

HOSPICE OF THE VALLEY

POSITION: Hospice Nurse Case Manager

SUMMARY: The Hospice Nurse Case Manager plans and delivers care to patients utilizing the nursing process of assessment, planning, interventions, implementation, and evaluation; and effectively interacts with patients, significant others, and other interdisciplinary team members while maintaining standards of professional nursing and clinical competency.

Reports to: Director of Clinical Operations

QUALIFICATIONS:

1. Graduate of an accredited school of nursing.
2. Valid license as a Registered Nurse in the State of California
3. Home Health and/or hospice experience highly desirable
4. Current Basic Life Support Certification
5. Minimum one year recent professional nursing experience
6. Valid California Driver's License
7. Able to cope with emotional stress and be tolerant of individual lifestyles
7. Sensitive to the needs of terminally ill patients and families and one's own feelings about dying and death.
8. Basic computer skills desirable

PHYSICAL DEMANDS:

1. Intermittent physical activity including walking, standing, sitting, lifting and supporting patients.
2. Incumbent may be exposed to virus, disease and infection from patients and specimens in working environment.
3. Incumbent will be required to work at patient's homes and be responsible for own transportation.
4. Incumbent may experience traumatic situations in the family setting.

DUTIES AND RESPONSIBILITIES:

Operates under the director of the Director of Clinical Operations and under the Medical Director's orders.

Responsible for identifying and coordinating patient/family care to support terminally ill patients and families in home, skilled nursing facility or residential care facility. Frequency of patient / family contacts will be at the discretion of the Case Manager and his/her assessment of need, but will be a minimum of once per week. The Case Manager endeavors to utilize teaching, assessment, and intervention skills to provide comfort care and maximize the quality of life for the patients and families.

Depending on the acuity of the patient, the Case Manager is expected to make 4-5 visits per day with documentation. Case load is approximately 10-12 patients for 40 hrs/week 8-10 patients for 32 hrs/week, 6-8 patients for 24 hrs/week and 4-6 patients for 20 hrs/week.

1. Assess home care needs, being aware of the physical, emotional, and spiritual aspects and gather data on social, economic and cultural factors which may influence health, well-being and quality of life.
2. Assist patients, family members or other clients with concern and empathy; respect confidentiality and privacy and communicate in a courteous and respectful manner.
3. Provide direct care to patients as prescribed in the Interdisciplinary Plan of Care in order to maintain the highest level of comfort and quality of life and assuming primary responsibility for case management.
4. Evaluate and perform ongoing assessment and revise initial written plan of care with Interdisciplinary collaboration weekly or as the needs and conditions of the patient/family change.
5. Authorize, coordinate and supervise care, as prescribed in the Interdisciplinary Plan of Care, with contracted vendors in order to meet the needs of the patient.

6. Attend and participate in weekly patient care conferences (PCC)
7. Document accurate and ongoing assessment of patient status via a variety of mediums of communication (verbal, written, email, computer documents and databases). Document patient care reflecting nursing interventions, patient response to care, patient needs, problems, capabilities, limitations, and progress toward goals. Documentation includes evidence of appropriate patient/significant other teaching, and the understanding of these instructions is noted in the medical record. Maintain up-to-date charts and records on patient care and regular communication with the patient's physician regarding changes in the patient's plan of care.
8. Investigate and follow through on unusual orders or requests for service or information.
9. Perform blood draws if required.
10. Participate in the agency's on-call rotation as prescribed by the needs of the agency to provide nursing service to clients when required outside office hours.
11. Be available, when possible, to meet a patient/family's need for continuous care in time of crisis.
12. Coordinate community resources and other agency disciplines participating in patient care.
13. Minimize non-productive time and fill slow periods with activities that will enable you to prepare to meet the future needs of the agency.
14. Supervise and maintain ongoing effective communication with other hospice personnel involved with patient care. This may involve formal and informal team meetings in addition to PCC.
15. Knowledge of and availability to perform patient intakes and information visits as needed including explanation of the hospice benefit/Medicare, complete physical assessment, completion of all pertinent paperwork, and communication of new patient status to the HOV team.
16. Knowledge and availability to handle patient information calls and overflow of intake/Triage calls.
17. Provide bereavement resources to the family as appropriate.
18. Participate in hospice and community health programs as requested to promote the growth and understanding of the hospice concept. This includes but is not limited to participation in HOV's Spend-a-Day program and HOV sponsored education events.
19. Participation in HOV company functions including attendance at Open Form and attending a minimum of 3 HOV sponsored in-services per year.
20. Establish HHA plan of care as well as indirectly and directly supervising the plan of care per regulations.
21. Perform as a member of the Hospice of the Valley team as a whole and participate in the Total Quality Management philosophy of the agency.
22. Performs other duties as assigned consistent with skills and training and the mission and goals of the agency.

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