

Position description

Position	Clinical Nurse Team Care Coordination		
Purpose	In collaboration with referrers such as GPs and hospital clinicians, provide care coordination to referred patients and achieve the objectives of the Team Care Coordination program.		
Approval date	26 September 2018	Approved by	Emma Gunn

Brisbane North PHN

Brisbane North PHN supports clinicians and communities in Brisbane's northern suburbs, Moreton Bay Regional Council and parts of Somerset Regional Council. It covers approximately 4,100 km² of urban, regional and rural areas, with a population of over 1,000,000.

The key objectives of the Brisbane North PHN are:

- increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and
- improving coordination of care to ensure patients receive the right care in the right place at the right time.

The PHN will achieve these outcomes by:

- understanding the health care needs of our community through analysis and planning, helping to identify and address service gaps
- providing practice support services so that GPs are better placed to provide care to patients, keeping them healthy and out of hospital
- supporting general practices in attaining the highest standards in safety
- assisting general practices in understanding and making meaningful use of eHealth systems
- working with other funders to purchase or commission health services for local groups most in need, including patients with complex chronic conditions or mental illness.

Key outcome areas

To ensure the organisation works effectively to achieve its annual business plan, each team member has responsibility for a range of activities and outcomes. These activities and outcomes are reviewed once a year formally and on an ongoing basis informally with team members and managers.

Role-specific

 provide timely phone and face to face assessment and review to deliver comprehensive coordination of health, community and social support services for people of any age who have complex chronic health conditions and needs

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- provide information and resources to empower patients to stay at the centre of their own care and make informed decisions
- maintain confidential client records with accurate data collection, assessment and case notes summaries
- liaise with health and community services providers to coordinate appropriate supports for patients
- work collaboratively with program referrers including general practice staff, general practitioners
 (GPs) and hospital staff to collectively improve patient's care and quality of life
- provide feedback/case summaries to referrers to support the integration of patient care
- conduct work activities in accordance with workplace health and safety policies in particular in relation to home visiting practices
- retain active professional relationships with government and non-government service providers and associated stakeholders in the primary care sector
- provide Service Navigation Coordinator phone support as required during absence or annual leave

General

- regularly attend team and staff meetings
- contribute to the pursuit of excellence through promoting and maintaining positive team spirit and
 organisational values, abiding by the organisation's Code of Conduct and Leadership Capability
 Framework, implementing all policies and procedures correctly and recommending quality
 improvements
- communicate effectively and respectfully with all members of the organisation and external stakeholders
- record all interactions in ChilliDB and other program and project databases on time, ensuring that information is relevant, accurate, up-to-date and accessible by other team members
- · comply with reporting requirements as directed by your manager
- deal with sensitive information in a confidential and professional manner
- complete other reasonable duties and projects as required to meet organisational objectives

Reporting relationships

Relationships

Reports to: Manager | Care Coordination

Direct reports: None

Level of delegation

(Per Delegation Matrix - CEO to staff)

Level 3 - All other Key selection criteria

Key selection criteria

Within the context of the key outcome areas described above, the ideal applicant will demonstrate the following:

Qualifications and experience

- Registered Nurse with AHPRA registration (or relevant government body)
- recent clinical experience and competency in advanced community nursing practice

- knowledge of local public and private primary health care services and resources related to the care of the aged, people with chronic health problems and their carers
- high level of critical analysis, problem solving and decision making in order to apply appropriate interventions in complex situations
- Well-developed written and communication skills with the ability to engage effectively with a range of stakeholders

Capabilities

The Brisbane North PHN Leadership Capability Framework applies to all roles within the organisation. Applicants must address these capabilities.

- leads self self-aware, proactive and adaptable; takes personal development opportunities and is resilient
- engages others at all levels with respect, collaboration and cultural sensitivity
- achieves outcomes in a high demand work environment with judgment and initiative
- drives innovation contributes to our culture of continuous quality improvement
- shapes systems works productively within internal and external systems and networks
- bases decisions on available evidence.

Other

- A current driver's licence is essential and use of a personal vehicle may be required, including travel between the PHN offices. Work-related mileage will be reimbursed at relevant rates.
- You may be required to work flexible hours. The role may include evening/weekend commitments for which time off in lieu is provided.

(Please note: This position description is subject to adjustment within reason and in consultation with your manager to meet the deliverables of the organisation.)