Post Description

1. Post Identification

Grade: Practice Nurse

Title: Practice Nurse – Diabetes care

Scale: 6

Accountabile to: Chief Nursing Manager or his/her delegate.

2. Summary of the Post

To specifically meet the needs of people with diabetes and their families, to provide experience and expertise and to support other health care professionals in the care they provide. The role is crucial in supporting and empowering people in self managing their diabetes more effectively whilst preventing complications and reducing emergency hospital admissions.

The Practice nurse – Diabetes care shall continuously work in conjuction and under the guidance of other Medical/Health Care Professions working within Active Ageing & Community Care. S/he is expected to share the values including : providing timely service, working towards achieving excellence and high quality care, giving person-centred service with a caring attitude, ensuring safety throughout the whole process, collaboration with all stakeholders, and enabling residents/clients and their relatives to be active participants throughout their journey living with diabetes.

3. Roles and Responsabilities

3.1 Be an active member of the interdisciplinary professional team and work in collaboration with all members of the health care team in the respective contexts.
3.2 Act as a force for team building, motivation, and change for all staff who are accountable to her/ himself.
3.3 Participate in the strategic development necessary for the maintenance of a Diabetes Care Service in Care Homes and Community by providing leadership, purpose, and vision.
3.4 Demonstrate higher levels of clinical decision-making and ability to monitor and improve standards of care.
3.5 To work autonomously to provide a specialist service throughout the available Care Homes, Community and other relevant areas that will need his/her specialist service.

3.6 To organize the planning and implementation of care for persons with diabetes residing in Care Homes and in the community and their relatives and maintain accurate clinical records.
3.7 To participate in the provision of a specialist outreach service for persons with diabetes residing in Care Homes and in the community.
3.8 Accept referrals directly from Health Care professionals as well as General Practitioners within Care Homes and the Community
3.9 To provide a service that is evidence-based and aims to improve the quality of life.
3.10 Deliver individualized resident/client care, based on principles of best practice. It is recognized that this may be achieved either directly, through personal contact, or indirectly through supervision of practices within Care Homes and the Community.
3.11 To deliver diabetes self-management programs for persons with Type 1 and Type 2 Diabetes.
3.12 Oversee and participate in the management of clients attending diabetes clinics receiving domiciliary service.
3.13 Be involved in the drafting of specifications and adjudication of new equipment and products relating to Diabetes Care.
3.14 Provide expert opinion and advice on Diabetes Care.
3.15 Discuss management of care with both residents/clients and their relatives, to create an understanding of the resident/client's condition and treatment.
3.16 Promote resident/client care independence through the provision of relevant diabetes education and support.
3.17 To participate in the provision of psychological care for persons with diabetes and their relatives.
3.18 Liase with other hospital staff members and other departments, to promote and maintain good working relationships, and high standards of care and service to residents/clients.
3.19 Disseminate relevant findings and information to members of the multidisciplinary team, who are involved with resident/client care, and who each have a contributory role towards the management of the resident/client.
3.20 Advise and support members of the resident's/client's family following the resident/client's discharge, and inform them of supportive services within the community.
3.21 Provide a telephone support system that is easily accessible to ambulatory community-based clients and establish a referral process from the community and Care Home settings.
3.22 Communicate, negotiate, and represent the residents/clients values and decisions with other professionals and community resource providers.
3.23 Strive to ensure the resident/clients's welfare is uppermost when making decisions, and include the resident/client when issues occur regarding the management of his/her care.
3.24 Ensure that the resident/client is kept informed on all matters pertinent to him/her, and represent the resident/client and his/her wishes when required to do so, in the interdisciplinary or other setting.

3.25 Evaluate the training needs of the health care professionals and develop appropriate information sessions, courses, conferences, and material for Care Homes and community staff in Malta and Gozo in relation to diabetes, including: diabetes care pathways, resident/client education and support, holistic resident/client care, treatment, prevention, and management of complications.
3.26 Contribute to the development and dissemination of clinical guidelines and policies in the management of residents/clients with diabetes to ensure their safety.
3.27 Develop and improve professional expertise via continuous professional development. Advise and support Nursing Managers and staff in the implementation of agreed policies and guidelines.
3.28 Be expected to be up to date with all new developments and innovations within diabetes care and management and maintain high standards of clinical competence through continuous training, self-education, and courses.
3.29 Participate and carry out research in relation to diabetes care and encourage the implementation of evidence-based practice.
3.30 Audit current nursing practice and implement changes as necessary.
3.31 Take responsibility of clinical audits and/or research projects as directed by the Nursing Management and to present reports to the relevant stakholders within Active Ageing and Community Care.
3.32 Liase with relevant support groups, NGO's, schools, local councils, media, etc, and in conjunction with these groups, organize and deliver seminars and educational activities according to their needs.
3.33 To work hand in hand with the Department of Health Promotion and Disease Prevention to increase awareness of Diabetes and its prevention in conjunction with the National Strategy for Diabetes.
3.34 Use of the Information Technology systems which may be in operation within the respective entity.
3.35 Any other duties according to the exigencies of the Public Service as directed by the Principal Permanent Secretary and Director (Nursing) Active Aging and Community Care.

4. Leadership

The post holder should be:

- Visible, accessible, approachable, and assertive.
- Able to build effective professional relationships, motivate and lead innovation and expertise in the clinical area.
- Able to inform the interdisciplinary team and the residents/clients, through effective communication and to address challenges and conflicts.
- Accept criticism and feedback constructively.
- Manage change.
- Develop and maintain optimal levels of care delivery.

- Respect and ensure that all policies, protocols, and procedures determined by respective authorities are adhered to.

5. Research

The post holder should:

- Be able to identify the need for research activity.
- Be able to develop research initiatives.
- Be able to disseminate and report research outcomes accordingly.
- Engage the support of the interdisciplinary team and respective authorities towards indicated research initiatives.

6. Confidentiality

The post holder is required to respect and maintain confidentiality in all matters relating to the diagnosis and treatment of residents and clients, to the individual members of staff, and to the organisation.

7. Data Protection

The post holder is to abide by the Data Protection Act.

8. Health and Safety

The post holder is to uphold all Health and safety regulations held by the respective authorities in the contexts.

9. Infection Prevention and Control

The post holder is required to observe and comply with the Infection Prevention and control Policies held by the respective authorities in the contexts.

10. Other Policies, Protocols and Procedures

The post holder is required to abide by all policies, protocols and procedures held by the respective authorities in the contexts.

11. Personal Specifications

Knowledge	• Demonstrate good knowledge on the pathophysiology of diabetes and its complications. • Demonstrate good knowledge on the pharmacokinetics and pharmacodynamics of the tablets available for the management of Type 2 Diabetes • Demonstrate proficient knowledge on the insulins and insulin regimens. • Demonstrate good knowledge on how to prevent and manage hyperglycemia, Diabetic Ketoacidosis, and hypoglycemia. • Demonstrate good knowledge on the complications related to uncontrolled diabetes and their prevention.
Experience	• Have experience in managing persons with diabetes either at clinic or wards level. • Demonstrates competence and experience in meeting the physiological, psychological, social and spiritual needs of persons with diabetes.
Skills, qualities and attributes.	• Capable of working as a team member with all stakeholders. • Demonstrates excellent written, computer, and presentation skills. • Excellent communication and interpersonal skills. • Able to communicate highly sensitive information to residents/clients and carers in a clear and empathetic manner. • Demonstrates ability to negotiate with others. • Demonstrates ability to adapt information in accordance to the need and level of understanding of residents/clients and their informal carers. • Keep skills up-to-date and relevant to the role. • Visible, accessible, approachable and assertive. • Able to build effective professional relationships, motivate and lead innovation, competence and expertise in the clinical area. • Accepts criticism and feedback constructively. • Manages change. • Develops and maintains optimal levels of care delivery. • Ability to work on own initiative and as part of a team. • Ability to motivate and inspire individuals and groups. • Effective time management and ability to prioritise.

	• Commitment to professional development both on a personal and practice level. • Recognises the limitations of own competency and professional boundaries and makes appropriate referrals to other specialists. • Demonstrates an understanding and commitment to equal opportunities and customer care. • Motivated and able to work flexibly within hospital, in the community and in liaison with professionals in other health care settings.

Deskrizzjoni tal-Kariga

1. Identifikazzjoni tal-Kariga

Grad: Practice Nurse

Titlu: Practice Nurse – Kura tad-Dijabete

Skala: 6

Jirraporta lil: Chief Nursing Manager jew lid-delegat tiegħu.[1]

2. Sommarju tal-Kariga

Sabiex jilqa' b'mod partikulari għall-bżonnijiet ta' persuni bid-dijabete u l-familji tagħhom, sabiex jipprovdi esperjenza u kompetenza, kif ukoll jappoġġja professjonisti oħra fil-kura tas-saħħa fil-kura li jipprovdu. Ir-rwol huwa kruċjali biex jassapportja u jsaħħaħ lill-persuni biex jieħdu ħsieb id-dijabete tagħhom b'mod aktar effettiv, waqt li jiġu evitati kumplikazzjonijiet u titnaqqas il-ħtieġa li wieħed jidħol l-isptar b'emergenza.

Il-Practice nurse - Kura tad-Dijabete għandu jaħdem il-ħin kollu f'kollaborazzjoni flimkien ma' professjonisti tas-Saħħa fi ħdan Anzjanità Attiva u Kura fil-Komunita`. Hu mistenni jaqsam ma' oħrajn il-valuri li jinkludu: li jipprovdi servizz fil-ħin, jaħdem lejn il-kisba tal-eċċellenza u kura ta' kwalità għolja, joffri servizz iċċentrat fuq il-persuna b'attitudni ta' kura, jiżgura s-sigurtà matul il-proċess kollu, jikkollabora ma' dawk kollha involuti, u jinkoraġixxi lir-residenti/klijenti u lill-qraba tagħhom biex jieħdu sehem b'mod attiv fil-vjaġġ ta' ħajjithom bid-dijabete.

3. Xogħol Ewlieni, Doveri u Responsabbiltajiet

3.1 Ikun membru attiv tat-tim professjonali interdixxiplinarju u jaħdem f'kollaborazzjoni mal-impjegati kolla tal-kura tas-saħħa fil-kuntest rispettivi.

3.2 Jaġixxi bħala forza biex jinbena t-tim, motivazzjoni u bidla għall-impjegati kolla li minnhom hu responsabbli.

[1] Kull referenza għall-ġeneru maskil fil-verżjoni bil-Malti tirreferi għal kwalunkwe ġeneru ieħor ukoll.

3.3 Jieħu sehem fl-iżvilupp strateġiku meħtieġ għaż-żamma ta' Servizz ta' Kura tad-Dijabete fid-Djar tal-Anzjani u fil-Komunit billi jipprovdi tmexxija, għan u viżjoni.

3.4 Juri livelli għoljin ta' teħid ta' deċiżjonijiet kliniċi, u l-abbiltà li jissorvelja u jtejjeb l-istandards tal-kura.

3.5 Jaħdem b'mod awtonomu u jipprovdi servizz speċjalizzat fil-firxa kollha tad-Djar tal-Anzjani, il-Komunità u oqsma oħra relevanti fejn ikun hemm il-ħtieġa għal dan is-servizz speċjalizzat.

3.6 Jorganizza l-ippjanar u l-implimentazzjoni tal-kura għal persuni bid-dijabete residenti fid-Djar tal-Anzjani, il-Komunità u l-qraba tagħhom u jżomm dokumentazzjoni klinika u eżatta.

3.7 Jieħu sehem fil-provvista ta' servizz outreach speċjalizzat għal persuni bid-dijabete residenti fid-Djar tal-Anzjani u fil-Komunità.

3.8 Jilqa' riferimenti direttament minn professjonisti tas-Saħħa u tobba tal-familja fir-Residenzi tal-Anzjani u fil-komunità.

3.9 Jipprovdi servizz ibbażat fuq l-evidenza bil-għan li titjieb il-kwalità tal-ħajja.

3.10 Joffri kura personalizzata lir-resident/klijent ibbażata fuq prinċipji ta' prattika tajba. Dan jista' jinkiseb direttament, permezz ta' kuntatt personali, jew indirettament permezz ta' superviżjoni tal-prattika fir-Residenzi tal-Anzjani u l-Komunità..

3.11 Joffri programmi ta' self-management tad-dijabete għal persuni b'Tip 1 u Tip 2.

3.12 Jissorvelja u jieħu sehem fil-ġestjoni tal-klijenti li jattendu l-kliniċi tad-dijabete u li jirċieviu servizz domiċiljari.

3.13 Jgħin fil-ħolqien ta' speċifikazzjonijiet u l-evalwazzjoni ta' tagħmir u prodotti ġodda relatati mal-Kura tad-Dijabete.

3.14 Joffri opinjoni u parir espert dwar il-Kura tad-Dijabete.

3.15 Jiddiskuti l-ġestjoni tal-kura kemm mar-residenti/klijenti kif ukoll mal-qraba tagħhom, sabiex jinħoloq fehim tal-kundizzjoni u t-trattament tar-residenti/klijent.

3.16 Jippromwovi l-indipendenza tar-resident/klijent permezz ta' edukazzjoni u appoġġ meħtieġ dwar id-dijabete.

3.17 Jieħu sehem fil-provvediment ta' kura psikoloġika għal persuni bid-dijabete u l-qraba tagħhom.

3.18 Jikkollabora ma' membri oħra tal-istaff tal-isptar u dipartimenti oħra sabiex jippromwovi u jkollu relazzjonijiet tajbin fuq ix-xogħol, u standards għolja ta' kura u servizz lir-residenti/klijenti..

3.19 Ixerred informazzjoni u sejbiet rilevanti lill-membri tat-tim interdixxiplinarju involuti fil-kura tar-resident/klijent u li kull wieħed minnhom għandu rwol kontributtiv fil-ġestjoni tar-residernt/klijent.

3.20 Jagħti pariri u appoġġ lill-membri tal-familja tal-klijent li jkun ħareġ mill-isptar u jinfurmahom dwar servizzi ta' sostenn fil-komunità.

3.21 Jipprovdi sistema ta' appoġġ bit-telefon li tkun faċilment aċċessibbli għar-residenti/klijenti ambulatorji fil-komunità, u jistabbilixxi proċess ta' riferiment mill-komunità u d-Djar tal-Anzjani.

3.22 Jikkomunika, jinnegozja u jirrappreżenta l-valuri u d-deċiżjonijiet tar-residenti/klijenti ma' professjonisti oħra u fornituri ta' riżorsi fil-komunità.

3.23 Jaħdem biex jiżgura li l-ġid tar-resident/klijent ikun dejjem l-iktar ħaġa importanti meta jittieħdu deċiżjonijiet, u jinkludi lill-klijent/resident meta jinqalgħu kwistjonijiet dwar il-ġestjoni tal-kura tiegħu.

3.24 Jiżgura li r-resident/klijent jinżamm infurmat dwar kull ħaġa rilevanti għalih, u jirrappreżenta lir-resident/klijent u x-xewqat tiegħu meta jkun meħtieġ, kemm fi ħdan tim interdixxiplinarju jew f'ambjent ieħor.

3.25 Jevalwa l-bżonnijiet ta' taħriġ tal-professjonisti fil-kura tas-saħħa u jiżviluppa sessjonijiet ta' informazzjoni, korsijiet, konferenzi u materjal xieraq għar-Residenti tal-Anzjani u tal-komunità relatat mad-dijabete f'Malta u Għawdex inkluż: mogħdijiet ta' kura, edukazzjoni u appoġġ lir-residenti/klijenti, kura ħolistika, trattament, prevenzjoni u ġestjoni tal-kumplikazzjonijiet.

3.26 Jikkontribwixxi għall-iżvilupp u t-tixrid ta' linji gwida kliniċi u policies dwar il-ġestjoni tal-residenti/klijenti bid-dijabete sabiex tiġi żgurata s-sigurtà tagħhom.

3.27 Jiżviluppa u jtejjeb il-kompetenza professjonali u jagħti pariri u appoġġ lin-Nursing Managers u lill-istaff fl-implimentazzjoni ta' policies u linji gwida miftiehma.

3.28 Hu mistenni li jżomm ruħu aġġornat dwar l-iżviluppi u l-innovazzjonijiet fil-kura u l-ġestjoni tad-dijabete u jżomm standards għolja ta' kompetenza klinika permezz ta' taħriġ kontinwu, awto-edukazzjoni u korsijiet.

3.29 Jibda u jieħu sehem f'inizjattivi ta' riċerka relatati mal-kura tad-dijabete filwaqt li jirsisti għall-implimentazzjoni tal-prattika bbażata fuq l-evidenza.

3.30 Jagħamel verifiki tal-prattika infermestika kurrenti u jimplimenta l-bidliet kif meħtieġ.

3.31 Jorganizza u jimplimenta programmi ta' verfika u/jew proġetti ta' riċerka kif dirett mill-management tan-Nursing u jħejji rapporti lill-partijiet interessati fi ħdan id-Dipartiment tal-Anzjanità Attiva u l-Kura fil-Komunità.

3.32 Jikkollabora ma' gruppi ta' sostenn rilevanti, NGOs, skejjel, kunsilli lokali, media, eċċ., u flimkien ma' dawn il-gruppi jorganizza seminars u attivitajiet edukattivi skont il-bżonnijiet tagħhom.

3.33 Jaħdem id f'id mad-Dipartiment għall-Promozzjoni tas-Saħħa u l-Prevenzjoni tal-Mard sabiex jiżdied l-għarfien dwar id-Dijabete u l-prevenzjoni tagħha, flimkien mal-Istrateġija Nazzjonali tad-Dijabete.

3.34 Jagħmel użu tas-sistemi tat-Teknoloġija tal-Informattika li jkunu qed jitħaddmu f'kull entità rispettiva.

3.35 Kwalunkwe doveri oħra skont l-eżiġenzi tas-Servizz Pubbliku kif diretta mis-Segretarju Permanenti Prinċipali jew mid-Direttur għas-Servizz tal-Infermiera, Anzjanità Attiva u Kura fil-Komunità.

4. Tmexxija

Min jokkupa l-kariga jrid:

- Ikun viżibbli, aċċessibbli avviċinabbli u assertiv.
- Ikun jaf jibni relazzjonijiet professjonali effettivi, jimmotiva u jmexxi l-innovazzjoni u l-għarfien espert fil-qasam kliniku.
- Ikun jaf jinforma t-tim interdixxiplinarju permezz ta' komunikazzjoni effettiva u jkun jaf jindirizza sfidi u kunflitti.
- Ikun taf jaċċettal-kritika u u kull informazzjoni oħra kostruttiva.
- Ikun jaf jimmaniġġja l-bidla
- Jiżviluppa u jsostni livelli ta' eżekuzzjoni tal-kura mill-aħjar.
- Jassigura li l-policies, protokolli u l-proċeduri stabbiliti mill-awtoritajiet rispettivi jkunu osservati.

5. Riċerka

Min jokkupa l-kariga jrid:

- Ikun kapaċi jidentifika l-ħtieġa għal attività ta' riċerka
- Ikun jaf jiżviluppa inizjattivi ta' riċerka.
- Ikun jaf iqassam u jirraporta r-riżultati tar-riċerka.

- Jinvolvi l-għajnuna tat-tim interdixxiplinarju u l-awtoritajiet rispettivi fl-inizjattivi indikati tar-riċerka.

6. Kunfidenzjalità

Min jokkupa l-kariga hu mitlub li jirrispetta u jżomm il-kunfidenzjalità f'kull materja relatata mad-dijanjosi u l-kura tar-residenti, lill-membri individwali tal-istaff u lill-organizzazzjoni.

7. Protezzjoni tad-Data

Min jokkupa l-kariga trid timxi mal-Att dwar il-Protezzjoni u l-Privatezza tad-Data

8. Saħħa u Sigurtà

Min jokkupa l-kariga jrid josserva r-regolamenti kollha tas-Saħħa u s-Sigurtà kif miżmuma mill-awtoritajiet rispettivi f'kull kuntest.

9. Kontroll ta' Infezzjoni

Min jokkupa l-kariga trid josserva u jaderixxi mal-policies ta' kontroll ta' infezzjoni kif preskritti mill-awtoritajiet rispettivi f'kull kuntest.

10. Policies, Protokolli u Proċeduri oħra

Min jokkupa l-kariga hu mitlub li jaderixxi mal-policies, protokolli u proċeduri kif miżmuma mill-awtorijiet rispettivi f'kull kuntest.

11. Speċifikazzjonijiet tal-Persuna

Għarfien	• Juri għarfien tajjeb tal-patofiżjoloġija tad-dijabete u l-kumplikazzjonijiet tagħha. • Juri għarfien tajjeb tal-farmakokinetika u l-farmakodinamika tal-pilloli disponibbli għall-immaniġġjar tad-Dijabete tat-Tip 2. • Juri għarfien avvanzat tal-insulini u r-reġimi tal-insulina. • Juri għarfien tajjeb dwar kif jiġu evitati u mmaniġġjati l-ipergliċemija, il-Ketoaċidożi Dijabetika, u l-ipogliċemija. • Juri għarfien tajjeb tal-kumplikazzjonijiet relatati mad-dijabete mhux ikkontrollata u l-prevenzjoni tagħhom.

Esperjenza	• Għandu esperjenza fil-ġestjoni ta' persuni bid-dijabete kemm fil-klinika kif ukoll fil-swali tal-isptar. • Juri kompetenza u esperjenza fl-ilħuq tal-bżonnijiet fiżjoloġiċi, psikoloġiċi, soċjali u spiritwali ta' persuni bid-dijabete.
Ħiliet, kwalitajiet u attributi	• Kapaċi jaħdem bħala membru tat-tim mal-partijiet interessati kollha. • Juri ħiliet eċċellenti tal-kitba, fuq il-kompjuter u f'preżentazzjonijiet. • Ħiliet ta' komunikazzjoni u relazzjonijiet interpersonali eċċellenti. • Kapaċi jikkomunika informazzjoni sensittiva ħafna lill-klijienti u lil dawk li jieħdu ħsiebhom b'mod ċar u empatiku. • Kapaċi jinnegozja ma' oħrajn. • Juri kapaċità li jadatta l-informazzjoni skont il-bżonnijiet u l-livell ta' fehim tal-klijenti/residenti u dawk li jieħdu ħsiebhom. • Iżomm il-ħiliet tiegħu aġġornati u rilevanti għall-irwol. • Viżibbli, aċċessibbli, faċli biex wieħed jersaq lejh u assertiv. • Kapaċi jibni relazzjonijiet professjonali effettivi, jimmotiva u jmexxi l-innovazzjoni, kompetenza u għarfien espert fil-qasam kliniku. • Jaċċetta l-kritika u feedback b'mod kostruttiv. • Jimmaniġġja l-bidla b'mod effettiv. • Jiżviluppa u jżomm livelli ottimi ta' kura. • Jaf jaħdem fuq inizjattiva personali u bħala parti minn tim. • Jaf jimmotiva u jispira individwi u gruppi. • Ġestjoni effettiva tal-ħin u l-kapaċità jippjana l-prijoritajiet. • Impenn għall-iżvilupp professjonali kemm fuq livell personali kif ukoll prattiku. • Jagħraf il-limiti tal-kompetenza tiegħu u l-konfini professjonali tiegħu u jagħmel riferiment kif meħtieġ lil speċjalisti oħra. • Juri fehim u impenn lejn opportunitajiet indaqs u kura tal-klijent. • Motivat u kapaċi jaħdem b'mod flessibbli fl-isptar, fil-komunità flimkien ma' professjonisti f'oqsma oħra tal-kura tas-saħħa.