St. Francis Hospice Dublin

JOB DESCRIPTION

(CLINICAL NURSE SPECIALIST

COMMUNITY PALLIATIVE CARE)

(WHOLE TIME, PERMANENT) (37.5HRS P.W.)

Job Reference: 2023 - 030
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1. JOB PURPOSE

Two teams provide Community Palliative Care services in St Francis Hospice, Dublin; one team based in Raheny serving Dublin Northeast and the second team based in Blanchardstown serving Dublin Northwest. However, staff contracts contain a flexibility clause and you may be requested to provide cover to the second team, when necessary. The CPC Team provides a seven-day service, from 8am until 9pm every day that includes on call and standby at weekends and bank holidays. Services are provided in patient's homes, Nursing homes and Community settings. In CPC, the Nurses work closely with the GP and the primary care team.

The CNS/CNM2 will, when required, act as a Specialist Palliative Care resource for the primary care team in the community and all other Community settings. The CNS/CNM2 is a key member of the multidisciplinary team providing an effective and efficient Specialist Palliative Care Service in North Dublin City and County. The CNS/CNM2 will be working in conjunction with the multidisciplinary team and will have extensive experience and advance expertise in the delivery of Specialist Palliative Care.

2. ACCOUNTABILITY

The position reports to and is accountable to the Director of Nursing/Assistant Director of Nursing or other designated officer in all matters relating to the job.

3. KEY DIMENSIONS

- Direct reporting to the Team Leader.
- Key relationships that will influence the success of the role: Multidisciplinary team.

4. OPERATING ENVIRONMENT

Contractual Hours: 37.5 per week.

Hours of work: Normal working week will be over a seven day spread, inclusive of weekends, on call and evenings up until 9.00pm. Details of starting and finishing times, which may vary in accordance with Hospice needs will be notified by your line manager. There will be times when you will be required to work outside of the normal office hours.

Location: This position is based in SFHD, which operates across two sites: Raheny & Blanchardstown. In the interest of patient care and changing needs, candidates are required to be flexible and are obliged to carry out duties in any department or location of the Hospice or associated locations when required to do so by the Leadership team.

As St. Francis Hospice Dublin is an expanding service, the demands for services can change and it will be necessary to meet these changes throughout the organisation. In such circumstances, it may be necessary to review the work location for this post and, on behalf of the Board of Directors, the Leadership Team reserves the right to change the terms and conditions as necessary. However, notification will be given of any such changes.

Garda Vetting: The successful candidate will be required to satisfactorily complete the Garda Vetting process prior to a formal job offer being made.

5. SALARY SCALES, ANNUAL LEAVE & PENSION SCHEME

Salary Scale: Department of Health - Consolidated Salary Scale (1st March 2023) – CNM2/Clinical Nurse Specialist (General) & Salary scale

	1.	1.	2.	3.	4.	5.	6.	7.	8.
CNS/CNM2	56,353	57,287	58,076	59,365	60,789	62,187	63,585	65,160	66,622

Annual Leave: 28 days per annum pro rata.

Pension Scheme: SFHD will contribute 7% of the successful candidate's basic annual salary.

6. THE PERSON: QUALIFICATIONS, EXPERIENCE, KNOWLEDGE & COMPETENCIES

	Essential	Desirable
Qualifications	• Registered in the General division of the Register of Nurses as maintained by NMBI • Have a post- registration level 8 QQI (Quality and Qualifications of Ireland) major academic award on the NFQ (National Framework of Qualifications) in Palliative Care or Oncology* • Commitment to completing a Nurse Prescribing Course within five years.	• MSc in Palliative care • Nurse Prescribing Course
Experience	• Five years post registration experience. • Two years' experience in Palliative Care or Oncology • Experience with participation within an MDT • Competent and confident IT skills - Word, Excel, Power Point and e-mail • Demonstrates evidence of continuing professional development	• Experience of working in a Oncology or other relative setting
Other	• Full driving license	

* Staff who have completed the post- registration level 8 QQI (Quality and Qualifications of Ireland) major academic award on the NFQ (National Framework of Qualifications) in Oncology will be employed as a CNM2.

PALLIATIVE CARE COMPETENCIES

Domain 1 – Principles of Palliative Care

As a CNS caring for people with life-limiting conditions, you should:

1. Demonstrate an in-depth understanding of the full spectrum of trajectories of life-limiting conditions (including prognostic factors, symptoms and problems)
2. Understand, recognise and assist in the management of pathological responses to loss which may impact on behaviour and decision-making of individuals and families.
3. Demonstrate leadership in the development and delivery of palliative care policy and provision.
4. Demonstrate leadership in the development and delivery of palliative care education.
5. Be able to identify and actively respond to the learning needs of people living with a life-limiting condition, their families and health care professionals, sharing palliative knowledge and supporting the provision of evidence-based practice in a variety of care settings.
6. Be able to influence policy by highlighting evidence to support palliative care practice developments.
7. Demonstrate a commitment to research in the field of palliative care and its application to practice.
8. Demonstrate a commitment to continued professional development appropriate to current role in specialist palliative care.

Domain 2 – Communication

As a CNS caring for people with life-limiting conditions, you should:

1. Demonstrate competence in communicating with individuals and their families in the context of palliative care.
2. Demonstrate the ability to respond to the needs of the family of a person with a life-limiting condition when information regarding diagnosis and prognosis is being provided.
3. Demonstrate leadership through the promotion of effective intra and interdisciplinary team communication in the palliative care setting.
4. Be able to analyse complex individual situations and share insights with colleagues.

Domain 3 - Optimising Comfort and Quality of Life

As a CNS caring for people with life-limiting conditions, you should:

1. Demonstrate advanced knowledge of disease processes, treatments, concurrent disorders and likely outcomes to guide clinical decision-making so as to optimise comfort and quality of life.
2. Demonstrate an ability to analyse complex clinical information to inform diagnosis and decision making.
3. Be able to participate in the discussion with the multidisciplinary team/colleagues promoting the appropriate recognition of the evolving needs and preferences of the individual and family over time, and facilitating the management of complex, competing and shifting priorities in goals of care.
4. In the context of scope of practice, provide advice on the appropriate pharmacological management of symptoms.
5. In the context of scope of practice, registration and locally agreed policy prescribe medication for the management of symptoms.

Domain 4 - Care Planning and Collaborative Practice

As a CNS caring for people with life-limiting conditions, you should:

1. Be able to facilitate and participate in key events in the care of the person with a life-limiting condition, such as family meetings and advance care planning

2. Demonstrate ability to recognise that the person with a life-limiting condition may lose capacity to make decisions at end-of-life
3. Understand that in situations where a person lacks capacity to make decisions, the nurse acts as an advocate to ensure decisions made are in the best interests of the person and follow the current Code of Conduct for each Nurse and Midwife
4. Be able to address questions regarding issues of organ donation or post mortem
5. Understand the importance of timely referral to primary care and palliative care teams in the management of the person with palliative care needs
6. Demonstrate an awareness of the need for communicating with primary care teams and other teams that may impact on the delivery of care to people with life-limiting conditions and their families.

Domain 5 - Loss, Grief and Bereavement

As a CNS caring for people with life-limiting conditions, you should:

1. Demonstrate an understanding of normal and pathological responses to the diagnosis/prognosis of a life-limiting condition and an ability to address the immediate management of such issues or make appropriate referral.
2. Understand the strategies to identify the losses that persons with cognitive and sensory impairment encounter and utilise appropriate interventions to address these when managing their palliative care needs.
3. Demonstrate an ability to identify those experiencing complicated grief and utilise resources to support them.
4. Appreciate the nature of disenfranchised grief in individuals, families, and carers and appropriate methods of addressing this grief.
5. Be able to act as a resource to support colleagues in the management of loss, grief and bereavement.

Domain 6 - Professional and Ethical Practice in the Context of Palliative Care

As a CNS caring for people with life-limiting conditions, you should:

1. Be aware of and act according to the current code of professional conduct for Nurses and Midwives, as it applies to the care of people with life-limiting conditions
2. Demonstrate an understanding of the difference between managing a life-limiting condition and providing end-of-life care.
3. Demonstrate a commitment to working in partnership with health care managers and providers to assess, coordinate, promote and improve safety in the context of palliative care.
4. Demonstrate an understanding of the process of quality improvement in the context of palliative care.
5. Demonstrate a commitment to advancing Palliative Care through the generation and application of knowledge and research.
6. Demonstrate leadership through advocating for on-going and continuous service development.
7. Facilitate appropriate engagement of service users in the development of palliative care services.
8. Communicate and advance the distinct contribution of palliative nursing.
9. Participate in the discussion and resolution of ethical dilemmas that may arise in palliative care.

7. Key Responsibilities and Accountabilities

The post holder's practice is based on the five core concepts of Clinical Nurse Specialist (Palliative Care) role as defined by the NCNM 4th edition (2008).

The concepts are:

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

Clinical Focus
The Clinical Nurse Specialist in Community Palliative Care:

- Articulates and demonstrates the concept of nursing specialist palliative care practice within the framework of relevant legislation, the Scope of Nursing and Midwifery Practice Framework (An Bord Altranais 2000a), The Code of Professional Conduct (An Bord Altranais 2000c) and Guidelines for Midwives (An Bord Altranais 2001).
- Possesses specially focused knowledge and skills in specialist palliative care practice at a higher level than that of a staff nurse.
- Performs a nursing assessment, plans and initiates care and treatment modalities within agreed interdisciplinary protocols to achieve patient-centered outcomes and evaluates their effectiveness.
- Identifies health promotion priorities in the area of specialist palliative care practice.
- Implements health promotion strategies for patient groups in accordance with public health agenda.

Direct Care
The Clinical Nurse Specialist in Community Palliative Care will:

- Provide a specialist palliative care nursing service for patients with specialist palliative care needs 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 specialist palliative care practice,
- 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 as appropriate,
- 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,
- Manage nurse led clinics with MDT input, as required,
- 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

Indirect Care

The Clinical Nurse Specialist in Community Palliative Care will:

- Identify and agree appropriate referral pathways for patients with specialist palliative care needs,
- 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 specialist palliative care,
- Take a lead role in ensuring the service for patients with specialist palliative care is in line with best practice guidelines and the Safer Better Healthcare Standards (HIQA, 2012).

Patient Advocacy

The Clinical Nurse Specialist in Community Palliative 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 and Training

The Clinical Nurse Specialist in Community Palliative Care will:

- Maintain clinical competence in patient management within specialist palliative care nursing, keeping up-to-date with relevant research to ensure the implementation of evidence based practice.
- Be committed to continuing professional development and engage in professional development reviews with your line manager.
- Provide the patients family and/or carer with appropriate information and other supportive interventions to increase their knowledge, skill and confidence in managing the patient.
- Contribute to the design, development and implementation of education programmes and resources for the patient, family and/or carer in relation to specialist palliative care thus empowering them to self-manage their condition.
- Provide mentorship and preceptorship for nursing colleagues and students on clinical placement as appropriate.
- Participate in training programmes for nursing, MDT colleagues and stakeholders as appropriate.
- Collaborate with the education team in the provision education internally and externally.
- Create exchange of learning opportunities within the MDT in relation to evidence based palliative 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 Specialist Palliative Care.
- Be responsible for addressing own continuing professional development needs and engage in professional development reviews with your line manager

Audit and Research

The Clinical Nurse Specialist in Community Palliative Care will:

- Establish and maintain a register of patients with specialist palliative care within the CNS Caseload,
- 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 specialist palliative care,
- Contribute to nursing research on all aspects of specialist palliative 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,
- 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

The Clinical Nurse Specialist in Community Palliative Care will:

- Provide leadership in clinical practice and act as a resource and role model for specialist palliative care 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 and national specialist palliative care CNS/Registered Advanced Nurse/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,
- Where appropriate develop and maintain relationships with specialist services in other 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 for Specialist Palliative Care,
- Network with other CNS's in specialist palliative care and in related professional associations,

Management

The Clinical Nurse Specialist in Community Palliative 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 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 the DoN.
- Support, promote and actively participate in sustainable energy, water and waste initiatives to create a more sustainable, low carbon and efficient health service.

8. 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 SFHD Policies, including, but not limited to:
    - CPC Manual
    - SFHD Safety Statement
    - Lone Workers Policy
    - Driving For Work Policy
    - Medication Policies
    - Infection Control Policies
    - Data Protection
- Ensure completion of incident/forms and clinical risk reporting,
- Continually monitor the service to ensure it reflects current needs ,
- Generate and contribute to the development of clinical standards and guidelines and support implementation,
- Implement and manage identified quality improvement initiatives.

GENERAL

- Comply with the Mission Statement, Ethos and Core Values of St. Francis Hospice Dublin.
- Comply with the St. Francis Hospice Dublin policies relating to confidentiality and ensure confidentiality in all matters of information obtained during the course of employment.
- Adhere to the Policies & Procedures of St. Francis Hospice Dublin at all times.
- Actively engage in continuous professional development and learning.
- Present and act in a professional manner at all the times.
- Carrying out any other reasonable duties, appropriate to the office that may be required from time to time.

The successful candidate will be required to update their knowledge and skills to fit the changing requirements of the post. Therefore, this Job Description is an outline of the current broad areas of

responsibility and accountability and should not be regarded as a comprehensive listing. It will be reviewed and updated in line with future needs.

The successful candidate will be required to maintain, enhance and develop their knowledge, skills and attitudes necessary to respond to a changing situation.

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.

Signature of Job Holder:	**Signature of Line Manager or Designated Officer:**
Job Title:	**Job Title:**
Date:	**Date:**