Home Help Service

Roles & Responsibilities

This paper sets out the HSE position in relation to the Clinical Governance role of the Public Health Nursing Service / Health Professionals in respect of the Home Help Service. The HSE position is being set out so that there is no ambiguity in relation to the fact that oversight of all clinical aspects of care continues to be undertaken on behalf of the HSE by health professionals.

1. **Relevant Documents/Policies/Legislation**
    a. National Standards for Safer Better Healthcare **(**Health Information & Quality Authority) *Under section 8(1)c of the Health Act 2007, the Authority has the function to monitor compliance with standards and to advise the Minister for Health and the HSE accordingly(Appendix 1)*
    b. The National Home Help Agreement (Appendix 2)
    c. The Job description of the Public Health Nurse (Appendix 3)
    d. *'Scope of Nursing and Midwifery Practice Framework'* The Nursing & Midwifery Board of Ireland, April 2000 (Appendix 4)
    e. '*Professional Guidance for NURSES WORKING WITH OLDER PEOPLE*' Irish Nursing & Midwifery Board April 2009 (Appendix 5)
2. **Definitions**
    a. **Personal care** – in the context of the home help service refers to assistance with activities of daily living (ADL), such as personal hygiene, bathing, dressing, functional transfers etc. The home help worker must be provided with direction from the health care professional (usually the public health or community nurse) and the professional must satisfy him/herself that the home help displays the ability to undertake the care required correctly and can do so even when the professional is not present. The home help must be made aware of what to do and who to contact if he or she is having a difficulty or experiences a change in the person's condition or reaction while undertaking the care duty. The **health care professional** principally the PHN service retains responsibility for the clinical care of the client on behalf of the HSE and in this context is responsible for interpretation of the clinical & personal care aspects of the Care Plan in context of the persons clinical / medical / physical needs
    b. **Domestic or Household Care** refers to assistance with essential domestic duties (instrumental activities of daily living - IADL) in the areas of the home occupied by the service user, which are essential in order to maintain the person in their own home e.g. nutrition and essential environmental care.

3. Service Description The home help service refers to all personal and domestic care services in the Community. The term home help worker is used to include home helps and home care assistants who deliver home based services (personal care and/or domestic tasks) to people who live at home. The home help service may be provided directly by the HSE or on behalf of the HSE through arrangements with voluntary or private providers regardless of the source of funding.

4. Management Structure – each Area will ensure that the appropriate management structure is in place above the Home Help Coordinator. Currently there are a range of structures in place to support the home help service but the crucial relationship that is required is as outlined above and that it is incumbent on all areas to ensure that the local management process is cognisant of the need for absolute clarity of approach as outlined.

5. Service Delivery Regardless of whether the home help service is subsequently delivered by HSE staff or by external service providers, HSE health professionals (principally public health and community nurses) undertake care needs assessments, document same, make determinations of care needs of clients and draw up and sign off the care plan. The health professional liaises with the home help co-ordinator to agree the level of home help service subsequently allocated to support the assessed need of the individual within available resources.

The assignment of the individual HSE employed home help worker will be undertaken by the home help co-ordinator, in consultation with the HSE healthcare professional(s) who undertook the assessment.

Assignment of non-HSE employed home help workers will be in line with the requirements of the Service Agreement with the provider.

6. HSE employed Home Help Co-ordinators have line management responsibilities for HSE employed home help workers. The co-ordinator is a member of the Health and Social Care Network and is responsible for the assignment of home help workers and allocation of home help services in consultation with the key health professionals in accordance with these guidelines. The home help co-ordinator has responsibility for the delivery of the home help service to primary care teams and are responsible for

- the assignment of individual home help workers in line with their assessed competencies to individual clients in consultation with health professionals
- management of home help workers including leave arrangements, payment of wages, data collection, HR requirements including references, vetting, etc
- allocation of home help services in close co-operation with the key health professionals
- supervision of home help workers non-clinical aspects of service
- The home help co-ordinator will, on the basis of the care plan signed off by the HSE health professional(s) who undertook the care needs assessment, develop in conjunction with the health professional and the client a schedule of services outlining the times and days of service and the tasks to be completed by the home help worker
- act as point of contact with the service for clients/families. However as Home Help Workers operate as part of a team they should make direct contact with the relevant PHN if the care needs of the client alter or if health/welfare concerns arise in relation to a client.
- identify and facilitate attendance for mandatory training
- liaising with clients to ensure necessary supplies and/or equipment are in place in the home for domestic care as per care plan

In this way the home help co-ordinator provides financial and non-clinical governance and HR management support to home help workers working closely with health professionals to ensure that home help service delivery is integrated seamlessly with

other services. The job description of the Home Help Co-ordinator does not permit Home Help Co-ordinators to undertake clinical /personal care needs assessments or reviews.

7. Clinical Role of PHN service / Key Health Professional

The lead Health Professional in relation o Home Help Services is predominantly the public health or community nurse unless there is good reason for the multi-disciplinary team (PCT) to nominate an alternative lead or key health professional.

- To assess & review client care needs and ADL & IADL deficits on behalf of the HSE. The home help service provided to individual service users is monitored and reviewed on a regular basis to ensure it continues to support the assessed need of the individual regardless of whether the service provider is the HSE, Voluntary Provider or a Private Provider. The intervals for formal review will be determined by the health professional at the time of undertaking the initial care needs assessment and at subsequent reviews. However a formal review of mainstream home help will be undertaken at least once every six months and at a minimum once every 3 months in the case of home help services as part of a Home Care Package or more regularly if determined by the health professional. Reviews shall be undertaken and documented by HSE health professional(s)
- To call up or determine on behalf of the HSE the types of services required to support the identified needs with particular reference to personal care inputs (including personal care which is to be provided by competent home helps)
- To complete the care plan on behalf of the HSE (in conjunction with other professionals as required and with Home Help Co-ordinator)
- To liaise with the Home Help Co-ordinator to agree the level of home help service subsequently allocated to support the assessed need of the individual within available resources (and based on a time to task tool). Should any difference of opinion arise that cannot be resolved through negotiation & agreement at this level then the Home Help Service Manager and the Health Professional Service Manager will meet to agree the way forward.
- Where it is clear or apparent in the course of attending in a clients home that home help services being procured privately by the client or their families (with or without HSE support) is inappropriate or of a poor standard it is incumbent on HSE staff to report such concerns appropriately.

Specifically in relation to HSE employees, the following additional responsibilities apply in relation to health care professional's role - ***generally PHN/community Nurse***

- Ensuring that HSE employed home helps personal care competencies are reviewed in line with the changing needs of the clients and with emerging practice.
- Certifying personal care skills & competencies as part of ongoing local/ national training and as part of appropriate certified training programmes e.g. Fetac certified programmes.

Home Help Service – Governance Framework

HSE Health Professional - usually PHN/Community Nurse	Home Help Coordinator (may be employed by HSE or other Service Provider)
Assess client care needs and document same	Line Manager for Home Help Workers
Identify ADL and IADL deficits requiring support and document in care plan	Responsible for the allocation of home help service in direct consultation with the key health professionals
Determine the care inputs required to support the client's assessed care needs	Prepare schedule of Home Help Services in consultation with Health Professional(s) setting out hours and days of attendance
Prepare and sign off Care Plan in consultation with relevant other health professionals and with HH Coordinator	Liaise with health professional(s) to agree appropriate level of home help input within limit of available resources and competence
Delegate personal care tasks to individual Home Help Worker & supervise same	Provide HR Support to Home Help Service including staff supervision, leave arrangements, payroll, etc
Orientate, instruct, guide and supervise the HSE Home Help Workers in personal care needs in relation to the care plan for the individual client.	Support integrated service delivery across HSE disciplines
Monitor/Review personal care inputs delegated to HSE employed Home Help Workers and monitor indirect service provision	Undertake environmental risk assessments in consultation with relevant health professionals
Monitor on-going care of clients, including clients receiving home help services from external voluntary and private providers, on behalf of HSE	Manage resources available for Home Help Service
Undertake care need reviews of clients as appropriate but at least once every 6 months for home help clients & once every 3 months where services are provided as part of a Home Care Package	Review delivery of non-personal care tasks and environmental risks at appropriate intervals
Monitor and raise any concern where it is clear or apparent that home help being procured privately by people or their families without HSE support is inappropriate or of a poor standard	Provide point of contact for home help clients with home help service

Appendix 1

Relevant HIQA Standards/ Legislation

National Standards for Safer Better Healthcare (Health Information & Quality Authority) *under section 8(1) c of the Health Act 2007, the Authority has the function to monitor compliance with standards and to advise the Minister for Health and the HSE accordingly*

Section 2: Effective Care and Support

Standard 2.2

Care is planned and delivered to meet the individual service user's initial and ongoing assessed healthcare needs, while taking account of the needs of other service users.

Standard 2.3

Service users receive integrated care which is coordinated effectively within and between services

2.3.1 Formally agreed systems, when care is provided by more than one service provider, to actively coordinate the provision of care. This is done in partnership with service users while respecting their confidentiality.

2.3.2 Active cooperation with other service providers, in particular when service users are transferring within and between services.

2.3.3 Sharing of necessary information to facilitate the safe transfer or sharing of care, in a timely and appropriate manner and in line with relevant data protection legislation.

2.3.4 Arrangements to facilitate effective communication and multidisciplinary team-working to deliver integrated care.

2.3.5 Provision of information about the process for transfer of care, to ensure clarity for service users and other service providers.

Standard 2.4

An identified healthcare professional has overall responsibility and accountability for a service user's care during an episode of care.

2.4.4 Identification of a healthcare professional who is accountable and responsible for the coordination of a service user's care, including during an episode of care involving multiple clinical specialties.

Standard 2.8

The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.

Section 3: Safe Care and Support

Standard 3.1

Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.

Standard 3.3

Service providers effectively identify, manage, respond to and report on patient-safety incidents.

Section 5: Leadership, Governance and Management

Standard 5.5

Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.

Standard 5.1

Service providers have clear accountability arrangements to achieve the delivery of high quality, safe and reliable healthcare.

Standard 5.2

Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare.

Standard 5.5

Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.

Standard 5.6

Leaders at all levels promote and strengthen a culture of quality and safety throughout the service.

Standard 5.7

Members of the workforce at all levels are enabled to exercise their personal and professional responsibility for the quality and safety of services provided.

Standard 5.8

Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.

Standard 5.9

The quality and safety of services provided on behalf of healthcare service providers are monitored through formalised agreements.

Section 6: Workforce

Standard 6.2

Service providers recruit people with the required competencies to provide high quality, safe and reliable healthcare.

Standard 6.3

Service providers ensure their workforce have the competencies required to deliver high quality, safe and reliable healthcare.

Section 7: Use of resources

Standard 7.1

Service providers plan and manage the use of resources to deliver high quality, safe and reliable healthcare efficiently and sustainably.

Standard 7.2

Service providers have arrangements in place to achieve best possible quality and safety outcomes for service users for the money and resources used.

Section 8: Use of Information

Standard 8.1

Service providers use information as a resource in planning, delivering, managing and improving the quality, safety and reliability of healthcare.

Standard 8.2

Service providers have effective arrangements in place for information governance

Standard 8.3

Service providers have effective arrangements for the management of healthcare records.

Appendix 2

National Home Help Agreement

The National Home Help Agreement states

Assessment of Need

The clients/families need for home help/home care services will in most instances be a subset of their overall care and support needs. The best practice model being developed envisages that the client/family needs will be assessed on a comprehensive basis using a common assessment tool by a health care professional who will be part of the primary care team. The aim of this approach is to provide a comprehensive and integrated care plan for each client/family. It is intended that the home help organiser will have important input into the assessment and ongoing monitoring of the non-clinical needs of the client/family. Once the assessment of the clients care needs have been reported on, the home help organiser will be responsible for the detailed specification of the clients home help needs so that these can be matched to the work specification to be given to the home help. As the home help will be one of the most frequent if not the most frequent visitor to the client's home they have an important role also in prompting changes to the service provision where for example a client's condition becomes more dependant, deteriorates or improves as the case may be or where needs other than those prescribed are manifest. Such prompting should be notified to the primary care team.

The home help organiser will have overall responsibility for the delivery of the non-clinical support he/she will also have a valuable role in prompting his/her colleagues in the other professions on changes in the client condition reported to them by the Home Help whom they supervise

Extract From National Home Help Agreement

Appendix 3 Job description of Public Health Nurse

Note: Sections in blue are prompts for HR personnel to facilitate local customisation and should not appear in advertised job specs

Job Title and Grade	**Public Health Nurse PCCC** *(Grade Code 2828)*
Competition Reference	*Completed by HR*
Closing Date	*Completed by HR*
Proposed Interview Date(s)	*Completed by HR*
Taking Up Appointment	*Completed by HR* *The successful candidate will be required to take up duty no later than xxxxxxxx.*
Location of Post	*This section will be completed locally and is post specific. It will provide candidates with an overview of the service. It should provide the following types of information:* ❑ *Where is the job located?* ❑ *Which geographical area?* ❑ *What are the possible future developments for the service?* ❑ *What is the team structure?*
Organisational Area	*Completed by HR*
Details of Service and Service development	The staff appointed to these posts will work within Primary, Community and Continuing Care (PCCC); the Public Health Nurse will be expected to provide a broad based integrated prevention, education and health promotion service. S/he will actively participate with other relevant care professionals in planning patient care and will attend case conferences, working as part of multi-disciplinary Primary Care Team delivering a coordinated approach to eligible client care. S/he will be required to actively participate with other relevant care professionals in planning patient care, and will be responsible for planning individual care plans as part of a multi-disciplinary team where appropriate and required. Within the context of the current HSE Reform Programme, 2007 – 2010, the reconfiguration of PCCC services into Primary Care Teams, the Public Health Nurse will maintain a high standard of nursing care, to share responsibility with the community nursing team for the management of nursing care and the patients' environment and to maintain a high standard of professional and ethnical responsibility. The staff appointed to these posts will work within Primary, Community and continuing Care (PCCC); working as part of multi- disciplinary (Primary Care Team) delivering a coordinated approach to client care, S/he may be required to work as a key worker for particular cases as required.
Reporting Relationship	Your reporting relationship will be to the Assistant Director of Public Health Nursing and to the Director of Public Health Nursing in accordance with the line management structure.
Purpose of the Post	The Public Health Nurse will coordinate and deliver a broad based preventative, educational, health promotion and treatment service delivery as part of the Primary Care Team in accordance with national agreements
Principal Duties and Responsibilities	**<u>Professional Responsibilities</u>** The Public Health Nurse will: • Practice Nursing according to the Code of Professional Conduct and Practice as laid down by the Nursing Board (An Bord Altranais) and Professional Clinical Guidelines • Comply with national, regional and local Health Service Executive (HSE) guidelines, policies, protocols and legislation • Work within his/her scope of practice and take measures to develop and maintain the competence necessary for professional practice • Work within his/her scope of practice and take measures to develop and maintain the

competence necessary for professional practice.

- Maintain the highest standard of professional behaviour and be accountable for his or her practice
- Be aware of ethical policies and procedures which pertain to his/her area of practice
- Respect and maintain the privacy, dignity and confidentiality of the client / patient subject to the safety, health and welfare of the client/family not being put at risk.
- Follow appropriate lines of authority within the Nurse Management structure
- Be on the An Board Altranais live register for PHN.

Clinical Practice

The Public Health Nurse will:

- Fulfil his/her statutory obligations within the legislation and HSE policies as appropriate to the role
- Promote the health, welfare and social wellbeing of the community (children, family, older persons, persons with disabilities, the chronically ill etc.)
- Manage a defined caseload based on primary care teams and evaluate and develop services within this caseload through a population health approach
- Actively participate as part of a multi-disciplinary Primary Care Team.
- Manage the care of an assigned caseload following a best practice and evidence based framework
- Assess, plan, implement and evaluate individual care plans within an agreed framework and in accordance with best practice
- Maintain and manage appropriate and accurate written records and reports regarding client care in accordance with the Nursing Board (An Bord Altranais) guidelines, child health and child care legislation, mental health legislation and other legal and local requirements
- Monitor and evaluate outcomes of care and health promotion interventions for individual clients / patients
- Report and consult with senior nursing management on clinical/social issues as appropriate
- Refer clients / patients to other services as required
- Promote, monitor and supervise care to ensure that it is carried out in an empathetic and ethical manner and that the dignity, spiritual and cultural needs of the client / patient are respected
- Actively participate as a multi-disciplinary team member in all aspects of service delivery and lead on issues as required within PCCC.
- Promote good interpersonal relationships with clients/patients, their family, social and community network supports in the promotion of person-centred care
- To initiate collaborative working with the client / patient, their family and the multi-disciplinary team, external agencies and services to facilitate the development of an appropriate care plan to ensure continuity of care
- Provide education and information to the client / patient, his/her family as required and be an advocate for the individual patient / client and for his / her family
- Delegate and supervise the work of appropriate staff in accordance with the nursing aspects of the care plan.
- Participate in clinical team meetings, case conferences and strategy meetings, taking a lead role when required.
- Participate in innovation and change in the approach to client / patient care delivery particularly in relation to new research findings, evidence based practice and advances in treatment
- Promote a positive health concept with clients and colleagues and contribute to the health promotion and disease prevention initiatives of the Health Service Executive
- Develop services to communities based on the assessed needs of that community in conjunction with the multidisciplinary team and with input and participation from the community (depending on national eligibility criteria).
- Provide nursing support to persons with a disability and their carers on an ongoing basis.
- Provide nursing support to families following bereavement, family disharmony or break-up within scope of practice
- Liaise with hospitals on discharge planning and perform home assessments prior to discharge from hospital or other institution where need identified

	• Effectively manage requests for home nursing following discharge from hospital or other institution. • Promote and participate as required in the primary and booster immunisation programmes. • Visit homes following early discharge/birth notification and for on-going child, maternal and family health services. • Liaise with and advise parents or guardians on all aspects of child health with particular emphasis on the benefits of breast-feeding. • Provide and participate in developmental screening/examination and pre-school health service. • Participate as required in the school health service and in subsequent follow up activities. • Provide regular preventive services for older people with a view to maintaining older people in dignity and independence at home in accordance with the wishes of the older person. • Initiate and operate clinics which provide a nursing service to clients and to participate in relevant and appropriate medical clinics as required • Identify and assess the need for the home help service • Identify and assess the need for and supervision of the home care attendant service **Education, Training & Development** *The Public Health Nurse will:* • Keep abreast of the latest developments in nursing practice as far as possible • Develop and use reflective practice techniques to inform and guide practice • Participate in the clinical / workplace induction of new nursing and support staff • Contribute to the identification of training needs pertinent to the clinical area • Develop teaching skills and participate in the planning and implementation of orientation, training and teaching programmes for nursing students and the nursing element of education for other health-care staff as appropriate • Identify and contribute to the continual enhancement of learning opportunities within a population health framework • Participate in regular performance / clinical reviews with his/ her line manager, identifying key performance objectives to achieve areas for improvement and appropriate plans / measures to achieve them in a supportive environment • Provide preceptorship to junior nursing colleagues when required. **Health & Safety** *The Public Health Nurse will:* • Participate in the development of policies/procedures and guidelines to support compliance with current legal requirements for the safe administration and storage of medicines and other clinical products where existing • Participate in the development of policies, procedures and guidelines with health and safety risk management personnel and participate in their development in conjunction with relevant staff and in compliance with statutory obligations • Observe, report and take appropriate action on any matter which may be detrimental to client / patient care or well being or inhibit the efficient operation of the assignment • Be aware of the principles of risk management and be individually responsible for risk management and health and safety issues in their area of work • Comply with HSE policies to minimise risk with particular reference to domiciliary visits and lone working **Administration** *The Public Health Nurse will:* • Ensure that records are safeguarded and managed as per HSE / local policy and in accordance with relevant legislation • Work closely with colleagues in the acute hospital services in order to provide a

	seamless service delivery to the client within the primary care structure. • Maintain records and submit activity data / furnish appropriate reports to the Director of Public Health Nursing as required • Contribute to policy development, performance monitoring, business planning and budgetary control • Maintain professional standards including patient and data confidentiality • Contribute to the development and implementation of information sharing protocols, audit systems, referral pathways, individual care plans and shared care arrangements • Contribute to ongoing monitoring, audit and evaluation of the service as appropriate • Accurately record and report all complaints to appropriate personnel according to local service policy **The above job specification is not intended to be a comprehensive list of all duties involved and consequently, the post holder may be required to perform other duties as appropriate to the post which may be assigned to him / her from time to time by the CEO or other designated officer. The post holder will contribute to the development of the post while in office.**
Eligibility Criteria Qualifications and/ or experience	Candidates must be registered in the Public Health Nurse Division of the Register of Nurses kept by An Bord Altranais or be entitled to be so registered bearing in mind Directive 2006/100/EC for those nurses that have trained in one of the other 26 member states in the EU. **Health** A candidate for and any person holding the office must be fully competent and capable of undertaking the duties attached to the office, taking account of health and safety and equality legislation, and be in a state of health such as would indicate a reasonable prospect of ability to render regular and efficient service. **Character** Each candidate for and any person holding the office must be of good character **Age** Age restrictions shall only apply to a candidate where he/she is not classified as a new entrant (within the meaning of the Public Service Superannuation Act, 2004). A candidate who is not classified as a new entrant must be under 65 years of age.
Post Specific Requirements	*This section may be used to include educational or experience requirements that are deemed necessary for a specific post in a specific location.*
Other requirements specific to the post	• As this post involves travel, a full driving licence and own transport is required
Skills, competencies, and/or knowledge	• Demonstrate practitioner competence and professionalism – demonstrates the highest level of clinical knowledge to carry out the duties and responsibilities of the role • Display evidence-based clinical knowledge in making decisions regarding client / patient care • Demonstrate knowledge of health, social and childcare legislation as appropriate to the role • Demonstrate understanding and/or experience of health promotion and disease prevention • Demonstrate a commitment to continuing professional development • Demonstrate evidence of effective planning, operations management and organising skills including awareness of resource management and importance of value for money • Demonstrate the ability to build and maintain relationships including the ability to work effectively in a multidisciplinary team environment • Demonstrate evidence of ability to empathise with and treat patients, relatives and colleagues with dignity and respect • Demonstrate leadership and team management skills • Demonstrate effective analytical, problem solving and decision making skills • Demonstrate initiative and innovation, identifying areas for improvement, implementing and managing change

Appendix 4

'Scope *of Nursing and Midwifery Practice Framework'*

Irish Nursing & Midwifery Board, April 2000

4.5 Delegation

Delegation is the transfer of authority by a nurse or midwife to another person to perform a particular role/function.

Each registered nurse and midwife is accountable for his/her own practice. The nurse or midwife who is delegating (the delegator) is accountable for the decision to delegate. This means that the delegator is accountable for ensuring that the delegated role/function is appropriate and that support and resources are available to the person to whom the role/function has been delegated. The nurse or midwife (or other person) to whom the particular role/function has been delegated is accountable for carrying out the delegated role/function in an appropriate manner.

When delegating a particular role/function, the nurse or midwife must take account of the following principles:

1. The nurse or midwife must ensure that the primary motivation for delegation is to serve the interests of the patient/client.

2. The nurse or midwife must ensure that the delegation is appropriate with reference to the definitions and philosophies of nursing or midwifery as appropriate.

3. The nurse or midwife must take the level of experience, competence, role and scope of practice of the person to whom the role/function is being delegated into account.

4. The nurse or midwife must not delegate to junior colleagues, tasks and responsibilities beyond their skill and experience.

5. The nurse or midwife must ensure appropriate assessment, planning, implementation and evaluation of the delegated role/function.

6. The nurse or midwife must communicate the role/function in a manner understandable to the person to whom it is being delegated.

7. The nurse or midwife must decide on the level of supervision and feedback necessary.

A nurse or midwife to whom a particular role/function has been delegated should take account of the following principles:

1. The nurse or midwife must consider if it is within their current scope of practice. If the delegated role/function is beyond the current scope of practice of the nurse or midwife, the nurse or midwife will need to consider the appropriateness of this delegation. In this

circumstance the nurse or midwife must refer to the An Bord Altranais Scope of Practice Framework.

2. The nurse or midwife must acknowledge any limitations of competence.

3. The nurse or midwife must provide appropriate feedback to the delegator.

Appendix 5 ***'Professional Guidance for NURSES WORKINGWITH OLDERPEOPLE'***

Irish Nursing & Midwifery Board April 2009

DOMAIN 4: ORGANISATION AND MANAGEMENT OF CARE
Performance Criteria: Indicators:

4.3 Delegates to other nurses and team members activities commensurate with their competence and within their scope of practice.

4.4 Facilitates the co-ordination of care, embracing the older person's choices and involvement.

4.1 Effectively manages nursing care of the older person within the multi-disciplinary team

Performance Criteria: Indicators:
• Identifies the most appropriate person to deliver care and gives directions for care activities delegated to other team members, including support staff within their scope of practice.

Performance Criteria: Indicators:
• Works with team members to ensure that care is appropriate, effective, safe and consistent.

• Collaborates with healthcare team members in providing best practice and establishes mechanisms for consultation regarding practice, consultation and referral.

• Liaises and works with agencies providing care for the older person.

- Collaborates with other healthcare team members in providing best practice and establishes mechanisms for consultation regarding practice and referral.