MINISTRY OF HEALTH AND SOCIAL SERVICES

TERMS OF REFERENCE

FAMILY NURSE PRACTITIONER

Background

Montserrat, a British overseas territory, is a small island in the Leeward island chain, with a land mass of 39.5 square miles and a resident population of 4922 persons (Census 2011). The eruption of the Soufriere Hills Volcano in 1995 rendered more than half of the island unsafe, as a result, three quarters of the island was declared an exclusion zone, which prohibits anyone from occupying that part of the island. Its capital, Plymouth, which housed a newly refurbished state of the art hospital yet to be fully occupied, was also destroyed. Hospital services were relocated to a former school in St. John's in the north of the island. Overtime, the school has been refurbished to provide the relevant secondary care services.

The delivery of health and social care on Montserrat is the responsibility of the Government and is administered under the Ministry of Health and Social Services (MOHSS). The mission of the MoHSS is to promote health and wellbeing, by empowering individuals and communities and assuring access to quality preventative, curative and rehabilitative health and social care services in partnership with other stakeholders.

At the national level, Montserrat's 2008-2020 Sustainable Development Plan cites Human Development as one of the Strategic Goals whereby all citizens would experience "human development and improved quality of life". The Government of Montserrat's Policy Agenda 2019/2020 outlines the strategic priorities of the Ministry of Health and Social Services as:

- Enhanced Human Development:
  - Increased access to essential medical services
  - Increased and expanded health promotion services to reduce public health concerns

- Sustainable Environmental Management and appropriate Disaster Mitigation Practices:

- Increased focused on mitigating disasters in addition to strengthening preparedness and emergency response.
- Physical infrastructure, designed and built for resilience against disasters.

- Increased access to essential and specialized medical services through leveraging technology as well as direct service provision.

- Increased and expanded health promotion services to reduce public health concerns, to reduce incidences and effect of non-communicable diseases, to improve the care of the elderly and including a focus on vector borne diseases.

- Increased focus on mitigating disaster in addition to strengthening preparedness and emergency response.

- Strengthened community-based treatment programs for vulnerable groups of society.

Infrastructure and Services

Level of Care	Description	Services
Tertiary	None	
Secondary Care	Glendon Hospital – Patients admitted and treated in general wards.	• Assessments • Brief Intervention • Crisis Stabilization • In-patient Treatment • Detoxification • Psychological consultations mainly in cases of attempted Suicide.

Level of Care	Description	Services
Primary Care	Four (4) Health Centres with the St. Johns Clinic being the main treatment centre.	• Assessments • Brief Intervention • Medical Management • Psychosocial Intervention • Crisis Intervention • Community Outreach (Private Homes and Institutions) • Psychological services (Assessments, Brief Counselling, Long Term Counselling and Psychotherapy)

Human Resources

Professional Staff

Role	Full/Part Time	Duties
District Nurses (x7)	Full time	Provides continued care in primary care setting as well as in the community.
Public Health Nurse (x1)	Full Time	
District Medical Officer	Full time	Provides weekly services to adults, children and the vulnerable population. Services include physical assessments and educational programs.

Non-Professional Staff

Role	Full/Part Time	Duties
Health Aide (6)	Full time	Support team for four (4) Health Centres, the Mental Health Unit and the Oriole Villas

Government Policy

One of the Vision Pillars in the 2008-2020 Sustainable Development Plan (SDP) is an 'Accessible comprehensive health care system'. Strategic Goal #2 which is 'Human Development' has a national outcome of 'a healthy population with full access to required health care'. Access to the Family Nurse Practitioners clinical services is universal and there is no cost to clients.

Strategic Plan for Ministry of Health & Social Services 2019/2010 – 2021/22

In keeping with the mandate for health under the SDP, the Ministry of Health's Strategic Plan references three (3) strategic objectives.

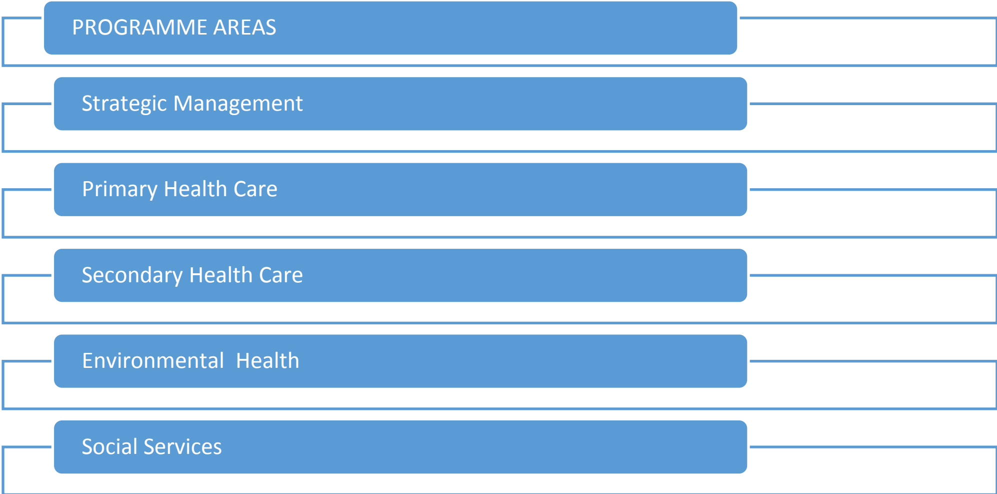
1) Prevention of Non-Communicable Diseases - expand and improve interventions to prevent NCDs.

2) Improved management of Non-Communicable Diseases- Expand and improve strategies to improve the management of NCDs.

3) Optimize delivery of health care on island- evidenced need to improve patient experience in some health care settings.

Thus, the Ministry of Health's Strategic Plan has seen the need to include Chronic Non-Communicable Diseases (CNCDs) as one of the priority areas. The prevention and management of CNCDs is also one of the components of the Health Improvement Program Prevention and management of Non-communicable diseases is a vital component of our health care service/programme and requires appropriate staffing complement for effective management. However, there have been extreme challenges over the years to fill the vacant post of Family Nurse Practitioner.

Programmatic areas for the Ministry of Health:



The Ministry of Health seeks to achieve that national outcome by increasing access to essential medical services as well as ensuring social protection for the vulnerable population. The position of Family Nurse Practitioner is included in Programme 451: Primary Health Care. As per the Ministry's Strategic Plan, the objective of programme 451 is "to improve health outcomes from equal access and utilisation of an increasing range of quality primary health services." One of the key strategies for 2018/19 is to "increase access to Primary Health Care services by building capacity of health care workers throughout the health care system and enhancing care processes and procedures."

Disease Profile

Despite advances in various technologies to manage and treat Diabetes and Hypertension, the global evidence indicates that these diseases, their co-morbidities and their respective complications such as heart attacks, blindness, renal failure and loss of limb have the potential to negatively impact on quality of life, health and productivity of individuals directly affected and their families; as well as national health budgets. The Diabetes and diabetes related illnesses epidemic was responsible for almost 4 million deaths in the 20 -79 age groups in 2017 and accounted for 6.8% of all-cause mortality in this age group.

The situation in Montserrat regarding Diabetes is quite similar to the global trend. The data from the Medical Records show that Diabetes and Hypertension are the leading causes for

admission to Hospital. Additionally, with the earlier onset of disease coupled with increased life expectancy; it can be inferred that persons will be affected by Diabetes and Hypertension for more than 50% of their lifetime. This has the potential to overwhelm the financing of health services.

Persons with CNCDs have the opportunity at least twice per week to access care at the health centers through the weekly Chronic Illness Clinic and the Doctor's Clinic. Additionally, the community nursing staff have implemented a number of initiatives such as the Workplace Screening Programme, School Health Programme, extension of the work day to 5pm on Tuesdays and Thursdays at St Johns Health Centre and Health Fairs; for the purpose of increasing awareness and to help individuals and their families with CNCDs to pay more attention to self-care. However, the observed impact is below what was anticipated; and especially so because of the nature of CNCDs and the fact that changes in behavior and lifestyle require greater support. Hence the need for the recruitment of a Family Nurse Practitioner to augment our Primary Health Care services and programmes especially in the areas of health promotion and disease prevention and management.

The Family Nurse Practitioner provides nursing and medical services to individuals across the life span. As such, the FNP is authorized under the Nurses and Midwives Act to order and interpret laboratory and other diagnostic tests, prescribe pharmacological agents and alternative therapies, teach and counsel patients and their families. This role is crucial to the management of persons living with CNCDs as the research evidence indicate that the FNPs focus on health promotion and disease prevention when providing care.

Main Purpose

To utilize the Primary Health Care approach which focuses on health promotion and disease prevention to provide care to individuals, families and communities.

Scope of Work

The Family Nurse Practitioner reports administratively to the Community Nursing Manager and clinically to the District Medical Officer(DMO). The Post holder directly liaises with other members of the Primary Health Care (PHC) team and for Secondary Health Care through the

referral system. As a trained public Health professional, the Family Nurse Practitioner (FNP) will be expected to be involved in disease surveillance for chronic Non Communicable Diseases, communicable diseases to include but not limited to vaccine preventable diseases and other health related conditions, domestic violence, road traffic accidents etc. The post holder will be expected to participate in disaster prevention and mitigation exercises. They will also be responsible for conducting or assist in research in accordance with the 2019/2022 Ministry of Health Strategic Plan.

The FNP will support the expansion and enhancement of PHC services for Chronic illness clinics such as diabetes, hypertension, asthma where counselling and teaching will be provided to the patients and their families.

Liaises directly with the Public Health Nurse (PHN) to increase cancer screening to include cervical and breast cancer. Also assist in the assessment and monitoring of overweight children in conjunction with the Public Health Nurse and Nutritionist.
The main tasks are related to clinical practice:

- To conduct comprehensive health examination including physical, psycho-social and developmental assessments of clients, families and communities

- Plan, implement and evaluate health care with individuals, family and the communities based on identified needs

- Manage health problems across all age groups according to established guidelines by:
    - Requesting, performing and interpreting selective laboratory and other diagnostic procedures
    - Ordering/ prescribing of drugs according to the Nurses and Midwives Act
    - Diagnose, treat and follow up cases as appropriate under the supervision of the District Medical Officer (DMO) and in accordance with the Nurses and Midwives Act
    - Ensure that assessments and care are recorded according to documentation standards

- Refer and accept referrals from other health professionals and agencies

- Participate in the development, monitoring and evaluation of programmes and services within the Primary Health Care Department.
- Participates in quality assurance audits and medication administration review.
- Facilitates and participates in continuing education
- Participates in the epidemiological surveillance of both Communicable and Non-Communicable Diseases and health related conditions
- Serves as a member of the Primary Health Care team
- Participates and assist in staff development programmes to include making presentations, co-ordinating continuing education programs to include workshops and other training events to keep abreast of current developments in the nursing industry.
- Assists in the assessment and delivery of care for mass casualty events and disaster preparedness
- Initiate and/or participate in research activities to define current and best practices in health care delivery and service
- Present research findings at conferences and other academic forum
- Conduct and/or participate in public education and other health promotion to create awareness, advocate healthy lifestyle and behaviour change.
- Assists in the identification and management of high-risk clients including vulnerable persons and chronic defaulters
- Assists in conducting community-based outreach screening programmes to include but not limited to school health, glaucoma and work place screening

- Assists in guiding and mentoring students and other members of staff in the clinical area

- Assists the District Nurses in the preparation, monitoring and evaluation of individualized plans of care especially for high-risk clients

- Perform other nursing and/or midwifery duties that may be required from time to time

Administrative Tasks

- Submit monthly, quarterly and annual reports to the Community Nursing Manager and Chief Medical Officer which details patient data such as demographics, visits, diagnosis, referrals and follow up.
- Prepare and regularly update work plans
  - This plan should outline key roles/tasks and expected outputs for each calendar year.
  - The Work Plan will include a time frame for key training sessions planned and development of protocols/procedures as per identified needs.
- Undertake the preparation of an end of contract report submitted with recommendations and agreed action plan prior to departure.

Personal Development

- Cooperate in clinical audits as required.
- Identify and seek opportunities for personal development in areas such as in-service education and other relevant areas to improve treatment outcomes.

Qualifications, skills and experience

Qualifications– Essential

- Certificate/ MSc Family Nurse Practitioner
- Certificate/BSc in General Nursing
- Valid basic life support (BLS) certificate
- Valid driver's licence
- Member of the professional association for Nurses (MNA)
- Certificate/Diploma / BSc in Midwifery

Qualifications – Desirable

- Master's Degree in Family Nurse Practitioner
- Post basic training Mental Health, Accident and Emergency or other post basic course

Skills

- Good communication skills (oral and written) to ensure patients are well informed, and the clinic is well promoted internally and to the public.
- Good interpersonal and team building skills
- Possess exceptional organizational skills and multitasking ability.
- Co-ordinating workshops and other staff development programmes
- Working with individuals, families and communities
- Experience in working with government, non-governmental agencies and groups at national and regional level

Knowledge

- Knowledge of computer applications
- Knowledge and experience in primary health practices/services
- Knowledge and experience in dealing with individuals of different age groups & cultural background
- Knowledge of Nurses and Midwives Act as it relates to practice
- Knowledge of regional guidelines for managing specific chronic non-communicable diseases in primary health care settings
- Knowledge of health promotion/disease prevention, monitoring and evaluation strategies

Personal Qualities

- Confidential and respectful
- Confidence in own professional knowledge to work both independent and interdependent
- Positive, motivational personality