Position Title: Care Coordinator (Registered Nurse/Allied Health Professional)

Campus: Stawell

Directorate: Aged and Community Care

Department: Transition Care Program (TCP)

Reporting to: Transition Care Program Team Leader

Grampians Transition Care Program Manager

Direct Reports: N/A

Appointment Terms/Conditions:

Classification and Code: Registered Nurse CAPR 3 – Clinical Nurse Consultant A or B (ZF4 – ZJ4) depending on year as Clinical Nurse Consultant

Allied Health Professional Grade 2, Year 1 – Year 4, dependent on years of experience

Enterprise Agreement: Nurses and Midwives (Victorian Public Sector) Single Interest Employer Agreement

Allied Health Professionals (Victorian Public Health Sector) Single Interest Enterprise Agreement

ORGANISATIONAL INFORMATION

Grampians Health was established on 1 November 2021, bringing together Edenhope and District Memorial Hospital, Stawell Regional Health, Wimmera Health Care Group and Ballarat Health Services as one united health service. More information can be found at www.grampianshealth.org.au

Our purpose is to provide high quality and accessible health care services in each of the communities we serve. We currently service the healthcare needs of more than 250,000 Victorians and we employ more than 6,300 people across 21 campuses and sites with an annual operating revenue of over $700m.

Collaboration *We are stronger together.*	***Compassion*** *We show that we care.*	***Accountability*** *We do what we say and say what we do.*	***Respect*** *We appreciate and value all people.*	***Innovation*** *We adapt and innovate to achieve best outcomes.*
Recognising and utilising strengths to share knowledge, solve problems, build relationships and deliver the best outcomes possible.	All people deserve to be treated with compassion, kindness and empathy.	Openness, honesty and transparency support us to be courageous, take responsibility for our actions and follow through on our commitments	Our actions and words reflect our commitment to a safe and fair health service for all.	Every day, we apply expertise and integrity to make responsible choices, always striving for continuous improvement.

POSITION PURPOSE

Care Coordination is defined as the integration of health and social care services and is considered an integral part of the overall health care delivery process. Care coordinators working within this role to provide clients with the individual support they require and the assistance they need during their health service journey. It is aimed at assisting the client to meet their own individual goals ranging from improvement in physical, cognitive and psychosocial functioning, to assist them to increase their capacity for independent living and maintain the client's functioning whilst assisting them and their significant others to make appropriate long-term arrangements.

The TCP Care Coordinator utilises a client centred approach to ensure collaborative care planning and monitoring, service facilitation and continuous communication with clients and their family/care providers. This is achieved through the provision of short-term support and active management for TCP clients at the interface of the acute/subacute and residential aged care sectors. These clients may have goals of returning home or considering transitioning to permanent care and require a period of adjustment to complete their restorative process, optimise their functional capacity and finalise and access their longer-term care needs and arrangements.

KEY ACCOUNTABILITIES

- Provide short term support and active care coordination for older people at the interface of acute/subacute and residential aged care sectors in line with the TCP Programme Guidelines.
- Coordinate all aspects of client care including admissions, care planning, care monitoring and exit/discharge planning in continued collaboration with clients/family/care providers and the multidisciplinary team.
- Provide advanced assessment, treatment/intervention and consultative services to TCP program clients.
- Future planning, initiation of supports and services with a focus on integration of care
- Liaison with service providers, GPs and specialists as required
- Ensuring a multi-disciplinary approach
- Where necessary, undertake an advocacy role on behalf of clients and / or their carers
- Ensure complete documentation, including all care coordination interventions relating to the client's admission to the community program
- Provision of care that meets the National Safety & Quality Health Service Standards (NSQHS), as well as the Aged Care Quality Standards.
- Maintain appropriate case load of clients pending occupancy requirements and individual complexities in consultation with TCP Team Leader and/or Manager.
- Ensure all escalations actioned immediately and reported to the TCP Team Leader and/or Manager
- Liaising and developing positive working relationships with internal and external stakeholders
- Early recognition of signs and symptoms of clinical deterioration considering clinical presentation and escalation of same in line with GH policy and procedure.
- Contribute to continuous improvement of the Transition Care Program through participation in quality activities
- Identify and participate in relevant research including to prepare and / or present papers at relevant workshops/seminars or conferences where the opportunity arises.
- Monitor new developments through journal review, attend and present at relevant GH in-services and attend other relevant external educational opportunities

KEY SELECTION CRITERIA

- Degree in Nursing or relevant Allied Health Profession including current AHPRA registration where required.
- A post graduate qualification or working towards in relevant area (highly desirable) e.g. Community Services/practice, Gerontology, Aged Care, Chronic Disease, Cognition, Mental Health etc.
- A clear understanding of the principles of TCP and core objectives
- Proven skills in assessment, management, care planning, goal setting and discharge planning for people with complex medical, aged and/or psychosocial needs
- Proven experience in Care Coordination or Case Management
- Previous experience working in a multi-disciplinary team
- Demonstrated high level communication, interpersonal and problem-solving skills
- Proven ability in managing difficult and challenging behaviors
- Demonstrated ability to practice independently and interdependently
- Experience with GP liaison and knowledge of referral pathways to other community providers
- High level computer skills;
- Holder of a current Victorian Drivers' licence

ORGANISATIONAL REQUIREMENTS

- Grampians Health is committed to a consumer centred approach in the provision of health care and services, consistent with our values, purpose and vision. It is expected that team members demonstrate the core values of consumer centred care in every interaction.
- All team members of Grampians Health are responsible for supporting the safety, participation, wellbeing and empowerment of children.
- Quality care is a strategic and operational priority at Grampians Health, achieved through our Governance Framework.
- Participation in the Grampians Health integrated quality improvement and risk management systems by being aware of responsibilities to identify, minimise and manage risks and identifying opportunities for continuous improvement in your workplace through communication and consultation with managers and colleague.
- You must ensure that the affairs of Grampians Health, its patients, clients and staff remain strictly confidential and are not divulged to any third party except where required for clinical reasons or by law. Such confidentiality shall extend to the commercial and financial interests and activities of Grampians Health.
- All team members must adhere to infection control policies and procedures, together with any State and/or Commonwealth Government Covid19 rules, protocols and orders.
- In accordance with current legislation and organisational policy, employees must be willing to undertake and maintain a police check, working with children check and where necessary an NDIS Worker screening check. Ongoing employment will be dependent on the provision of satisfactory checks.

OTHER RELEVANT INFORMATION

- At Grampians Health we recognise and respect diversity. Each person has a right to high-quality health care and opportunities regardless of diversity factors which might include aspects such as cultural, ethnic, linguistic, religious background, gender, sexual orientation, age, and socioeconomic status. Inclusiveness improves our service to our community and promotes engagement amongst Grampians Health employees.
- All Grampians Health employees are required to take reasonable care of their own health and safety in the workplace as well as take reasonable care for the health and safety of others who may be affected by their acts or omissions. Persons with delegated management functions have an additional duty to provide and maintain a working environment that is safe and free of risks to health, so far as is reasonably practicable in areas where they have management or control. All employees have a duty to report issues they cannot rectify, follow all existing Grampians Health policies and protocols relating to health, safety, wellbeing and injury management and cooperate with any action taken by Grampians Health to comply with the OHS Act or Regulations.
- Statements included in this Position Description are intended to reflect in general the duties and responsibilities of this position and are not to be interpreted as being all inclusive.
- Management may alter this Position Description if and when the need arises. Any such changes will be made in consultation with the affected employee(s).
- An annual performance review will occur with your Manager. Your performance review is intended to be a positive discussion, outlining the key roles and responsibilities outlined in this Position Description. The performance review discussion provides an opportunity to clarify your role, revise key performance activities and identify any objectives or goals for the year ahead.