UNION JOB DESCRIPTION

JD6100

JOB TITLE:	Community Liaison Nurse	**JOB DESCRIPTION NO.:**	6100
CLASSIFICATION:	Community Health - Profile Classification - Level 3	**GRID/PAY LEVEL:**	NL3
COLLECTIVE AGREEMENT:	Nurses Bargaining Association	**HSCIS NO.:**	25001
UNION:	BCNU	**JOB/CLASS CODE:**	80352
PROGRAM/DEPARTMENT:	Regional Clinical Operations: Community Access, Capacity and Transitions, Community Health Services, Access and Flow	**BENCHMARKS (If Applicable):**	
REPORTING TO:	Manager or designate		
FACILITY/SITE:	VIHA: South Island, Central Island, North Island Health Services Delivery Areas		

JOB SUMMARY:

In accordance with the Vision, Purpose, and Values, and strategic direction of the Vancouver Island Health Authority (Island Health), patient and staff safety is a priority and a responsibility shared by everyone; as such, the requirement to continuously improve quality and safety is inherent in all aspects of this position.

The Community Liaison Nurse practices in accordance with the standards of professional practice and code of ethics as outlined by British Columbia College of Nurses and Midwives (BCCNM) as well as within a patient/client and family centered care model.

Reporting to the designated Manager or designate within Regional Clinical Operations, the Community Liaison Nurse works as a member of the inter-professional health care team and is responsible for complex discharge planning and coordination which includes: assessing, planning, organizing, documenting and evaluating the care needs of clients and their caregivers/families requiring community-based services; fostering and promoting continuity of care and co-operative partnerships by liaising with client/families, primary care physicians, long-term care homes, community health services, acute care hospitals and other programs/organizations involved in the provision of services; and works in acute care.

Travel may be a requirement of this position. Transportation arrangements must meet the operational requirements of Island Health in accordance with the service assignment and may require the use of a personal vehicle.

TYPICAL DUTIES AND RESPONSIBILITIES:

1. Performs a variety of functions related to complex discharge planning and care coordination including:
    - Developing a collaborative, integrated and consistent process for discharge planning, transition support and ongoing care requirements.
    - Assessing, planning, organizing, documenting, and evaluating the service needs and goals for clients and their caregivers/families, including financial assessments.
    - Reviewing client care needs and goals by planning, organizing and evaluating changes to the care plan for discharge as required.
    - Collaborating and consulting with other care services and the inter-professional health care team.
    - Determining eligibility and providing appropriate access to Community Health Services.

- Arranging home support and other care services to facilitate hospital discharge.
- Promoting and facilitating client independence by exploring all care options.
- Identifying clients at risk and providing appropriate intervention for discharge planning, as required.
- Acting as a client advocate.

2. Plans, participates and facilitates client care conferences.

3. Fosters continuity of care by liaising with client/families, primary care physicians, long-term care facilities, community health services and other programs/organizations.

4. Establishes eligibility for, and authorizes home support services through home support agencies in accordance with contractual requirements, as required.

5. Acts as a resource by communicating and educating clients, caregivers/families and the community about Community Health Services, policies and procedures including presentations to community, professional, and other groups.

6. In collaboration with the inter-professional team, makes recommendations on care planning, transition options or escalation pathways for specific individual patients/clients when existing service criteria may not fit with patient/client and caregiver needs.

7. Contributes to the development of client-centred standards based on best practices.

8. Contributes to the orientation and training of staff, students and other health professionals.

9. Participates in quality assurance activities and projects as required. Advises Manager of opportunities for improved efficiencies, recognizing and reporting poor resource utilization.

10. Maintains knowledge of current resources, encompassing a range of service or program options available to meet complex client care planning and health service needs in relation to discharge planning.

11. Ensures a safe and healthy working environment by observing and promoting universal precautions and infection control procedures; removing obvious hazards; reporting faulty equipment, accidents, injuries and near misses; and adhering to and enforcing rules regarding safety.

12. May be required to travel to other Island Health sites to perform tasks as assigned.

13. Performs other related duties as assigned.

QUALIFICATIONS:

Education, Training And Experience

- Graduation from a recognized nursing program or evidence of an equivalent combination of education, training and experience.
- Registration with the BC College of Nurses and Midwives (BCCNM) as a practicing RN registrant.
- Three (3) year's recent related experience in gerontology, including a combination of acute and community health experience, or an equivalent combination of education, training and experience.
- Valid Class 5 BC Driver's License.

Skills And Abilities

- Ability to communicate effectively, both verbally and in writing.
- Ability to work independently and as a member of a team.
- Ability to work effectively as part of a inter-professional health care team, with other staff, other programs/organizations and with clients and their caregivers/families.
- Ability to deal with others effectively, and foster and promote good public relations.

- Ability to utilize sound judgement, strong observation and assessment skills, tact, and empathy.
- Ability to resolve conflict, problem-solve and build consensus.
- Ability to manage time and resources, fostering collaboration across disciplines, and care settings.
- Ability to integrate and evaluate data from multiple sources to support decision-making and problem-solving.
- Ability to maintain a commitment to continuing professional development as required by the employer.
- Ability to demonstrate a working knowledge of applicable legislation; apply nursing process as required and described in BC College of Nurses and Midwives Standards of Practice; and demonstrate clinical competence including areas of chronic disease management, health promotion and illness prevention
- Ability to maintain current knowledge of Community Health Services (CHS) and act as a resource to clients, families, and the inter-professional health care team regarding available service options.
- Ability to apply evidence-informed practice, drawing on nursing, health-related disciplines, and relevant research.
- Ability to operate related equipment including computers and software.