



# Enhanced Community Care Implementation Guidance

# Enhanced Community Care Older Persons' Service Model – Implementation Guide



## Introduction

The National Integrated Care Programme for Older Persons' (NICP OP) is leading out on the development of an end to end pathway that describes cohesive primary, secondary and acute care services for older people with a specific focus on those with more complex needs and frailty. There is substantial emerging evidence (locally and internationally) that focusing on the management of the needs of the 'frail older adult' can produce significant dividends for both the older populations who use them and the systems that serve them (BGS, 2014; NCPOP, 2012). This involves standardised assessment, bespoke care pathways, appropriate expertise in its management and

ensuring key points of contact are made available to older adults and their carers that coordinate care and anticipate on going needs (thereby reducing periods of 'crisis'). This requires a re-design of the way in which care for the older person is organised and delivered as articulated in the Older Persons'/Chronic Disease Service Model shown here.



## Core Ingredients of Integrated Care for Older People

The Integrated Care Programme has produced a number of guidance documents that describe the design and implementation of integrated care and specialist pathways for older people in Ireland. These include the *Making a Start in Integrated Care for Older Persons (2017)* that sets out the 10 Step Framework for implementation; *Implementing Integrated Care for Older Persons in Ireland – Early Stage Insights and Lessons for Scale-Up (2018)*; and *Case Management Approaches to Support Integrated Care for Older Adults (2018)*. See <https://www.icpop.org/publications-presentations> Each of these documents discusses the core ingredients for implementing Integrated Care for Older People including comprehensive assessment (interRAI) that can be summarised as follows:



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## Resourcing the Service Model

A resource modelling exercise has been undertaken to define the core membership of the multi-disciplinary teams required to deliver specialist care to older people in the Ambulatory Care Hub and Frailty at the Front Door care settings. The approach to mapping resource to specialist community team hubs was underpinned by the key principle that each hub would service\*<sup>3</sup> community health networks (CHNs) with a total population of circa 150,000.

- In keeping with international population health needs norms, age attuned population data sets (over 75yrs) were used as a proxy for potential demand within each CHN. This identified areas that had pockets of older residents (with greater needs) and those areas with a younger but 'emerging' older population.
- Geographical boundaries and rurality was factored into resource mapping to identify areas with a large and diverse rural spread as this impacts on domiciliary visit capabilities of specialist teams and proximity to specialist hubs.
- The UK Frailty index was mapped to the existing CSO (2016) data to identify potential prevalence within each CHN. This identified the top 3% most likely to be severely frail, 12% with moderate frailty and 35% with mild or pre frail qualities. The service model anticipates that a mix of severe and moderate/severe older persons will be cared for within the specialist community hub. In tandem with this, in-reach/out-reach function between community and acute hospital care and the mild/pre fail older-person will continue to live well at home with supports in place.
- Deprivation data, linked to the older person CSO (2016) data by CHN, was utilised to identify CHNs with the highest deprivation to ensure coverage by a specialist community team as a priority, in particular those populations deemed "extremely disadvantaged" and "very disadvantaged".
- Operational performance data from the national unscheduled care performance report was utilised to identify those acute hospitals demonstrating high TrolleyGAR figures, high attendances and admissions for the over 75 population and increased delayed transfers of care. This was then mapped across to the specialist community teams that would be geographically linked to these acute hospitals.

## Resources included in this Pack

This pack has been produced as additional guidance for local sites as they implement their own end to end pathway of integrated care for older people. The pack includes;

- Guidance on the establishment of a specialist ambulatory care hub as a secondary care service for frail older adults with complex care needs.
- Guidance on implementing Frailty at the Front Door teams.
- A description of specialist inpatient care pathways for frail older adults.
- The ICPOP Older Persons' suite of metrics.
- Guidance on local governance structures for implementation oversight.
- A sample Heat Map for completion by local sites detailing the current state of play under each component of the Service Model using a RAG rating as follows: RED 'Required Component'; AMBER 'Developing Component'; GREEN 'Existing Component'.
- Appendix with suggested roles and responsibilities for each individual member of the teams as guidance to aid in recruitment of new posts.
- Age attuned data is available on the acute inpatient care journey through the Older Persons' Dashboard. Work is currently underway to develop the dashboard further to provide a single view of a local health economy across hospital and community to reflect the end to end Older Persons pathway. Access to the dashboard is granted following the submission of the application form included with this pack that should be submitted to the National Older Persons' Programme.
- Description of interRAI Assessment Tool.

\*Please note; In applying the above criteria when mapping resources the number of CHNs covered within a range between 2-4 rather than 3 in all cases.

# Enhanced Community Care Older Persons' Service Model – Implementation Guide



## The journey from Pilot Sites to National Scale Up

Over the past five years we have been on a journey of learning as to what should integrated care for older people look like in Ireland. That journey has largely depended on local clinical and managerial leaders in pilot sites around the country who volunteered their time to test elements of an end to end pathway in their local health systems and inform our national guidance. We are deeply indebted to all of those people and look forward to the next chapter as we collectively scale up the programme across the country.

Dr. Siobhan Kennelly  
NCAGL Older Persons

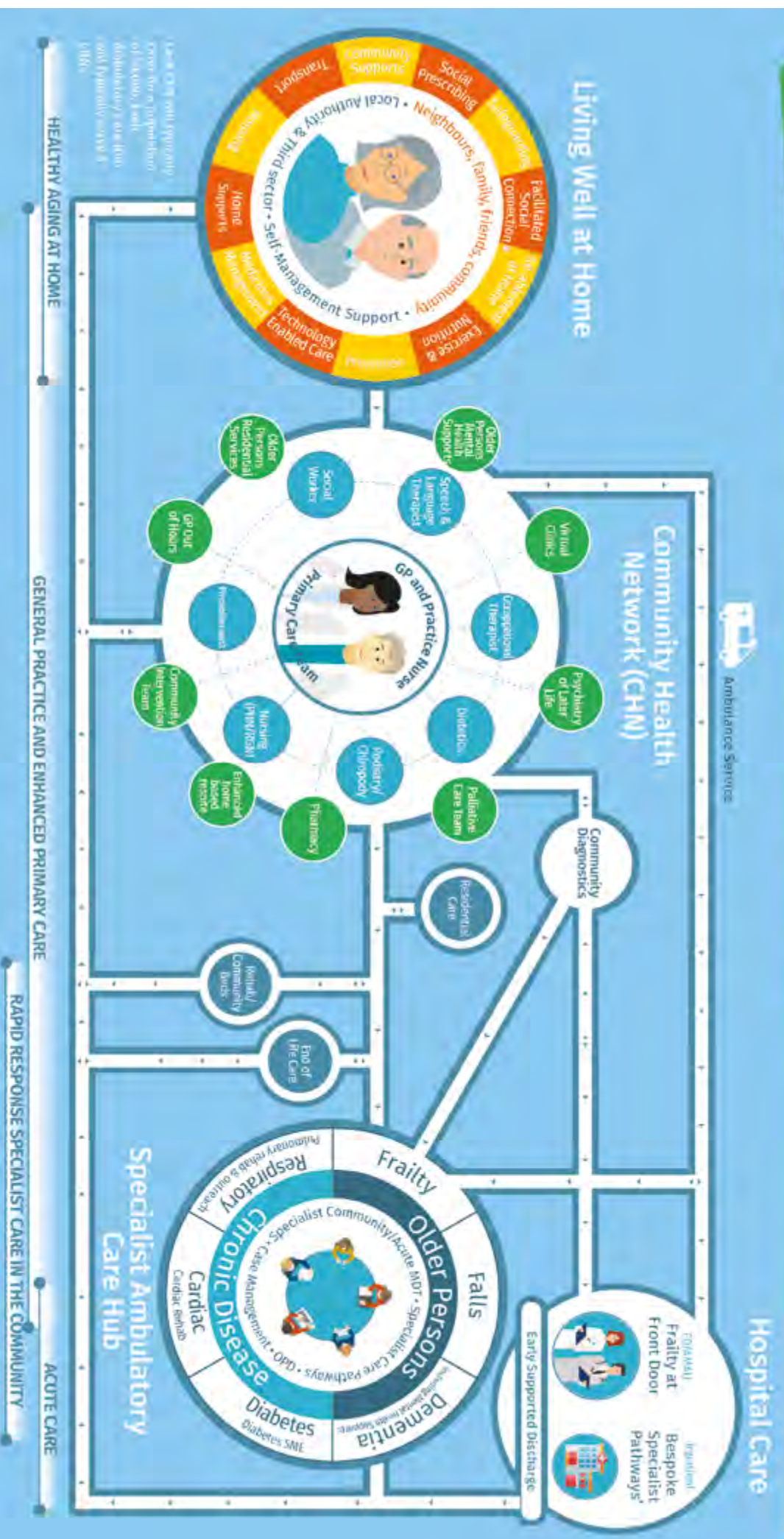
Mr. PJ Harnett  
AND Older Persons Strategy and Planning



# Older Persons/Chronic Disease Service Model

Shift Left of  
Resources & Activity

Least Intensive Setting / Care / Interventions



# Enhanced Community Care Implementation Pack

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# Enhanced Community Care Specialist Ambulatory Care Hub - Older Persons



A hub provides a service architecture around which integrated services can be further developed and it offers opportunities for emergent or disconnected service offerings to be connected-in. It also has the effect of streamlining care pathways, and in turn generating efficiencies. From a patient and carer perspective, it provides a single point of access and co-ordination, thus avoiding duplication of effort and sequential assessment.

## Team Structure

The proposed team structure is as follows:

Consultant Physician in Geriatric Medicine 0.5WTE  
(matched with 0.5WTE in ED)  
Senior Registrar 0.5 WTE (matched with 0.5WTE in ED)  
ANP General 1.0WTE, CNS General 1.0WTE  
Senior Occupational Therapist 1.0WTE  
Senior Physiotherapist 1.0WTE  
CNS Nursing Homes Outreach 1.0WTE  
SLT 0.5WTE, Dietician Senior 0.5WTE  
Senior Social Worker 1.0WTE  
Therapy Assistant Physio 1.0WTE  
Therapy Assistant OT 1.0WTE  
Operational Team Lead (Grade 8) 1.0WTE  
Grade IV 1.0WTE.

## Governance

Clinical governance is provided by the Specialist Geriatric Service (SGS). Operational Governance is provided by the Integrated Care Team Lead.

## Key Functions of an Ambulatory Care Hub

1. Primary care Community Health Network (CHN) liaison
2. Older Persons Streamlined Pathways
3. Nursing Home Outreach Support
4. Linkages with Frailty at the Front Door (FFD)
5. FFD functions

## Functions of the Team

The ambulatory hub will offer a single point of access for older persons with complex care offering:

- Single point of Access-Triage
- Standardised Assessment (interRAI)
- Appropriate Interventions
- Specialist care planning, pathways for falls, frailty, memory.
- Co-ordination with Home Care and Social Supports
- Signposting to supports to live well

## Key Linkages

*Integrated working within secondary care involving emergency physicians, geriatricians, acute physicians, nurses and therapists working closely with community mental and physical health and social care teams may provide the best model for decreasing admission, readmission, and minimising length of stay, morbidity and mortality.<sup>1</sup> Key linkages for the team include acute medicine, ED FFD Teams, Discharge Co-ordinators, Home Care Manager, Intermediate care facilities, Rehabilitative Care, GP, PCT, CIT, PHN's, Psychiatry of Later Life Team, Mental Health Services, NAS, Health and Wellbeing, Residential Care Facilities, NGO's, Local Authority.*

## Outcomes Measurement

- 10% reduction in admissions for >75's in ED's in hospitals, increasing to 20%.
- 10% reduction in acute hospital bed days used in the acute hospitals served by the specialist team.
- 20% reduction in proportion of >75's in acute hospitals served by the specialist teams referred to long term care via the acute hospital.
- 10% reduction in unscheduled re-admission rates of >75's discharged from the acute hospital in previous 28 days.





# Enhanced Community Care Frailty at the Front Door



The aim of the Frailty at the Front Door Team is to improve the experience and outcomes of older people >65 living with frailty presenting to acute services, and to reduce unnecessary hospital admissions, lengths of stay and re-admission rates for this cohort of patients. This is facilitated by;

**1. The timely screening for frailty using a validated tool, e.g. Prisma 7, Rockwood Frailty Scale, interRAI.**

**2. The commencement of a Comprehensive Geriatric Assessment for all patients >75 who screen positive for frailty**

**3. Co-ordinated case management of the onward patient journey through the hospital if admitted, or to home or other care settings if appropriate to discharge.**

## Team Structure

The proposed team structure is as follows

Consultant Physician in Geriatric Medicine 0.5WTE  
(matched with 0.5WTE in Community)

Senior Registrar 0.5 WTE (matched with 0.5WTE in Community)

CNS General 1.0WTE

Senior Occupational Therapist 1.0WTE

Senior Physiotherapist 1.0WTE

Grade IV 1.0WTE

Therapy Assistant 1.0WTE.

## Governance

Clinical governance is provided by the Specialist Geriatric Service (SGS).

## Functions of the Team

1. Introduce screening for frailty in acute floor.
2. Initiate CGA in acute floor context (interRAI).
3. Implement bespoke care pathways in the acute floor to minimise PET
4. Adopt a HOME FIRST approach through multi-agency approach.
5. Undertake inreach and outreach functions to reduce AvLoS.

## Key Linkages

*Integrated working within secondary care involving emergency physicians, geriatricians, acute physicians, nurses and therapists working closely with community mental and physical health and social care teams may provide the best model for decreasing admission, readmission, and minimising length of stay, morbidity and mortality.<sup>1</sup> Key linkages for the team include acute medicine, ED FFD Teams, Discharge Co-ordinators, Home Care Manager, Intermediate care facilities, Rehabilitative Care, GP, PCT, CIT, PHN's, Psychiatry of Later Life Team, Mental Health Services, NAS, Health and Wellbeing, Residential Care Facilities, NGO's, Local Authority.*

## Outcomes Measurement

- 10% reduction in admissions for >75's in ED's in hospitals, increasing to 20%.
- 10% reduction in acute hospital bed days used in the acute hospitals served by the specialist team.
- 20% reduction in proportion of >75's in acute hospitals served by the specialist teams referred to long term care via the acute hospital.
- 10% reduction in unscheduled re-admission rates of >75's discharged from the acute hospital in previous 28 days.



# Enhanced Community Care Acute Inpatient Pathway of Care



## Acute Inpatient Pathway of Care

The National Clinical Programme for Older People (NCPOP, 2012) '*Specialists Geriatric Services Model of Care, Acute Service Provision*' outlines the inpatient pathway of care for older people. The core aim is to develop and implement specialist multidisciplinary geriatric services, with dedicated specialist in-patient wards, providing Comprehensive Geriatric Assessment (CGA), treatment, rehabilitation and appropriate discharge planning. This pathway for older persons supports better outcomes, reduced readmissions rates, reduced rates of long-term care use, reduced functional decline and improved quality of life.<sup>1, 2, 3</sup>

## Team Structure

The members of the Specialist Geriatric Team (SGT) are dedicated to the SGS with clinical reporting relationship to the consultant Geriatrician. The team should have an appropriate skill-mix of grades and should develop or maintain core competencies in this area. The SGTs core members are:

Consultant Geriatrician  
Clinical Nurse Specialist  
Physiotherapist  
Occupational Therapist  
Speech and Language Therapist  
Medical Social Worker  
Clinical Nutrition Services  
Business Management/Administration Support.

There should also be access to: orthoptist, pharmacist, psychologist/psychiatry of old age, podiatrist, audiologist and others.

## Governance

Clinical governance is provided by the Specialist Geriatric Service (SGS).

## Functions of the SGS and SGT

### Patient inflow (Ingress)

- Each Specialist Geriatric Service (SGS) has defined and agreed criteria with their Emergency Department (ED), AMAU and Community to determine whether a patient should be referred to the Specialist Geriatric Team (SGT).
- The SGS links with the ED/AMAU when an older person at risk is identified as requiring referral including timely commencement of Comprehensive Geriatric Assessment (interRAI) or admission to a Specialist Geriatric Ward (SGW).
- Once referred, decisions about the appropriate SGS to meet the patients need are made by a senior professional to a specified time-frame supported by care needs assessment data..
- Each hospital receiving acutely ill older adults has a dedicated specialist Geriatric ward with appropriate staffing levels and a designated multidisciplinary specialist geriatric team.

### Patient Egress

- Each hospital has access to onsite and offsite rehabilitation beds and delivers a structured rehabilitation programme for older people.
- A systematic approach to integrated discharge planning is facilitated on admission of the frail older persons into an SGW with an SGT.
- Each SGS provides outpatient services, including sub-specialty clinics with rapid access slots for urgent referrals.
- Each hospital receiving acutely ill older adults has an ambulatory care hub (with access to diagnostics/therapy staff enabling 'rapid access', CGA and ongoing therapy to support Early Supported Discharge).
- Each SGS provides an outreach service prioritising patients in long term care referred by the GP or medical officer. The outreach service liaises with psychiatry of old age and supports training and education of community-based staff (supported by the NCPOP National Frailty Education Programme).

1 HSE and RCPI (2012) National Clinical Programme for Older People, Specialist Geriatric Services, Acute Model of Care. Accessed at: <https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/specialist-geriatric-services-model-of-care.pdf>

2 Ellis G, Gardner M, Tsiachristas A, Langhorne P, Burke O, Harwood RH, Conroy SP, Kircher T, Somme D, Saltvedt I, Wald H, O'Neill D, Robinson D, Shepperd S. Comprehensive geriatric assessment for older adults admitted to hospital. Cochrane Database of Systematic Reviews 2017, Issue 9. Art. No.: CD006211. DOI: 10.1002/14651858.CD006211.pub3

3 HSE and RCPI (2016) National Clinical Programme for Older People, Specialist Geriatric Team Guidance on Comprehensive Geriatric Assessment. Accessed at: <https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/comprehensive-geriatric-assessment-document-.pdf>

# Enhanced Community Care Acute Inpatient Pathway of Care



- Each hospital-based SGT has agreed protocols to facilitate communication with GP's and Primary Care Teams (PCTs). A single access point is established to support referral. Outcome of hospital assessment and care is communicated in a timely manner to the referral source.

## Key Linkages

Acute medicine, Emergency medicine, Stroke medicine, Ortho-geriatrics, Ambulatory care Hubs, General Practitioner, Primary Care Team, Community based Integrated Care Team, Community Intervention Team, Rehabilitative Care, Psychiatry of old age, Mental Health services, Palliative Care services, other specialists services and NGO's, Local Authority, family members/ carers.

## Outcomes Measurement

- 10% reduction in admissions for >75's in ED's in hospitals, increasing to 20%.
- 10% reduction in acute hospital bed days used in the acute hospitals served by the specialist team.
- 20% reduction in proportion of >75's in acute hospitals served by the specialist teams referred to long term care via the acute hospital.
- 10% reduction in unscheduled re-admission rates of >75's discharged from the acute hospital in previous 28 days.
- 50% reduction in waiting times for urgent OPD appointments on the Geriatric waiting lists in acute hospital services.

# Enhanced Community Care

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

Establishing a local governance structure across health and social care (including the third sector) with senior sponsorship is a fundamental starting point on the journey towards integrated services for older people (ICP OP 2018)\*. Slaintecare advocates the creation of an enabling environment to address implementation (Figure 1).

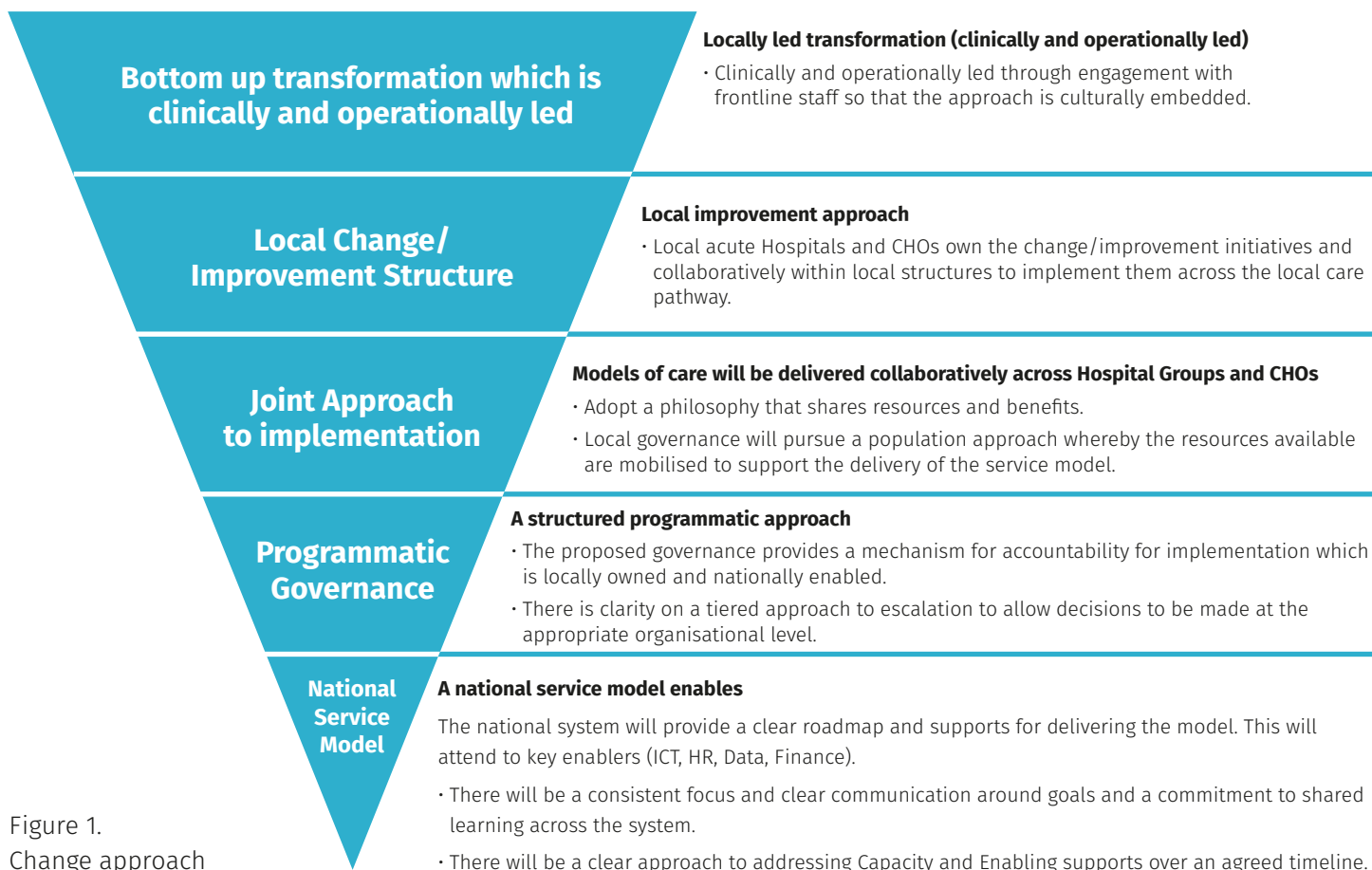


Figure 1.  
Change approach

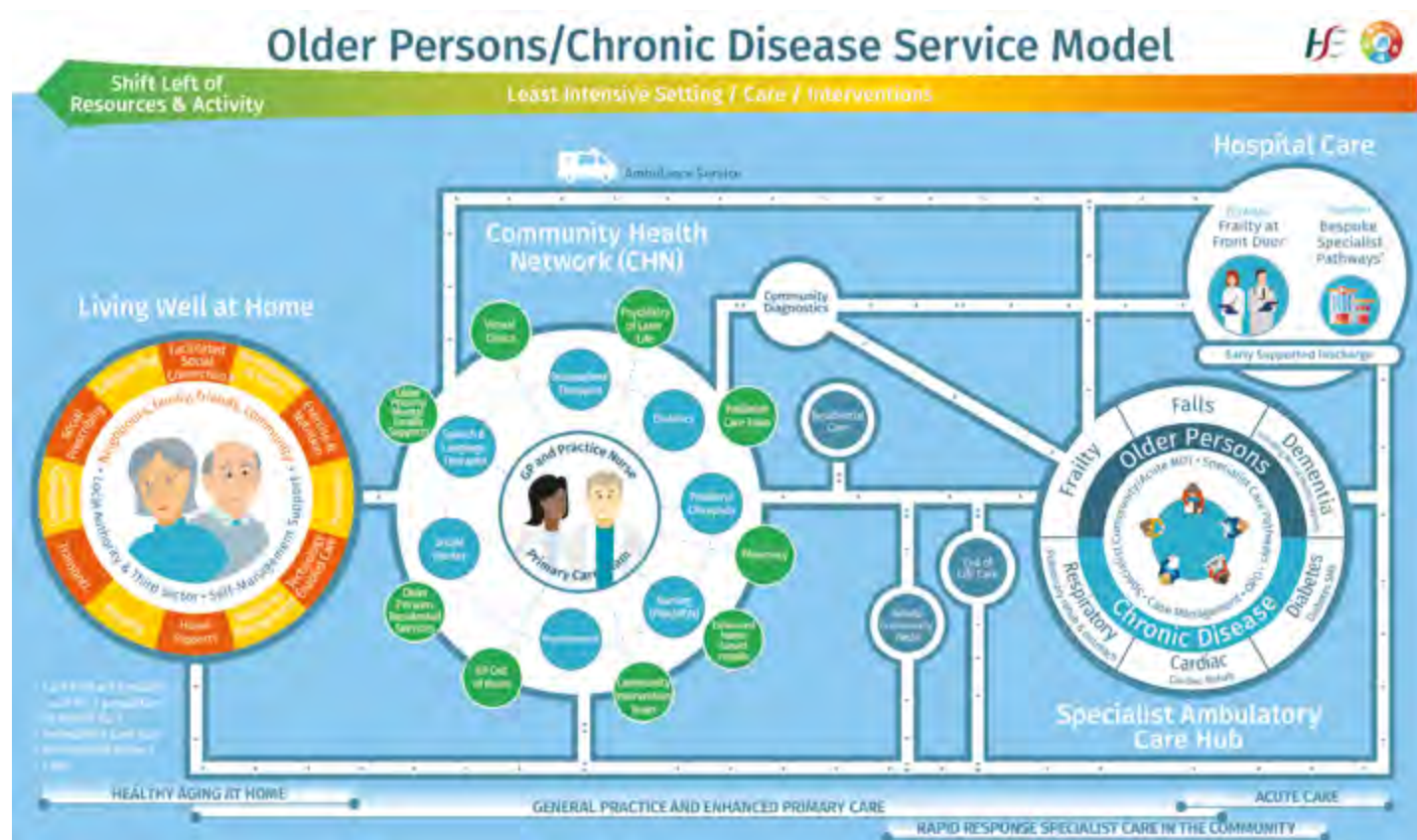
It is often the case that examples of governance are already well established in many areas, for example Area Crisis Management Teams or Winter Action Teams in the context of COVID or for specified purpose (e.g. discharge planning). The proposed governance builds on local informal professional and managerial networks. In the context of facilitating the change/reform agenda (Winter/NSP 2020/21 and corporate plan) the key function of the local governance group is to enable integrated service development to provide bespoke care pathways for older people/chronic disease. The governance group membership must be made up of senior decision makers and so membership must have sufficient seniority within their respective areas of responsibility to facilitate the implementation of the service model (Figure 2).

### They will focus on 5 key areas:

1. Provide operational oversight of service change.
2. Integrate service developments and exiting services into 1 coherent model locally (reflecting Fig 2).
3. Provide senior leadership on servicing integrated pathways (exemplified by shared resources/ personnel).
4. Support clinical and operational leadership in implementation of discrete service elements (e.g. Ambulatory Hub, FFD)
5. Facilitate delivery of enablers, particularly data collection in order to drive service improvement.



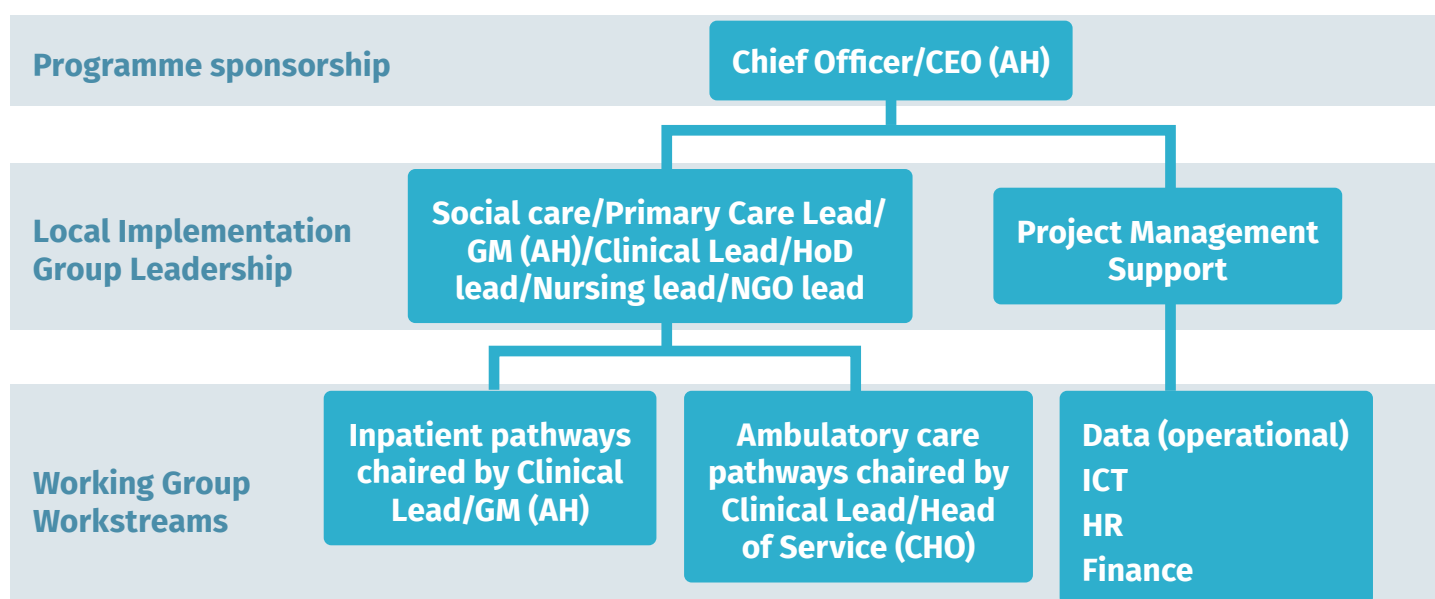
## Guidance on local governance structures to support implementation of integrated service model



*Figure 2. Older Person/Chronic Disease Service Model*

### 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 operational lead in each local health economy (CHO/AH) is essential.








# Enhanced Community Care

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

### Example of tasks for local implementation group/working group

AREA OF FOCUS	EXAMPLES OF KEY MEMBERS	KEY TASKS	DATA TO BE COLLECTED
<div>Living well with support</div> <div></div>	<ul style="list-style-type: none"><li>• Service User Representative</li><li>• Local Authority Age Friendly Programme Manager</li><li>• NGO rep</li><li>• Third Sector Organisations</li><li>• Health and Wellbeing Senior Management</li></ul>	<ul style="list-style-type: none"><li>• Asset Mapping of resources (e.g. mobilised during COVID)</li><li>• Focus on wider health ecosystem supports</li><li>• Participating in Frailty/Falls Prevention.</li><li>• Communications and awareness raising.</li></ul>	<div>Service Improvement Projects co-designed with service users.</div> <ul style="list-style-type: none"><li>• Referrals to preventative interventions.</li></ul>
<div>Ambulatory Care Pathways</div> <div></div>	<ul style="list-style-type: none"><li>• Clinical lead</li><li>• Primary Care Senior Management</li><li>• Social Care Senior Management</li><li>• GP Representative</li><li>• Senior PHN Representative</li><li>• HoD lead</li><li>• Home care lead</li><li>• CIT lead</li></ul>	<ul style="list-style-type: none"><li>• Demand and capacity planning (profiling population by CHN</li><li>• Profiling services (directory)</li><li>• Develop the hub as the primary point of access.</li><li>• Develop liaison /linkages between ambulatory hub/specialist community team acute hospital and primary care.</li><li>• Develop opportunistic case finding.</li><li>• Define specialist roles within the integrated care team e.g. CNS, ANP to service pathways</li><li>• Define and develop priority care pathways on falls, frailty, dementia</li><li>• Define Ambulatory HUB (SoP)</li></ul>	<ul style="list-style-type: none"><li>• Register of at risk older adults in CHN.</li><li>• No. of people with complex care needs identified and managed within the CHN.</li><li>• Number of patients on a caseload</li><li>• The number of patients on the MDT caseload during the reporting Period with:<div><div>High</div><div>Moderate</div><div>Low</div><div>Complex Care Needs</div></div>supported by care assessment data.</li><li>• Total number of patients on caseload with a completed CGA</li></ul>
<div>Inpatient pathways</div> <div></div>	<ul style="list-style-type: none"><li>• Community Therapy/ Rehab Management</li><li>• Clinical Lead</li><li>• AH Managerial Lead Integrated services</li><li>• HoD leads</li><li>• Senior Nursing lead</li><li>• Patient Flow Lead</li><li>• General Manager</li></ul>	<ul style="list-style-type: none"><li>• Adopt a Home First Focus.</li><li>• Plan pathway based on demand and capacity planning (use ICP OP dashboard)</li><li>• Develop Frailty at Front Door Function</li><li>• Cohort capacity for maximising flow</li><li>• Address early supported discharge component between care settings.</li></ul>	<ul style="list-style-type: none"><li>• No. of cohorted beds</li><li>• PET Times for &gt;75's</li><li>• No of patients screened positive for frailty</li><li>• No. of CGA's completed</li><li>• AvLOS for &gt;75's with complex needs</li></ul> <div>No. of patients discharged to MDT with care plan</div>

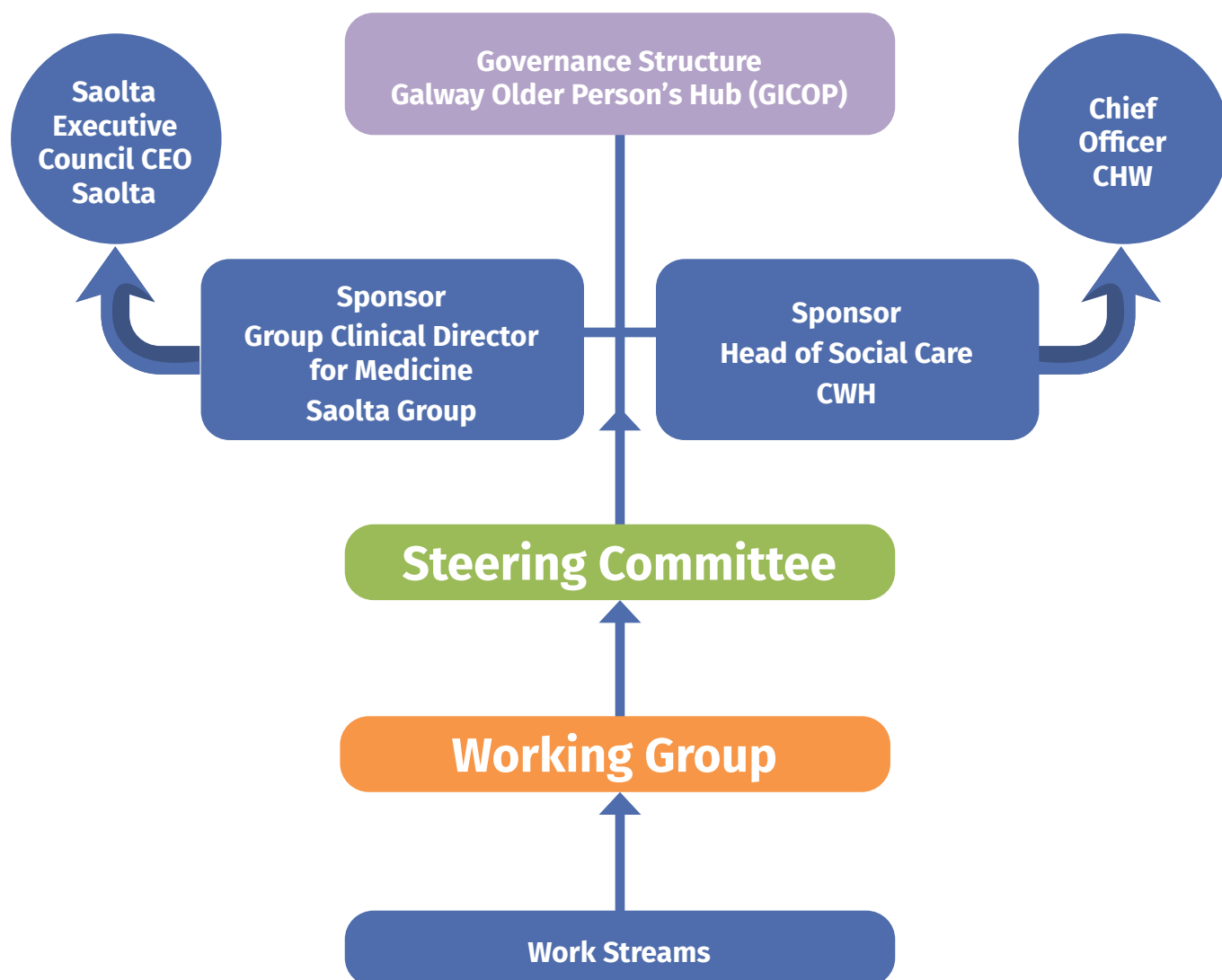
### The scope of the local implementation group would also address the following:

- To ensure the project remains aligned with the national service model and 10-step framework
- To ensure the project remains within scope, is implemented within agreed timelines and within allocated budget.
- Set up working group teams as required managing elements of the project work.
- To oversee the development and operation of the integrated care MDT 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 Older Persons Service Model.
- 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 older adults are offered to key staff locally (e.g. National Frailty Education Programme)

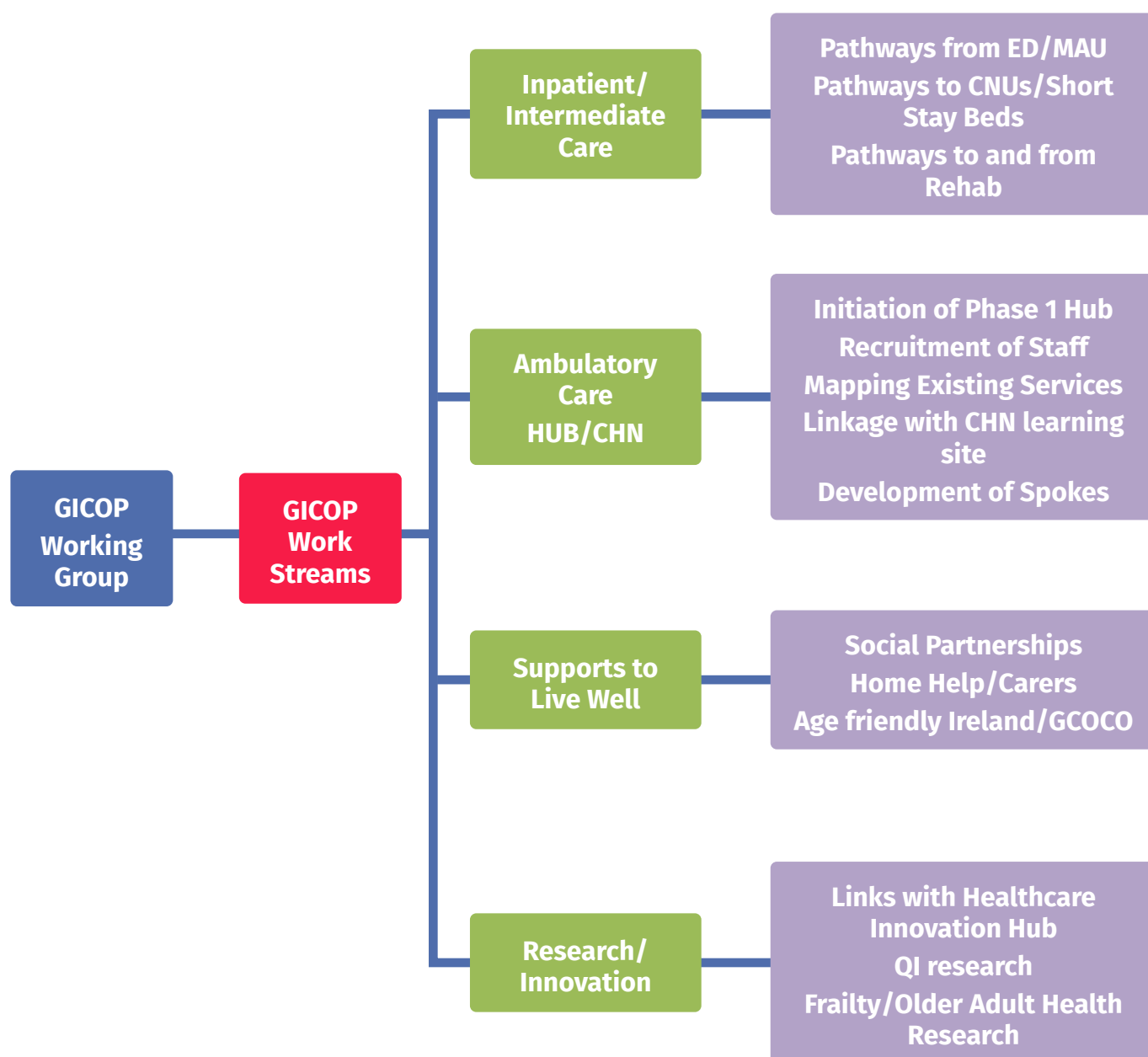
# Enhanced Community Care

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

Examples of local governance structures (Galway)



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



### References:

1. Collins, B (2016) New Care Models, Emerging Innovations in Governance and Organisational Form, The Kings Fund, London.
2. ICP OP (2020); Making a start in Integrated care for older persons – A practical guide to the implementation of integrated care programmes for Older Persons at [www.icpop.org](http://www.icpop.org) )
3. Jupp, B. (2015) Recognising accountability in an age of Integrated Care, The Nuffield Trust, London.
4. Nicholson, C. Jackson, C. Marley, J. (2013) A governance model for integrated primary/secondary care for the health-reforming first world. Results of a systematic review. BMC Health Services, Research, 13, 528.

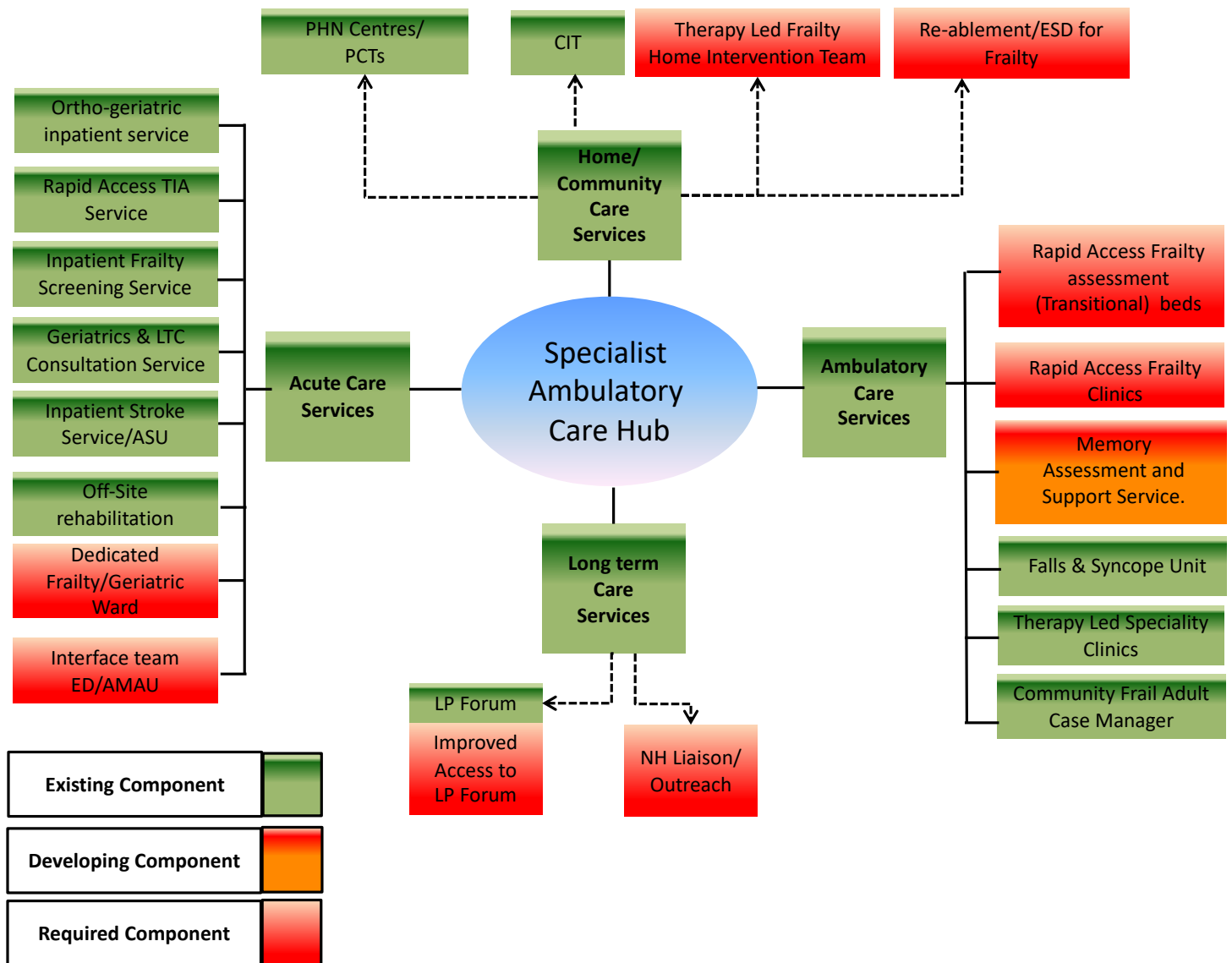


# Enhanced Community Care Suite of Metrics for OP pathway

Indicator	Primary Care Reporting	Integrated care reporting		
	Primary Care (Enablers)	Ambulatory/Community Care	Acute Floor	Acute Inpatient
<b>Structural</b>	'Register' of at risk older persons in place	Older persons with complex care needs can access a HUB which acts as a single point of contact for specialist MDT assessment There is an inreach function to the acute setting	A bespoke age attuned pathway is in place for older persons with complex care needs on the acute floor There is an inreach function to inpatients	Number of cohorted specialist bed days meets the demands of older persons with complex care needs. There is an outreach function to primary & community care
<b>Process</b>	Number of older persons recorded on the 'register' by Community Health Network  Receipt of MDT transfer of care plan within 24hours of discharge from acute hospital	The number of all patients <ul style="list-style-type: none"> <li>Referred</li> <li>Accepted on to caseload</li> <li>Discharged from caseload</li> <li>Remaining on the MDT caseload at close of business on the final day of the reporting period.</li> </ul>	<ul style="list-style-type: none"> <li>The total number of attendances on the acute floor aged &gt;75 years during the reporting period.</li> <li>The total number of acute floor attendances aged &gt;75 years who have received a screening assessment during the reporting period</li> <li>The number aged &gt;75 who screen positive for frailty following assessment</li> </ul>	AVLOS (Medical) <ul style="list-style-type: none"> <li>All Patients YTD 75+</li> <li>Age 75+ Excluding Those &gt;30 Days YTD</li> <li>Patients 75+ % Of Total Bed Occupancy YTD</li> <li>Patients 75+ Median LOS Over 30 Days</li> </ul>
		The number of patients on the MDT caseload during the reporting Period with: <ul style="list-style-type: none"> <li>High</li> <li>Moderate</li> <li>Low</li> </ul> Complex Care Needs	Total number of CGAs commenced by the MDT acute floor team during the reporting period	<ul style="list-style-type: none"> <li>Number of discharges from cohorted ward</li> <li>Number of patients in a cohorted ward discharged with an MDT transfer of care plan</li> </ul>
		Source of referral; <ul style="list-style-type: none"> <li>GP/Primary care team</li> <li>Self/relation/carer</li> <li>Acute floor</li> <li>Inpatient</li> <li>OPD</li> </ul> Acute Other	Total number of older persons >75 years re-attending within 7 days on the acute floor	<ul style="list-style-type: none"> <li>Number of cohorted beds</li> <li>Bed day demand</li> </ul>
		<ul style="list-style-type: none"> <li>Number of patients seen with a discharge destination of               <ol style="list-style-type: none"> <li>Home</li> <li>Tertiary care</li> <li>Long Term Care</li> </ol> </li> </ul>	Source of each referral within the reporting period. Either <ul style="list-style-type: none"> <li>•GP/PHN</li> <li>•Nursing Home</li> <li>•OPD/ Day Case</li> <li>• Self/Home</li> <li>•Ambulatory care hub</li> </ul>	
		<ul style="list-style-type: none"> <li>Total number of patients on caseload with a completed CGA</li> </ul>	Percentage of: <ul style="list-style-type: none"> <li>PET &lt; 6Hr 75+</li> <li>PET &lt; 9Hr 75+</li> <li>PET &lt; 24Hr 75+</li> </ul>	Percentage change from the same month in the preceding year. Indicate if increased or decreased
		<ul style="list-style-type: none"> <li>Number of patient questionnaires completed at entry, discharge and 3 months post e.g. EQ5D (PROMS)</li> <li>Number of Patient Narrative stories reviewed each quarter (PREMS)</li> </ul>	Admission rate (%) for older persons >75 years during the reporting period	
		<ul style="list-style-type: none"> <li>Number of older persons who have received the right level of care, at the right time in the most appropriate location closer to home will increase</li> <li>Patient experience will improve</li> </ul>	<ul style="list-style-type: none"> <li>PET times will meet national targets (HSE NSP 2019)</li> <li>Patient experience will improve</li> </ul>	<ul style="list-style-type: none"> <li>AVLOS targets will be age attuned in line with national standards (HSE NSP 2019)</li> <li>Patient experience will improve</li> </ul>
<b>Benefits</b>	Early identification of at risk cohort of patients in CHN	Alternative point of access in place that avoids acute hospital attendance.	Older persons attending the acute floor are triaged using a frailty screening tool PET times will improve	Older Persons with complex care needs have a care plan and the primary and ambulatory care teams are aware of the discharge and plan.
<b>Strategic Objective</b>	Improving Population Health	Delivering Care Closer to Home	Developing Specialist Hospital Care	Developing Specialist Hospital Care



# Enhanced Community Care Generic Heatmap



# Enhanced Community Care Suite of generic Job Roles & Responsibilities for Community ICP OP Teams October 2020

## Job Descriptions: Roles & Responsibilities

Examples of the roles and responsibilities of each team member are detailed below for sites to develop job descriptions to enable the recruitment process. Full example job descriptions are available for each post from the national ICP OP team by request.

## Details of the Integrated Care service/Background to the posts

Sláintecare has been designed to create a modern, responsive health and social care service which meets the changing needs of Ireland's population. The proposed new model of coordinated health and social care is needed to meet the needs of our older population, with its more complex set of clinical and social care needs, and to address the growing prevalence of chronic disease. (Sláintecare Report, 2017)

Implementing integrated services and pathways for older people with complex health and social care needs, enables a shift in the delivery of care from the acute hospitals towards community based, planned coordinated care. The objective of the National Integrated Care programme for Older People (NICPOP) is to improve the quality of life for older people by providing access to integrated care and support that is planned around their needs and choices, enabling them to live well in their own homes and communities (HSE, 2017).

The integrated older persons service is a specialist multidisciplinary service primarily targeting and managing the complex care needs of the older person with multiple co-morbidities across a continuum of care. The overall aims of the service are to:

- Provide a specialist geriatric opinion using a multidisciplinary approach to support older people with complex care needs.
- Implement Standardised Care Needs Assessment using interRAI assessments suite.
- Develop a person-centred care planning approach that supports robust and timely communication across care settings.
- Support appropriate and timely reduction of Emergency Department (ED) attendance through the development of care pathways that support GPs and others in assessment of older people with escalating care needs.
- Provide support and education to the older person, carers and healthcare professionals.

# Enhanced Community Care Suite of generic Job Roles & Responsibilities for Community ICP OP Teams October 2020

**Clinical Nurse Specialist: Gerontology**

**Clinical Nurse Specialist (Residential Care Facilities Older Persons Liaison)**

**Senior Dietitian**

**Consultant Physician in Geriatric Medicine (Shared Community / Acute) post**

**Administrative Officer, Grade IV**

**Medical Social Worker**

**Therapy Assistant (OT/Physiotherapy Assistant)**

**Senior Occupational Therapist**

**Older Persons Services Operational Team Lead, Grade 8**

**Registered Advanced Nurse Practitioner (RANP) (Older Persons)**

**Senior Physiotherapist**

**Senior Speech & Language Therapist**

**Specialist Registrar (Older Persons)**

**Older Persons Dashboard: User Agreement**

*The post holder's practice is based on the five core concepts of the CNSp. role as defined by the NCM 4th edition (2008). The concepts are:*

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

### Clinical Focus –

The CNSp. Gerontology – 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

*The CNSp. Gerontology – Integrated Care will:*

- Provide a specialist gerontological nursing service for older people in collaboration with the ICT who require support and treatment through the continuum of care.
- In collaboration with ICT colleagues undertake a comprehensive geriatric assessment to include physical, psychological, social and spiritual elements of care.
- Use the outcomes of assessment to develop and implement plans of care/case management in conjunction with the ICT team the older person, 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 ICT and patient, family and/or carer as appropriate.
- Make alterations in the management of patient's condition in collaboration with the ICT and the patient in line with agreed pathways and policies, procedures, protocols and guidelines (PPPG's).
- Accept appropriate referrals from IDT colleagues as per agreed referral arrangements.
- Co-ordinate investigations, treatment therapies and patient follow-up arrangements.
- 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 Health Professional Colleagues across Primary and Secondary Care to provide a seamless service delivery to the patient, family and/or carer.
- In consultation with medical and pharmacy colleagues support medication reviews taking cognisance of poly-pharmacy.
- Identify and promote specific symptom management strategies as well as the identification of triggers which may cause exacerbation of symptoms.
- Provide older people / their families 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 patients' needs.

### Indirect Care

- Collaborate with colleagues in Community Health Networks in the establishment, reform and planning of services that reflect a population health approach.
- Work with the ICT Lead and the Specialist Geriatric Team to ensure that the most appropriate patients are admitted directly under the Care of the Older Persons service.
- Provide expert advice to Health Care Professionals regarding patients not under the care of the Older Persons Service.
- Establish and agree methods of referrals from Acute / Community settings within an agreed governance structure.
- Participate in case review with MDT colleagues
- Use a case management approach to patients with complex needs in collaboration with ICT colleagues / Acute and Community services.
- Take a proactive role in the formulation and provision of evidence based PPPGs relevant to practice setting.
- Take a lead role in ensuring the service for older people is in line with best practice guidelines, Safer Better Healthcare Standards (HIQA, 2012) Residential Care Standards (HIQA, 2016).

### Patient/Client Advocate

- Communicate, negotiate and represent older person, family and/or carer values and decisions in relation to their condition in collaboration with ICT colleagues.
- 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



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### **Education & Training:**

- Maintain clinical competence in the management and care of the older adult, keeping up-to-date with relevant research to ensure the implementation of evidence based practice.
- Provide the older person, family and/or carer with appropriate information and other supportive interventions to increase their knowledge, skill and confidence in managing their condition.
- Contribute to the design, development and implementation of education programmes and resources for the older person, family and/or carer thus empowering them to self - manage their condition.
- Provide mentorship and preceptorship for nursing colleagues as appropriate.
- Participate in training programmes for nursing, ICT colleagues and key stakeholders as appropriate.
- Create exchange of learning opportunities within the ICT in relation to evidence based gerontological nursing 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 gerontological nursing care.
- Be responsible for addressing own continuing professional development needs.

### **Audit & Research:**

- Establish and maintain a register of older people within the CNSp. Gerontology – Integrated Care caseload.
- Maintain a record of clinically relevant data aligned to National Key Performance Indicators (KPI's) as directed and advised by the DPHN / ICT Lead
- Provide yearly reports/updates on caseload and activity levels as required for service planning.
- Identify, initiate and conduct nursing and ICT audit and research projects relevant to the area of practice.
- Identify, critically analyse, disseminate and integrate best evidence relating to gerontological care.
- Contribute to nursing research on all aspects of gerontological 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 (insert agreed KPIs/clinical targets) which will provide evidence of the effectiveness of the CNSp. interventions undertaken 3 or 4 - Refer to the National Council for the Professional Development of Nursing and Midwifery 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 ICPOP KPIs. 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 Health Professional colleagues (Acute and Community).

### **Consultant:**

- Provide leadership in clinical practice and act as a resource and role model for gerontological nursing practice.
- Generate and contribute to the development of clinical standards and guidelines and support implementation.
- Use specialist gerontological nursing knowledge to support and enhance generalist nursing practice.
- Develop collaborative working relationships with local CNSp. Gerontology, Registered Advanced Nurse /ICT colleagues as appropriate, developing person centred care pathways to promote an integrated model of care delivery.
- With the support of the ICT lead / DPHN, 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 Integrated Care Programme Older People (ICPOP) [www.hse.ie/nora](http://www.hse.ie/nora)
- and the National Clinical Programme for Older People (NCPOP) <http://www.hse.ie/eng/about/Who/clinical/natclinprog/olderpeopleprogramme/geriatric.pdf>

Network with other CNSp. in related professional associations.

*The post holder's practice is based on the five core concepts of Clinical Nurse Specialist 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 (Residential Care Facilities Older Persons Liaison) 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

*The CNSp. Residential Care Facilities Older Persons Liaison will:*

- Provide expert specialist gerontological advice & nursing input for older people living with frailty and with complex care needs in RCFs who require support and treatment through the continuum of care.
- Within the multidisciplinary context support the decision-making process on the appropriateness of potential decisions to escalate patient management/ transfer to acute hospital setting where this part of an expanded core integrated care team function.
- Undertake comprehensive assessment to include physical, psychological, social and spiritual elements of care using best evidence based gerontological nursing practice as directed by the integrated care team clinical lead.
- Use the outcomes of patient assessment to develop and implement integrated plans of care/case management in conjunction with the multi-disciplinary team (MDT) and the resident, family and/or carer as appropriate.
- Monitor and evaluate the resident's response to treatment and amend the plan of care accordingly in conjunction with the MDT and resident, family and/or carer as appropriate.
- Make alterations in the management of resident'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 resident, family and /or carer as appropriate, to assess their 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 resident, family and/or carer as appropriate.
- In consultation with the Integrated Care Team Clinical Lead participate in medication reconciliation taking cognisance of poly-pharmacy and support medical and pharmacy staff with medication reviews and medication management where this is part of an expanded core integrated team function.
- Identify and promote specific symptom management strategies as well as the identification of triggers which may cause exacerbation of symptoms.
- Identify health promotion priorities for the resident, 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 resident's needs.
- Promote and support the use of National Transfer Document for use when an older person is being transferred from Residential to Acute Care Settings.

### Indirect Care

*The CNSp. Residential Care Facilities Older Persons Liaison will:*

- Collaborate with colleagues in Community Health Networks in the establishment, reform and planning of services that reflect a population health approach.
- Identify and agree appropriate referral pathways for the older person.
- Participate in case review with MDT colleagues.
- Use a case management approach to patients with complex needs in collaboration with MDT in Primary and Secondary Care as appropriate.
- Take a proactive role in the formulation and provision of evidence based PPPGs relating to practice setting.
- Take a lead role in ensuring the service for the older person patients is in line with best practice guidelines and the Safer Better Healthcare Standards (HIQA, 2012), Residential Care Standards (HIQA, 2016).

### Patient/Client Advocate

*The CNSp. Residential Care Facilities Older Persons Liaison will:*

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

Education & Training:

The CNSp. Residential Care Facilities Older Persons Liaison will:

- Maintain clinical competence in the management and care of the older adult, keeping up-to-date with relevant research to ensure the implementation of evidence based practice.
- Provide the resident, family and/or carer with appropriate information and other supportive interventions to increase their knowledge, skill and confidence in managing their condition.

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- Contribute to the design, development and implementation of education programmes for the older person, family and/or carer thus empowering them to self - manage their condition.
- Provide mentorship and preceptorship for nursing colleagues as appropriate.
- Participate in training programmes including the National Frailty Education Programme, National Dementia Office - Dementia Education Programmes for nursing, MDT colleagues and key stakeholders as appropriate.
- Create exchange of learning opportunities within the MDT in relation to evidence based gerontological nursing care delivery through journal clubs, conferences.
- 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 gerontological nursing care.
- Be responsible for addressing own continuing professional development needs.

**Audit & Research:*****The CNSp. Residential Care Facilities Older Persons Liaison will:***

- Establish and maintain a register of older people 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 DoN.
- 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 gerontological care.
- Contribute to nursing research on all aspects of gerontological 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 which will provide evidence of the effectiveness of Clinical Nurse Specialist (Residential Care Facilities Older Persons Liaison) interventions undertaken 3 or 4 - Refer to the National Council for the Professional Development of Nursing and Midwifery 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 NICPOP & ICPOP Sites. 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:*****The CNSp. Residential Care Facilities Older Persons Liaison will:***

- Provide leadership in clinical practice and act as a resource and role model for gerontological nursing 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 CNSp. Gerontology, Registered Advanced Nurse Practitioners Older persons/Acute Medicine/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 Older Persons – Acute Service Provision Model of Care. Integrated Care Programme Older Persons – 10 steps Framework.
- Network with other Clinical Nurse Specialists in Older Persons Integrated Care/ Chronic Disease Management in related professional associations.

*The Senior Dietitian will:*

### Professional

- Provide expert opinion, advice and guidance to dietetic colleagues, medical team members and other health professionals working in xxxx Integrated Care Programme for Older People.
- Demonstrate advanced ethical awareness and responsibility in team approach to service delivery to patients.
- Recognise and respect the roles of other professionals within HSE xxxx Integrated Care Programme for Older People.
- 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.
- Integrate specialist knowledge from all relevant professionals in the development of guidelines / standards / protocols / policies.
- Establish, maintain and improve procedures for collaboration and cooperation between Acute Services, Primary Care and Voluntary Organisations as appropriate.
- Promote a high standard of service.
- Be aware of national policy, guidelines and consultations and in conjunction with the Dietitian Manager, develop local policies and care pathways within this specialist area.
- Develop and maintain high standards of dietetic clinical practice within Integrated Care Programme for Older People.
- Understand and participate in the Health Services strategy programmes.
- Generate new concepts, knowledge and skills, in order to develop and promote the Senior Dietitian role within the health service.
- Set and monitor performance standards.
- Seek ways to benchmark and assure quality of dietetic clinical practice within HSE xxxx Integrated Care Programme for Older People.
- Undertake audit to establish service needs and monitor current service.

### Service Delivery, Planning and Development

- Collaborate with colleagues in Community Health Networks in the establishment, reform and planning of services that reflect a population health approach.
- Negotiate strategic plans for service delivery in conjunction with line manager.
- Develop innovative models of dietetic care and service delivery in HSE Integrated Care Programme for Older People.
- Liaise with line manager and with other departments to ensure safe and effective service delivery consistent with health service management strategies.
- Take responsibility for achieving service delivery targets by monitoring, recording and reporting activity levels.
- Provide expert opinion, advice and guidance to the Integrated Care Programme for Older People.
- Collaborate with relevant stakeholders in relation to the strategic direction of the service.
- Generate innovative solutions to continuously improve results.
- Facilitate change where necessary in order to maintain services at an optimal level.
- Be involved in healthcare reform initiatives relevant to HSE Integrated Care Programme for Older People.
- Participate in setting national dietetic standards for older people services within the HSE.
- Provide leadership in nutrition support.

### Research

- Use a broad range of resources to identify key issues that may impact on dietetic practice within HSE Integrated Care Programme for Older People.
- Critically evaluate and draw sound conclusions from evidence available pertaining to the dietetic care of older people.
- Evaluate effectiveness and outcome of any new or altered therapies implemented and revises practice based on results.
- Actively support and contribute to journal clubs and relevant special interest groups. Forms links with research-associated bodies, as appropriate.

### Education and Development

- Engage with professional disciplines & academic / training institutions in developing and evaluating educational programmes / modules in dietetics in care of older people.
- Contribute where appropriate to the implementation and delivery of these programmes
- Contribute to the critical assessment of participants undertaking such modules, as deemed appropriate by the institution / discipline.
- Formulate programmes to achieve agreed learning objectives of others at local departmental level as well as at national level.
- Actively participate in a structured CPD process.
- Be involved in the collection, processing and analysis of data, for use as a national resource.
- Disseminate advanced clinical practice guidelines.
- Produce current, clear, evidence-based resources for patients and carers, and / or health professionals, suitable for use locally and / or nationally.
- Represent governing body at relevant local and national working parties to develop new local and / or national guidelines and policies pertinent to dietetics and care of older people.
- Act as a resource, both regionally and nationally in nutritional needs and care of older people.
- Lead protocol / standards / policy / guideline development.

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**Leadership / Operational**

- Accept leadership roles in local or national committees and organisations to promote nutrition and dietetic practice in integrated care of older people.
- Encourage and inspire others to work to high standards of clinical practice by being an effective motivator.
- Use new evidence-based practice initiatives and evaluate performance.
- Regularly update skills, advance knowledge and reflect on their own practice.
- Act as a resource and share information with team members and other health professionals.
- Ensure involvement of staff in the development and in the implementation of clinical pathways.
- Support / guide entry level staff in developing, evaluating and auditing in the care of older people.
- Guide and direct the work of others and be responsible for the proper use of resources.
- 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.
- Support, promote and actively participate in sustainable energy, water and waste initiatives to create a more sustainable, low carbon and efficient health service.

### Consultant Physician in Geriatric Medicine (Shared Community / Acute) post

- Provision of advice, screening, assessment and intervention to maximise the independence of older people and enable them to live in the community
- Lead out on the development of clear pathways and referral models (in conjunction with ICP OP MDT) where appropriate and facilitating earlier discharge /admission avoidance
- Enable through ICP OP, a single point of contact for Geriatric Services (ambulatory hub approach) for all stakeholders including GPs, providing interface between acute and community services
- Provide specialist geriatric services to residential care facilities to develop gerontologically attuned care plans with emphasis on medication reviews and end of life care planning
- Put in place ongoing educational programme for colleagues in community and acute care
- Clinical Lead for xxx Clinical Network Hub for Care of Older Persons linking ambulatory care, acute care and community/residential settings
- Visits to Community hospitals / Local Placement forum

#### **The post holder will be appointed to xxx Community Healthcare/University Hospital xxx with assignment to both acute hospital and xxx Community Services**

- (1) To attend at such times as may be determined by the General Manager of xxx or other designated officer, and in emergencies as required, and to remain in attendance there at as long as his/her services are required.
- (2) To attend as required at any clinic maintained by xxx and to provide either there at or in the appropriate hospitals, a diagnosis, treatment or consultant service as may be appropriate for or in respect of eligible patients.
- (3) To visit regularly and be responsible for the medical care and treatment of patients under his/her charge in the hospital.
- (4) To participate in the development of and undertake all duties and functions pertinent to the Consultant's area of competence, as set out within the Service Plan and in line with policies as specified by the Employer.
- (5) To ensure that duties and functions are undertaken in a manner that minimises delays for patients and possible disruption of services.
- (6) To work within the framework of the hospital/agency's service plan and /or levels of service (volume, types etc.) as determined by the Employer. Service planning for individual clinical services will be progressed through arrangements as apply.
- (7) To co-operate with the expeditious implementation of the Disciplinary Procedure.
- (8) To formally review the execution of the ICP OP and Service Plan with the Clinical Director/Employer periodically. The Service Plan shall be reviewed periodically at the request of the Consultant or Clinical Director/ Employer. The Consultant may initially seek internal review of the determinations of the Clinical director regarding the Service Plan.
- (9) To participate in the development and operation of existing and emerging structures and in such management or representative structures as are in place or being developed. The consultant shall receive training and support to enable him/her to participate fully in such structures.
- (10) To provide, as appropriate, consultation in the Consultant's area of designated expertise in respect of patients of other Consultants at their request.
- (11) To ensure in consultation with the Clinical Director that appropriate medical cover is available at all times having due regard to the implementation of the European Working Time Directive as it relates to doctors in training.
- (12) To supervise and be responsible for diagnosis, treatment and care provided by non-Consultant Hospital Doctors (NCHDs) treating patients under the Consultant's care.
- (13) To participate as a right obligation in selection process for non-Consultant Hospital Doctors and other staff as appropriate. The employer will provide training as required. The Employer shall ensure that a consultant representative of the relevant specialty/sub-specialty is involved in the selection process
- (14) To participate in clinical audit and proactive risk management and facilitate production of all data/information required for same in accordance with regulatory, statutory and corporate policies and procedures.
- (15) To participate in and facilitate production of all data/information required to validate delivery of duties and functions and inform planning and management of service delivery.
- (16) To ensure that infection control policies and guidelines are followed in their area of work/responsibility.
- (17) To ensure that all Health and Safety regulations are rigidly adhered to in their area of work/responsibility.
- (18) To provide, maintain and verify all relevant information required by the HSE and to formulate accurate inputs to service planning and the review of the service performance.
- (19) To perform such other duties appropriate to the officer as may be assigned to him/her by the General Manager xxx Community Healthcare
- (20) To Collaborate with colleagues in Community Health Networks in the establishment, reform and planning of services that reflect a population health approach.

#### Administrative Officer, Grade IV

- To support the integrated care pathway lead and team..
- To provide the necessary administrative supports to optimise patient flows in the integrated care pathway.
- To ensure the efficient day to day administration in designated areas of responsibility.
- To ensure that deadlines are met and that service levels are maintained
- To assist in maintaining the necessary administrative records and to ensure that all documentation is filed correctly and kept readily available for the required disclosure period.
- To work as part of a team, ensuring that all members are treated with dignity and respect
- To ensure that service users are treated with dignity and respect.
- To supervise and ensure the well being of staff within supervisory remit as applicable.
- To contribute to quality assurance by assisting in data collection/audit.
- To maintain at all times accurate attention to detail and consistent adherence to standard operating procedures.
- To embrace change and adapt local work practices accordingly.
- To collate reports and statistics as required by the Integrated Care Team and others from time to time.
- To provide any other administrative support as requested.

### Professional / Clinical

- The person holding this post is required to support the principle that the care of the patient comes first at all times and will approach their work with the flexibility and enthusiasm necessary to make this principle a reality for every patient to the greatest possible degree
- Maintain throughout the service awareness of the primacy of the patient in relation to all hospital activities.
- To provide a comprehensive social work service as part of a multidisciplinary team
- To provide counselling, emotional and practical support to patients and their families which will assist them in developing strategies to cope with the psychosocial and emotional impact of illness
- Carry out social assessments where social issues are a factor in illness management and advise the MDT on assessment outcomes
- To provide clinical input into Common Geriatric Assessments and care planning processes.
- To deliver integrated care for people referred, through liaison and collaboration with hub team members initially, and stakeholders as relevant within the CHO, hospital, private and voluntary sectors, in accordance with GDPR and confidentiality principles and policy
- To contribute to the design, implementation and quality assurance of integrated multidisciplinary clinical care pathways in dementia and frailty.
- To be a resource to the MDT regarding the psychosocial aspects of the patient's life which may impact on ability to cope with illness
- Assist in care planning in the context of the MDT
- To consult and liaise with other agencies
- To Collaborate with colleagues in Community Health Networks in the establishment, reform and planning of services that reflect a population health approach.
- Ensure the delivery of social work services in accordance with legislation, policies and procedures, guidelines and protocol
- Participate in development of a Community Social Work Service in CHO xx
- Keep adequate records
- Perform other duties as may be assigned from time to time by the Principal Social Worker and/or Service Lead
- Take an active role in appropriate level of planned professional supervision in accordance with local/national policy

### Education & Training:

- Maintain standards of practice and levels of professional knowledge by monitoring and reviewing the standards within your area of responsibility, participating in and organising continuous professional development initiatives and professional development planning.
- Keep updated on current and impending legislation and the perceived impact on practice.
- Keep abreast of developments in national policies and strategies and international best practice.
- Keep up to date with organisational developments within the Irish Health and Social Services.
- Actively engage in staff development and training by making recommendations with regard to the ongoing education, mentoring, training and in-service needs of social work team.
- Act as a resource by participating in and promoting the education and training of Social Work colleagues, other health professionals and service user groups including clinical audit and research.
- Foster an understanding of the role and contribution of social work by providing professional consultation and education to other members of the service.

### KPI's:

- The identification and development of Key Performance Indicators (KPIs) which are congruent with the development of GICOP 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.
- To engage in service audit and evaluation

### 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 Hospital Building 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 Hospitals 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.
- It is the post holders' specific 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 responsibility of the post holder to be aware of and comply with the HSE Health Care Records Management / Integrated Discharge Planning / (HCRM / IDP) Code of Practice.



## Therapy Assistant (OT/Physiotherapy Assistant)

Assist clients with rehabilitation exercises at home as directed and instructed by physiotherapist.

- Assist in providing exercises and interventions related to continence promotion, including pelvic floor exercises, checking patient fluid/voiding diaries, provision of and reading of information leaflets - all as directed by nurse specialist/consultant.
- Assist in attending to the personal care needs of clients who are recovering from acute illness (includes bathing, toileting etc), moving and handling of patients/ clients, feeding, fitting of equipment etc as directed, where necessary.
- Conduct questionnaires/surveys/feedback forms on patients and relatives, as directed.
- Assist in information provision on services, as directed.
- Be responsible for the transport of clients' medical charts, equipment and products etc to and from their homes as necessary.
- Ensure recording in clients' charts of actions, maintaining up to date records.
- May involve basic IT work of entering data into computerised spreadsheet or word documents, all as directed.
  - Respect patients/ clients and their families showing dignity, courtesy and professionalism at all times.
  - Maintain the confidentiality of all information made available to him / her during the course of his / her work.
  - Act as an advocate for patients/ clients, as appropriate.
  - Assist in the provision of a quality service and work in line with national and locally devised policies and regulations.
  - Maintain a strict code of personal and general hygiene in the workplace as per work schedules and existing policies and procedures.
  - Carry assigned bleep/phone and be contactable at all times while on duty.

### Health & Safety

#### *The Therapy Assistant will:*

- In accordance with Health and Safety at work policy, it is each staff members responsibility to observe all rules relating to Health and Safety and Conduct at Work and to use any equipment provided in a safe and responsible manner.
- Understand and adhere to all relevant HSE policies, guidelines and procedures, comply
- with health and safety, infection control and risk management procedures, comply with statutory obligations.
- Report any incident or potential incident which may compromise the health and safety of patient/ clients / residents, staff or visitors and take appropriate action.
- Report any accidents, near misses to the person in charge and ensure completion of incident / near miss forms.
- Not undertake any duty related to patient/ client / resident, care for which he/she is not trained.
- Attend training courses as required e.g. CPR, Hygiene, HACCP, Fire Prevention etc.
- Conduct his / herself in a manner that ensures safe patient/ client care.

### Education & Training

#### *The Therapy Assistant will:*

- As directed, attend induction and mandatory in-service education
- As directed, participate in the induction of new staff
- Maintain continuous personal and participate in team-based development, education, training and learning.
- Participate in appraisal and the development of a personal development plan in conjunction with his / her line manager.

### Administrative Duties:

#### *The Therapy Assistant will:*

- Attend staff meetings and contribute constructively to the smooth running of the unit
- To Collaborate with colleagues in Community Health Networks in the establishment, reform and planning of services that reflect a population health approach.

Contribute to the maintenance of updating of patient/ client / resident documentation

### Professional / Clinical

#### *The Senior Occupational Therapist Occupational Therapist will:*

- Be responsible for the maintenance of standards of practice of self and staff appointed to clinical / designated area(s)
- Be responsible for managing own caseload and for assessment, planning, implementation and evaluation of treatment programmes for service users according to service standards
- 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
- Ensure the quality of documentation of all assessments, treatment plans, progress notes, reports and discharge summaries are in accordance with local service and professional standards
- Foster and maintain professional working relationships with colleagues, front line managers, and other healthcare personnel in the team
- In conjunction with the Occupational Therapist Manager be involved in service planning and development by anticipating the changing needs of the service and service users for the inpatient service
- Provide direction and support to ensure the continuing development of the occupational therapy staff grades and students in the Occupational Therapy Service
- Demonstrate a commitment to research and evidence based practice, identifying and contributing to research, clinical evaluation and audit opportunities
- Assist /be responsible as designated for the day-to-day running of the Integrated Care Team for Older Persons Occupational Therapy Service by supervising staff, prioritising and allocating work
- Communicate verbally and / or in writing results of assessments, treatment / intervention programmes and recommendations to the team and relevant others in accordance with service policy
- Liaise closely with MDT members in the Hospital and the community setting (PCCC) to avoid duplication of services and maximise patient outcomes and act as a key worker for particular cases if required
- Coordinate and link with PCCC colleagues in the team catchment area.
- Participate in teams as appropriate, communicating and working in co-operation with other team members
- Undertake cognitive assessments to support the Consultant Geriatrician and team in assessing and planning the care for clients post diagnosis; including assessment and prescription of memory and assistive enabling devices and technology for cognitive rehabilitation / support
- Attend review meetings, team meetings, case conferences, ward rounds etc. as designated by Occupational Therapist Manager
- Ensure that staff in the designated service area(s) arrange and carry out duties in a timely manner, within settings appropriate to service user's needs, and in line with local policy/guidelines
- Be responsible for adhering to existing standards and protocols and for leading out on the development and maintenance of standards / strategies for quality improvement and outcome measurement
- Coordinate and run essential stock for supply to clients in the catchment area
- Seek advice and assistance with any assigned duties in line with principles of evidence based practice and clinical governance
- Be responsible for promoting positive staff morale and team working in conjunction with the Occupational Therapist Manager
- Incorporates national and international Evidence Based Occupational Therapy Practice (EBOTP) into their practice
- Ensure that professional standards are maintained in relation to confidentiality, ethics and legislation
- Operate within the scope of Occupational Therapy practice within Ireland and in accordance with local guidelines
- Adhere to the Ethics for Occupational Therapists from CORU and the AOTI.

### Education and Training

#### *The Senior Occupational Therapist Occupational Therapist will:*

- Participate in all mandatory training programmes
- Participate in continuing professional development including in-service training, attending and presenting at conferences / courses relevant to practice, contributing to research etc. as agreed by the Occupational Therapist Manager
- Engage in professional clinical Occupational Therapist supervision as designated by the Occupational Therapist Manager
- Engage in peer support with Senior Occupational Therapist colleagues
- Be responsible for the direct supervision of Staff Grade Occupational Therapists and or Occupational Therapy Assistants assigned to them on the inpatient service
- Manage, participate and play a key role in the practice education of student therapists, undertaking fieldwork supervisor responsibilities as required
- Take part in teaching / training / supervision of other Occupational Therapy and non-Occupational Therapy staff / students and attend practice educator courses as appropriate
- Assist in the induction of newly hired / qualified occupational therapists as designated by the Occupational Therapist Manager
- Update knowledge of occupational therapy by personal study, attending lectures and courses
- Develop and maintain competence in current developments in all clinical areas relevant to their remit and the implications which they may have for clinical practice
- Participate in department run training programmes / courses in the speciality area for internal and external occupational therapists / specialist clinicians.

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### Research & Development

*The Senior Occupational Therapist Occupational Therapist will:*

- Undertake research relevant to their clinical practice in collaboration with peers / colleagues
- Promote occupational therapy practice in line with relevant research and evidence base
- Initiate or participate in innovations in uni / multidisciplinary practice In collaboration with the Occupational Therapist Manager and members of the multidisciplinary team
- Disseminate information through seminars and publications, as appropriate
- Network with other clinical specialists in the Association of Occupational Therapists of Ireland (AOTI), education providers and other professional bodies to exchange and enhance knowledge base and practice
- Engage with the relevant Advisory Group of the Association of Occupational Therapists of Ireland (AOTI).

### Health & Safety

*The Senior Occupational Therapist Occupational Therapist will:*

- Promote a safe working environment in accordance with Health and Safety legislation
- Be aware of and implement agreed policies, procedures and safe professional practice by adhering to relevant legislation, regulations and standards
- Actively participate in risk management issues, identify risks and take responsibility for appropriate action
- Ensure the safety of self and others, and the maintenance of safe environments and equipment used in Occupational Therapy in accordance with legislation
- Develop and promote quality standards of work and co-operate with quality assurance programmes
- Report any adverse incidents in accordance with organisational guidelines.

### Administrative

*The Senior Occupational Therapist Occupational Therapist will:*

- Collaborate with colleagues in Community Health Networks in the establishment, reform and planning of services that reflect a population health approach.
- Be responsible for the co-ordination and delivery of service in designated area(s)
- Review and allocate resources within the designated area, in collaboration with the Occupational Therapist Manager and relevant others
- Promote good working practice and uniformity of standards of best practice
- Promote quality by reviewing and evaluating the Occupational Therapy service regularly, identifying changing needs and opportunities to improve services, in collaboration with the Occupational Therapist Manager and relevant others
- Develop and implement service / business plans, quality initiatives, audits etc. and report on outcomes in collaboration with the Occupational Therapist Manager
- Collect and evaluate data about the service user group and demonstrate the achievement of the objectives of the service
- Oversee the upkeep of accurate Healthcare Records and other documentation in line with best clinical governance, organisational requirements and the Freedom of Information Act, GDPR and provide reports and other information / statistics as required
- Represent the department / team at meetings and conferences as appropriate
- Liaise with the Occupational Therapist Manager regarding the needs, interests and perspective of Occupational Therapy staff
- Promote good team working, and a culture that values diversity
- Participate in the management of Occupational Therapy stock and equipment in conjunction with the Occupational Therapist Manager and designated others
- Engage in IT developments as they apply to service user and service administration
- Keep up to date with developments within the organisation and the Irish Health Service
- Plan leave (including annual / study) within the inpatient staffing cohort to ensure that occupational therapy cover is adequate across the inpatient services
- Perform such other duties appropriate to the office as may be assigned by the Occupational Therapist Manager

### Operational responsibilities

1. Ensure the ambulatory care hub functions are fulfilled in accordance with its Operational Policy within the allocated budgetary framework by the provision of effective team leadership.
2. In collaboration with Network manager Heads of Discipline/ DPHNs and other staff, establish the hub as the single point of referral / contact for older persons services under the umbrella of the ambulatory care assessment centre
3. Develop with the clinical leader and team members in conjunction with the community effective structures to ensure the team fulfils its principal functions with its targeted client group.
4. Develop structures that support basic team functions such as triage, assessment, allocation and review of workloads and work closely with Ambulatory Outreach team lead.
5. Work with the CHN to support the population health planning function locally in order to use data for the purposes of case finding and working towards a model of risk stratification for older persons resource management.
6. Ensure that the services provided by the team are well organised, responsive, needs led, user focused and of the best quality.
7. Ensure that policies and procedures are in place, understood, accessible, reviewed and consistent with quality standards and recognised best practice.
8. Ensure the effective operational management of the team and to be responsible for ensuring the delivery of high quality appropriately targeted services that are in accordance with the objectives of ICP OP
9. Work with the clinical leader to ensure clinical services are developed and provided by the team that are evidence based and of the highest standard in accordance with recognised best practice.
10. Participate in the development of operational and clinical practices to ensure care pathways are integrated.
11. Ensure procedures are in place to support receipt of referrals, assessment, allocation and closing of cases. In particular ensuring systems are in place to register and review service users, to respond to referrals in a timely and appropriate fashion and to signpost to the correct clinical service
12. Ensure systems are in place to respond promptly, appropriately and in an open manner to complaints and queries about the work of the team.
13. Support the use of case management technology currently being developed and ensuring that staff are supported in the use of existing and emerging technology including e-referrals, healthlink.
14. Develop mechanisms to collate and report the work of the unit locally and nationally in line with nationally agreed KPIs as required

### Project/Change management

1. Support the development and implementation of services and models of care according to the agreed development plan for older persons services particularly in relation to the urgent ambulatory care model and proactive case management.
2. Input to support the development and implement new pathways of care and processes to manage older persons care needs in an innovative way and where possible outside the acute centre
3. Responsibility for proactively promoting a working environment which is consistent with a learning organization
4. Take a lead in creating a work environment that is responsive to local changes in service models or service user and carer needs.
5. Ensure that there is a team culture that is responsive to change based on emerging models of service delivery.
6. Utilise standardised and evidence-based project management and change management methodologies, work in a programmatic way to deliver change in conjunction with stakeholders, project teams and management
7. Manage project activities on a day to day basis in conjunction with local project teams.
8. Implement an integrated process for the identification and management of risks and issues in the operation of the specialist team
9. Map and plan for the management of dependencies and liaise with local project teams to ensure that dependencies are effectively managed.
10. Monitor the progress of the project providing progress reports for internal and external stakeholders, as required
11. Ensure that the appropriate level of project governance is in place, is maintained and is adhered to.

### People management

1. Ensure the efficient use of human resources ensuring safe levels of staffing which reflect the necessary and appropriate skill mix.
2. Ensure effective arrangements exist within the team to provide a forum for clinical decision making, monitoring of workloads and access to supervision for staff making use of professional advice where appropriate.
3. Ensure all staff are in receipt of regular appraisal and professional development liaising with professional heads and training departments as appropriate.
4. Ensure the best possible working relationships are developed within the team seeking input from professional heads as necessary.
5. Participate in the recruitment of staff within the team in liaison with professional heads and in accordance with the HSE's services selection procedures.
6. Develop and maintain procedures which result in good communication within the team, across the locality and with external/partner agencies.
7. Ensure systems are in place monitor sickness absence, annual leave, training and study leave, taking any appropriate action as required to ensure adequate staff availability to enable the team to fulfil its remit.

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### **Resource Management**

1. Responsible for the devolved nominal budgets within the team ensuring that the team works effectively within their allocated financial framework.
2. Identify any potential areas/events/situations that may have an adverse impact on financial expenditure for the service. This will include taking appropriate action to eliminate or minimise such adverse impact and informing the line Manager at the earliest possible opportunity.
3. Ensure that priorities are set and adhered to for the purchase and use of materials and equipment making recommendations for expenditure not within this control, based on assessment of priorities.
4. To ensure an agreed approach is in place for clinical and professional supervision of staff within the team

### **Performance Management**

1. Develop systems to monitor activity and provide regular feedback on the progress/activity of the team to the line manager and wider management team including the production of an Annual Report.
2. Ensure that the team works within the parameters of the ICP OP and local / national data requirements.
3. Work with the clinical leader and the clinical governance structures to implement performance systems to ensure services provided by the team are appropriate, effective and audited regularly.
4. Work with the clinical leader, other HSE managers and Professional Heads to ensure that national and local policy and recommendations are incorporated into practice.
5. Support the implementation of ICP OP information systems e.g. integrated case file, integrated care systems to ensure timely inputting of information by team members to support effective HSE reporting requirements.
6. Ensure that all staff, service users and visitors adhere to relevant legislation (e.g. Health and Safety at Work Act) and ensure that the HSE procedures are followed including staff attendance at mandatory training.

### **Community Network management**

1. Represent the service on the Local ECC Implementation group, Local Older persons workstreams, at meetings/forums/working groups as mutually agreed by line manager.
2. Ensure that the team interface effectively and proactively with other community services and agencies inside and outside of the HSE
3. Engage with National ICP OP, clinical programme, and Older persons strategy and planning and Primary care strategy and planning.
4. Identify and engage with relevant stakeholders, including patients and service users to enable co-design and evidence informed delivery of agreed outputs, outcomes and benefits. Ensure the promotion and development of seamless services for service users and carers across the CHN.
5. Develop and maintain the strong working relationships with GPs, Service Providers and Voluntary Groups.
6. Stakeholder analysis and mapping
7. Develop a Communication and engagement strategy
8. Co-ordinate and lead on stakeholder meetings

### **Self management**

1. Ensure that as a member of the team, you are fully aware of current developments and practice in older person's services / ambulatory care models
2. Attend regular management/professional supervision.
3. Through supervision and appraisal and discuss/identify/access training as appropriate. Be aware of, and reflect on, own practice as a manager/clinician.
4. Be aware of, and adhere to, all HSE policies, acting as a role model to other staff.
5. Manage time effectively.
6. Continue to meet professional standards of practice and relevant professional legislation.
7. Undertake other duties as requested by the line manager



## Registered Advanced Nurse Practitioner (RANP) (Older Persons)

The RANP (Older Persons) 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 RANP (Older Persons) has a duty and responsibility to demonstrate and practise.

### Domain 1: Professional Values and Conduct

#### Standard 1

*The RANP (Older Persons) 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 in the care of the frail older adult

The initial caseload and scope of practice for the RANP (Older Persons) is agreed as follows:

Older Adults referred to the Inpatient Rehabilitation service requiring RANP assessment.

Older Adults referred to the Integrated Care Team for Older Adults requiring RANP assessment and intervention.

### The inclusion criteria for the RANP (Older Persons) are as follows:

Rehabilitation Service: All older adults requiring pre rehabilitation RANP assessment across acute care UHLG.

Integrated Care Team for Older Adults which provides a specialist to older people living in the community, initial inclusion criteria being individuals over seventy five years of age with a Rockwood Frailty Scale score of 4-6. These criteria will be reviewed on a continuous basis in line with population need and demand.

### The exclusion criteria for the RANP (Older Persons) are as follows:

#### Adults under sixty five years of age.

- 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 RANP 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 being an eclectic approach which emphasises a caring therapeutic relationship between the RANP and his/her patients, recognising that RANPs work in partnership with their multidisciplinary colleagues.

- Articulating and promoting the RANP 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 RANP (Older Persons) will utilise advanced knowledge, skills, and abilities to engage in senior clinical decision making by:*

- Conducting a comprehensive holistic Geriatric 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 RANP (Older Persons) 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 (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

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- 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 RANP (Older Persons) will negotiate and advocate with other health professionals to ensure the beliefs, rights and wishes of the person are respected by:*

- Collaborate with colleagues in Community Health Networks in the establishment, reform and planning of services that reflect a population health approach.
- 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 RANP (Older Persons) 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 RANP (Older Persons) will lead in multidisciplinary team planning for transitions across the continuum of care by:*

- Demonstrating clinical leadership in the design and evaluation of services in the inpatient rehabilitation referral pathway and processes and in the Integrated Care team for Older Adults.
- Identifying gaps in the provision of care and services for older adults 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.

### Professional / Clinical

#### *The Senior Physiotherapist will:*

- 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
- Be a lead clinician in assigned, allocated clinical areas of responsibility and carry a clinical caseload appropriate to the post
- Take a lead role in service development as relevant to the role
- Lead a team of staff grades as appropriate to the role
- 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
- S/He may be required to work as a key worker for particular cases
- Be responsible for standards of professional and clinical practice of self and staff appointed to clinical / designated area(s) in line with the Scope of Practice of Irish Society of Chartered Physiotherapists and national, regional and local Health Service Executive (HSE) guidelines, policies, protocols and legislation
- Be a clinical resource for other Physiotherapists
- Plan and manage resources efficiently in assigned areas of responsibility
- 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)
- Apply health promotion as an ethos across the clinical area to promote health and wellbeing
- 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

### 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 co-ordination and delivery of a quality service in line with best practice and professional standards
- 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, monitor and uphold the standards of professional practice within their Physiotherapy team

### Administrative

#### *The Senior Physiotherapist will:*

- Collaborate with colleagues in Community Health Networks in the establishment, reform and planning of services that reflect a population health approach.
- 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

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### Senior Physiotherapist continued

- 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
- As a mandated person under the Children First Act 2015 you will have a legal obligation to report child protection concerns at or above a defined threshold to TUSLA & to assist Tusla, if requested, in assessing a concern which has been the subject of a mandated report
- 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.
- Support, promote and actively participate in sustainable energy, water and waste initiatives to create a more sustainable, low carbon and efficient health service.

### Professional / Clinical

#### *The Senior Speech & Language Therapist will:*

- Communicate and work in co-operation with the Speech & Language Therapy Manager, Consultant Geriatrician and other team members in providing an integrated quality service, taking the lead role as required.
- Be a lead clinician in assigned, allocated clinical areas of responsibility and carry a clinical caseload appropriate to the post
- Take a lead role in service development and ongoing evaluation as relevant to the role
- Lead a team of staff grades as appropriate to the role.
- 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
- S/He may be required to work as a key worker for particular cases.
- Be responsible for standards of professional and clinical practice of self and staff appointed to clinical / designated area(s) in line with Professional Scope of Practice and national, regional and local Health Service Executive (HSE) guidelines, policies, protocols and legislation.
- Be a clinical resource for other Speech & Language Therapists.
- Plan and manage resources efficiently in assigned areas of responsibility
- 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).
- Apply health promotion as an ethos across the clinical area to promote health and wellbeing .
- 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.

### Education & Training

#### *The Senior Speech & Language Therapist will:*

- Participate in mandatory training programmes.
- Take responsibility for, and keep up to date with Speech & Language Therapy 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 to Speech & Language Therapists in training 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 Speech & Language Therapist will:*

- Be responsible for the co-ordination and delivery of a quality service in line with best practice and professional standards.
- 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 Speech & Language Therapy 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 Speech & Language Therapy 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, monitor and uphold the standards of professional practice within their Speech & Language Therapy team.

### Administrative

#### *The Senior Speech & Language Therapist will:*

- Collaborate with colleagues in Community Health Networks in the establishment, reform and planning of services that reflect a population health approach.
- Contribute to the service planning process.
- Assist the Speech & Language Therapy Manager and relevant others in service development encompassing policy development and implementation.
- Review and evaluate the Speech & Language Therapy 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 Speech & Language Therapy 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 Speech & Language Therapy stock and equipment in conjunction with the Speech & Language Therapy 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 Speech & Language Therapy Manager



## Specialist Registrar (Older Persons)

### *The Specialist Registrar in the Older Persons' Hub will:*

- Collaborate with colleagues in Community Health Networks in the establishment, reform and planning of services that reflect a population health approach.
- Facilitate the day to day running of the hub in conjunction with ANPs and Consultants
- Provide rapid access to multidisciplinary comprehensive geriatric assessment for older people
- Provide a continuity of care for these complex older patients who attend regularly
- Facilitate more Tilt Table and other diagnostic testing for patients attending the hub
- Contribute to the MDT and care planning meetings
- Act as a link between geriatric medical teams and rehab teams regarding facilitating early discharge and follow up
- Act as a link between ED doctors and GPs about appropriate referrals
- Ensure audit of service at regular intervals to ensure it is meeting KPIs
- Facilitate clinics in the spoke centres at Tuam and Loughrea initially.
- Help to streamline and improve service provision after the initial phase.
- 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.

### **KPI's**

#### *Older people who are users of the Older Persons' Hub will:*

- Meet targets set out by ICPOP in terms of ambulatory care hub metrics
- Have timely access to ambulatory specialist geriatric services
- Have a comprehensive geriatric assessment including specialist physio, OT, MSW and nursing
- Have an integrated care plan established in conjunction with their GP on discharge
- Have a point of contact at the interface between acute and community services to avoid admission where possible
- Be discharged earlier from hospital because they will have follow up in the Hub
- Have reduced loss of function due to multiple hospital admissions
- Have less inappropriate hospital admissions

#### *KPIs will be based on:*

- Proportion receiving CGA
- Proportion receiving a multi-disciplinary falls assessment
- Proportion reviewed in the 'Hub and Spoke'
- Functional or Frailty Status at discharge (based on the Clinical Frailty Scale as per Frailty Service guidelines) from the service
- Receiving timely and appropriate, enhanced home care supports,
- Hospital readmission rates (30 and 90 day) for those reviewed post hospital discharge
- Institutionalisation rates
- Satisfaction with care from service user

### **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

*continued on next page*



### Specialist Registrar (Older Persons) continued

- 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.

# Health Intelligence Ireland Information Governance – User Agreement

## Purpose

Health Intelligence Ireland supports the quest for better health for patients, their families and the population. It provides controlled web access to health related data, analyses and maps to inform the planning, safe delivery and quality assurance of services, and to enable epidemiology and research.

### Terms of agreement

1. Data is exclusively used for the above purpose.
2. The confidentiality and privacy of data are respected in accordance with the provisions of data protection and other relevant legislation.
3. Usernames and passwords are not shared with others.
4. The user is fully responsible for the analysis and interpretation of results – with special care being taken in light of the quality of the data (such as its completeness, accuracy or timeliness).
5. External reports, presentations or publications do not contain data that could directly or indirectly identify individual patients (e.g. cells with 4 or fewer cases where such data alone or combined with other data could compromise individual confidentiality) are not shown.
6. Data is not used for record linkage purposes, or to identify/contact patients, or shared with third parties unless appropriate information governance/data protection/ethical processes have been followed.
7. In any output: the source(s) of the data source/s are appropriately acknowledged together with the wording "Accessed using Health Intelligence Ireland"; map/report Z/R and licence number(s) and the Health Intelligence Ireland logo and any system accreditations remain on any outputs. Following publication, a copy/reference is forwarded to Health Intelligence Ireland and the relevant data source/s as a matter of courtesy.
8. Health Intelligence Ireland is informed should data quality or analysis issues be identified.
9. The user informs the Group Controller (see below) when their details or role requires updating or inactivation.
10. The Group Controller is responsible for enabling and maintaining appropriate role-based user access.

Health Intelligence Ireland creates the Agency folder (e.g. national body) giving access to the Agency Controller/s. The Agency Controller creates a Section Folder/s (e.g. department/programme) giving access to the Section Controller/s. The Section controller creates a Group folder/s (e.g. team/laboratory) giving access to the Group folder Controller/s. The Group Controller provides user access to the analytical and display tools.

Please complete template A if you are a new user and do not have an existing Health Atlas account or template B if you are an existing user and already have login details

Name	Email	Associated Hospital	Job Title	Work Phone	Access Level	Organisation	Department Head	Detpartment Head Job Title	Department Head Work Phone	Department Head Email
					Read Only					

TEMPLATE A

Name	Associated Hospital	Email	Access Level

TEMPLATE B

