Clinical Focus** The CNSp will have a strong patient focus whereby the specialty defines itself as nursing and subscribes to the overall purpose, functions and ethical standards of nursing. The clinical practice role may be divided into direct and indirect care. Direct care comprises the assessment, planning, delivery and evaluation of care to the patient, family and/or carer. Indirect care relates to activities that influence others in their provision of direct care. The CNSp will work in conjunction with the Pulmonary rehabilitation Coordinator and other team members in co-ordinating and developing the PR service to meet the needs of the population it serves in line with the objectives of the organisation. **Direct Care** Clinical Nurse Specialist (CNSp), Respiratory - Pulmonary Rehabilitation will: • Provide a specialist nursing service for patients with respiratory disease that incorporates evidence based knowledge, investigative and analytical skills and specialist assessment techniques to triage comprehensibly assess and manage a range of complex presentations. • Use the outcomes of patient assessment to develop and implement plans of care in conjunction with MDT colleagues, the patient and /or carer providing and receiving complex sensitive information, taking into account physical,

	psychological and social care needs when taking a clinical history and assessing patient's suitability for PR. • Make alterations in the management of patient's condition in collaboration with the MDT and the patient in line with agreed pathways and policies, procedures, protocols and guidelines (PPPG's). • Organise and implement delivery of a comprehensive PR programme of education and exercise that is of a high standard with MDT colleagues, that is safe and that meets the needs of all patients supported by other team members and the PR coordinator. • Be able to offer appropriate advice to patients following completion of the programme to help them achieve and maintain fitness and healthy living in the long term. • Assist physiotherapy colleagues with an exercise prescription for each patient. Instructs patients on the basic components of the exercise including warm-up, aerobic exercise and cool-down. Instructs patients in self-monitoring techniques. Provide specialist nursing service to deliver a quality PR programme to respiratory patients. • Manage nurse led Respiratory or Pulmonary Assessment clinics with MDT input • Provide spirometry service to confirm differential diagnosis and staging of disease if not previously undertaken. • Review and assess patients' inhaler treatments make adjustments/recommendations on treatment plans and facilitate onward referral as appropriate. • Monitor and evaluate the patient's response to treatment and amend the plan of care accordingly in conjunction with the GP/Consultant/MDT and patient, family and/or carer as appropriate. • If a Registered Nurse Prescriber (RNP) the nurse must work within the scope of their practice and adhere to the regulations set down by NMBI pertaining to this role and, local policy requirements. • Participate in medication reconciliation taking cognisance of poly-pharmacy and support medical and pharmacy staff with medication reviews and medication management. • Provide specialist interventions including breathing control and breathlessness management • Plan and implement the education component of the PR class with MDT colleagues • Identify and promote specific symptom management strategies as well as the identification of triggers which may cause exacerbation of symptoms. Provide

	patients with appropriate self-management strategies and escalation/de-escalation plans. • Use agreed direct pathway for patients who may present/become clinically unwell at time of attending/engaging with the service • Provides background on reason for any readmissions and potential causes and/or suggestions for prevention of future readmissions. • Identify health promotion priorities for the patient, family and/or carer and support patient self-care in line with best evidence and utilising principles laid out by MECC (Make Every Contact Count). This will include the provision of educational and health promotion material which is comprehensive, easy to understand and meets patients' needs. • Assess patient understanding of treatment proposals, gain informed consent and have the capacity to work within a legal framework with patients who lack capacity to consent to treatment. • Communicate with patients, families and friends, assess needs and provide relevant support, information, education, advice and counselling when and where necessary. **Indirect Care** • Manage, develop and evaluate Pulmonary Rehabilitation pathways with the Pulmonary Rehabilitation coordinator, GPs, Consultant and integrated teams. • Participate in case reviews with MDT colleagues as required. • Take a proactive role in the formulation and provision of evidence based PPPGs relating to Integrated Care and PR. Contribute to the development and implementation of information sharing protocols, audit systems, referral pathways, individual care plans and shared care arrangements through regular collaboration/meetings with respiratory nurses locally and nationally. • Manage clinical risk within own clinical caseload, to have up to date knowledge of indications, contraindications and precautions for any treatment skills and techniques selected and applied throughout an individual course of treatment. • Arrange referrals to other appropriate specialist services as deemed necessary • Refer for further clinical psychological evaluation if felt necessary or requested by the patient and/or their family. • Effectively manage time and caseload in order to meet the needs of an evolving service • Work closely with colleagues across services in order to provide a seamless integrated service for the patient

- Identify and utilise professional and voluntary resources and facilities at local and national level by direct and indirect referral
- Discuss and triage PR referrals with team members.
- Refer to relevant services to assist with procurement of domiciliary equipment and respiratory therapies that may be required by the patient such as oxygen
- Participate in the Departmental Clinical Governance processes, working in partnership with the Head of Departments, CNM3/ADPHN, and Clinical Governance lead and local respiratory governance groups.
- Ensure that effective clinical governance procedures are maintained and evolve according to defined needs and demands in Respiratory care.
- Maintain professional standards including patient and data confidentiality in line with HSE policy
- Develop and implement strategies as part of the Integrated Care team for delivering effective PR within a changing environment using IT and alternative delivery strategies as needed.
- Assist with the waiting list ensuring appropriate demand and capacity management in liaison with PR co-ordinator and physiotherapy colleagues.
- Review the effectiveness of PR through monitoring and interpretation of clinical outcome measures

Patient/Client Advocate

Clinical Nurse Specialist, Respiratory - Pulmonary Rehabilitation will:

- Communicate, negotiate and represent patient's family and/or carer values and decisions in relation to their condition in collaboration with MDT colleagues in both Primary and Secondary Care as appropriate
- Develop and support the concept of advocacy particularly in relation to patients' participation in decision making thereby enabling informed choice of treatment options.
- Respect and maintain the privacy, dignity and confidentiality of the patient, family and/or carer
- Establish, maintain and improve procedures for collaboration and cooperation between acute services, Community services, Primary Care and voluntary organisations as appropriate.
- Proactively challenge any interaction which fails to deliver a quality service to patients.

- Take appropriate action on any matter identified as being detrimental to staff and/or service user care or wellbeing which may inhibit the effective provision of effective care.
- Participate in meetings as a patient and service representative when requested to advocate and support the development of services/staff in respiratory care
- Support the development of local patient advocacy groups pertinent to specialty
- Contribute to case conferencing meetings with supporting consultant and other members of the MDT
- Provide and advocate for appropriate assessments, supports and strategies for patients with disease related changes and difficulties.

Education & Training

Clinical Nurse Specialist, Respiratory - Pulmonary Rehabilitation will:

- Maintain clinical competence in patient management within respiratory nursing, keeping up-to-date with relevant research to ensure the implementation of evidence based practice.
- Provide the patient, family and/or carer with appropriate information and other supportive interventions to increase their knowledge, skill and confidence in managing their respiratory conditions.
- Contribute to the design, development and implementation of education programmes and resources for the patient, family and/or carer in relation to Asthma and/or COPD thus empowering them to manage their own condition independently and autonomously.
- Provide mentorship and preceptorship for nursing colleagues as appropriate.
- Participate in training programmes for nursing, MDT colleagues and key stakeholders as appropriate.
- Address the educational needs of nursing and other professionals by participating in or facilitating training programmes for all members of the MDT.
- Create exchange of learning opportunities within the MDT in relation to evidence based respiratory care delivery through journal clubs, conferences etc.
- Develop and maintain links with Regional Centres for Nursing & Midwifery Education (RCNMEs), the Nursing and Midwifery Planning and Development Units (NMPDUs) and relevant third level Higher Education Institutes (HEIs) in the design, development and delivery of educational programmes in respiratory care
- Be responsible for addressing own continuing professional development needs.

	• Develop and deliver education and training programmes for the wider primary and secondary care MDTs as requested or deemed necessary • Seek advice and assistance with assigned cases which prove to be beyond the scope of their professional competence. **Audit & Research** Clinical Nurse Specialist, Respiratory - Pulmonary Rehabilitation will assist the PR coordinator with: • Establishing and maintain a register of patients within the PR patient group • Collecting and maintain a record of clinically relevant data aligned to the business intelligence unit (BIU) and National KPI's as directed and advised by the PR coordinator, the National Clinical Programmes and senior management. • Providing annual reports/updates on patient numbers and activity levels as required for service planning. • Identifying, initiate and conduct nursing and collaborative MDT audit and research projects relevant to the area of practice. • Identifying, critically analyse, disseminate and integrate best evidence relating to respiratory care into practice. • Contributing to nursing research on all aspects of PR and respiratory care. • Using the outcomes of audit to inform service provision and the need for change • Contributing to service/business planning and budgetary processes through use of audit data and specialist knowledge • Contributing to the examination of patients and staff's experiences when engaging with PR and Integrated services. • Assuring all patient evaluations are performed and results communicated to the appropriate stakeholders. • Monitoring, access, utilise and disseminate current relevant research to advise and ensure the provision of informed evidence based practice. • Representing the department / team at local, national and international meetings and conferences as appropriate. Clinical Nurse Specialist, Respiratory - Pulmonary Rehabilitation will:

	• Provide leadership in clinical practice and act as a resource and role model to primary care staff in the area of respiratory practice and PR; • Generate and contribute to the development of clinical standards and guidelines and support implementation with other MDT members. • Use specialist knowledge in Respiratory Care to support and enhance generalist Nursing/Midwifery practice. • Develop collaborative working relationships with local respiratory Physiotherapists/ CNSp's/Registered and Candidate Advanced Nurse Practitioner GP/Consultant/MDT colleagues as appropriate, developing person centred care pathways to promote the integrated model of care delivery; • With the support of the DPHN/PR Coordinator attend integrated care planning meetings as required. • Develop and maintain relationships with specialist services in Voluntary Organisations which support patients in the community. • Liaise with other health service providers in the development and on-going delivery of the National Clinical Programme model of care. • Network with other Clinical Nurse Specialist's in PR and respiratory care and in related professional associations. • Liaise with other chronic disease specialist teams (such as diabetes/heat failure) to discuss joint management/assessment needs of patients as necessary.

Physiotherapist (Staff Grade)

Job Specification,

Job Title & Grade	**Physiotherapist Staff Grade in Pulmonary Rehabilitation** *(Grade Code 314X)*
Purpose of the Post	The provision of a quality Physiotherapy service in line with standards of Physiotherapy practice. To provide quality, client centred Physiotherapy assessment and treatment to identified client groups at designated centres as directed by the Physiotherapy Manager and Clinical Specialist Physiotherapist Pulmonary Rehabilitation Co-ordinator.
Principal Duties and Responsibilities	**<u>Professional / Clinical</u>** *The Physiotherapist Staff Grade will:* • Carry a clinical caseload appropriate to the post. • Be responsible for client assessment, development and implementation of individualised treatment plans that are client centred and in line with best practice. • Be responsible for goal setting in partnership with the client, family and other team members as appropriate. • Communicate and work in co-operation with other team members. • Develop effective communication with and provide instruction, guidance and support to service users, family, carers etc. • Document client records in accordance with professional standards and departmental policies. • Provide a service in varied locations in line with local policy / guidelines and within appropriate time allocation (e.g. clinic, home visits). • Participate in review meetings, case conferences, ward rounds etc. as appropriate. • Maintain professional standards of practice. • Maintain quality standards of work and co-operate with quality assurance programmes. • Work within own scope of professional competence in line with principles of best practice, professional conduct and clinical governance. • Seek the advice of relevant personnel when appropriate / as required. • Operate within the scope of practice of the Irish Society of Chartered Physiotherapists. **<u>Education & Training</u>** *The Physiotherapist Staff Grade will:* • Participate in mandatory training programmes. • Take responsibility for, and keep up to date with Physiotherapy practice by participating in continuing professional development such as reflective practice, in service, self-directed learning, research, clinical audit etc. • Engage in performance review processes including personal development planning. • Participate in the practice education of student therapists. Take part in teaching / training / supervision of staff / others as appropriate (once sufficient clinical experience has been attained) and attend practice educator courses as relevant to role and needs.

Health & Safety

The Physiotherapist Staff Grade will:

- Implement agreed policies, procedures and safe professional practice and adhere to relevant legislation, regulations and standards.
- Work in a safe manner with due care and attention to the safety of self and others.
- Be aware of risk management issues, identify risks and take appropriate action.
- Report any adverse incidents or near misses.
- Adhere to department policies in relation to the care and safety of any equipment supplied for the fulfilment of duty.
- Report any malfunctions or defects in equipment or any such suspicions immediately to the Senior Physiotherapist / Physiotherapy Manager.
- Have a working knowledge of the Health Information and Quality Authority (HIQA) Standards as they apply to the role for example, Standards for Healthcare, National Standards for the Prevention and Control of Healthcare Associated Infections, Hygiene Standards etc. and comply with associated HSE protocols for implementing and maintaining these standards as appropriate to the role.

Administrative

The Physiotherapist Staff Grade will:

- Actively participate in the improvement and development of Physiotherapy services by liaising with the Clinical Specialist Physiotherapist / Physiotherapy Manager.
- Gather and analyse statistics and participate in audits as directed by the Senior Physiotherapist / Physiotherapy Manager.
- Represent the department at meetings and conferences as designated.
- Assist in ensuring that the Physiotherapy service makes the most efficient and effective use of developments in IT.
- Promote a culture that values diversity and respect in the workplace.
- Keep up to date with organisational developments within the Irish Health Service.
- Carry out other duties appropriate to the post as required from time to time by the Physiotherapy Manager.
- Support, promote and actively participate in sustainable energy, water and waste initiatives to create a more sustainable, low carbon and efficient health service.

The above Job Specification is not intended to be a comprehensive list of all duties involved and consequently, the post holder may be required to perform other duties as appropriate to the post which may be assigned to him/her from time to time and to contribute to the development of the post while in office.

Clinical Nurse Specialist **(Cardiovascular Disease)**

Job Specification & Terms and Conditions

Job Title and Grade	*Clinical Nurse Specialist Cardiovascular Disease – Integrated Care (CNSp. CVD)*
Purpose of the Post	The role of the CNSp. CVD will differ according to the needs and configuration of established cardiology services at each site. The purpose of this integrated care CNSp. CVD post is to: provide expertise and specialist nursing services to patients with a cardiovascular condition both in hospital outpatient settings and in primary care. The post holder will liaise between acute cardiology services and integrated cardiology services in the community along with other agencies to deliver effective evidenced based care. They will use resources efficiently to achieve the best possible outcomes in keeping with the approved models of care and HIQA standards. The person appointed to this post will work in the newly formed Integrated Care Cardiology Service. The post holder will work as part of a multidisciplinary team (MDT) delivering coordinated evidence based care for patients in primary care whilst liaising closely with secondary care. The Integrated Care CNSp. CVD will deliver nurse-led clinics to provide support to patients and their GPs in creating management plans, assessing relevant treatments, assisting with diagnosis development and will provide education to patients and staff. This post is 80% working with GP's in Primary Care, and 20% of CNSp CVD role will involve working with the Secondary Care Cardiology Team. In order to ensure continuity of service to patients the CNSp CVD may be required to rotate/ cover other parts of the integrated cardiology service such as Cardiac Rehabilitation. This will also promote service integration and enhance skillset development. It will be dependent on identified service needs at each site. If deemed appropriate, site rotation should occur within the first 3-6 months of taking up the post. The CNSp. CVD caseload will focus initially on the following patient groups: • Chronic Cardiovascular Disease • Atrial Fibrillations • Ischaemic Heart Disease

	Role Responsibilities The CNSp. CVD will deliver care in line with the five core concepts of the role set out in the Framework for the Establishment of Clinical Nurse/ Midwife Specialist Post, 4th ed. National Council for the Professional Development of Nursing and Midwifery (NCNM) 2008. The concepts are: • Clinical Focus • Patient/Client Advocate • Education and Training • Audit and Research • Consultant **Clinical Focus** The CNSp. CVD will have a strong patient focus whereby the specialty defines itself as nursing and subscribes to the overall purpose, functions and ethical standards of nursing. The clinical practice role may be divided into direct and indirect care. Direct care comprises the assessment, planning, delivery and evaluation of care to the patient, family and/ or carer. Indirect care relates to activities that influence others in their provision of direct care. The CNSp. CVD will work in conjunction with other team members in co-ordinating and developing the Integrated Care Service to meet the needs of the population it serves in line with the objectives of the organisation. **Direct Care** The Integrated Care CNSp. CVD will: • Provide a specialist nursing service for patients with cardiovascular disease that incorporates evidence based knowledge, investigative and analytical skills and specialist assessment techniques to triage comprehensibly assess and manage a range of complex presentations. • Use the outcomes of patient assessment to develop and implement plans of care/ case management in conjunction with the GP/ Consultant/ MDT and the patient, family and/ or carer as appropriate. • Monitor and evaluate the patient's response to treatment and amend the plan of care accordingly in conjunction with the GP/ Consultant/ MDT and patient, family and/ or carer as appropriate. • Make alterations in the management of patient's condition in collaboration with the GP/ Consultant/ MDT and the patient in line with agreed pathways, policies, protocols and guidelines (PPPG's). • Manage nurse led Cardiology Clinics with GP/ Specialist input • Evaluate clinical problems using objective measurement tools • In conjunction with other team members, co-ordinate investigations, therapies and patient follow-up in secondary or primary care as appropriate.

	• Use a case management approach to patients with complex needs, to include prescribing of appropriate medications if a Registered Nurse Prescriber (RNP) under governance protocols with a collaborative working agreement with each practice. • Use agreed direct pathway for patients who may present/ become clinically unwell at time of attending/ engaging with the service. • In collaboration with the GP and Consultant, co-ordinate investigations, treatment therapies and patient follow-up and referrals as required. • Communicate with patients, family and/ or carer as appropriate, to assess patient's needs and provide relevant support, information, education, advice and counselling as required. • Work collaboratively with MDT colleagues across Primary and Secondary Care to provide a seamless service delivery to the patient, family and/ or carer as appropriate. • Participate in medication reconciliation taking cognisance of poly-pharmacy and support medical and pharmacy staff with medication reviews and medication management. • Provide specialist interventions as appropriate • Identify and promote specific symptom management strategies as well as the identification of triggers which may cause exacerbation of symptoms. Provide patients with appropriate self-management strategies and escalation/ de-escalation plans. • Identify health promotion priorities for the patient, family and/ or carer and support patient self-care in line with best evidence and using the principles laid out by MECC (Make Every Contact Count). This will include the provision of educational and health promotion material which is comprehensive, easy to understand and meets patients' needs • Assess patient understanding of treatment proposals, gain informed consent and have the capacity to work within a legal framework with patients who lack capacity to consent to treatment. • Communicate with patients, families and friends, assess needs and provide relevant support, information, education, advice and counselling when and where necessary. **<u>Indirect Care</u>** • Identify and agree appropriate referral pathways for patients with cardiovascular disease • Participate in case review with MDT colleagues • Use a case management approach to patients with complex needs in collaboration with MDT in both Primary and Secondary Care • Take a proactive role in the formulation and provision of evidence based PPPGs relating to Integrated Care. Contribute to the development and implementation of information sharing protocols, audit systems, referral pathways, individual care plans and shared care arrangements through regular collaboration/ meetings with cardiology nurses locally and nationally. • Manage clinical risk within own clinical caseload, to have up to date knowledge of indications, contraindications and precautions for any treatment skills and techniques selected and applied throughout an individual course of treatment.

	• Arrange referrals to other appropriate specialist services as deemed necessary • Refer for further clinical psychological evaluation if felt necessary or requested by the patient and/ or their family. • Effectively manage time and caseload in order to meet the needs of an evolving service • Work closely with colleagues across services in order to provide a seamless integrated service for the patient • Identify and utilise professional and voluntary resources and facilities at local and national level by direct and indirect referral • Refer to relevant services to assist with procurement of domiciliary equipment and therapies that may be required by the patient • Participate in the Departmental Clinical Governance processes, working in partnership with the Head of Departments, CNM3/ ADON, and Clinical Governance lead and local cardiology governance groups. • Ensure that effective clinical governance procedures are maintained and evolve according to defined needs and demands in cardiology care. • Maintain professional standards including patient and data confidentiality in line with HSE policy • Develop and implement strategies as part of the Integrated Cardiology Care Team for delivering effective care within a changing environment using IT and alternative delivery strategies as needed. **<u>Patient/Client Advocate</u>** The Integrated Care CNSp. CVD will: • Communicate, negotiate and represent patient's family and/ or carer values and decisions in relation to their condition in collaboration with GP/ Consultant/ MDT colleagues in both Primary and Secondary Care as appropriate • Develop and support the concept of advocacy, particularly in relation to patient participation in decision making, thereby enabling informed choice of treatment options • Respect and maintain the privacy, dignity and confidentiality of the patient, family and/or carer • Establish, maintain and improve procedures for collaboration and cooperation between Acute Services, Primary Care and Voluntary Organisations • Proactively challenge any interaction which fails to deliver a quality service to patients. • Participate in meetings as a patient and service representative when requested to advocate and support the development of services/ staff in cardiovascular care • Support the development of local patient advocacy groups pertinent to specialty • Provide and advocate for appropriate assessments, supports and strategies for patients with disease related changes and difficulties. **<u>Education & Training</u>**

The Integrated Care CNSp. CVD will:

- Maintain clinical competence in patient management within cardiology nursing, keeping up-to-date with relevant research to ensure the implementation of evidence based practice.
- Provide the patient, family and/ or carer with appropriate information and other supportive interventions to increase their knowledge, skill and confidence in managing their cardiovascular conditions.
- Contribute to the design, development and implementation of education programmes and resources for the patient, family and/ or carer in relation to cardiovascular disease thus empowering them to manage their own condition independently and autonomously.
- Participate in training programmes for nursing, MDT colleagues and key stakeholders as appropriate.
- Create exchange of learning opportunities within the MDT in relation to evidence based cardiovascular care delivery through journal clubs, conferences etc.
- Develop and maintain links with Regional Centres for Nursing & Midwifery Education (RCNMEs), the Nursing and Midwifery Planning and Development Units (NMPDUs) and relevant third level Higher Education Institutes (HEIs) in the design, development and delivery of educational programmes in cardiovascular care;
- Develop and deliver education and training programmes for the wider primary and secondary care MDTs as requested or deemed necessary
- Be responsible for addressing own continuing professional development needs.

Audit & Research

The Integrated Care CNSp. CVD will:

- Collect and maintain a record of clinically relevant data aligned to the business intelligence unit (BIU) and National KPI's as directed and advised by the National Heart Programme and senior management.
- Provide annual reports/ updates on patient numbers and activity levels as required for service planning.
- Identify, initiate and conduct nursing and collaborative MDT audit and research projects relevant to the area of practice.
- Identify, critically analyse, disseminate and integrate best evidence relating to cardiovascular care into practice.
- Contribute to nursing research on all aspects of cardiology nursing care
- Use the outcomes of audit to inform service provision and the need for change
- Contribute to service planning and budgetary processes through use of audit data and specialist knowledge.
- Monitor, access, utilise and disseminate current relevant research to advise and ensure the provision of informed evidence based practice.
- Contribute to the examination of patients and staffs experiences when engaging with Cardiac Rehabilitation and Integrated services
- Assures all patient evaluations are performed and results communicated to the appropriate stakeholders.

- Represent the department/ team at local, national and international meetings and conferences as appropriate.

Consultant

The Integrated Care CNSp. CVD will:

- Provide leadership in clinical practice and act as a resource and role model to primary care staff in the area of cardiology practice.
- Generate and contribute to the development of clinical standards and guidelines and support implementation.
- Use specialist knowledge in cardiology care to support and enhance generalist nursing/ midwifery practice.
- Develop collaborative working relationships with local cardiology CNSp's/ Registered and Candidate Advanced Nurse Practitioner's / GP's/ Consultants/ MDT colleagues as appropriate, developing person centred care pathways to promote the integrated model of care delivery.
- With the support of the DPHN, attend integrated care planning meetings as required.
- Develop and maintain relationships with specialist services in voluntary organisations which support patients in the community.
- Liaise with other health service providers in the development and on-going delivery of the models of care.
- Network with other CNSp.'s in cardiology care and in related professional associations.
- Support the development of local disease specific patient support groups by acting as a specialist resource and point of contact for educational elements as needed.
- Liaise with other chronic disease specialist teams (such as diabetes) to discuss joint management/ assessment needs of patients as necessary.
- Be required to lead out on elements of nursing as a representative for Integrated Cardiology Care.

The above Job Specification is not intended to be a comprehensive list of all duties involved and consequently, the post holder may be required to perform other duties as appropriate to the post which may be assigned to him/ her from time to time and to contribute to the development of the post while in office.

Cardiac Rehabilitation Coordinator (Cardiovascular Disease)

Job Specification & Terms and Conditions

Job Title and Grade	**Cardiac Rehabilitation Coordinator (Grade Code TBC)** Post can be held by either a CNS or Senior Physiotherapist – to be clarified
Purpose of the Post	**Purpose of the Post** The need to reform the healthcare services in Ireland in order to provide a more sustainable, integrated and patient-centred approach has come to the fore in recent health policies and strategies. Integrated care requires health and social care services to work together across different levels and sites in order to provide end-to-end care that meets patient need. Cardiac Rehabilitation requires an integrated professional team, consisting of qualified practitioners, led by a trained programme manager/ Coordinator - who will provide the overview necessary to ensure all components of cardiac rehabilitation and prevention are delivered. The Cardiac Rehabilitation Coordinator will offer dynamic leadership to promote and develop a high quality evidenced based Cardiac Rehabilitation Service championing innovation to improve and support service delivery. They will act as the representative clinical lead at local and national strategic development meetings disseminating information and acting on initiatives and improvements within the resources available. The post holder will coordinate resources and services for the Cardiac Rehabilitation Programme. The post holder will also act as an expert clinical resource offering supervision, education and on-going support to staff and teams managing complex cardiovascular patients. The Cardiac Rehabilitation Coordinator will be a highly competent, visible and experienced autonomous practitioner who uses specialist knowledge and advanced skills to support Cardiac Rehabilitation Services. They will have a good understanding of the vision of the HSE and Sláintecare and to be able to translate this into a local context for operational implementation within their team and local area.

	They will demonstrate advanced clinical judgement and critical decision-making skills based upon evidence based practice. The post-holder will utilise their advanced level knowledge and skills to: • Triage referrals and identify complex cases and optimise treatment with the Integrated Care Consultant Cardiologist and GP before commencing cardiac rehabilitation. • Accurately undertake specialist clinical skills, interpreting and analysing clinical and non-clinical tests to form an accurate assessment and decide suitability for cardiac rehabilitation. • Demonstrate a strong working knowledge of guidelines for best practice, competence in physical assessment skills and treatment of complex cardiovascular patients for cardiac rehabilitation • Assess, diagnose, plan, implement and evaluate treatments and interventions of cardiac rehabilitation • Integrate both pharmacological and non-pharmacological aspects of cardiac rehabilitation into patient care/ management plans • Be a competent autonomous practitioner, leading innovation and demonstrating cardiology clinical expertise and acting as a role model for others. • Lead, support and develop the team of health care professionals delivering cardiac rehabilitation and cardiovascular care to a wide range of patients. • Liaise with and give specialist advice to other members of the Multidisciplinary team (MDT) regarding the medical management of patients with cardiovascular problems, have knowledge of disease management pathways within secondary and primary care and be able to signpost and refer on appropriately • Carry out risk assessment of the service, equipment and environment to minimise risk within the team. • Continuously evaluate patient progress and outcomes. • Develop operational pathways, protocols and procedures to ensure the delivery of safe cardiac rehabilitation in accordance with local and national clinical standards. • Effectively manage capacity within the team and performance including waiting list management • Work with the Specialist Cardiology MDT and the service lead to strategically develop and operationally manage the Cardiac Rehabilitation Service. • Undertake the evaluation of current practices through the use of evidence based practice, audit and outcome measures and act upon results through making recommendations and implementing change. • Supporting staff during the process of change within the team and organisation.
	Communication and Working Relationships • To provide specialist exercise advice and support to multidisciplinary colleagues in the Cardiology Service and other professionals countywide involved in the delivery of cardiac rehabilitation.

	• Develop strong links with Peer Support Groups and promote patient self-management in the community working in partnership with relevant agencies. • Communicates with colleagues in the Integrated Care Cardiology Service and wider MDT, service users, carers, stakeholders, the public and their representatives, ensuring effective and accurate information is delivered. • To actively engage with, listen to and seek views of team members, patients/ carers and key stakeholders to influence, enhance and improve accessibility and inclusiveness of future service development. • To communicate with all team members and other relevant health, social care and education professionals e.g. social workers, specialist practitioners, GPs and practice staff, consultants, and any other statutory, voluntary and independent sector professionals. • To be responsible for the initiation of communication links with patients/ carers in highly stressful/ complex situations to seek resolution, agreement regarding future treatment/ care and gain co-operation. ***Management of the service*** • To take personal responsibility for maximising opportunities to improve the use of resources and the quality of services that you are accountable for and to ensure that your line manager is engaged in the plans particularly where support is required to make the change happen effectively. • To implement clinical governance and risk management and act upon aspects of service delivery that is identified as requiring attention. • To participate in and supervise all aspects of the cardiac rehabilitation service including triage, assessment, reviewing and initiating treatment in the home or clinic setting. • To network with other cardiac rehabilitation services locally, regionally and nationally, benchmarking the service against advances in cardiology care/ services ensure sharing and implementation of good practice • To facilitate the sharing of information across disciplines and agencies as appropriate acting as a resource for specialist knowledge and advice in relation to the management of complex cardiovascular patients • To develop and sustain dynamic and responsive multidisciplinary/multi agency community services delivering best practice. • To work with the Locality Clinical Lead and other team leaders/managers to proactively support the development and redesign of care pathways embracing the concept of care closer to home and expanding/enhancing multi-disciplinary/multi agency working, community services and community hospitals. • To coordinate the MDT rota, annual leave, study leave. • To develop appropriate support, teaching, mentorship mechanisms for all team members and facilitate the sharing of information across disciplines and agencies. • To adhere to professional codes of physiotherapy conduct and standards of competence relevant to team members and to provide specialist and expert clinical advice. • To use technology as an aid for data capture in order to plan, implement, monitor and report upon outcomes and information.

	• To offer innovative clinical leadership and management solutions to enable most effective use of resources for the benefit of patients. • To ensure referral, assessment, planning, review and closure/discharge procedures within the team are consistent with expectations. • To continuously review and integrate new developments and practice into the team to enhance service delivery. • To audit, monitor and research service delivery, in order to continuously improve and develop the service. • To assist the Locality Clinical Lead in producing reports to inform management groups, clinical forums, business development/planning and performance management monitoring. • To be accountable for the planning of evidenced based, proactive specialist interventions requiring a high level of expertise in clinical skills. • To promote health and wellbeing, the prevention of ill health and foster independence at every opportunity, whilst respecting the patient right to choose. • To offer creative and dynamic leadership and management solutions to enable the delivery of effective change and subsequent service improvement. • Responsible for the policy implementation and policy or service development within your team. • To initiate and encourage evidence based practice and research within team and service to drive improvements. • Chair meetings related to service delivery or case management where appropriate • Co-ordinate services from Phase 1 through to phase IV, and ensures all aspects of the service are delivered according to a national standard. • Co-ordinate appropriate referrals into and from the service. • Demonstrates strong leadership and team management skills. • Strong organizational skills • Provision of safe and appropriate physical layout, with availability/ access to prompt assistance, and complying with Occupational Health and Safety for both patients and staff. • Develops the education programme for phases 1-3. In conjunction with members of the MDT, continually review the content and quality and update same • Discusses risk factor management with staff, MDT members and makes appropriate referrals and recommended changes according to guidelines. • Identify appropriate content for MDT/ external referrals • Liaises with relevant cardiovascular nurse specialists in other disciplines, as appropriate, regarding patients' conditions. • Liaise with community services and GP's as appropriate. • Development, implementation and review of quality assurance documents, risk assessment, policy, procedures and guidelines • Management of service resources • Promotes Patient advocacy ***Team and People Development***

	• To ensure the skills and talents are actively recognised and developed within your team and the wider organisation. • To take active steps to encourage, support and promote a culture of development, improvement and learning within the team. • To encourage a proactive culture of 2 way communication and the sharing of information within the team and across disciplines that supports the philosophy of a well informed and positively engaged workforce. • To promote and publicise your team/ service within the organisation. ***Staff Management and Personal Development*** • To provide leadership to junior staff and support staff through supervision, training and appraisal. • Provide supervision and appraisal for junior staff and students within the team. • Participates in in-service training with the Cardiac Rehabilitation Team and wider Integrated Care Cardiology Team. • To manage and undertake audit and research in specific areas of clinical practice and service delivery using a range of research methodologies as part of a wider MDT. • Take responsibility for own learning and performance including participation in clinical supervision and maintaining awareness of relevant research evidence. • Act as a constant source of clinical and theoretical knowledge for members of MDT as well as patients and their significant others, providing support and clinical advice. • Responsible for initiating and developing R&D programmes or activities. ***Clinical Activities*** • As an autonomous practitioner, undertake advanced assessments of patients with diverse or complex physical, psychological, cognitive and behavioural conditions in order to formulate a diagnosis and deliver appropriate treatment plans including exercise therapy e.g. Advanced HF with co-morbidities and several anxiety related issues. • To undertake all aspects of clinical duties as an autonomous practitioner, including professional and legal accountability and managing clinical risk for all aspects of own work. • Aspects of work will include delivery of treatment as an individual practitioner or as part of a MDT. • To be responsible for the safe and competent assessment and treatment of patients with a complex history of cardiovascular conditions and co-morbidities within national and service guidelines and policies. • As an autonomous practitioner, undertake advanced assessment of patients with diverse or complex physical, psychological, cognitive or behavioural conditions in order to deliver appropriate exercise therapy. • Develop education in collaboration with the MDT ensuring that all patient care is based on current research and best practice.

	Strategic Development, Planning and Organising • To participate in service development and innovative ways of delivering exercise prescription for vulnerable people in the community with complex cardiovascular conditions, e.g. investigating and implementing the use of technology to support the delivery of cardiac rehabilitation programmes to people at home. • Collation and interpretation of statistical data collected to measure outcomes and impact of cardiac rehabilitation programmes. • Responsibility for planning and coordinating safe delivery of cardiac rehabilitation. Includes access to groups and ensuring correct staff:patient ratio (in keeping with National Guidelines). • To participate in the development of team policies as required. • Demonstrate clinical leadership in the effective and efficient use of resources, e.g. ordering stock, travel. ***Administrative*** • Maintain waiting list and appropriate KPIs in line with National Heart Programme • Ensure that all accidents, incidents and hazards are reported and dealt with according to organisational requirements. • Maintain accurate documentation in line with professional and organisational policies and procedures. • Complies with the Data Protection Act and GDPR requirements. • Compliance with organisational policy in reporting any untoward accident or incident using the appropriate recording system. • To comply with organisational Health and Safety policies. ***Research, Innovation and Development of the service*** • Identifies specific areas where there is a gap in service provision, i.e. psychological intervention, stress management, dietary, pharmacy, smoking cessation, etc and create a business case as appropriate. • Audit the service provision and the stakeholder's satisfaction with the service annually. • Liaise with the Medical Director regarding current service/ statistics and expansion of the service. • Conduct research on different aspects of the service and guides and directs staff regarding same. • Attend National/ International conferences and present research as appropriate. ***Education*** • On-going professional and service development. • Organise and deliver BLS training for patients and family members. • Ensures staff members complete mandatory training and appropriate continuous professional development.

	• Develop and provide education and clinical programmes for relevant groups i.e. degree students, post grads and phase 4 exercise students. **The above Job Specification is not intended to be a comprehensive list of all duties involved and consequently, the post holder may be required to perform other duties as appropriate to the post which may be assigned to him/her from time to time and to contribute to the development of the post while in office.** **The reform programme outlined for the Health Services may impact on this role and as structures change the job description and reporting relationships may be reviewed.** **This job description is a guide to the general range of duties assigned to the post holder. It is intended to be neither definitive nor restrictive and is subject to periodic review with the employee concerned.**

Senior Physiotherapist **(Cardiology Integrated Care)**

Job Specification & Terms and Conditions

Job Title and Grade	**Senior Physiotherapist (Cardiology - Integrated Care)** **Cardiac Rehabilitation Service**
Purpose of the Post	The need to reform the healthcare services in Ireland in order to provide a more sustainable, integrated and patient-centred approach has come to the fore in recent health policies and strategies. Integrated care requires health and social care services to work together across different levels and sites in order to provide end-to-end care that meets patient need. The Senior Integrated Care Physiotherapist will: • Work in conjunction with other team members in co-ordinating and developing the service to meet the needs of the population it serves in line with the objectives of the organisation • Be responsible for the provision of a high quality Physiotherapy service in accordance with standards of professional practice • Carry out clinical and educational duties as required • Work with the Physiotherapy Manager/ Cardiac Rehabilitation Coordinator in ensuring the co-ordination, development and delivery of a quality, client centred physiotherapy service across and between networks in the geographical area. More specifically, the Senior Physiotherapist, as part of the Integrated Care Cardiology Team and Primary Care based Cardiac Rehabilitation Service will: • Manage, develop and evaluate an Integrated Care Cardiology service in the community setting; • Plan and implement assessment and review clinics for patients meeting the criteria • Manage, develop and evaluate an admission avoidance programme with the CR Coordinator, GP and Consultant Lead • Be an expert resource in cardiology care to physiotherapists working in primary care • Contribute to business planning and business cases • Develop and maintain guidelines and protocols relating to Cardiology Integrated Care • Develop and implement strategies as part of the Integrated Care team for delivering effective care of chronic cardiovascular conditions within a changing environment.

	80% of the role will be based in the Primary Care setting with 20% of the post holders time being spent in Secondary Care working with the Integrated Care Cardiology Team.
	Principal Duties and Responsibilities **<u>Professional / Clinical</u>** The Senior Physiotherapist will: • Be a lead clinician in the area of Cardiac Physiotherapy and carry a clinical caseload appropriate to the post • Be responsible for client assessment, development and implementation of individualised plans, assessment and review clinics in line with best practice • Be responsible for goal setting in partnership with client, family and other team members as appropriate • Be responsible for standards of practice of self and staff appointed to clinical/ designated area(s) • Be a clinical resource for other Physiotherapists • Communicate and work in co-operation with the Physiotherapy Manager, Cardiac Rehabilitation Coordinator and other team members in providing an integrated quality service, taking the lead role as required • Communicate effectively with and provide instruction, guidance and support to, staff clients, family, carers • Document client records in accordance with professional standards and departmental policies • Provide a community based service in line with local policy/ guidelines and within appropriate time allocation (e.g. GP practice, health/ primary care centres, clinic) • Participate and be a lead clinician as appropriate in review meetings, case conferences etc. • Develop and promote professional standards of practice • Work within own scope of professional competence in line with principles of best practice, professional conduct and clinical governance • Seek advice of relevant personnel when appropriate/ as required • Operate within the scope of practice of the Irish Society of Chartered Physiotherapists • Provide weekend and on call service where it is a requirement of the post **<u>Education & Training</u>** The Senior Physiotherapist will: • Participate in mandatory training programmes including CPR and anaphylaxis training • Take responsibility for, and keep up to date with Physiotherapy practice by participating in continuing professional development such as reflective practice, in service, self-directed learning, research, clinical audit etc. • Be responsible for the induction and clinical supervision of staff in the Integrated Care Cardiology Service

	• Provide clinical supervision/ evaluation to undergraduate physiotherapists as directed by the Physiotherapy Manager. Take part in teaching/ training/ supervision/ evaluation of staff/ students and attend practice educator courses as relevant to role and needs • Engage in personal development planning and performance review for self and others as required within the integrated care team • Develop advanced skills as relevant to cardiovascular care **<u>Quality, Safety & Risk</u>** The Senior Physiotherapist will: • Be responsible for the co-ordination and delivery of a quality service in line with best practice • Develop and monitor implementation of agreed policies, procedures and safe professional practice by adhering to relevant legislation, regulations and standards • Ensure the safety of self and others, and the maintenance of safe environments and equipment used in Physiotherapy in accordance with legislation • Assess and manage risk in their assigned area(s) of responsibility • Take the appropriate timely action to manage any incidents or near misses within their assigned area(s) • Report any deficiency/ danger in any aspect of the service to the team or Physiotherapy Manager/ Cardiac Rehabilitation Coordinator as appropriate; • Be responsible for the safe and competent use of all equipment, aids and appliances both by clients and staff under their supervision; • Develop and promote quality standards of work and co-operate with quality assurance programmes; • Oversee and monitor the standards of best practice as appropriate • Have a working knowledge of HIQA Standards as they apply to the role, for example, National Standards for Safer Better Healthcare, National Standards for the Prevention and Control of Healthcare Associated Infections, Hygiene Standards etc. and comply with associated HSE protocols for implementing and maintaining these standards. **<u>Administrative</u>** The Senior Physiotherapist will: • Contribute to the service planning process • Assist the Physiotherapy Manager/ Cardiac Rehabilitation Coordinator and relevant others in service development encompassing policy development and implementation • Review and evaluate the Physiotherapy service regularly, identifying changing needs and opportunities to improve services in conjunction with MDT • Collect and evaluate data about the service area as identified in service plans and demonstrate the achievement of the objectives of the demonstrator project and there after the service • Oversee the upkeep of accurate records in line with best practice

	• Collate and maintain accurate statistics and render reports as required • Represent the department / team at meetings and conferences as appropriate • Inform the Physiotherapy Manager/ Cardiac Rehabilitation Coordinator of staff issues (needs, interests, views) as appropriate • Promote a culture that values diversity and respect in the workplace • Participate in the control and ordering of Physiotherapy stock and equipment in conjunction with the Physiotherapy Manager/ Cardiac Rehabilitation Coordinator • Be accountable for the budget, where relevant • Keep up to date with organisational developments within the Irish Health Service • Engage in IT developments as they apply to clients and service administration • Perform such other duties appropriate to the role as may be assigned by the Physiotherapy Manager **The above Job Specification is not intended to be a comprehensive list of all duties involved and consequently, the post holder may be required to perform other duties as appropriate to the post which may be assigned to him/ her from time to time and to contribute to the development of the post while in office.**

Staff Nurse Cardiac Rehabilitation Service

Job Specification & Terms and Conditions

Job Title and Grade	**Staff Nurse Cardiac Rehabilitation Service**
Purpose of the Post	The need to reform the healthcare services in Ireland in order to provide a more sustainable, integrated and patient-centred approach has come to the fore in recent health policies and strategies. Integrated care requires health and social care services to work together across different levels and sites in order to provide end-to-end care that meets patient need. The Staff Nurse will assess, plan, implement and evaluate care to the highest professional and ethical standards within the model of nursing care practiced in the relevant care setting (i.e. Cardiac Rehabilitation). The staff nurse will provide holistic, person centred care, promoting optimum independence and enhancing the quality of life for service users.
Principal Duties and Responsibilities	**Professional Responsibilities** *The Staff Nurse will:* • Practice Nursing according to the Code of Professional Conduct as laid down by the Nursing Board (An Bórd Altranais) and Nursing and Midwifery Board of Ireland (Cnáimhseachais na hÉireann) and Professional Clinical Guidelines • Adhere to national, regional and local HSE guidelines, policies, protocols and legislation • Work within their scope of practice and take measures to develop and maintain the competence necessary for professional practice • Maintain a high standard of professional behaviour and be accountable for their practice • Be aware of ethical policies and procedures which pertain to their area of practice • Respect and maintain the privacy, dignity and confidentiality of the patient • Follow appropriate lines of authority within the Nurse Management structure **Clinical Practice** *The Staff Nurse will:* • Deliver the nursing care of an assigned group of patients within a best practice/ evidence based framework

	• Manage a designated caseload • Promote the health, welfare and social wellbeing of patients within our services • Actively participate as a multi-disciplinary/ inter-disciplinary team member in all aspects of service delivery including case conferences, clinical meetings, team meetings • Assess, plan, implement and evaluate individual person centred care programmes within an agreed framework and in accordance with best practice • Develop and promote good interpersonal relationships with patients, their family/ social network supports and the interdisciplinary care team in the promotion of person centred care • Ensure that care is carried out in an empathetic and ethical manner and that the dignity and spiritual needs of the patient are respected • Promote and recognise the patients' social and cultural dimensions of care and the need for links with their local community • Collaborate and work closely with the patient, their family, the multi-disciplinary/ inter-disciplinary team, external agencies and services to facilitate discharge planning, continuity of care and specific care requirements • Provide appropriate and timely education and information to the patient, their family and be an advocate for the individual patient and for their family • Report and consult with senior nursing management on clinical issues as appropriate • Maintain appropriate and accurate written nursing records and reports regarding patient care in accordance with local/ national/ professional guidelines • Participate in innovation and change in the approach to patient care delivery particularly in relation to new research findings, evidence based practice and advances in treatment • Participate in clinical audit and review • Participate in community needs assessment and ongoing community delivery of care as appropriate • Undertake Key Worker role as appropriate • Promote a positive health concept with patients and colleagues and contribute to health promotion and disease prevention initiatives of the HSE • Delegate to and supervise the work of other grades of staff within the remit of their role, as appropriate • Demonstrate flexibility by rotating/ assisting in other units/ care settings as required to meet nursing resource needs and the requirements of the Integrated Care Cardiology Service • Refer clients to other services as required **<u>Clinical Governance</u>** *The Staff Nurse will:* • Participate in clinical governance structures within the local/ regional/ national clinical governance framework

	• Have a working knowledge of HIQA Standards as they apply to the role/ care setting, for example, Standards for Healthcare, National Standards for the Prevention and Control of Healthcare Associated Infections, Hygiene Standards etc. • Contribute to ongoing monitoring, audit and evaluation of the service as appropriate • Accurately record and report all complaints to appropriate personnel according to local service policy • Participate in the development of policies/ procedures and guidelines to support compliance with current legal requirements, where existing, for the safe storage and administration of medicines and other clinical products • Participate in the development of policies/ procedures and guidelines with health, safety, fire, risk and management personnel and participate in their development in conjunction with relevant staff and in compliance with statutory obligations • Observe, report and take appropriate action on any matter which may be detrimental to patient care or well being • Be aware of, and comply with, the principles of clinical governance including quality, risk and health and safety and be individually responsible for clinical governance, risk management/ health and safety issues in their area of work • Participate in the development, promotion and implementation of infection prevention and control guidelines • Adhere to organisational dress code • Assume responsibility for and coordinate the management of the unit/ care setting in the absence of the Clinical Nurse Manager/ Cardiac Rehabilitation Coordinator **<u>Education, Training & Development</u>** *The Staff Nurse will:* • Take responsibility for own competency and learning and development needs and actively contribute to the learning and development of the interdisciplinary team • Complete all mandatory training as deemed necessary by the Director of Public Health Nursing and ABA • Participate in performance evaluation/ review with their line manager, identifying areas for improvement and appropriate plans/ measures to achieve them • Provide feedback to the Clinical Nurse Manager/ Cardiac Rehabilitation Coordinator or the designated officer with regard to compilation of proficiency assessments for students in the clinical setting • Develop and use reflective practice techniques to inform and guide practice as part of their daily work • Identify and contribute to the continual enhancement of learning opportunities within a population health framework • Participate in the clinical/ workplace induction of all new nursing and support staff • Contribute to the identification of training needs pertinent to the clinical area

	• Develop teaching skills and participate in the planning and implementation of orientation, training and teaching programmes for nursing students and other health-care staff as appropriate • Having undergone appropriate training, act as a mentor/ preceptor or clinical assessor for students • Participate in the development of performance indicators in conjunction with the Clinical Nurse Manager/ Cardiac Rehabilitation Coordinator • Participate in innovation and change in the approach to service user care delivery, and contribute to the service planning process, based on best practice and under the direction of Nurse Management/ Nurse Practice Development, particularly in relation to new research findings and advances in treatment **<u>Administration</u>** *The Staff Nurse will:* • Ensure that records are safeguarded and managed as per HSE/ local policy and in accordance with relevant legislation • Work closely with colleagues across the integrated services programme in order to provide a seamless service delivery to the client within the integrated services programme • Maintain records and submit activity data/ furnish appropriate reports to the as required • Contribute to policy development and formulation, performance monitoring, business planning and budgetary control • Maintain professional standards including patient and data confidentiality • Contribute to the development and implementation of information sharing protocols, audit systems, referral pathways, individual care plans and shared care arrangements • Contribute to ongoing monitoring, audit and evaluation of the service as appropriate • Ensure that the care setting is maintained in good order using appropriate models, that supplies are adequate and that all equipment is in good working order and ready for immediate use • Ensure that equipment is safe to use and report any malfunctions in a timely manner • Assist with ordering of supplies as required and ensure the appropriate and efficient use of supplies is made and exercise economy in the use of consumables • Undertake other duties as required by the Cardiac Rehabilitation Coordinator/ DPHN as appropriate **The above Job Specification is not intended to be a comprehensive list of all duties involved and consequently, the post holder may be required to perform other duties as appropriate to the post which may be assigned to him / her from time to time and to contribute to the development of the post while in office.**

	The reform programme outlined for the Health Services may impact on this role and as structures change the job description and reporting relationships may be reviewed. **This job description is a guide to the general range of duties assigned to the post holder. It is intended to be neither definitive nor restrictive and is subject to periodic review with the employee concerned**.

Clinical Psychologist Cardiac Rehabilitation Service – Primary Care

Job Title and Grade	**Clinical Psychologist** **Cardiac Rehabilitation Service – Primary Care**
Purpose of the Post	**Purpose of the Post** The Clinical Psychologist will offer Individual assessment, formulation and psychological intervention in both one to one and group sessions and psycho-education for patients as part of a comprehensive Cardiac Rehabilitation Service. They will act as the representative clinical lead at local and national strategic development meetings disseminating information and acting on initiatives and improvements within the resources available. The post holder will act as an expert clinical resource offering supervision, education and on-going support to staff and teams managing complex cardiovascular patients. The Clinical Psychologist will be a highly competent, visible and experienced autonomous practitioner who uses specialist knowledge and advanced skills to support Cardiac Rehabilitation services. They will have a good understanding of the vision of the HSE and Sláintecare and to be able to translate this into a local context for operational implementation within their team and locality area. They will demonstrate advanced clinical judgement and critical decision-making skills based upon evidence based practice.
Principal Duties and Responsibilities	• Co-ordinate psychological assessment and therapeutic interventions for people identified with psychological need at initial screening assessment. • Facilitate psycho-education regarding stress management and coping to all participants. This can facilitate an introduction to the emotional impact of a cardiac event on psychological wellbeing and coping. This should then be further supported with either one to one or group sessions as required.
	• This can be screened for with participants at the end of this introductory session or at the initial assessment. • Offer an 8 week evidence based group to all participants to address coping which may include CBT for coping & stress management/ living well, mindfulness based cognitive therapy or stress reduction (training dependent). • Use evidence based practice and empirically supported treatment of mental health issues as per best practice guidelines. • Treat adjustment disorder, anxiety, depression, low mood, GAD/PTSD & certain pre morbid personality aspects that may impede recovery, among others. • Treat complex presentations precipitated by adverse coping and underlying psychological distress such as eating disorders, self-neglect, substance dependency, interpersonal difficulties that trigger adverse coping • Explore the impact on recovery of grief, unresolved issues, family distress, anger, stress and confidence in health • Select appropriate measures to assess clinical change and outcomes in Cardiac Rehabilitation. • Complete cognitive neuropsychological assessments of adults where cardiovascular damage may have resulted in cognitive damage and communicate the results and interventions required with the participant/ identified key staff (e.g. MDT, GP, referral agents) • Participate in MDT discussion re assessment/ recommendations re formulation of needs and suitability for intervention • Link with services beyond Cardiac Rehabilitation where further need is required. • Contribute to service planning, innovation, evaluation and the development of the Cardiac Rehabilitation Service • Maintain ongoing records/supervision/CPD as per guidelines • Adhere to Professional Code of Conduct as per PSI guidelines **The above Job Specification is not intended to be a comprehensive list of all duties involved and consequently, the post holder may be required to perform other duties as appropriate to the post which may be assigned to him/ her from time to time and to contribute to the development of the post while in office.**

Iministration Assistant – Cardiac Rehabilitation Team (Grade IV)

Job Title and Grade	**Administration Assistant – Cardiac Rehabilitation Team (Grade IV)**
Purpose of the Post	To provide an efficient and effective administrative support and co-ordination service to the Cardiac Rehabilitation Service.
Principal Duties and Responsibilities	**Principal Duties and Responsibilities** • To provide secretarial and admin support to the Cardiac Rehabilitation Service - Primary Care • To co-ordinate and manage the diary of the Cardiac Rehabilitation Service - Primary Care • Prioritisation and filtering of written, electronic and verbal communication to be dealt with personally or brought to the attention of the Cardiac Rehabilitation Coordinator or relevant team member. • To screen and manage referrals with the Cardiac Rehabilitation Coordinator, re-direct as appropriate and prioritise to ensure it is dealt with efficiently and effectively on behalf of the Cardiac Rehabilitation Service - Primary Care • To co-ordinate and quality assure appropriate appointments, documents and correspondence on behalf of/ in liaison with the Cardiac Rehabilitation Team for assessment and classes. • To organise education sessions in coordination with Cardiac Rehabilitation Coordinator and other relevant stakeholders • To keep the Cardiac Rehabilitation Coordinator fully appraised of all daily events requiring attention or awareness via text or telephone as appropriate • To attend departmental meetings as required to generate and produce detailed minutes/ action lists and circulate once approved in a timely manner to membership of such committees/ working groups as may be required • Maintenance of a good working knowledge of issues within the Cardiac Rehabilitation Service • Promote and maintain a customer focused environment. Act on feedback from service users and notify supervisor of any deficiencies. **Communications & Interpersonal Skills** Demonstrate: • Ability to listen effectively and extract relevant referral information from clients • Ability to maintain a calm and compassionate approach • Good communication and interpersonal skills including the ability to present information in a clear and concise manner • Excellent telephone and communication skills including strong written communication skills.
	Planning & Managing Resources Demonstrate: • Excellent planning and organisational skills including using computer technology effectively • The ability to manage deadlines and effectively handle multiple tasks • The ability to manage within allocated resources and a capacity to respond to changes in a plan. **Evaluating Information, Problem Solving & Decision Making** Demonstrate: • Flexibility, problem solving and initiative skills including the ability to adapt to change • The ability to appropriately analyse and interpret information, develop solutions and contribute to decisions quickly and accurately as appropriate • The ability to recognise when it is appropriate to refer decisions to a higher level of management. **Team Working** • To liaise with all staff in the Cardiac Rehabilitation Service - Primary Care where appropriate and contribute effectively to a positive and supportive team environment • To contribute to continuous process improvement within the service particularly in the area of technology • To maintain and update files and develop and maintain appropriate manual, electronic filing and tracking systems on an on-going basis. **Commitment to a Quality Service** Demonstrate: • Great attention to detail and high levels of accuracy • Awareness and appreciation of the customer • A commitment to maintaining high work standards • A commitment to providing a quality service and customer service skills. **Other Duties** • To perform such other duties as required and as appropriate to the grade, whether or not connected with or incidental to the functions of the Cardiac Rehabilitation Service. • To undertake all duties in a confidential, professional and courteous manner when representing the Cardiac Rehabilitation Service.

	The above Job Description is not intended to be a comprehensive list of all duties involved and consequently the post holder may be required to perform other duties as appropriate to the post which may be assigned to him/her from time to time and to contribute to the development of the post while in office

Seirbhís Sláinte
Nios Fearr
á Forbairt

Building a
Better Health
Service

hi
Healthy
Ireland