Ord Valley Aboriginal Health Service

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Aboriginal Corporation ICN 275

Job Description Form

Chronic Disease – Aboriginal Health Practitioner or Registered Nurse

Vision Statement

Aboriginal people in Kununurra and the North-East Kimberley are supported to live **prosperous lives that are strong, healthy, and culturally safe**.

The Purpose that defines us

We bring **clinical, cultural, and community expertise** to deliver accessible and **holistic health and wellbeing care** for people in the North-East Kimberley.

Aboriginal Community-led

We are connected and accountable to the communities we serve. We are governed by Aboriginal community leaders. We deliver services in culturally safe ways, bringing the best of medical and cultural expertise to achieve positive health outcomes. Working with and responding to Aboriginal communities is central to what we do.

Organisational Values

The Ord Valley Aboriginal Health Service has been providing critical health and support services to local Aboriginal people since 1984. Our ambition is to deliver socially, culturally, and financially accessible health care that supports communities in the North-East Kimberley to be strong, healthy, and safe. The organisation operates on the foundational pillars of Aboriginal leadership, self-determination and cultural diversity that underpin and shape the way the organisation conducts its business.

Community — We bring our connection with community to everything we do — PEOPLE TOGETHER

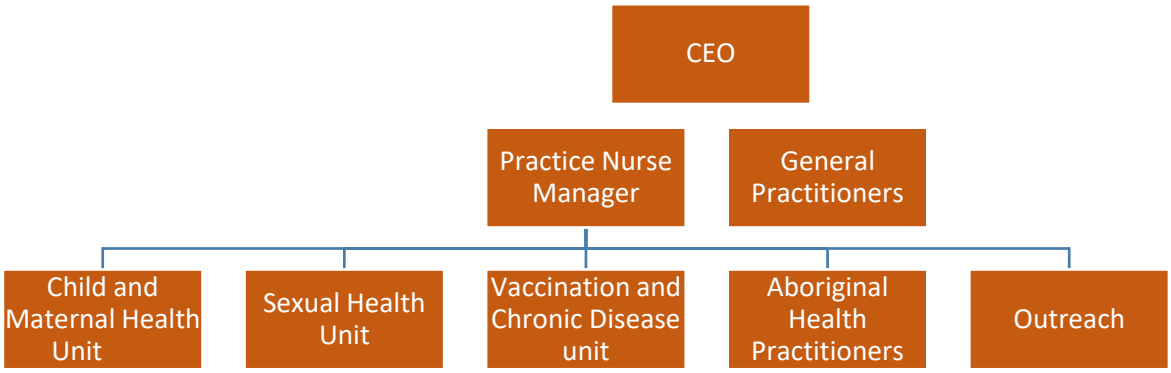
Respect — We show respect for a people, cultures and backgrounds — HEALTHY TOGETHER

Passion — We are deeply motivated to achieve outcomes — MY MOB

Equality — We strive for equality, fairness and empathy for all people — HEALTH & WELLBEING

Position Title	Chronic Disease – AHP or RN
Work Group	Clinic
Work Unit	Clinic
Reports To	Practice Nurse Manager
Direct Reports	0
Award / Agreement	*Nurses Award 2020 or ACCHS Award*
Award Classification	$84,847.46 - $98,025.41
Approved by CEO	28.07.2023

Team Structure



Position Purpose

This position is responsible for providing integrated person-centred primary health care to clients who are either at risk of developing or have been diagnosed with a chronic condition; whilst ensuring model of care meets the needs of Aboriginal clients within the context of their cultural identity and social circumstances.

This role works with the OVAHS team in providing a quality and client focused health care environment.

Aboriginal and/or Torres Strait Islander persons are strongly encouraged to apply.

Strategic Alignment

The organisation's Strategic Plan 2023- 2026 has four (4) overarching strategic goals, with each goal having specific outcomes.

The role of the Chronic Disease Nurse is aligned with all four Strategic Goals.

Primary health Care

Primary health care is the first means of accessing the health care system for many people and is critical to individual, family and community health outcomes.

Social and Emotional Wellbeing

Social and emotional wellbeing relates to the mental health for individuals and communities and is a key component for the overall health of Aboriginal people.

Specialised Health

Our communities deserve targeted support to prevent and address complex health needs, including chronic disease and disability.

Population Health

Reducing future health challenges and to Close the Gap requires long-term system change and community - wide solutions.

Key Stakeholder Relationships

External

- Aboriginal Community Controlled Health Services across the Kimberley region and Western Australia, other not-for-profit services, and businesses as relevant to the role
- Liaises with a variety of government agencies, stakeholder representative groups and community groups.

Internal

- Maintains close working relationships with other officers, team members and employees of Ord Valley Aboriginal Health Services.
- Works in collaboration with the Senior Management Team and in consultation with the Board of Directors.

Responsibilities of this Position

Clinical Practice

- Spend time with patients exploring their understanding of their condition, treatments, and

their role in reaching the best health they possibly can despite their illness.
- Offer support geared to the patients' needs in improving their health literacy using tools.
- Arrange and support patients on their journey to see OVAHS GP for health checks and treatments related to their conditions.
- Provide screening and investigations such as retinal screening and blood test always engaging and explaining the purpose of the investigations and tests.
- Follow up on patients who do not attend appointments or comply with treatment, both with OVAHS and external services referred patients, for feedback and to work with them on strategies to improve access and to work on what care they believe is needed.
- Refer and support patients to attend other non-clinic services.
- Ensure billing for services is completed as and where appropriate.

Partnerships and advocacy

- Use feedback from patients to inform practice.
- Consult with organisations such as BOABS and WACHS on patient feedback.
- Support service providers in the use of tools such as Teach Back method (DeWalt et al., 2010)
- OVAHS will provide training sessions on communications with patients to OVAHS and external services.
- Promote the notions of health literacy and the role of the service provider to new workers during orientation.

Education and health promotion

- Challenge the notions of why Aboriginal patient are not compliant with treatment.
- Challenge where change is needed by encouraging reflection and change in current practices.
- Encourage communication and Aboriginal people to have a voice through feedback.

General Chronic Conditions

- Work closely and collaboratively with the Chronic Conditions team to provide best practice in patient care.
- Follow the lead of the OVAHS Chronic Conditions Nurse Practitioner in providing safe, efficient, and effective provision of chronic conditions prevention and management including diabetes, CVD, respiratory, cancer and renal.
- Ensure coordinated patient care by maintaining assessment and pathology schedules, referring to and working with allied health services, supporting patient self-direction in health care plans and preparing for visiting specialists' clinics.
- Initiate and contribute to chronic disease GP Management Plans and team care arrangements and reviews for identified chronic conditions clients.
- Maintains chronic conditions patient lists, working with OVAHS team and external services to implement, update and regularly review client care and care plans.
- As a member of OVAHS clinic team implement strategies for the prevention and early detection of chronic diseases which have a high prevalence in Aboriginal communities
- Provide documented evidence of periodic analysis and revision of expected outcomes, interventions, and priorities in the clients' condition, needs or circumstances, and evaluate and follow up regarding new strategies to meet unmet needs or new needs as they arise.
- Identify and participate in training and education needs for work colleges in the areas of chronic disease.
- Lead continuous quality improvement activities in the ongoing endeavours to improve

chronic disease health services and outcomes for Aboriginal people.
- Promote OVAHS service areas: Sexual Health, Maternal and Child Health, Women's Health and Mental Health services to clients and initiate referrals.
- Maintain a clean and hygienic environment in the clinic and participate in maintaining, restocking, calibrating, and replacing clinic stores and equipment.

Integrated Chronic Disease Program

- Monitor client health literacy and client satisfaction over the course of the program. through completion of surveys
- Ensure all clients in the program have an individualised, comprehensive care plan in place for their chronic conditions.
- Complete teach back method training and utilise this to increase client understanding.
- Deliver in service training for staff on aspects of the program or a particular chronic. disease to improve knowledge amongst the team.
- Data for reporting to be accurate and kept up to date.

Workforce development

- Be available to meet annually with the Practice Nurse Manager to carry out regular performance appraisals.
- Participate in ongoing professional development to maintain sexual health and primary health care related skills and knowledge.
- Orientate new staff to ensure the ongoing integration of sexual health care delivery into all clinical roles.
- Act as a clinical resource to support and develop other members of the health team.
- Support the widespread uptake, implementation and revision of the Kimberley Sexual Health Protocols including the development of new protocols as required.

Evaluation

- Ongoing evaluation of screening coverage and uptake for OVAHS client population.
- Seek feedback from the community and target groups regarding planning, implementation and evaluation of any strategies developed.
- Work with the Regional Sexual Health Coordinator to regularly feedback progress the funding body.

Quality Management System

- Actively participate in the organisation's QMS (LOGIQC).
- Identify and participate in continuous quality improvement activities and apply quality improvement principles to all duties performed.
- Demonstrate leadership and commitment to promote continuous quality improvement initiatives, give assurance that the quality objectives are measured and ensure the QMS achieves intended results by engaging and supporting employees to contribute to the effectiveness of the QMS.

General

- Demonstrate a strong commitment to uphold and contribute to the organisation's mission, objectives, and values.
- Support and promote teamwork through open communication, collaboration and contribute to a positive workplace culture.
- Attend and participate in professional development activities including workshops and training as required.
- Attend and participate in Employee Development Days.
- Participate and comply with all Work Health and Safety responsibilities as per the *Work Health and Safety Act 2020* (WA).
- Identify and assist to reduce Work Health and Safety hazards and risks.
- Follow the reasonable direction of Work Health and Safety representatives.
- Be accountable for the safe, efficient, and effective use of resources, including assisting with forward planning for OVAHS.
- Manage recall lists for clients with STIs.
- Contribute to Medicare benefits schedule items.
- Work with external agencies to deliver best practice client care including Community Health, Department of Child Protection and Hospital Services.
- Visit OVAHS remote clinics (Glen Hill and Doon Doon) to increase STI screening opportunities and provide primary health care.

NOTE: This job description is not intended to be all-inclusive. Employees may perform other related duties as negotiated to meet the ongoing needs of the organisation.

Position Performance Indicators

The below Key Performance Indicators (KPI's) are used to assess, measure, evaluate, manage, and reward performance within each key result area of this position.

The below KPI's are to be assessed in line with the organisation's performance development framework.

Key Result Area	Key Performance Indicators
Compliance & Reporting	• Effective completion of all Work Unit contractual obligations including program delivery, funding reports, evaluations, and compliance requirements.
Quality Management System (QMS)	• Ensure all tasks assigned to this position are completed within a six (6) week period. • Actively lead continuous quality improvement initiatives across the organisation and promote an environment of effective CQI practices.

Selection Criteria

Competencies are the specific knowledge, skills and attributes needed to successfully undertake the role. The profile is used for recruitment, performance review, planning, and training and development activities.

Qualifications, Skills, Experience and Knowledge

Essential

1. Current registration with the Australian Health Practitioners Regulatory Authority – (AHPRA) with at least 3 years professional experience.
2. Current Provider Number (if an Aboriginal Health Practitioner).
3. Demonstrated competency in the coordination, management, and promotion of the principles of clinical management for people with, or at risk of developing, a chronic condition(s) including diabetes, renal disease, cardiac disease, and chronic respiratory conditions.
4. Practice within clinical standards and quality of care, which is effective, efficient and in accordance with best practice and agreed standards and policies.
5. Ability to support an integrated care model which includes self-management and adherence to models of supporting patient's health literacy needs.
6. Knowledge and understanding of the issues faced by Aboriginal people in rural and remote areas and the impact they have on health and wellbeing.
7. Demonstrated knowledge, competence and attitudes required to provide Primary Health Care nursing within a patient centred and culturally appropriate approach to care.
8. Ability to work collaboratively and effectively as a part of an internal and wider external team in coordinating chronic conditions prevention, and management of the progression of the disease process.
9. Able offer health promotion and education about many aspects of the disease process and healthy lifestyles to community members.
10. Written and computing skills of a level congruent with developing and evaluating detailed care plans and for preparing reports for management.
11. Demonstrate incorporation of quality and risk management within practice.
12. Can function as a team member and the capacity to work without supervision.
13. Can work for short periods under extreme weather conditions when on outreach and community visits.

Desirable

- The person identifies as Aboriginal and/or Torres Strait Islander and is acknowledged as such by their community.
- Post Graduate studies in Chronic Disease, Renal, PHC or Aboriginal Health.
- Previous nursing experience in a primary health care facility.
- Previous experience working in Aboriginal health.

Practical Requirements

- A current Western Australian driver's license and willingness to drive is essential.
- A current National Police Check (within previous 3 months).
- A current Working with Children Check
- Some work out of normal hours of duty will be required.

- Depending on the nature of the region, some travel on light aircraft may be required.
- Intra and inter-state travel including overnight absences may also be required.

Acknowledgment and Acceptance by Appointed Employee

I certify that I have read and understand the responsibilities assigned to this position.

Employee Name:	
Signature:	
Date:	