

PORTLAND

PURPOSE

To provide staff appointed to a position details of the inherent requirements and or duties of the position.

TARGET AUDIENCE

Portland District Health (PDH) staff appointed to a position as per position statement

POLICY / PROCEDURE / GUIDELINE

- Assume responsibility and accountability for own actions and the delegation and supervision of nursing care to other Registered Nurses (RNs).
- Promote optimal outcomes while delivering values based and patient centred care through competent practice in the following functional areas

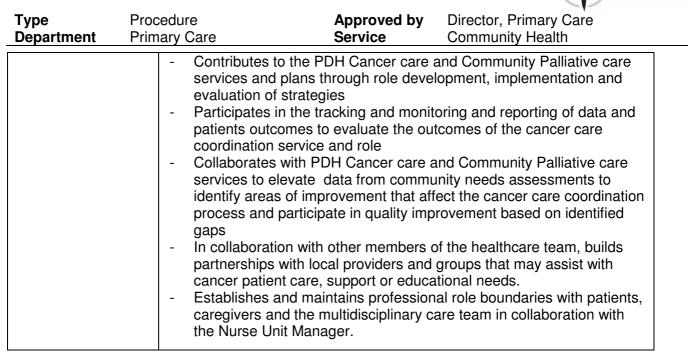
Coordination of Care	 Assesses patient needs upon initial encounter and periodically throughout navigation, matching unmet needs with the appropriate services and referrals and support services, such as palliative care, allied health, medical specialists and financial services Identifies potential and real barriers to care (e.g. transportation, caring responsibilities, housing, language, culture, literacy, employment, financial) and facilitates referrals as appropriate to mitigate barriers Develops knowledge of available local, community and national resources and the quality of services provides; also established relationships with the provider of these services Uses appropriate screening/ assessment tools and methods (e.g. carer stress, pain scale, motivational interviewing) to promote a consistent wholistic plan of care Facilities timely scheduling of appointments, diagnostic testing and procedures to advance the plan of care and to promote continuity of care Participates in coordination of the plan of care with the multidisciplinary team, promoting timely follow up on treatment and supportive care recommendations Facilitates individualised care within the context of functional status, cultural considerations, health literacy, psychosocial and spiritual needs for the patients, families and care givers Applies knowledge of clinical guidelines and speciality resources throughout the cancer continuum Support a smooth transition of patients from active treatment into survivorship, chronic cancer management or end of life care Assists patients with cancer with issues related to treatment goals, advanced care directives, palliative care and end of life concerns using a framework that is non-judgemental and non-discriminatory Maintains accurate and timely documentation of patient encounters and provided services
Communication	 Builds therapeutic and trusting relationships with patients, families and caregivers through effective communication and listening skills

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Type Department	Procedure Primary Care	Approved by Service	Director, Primary Care Community Health
	 providers to o Advocates fo care that inclu- with optimal o Provides psyc for patients, fi- high emotiona Empowers patheir needs Adheres to est and privacy Promotes a patheir needs Adheres to est and privacy Promotes a patheir needs Ensures all car identified level Facilitates con team to prevent affect patient Provides candomic 	optimize outcomes r patients to promote values shared decision ma outcomes chosocial support to and amilies and care givers, al stress and anxiety atients and families to se stablished regulations co patient and family centred ing and advocacy for pa ommunication is cultural of health literacy mmunication among me ent fragmented or delaye outcomes	ly sensitive and appropriate for mbers of the multidisciplinary ed care that could adversely awareness raising to groups,
Education	 taking into co cultural influe Provides and about diagnor post-treatmen Educates pat Nurse Coordi Orientates an cancer care p available reso Promotes aut provision of ir Educates and families and of follow up Assesses and strategies thr Provides anti- patients in co expected oute Obtains or de 	es educational needs of patients, families and caregivers by the consideration barriers to care (e.g. literacy, language, influences, comorbidities) s and reinforces education to patients, families and caregivers agnosis, treatment options, side effect management and atment care and survivorship es patients, families and care givers on the role of the Cancer coordinator es and educates patients, families and care givers to the care pathways, the multidisciplinary team member roles and e resources es autonomous decision making by patients through the n of individualised education and support es and reinforces the significant adherence with patients, and care givers regarding treatment schedules, protocols and o es and promotes healthy lifestyle choices and self-care es through education and referral to services s anticipatory guidance and manages expectations to assist in coping with the diagnosis of cancer and its potential or	
Professional Ro	the care of pa cancer - Demonstrates	atients with a past, curre s effective communication	nced based practice to improve nt or potential diagnosis of on with peers, members of the organisations and resources

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Source: Oncology Nursing Society. '2017 Oncology Nurse Navigator Core Competencies'

- Foster positive team dynamics and workplace culture.
- Ensure documentation of client/patient/resident care is in accordance with Portland District Health policies and discipline specific guidelines.
- Collate and report data that will assist in the development of appropriate pathways and protocols as well as the management and evaluation of the service.
- Facilitate a learning environment by implementing strategies that support and promote education, learning, and workforce development, including leadership and research initiatives.
- Actively participate in clinical networks and work collaboratively with health care teams across the care continuum.
- Participate in ongoing professional development of self and others, particularly other Registered Nurses, and take an active role in the performance appraisal process.
- Undertake relevant professional development and training, including PDH mandatory training, and maintain Continuing Professional Development (CPD) portfolio and renewal of registration with Australian Health Practitioner Regulation Agency (AHPRA)
- Contribute to quality health care and the nursing profession, by participating in research activities
- Ability to organise programs and/or special projects, as required and/or delegated.
- Demonstrate the ability to assume extra responsibilities as requested by the line manager or senior clinicians.
- Attend team meetings and other relevant external meetings as directed by line manager.
- Participates in approved research, as appropriate
- Other duties as required or directed to undertake

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Туре	Procedure	Approved by	Director, Primary Care
Department	Primary Care	Service	Community Health

DEFINITIONS / ABBREVIATIONS

Duty List – A list of the main tasks (inclusive of the inherent requirements) of the position.

EVALUATION

This document will be reviewed in the event of a change to position duties, prior to advertising for a new position or within 3 years.

KEY ALIGNED DOCUMENTS

Occupational Health & Safety Policy Recruitment and Selection Policy

KEY LEGISLATION, ACTS & STANDARDS

NSQHS Standards Edition 2 Aged Care Quality Standards Fair Work Act 2009

REFERENCES

AUTHORS / CONTRIBUTORS

Name	Position	Review date
Name	Position	Date
Margaret Cadenhead Joanna Spurge Carolyn Milliard	Director, Primary Care Nurse Unit Manager Nurse Unit Manager	17 June 2020

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