Te Whatu Ora
Health New Zealand
Taranaki

Community Support Service - Care Manager

1. PURPOSE OF POSITION

The role of Care Manager supports older people and those living with long term chronic health conditions to access Aged Residential Care (ARC) and / or Home Based Support Services (HBSS). The role involves working with the service user and the whanau/ family to understand what types and levels of support the individual is eligible for and what supports and services are available. A core component of the role is helping people to navigate a transition to or move into Aged Residential Care.

The Care Manager undertakes comprehensive assessments using the appropriate tool from the interRAI suite, with consent, and in collaboration with the person, their family/whanau/caregivers and relevant service providers. Assessments are undertaken for Older People, Palliative clients and people who have been diagnosed with complex Long Term Chronic Health Conditions requiring support services.

Following assessment the Care Manager will develop person-centred plans of care within available resources. The Care Manager will liaise, coordinate, implement and review a package of services to meet the person's needs to enable them to achieve optimal safety, wellness and independence within their own environment. Additionally, the Care Manager will facilitate referrals to primary, secondary and community services that have a preventative, restorative and/or supportive function enabling the person to self-manage where possible and as appropriate.

The Care Manager works in partnership with other team members, peer reviewing complex assessments to ensure consistency. They will work closely with the Duty Manager who manages and coordinates the 'daily desk' and supports the triaging of referrals and assignment to the Care Manager team. Care Managers have a close relationship to the Home Support Unit, Administration Team, and Allied and Nursing staff who also support individuals and whanau with ensuring that peoples support needs are met with the most comprehensive and appropriate services possible.

2. ORGANISATIONAL VALUES

Te Whatu Ora Taranaki our mission (Te Kaupapa) is improving, promoting, protecting and caring for the health and well-being of the people of Taranaki. Te Whatu Ora Taranaki values define who we are as an organisation, the way we work with each other, our patients, whanau and external partners. Our Te Ahu Te Whatu Ora Taranaki values are:

Partnerships	WHANAUNGATANGA	We work together to achieve our goals
Courage	MANAWANUI	We have the courage to do what is right
Empowerment	MANA MOTUHAKE	We support each other to make the best decisions
People Matter	MAHAKITANGA	We value each other, our patients and whanau
Safety	MANAAKITANGA	We provide excellent care in a safe and trusted environment

3. DIMENSIONS

Reports to:	Team Leader - Community Support Service
Number of people reporting to you	-
Financial limits authority	-
Operating Budget	-

4. WORKING RELATIONSHIPS

External	Internal
People and their family/whanau who interact with Te Whatu Ora Taranaki health service. Community Health stakeholders (i.e. Hospice, Access Ability, Red Cross, St Johns) General Practitioner's and Practice Nurses PHO's Staff from other NASC's Home Support Provider agencies ACC Aged Residential Care Facilities Ministry of Health TAS	Community Service Manager Community Health Integration Centre staff Nurse Managers, Complex Discharge Coordinators ACC team Professional advisors / Leads Maori Health Team / Te Pae Harakeke District Nursing Clinical Nurse Specialists Geriatricians Administration staff EICATT/Intermediate Care teams Allied Health teams – inpatient and out patient Discharge Coordinator Mental Health Services for Older People service Social Workers Mental Health

5. ACCOUNTABILITIES

Key area of responsibility	Expected outcomes
1. Assessment Effectively completes and documents comprehensive assessments, ensuring client's needs, risks, strengths and goals are identified	• Clients will be assessed using the appropriate InterRAI assessment tool. • Assessments will be undertaken in the most appropriate setting for the client i.e. at home / hospital / hospice or an Aged Residential Care Facility (ARCF) • Assessments will involve clients, their family/whanau/caregivers, clinicians and other service providers as appropriate and with consent.

	• Assessment will be culturally responsive and support Maori preferences for time frames and settings. • Clinical knowledge and reasoning will be utilised in the assessment process. • Immediate risks will be identified and addressed. Clinical advice/ education will be provided in relation to assessment findings. • Timely response and prioritising of referrals for hospital discharges and palliative clients at end of life. • Participate in peer reviews to ensure consistency of assessment. • Work in partnership with Duty Manager and Team Leader where assessments are complex or challenging.
2. Care Planning Care plans will be developed to meet clients assessed needs, facilitating optimal self-management where possible	• Care plans will be developed in partnership with the service user and their family/whanau/caregiver, establishing goals and anticipated outcomes. • Care plans will be culturally appropriate and reflect the clients prioritised needs. • Care Plans will consider the wants of the service user and whanau in relation to the care needs and where possible, as per policy and funding guidance endeavor to accommodate these. • InterRAI Clinical Assessment Protocols (CAPs) and service guidelines are utilised in the care planning process. • A preventative and restorative approach that eliminates or minimizes the need for ongoing support and promotes quality of life is utilised where appropriate. • Structure & implementation of complex support packages will enable clients to remain in their own homes if that is appropriate. • Case conference, Multi-Disciplinary Team (MDT), Family and other meetings are attended to ensure all relevant information regarding clients is received and used for care planning. • Identifies culturally appropriate service delivery options using an approach that makes best use of the broad range of primary, secondary and community services (both funded and non-funded) available to older people. • Undertakes co- ordination of services in conjunction with the administrative team and Home Support Unit. • Peer reviewing of permanent care entry/reviews of levels of care within Ministry of Health time frames, using interRAI outcomes and utilising a high level of clinical judgement/expertise
3. Monitoring and Review	• A review schedule will be maintained, as specified in the care plan or in response to client need. • Reviews/ reassessments will be completed in partnership with the client, their family/whanau/ caregiver and relevant

Care plans will be monitored, reviewed and modified as required	service providers taking in to account identified goals and anticipated outcomes. • Care plans will be modified in response to client need or effectiveness of interventions. Will ensure that that there is a shared understanding of changes and/ or adjustments to service provision as required.
4. Clinical Duties Limited clinical duties associated with the Care Managers professional scope of practice are undertaken	• Profession specific knowledge and competencies will be utilised in all aspects of the role. • Limited profession specific advice / intervention will be provided to clients as a "first response" in situations where clients have not yet been referred to the relevant service. • In consultation with the Duty Manager and/or Team Leader refer individuals to other services, as may be required, and except in safety situations, where the individual and/or their whanau gives consent. • Clients and family/whanau/caregivers give consent to and are fully informed regarding profession specific intervention. • Clinical records are kept in accordance with professional and service requirements.
5. Develop and maintain relationships **Effective relationships are developed and maintained with all stakeholders**	• Strong relationships are developed and maintained with health professionals and service providers working across the primary, secondary and community care sector. • Effective communication with clients, family/whanau/caregivers and service providers will promote optimal understanding of the assessment, care planning and care management process • Case conferences are attended as required to assist in facilitating hospital discharge to the community or to residential facility. • Communication is facilitated between agencies, services and providers to ensure interventions and services identified within the care plan are delivered effectively and alternative responses are sought if required. • Effective relationships are established with GP practices within the Care Managers cluster, ensuring that outcomes of the assessment and care planning process are shared with client consent. • Completion of InterRAI assessments will be undertaken in inpatient area or Hospice Taranaki to facilitate timely hospital discharge to residential care. • The Advance Care Planning (ACP) service is communicated to individuals and whanau as may be appropriate

Organisational Accountabilities	Expected Outcome for all Employees
Health Equity	Te Whatu Ora Taranaki strives to eliminate health inequalities and achieve health equity for the Taranaki population. In practical terms this means all staff are required to implement

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	relevant health equity policies, procedures, approaches and guidelines issued from time to time including:
	• The Pae Ora Framework which requires:
	  ○ Demonstrating the principles of Tino Rangatiratanga, Equity, Active Protection, Options and Partnership under the Te Tiriti o Waitangi;
	  ○ improving understanding of the determinants of ethnic inequalities in health, in particular the "Drivers of ethnic inequalities in health" and the "Pathways to Inequalities" both of which are referenced in the Te Whatu Ora Taranaki Pae Ora Framework;
	  ○ Ensuring Health Equity assessment is embedded into your practise where services, policies or programmes are expected to improve outcomes for Māori;
	  ○ Effectively implementing health equity approaches outlined for Health Professionals in "Equity of Health Care for Maori: A Framework" published by the Ministry of Health to support He Korowai Oranga Refresh 2014, national Maori Health Strategy;
	  ○ Ensuring appropriate health literacy responses are used for effective engagement with Māori.
	• You must ensure accurate ethnicity data collected or held for patients and clients you interact with by following the Te Whatu Ora Taranaki Ethnicity Data Collection Policy and procedures;
	• You must attend the Cultural Competency training provided by and for staff of the Te Whatu Ora Taranaki including Treaty of Waitangi workshop, General/Clinical Refreshers, Engaging Effectively with Maori and any other training identified as essential for staff.

Health and Safety	• Maintains a safe and healthy environment • Complies with health & safety policies and procedures • Carries out work in a way that does not adversely affect their health and safety or that of other workers • Complies with procedures and correctly use personal protective equipment and safety devices provided • Contributes to hazard identification and management process • Reports accurately near misses/incidents/accidents in a timely manner • Participates in health and safety matters
Personal Development	• Fully contributes to the individual's team performance and is committed to identify and pursue opportunities for developing new knowledge and skills. • Participates in the performance appraisal process where personal performance and development is reviewed. • Willing to accept new responsibilities, acquire and demonstrate relevant new knowledge.

6. VARIATION TO DUTIES

Duties and responsibilities described above should not be construed as a complete and exhaustive list as it is not the intention to limit in any way the scope or functions of the position. Duties and responsibilities can be amended from time to time either by additional, deletion or straight amendment to meet any changing conditions, however this will only be done in consultation with the employee.

7. CAPABILITY REQUIREMENTS

Capabilities are the behaviours demonstrated by a person performing the job. Capabilities identify what makes a person most effective in a role. Those listed below are expected for the **Community Support Service** team roles in the organisation. The required capabilities can change as the organisation develops and the roles change.

Capability
Effective Communication Shares well thought out, concise and timely information with others using appropriate mediums. Ensures information gets to the appropriate people within the organisation to facilitate effective decision making
Decision Making/Problem Solving Demonstrates effective and timely decision making/problem solving techniques. Aware of the impact of decisions on key stakeholders and consults as appropriate utilizing available resources. Is proactive and effective when problem solving is required.
Innovation/Initiative Continually strives for new and improved work processes that will result in greater effectiveness and efficiencies. Questions traditional ways of doing things when choosing a course of action or finds new combinations of old elements to form an innovatve solution.
Resilience/Flexibility Articulates differing perspectives on a problem and will see the merit of alternative points of view. Will change or modify own opinons and will switch to other strategies when necessary. Adjusts behaviour to the demands of the work environment in order to remain productive through periods of transition, ambiguity, uncertainty and stress.
Cultural Safety Demonstrates a commitment to cultural safety by meeting and exceeding the cultural needs of clients/customers/colleagues. Manages cultural ambiguity and conflicting priorities well. Understands concepts of whanaungatanga and manaakitanga and Maori cultural orientation to whanau, hapu and iwi.
Teamwork Works to build team spirit, facilitates resolution of conflict within the team, promotes/protects team reputation, shows commitment to contributing to the teams success

8. EDUCATION

Holds a tertiary health qualification and current NZ Annual Practising Certificate (or professional equivalent) which has assessment as part of the scope of practice (e.g. Registered Nurse, Occupational Therapist, Physiotherapist, Speech & Language Therapist, Social Worker etc.)

9. SKILLS

Excellent communication and interpersonal skills.
Sound clinical knowledge.
Knowledge and understanding of health and / or mental health changes and their impact on a person
Strong cultural awareness and ability to implement strategies that is responsive to the health needs of Maori.
Ability to practice autonomously
Ability to plan and prioritise
Ability to take a creative and innovative approach to problem solving to ensure that the diverse needs of different client groups can be met effectively.
Knowledge of disability support and health service funding streams.
Commitment to quality improvement and client satisfaction.
Knowledge of a wide range of formal and informal local health and disability support services for people within the Taranaki region.
Strong commitment to ongoing training and professional development.
Stong computer and keyboard skills.
Competent driver with full NZ licence.

10. EXPERIENCE

Able to demonstrate:
Previous experience working with older people and /or those with Chronic Health Conditions.
Experience in assessment and care planning processes (desirable).
Experience working in the community and as part of a MDT would be preferred.