Te Whatu Ora
Health New Zealand
Taranaki

Complex Care Coordinator

1. PURPOSE OF POSITION

The Complex Care Coordinator's (CCC) primary role is to facilitate and coordinate safe and timely patient flow of complex patients from the point of acceptance into the service through to discharge. The role requires effective interdisciplinary communication and collaboration with patients, family/whānau, Te Whatu Ora Taranaki internal staff and external organisations.

The position will ensure that patients who are deemed complex in nature receive timely, coordinated, and proactive clinical interventions and robust discharge planning to facilitate efficient and patient-centred discharges. The role will include coordination of patient care across the continuum from pre-hospital admission to discharge from hospital services.

The role will deliver and ensure a high quality, patient focussed service with a strong emphasis on efficient, high quality and cost-effective patient pathways, decreasing length of stay, optimal bed utilisation and effective discharging before 11am. The role requires a significant coordination component including facilitation of management plans and multidisciplinary meetings.

2. ORGANISATIONAL VALUES

Te Whatu Ora Taranaki mission (Te Kaupapa) is improving, promoting, protecting, and caring for the health and well-being of the people of Taranaki. Te Whatu Ora Taranaki values define who we are as an organisation, the way we work with each other, our patients, whānau and external partners. Our Te Ahu Te Whatu Ora Taranaki values are:

Partnerships	WHĀNAUNGATANGA	We work together to achieve our goals
Courage	MANAWANUI	We have the courage to do what is right
Empowerment	MANA MOTUHAKE	We support each other to make the best decisions
People Matter	MAHAKITANGA	We value each other, our patients and whānau
Safety	MANAAKITANGA	We provide excellent care in a safe and trusted environment

3. DIMENSIONS

Reports to (operationally):	(Nurse) Manager
Number of people reporting to you	Nil
Financial limits authority	Nil
Operating Budget	Nil

4. WORKING RELATIONSHIPS

External	Internal
Primary Health Organisations Residential Aged Care Hospice Taranaki Disability Support Services Non-Government Organizations Community groups & organisations Other Districts Community Providers ACC	Directors of Nursing & Allied Health Nurse Manager / Midwife Manager Clinical Nurse Manager / Clinical Midwife Manager Clinical Coordinators Clinical Nurse Specialists Clinical Midwife Specialist Departs of Medicine/Surgery/Orthopedics Allied Health teams / MDT Māori Health Team Nursing staff Medical Staff Administration/reception staff Palliative/Hospice ACC Team

5. ACCOUNTABILITIES

Key area of responsibility	Expected outcomes
Coordination of patient flow, quality of patient pathways and discharges for complex patients Effectively performs the Complex Care Coordinator role to ensure excellent service provision.	• Early **identification** of patients with complex care needs, liaising with all relevant teams in the surgical pathway • Liaise with the MDT to facilitate accurate **assessment** of patient needs to ensure appropriate provisions and care is in place • Collaborates with the patient/family/ whānau, internal multidisciplinary team (MDT), and external providers to develop **management plans** for complex patients • Focus on facilitating planned and proactive "**prehabilitation**" prior to admission to achieve a successful clinical outcome and efficient discharge • Ensure plans are in place to support **timely discharge** of complex patients • Actively manage and track patient **progress against care plan milestones** • Maintain an overview of all referred complex patients for the service, including actively managing patient **progress through the health system** • Monitor **patient flow** through the service with a focus on optimising their journey • Arrange, coordinate, and attend regular **virtual ward rounds** and **discharge planning meetings**, and raise any relevant issues with the multi-disciplinary team to ensure resolution • Adopt strategies to minimise **bed utilisation** and reduce **length of stay** for planned procedures • Ensures that **clinical pathways** are followed, and pathways are audited and updated on the basis of evidence based best practice • Demonstrates cultural competence and utilisation of **Tikanga best practice** principles
Enhance patient outcomes and patient and family/whānau satisfaction Develop and review outcomes and communicate discharge plans to patients and their families/whānau to ensure	• Ensure that patients, relatives/whānau and carers are provided with **information** about their health journey and that appropriate levels of support are provided • Is available to patient, families/ whānau and the patient care team as the identified contact for care co-ordination **issues** • Clarifies the Complex Care Coordinator role for patients and families/ whānau

quality service provision.	• All concerns/complaints are addressed through the appropriate channels in a timeframe acceptable to all involved as per the Te Whatu Ora Taranaki policy and procedures • Potential risks are identified and managed regarding the plan of care and the patient, families/ whānau and relevant staff are assisted to resolve issues • Ensures that clinical pathways are followed, and pathways are audited and updated as necessary
ACC, Non acute rehabilitation and Non-Resident work stream Support and facilitation	• Understands ACC processes • Works in collaboration with Te Whatu Ora Taranaki ACC team • Identifies those patients eligible for the Non-Acute Rehab stream and notifies administration staff
Planning, Evaluation and reporting activities	• Lead & champion the establishment and maintenance of efficient patient pathways that support the discharge process • Collate monthly service data that includes (but is not limited to): o Referrals received o Length of stay data o Estimated Day of Discharge (EDD) data o Discharge before 11am o Readmission rates within 28 days
Liaison Activities	• Maintain professional and open communication and networks within the District and with external providers

Organisational Accountabilities	**Expected Outcomes**
Health Equity	Te Whatu Ora Taranaki strives to eliminate health inequalities and achieve health equity for the Taranaki population. In practical terms this means all staff are required to implement relevant health equity policies, procedures, approaches and guidelines issued from time to time including: • the Pae Ora Framework which requires: o Demonstrating the principles of Partnership, Participation and Protection under the Treaty of Waitangi; o improving understanding of the determinants of ethnic inequalities in health, in particular the "Drivers of ethnic inequalities in health" and the "Pathways to Inequalities" both of which are referenced in the Te Whatu Ora Taranaki Pae Ora

Organisational Accountabilities	Expected Outcomes
	Framework, Appendix 1. o Ensuring Health Equity assessment is embedded into your practise where services, policies or programmes are expected to improve outcomes for Māori. o Effectively implementing health equity approaches outlined for Health Professionals in "Equity of Health Care for Māori: A Framework" published by the Ministry of Health to support He Korowai Oranga Refresh 2014, national Māori Health Strategy. o Ensuring appropriate health literacy responses are used for effective engagement with Māori. • You must ensure accurate ethnicity data is collected or held for patients and clients you interact with by following the Te Whatu Ora Taranaki Ethnicity Data Collection Policy and procedures • You must attend the Cultural Competency training provided by and for staff of the Te Whatu Ora Taranaki including Treaty of Waitangi workshop, General/Clinical Refreshers, Engaging Effectively with Māori, and any other training identified as essential for staff
Health and Safety	• Maintains a safe and healthy environment • Complies with health & safety policies and procedures • Carries out work in a way that does not adversely affect their health and safety or that of other workers • Complies with procedures and correctly use personal protective equipment and safety devices provided • Contributes to hazard identification and management process • Reports accurately near misses/incidents/accidents in a timely manner • Participates in health and safety matters
Personal Development	• Fully contributes to the individual's team performance and is committed to identify and pursue opportunities for developing new knowledge and skills • Participates in the performance appraisal process where personal performance and development is reviewed. • Willing to accept new responsibilities, acquire and demonstrate relevant new knowledge

6. VARIATION TO DUTIES

Duties and responsibilities described above should not be construed as a complete and exhaustive list as it is not the intention to limit in any way the scope or functions of the position. Duties and responsibilities can be amended from time to time either by additional, deletion or straight amendment to meet any changing conditions, however this will only be done in consultation with the employee.

7. CAPABILITY REQUIREMENTS

Capabilities are the behaviours demonstrated by a person performing the job. Capabilities identify what makes a person most effective in a role. Those listed below are expected for the Nursing Directorate team roles in the organisation. The required capabilities can change as the organisation develops and the roles change.

Capability
Effective Communication Shares well thought out, concise and timely information with others using appropriate mediums. Ensures information gets to the appropriate people within the organisation to facilitate effective decision making
Decision Making/Problem Solving Demonstrates effective and timely decision making/problem solving techniques. Aware of the impact of decisions on key stakeholders and consults as appropriate utilizing available resources. Is proactive and effective when problem solving is required.
Innovation/Initiative Continually strives for new and improved work processes that will result in greater effectiveness and efficiencies. Questions traditional ways of doing things when choosing a course of action or finds new combinations of old elements to form an innovatve solution.
Resilience/Flexibility Articulates differing perspectives on a problem and will see the merit of alternative points of view. Will change or modify own opinons and will switch to other strategies when necessary. Adjusts behaviour to the demands of the work environment in order to remain productive through periods of transition, ambiguity, uncertainty and stress.
Cultural Safety Demonstrates a commitment to cultural safety by meeting and exceeding the cultural needs of clients/customers/colleagues. Manages cultural ambiguity and conflicting priorities well. Understands concepts of whānaungatanga and manaakitanga and Māori cultural orientation to whānau, hapu and iwi.

Capability
Teamwork Works to build team spirit, facilitates resolution of conflict within the team, promotes/protects team reputation, shows commitment to contributing to the teams success

8. EDUCATION

- Experienced Registered Health professional
- Current New Zealand Annual Practicing Certificate
- Relevant Post graduate study or working towards (PG Cert required for RN)
- Senior or Expert PDRP (or equivalent competency)

9. SKILLS

- Perceived as highly effective, progressive, and knowledgeable in area of practice, according to legal, ethical, cultural safety and professional standards
- Demonstrable understanding of and commitment to discharge planning and coordination
- Excellent interpersonal and ability to engage in effective communication
- Proven leadership & time management combined with adaptability and flexibility
- Ability to resolve conflict
- Ability to effectively engage and liaise with a multitude of internal and external service providers
- Excellent organisational skills regarding coordination of patient care

10. EXPERIENCE

- Minimum of four years post graduate experience in clinical care
- Experience in previous patient coordination roles

11. Tasks and KPIs

Workplan, accountabilities, key performance indicators (KPIs) and reporting responsibilities will be developed with line manager and reviewed on an annual basis