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**Clinical Nurse Specialist**

**Diabetes – Integrated Care**

**Sain-Altra Cliniciúil (Cúram Pobail/Cúram Príomhúil)**

**Job Specification & Terms and Conditions**

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| **Job Title and Grade** | **Clinical Nurse Specialist (Diabetes – Integrated Care)**  **Clinical Nurse Specialist Grade Code 2628** |
| **Remuneration** | Salary Scales as of March 2025, 60,854 61,862 62,715 64,106 65,644 67,154 68,664 70,364 71,943 74,658 76,897 LSI |
| **Competition Reference** | SLPC2509 |
| **Closing Date** | Friday 30th May 2025 @12:00 Noon |
| **Proposed Interview Date (s)** | Proposed interview dates will be indicated at a later stage. Please note you may be called forward for interview at short notice**.** |
| **Taking up Appointment** | A start date will be indicated at job offer stage. |
| **Duration of Post** | There is currently one permanent part time post available, Please note this campaign will create a recruitment panel to fill future vacancies, from which current and future, permanent and specified purpose vacancies of full or part-time duration may be filled. |
| **Location of Post** | This is an appointment to the West North West Region of the Health Service Executive.  **The base for the post will be the Benbulbin Chronic Disease Management hub, in Sligo. This role covers Sligo, Leitrim, South Donegal and West Cavan.**  In line with the Model of Care, 80% of the CNS role will involve working with MDTs including General Practitioners (GP’s) in the Specialist Ambulatory Care Hub, and 20% of CNS role will involve working with the Consultant Endocrinologist in the Specialist Ambulatory Care Hub and/or in Secondary Care OPD. There will be a strong focus on service integration and team-working. |
| **Informal Enquiries** | **Suzanne Keenan, Operational Lead, CDM,**  [**Suzanne.keenan@hse.ie**](mailto:Suzanne.keenan@hse.ie) **0879334471**  **Caroline McGoldrick, ADPHN,**  [**Caroline.McGoldrick@hse.ie**](mailto:Caroline.McGoldrick@hse.ie) **0879949954** |
| **Details of Service/Background to the post** | In line with Sláintecare (2017) and the Department of Health’s Capacity review (2018), a shift in healthcare service provision is now required to place the focus on integrated, person-centred care, based as close to home as possible. In order to enable this, the Integrated Care Programme for the Prevention and Management of Chronic Disease (ICPCD) is supporting the national implementation of a model of integrated care for the prevention and management of chronic disease as part of the Enhanced Community Care Programme (ECC). The Model of Care for the Integrated Prevention and Management of Chronic Disease has a particular focus on preventive healthcare, early intervention and the provision of supports to live well with chronic disease.  The investment in the ECC programme will be delivered on a phased basis with a view to national coverage being achieved within a two- to three- year period. Three priority areas have been identified as follows:   1. Structural reform of healthcare delivery within the community with Community Health Networks (CHNs) becoming the basic building blocks for the organisation, management and delivery of community services across the country; 2. Creating Specialist Ambulatory Care Hubs within the community to support primary care management of chronic disease and older people with complex needs; and, 3. Scaling Integrated Care for Older People and Chronic Disease through the recruitment of specialist integrated care teams including Frailty at the Front Door Teams.   The focus is on providing an end-to-end pathway that will reduce admissions to acute hospitals by providing access to diagnostics and specialist services in the ambulatory care hubs in a timely manner. For service users who require hospital admission, the emphasis is on minimising the hospital length of stay, with the provision of post-discharge follow up and support for people in the community and in their own homes, where required. A shared local governance structure across the local acute hospitals and the associated CHO will ensure the development of a fully integrated service and end-to-end pathway for individuals living with chronic disease.  The ECC Programme is underpinned by a set of key principles including:   * Eighty percent of services delivered in Primary Care are through the GP and CHNs; * Identifying and building health needs assessments at a CHN level (approximate population of 50,000) based on a population stratification approach to include identification of  people with chronic disease and frequent service users, thereby ensuring the right people get the right service based on the complexity of their health care needs; * Utilisation of a whole system approach to integrating care based on person centred models, while promoting self-care in the community; * The Older Persons and Chronic Disease Service Models set out an end to end service architecture for the identification and management of frail older adults with complex care needs and people living with chronic disease; * Learning from, and delivering services, based on best practice models and the extensive work of the integrated care clinical programmes to date, particularly in the areas of Older Persons and Chronic Disease; * Embed preventive approach to chronic disease into all services; * Availability of a timely response to early presentations of identified conditions and the ability to manage appropriate levels of complexity related to same in the community; * Resources applied intensively in a targeted manner to a defined population, implementing best practice models of care to demonstrate the delivery of specific outcomes and sustainable services; and, * The need to frontload investment, coupled with reform to strengthen community services.   **Diabetes in Ireland**  Diabetes is a serious global public health issue which has been described as the most challenging health problem in the 21st century. Cases of diabetes have progressively increased worldwide; between 1980 and 2008 there was a two-fold increase in the number of adults with diabetes. Type 2 diabetes is the main driver of the epidemic, accounting for approximately 90 % of all cases. In Ireland, in people aged 18 years and over, the prevalence of diagnosed diabetes increased from 2.2 % in 1998 to 5.2 % in 2015; representing an absolute mean increase of 0.17 % per year. In 2015, the incidence of diagnosed diabetes was 0.2/100 population.  Diabetes places a significant burden of care on the individual, health care professionals and the wider health system. Individuals with diabetes are two to four times more likely to develop cardiovascular disease relative to the general population and have a two to five-fold greater risk of dying from these conditions. Diabetes is a significant cause of blindness in adults, non-traumatic lower limb amputations and end-stage renal disease resulting in transplantation and dialysis. In the Irish Longitudinal Study on Ageing (TILDA), among people aged 50 years and over with type 2 diabetes, 26% reported microvascular complications and 15% reported macrovascular complications. This means that as well as being an important public health issue, Type 2 diabetes is a huge financial burden to the Irish health service where diabetes care consumes up to 10% of the Irish healthcare budget.  **National Clinical Programme for Diabetes**  The National Clinical Programme Diabetes (NCP Diabetes) was established in 2010 under the HSE’s Clinical Strategy and Programmes Division. Working under the direction of the National Clinical Advisor and Group Lead (NCAGL) for Chronic Disease and supported by the RCPI Diabetes Clinical Advisory Group, the aim of the NCP Diabetes is to save the lives, eyes and limbs of people living with diabetes in Ireland by:   * Decreasing morbidity and mortality through correct and early diagnosis * Providing correct treatment based on best practice guidelines for treatment (self-management, primary care and secondary care).   Guided by the model of care for chronic disease, the NCP Diabetes aims to influence positive change and improve care for people living with diabetes across the entire spectrum of healthcare delivery: self-management support; general practice; specialist support to general practice; specialist ambulatory care; and hospital inpatient specialist care.  The role of the CNS will differ according to the needs and configuration of established diabetes services at each site. The purpose of this Clinical Nurse Specialist, Diabetes Integrated Care post is to provide expertise and specialist nursing services to service users with Type 2 Diabetes both in the hospital outpatient settings and in primary care. The post holder will liaise between acute diabetes services and integrated diabetes services in the community along with other agencies to deliver effective evidenced based care. They will use resources efficiently to achieve the best possible outcomes in keeping with the National Clinical Programme Diabetes model of care and HIQA standards.  The person appointed to this post will work in Diabetes Integrated Care services. The post holder will work as part of a multidisciplinary team delivering coordinated evidence based care for service users in primary care whilst liaising closely with secondary care. |
| **Reporting Relationship** | * The professional reporting relationship is to the Director of Public Health Nursing (DPHN) or designated Nursing Manager. * The clinical reporting relationship is to the associated Consultant Endocrinologist / Integrated Care Consultant Endocrinologist or senior clinical decision maker with responsibility for the service/service user. * Will report to the Operational Lead Integrated Care ICPCD Specialist Community Team on operational and administrative matters. |
| **Key Working Relationships** | The CNS will work collaboratively with a range of internal and external stakeholders including:  The Consultant Endocrinologist(s), Diabetes Candidate Advanced Nurse Practitioners and Registered Advanced Nurse Practitioners (cCNSs/CNSs), Dietitians, Podiatrists and work in partnership with the multi-disciplinary teams across primary and secondary care.  Healthcare professionals and stakeholders involved in the provision of integrated Diabetes care in the acute setting.  Director of PHN nursing and team  Director/Assistant Director of Nursing/Line Manager  General Practitioners  Multidisciplinary Team colleagues in the chronic disease teams in the ambulatory care hub and acute setting  Community Network Managers  Multidisciplinary Team colleagues in primary and secondary care  Other key stakeholders within services, including Diabetes National Clinical Programme and the National Integrated Care Programme for Prevention and Management of Chronic Disease  Service users/families and carers  Nursing and Midwifery Board of Ireland  Educational Bodies  Nursing and Midwifery Planning and Development Units  Centres of Nursing and Midwifery Education  National Clinical Leadership Centre  Other relevant statutory and non-statutory organisations |
| **Purpose of the Post** | The CNS post holder will deliver care in line with the five core concepts of the role set out in the Framework for the Establishment of Clinical Nurse/Midwife Specialist Posts, 4th edition, National Council for the Professional Development of Nursing and Midwifery (NCNM) 2008.  The concepts are:   * Clinical Focus (Direct and Indirect Care) * Service user/client Advocacy * Education and Training * Audit and Research * Consultancy (including leadership in clinical practice)   **Caseload**  The CNS will work as part of a multidisciplinary team who will be responsible for implementing the delivery of the Model of Integrated Care for service users aged 16 years and older with Type 2 Diabetes within the community healthcare organisation/health region.  In line with the Model of Care, 80% of the CNS role will involve working with MDTs including General Practitioners (GP’s) in the Specialist Ambulatory Care Hub, and 20% of CNS role will involve working with the Consultant Endocrinologist in the Specialist Ambulatory Care Hub and/or in Secondary Care OPD. There will be a strong focus on service integration and team-working. |
| **Principal Duties and Responsibilities** | **Clinical Focus**  Clinical Nurse Specialist (Diabetes – Integrated Care) will have a strong service user focus whereby the specialty defines itself as Nursing and subscribes to the overall purpose, functions and ethical standards of Nursing. The clinical practice role may be divided into direct and indirect care. Direct care comprises the assessment, planning, delivery and evaluation of care to the service user, family and/or carer. Indirect care relates to activities that influence and support the provision of direct care.  **Direct Care**  *Clinical Nurse Specialist (Diabetes – Integrated Care) will:*   * Provide a specialist nursing service for service users with a diagnosis of Diabetes who require support and treatment through the continuum of care. * Undertake a comprehensive service user assessment to include physical, psychological, social and spiritual elements of care using best evidence based practice in Diabetes care. * Use the outcomes of the service user assessment to develop and implement plans of care/case management in conjunction with the multi-disciplinary team (MDT) and the service user, family and/or carer as appropriate. * Monitor and evaluate the service user’s response to treatment and amend the plan of care accordingly in conjunction with the MDT and the service user, family and/or carer as appropriate. * Make alterations in the management of service user’s condition in collaboration with the MDT and the service user in line with agreed pathways and policies, procedures, protocols and guidelines (PPPG’s). * Accept appropriate referrals from MDT colleagues. * Co-ordinate investigations, treatment therapies and service user follow-up. * Communicate with service users, family and /or carer as appropriate, to assess service users’ needs and provide relevant support, information, education, advice and counselling as required. * Where appropriate work collaboratively with MDT colleagues across Primary and Secondary Care to provide a seamless service delivery to the service user, family and/or carer as appropriate. * Participate in medication reconciliation taking cognisance of poly-pharmacy and support medical and pharmacy staff with medication reviews and medication management. * Identify and promote specific symptom management strategies as well as the identification of triggers that may cause exacerbation of symptoms. Provide service users with appropriate self-management strategies and escalation pathways. * Identify health promotion priorities for the service user, family and/or carer and support the individuals’ self-care in line with best evidence and using the principles laid out by MECC (Make Every Contact Count). This will include the provision educational and health promotion material, which is comprehensive, easy to understand and meets service users’ needs. * Support the initiation and continuing care of service users with Type 2 Diabetes who have been commenced on insulin/injectable therapy. * Fast track emergency referrals e.g. service users with urinary ketones or foot ulcerations to the appropriate member of the MDT for review and collaborative management planning.   **Indirect Care**  *Clinical Nurse Specialist (Diabetes – Integrated Care) will:*   * Identify and agree appropriate referral pathways for service users with Diabetes. * Participate in case review with MDT colleagues. * Manage, develop and evaluate admission avoidance pathways with GPs, Consultant and integrated teams. * Use a case management approach to service users with complex needs in collaboration with MDT in both Primary and Secondary Care as appropriate. * Take a proactive role in the formulation and provision of evidence based PPPGs relating to Integrated Care. Contribute to the development and implementation of information sharing protocols, audit systems, referral pathways, individual care plans and shared care arrangements through regular collaboration/meetings with diabetes nurses locally and nationally. * Manage clinical risk within own clinical caseload, to have up to date knowledge of indications, contraindications and precautions for any treatment skills and techniques selected and applied throughout an individual course of treatment. * Maintain professional standards including service user and data confidentiality in line with HSE policy. * Effectively manage time and caseload in order to meet the needs of an evolving service. Take a lead role in ensuring the service for service users with Diabetes is in line with best practice guidelines and the Safer Better Healthcare Standards (HIQA, 2012).   **Service User/Client Advocate**  *Clinical Nurse Specialist (Diabetes – Integrated Care) will:*   * Communicate, negotiate and represent service user’s/family and/or carer values and decisions in relation to their condition in collaboration with MDT colleagues in both Primary and Secondary Care as appropriate. * Develop and support the concept of advocacy, particularly in relation to the service users’ participation in decision making, thereby enabling informed choice of treatment options. * Respect and maintain the privacy, dignity and confidentiality of the service user, family and/or carer. * Establish, maintain and improve procedures for collaboration and cooperation between Acute Services, Primary Care and Voluntary Organisations as appropriate. * Proactively challenge any interaction which fails to deliver a quality service to service users.   **Education & Training:**  *Clinical Nurse Specialist (Diabetes – Integrated Care) will:*   * Maintain clinical competence in nursing management within Diabetes Nursing, keeping up-to-date with relevant research to ensure the implementation of evidence based practice. * Provide the service user, family and/or carer with appropriate information and other supportive interventions to increase their knowledge, skill and confidence in managing their Diabetes. * Contribute to the design, development and implementation of education programmes and resources for the service user, family and/or carer in relation to Diabetesthus empowering them to self-manage their condition. * Provide mentorship and preceptorship for nursing colleagues as appropriate. * Participate in training programmes for Nursing, MDT colleagues and key stakeholders as appropriate. * Create exchange of learning opportunities within the MDT in relation to evidence based Diabetes care delivery through journal clubs, conferences, etc. * Develop and maintain links with Regional Centres for Nursing & Midwifery Education (RCNMEs), the Nursing and Midwifery Planning and Development Units (NMPDUs) and relevant third level Higher Education Institutes (HEIs) in the design, development and delivery of educational programmes in Diabetes care. * In tandem with the line management structure, be responsible for addressing own continuing professional development (CPD) needs to maintain competencies required for the role. * Use agreed protected time for research, education and professional development. * With the line manager, use the Professional Development Planning Framework for Nurses and Midwives to plan and self-assess additional CPD needs.   **Audit & Research:**  *Clinical Nurse Specialist (Diabetes – Integrated Care) will:*   * Establish and maintain a register of service users with Diabeteswithin Clinical Nurse Specialist Caseload. * Maintain a record of clinically relevant data aligned to National Key Performance Indicators (KPI’s) as directed and advised by the, DPHN, National Clinical Programme and senior Clinical decision maker. * Identify, initiate and conduct Nursing and MDT audit and research projects relevant to the area of practice. * Identify, critically analyse, disseminate and integrate best evidence relating to Diabetes care into practice. * Contribute to nursing research on all aspects of Diabetes care. * Contribute to service planning and budgetary processes through use of audit data and specialist knowledge. * Monitor, access, utilise and disseminate current relevant research to advise and ensure the provision of informed evidence based practice. * Use the outcomes of audit to improve nursing service provision and advocate, when appropriate, for improvement of non-nursing services.   ***Audit expected outcomes including:***   * Collate data (agreed KPIs/clinical targets) which will provide evidence of the effectiveness of the CNS interventions. Refer to National KPIs associated with the specialty. KPI’s should have a clinical nursing focus as well as a breakdown of activity - service users seen and treated. * Evaluate nursing audit results and research findings to identify areas for quality improvement in collaboration with nursing management and MDT colleagues (Primary and Secondary Care).   **Consultant (including Leadership in clinical practice)**  *Clinical Nurse Specialist (Diabetes – Integrated Care) will:*   * Provide leadership in clinical practice and act as a resource and role model for Diabetespractice. * Generate and contribute to the development of clinical standards and guidelines and support implementation. * Use specialist knowledge to support and enhance generalist nursing practice. * Develop collaborative working relationships with local DiabetesClinical Nurse Specialist /Registered Advanced Nurse Practitioner/MDT colleagues as appropriate, developing person centred care pathways to promote the integrated model of care delivery. * With the support of the Director of Public Health Nursing, attend integrated care planning meetings as required. * Where appropriate develop and maintain relationships with specialist services in voluntary organisations which support service users in the community. * Network with other Clinical Nurse Specialist in Diabetesand in related professional associations. * Liaise with other chronic disease specialist teams (i.e. Cardiology and Respiratory) to discuss joint management/assessment needs of service users as necessary. * Liaise with other health service providers in the development and on-going delivery of the Diabetes National Clinical Programme and Integrated Care Programme for the Prevention and Management of Chronic Disease model of care. |
| **Health and Safety** | These duties must be performed in accordance with local organisational and the HSE health and safety polices. In carrying out these duties the employee must ensure that effective safety procedures are in place to comply with the Health, Safety and Welfare at Work Act (2005). Staff must carry out their duties in a safe and responsible manner in line with the local policy documents and as set out in the local safety statement, which must be read and understood.   * Have a working knowledge of the Health Information and Quality Authority (HIQA) Standards as they apply to the role for example, Standards for Healthcare, National Standards for the Prevention and Control of Healthcare Associated Infections, Hygiene Standards etc.and comply with associated HSE protocols for implementing and maintaining these standards as appropriate to the role. * To support, promote and actively participate in sustainable energy, water and waste initiatives to create a more sustainable, low carbon and efficient health service.   **Quality, Risk and Safety Responsibilities**  It is the responsibility of all staff to:   * Participate and cooperate with legislative and regulatory requirements with regard to quality, risk and safety. * Participate and cooperate with local quality, risk and safety initiatives as required. * Adequately identifies, assesses, manages and monitors risk within their area of responsibility. * Participate and cooperate with internal and external evaluations of the organisation’s structures, services and processes as required, including but not limited to, The National Hygiene Audit, National Decontamination Audit, Health and Safety Audits and other audits specified by the HSE or other regulatory authorities. * Initiate, support and implement quality improvement initiatives in their area which are in keeping with local organisational quality, risk and safety requirements. * Contribute to the development of PPPGs and safe professional practice and adhere to relevant legislation, regulations and standards. * Comply with Health Service Executive (HSE) Complaints Policy. * Respond immediately and appropriately to ensure the safety of any service user that you are aware has been put at risk. * Ensure completion of incident/near miss forms and clinical risk reporting. * Adhere to department policies in relation to the care and safety of any equipment supplied and used to carry out the responsibilities of the role of Clinical Nurse Specialist in Diabetes care.   **Specific Responsibility for Best Practice in Hygiene**  Hygiene is defined as: “The practice that serves to keep people and environments clean and prevent infection. It involves the study of preserving one’s health, preventing the spread of disease, and recognising, evaluating and controlling health hazards. In the healthcare setting it incorporates the following key areas: environment and facilities, hand hygiene, catering, management of laundry, waste and sharps, and equipment” (HIQA, 2008; P2). It is the responsibility of all staff to ensure compliance with local organisational hygiene standards, guidelines and practices. |
| **Management / Administration:** | *Clinical Nurse Specialist (Diabetes - Integrated Care) will:*   * Provide an efficient, effective and high quality service, respecting the needs of each service user, family and/or carer. * Effectively manage time and caseload in order to meet changing and developing service needs. * Continually monitor the service to ensure it reflects current needs. * Implement and manage identified changes. * Ensure that confidentiality in relation to service user records are maintained. * Represent the specialist service at local, national and international fora as required. * Maintain accurate and contemporaneous records and data on all matters pertaining to the planning, management, delivery and evaluation of care and ensure that this service is in line with HSE requirements. * Contribute to the service planning process as appropriate and as directed by the DPHN. * Have a working knowledge of the Health Information and Quality Authority (HIQA) Standards as they apply to the role for example, Standards for Healthcare, National Standards for the Prevention and Control of Healthcare Associated Infections, Hygiene Standards etc.and comply with associated HSE protocols for implementing and maintaining these standards as appropriate to the role. * To support, promote and actively participate in sustainable energy, water and waste initiatives to create a more sustainable, low carbon and efficient health service.   **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 and to contribute to the development of the post while in office.** |
| **Eligibility Criteria**  **Qualifications and/or experience** | **Candidates must have at the latest date of application:**   1. **Professional Qualifications, Experience, etc** 2. Be a registered nurse/midwife on the active Register of Nurses and Midwives held by An Bord Altranais and Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) or be eligible to be so registered.   **And**   1. Be registered in the division(s) of the Nursing and Midwifery Board of Ireland (Bord Altranais agus Cnáimhseachais na hÉireann) Register for which the application is being made or be entitled to be so registered.  |  |  | | --- | --- | |  | **Or**  In exceptional circumstances, which will be assessed on a case by case basis be registered in another Division of the register of Nurses and Midwives.  **And**  (iii) Have a minimum of 1 years’ post registration full time experience or an aggregate of 1 years’ full time experience in the division of the register in which the application is being made (taking into account (ii) (iii) if relevant)  **And**  (iv) Have a minimum of 1 years’ experience or an aggregate of 1 years’ full time experience in specialist area of **Diabetes** Nursing Care  **And**  (v) Have successfully completed a post registration programme of study, as certified by the education provider which verifies that the applicant has achieved a Quality and Qualifications Ireland (QQI), National Framework of Qualifications (NFQ) major academic Level 9 or higher award that is relevant to the specialist area of care of Diabetes Nursing (equivalent to 60 ECTS or above), and in line with the requirements for specialist practice as set out by the National Council for Nursing and Midwifery 4th ed (2008).  Alternatively provide written evidence from the Higher Education Institute that they have achieved the number of ECTS credits equivalent to a Level 9 or higher standard, relevant to the specialist area of care (equivalent to 60 ECTS or above), and in line with the requirements for specialist practice as set out by the National Council for Nursing and Midwifery 4th ed (2008) **Diabetes Nursing** care prior to application\* (See \*\*Note below).  **And**  (vi) Be required to demonstrate that they have continuing professional development (CPD) relevant to the specialist area of Diabetes Nursing.  **\*\***Note 1: For Nurses/Midwives who express an interest in CNS/CMS roles and who currently hold a level 8 educational qualification in the specialist area (equivalent to 60 ECTS or above), this qualification will be recognised up to September 2026.  Have the ability to practice safely and effectively fulfilling his/her professional responsibility within his/her scope of practice  **2. Annual registration**  (i) Practitioners must maintain live annual registration on the appropriate/relevant Division of the register of Nurses and Midwives maintained by the Nursing and Midwifery Board of Ireland (Bord Altranais agus Cnáimhseachais na hÉireann) for the role.  And  (ii) Confirm annual registration with NMBI to the HSE by way of the annual Service user Safety Assurance Certificate (PSAC).  **3. Health**  Candidates for and any person holding the office must be fully competent and capable of undertaking the duties attached to the office and be in a state of health such as would indicate a reasonable prospect of ability to render regular and efficient service.  **4. Character**  Candidates for and any person holding the office must be of good character.  *Please note that appointment to and continuation in posts that require statutory registration is dependent upon the post holder maintaining annual registration in the relevant division of the register maintained by Bord Altranais agus Cnáimhseachais na hÉireann (Nursing & Midwifery Board of Ireland) by way of the Service user Safety Assurance Certificate (PSAC)* | |
| **Post Specific Requirements** | Demonstrate depth and breadth of nursing experience in the specialist area of diabetes as relevant to the role.  In order to develop effective and more efficient services, the post holder is required to:   * Have undertaken or agree to undertake, within an agreed timeframe, the Nurse Prescribing of Medicinal Products Certificate * Have undertaken or agree to undertake, within an agreed timeframe, the Nurse Prescribing of Ionising Radiation Certificate, if clinically relevant to the role   Formally apply for entry onto the Interim ONMSD CNS/CMS database (until the database is transferred to its permanent location). |
| **Skills, competencies and/or knowledge** | **Professional Knowledge**  *Clinical Nurse Specialist (Diabetes – Integrated Care) will:*   * Practice in accordance with relevant legislation and with regard to The Scope of Nursing & Midwifery Practice Framework (Nursing and Midwifery Board of Ireland, 2015) and the Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives (Nursing and Midwifery Board of Ireland, 2021). * Maintain a high standard of professional behaviour and be professionally accountable for actions/omissions. Take measures to develop and maintain the competences required for professional practice. * Adhere to the Nursing & Midwifery values of Care, Compassion and Commitment (DoH, 2016). * Adhere to national, regional and local HSE PPPGs. * Adhere to relevant legislation and regulation. * Adhere to appropriate lines of authority within the midwife management structure. * Demonstrate practitioner competence and professionalism as it related to CNS. * Demonstrate an awareness of current and emerging nursing strategies and policy in relation to the clinical/specialist area. * Demonstrate the ability to relate nursing research to nursing practice. * Demonstrate an awareness of HR policies and procedures including disciplinary procedures. * Demonstrate an awareness of relevant legislation and policy e.g., health and safety, infection control etc. * Demonstrate a commitment to continuing professional development. * Demonstrate a willingness to develop IT skills relevant to the role.     *Clinical Nurse Specialist (Diabetes – Integrated Care) will demonstrate:*   * In-depth knowledge of the role of Clinical Nurse Specialist (Diabetes – Integrated Care). * In-depth knowledge of the pathophysiology of Diabetes. * The ability to undertake a comprehensive assessment of the service user with Type 2 Diabetes**,** including taking an accurate history of their condition and presenting problem. * The ability to employ appropriate diagnostic interventions to support clinical decision making and the service users’ self- management planning. * The ability to formulate a plan of care based on findings and evidence based standards of care and practice guidelines. * The ability to follow up and evaluate a plan of care. * Knowledge of health promotion principles/coaching/self-management strategies that will enable people to take greater control over decisions and actions that affect their health and wellbeing. * An understanding of the principles of clinical governance and risk management as they apply directly to Clinical Nurse Specialist (Diabetes – Integrated Care) role and the wider health service. * Evidence of teaching in the clinical area. * A working knowledge of audit and research processes. * Evidence of computer skills including use of Microsoft Word, Excel, E-mail, PowerPoint. * Knowledge of National Clinical and Integrated Care Programmes as they pertain to diabetes and chronic disease management. * A high standard of professionally accountability and professional behaviour. * Self-direction in maintaining the competences required for professional practice.      * Knowledge of national, regional and local HSE PPPGs. * Ability to operate professionally within appropriate lines of authority within the nurse/midwife management structure and across Multidisciplinary teams. * An understanding of the principles of clinical governance and risk management as they apply directly to Clinical Nurse Specialist (Diabetes Acute – Integrated Care) role and the wider health service.   **Communication and Interpersonal Skills**  Demonstrate:   * Emotionally intelligent communication skills. * The ability to influence others effectively. * Ability to build and maintain relationships particularly in the context of MDT working. * Ability to present information in a clear and concise manner. * Ability to manage groups through the learning process. * Ability to provide constructive feedback to encourage future learning. * Effective presentation skills.   **Organisation and Management Skills:**  Demonstrate:   * Evidence of effective organisational skills including awareness of appropriate resource management and the importance of value for money. * Ability to plan and organise effectively. * Ability to attain designated nursing targets, manage deadlines and multiple tasks. * Ability to be self-directed, work on own initiative. * A willingness to be flexible in response to changing local/organisational requirements.   **Building & Maintaining Relationships including Team and Leadership skills**  Demonstrate:   * The ability to work on own initiative as well as the ability to build and maintain relationships with MDT colleagues. * With the required support, demonstrate leadership in clinical practice. * A knowledge of change management and team management skills. * Adopts a collaborative approach to service user care by co-ordination of care/interventions and interdisciplinary team working.   **Commitment to providing a quality service:**  Demonstrate:   * Awareness and respect for the service user’s and family/carers’ views in relation to their care. * A strong commitment to/Evidence of providing quality improvement programmes. * The ability to/evidence of conducting audit. * Demonstrates integrity and ethical stance. * Demonstrate motivation, initiative and an innovative approach to job and service developments, is flexible and open to change.   **Analysing and Decision Making**  Demonstrate:   * Adopts an overview of complex problems before generating solutions and anticipates implications. * Effective analytical, problem solving and evidenced-based decision making skill. * Uses a range of information sources and knows how to access relevant information to address issues. |
| **Other requirements specific to the post** | * Access to appropriate transport to fulfil the requirement of the role. |
| **Campaign Specific Selection Process**  **Ranking/Shortlisting / Interview** | A ranking and or shortlisting exercise may be carried out on the basis of information supplied in your application form. The criteria for ranking and or shortlisting are based on the requirements of the post as outlined in the eligibility criteria and skills, competencies and/or knowledge section of this job specification. Therefore it is very important that you think about your experience in light of those requirements.  Failure to include information regarding these requirements may result in you not being called forward to the next stage of the selection process.  Those successful at the ranking stage of this process (where applied) will be placed on an order of merit and will be called to interview in ‘bands’ depending on the service needs of the organisation. |
| **Diversity, Equality and Inclusion** | The HSE is an equal opportunities employer.  Employees of the HSE bring a range of skills, talents, diverse thinking and experience to the organisation. The HSE believes passionately that employing a diverse workforce is central to its success – we aim to develop the workforce of the HSE so that it reflects the diversity of HSE service users and to strengthen it through accommodating and valuing different perspectives. Ultimately this will result in improved service user and employee experience.  The HSE is committed to creating a positive working environment whereby all employees inclusive of age, civil status, disability, ethnicity and race, family status, gender, membership of the Traveller community, religion and sexual orientation are respected, valued and can reach their full potential. The HSE aims to achieve this through development of an organisational culture where injustice, bias and discrimination are not tolerated.  The HSE welcomes people with diverse backgrounds and offers a range of supports and resources to staff, such as those who require a reasonable accommodation at work because of a disability or long term health condition.  For further information on the HSE commitment to Diversity, Equality and Inclusion, please visit the Diversity, Equality and Inclusion web page at <https://www.hse.ie/eng/staff/resources/diversity/> |
| **Code of Practice** | The Health Service Executive will run this campaign in compliance with the Code of Practice prepared by the Commission for Public Service Appointments (CPSA).  The CPSA is responsible for establishing the principles that should be followed when making an appointment. These are set out in the CPSA Code of Practice. The Code outlines the standards that should be adhered to at each stage of the selection process and sets out the review and appeal mechanisms open to candidates should they be unhappy with a selection process.  The CPSA Code of Practice can be accessed via <https://www.cpsa.ie/>. |
| The reform programme outlined for the Health Services may impact on this role and as structures change the job specification may be reviewed.  This job specification is a guide to the general range of duties assigned to the post holder. It is intended to be neither definitive nor restrictive and is subject to periodic review with the employee concerned. | |

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**Clinical Nurse Specialist (Diabetes – Integrated Care)**

**Terms and Conditions of Employment**

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| **Tenure** | The current vacancy(s) available is permanent and part-time..  The post is pensionable. A panel may be created from which permanent and specified purpose vacancies of full or part time duration may be filled. The tenure of these posts will be indicated at “expression of interest” stage.  Appointment as an employee of the Health Service Executive is governed by the Health Act 2004 and the Public Service Management (Recruitment and Appointments) Act 2004 and Public Service Management (Recruitment and Appointments) Amendment Act 2013. |
| **Remuneration** | The salary scale for the post March 2025 is: 60,854 61,862 62,715 64,106 65,644 67,154 68,664 70,364 71,943 74,658 76,897 LSI  New appointees to any grade start at the minimum point of the scale. Incremental credit will be applied for recognised relevant service in Ireland and abroad (Department of Health Circular 2/2011). Incremental credit is normally granted on appointment, in respect of previous experience in the Civil Service, Local Authorities, Health Service and other Public Service Bodies and Statutory Agencies |
| **Working Week** | The standard weekly working hours of attendance for your grade are **37.5** hours per week. Your normal weekly working hours are **37.5** hours. Contracted hours that are less than the standard weekly working hours for your grade will be paid pro rata to the full time equivalent. |
| **Annual Leave** | The annual leave associated with the post will be confirmed at Contracting Stage. |
| **Superannuation** | This is a pensionable position with the HSE. The successful candidate will upon appointment become a member of the appropriate pension scheme. Pension scheme membership will be notified within the contract of employment. Members of pre-existing pension schemes who transferred to the HSE on the 01st January 2005 pursuant to Section 60 of the Health Act 2004 are entitled to superannuation benefit terms under the HSE Scheme which are no less favourable to those which they were entitled to at 31st December 2004. |
| **Age** | The Public Service Superannuation (Age of Retirement) Act, 2018\* set 70 years as the compulsory retirement age for public servants.  **\* Public Servants not affected by this legislation:**  - Public servants joining the public service, or re-joining the public service with a 26 week break in service, between 1 April 2004 and 31 December 2012 (new entrants) have no compulsory retirement age.  - Public servants, joining the public service or re-joining the public service after a 26 week break, after 1 January 2013 are members of the Single Pension Scheme and have a compulsory retirement age of 70. |
| **Probation** | Every appointment of a person who is not already a permanent officer of the Health Service Executive or of a Local Authority shall be subject to a probationary period of 12 months as stipulated in the Department of Health Circular No.10/71. |
| **Protection of Children Guidance and Legislation** | The welfare and protection of children is the responsibility of all HSE staff. You must be aware of and understand your specific responsibilities under the Children First Act 2015, the Protections for Persons Reporting Child Abuse Act 1998 in accordance with Section 2, Children First National Guidance and other relevant child safeguarding legislation and policies.  Some staff have additional responsibilities such as Line Managers, Designated Officers and Mandated Persons. You should check if you are a Designated Officer and / or a Mandated Person and be familiar with the related roles and legal responsibilities.  For further information, guidance and resources please visit: [HSE Children First webpage](https://www.hse.ie/eng/services/list/2/primarycare/childrenfirst/resources/). |
| **Infection Control** | Have a working knowledge of Health Information and Quality Authority (HIQA) Standards as they apply to the role for example, Standards for Healthcare, National Standards for the Prevention and Control of Healthcare Associated Infections, Hygiene Standards etc. and comply with associated HSE protocols for implementing and maintaining these standards as appropriate to the role. |
| **Health & Safety** | It is the responsibility of line managers to ensure that the management of safety, health and welfare is successfully integrated into all activities undertaken within their area of responsibility, so far as is reasonably practicable. Line managers are named and roles and responsibilities detailed in the relevant Site Specific Safety Statement (SSSS).  Key responsibilities include:   * Developing a SSSS for the department/service[[1]](#footnote-1), as applicable, based on the identification of hazards and the assessment of risks, and reviewing/updating same on a regular basis (at least annually) and in the event of any significant change in the work activity or place of work. * Ensuring that Occupational Safety and Health (OSH) is integrated into day-to-day business, providing Systems Of Work (SOW) that are planned, organised, performed, maintained and revised as appropriate, and ensuring that all safety related records are maintained and available for inspection. * Consulting and communicating with staff and safety representatives on OSH matters. * Ensuring a training needs assessment (TNA) is undertaken for employees, facilitating their attendance at statutory OSH training, and ensuring records are maintained for each employee. * Ensuring that all incidents occurring within the relevant department/service are appropriately managed and investigated in accordance with HSE procedures[[2]](#footnote-2). * Seeking advice from health and safety professionals through the National Health and Safety Function Helpdesk as appropriate. * Reviewing the health and safety performance of the ward/department/service and staff through, respectively, local audit and performance achievement meetings for example.   **Note**: Detailed roles and responsibilities of Line Managers are outlined in local SSSS. |

1. A template SSSS and guidelines are available on the National Health and Safety Function/H&S web-pages [↑](#footnote-ref-1)
2. See link on health and safety web-pages to latest Incident Management Policy [↑](#footnote-ref-2)