Registered Nurse - Case Manager (Salem) & Clinical Liaison (Salem)

Registered Nurse- Case Manager Job Description:
The Registered Nurse Case Manager serves as a member of the interdisciplinary care team. The RN Case Manager participates in the development and coordinates the implementation of the interdisciplinary plan of care. The RN Case Manager plans, organizes, and provides nursing care to the terminally ill and their families.

Provides skilled nursing patient care or service within the established plan of care. Coordinates all services relative to providing skilled nursing care. Demonstrates exceptional service to patients, families, referral sources, co-workers and other customers. Assists team members as needed to ensure that this level of service is consistently provided. Assesses patient physical, psychological, social, and environmental status; identifies problems and appropriate interventions and initiates the Plan of Care based on these findings. Includes the patient and family in the planning process.

Reports pertinent observations and reactions regarding changes in patient status; identifies problems and appropriate interventions and updates the Plan of Care based on these findings. Communicates with the Clinical Team Lead and physician regarding observations and recommended interventions. Teaches the patient and family/caregiver self-care techniques as appropriate. Provides medication, diet and other instructions as ordered by the physician and recognizes and utilizes opportunities for health counseling with patients and families/caregivers. Works in concert with the interdisciplinary group. Ensures that arrangements for equipment and other necessary items and services are provided timely. Assists the patient and family/caregiver and other team members in providing continuity of care, emotional, spiritual and psychosocial support. Completes all documentation in a concise, accurate and timely manner. Provides written instructions to home health aides for patient care consistent with the established plan of care. Supervises home health aides on a routine basis to ensure adherence to the plan of care. Updates the home health aide plan of care as indicated. Provides LPN/LVN supervision as directed by the Clinical Team Lead. Attends interdisciplinary group meetings. Participates in on-call rotation as assigned by the Clinical Team Lead. Maintains patient confidentiality at all times. Takes part in timely and appropriate discharge planning when indicated by the patient’s plan of care. Actively participates in quality assessment performance improvement teams and activities as assigned.

Required Skills
Demonstrates excellent observation, problem solving, verbal and written communications; nursing skills per competency checklist. Shows ability to organize and prioritize workload independently. Maintains a current CPR certification. Must be a licensed driver with reliable transportation that is insured in accordance with state and/or organization requirements and is in
good working order. Registered nurse with current licensure to practice professional nursing in the state.

Required Experience
Prior home health or hospice experience or (1) year of recent medical/surgical experience strongly preferred.

Clinical Liaison- Job Description:

Job Description Summary
The clinical liaison orients patients and families to hospice services, evaluates the patient's hospice appropriateness, assesses needs, and plans and coordinates care for in order to meet the end of life care needs of individuals admitted to hospice. The clinical liaison is responsible for establishing and maintaining professional relationships within their assigned facilities. The clinical liaison will work with their assigned facilities to establish the appropriate level of care for referred patients. The clinical liaison will provide educational presentations related to hospice care as indicated.

Essential Job Functions/Responsibilities
1. Establishes and maintains harmonious relationships with assigned facility leaders, health care professionals and hospice staff.
2. Ensures comfortable transition of patient to hospice care by providing hospice education and orientation, education in disease process and preparation for end of life care needs, plan of care initiation, and coordination of care with multiple hospice and non-hospice service providers.
3. Reviews available medical records and completes initial assessment of patient to determine hospice appropriateness per Medicare guidelines. Requests additional documentation and information as needed.
4. Documents complete history and physical assessment.
5. Develops a care plan based on patient and family end of life goals, using nursing diagnoses and incorporating palliative nursing actions. Includes the patient, family and when appropriate community providers such as facility staff, in the planning process.
6. Initiates at the time of admission those preventative and palliative nursing procedures needed for patient comfort, safety and quality of life. Administers medications and treatments as prescribed by the physician. Documents response to interventions administered on admission as part of initial assessment.
7. Ensures needed supplies, equipment and medications are provided.

8. Coordinates care for patients who are receiving General Inpatient Hospice Care and ensures that these patients are transitioned to another level of care if/when GIP is no longer indicated.

9. Assists agency in providing timely hospice care by performing hospice evaluations and assessments for unassigned facilities and completing routine nursing visits when requested.

Communication

1. Establishes and maintains lines of communication with facility staff, referral sources and team members.

2. Confers with hospice Medical Director to ensure hospice appropriateness and appropriate level of care for all admissions. Works with facility and other members of the hospice team to coordinate transfer of non-GIP patients to the appropriate level of care in a timely manner.

3. Communicates with facility staff and patient's primary physician regarding hospice admission, level of care and initial plan of care. Requests and receives new orders as needed for patient comfort.

4. Reports to Clinical Team Lead and other members of IDG regarding the patient's level of care and initial plan of care.

5. Provides report to hospice on-call team regarding admission as appropriate. For patients on GIP level of care, provides daily report to on-call team regarding patient's status and anticipated needs.

6. Communicates with patient and family clearly, with respect, and in a manner that promotes patient dignity. Uses culturally competent communication that respectful of diverse communities.

7. Acts as a liaison between the patient/family, the facility and the hospice team to address patient/family needs, concerns, or complaints.

8. Uses therapeutic listening and communication techniques with patient and family. Teaches self-care techniques to patient and family as appropriate.

9. Carefully guards patient right to privacy in accordance with values of respect dignity and HIPPA.

10. Attends interdisciplinary group meetings as possible.