POSITION DESCRIPTION

Clinical Nurse Consultant A/B – Complex Care

Supporting Everyone to be healthy and live well

PURPOSE OF THE ROLE

The CNC-Complex Care is a senior clinical nursing position that encompasses a varied caseload across the spectrum of the health Independence Program.
The role provides high quality management of a caseload of clients, that may require ongoing intensive care coordination, and works within the Complex Care team, in collaboration with the ERH and external Multi-Disciplinary health care coordination team of the individual client.

The nursing responsibilities of the role include various elements of client self-management skills, health literacy education, clinical nursing management and/or support to become and maintain health independence though evidence based clinical pathways. A component of the role is to reduce avoidable hospital presentations, admissions or readmissions to hospital and coordinating client care and support activities aimed at optimizing the client's health independence.

Position Details	
Position Title:	Clinical Nurse Consultant A/B- Complex Care
Department	Community Services
Reports to:	IPAC Manager
Positions Reporting to this role:	Nil
FTE:	To be determined
Budget:	IPAC
Enterprise Agreement:	Nurses and Midwives Enterprise Agreement 2024-2028
Position Classification:	CAPR 3.1 Clinical Nurse Consultant A (Year 1-2) Clinical Nurse Consultant B (Year 3 and thereafter) (ZF4-ZJ4)
Position Description last reviewed:	June 2025

Essential:
Qualifications: • Tertiary Health qualifications in a specialist field. • Ongoing CPD in Chronic Disease Management. • Registered Nurse with Nursing and Midwifery Board of Australia (NMBA) • Annual training as per the ERH Learning Management System (LMS) • Yearly Code Grey / Aggression Training • BLS
Desirable:
Minimum 4 years post qualification in acute nursing

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Key Accountabilities

The CNC Complex Care demonstrates well-developed clinical competencies, a commitment to achieving the provision of a holistic chronic disease management service and professional attributes necessary to accomplish the following:

- Provide advanced nursing care to people recovering from a medical illness or with chronic and complex health needs receive appropriate services to maximise their health.
- Works as the primary point of contact to:
  - support the intake and triage of new patient referrals,
  - Undertake Initial Needs assessment, and a Comprehensive assessment,
  - Plan, implement and evaluate goal directed care planning,
  - care and service coordination within a multi-disciplinary setting to facilitate effective transition of bed- based care from ERH into the community preventing readmission into hospital.
- Assesses all referrals, coordinates and responds to referrals against HIP admission criteria in a timely manner.
- Manages and maintains own allocated client case load with face to face visiting of clients in their homes weekly to fortnightly- equals two and above visits per day.
- Provides health literacy and self help coaching to clients with chronic disease in the community.
- Demonstrates proficiency in the use and purpose of the Remote Patient Monitoring system and devices. Educating clients in the use of such devices.
- Demonstrating a holistic approach to the management of clients with chronic diseases consistent with the Health Independence Program, (HIP) model of care.
- Capacity building of key health providers through effective marketing of the program and education relating to the principles of chronic disease management.
- Incorporation of self- management goals of individual clients into their health care plan.
- Timely clarification of client medical guidelines established through a well- developed rapport with medical staff.
- Maintain Department of Health Key performance Indicators for the Complex Care program under the HIP Guidelines and IPAC Department Standard Operating Procedures:
  - Clients are contacted for screening of referral within 3 working days (target 80%)
  - Admission to first face to face contact less than 10 working days (target 80%)
  - Documented communication to GP, Medical Health Record and other primary care services at handover/transition and discharge (target 100%)
  - Length of episode of care 1 - 6 months, extension to program required with approval of manager
  - All clients are formally case reviewed with peers, meetings 2-3 times a week
- Involvement in committees and working parties, conducted within ERH and external to the organisation.
- Meet and continue to adhere to the requirements of ERH Credentialing and Professional Standards Policy.
- Maintaining a cohesive working environment.
- Undertaking professional development specific to Complex Care needs.
- Assisting the IPAC Team to achieve effective and efficient management of personnel, material and financial resources.
- Supporting the IPAC Manager in the development of policy and procedure incorporating best practice principles to underpin the Complex Care program.
- Assisting with the preparation and implementation of the IPAC Business Plan.

• Planning and organisation of workload to achieve specific objectives in the most efficient way with resources and time available • The Complex Care Coordinator may be requested to perform other duties, as reasonable and appropriate, from time to time.
Satisfactory evidence of; National police check, NDIS screening check, Working with Children's and Vaccination status in line with policy and procedure at this time.

Key Selection Criteria
KSC 1: Registered Nurse holding tertiary health care qualifications with relevant post graduate clinical experience or equivalent
KSC 2: Demonstrated ability to work autonomously and effectively within a multi-disciplinary health care team. Demonstrated ability to communicate professionally and effectively with people at all levels. Sound leadership and collaboration skills.
KSC 3: Demonstrated commitment to providing seamless care intervention across the acute and community interface
KSC 4: Knowledge of health care services, community support programs and agencies operating in the ERH catchment
KSC 5: Well developed interpersonal and written communication skills using IT platforms
KSC 6: Sound clinical and organizational skills, the ability to be effective, flexible and responsive in a changing environment in the management of clients with chronic disease
KSC 7: Understanding of the Health Independence Program, (HIP), model of care and Complex Care background and objectives
KSC 8: Demonstrate understanding and application of continuous quality improvement

Organisational Responsibilities
Positively promote ERH within and externally to the organisation
Comply with the ERH and Victorian Public Sector Code (VPS) of Conduct
Each employee has a responsibility to comply and promote practices with all ERH policies and procedures and familiarise themselves with those relevant to their position
Comply with relevant registration bodies mandatory continuing professional development requirements
Carry out all work and interactions in alignment with the CARE values
Report all incidents and near misses as soon as possible after the event
Participate in risk management activities and assist with identification and control of risks within their department or area of work
Actively support compliance with the National Safety & Quality Health Service Standards and other professional standards and relevant regulatory requirements

CARE Values	
All staff are expected to behave in a way that is in alignment with our corporate values:	
Collaboration	Works with a team focus Cooperates with others and gains input and support to assist in achieving objectives We work with others to achieve shared goals

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Accountability	Monitors the impact of one's own behaviour on others Supports a "no-blame" culture in reporting incidents and helping to effectively resolve them
Respect	Treats people fairly and openly Treats people with dignity Demonstrates personal standards of consistency, tolerance and patience
Excellence	Consistently supports and follows organisational policies and procedures Actively participates in identifying opportunities to improve what we do

Key Relationships	
Internal	**External**
IPAC Manager, Complex Care Team, Allied Heath Teams, Doctors, Nurses	GP's, Community Service Providers, other health services

Leadership Capabilities

The table below indicates the leadership capability levels required. This table will need to be read in conjunction with the ERH Leadership Capability Framework.

✓ **PLEASE USE A TICK ICON TO INDICATE REQUIRED LEVEL**

Category	**Descriptors**	Foundation	Proficient	Advanced	Highly Advanced
Collaboration	Inspires direction & purpose		•		
	Turns challenges into opportunities			•	
	Communicates effectively			•	
	Builds relationships			•	
	Works collaboratively			•	
Accountability	Acts with integrity		•		
	Demonstrates accountability		•		
	Drives accountability			•	
	Manages self			•	
	Promotes innovation			•	
Respect	Accessible communicator		•		
	Values difference		•		
	Consistently articulates direction		•		
	Empowers others		•		
	Respectfully influences		•		
Excellence	Delivers results			•	
	Plans and prioritises			•	
	Thinks and solves problems			•	
	Consumer focus			•	
	Innovation change leader			•	

TERMS & CONDITIONS OF EMPLOYMENT:
Terms and conditions are in accordance with the Letter of Offer and Contract of Employment.

I acknowledge that I have received a copy of this position description. I have read (or have had read to me) and understand the requirements of this position. I agree to work in accordance with this position description.

Signed: Date: / /

Print Name:

cc: Employee File