WINNIPEG REGIONAL HEALTH AUTHORITY
POSITION DESCRIPTION (Non-Management)

DATE: June 26, 2017
Revised: October 25, 2019
Revised: October 14th, 2020

POSITION TITLE: Transitional Complex Care Coordinator (Previously CHSS) **JOB CODE: 30002279**

DEPARTMENT: Home Care **UNION**: MAHCP

SUPERVISOR'S TITLE: Team Manager

SUPERVISORY RESPONSIBILITIES: none

EDUCATION:

- Graduate of an approved Bachelor of Nursing education program required (with current CRNM registration).

SPECIAL TRAINING:

- Wound Care & Diabetes courses an asset.
- Additional chronic disease management education preferred

EXPERIENCE:

- Two Years Recent, relevant experience and demonstrated competency in community health, home care, and/or primary care/primary health care is required
- Experience in emergency, medicine, rehabilitation, Hospital Based Case Coordination and/or community an asset
- Relevant experience working with complex psycho-social case management an asset
- Competent in Windows-based computer programs (Word, Excel, PowerPoint, Outlook)
- Competence in Procura software and assessment tool interRAI-HC preferred

OTHER:

A) Knowledge of:

- College of Registered Nurses of Manitoba Standards of Practice for Registered Nurses.
- Canadian Nurses Association Code of Ethics for Registered Nurses.
- Community Health Nurse Standards of Practice & Home Health Competencies
- Scope of practice document as documented in the Registered Nurses Act
- Regional/Facility unit policies, procedures, protocols, and guidelines.
- Personal Health Information Act (PHIA), Protection of Persons in Care Act, Mental Health Act, Workplaces Hazardous Material Information System (WHMIS) Principles of Routine Practices (Universal Precautions) and other legislated acts.
- Roles and responsibilities of members of the healthcare team.

- Principles of delegation.
- Principles of adult learning and teaching strategies.
- Alternate care environments suitable for community living.
- Nursing care knowledge related to community nursing.

B) Abilities and Skills:

- Demonstrated effective oral and written communication skills.
- Preference will be given to those applicants competent in an Indigenous language and/or knowledge of Indigenous customs, traditions and values.
- Demonstrated critical thinking/problem solving skills.
- Assessment of Home Care eligibility
- Ability to coordinate delivery of a broad range of professional and non-professional services.
- Ability to prioritize care for an individual or group (s).
- Ability to evaluate need for assignment and assign care appropriately.
- Ability to evaluate medical stability for safe discharge planning.
- Ability to respond to a variety of simultaneous demands.
- Ability to liaise with agencies or facilities involved with clients, their families and caregivers.
- Ability to function in a demanding and stressful environment.
- Ability to maintain concentration with frequent interruptions.
- Ability to adapt quickly to changing situations.
- Ability to perform independently and as a member of the healthcare team.
- Ability to recognize and pursue self-development opportunities

C) Physical Demands and Working Conditions:

- Good physical and mental health.
- Available to work days, evenings and weekends.
- Use of a reliable motor vehicle suitable for all environmental conditions.
- May be exposed to infectious diseases, blood and body fluids, toxic materials, noise, allergens, physical and emotional stress
- May encounter aggressive and/or agitated clients/visitors/staff

D) Licenses, Registrations, etc.

- Responsible for maintaining and providing proof of registration with the College of Registered Nurses of Manitoba (CRNM)
- Valid Manitoba Class 5 Driver's license required and use of a vehicle.

I. MAIN FUNCTION: (In order of Importance):

The Home Care Program provides a broad range of services that can assist people to remain in a community setting. Under the general supervision of the Team Manager and while demonstrating a commitment to the mission, vision and values of the WRHA, the Transition Complex Care Coordinator assesses complex clients and determines eligibility for various Centralized WRHA Home Care supports. The TCCC in collaboration with the client, family, relevant interdisciplinary team members, community, and systems team members, reviews and assists in the transition of complex clients to/from various care settings as well as to/from various community supports. Additionally, the TCCC establishes and maintains liaison with local health care services, hospital, and community partners. The TCCC works in collaboration with Centralized Home Care to identify process improvements to facilitate transitions and optimize supports for complex community clients.

II. POSITION DUTIES AND RESPONSIBILITIES:

- Maintains extensive understanding of Centralized Home Care eligibility, supports and processes.
- Receives referrals and proceeds with assessment of client and family to determine Home Care eligibility.
- Assesses need for community based supports/services.
- Completes assessments with clients and families including the collection of physical, psychosocial, spiritual, cultural and economic data. This assessment is used independently or in collaboration with the team to identify health needs
- Utilizes available data, collected by other members of healthcare team, to further identify health needs
- Collaborates with client health care team, community services providers and client/family/substitute decision maker to compile comprehensive information regarding the client's care needs in the context of their community setting.
- Assesses and contributes to decisions about the safety of the home environment with the goal of optimizing client safety and taking actions to support a safe work environment for all members of the home health care team
- Reviews the established care plan or collaboratively develops individualized plan of care, (including discharge plan) incorporating data from a variety of sources, in collaboration with other members of the healthcare team, and other systems as appropriate.
- In collaborations with other community living service providers, identifies and addresses system issues that impact or limit the client's ability to live in the community.

- Identifies learning needs with clients and families and provides linkages to appropriate education, including current health state, symptom management, preventative care, wellness strategies, capacity building, self-advocacy, and systems navigation.

- Documents assessments and client care plan in client's health care record.

- Works with clients, families and other members of the healthcare team to re-evaluate and modify the plan of care according to changes in the client's health status. Focuses on restorative or preventative care to reduce unnecessary health care utilization.

- Liaises with agencies or facilities involved with clients and their families and caregivers.

- Is knowledgeable of WRHA guidelines and service limits, and incorporates this knowledge in creating sustainable care plans with clients and families.

- Works in an integrated service delivery model with community service delivery programs to deliver comprehensive, client and family centered care.

- Maintains current case count: ensures proper submission of statistics.

- Plans and organizes work schedule and manages caseload demands effectively.

- Utilizes consultation and supervision.

- Participates with other staff in interpreting the program and resources provided through the Home Care Program to the public and/or other agencies.

- Takes initiative to establish and maintain liaison with the local health care services and the informal community resource network.

- Participates in educational development when required of new staff, students and related to the program.

- Keeps current developments within own discipline as these relate to the Home Care Program.

PROFESSIONAL RESPONSIBILITIES

- Provides care in a professional manner consistent with the Registered Nurses Act, College of Registered Nurses of Manitoba Standards, and Canadian Nurses Association Code of Ethics.

- Reports unsafe practice, professional incompetence, professional misconduct and incapacity or unfitness to practice of any healthcare team members through the appropriate channels.

- Advocates for clients while respecting their right to self-determination.

- Provides constructive feedback to members of the healthcare team in a timely manner.

QUALITY IMPROVEMENT

- Participates in meetings, committees, councils, teams, etc. to improve client care, processes and work environment as assigned.
- Supports and participates in the program's quality improvement initiatives/plans.
- Demonstrates openness to ideas/changes that support quality client care.
- Performs in a manner that reflects the values of trust, compassion and excellence of service in interactions with clients, families, the healthcare team and the public.

EDUCATION AND RESEARCH

- Maintains and improves clinical expertise through formal and informal education opportunities.
- Assumes responsibility for maintaining competency in own nursing practice.
- Develops own performance improvement plan to enhance area of nursing practice.
- Acts as a resource and role model for students, colleagues and others.
- Participates in educational and research activities

INTERPROFESSIONAL PRACTICE

- Works in an integrated service deliver model with other and other community service delivery programs.
- Seeks out, integrates and values as a partner, the input and engagement of the patient/client/resident/family/community in designing and implementing care and services.
- Understands ones' own role and the roles of other health providers and uses this knowledge appropriately to establish and achieve patent/client/resident/family/community goals.
- Applies the principles of cultural proficiency, team dynamics and group processes to enable quality client care and effective inter-professional collaboration to emerge in everyday practice.
- Understands the principles that support a collaborative practice model including shared decision-making and accountability for one's own actions.
- Communicates with other care providers in a collaborative, responsive and responsible manner.

- Applies leadership principles that support a collaborative practice model including shared decision-making and accountability for one's own actions.

- Consistently communicates in a respectful, responsive, and responsible person-centered manner.

- Engages self and others including the patient/client/resident/family in a positive manner and constructively addresses disagreements as they arise.

- Engages in relationships with care, dignity and respect regardless of race, ethnicity, culture, ability or language proficiency.

OTHER

- Maintains current knowledge of Emergency and Continuity Plans and appropriate response to Emergency Codes (Emergency Public Address Announcements).

- Adheres to all safety and health regulations and safe work practices.

- May be required to perform other duties and functions related to this job description not exceeding above stated skills and capabilities.