



**North Eastman Health Association Inc.  
Job Description**

**Home Care Case Coordinator**

**POSITION SUMMARY:**

The Home Care Case Coordinator is a member of the program team and a multi-disciplinary site team, with the goal of assisting clients to remain in the community and when that is no longer viable facilitating placement into a facility. Primary responsibilities relate to: client intake and assessment, to determine program eligibility; care planning and case coordination, caseload management and program/resource planning.

**REPORTS TO:** Manager, Home Care Services

**UNION:** MGEU - Professional Technical

**SUPERVISORY:**

The following classifications report to the incumbent.

- Home Care Nurse. (Direct Service)

**QUALIFICATIONS**

Education & Experience

- Baccalaureate Degree in Nursing is preferred with active registration in CRNM;
- Two years of recent related community experience is preferred;
- Other combinations of education and experience will be considered.

Knowledge, Skills and Abilities

- Demonstrated communication skills, both written and oral;
- Knowledge/experience working with clients with dementia (and their families) an asset;
- Ability to work independently;
- Ability to maintain positive working relationships with staff to work in a team setting; individuals, families, community and other health care workers;
- Basic introductory computer skills would be an asset;
- Valid drivers' license and vehicle required;

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- Work schedule may include evenings and weekends;

## **POSITION DUTIES AND RESPONSIBILITIES**

### **1. Intake and Assessment:**

- Receives referral information.
- Reviews information, prioritizes and determines the need for a Home Care Assessment or redirects the referral appropriately.
- Ensures the case is registered on Home Care;
- Conducts a comprehensive assessment of client/family situation to determine eligibility and care needs related to Home Care and/or institutional placement.
- Admits eligible cases to Home Care or redirects appropriately.

### **2. Care Planning and Case Coordination**

- Analyses data received from assessment, identifies patterns/needs and prioritizes same.
- Identifies appropriate discipline coordinator or assumes responsibilities for case coordination as appropriate.
- Develops a plan of care including statements of client need, objectives, service provision, and evaluation criteria.
- Takes responsibility for implementation and coordination of the plan of care. May include initiating medical, rehabilitative or consultative services as necessary to meet client need.
- Provides professional intervention where appropriate through professional counselling/teaching/guidance/crisis intervention/referral, etc.
- Responsible for the ongoing management of the cases including monitoring evaluation, reassessment, and adjustment of the plan of care.

### **3. Caseload Management**

- Plans and organizes work schedule.
- Manages caseload demands effectively.
- Carries out activities necessary to meet program guidelines.
- Responsible for presentation of cases to Regional Panel.
- Maintains current case count; ensures proper submission of statistics.
- Utilizes consultation and supervision.
- Responsible for assignments to and supervision of Home Care Nurses.

### **4. Program/Resource Planning**

- Gathers data regarding resources and resource needs related to caseload/community.
- Participates with other program (& related) staff in development of needed community resources.

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- Participates with other program 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.

## **5. Team Participation**

- Works cohesively with the Home Care and multidisciplinary team in the care planning process, including discharge planning from hospital;
- Attends and participates at team meetings as appropriate and contributes to case management meetings.
- Participates with team in identifying community needs and gaps in service.
- Represents program at team level.
- Works within Regional and Department Policy.

## **6. Professional Development (Self & Others)**

- Participates in the education of related care professionals.
- Participates in the orientation of new staff.
- Contributes to the education experience of assigned students.
- Participates in studies and research related to the program.
- Keeps current of developments within own discipline as these relate to the Home Care program.

# **HOME CARE NURSE**

## **POSITION SUMMARY:**

Under the supervision of the Case Coordinator, the Home Care Nurse functions as a member of the multi-disciplinary team. The Home Care Nurse administers those functions/ activities as assigned to them by the Case Coordinator. The Home Care Nurse works with the team to promote an integrated, holistic health service that is responsive to the needs of the residents/ staff of the North Eastman Health Association.

**REPORTS TO:** Home Care Case Coordinator

**UNION:** Manitoba Nurses Union

## **QUALIFICATIONS:**

Education and Experience

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- Registered Nurse with additional education or preparation applicable to the position
  - Currently registered and in good standing with CRNM
  - Minimum of one year related experience
  - Must possess a valid Manitoba driver's license and have access to personal vehicle

#### Knowledge, Skills and Abilities

- Ability to foster and maintain positive working relationships both individually and in a team setting.
- Ability to work independently; to work alone and to work in isolated areas. Basic introductory computer skills would be an asset.
- Work schedule to include weekends and evenings as required.
- Keep current with new policies/ procedures as indicated within their own professional expertise.
- Ability to maintain privacy and confidentiality.
- Ability to communicate effectively both orally and in writing.
- Ability to prioritize and organize assignments in an efficient manner.
- Other duties as assigned.

#### **Position Duties and Responsibilities:**

- Responsible to provide comprehensive nursing care to clients and families as assigned by the Case Coordinator.
- Formulates a plan for the nursing care function.
- Implements the nursing intervention.
- Monitors and evaluates care and services provided to client/ families.
- Documents nursing care according to established charting guidelines.
- Provides current information on client health status to the Case Coordinator as required.
- Provides teaching/ counseling to individuals and families as related to the client's nursing care plan.
- Participates in the identification, development and implementation of client/ staff education programs.
- Provides teaching as required to direct service workers in relation to the client service plan.
- Participates in case conferences and staff meetings as required.
- Keeps current with new policies/procedures as indicated within their own professional expertise.