**HELP FOR HEALTH**

**JOB DESCRIPTION**

**JOB TITLE:** Registered Nurse (RN) — Community Care

**REPORTS TO:** Clinical Director

**PURPOSE/SUMMARY:**

The Registered Nurse/Case Manager plans, organizes and coordinates the care of all assigned cases. The RN/Case Manager, in consultation with other disciplines/professionals, select as outcome goals and skilled interventions. The RN/Case Manager effectively uses agency and community resources, to achieve patient and family independence with patient care, in the patient’s place of residence. The RN/Case Manager coordinates the services of all disciplines to achieve outcome goals established by the team.

**COMMUNITY RN ESSENTIAL JOB FUNCTIONS/RESPONSIBILITIES:**

* Maintains working knowledge of current hospice coverage guidelines, admission criteria, documentation requirements and manages patient care accordingly.
* Effectively manages initial home visit; introducing services, admission criteria, process for determining patient eligibility and for obtaining required consents when eligibility is confirmed.
* Completes an accurate, initial comprehensive head to toe, and other assessments of patient and family to determine home hospice needs; obtains a history of current and previous illness.
* Determines patient eligibility for admission based on admission guidelines, regulatory requirements and the suitability/adaptability/safety of patient’s home for hospice delivery.
* Uses health assessment data, input from agency team members, the physician, patient and family, to determine patient needs.
* Effectively manages patient and family expectations regarding agency services.
* Establishes appropriate diagnosis based on patient assessment and history and focus of hospice care.
* Assesses the patient/caregiver willingness/ability/barriers to learn patient care techniques and for achieving independence in care; documents patient/family response to teaching.
* Attend Interdisciplinary Team meetings or supply input and facilitate discussion of issues from caseload for full staff discussion, consultation and evaluation.
* Seeks input from interdisciplinary team, physician, patient and family when establishing outcome goals and plan of care.
* Develops an Individualized Care Plan, incorporating appropriate skilled interventions, and necessary medical supplies/equipment and ancillary/specialty services, to achieve outcome/discharge goals.
* Maintain up-to-date records using computerized medical record system so that problems, plans, action and goals are accurately and clearly stated and changes are reflected as they occur; documentation is completed within established agency guidelines and to meet regulatory requirements.
* Outlines Hospice Aide care plan, as applicable; performs ongoing hospice aide oversight, per state payer requirement and state regulations.
* Projects realistic visits by discipline and medical supplies required per planned interventions and goals, write Plans of Care orders accordingly.
* Initiates the Plans of Care and related nursing interventions; conducts goal-oriented visits; ensures other nursing team members have information needed for continuity of care and continued progress.
* Regularly evaluates patient progress, in collaboration with team members; revises patient’s Individualized Plan of Care accordingly every two week and when changes are needed.
* Maintain regular communication with Clinical Director to review caseload and/or unusual or potentially problematic patient/family issues.
* Assist other nurse/case managers including assuming primary responsibility for patients when necessary.
* Share in on-call rotation, providing 24-hour, seven-day-a-week coverage to patients/families as necessary. Nurse is able to give a detailed report to the oncoming nurse.
* Nurse administers medications and treatments as prescribed by the physician and per patient’s Plan of Care.
* Provides patient/family education per Plan of Care and medication changes; assesses and documents response to teaching.
* Advocates for the patient as required.
* Performs appropriate nursing assessments every two weeks and revises Plan of Care accordingly.
* Provide appropriate support to family and caregivers at time of death and perform bereavement assessment if requested.
* Participate in the organization’s QAPI Performance Improvement Program as appropriate.
* Participate in Help for Health’s orientation, in-service trainings, monthly mandatory staff and nurses meetings, and other opportunities for learning provided.
* Participate in agency and community programs as requested to promote professional growth and understanding of hospice care.
* Demonstrate familiarity with policies of the agency and rules and regulations of State and Federal bodies which aid in determining policies.
* Complete 12 hours of in-service training every year in the required time frame.
* Responsible for maintaining current CPR certification.
* Other duties as assigned.

**EDUCATION/EXPERIENCE:**

1. Graduate of an accredited school of nursing program.
2. One to two years of home health/hospice (preferred) or recent experience in an acute care/rehabilitation setting providing care for the adult patient.
3. Current Wyoming license

**SKILLS:**

Applicant must have excellent observation, verbal and written communication skills, problem solving skills, basic math skills, nursing skills per competency checklist. Must be able to utilize good judgment, demonstrate patience and maintain a professional demeanor at all times. Demonstrate good verbal and written communications, and organizational skills.

Must have reliable transportation, valid driver’s license and vehicular insurance in order to travel in Fremont County.