Role Description

Position: Nurse Practitioner Older Adult - Community

Service: Kenepuru, Kapiti & Community Health

Directorate: Medicine, Cancer & Community (MCC) Directorate

Responsible to: Operations Manager - Kenepuru, Kapiti & Community Health

Associate Director of Nursing - MCC

Our Mission:
Together, Improve the Health and Independence of the People of the District

Our Vision
Better Health and Independence for People, Families, and Communities

Our Values:
- Innovation
- Action
- A focus on People and Patients
- Living the Treaty
- Professionalism through Leadership, Honesty, Integrity and Collaboration
- Excellence through Effectiveness and Efficiency
Context that this role operates within

Organisation perspective

The Capital and Coast District Health Board (CCDHB) covers a region extending from Wellington to Otaki. It comprises key delivery arms in primary, secondary and tertiary health. Hospital and Health Services (HHS) is primarily responsible for the hospital and health services delivered via a new Wellington Regional Hospital (opened in March 2009), a secondary and community facility at Kenepuru, a forensic mental health unit at Kenepuru Community Hospital and Kapiti Community Hospital. The total operating budget for the provider arm is approximately $570M.

There is an ongoing change programme begun in 2008 to resolve HHS performance with a target of achieving performance in the top five District Health Boards and a break even operating result.

We are focused on improving the health of our local people, families and communities – and reducing inequalities within our population. To support this we will ensure:

- integrated delivery of services backed by sound infrastructure
- financial and clinical viability of services, facilities and support
- a “culture” that supports health improvement and addresses disability needs locally and across our region
- the development of clinical leadership
- regional collaboration

Priorities in the current year for HHS are:

- Apply and pursue our triple aim of improving the health of our population, improving the patient experience and reducing the per capita cost of delivering these health services
- Improving the health of children
- Collaboration towards integrated health service delivery with community providers
- Develop a workforce strategy that supports the delivery of our goals and improves results
- Delivering on Health Performance targets and Ministers expectations

Directorate perspective:

The key areas of focus for the Medicine, Cancer and Community Directorate are:

- To lead and develop new models of care as well as new ways of working across the health system between primary, community, and secondary care settings
- To participate in the collaboration with Hutt Valley and Wairarapa DHBs to establish wider regional clinical services
- To strengthen a quality and patient safety culture through an effective clinical governance framework
- The establishment of sustainable work force models within the Directorate
- To ensure improved financial performance in line with the DHB’s financial recovery plan
• To participate in the Integrated Collaborative Care priorities as they relate to the Directorate
• Support the provision of better, sooner, more convenient services across the wider DHB.

The Directorate oversees four operational areas:
• Blood & Cancer, Renal, and Palliative Care services
• Regional and Ambulatory services
• Medicine, Acute flow and Emergency services
• Kenepuru, Kapiti and Community services.

Operational perspective:

The Directorate’s Kenepuru, Kapiti and Community Division (KKC) is made up of the following Services based across 3 CCDHB sites – Wellington, Kenepuru and Kapiti:
• Capital Support – Under 65 Needs Assessment Service Co-ordination (NASC)
• Oversight of the Kapiti Health Centre operations
• Community Health Services – District Nursing and short term home help and personal cares
• Kenepuru Accident and Medical Clinic – Primary care accident and medical clinic operational 24 hours/7 days located on the Kenepuru Hospital campus
• Kenepuru Surgical Unit – unit at Kenepuru Community Hospital – surgical and orthogeriatrics
• Older Adult, Rehabilitation and Allied Health (ORA) Services which include:
  o 3 inpatient wards at Kenepuru Community Hospital including a multidisciplinary allied health team
  o Multidisciplinary community teams – Wellington, Kenepuru and Kapiti
  o Discipline specific allied health teams (Physiotherapy, Occupational Therapy, Social Work, Dietetics, Speech Language Therapy) providing inpatient and outpatient treatment
• Diabetes and Endocrine – Specialist Service offering medical, nursing, education and research functions

Service Perspective:

The Older Adult, Rehabilitation and Allied Health Service (ORA) covers the Wellington, Porirua and Kapiti communities. The service provides specialist gerontology assessment and management, stroke rehabilitation and rehabilitation for the older and younger adults.

A primary focus of the service is specialised health and disability services for older people with complex social, functional/medical needs requiring assessment, treatment and, if appropriate, rehabilitation.

The focus of the older adult speciality (Gerontology) is on the total social and health care needs of the person as advanced age interacts with the whole range of acute, acute-on-chronic and chronic illness in this vulnerable population.

In addition to providing direct healthcare to older adults, the ORA service also liaises with inpatient services, Community - Non Government Organisations/Home based support, Primary Health, and Aged Residential Care (ARC) facilities. Comprehensive geriatric assessment and treatment is effective either in the hospital or community setting. Access to specialist practitioners for organisations providing community-based and ARC for the frail older people is important.
The ORA service has recently introduced a pilot based in the emergency department (ED) named the Care of the At Risk Elderly patient who is frail (CAREFUL) team. This involves a small geriatrician led MDT based in the ED with the aim of identifying frail elderly patients early on in their hospital journey and providing an early comprehensive geriatric assessment. This pilot has assisted in linking community services, primary health and ARC with secondary inpatient care.

Ongoing development of the older person services at CCDHB is in response to the current and future expected needs associated with the demographic changes in our aging population. Corresponding with this growth is a rise in the complexity of need in the older adult and a drive to reduce unnecessary admissions to secondary care inpatient services.

Principal decisions of care in aged care primary health care reside with the General Practitioner (GP) in Primary Health or ARC team. Initiatives that support the frail elderly to age-in-place or remain in ARC with lower level acute or acute-on-chronic illness should be supported by timely access to specialised practitioners in older adult health care.

Advanced practice nursing (APN) roles in older adult care the Nurse Practitioner (NP) or Nurse Practitioner Candidate that increase specialist support to primary health care, community and aged care sectors can address challenging complex care situations and achieve better integration of services for older patients.

Developing this NP expertise in the Kenepuru & Wellington region will increase timely access to specialist gerontology assessment and therapy in the community.

**Role Perspective**

The role intent is to complement existing both Hospital and Health Services (HHS) - inpatient and community and PHC – community, primary health and ARC. The HHS linkage will primarily be with the Medical Assessment Patient Unit (MAPU) the CAREFUL Team in ED, District Nursing, ORA community and inpatient services. The NP will link with the CAREFUL team to support frail elderly patients post discharge or prior to acute admission. A key component is supporting primary care, and ARC who care for frail elderly patients. The NP will assist in diagnosis and treatment planning to promote optimal outcomes for the frail elderly.

The role looks to future health needs and provides opportunity for clinical leadership and improved consultation with the primary and ARC sectors to contribute to identified health priorities.

The Nurse Practitioner Older Adult will:

- Provide advanced nursing skills and knowledge beyond the level of the advanced RN through consultation and short-term direct case load work to enhance HHS services discharging complex frail elderly patients to support ORA Liaison Nursing Team and Districts Nurses.
- Provide leadership within clinical practice through consultation service and complex case review to GPs in Primary Health and ARC services.
- Provide clinical expertise and support to SIDU’s Health of Older Person’s Portfolio Managers.
- Contribute clinical expertise and support in the development of clinical capability in care (knowledge, skill and leadership) of older people with complex health needs.
• Provide an additional advanced nursing resource to jointly work with health professionals on gerontology syndrome care issues, to manage very complex situations associated with increased patient/resident vulnerability.

• Provide an opportunity for clinical leadership/mentoring to support the work of other registered nurses with older frail people (ORA Liaison Team, District Nursing).

• Improve health outcomes for older persons in our CCDHB Kenepuru & Wellington region by improving timely access to comprehensive geriatric assessment, diagnosis, care planning with interventions, and support services.

• Provide an additional advanced nursing resource to jointly work with health professionals and personnel targeting older adults’ health issues and risk associated with common geriatric syndromes e.g. polypharmacy, falls, incontinence, weight loss, cognitive impairment and delirium associated with increased patient/resident frailty.

• Support access to timely therapeutic specialist gerontology nursing advice to promote optimal clinical care for the unwell or acutely unstable patient.

• Prevent hospitalisation when older patients can be best supported in the community or ARC setting.

• Contribute to improved coordination of care across sectors and disciplines.

• Network with other NPs (Older Adult and Mental Health Older People) across the 3DHBs to advise for the population and optimal service integration and delivery.

While the role reports to the Operations Manager of Kenepuru, Kapiti and Community Health it is expected that the NP will have:

• a close working relationship and responsibility to the Directorate’s Associate Director of Nursing (ADON) for the MCC Directorate.

• a clinical supervisor and mentor in the Clinical Leader (or delegate) ORA services.

• a professional linkage to the Director of Nursing & Midwifery Office will be supported by the ADON-Practice Development.
Purpose of the role
To provide and facilitate comprehensive clinical care and advanced nursing expertise for frail older adults with complex needs to complement existing services in the HHS, primary health and ARC sectors. This includes consultation, diagnosis, support, advice, training and education to relevant staff to support the delivery of high quality specialist older adult health care. A community-based caseload, which involves advanced clinical assessment and treatment delivery, is integral to the role.

Key Accountabilities

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<tr>
<th>Key Accountability</th>
<th>Deliverables / Outcomes</th>
<th>Key Performance Indicators / Measures</th>
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</table>
| 1. Professional responsibility and leadership | • Role models and leads advanced nursing practice characterised by critical thinking, evidence based nursing and knowledge in the provision of health care services to patients/residents in a variety of settings  
• Promotes optimal nursing contribution in the ORA service, ARC and PHC with relevant multidisciplinary and intersectorial groups.  
• Demonstrates nursing leadership that positively influences the health outcomes of patient/population group and the profession of nursing  
• Considers the impact of the wider determinants of health including emerging health policy and findings and modifies practice accordingly  
• Collaborates and leads effectively within the nursing and multidisciplinary teams  
• Uses advanced evidence based nursing knowledge and skills to underpin clinical decision making processes involved in response to actual and potential health needs for the population group  
• Identify practice areas of concern and lead planning for addressing areas of practice and knowledge gaps  
• Demonstrates skilled mentoring, coaching and teaching of health care colleagues  
• Upholds the Treaty of Waitangi and cultural safety in nursing | • Application/adaptation of advanced nursing knowledge, expertise and evidence based care to improve the health outcomes  
• Leadership role in complex clinical gerontology care situations across settings and disciplines and follows through with required change to systems and processes as necessary  
• Accessed as a nursing resource across health services locally and regionally  
• Feedback from clinicians within the multidisciplinary team and intersectorial groups  
• Regular attendance at relevant meetings and contribution  
• Initiates change and responds proactively to changing systems  
• Evidence of creatively generating new approaches to the extension of the nursing knowledge and delivery of expert care within resource constrained environments  
• Activities at a local systems level that promote the positive contribution of nursing to health care delivery and equity of health outcomes  
• Peer review on mentoring, coaching and teaching  
• Patient and service feedback /evaluation of NP activities  
• Contributes to service planning  
• Recognised as an authority on frail older adult gerontology specialty care practices locally, regionally and nationally  
• Input to relevant service and national submissions clinical leadership and consultancy evident  
• Contributes to a culturally safe environment and role models effective outcomes linked with working both with Māori peoples’ social and physical contexts. |
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| 2. Clinical Expertise and nursing care management | • Demonstrates best practice for frail older adults through advanced comprehensive health assessment skills and diagnostic decision making  
• Uses advanced enquiry skills to assess, diagnose, implement and evaluate care and treatment  
• Demonstrates accountability for autonomous, interdependent and collaborative practice in relation to patient care and within the health care team  
• Uses knowledge of pathophysiology and pharmacology, and advanced holistic clinical assessment skills to perform diagnoses and to plan care and treatment including prescribing practice  
• Orders and interprets appropriate diagnostic and laboratory tests and explains the necessity, preparation, nature and anticipated effects of procedure(s) to patients, patient’s family, staff, and other members of the health care team  
• Utilises current research and evidence-based, advanced holistic assessment and diagnostic reasoning to form sound professional judgements in practice and consults as required  
• Direct client care within a range of contexts and situations  
• Consistently involves client in decision making processes and uses client information to determine management strategies  
• Demonstrates confident and independent practice that is based on the synthesis of theory and practice knowledge from nursing and other disciplines  
• Uses a formal approach to monitor and evaluate client responses to interventions  
• Contributes to clinical collaboration that optimises health outcomes for the client  
• Provides expert advice  
• Provides oversight through consultation with RNs reviewing health status regarding changes in levels of care – to optimise identification and management of reversible conditions | • Models expert advanced nursing practice skills  
• Demonstrates effective clinical management of case load  
• Case load is responsive to increased experience, patient experience and service changing priorities  
• Consistently uses appropriate tests and investigations based upon patient’s clinical status to support clinical reasoning and document patients response  
• Documentation standards met  
• Case evidence of timely referral and consultation when an issue is outside scope of practice or level of expertise/experience  
• Maintains and supports expertise in nursing practice  
• Identifies and acts on educational needs of the patient/resident, patient’s family and nursing staff  
• Advocates on behalf of patient/family/ colleagues as appropriate  
• Evaluates direct patient practice activities and effectiveness  
• Participates in case and peer review  
• Feedback from patient/family members and health care professionals  
• Health care professional feedback on information promptness and quality when addressing identified care issues  
• Intermittent audit of referral numbers  
• Inter-sector feedback  
• Acts as a consultant to SIDU  
• Contributes to best practice in ARC and ORA review of levels of care |
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| 3. Interpersonal, interprofessional practice and quality improvement | • Reflects and critiques the practice of self and others  
• Works with staff to continuously improve nursing practice and patient outcomes in all areas related to gerontology  
• Acts as an agent to foster collaboration between members of all disciplines in the health care team to work towards seamless quality patient care.  
• Actively involved in quality assurance activities that monitor and improve the quality of health care and the effectiveness of own practice  
• Demonstrates responsibility for quality of health care, risk management and effective resource utilisation  
• Contributes to increasing practice expertise and improved standards to address reportable events/risks  
• Critiques and develops clinical standards  
• Actively manages risk  
• Influences purchasing and allocation of resources through use of evidence based findings.  
• Provides SIDU with specialty advice following complex audits and complaints. | • Evidence Participation impact on the development of the patient plans and relevant service plans and ongoing improvement activities  
• Continuously improves care processes to improve patient outcomes and documentation  
• Champions quality improvement methodology with a focus on high standards of care  
• Aligns quality and safety (care indicator) activities with service strategic direction, District Annual Plan and Nursing Strategic Plan –relevant to practice and settings  
• Expert advice provided to investigations, assessment of practice and monitors and reviews outcomes.  
• Reportable events and complaints addressed sensitively and when applicable reports on corrective procedures in relation to complaints in ARC sector  
• Risk minimisation evidence in action plans in monthly reports to address clinical issues/complaints  
• Evidence of professional contribution to standards, quality initiatives and development of policies, procedures and practice guidelines, clinical pathway to optimise nursing practice |
| 4. Professional development | • Maintain the NCNZ requirements for NP scope of practice registration  
• On-going practice development  
• Annual Senior Nurse Performance Review  
• Network and participates in advanced practice forums NP  
• Networks with NP (Older Adult) across the 3DHB to advise with a population focus on optimal service integration and delivery.  
• Participates in regular formal professional supervision and peer review with Clinical leader or SMO delegate  
• Annual targeted national and international professional development to support practice and leadership contribution | • Registration and professional management requirements met  
• Monthly reports and 2-monthly joint practice review with ADONs  
• Mentoring and education activities  
• Professional supervision record  
• Participates in peer review, case review and debriefing activities  
• Contribution at local, regional and national advanced practice level  
• Evidence of continued practice and leadership skills in professional development plan, record and career plan  
• Conferences attendance and contribution includes national and international activities  
• Collaboration on practice development changes and follow-up required. |
### Key Accountability

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<td>- Drives practice development in staff through the optimal development and use of guidelines</td>
<td>- Reports on education plan activities in monthly report - Contributes to and participates in relevant education programmes and improvement projects</td>
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<td>- Informs services education plan and activities</td>
<td>- Research and quality practice development project activities/reports</td>
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<td>- Contributes to the identification of possible research/quality practice projects and participates in the development, implementation and feedback</td>
<td>- Responsive development and review of standards of practice, protocols and policies</td>
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<td>- Strategic input into service education activities</td>
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#### 5.Occupational Health & Safety

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<td>- Complies with responsibilities under the Health &amp; Safety in Employment Act 1992</td>
<td>- Has read and understood the Health &amp; Safety policy and procedures.</td>
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<td>- Actively manages risk</td>
<td>- Actively supports and complies with Health &amp; Safety policy and procedures.</td>
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<td>- Evidence of support and compliance with health and safety policy and procedures including use of protective clothing and equipment as required, active participation in hazard management and identification process, and proactive reporting and remedying of any unsafe work condition, accident or injury.</td>
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Key Relationships & Authorities

Reports to:
- Operations Manager
- ADON MCC

Key relationships within directorate/service:
- ORA Geriatricians, medical staff
- Associate Director of Nursing
- CAREful team
- MAPU
- Nurse Practitioner (older Adult) – Kapiti
- CNS Older Adult and Liaison Nursing Team
- District Nurses
- ORA Clinical Leader
- ORA Multi Disciplinary Team
- Kenepuru (HOP) inpatient units

Key relationships outside directorate/service:
- Medical and Nursing Specialists
- Psychogeriatric team
- Laboratories, Pharmacy, Radiology
- Nurse Practitioners within the 3 DHBs
- SIDU Portfolio Managers
- ADON-Practice Development -DONM Office

External to CCDHB
- Primary health GPs and PHC Teams
- Wellington Free Ambulance
- Care Coordination Centre and Care Manager Service
- Community home base support Services
- Aged Residential Care providers
- Non-Government Organisations (e.g. Age Concern NZ; The Parkinson Society of NZ)
- Professional Association/College (e.g. NZ Association of Gerontology)
- Sub regional Older Adult Services

Nurse Practitioner

Has these direct reports:
- Nil
### Capability Profile

#### Competencies

The role holder must be able to demonstrate achievement of the Nursing Council New Zealand (NCNZ) competencies for the Nurse Practitioner scope of practice. See [www.nursingcouncil.org.nz](http://www.nursingcouncil.org.nz) and [www.hpca.govt.nz](http://www.hpca.govt.nz).

In addition to the above, solid performance in the role requires demonstration of the following CCDHB competencies. These competencies provide a framework for selection and development.

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<th>Competency</th>
<th>Behaviours</th>
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| **Communication and Interpersonal Skills** | • Has excellent communication and negotiation skills so that appropriate and timely clinical care can be provided in a cohesive manner from a range of services across continuum of care.  
• Situations may often call for tact, diplomacy and will require information to be handled in a discreet and sensitive manner  
• In conflict situations is able to exercise sound judgement, negotiation and persuasiveness skills, toward facilitating a workable outcome. |
| **Problem solving**             | • Uses rigorous logic and methods to solve difficult problems with effective solutions  
• There will be a requirement to be able to prioritise issues and negotiate time frames, while still providing a quality customer service.  
• The range of problems will be diverse and require solutions customised to meet the circumstances of the patient/family  
• Probes all fruitful sources for answers  
• Can see hidden problems  
• Is excellent at honest analysis |
| **Priority setting**            | • Spends his/her time and the time of others on what’s important  
• Quickly zeroes in on the critical few and puts the trivial many aside  
• Can quickly sense what will help or hinder in accomplishing a goal  
• Eliminates roadblocks  
• Creates focus |
| **Customer Focus**              | • Is dedicated to meeting the expectations and requirements of internal and external customers  
• Gets first-hand customer information and uses it for improvements in products and services  
• Acts with customers in mind  
• Establishes and maintains effective relationships with customers and gains their trust and respect |
| **Integrity and trust**         | • Is widely trusted  
• Is seen as a direct, truthful individual  
• Can present the unvarnished truth in an appropriate and helpful manner  
• Keeps confidences  
• Admits mistakes  
• Doesn’t misrepresent her/himself for personal gain |
| **Negotiating**                 | • Can negotiate skilfully in tough situations with both internal and external groups  
• Can settle differences with minimum noise  
• Can win concessions without damaging relationships  
• Can be both direct and forceful as well as diplomatic  
• Gains trust quickly of other parties to the negotiations  
• Has a good sense of timing |
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<tr>
<td><strong>Teamwork</strong></td>
<td>• Develops constructive working relationships with other team members.</td>
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<td>• Has a friendly manner and a positive sense of humour.</td>
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<td>• Works cooperatively - willingly sharing knowledge and expertise with colleagues.</td>
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<td>• Shows flexibility - is willing to change work arrangements or take on extra tasks in the short term to help the service or team meet its commitments.</td>
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<td>• Supports in word and action decisions that have been made by the team.</td>
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<td>• Shows an understanding of how one’s own role directly or indirectly supports the health and independence of the community.</td>
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<td><strong>Taking responsibility</strong></td>
<td>• Is results focussed and committed to making a difference.</td>
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<td>• Plans and organises work, allocating time to priority issues, meeting deadlines and coping with the unexpected.</td>
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<td>• Adjusts work style and approach to fit in with requirements.</td>
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<td>• Persevers with tasks and achieves objectives despite obstacles.</td>
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<td>• Is reliable - does what one says one will.</td>
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<td>• Consistently performs tasks correctly - following set procedures and protocols.</td>
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<td><strong>Cultural Skills</strong></td>
<td>• Words and actions show an understanding of the implications for one’s work of Te Tiriti o Waitangi principles and Maori perspective as tangata whenua.</td>
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<td>• Values and celebrates diversity - showing respect for other cultures and people’s different needs and ways of living.</td>
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<td>• Shows an awareness of gaps in, and a desire to increase, cultural knowledge and inter-cultural practice relevant to one’s work.</td>
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<td>• Accesses resources to make sure culturally appropriate and language appropriate services are provided.</td>
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|                  | • Draws on a client’s own cultural resources and support frameworks.
Other aspects of capability not covered by the above competencies

a) Knowledge and Experience:
   - Evidence of advanced nursing expertise and working across care settings
   - Leadership experience and knowledge
   - Knowledge of current issues within nursing and in health of the Older Adult specialty nursing.
   - Sound knowledge and understanding of medico/legal and ethical responsibilities
   - An understanding of population health
   - Evolution of excellent communication, interpersonal and facilitation skills
   - Knowledge of clinical quality improvement strategies
   - Demonstrate an ability to access and use available clinical information systems
   - Advanced clinical assessment and management skills in define specialty patient care

b) NP Essential Professional Qualifications / Accreditations / Registrations:
   - Registration with the Nursing Council of New Zealand as a Nurse Practitioner in Health of the Older Adult
   - NP roles and experience

c) Someone well-suited to the role will place a high value on the following:
   - Skills in problem solving, priority setting, delegation and planning.
   - The ability to communicate effectively with all levels of staff and develop relevant networks.
   - The ability to work in a wide range of patient settings across the continuum of care.
   - A capacity to demonstrate strong clinical leadership.
   - Coordination of services to clients
   - Delivering identified outcomes
   - Measurement and monitoring
   - A strong patient care focus with strengths in sharing that information
   - High quality care for the patient/client/whanau
   - Ability to self evaluate and reflect on practice
   - The development of the nursing profession

CCDHB is committed to supporting the principles of Equal Employment Opportunities (EEO) through the provision and practice of equal access, consideration, and encouragement in the areas of employment, training, career development and promotion for all its employees.

CCDHB is committed to Te Tiriti o Waitangi principles of partnership, participation, equity and protection by ensuring that guidelines for employment policies and procedures are implemented in a way that recognises Māori cultural practices.

The role description will be reviewed regularly in order for it to continue to reflect the changing needs of the organisation. Any changes will be discussed with the position holder before being made.