POSITION DESCRIPTION: CLINICAL NURSE SPECIALIST – DIABETES		
Background	THINK Hauora is a network that designs, delivers and supports primary health care services across Otaki, Horowhenua, Manawatu and Tararua. THINK Hauora has a strong focus on equity and a commitment to collaborating and partnering to improve outcomes for our communities. This position description (PD) captures the expected functions of the position and is reviewed from time to time as required and considered as part of the annual performance review process.	
Purpose	The Clinical Nurse Specialist – Diabetes provides advanced diabetes nursing expertise across primary and community care, supporting people and whānau with complex diabetes-related needs through specialist assessment, care planning, self-management support, clinical coordination. Much of this is done in partnership with general practice, iwi/Māori providers, community services and secondary care. The role provides clinical leadership, mentoring, education and quality improvement to strengthen provider capability, improve equity of access and outcomes and support safe, evidence-based diabetes care across the rohe.	
Primary Functions	The primary functions of this role include: • Develop and maintain a high trust relationship with General Practice Teams, Iwi/ Māori providers and other primary care providers across the rohe. • Work in partnership and holistically with the client and family/whānau, utilising a Whānau Ora approach with Comprehensive Health Assessment and Care Planning and client centred goals whānau. • Provide clinical expertise and leadership that ensures services - to clients are provided in the most effective and efficient way. • Actively contribute to the development of the specialty in general, and nursing through improvement initiatives. • Support General Practice Teams to introduce and implement new tools and models of care that will enhance client management, promote self-management support for their practice population. • Working collaboratively with General Practice Teams, other health providers and secondary care colleagues to ensure the client receives equitable provision of service and support in a clinically responsive and timely manner. • Contribute to the development of capability of General Practice teams, sub-contracted providers, peers and colleagues. • Contribute to the implementation of collaborative clinical pathways for people with long term conditions, particularly diabetes.	
Reports to	General Manager, Clinical and Network Services	
Direct reports	N/A	
Functional Relationships	**Internal** • Chief Executive Officer • Principal Medical Advisor • General Manager Strategy and Enablement • Quality Manager • Integrated Support Manager	**External** • General Practices Network • Te Whatu Ora • Kaupapa Hauora providers • Community providers • Social Services • Secondary care

	• Clinical Programmes Manager • Primary Health Network Manager	
Primary Location	Based in the offices of THINK Hauora, 200 Broadway Avenue, with travel across the region, including Horowhenua, Manawatu and Tararua districts	
Salary Range	In accordance with the skills and experience to undertake the role competencies	
Nature of Position	Permanent, Part-time (0.6 FTE)	
Status as described in the Vulnerable Children's Act 2014	In line with the Vulnerable Children Act 2014 and our service agreement with Health New Zealand – Te Whatu Ora, this position has been identified as a **Core Worker** position.	
Health and Safety	All staff and governance at THINK Hauora participate in health and safety management practices, ensure that work is done in a safe environment, reports and works to eliminate, isolate or minimise any hazards, and applies THINK Hauora's health and safety policies and procedures. Staff must act to ensure that THINK Hauora complies with its responsibilities under the Health and Safety at Work Act 2015 and any subsequent amendments or replacement legislation. Be able to demonstrate actions in an emergency situation that are specific to the workplace and are designed to keep individuals safe.	

ORGANISATIONAL VISION, MISSION and VALUES	
Our Strategy	**THINK Hauora 2019-2025 Strategy** supported by Ka Ao, Ka Awatea, Māori Health Strategic Framework
Our Vision	**Tūhonotia te hapori ki te Ora – Connecting Communities for Wellbeing**
Our Strategic Aims	**Whānau Ora:** Developing a Whānau Ora approach to accelerate and ensure equity of Māori health outcomes **Equity:** Driving equity of outcomes through people, community voice and data **Access:** Ensuring access to health care is easy, available, cross-sectors **Value:** Creating value through teams, technology and performance **Innovation:** Activating innovation, engagement and delivery of excellence **Networking:** Enabling networking and relationships to achieve partnerships **Growth:** Driving sustainability through system and alignment focus
Our Values	**Trust:** Maintaining open and honest relationships **Respect:** Embracing diversity, uniqueness and ideas **Unity:** Valuing strengths and skills **Accountability:** Working in a transparent and responsible manner **Courage:** Participating with confidence and enjoyment
Equity	THINK Hauora is committed to improving access to services and achieving equity of health outcomes across communities. We provide support and guidance to the wider workforce to do the same. THINK Hauora believes in equity and requires staff to "stop, look, listen and think" about how they can design, develop and deliver services that create and maintain equitable environments to effect change and ensure that whānau flourish.
Commitment to Te Tiriti o Waitangi:	THINK Hauora is committed to Te Tīriti o Waitangi and aspires to be an exemplar Te Tīriti Partner whose Board and employees actively contribute to the achievement of Pae Ora (Healthy Futures for Māori) across our rohe. We maintain this by expressing and activating the five principles of Te Tīriti o Waitangi across all layers of our Organisation.

	Tino Rangatiratanga | Self-determination **Mana Taurite** | Equity **Whakamarumarutia** | Active Protection **Kōwhiringa** | Options **Pātuitanga** | Partnership Our suite of policies will actively ensure Pae Ora is realised through the pathways of Whānau Ora (Healthy Families), Mauri Ora (Healthy Individuals), Wai Ora (Healthy Environment).

KEY RESPONSIBILITIES		
Key Competency	**Activities**	**Expectations**
Management of Nursing Care	• Applies in-depth knowledge and understanding of the presentation, progression, pathophysiology and prognosis of diabetes to client care • Applies in-depth knowledge and understanding of therapeutic interventions, including relevant pharmacology and medicines management to client care • Aware of the wider determinants of health and the impact that these have on wellness and peoples' situations • Undertakes comprehensive health assessment in partnership with client/family/ whānau and relevant health care providers • Develops and documents a comprehensive plan of care in partnership with client/family/ whānau and relevant health care providers, • Provides evidence-based nursing care to people with diabetes within the overall philosophy of enabling and promoting independence, dignity and choice • Implements effective community-based primary prevention, secondary prevention and rehabilitation strategies that will decrease the risk factors of those experiencing diabetes • Works with people with diabetes and their families/ whānau in planning for the future and supporting access to resources for making choices about end of life care (if applicable). • Plan and implement transfer of care and/or discharge of the person with diabetes as per agreed protocols • Aware of cross-cultural communication strategies, and applies these understandings in order to enhance therapeutic and professional relationships • Ensures that the service identifies and addresses issues of equity and access for people with Long Term Conditions	• All clients have a standardised Comprehensive Assessment, Care Plan and Action Plan • Evidence of client consent • Evidence of copy of the plan given to the client • Evidence of collaboration with providers in the development of assessment and care plan • Evidence of review and evaluation of assessment and care plans within agreed timeframes • Each consultation is fully documented in a client record • Audits of assessment and care plans completed and recommendations actioned • All referrals actioned appropriately and in accordance with the Ministry of Health and NZ Guidelines • Evidence-based best-practice guidance is followed per current Health NZ / Te Whatu Ora clinical guidelines and the National Diabetes Nursing Knowledge and Skills Framework (NDNKSF)

Provides Care Coordination for Complex clients through Case Management	• Work with General Practice Teams to identify and confirm the health and wellbeing needs of clients through Practice Profile/Disease Registers and referrals from healthcare providers • Actively supports the General Practice Team to analyse and interpret data in defined chronic condition populations • Ensure processes established with other providers for identifying those people with moderately complex diabetes, to assess, plan and coordinate their care • Apply in-depth knowledge and understanding of, and ability to manage, inter-professional and interagency working • Coordinate and organise plans of care for complex clients, ensuring an integrated approach to service delivery • Monitor the care provided for clients with diabetes, which may result in hospital admission and readmission • Apply in-depth knowledge of relevant legal and ethical issues related to caring for people with long term conditions • Recognise the impact of socio- economic and personal circumstances on people with long term conditions and advise on relevant support services	• Applies Case Management Process for clients with specific complex chronic care needs • Record keeping and report writing identifies methods and • Systems to promote effective communication and engagement • Clients are seen according to THINK Hauora entry/exit criteria • Aware of client complaints process and Client Code of Rights • Regular case review with specialist and secondary care- based colleagues

Supports self-care, self-management and enabling independence in partnership with the client, family/whānau and interdisciplinary team members	• Promote effective client self-management and self- management support (individual and group) to address specific health and wellbeing needs • Taking into account readiness to change, self-efficacy and advocacy, support the client/family/whānau with collaborative problem definition • Target the issues that are of the greatest importance to the client/family/whānau, help set realistic goals, and develop a personalised plan of care • Incorporates motivational interviewing techniques into self- management support • Provide active and sustained follow up at regular intervals to ensure improved health outcome • Awareness of cultural responsiveness to others • Incorporates Whānau Ora principles into care delivery when appropriate	• Working knowledge of the Chronic Care Model (CCM) and its role in improving services • Evidence of delivering client/group self-management support training • Evidence of collaborative working • Auditing of client satisfaction survey • Application of cultural principles

Professional Practice and Leadership	• Acts as a clinical expert, role model, mentor, educator, service leader and contributor to diabetes targets
	• Acts as a resource person for other nurses and health practitioners
	• Demonstrates clinical leadership, taking responsibility for the continuing development of self and others through:
	  ○ Personal and professional development:
	  ○ appraisal, supervision and support
	  ○ professional accountability
	  ○ reflective practice
	  ○ team working and development
	  ○ educational programmes, coaching
	  ○ communication skills within the team and other services/agencies
	• Demonstrates understanding of the issues relating to personal and professional competence
	• Demonstrates understanding of current policy, strategy and guidelines related to long term conditions
	• Assist in the development of relevant clinical policies and procedures
	• Contributes to clinical governance, networks, and collaborative clinical pathways development, implementation, and review
		• Works in a consultative/collaborative manner within the team
		• Supports the development of organisation policy and practice
		• Provides professional peer support to other team members
		• Evidence of engagement with professional organisations
		• Completion of Performance Appraisal annually
		• Completion of Professional Development Plan (PDR) annually

Interagency and Partnership Working	• Apply in-depth knowledge and understanding of collaborative and interagency working • Work across organisation and professional boundaries to enable personalised care to be delivered • Contribute to the review of the current system and assist in the development of any future systems to improve care received by clients. • Support primary health care providers to ensure that referrals to other health practitioners and services are effective and timely • Maintain liaison with primary health care providers by developing systems to ensure outcomes/letters are sent to general practice teams (GPT's) and other Health Professionals as appropriate • Plan and deliver specific training programmes for primary health care providers, peers and colleagues involved in the care of people with long terms conditions • Knowledge and understanding of Health NZ population health targets and their relevance in the primary health sector • Demonstrate conflict and dispute management skills	• Case management population identified and allocated to appropriate provider • Evidence of exchange of information between primary health care providers and other members of the multidisciplinary team • Annual review monitoring for clients is completed (if applicable) • Referrals are stored in the Patient Management System (PMS) at THINK Hauora and/or the practice • Number of provider training sessions provided

Service Development & Quality Improvement	• Aware of Service and Quality improvement tools and processes • Demonstrate understanding of organisational development and change management • Contribute to service development initiatives to people with long term conditions in multiple settings with multiple stakeholders, as agreed with the Line Manager • Develop and implement quality improvement activities appropriate to the service • Participate in the development and implementation of standardised, best practice- based systems and processes. • Skilled in managing clinical events, including risk assessment and appropriate management of risk • Act as an agent of change for the improvement of service delivery • Awareness of effective significant event management (SEM)	• Clinical audits completed as appropriate • Improvements implemented from client and provider satisfaction surveys or audits • Aware of contracts as relevant to role • Structured approach to Service and Quality improvement is evident • Accurate completion of SEM forms
Improve Health Outcomes for Māori	• Engage and further develop relationships with Iwi/Māori providers • Support and encourage the development of an effective culturally competent and responsive workforce • Support sustainable organisational commitment to Whānau Ora and Ka Ao, Ka Awatea	• Practices are supported to reduce health inequities for their enrolled populations • Whānau centred aspirations, needs and realities form the foundations of care provided • Demonstrates an understanding of the Whānau Ora outcome goals
Communication	• Expresses ideas and relays information in a manner that captures the clients attention, helping them to understand and act on the communication	
Respects Others & Builds Trust	• Demonstrates respect for others and builds trust through consistent behaviour; demonstrates integrity in all actions	
Technical and Professional Knowledge & Skills	• Has the required level of technical and professional skill or knowledge in position-related areas	
Health & Safety	• Ensure that work is completed in a safe environment, and report and work to eliminate, isolate or minimise any hazards • Participate in health and safety management practices for all employees, and apply the organisation's health and safety policies and procedures	• The organisation complies with its responsibilities under the Health and Safety at Work Act 2015 including any subsequent amendments or replacement legislation.

	• Be able to demonstrate actions in an emergency situation that are specific to the workplace and are designed to keep individuals safe.	
Other Duties	• Carry out other duties as requested by the Chief Executive.	• Readily performs activities that contribute to the role and the THINK Hauora strategy as requested and required.

PERSONAL SPECIFICATIONS	
Qualifications	• Registered Nurse (RN) under comprehensive scope with a current Annual Practising Certificate • Minimum 5 Years nursing experience in Primary Health and/or diabetes specialty • Senior/Expert level Professional Development and Recognition Programme (PDRP) Portfolio (Clinical Practice), or working towards this within an agreed timeframe • Designated prescriber within the diabetes specialty, or working towards authorisation • Demonstrated ability to provide specialty-to-expert diabetes care and education aligned with the National Diabetes Nursing Knowledge and Skills Framework (NDNKSF); Aotearoa College of Diabetes Nurses (ACDN) accreditation desirable • Current driver's licence
Essential	• Computer literacy • Demonstrated clinical leadership and influence across multidisciplinary teams • Knowledge of healthcare regulations and standards, with a commitment to ensuring compliance and delivering high-quality care. • Ability to work collaboratively across primary and secondary care • Excellent verbal and written communication skills, with the ability to convey complex information clearly and concisely. • Strong analytical and problem-solving skills, with the ability to identify issues and implement effective solutions. • Experience in developing and maintaining strong relationships with general practices and other healthcare providers. • Ability to provide clinical leadership and support to team members, fostering a culture of continuous learning and professional development.
Desired	• Recognised as effective, progressive, and knowledgeable • Aotearoa College of Diabetes Nurses (ACDN) accreditation

EMPLOYEE ACCEPTANCE

This Position Description has been agreed between:

Management Representative (print then sign) Date:

and

Employee (print then sign) Date: