

PIEDMONT HOSPITAL JOB DESCRIPTION

JOB TITLE: Heart Failure Resource Center Staff Nurse **JOB #:** CARD-

DEPARTMENT: Heart Failure Resource Center - #6018

REPORTS TO: Manager Cardiovascular Quality and Heart Failure Disease Management Team

SUPERVISES: None

RESPONSIBLE FOR:

Assists with development and coordinates Heart Failure Resource Center programs, including outpatient follow-up, education, infusion and telemonitoring, which meet the multiple service needs of high-risk adult patients with heart failure. Establishes a relationship with the person after discharge from the hospital and works collaboratively with their physician to improve health management. The nurse assists with initial evaluations with a focus on physical assessment, education, disease management, ongoing monitoring and early interventions. Serves in the role of educator, consultant, coordinator and researcher within heart failure disease management.

QUALIFICATIONS:

Graduate from an accredited school of nursing. Current licensure to practice Nursing in Georgia. Three years of clinical experience in a specialty area of clinical practice, with demonstrated clinical competence. Demonstrates a theory-based practice and embraces PMC Professional Nursing Practice Model demonstrating a wholistic approach in meeting the needs of persons and families. Maintains membership in at least one health care professional organization, with a Heart Failure focus preferred. Maintains an up to date knowledge of current trends, nursing practices and research related to the specialty of cardiology and heart failure. Ability to work autonomously within a self directed work team and is directly accountable for practice. Understands the principles and strategies of both telemanagement and disease management. Advanced technology skills including databases, word processing, graphic programs, internet access, modem and wireless communications. BCLS within 30 days of employment and ACLS within 1 year of employment.

ESSENTIAL FUNCTIONS:

1. Assists with the development, implementation and ongoing coordination of the Heart Failure Resource Center (HFRC) programs.
2. Identifies and provides outpatient follow up for patient's with heart failure, including physical assessment, education, disease management, infusion therapy, ongoing monitoring and early intervention for heart failure patients.
3. Identifies, coordinates and provides Community Telemonitoring for patient's with heart failure, including equipment installation, education and daily monitoring of patients.
4. Assumes responsibility for maintaining own current competency file.

JOB PERFORMANCE STANDARDS

Job # CARD- Heart Failure Resource Center Staff Nurse

All functions shall be performed in a competent, high quality, timely and cost-effective manner in accord with departmental procedures or protocols. Quality is defined as correct, accurate, thorough and age-appropriate. Other performance measures and/or expansion of the above also apply if included below.

Functions and Performance Standards	Rating
<p>1) Assists with the development, implementation and the ongoing coordination the Heart Failure Resource Center (HFRC) programs.</p> <ul style="list-style-type: none"> a) Assists in the review and the revision of position descriptions pertinent to staff working in the HFRC. b) Assists in the interview process for new positions. c) Assists with the development, revision and approval of all policies and procedures for the HFRC. Assures that each area of responsibility has clinical/technical policies in place to address specific areas of operations. d) Reviews all HFRC policies and procedures yearly to ensure compliance e) Meets on a routine basis with co-medical directors to address patient core needs, protocol revisions and operational issues. f) Delegates responsibilities to appropriate personnel and ensures that they are completed in an effective and efficient manner.. g) Ensures that technical and professional charges are provided on a daily basis to appropriate personnel for entry into patient accounts. h) Works with the team to identify, evaluate and report monthly, quarterly and annual outcomes for the HFRC. 	<p>1 2 3</p>
<p>2. Identifies and provides outpatient follow up, including physical assessment, education, disease management, infusion therapy, monitoring and early intervention for heart failure patients.</p> <ul style="list-style-type: none"> a) Identifies and develops referral process for the HFRC. b) Assists APRN with patient assessment <ul style="list-style-type: none"> i. Physical assessment, H&P ii. Symptom assessment specific to heart failure disease state. iii. Needs assessment iv. Educational assessment v. Functional assessment vi. Medication regimen vii. Self care/quality of life assessment c) Provides input for plans of care. <ul style="list-style-type: none"> i. Collaborates with physician and patient to develop a plan of care. ii. Identifies patients appropriate for outpatient infusion and telemonitoring program. iii. Arranges for follow-up through HFRC visits and phone calls. 	<p>1 2 3</p>

<ul style="list-style-type: none"> iv. Recommends follow up frequency based on individual patient need. d) Implements interventions as outlined by APRN and/or MD. <ul style="list-style-type: none"> i. Communicates patient status and plan of care with physician. ii. Interprets assessment data accurately, including vital signs, lab work, and telemetry to direct appropriate intervention. iii. Initiation and titration of Ace Inhibitor and Beta Blockers to target dose. iv. Assess needs for additional IV diuretic or medication adjustments. v. IV Natreacor infusion for decompensated heart failure vi. Arranges for consults, lab testing, diagnostic testing or referrals as necessary. vii. Actively participates in health care team meetings and/or family conferences, when necessary, to facilitate the coordination of complex services and resources. viii. Conducts group education classes for patients with heart failure ix. Documents intervention accurately according to policy and procedure. x. Initiates education process with patient/significant other with explanation of condition, therapies and expected outcome. e) Evaluates patient's progress. <ul style="list-style-type: none"> i. Evaluates effectiveness of intervention with relation to outcomes. ii. Documents patient's response to interventions. iii. Involves patient/significant other in evaluation process. f) Performs follow up phone management. <ul style="list-style-type: none"> i. Calls patients to check on status, and returns calls from patients regarding medical conditions. ii. Refers patients to their physician as necessary. g) Coordinates inpatient admission for acute deterioration of condition. h) Assesses end-of-life issues and concerns with patient and family. i). Refer to palliative care and/or Hospice care as appropriate. 	
<p>3. Identifies, coordinates and provides telemonitoring for patient's with heart failure, including equipment installation, education and daily monitoring of patients.</p> <ul style="list-style-type: none"> a) Conducts referral assessments and screenings to identify appropriate persons for telemonitoring services based on established inclusion criteria, such as multiple hospital admissions, polypharmacy, high cost complex care, frailty, etc. b) Collaborates with the physician and other disciplines such as social work, respiratory therapy, dietician, pharmacist, laboratory etc. to complete a comprehensive health assessment. c) In conjunction with APRN's, develops implements and monitors an integrated goal oriented plan of care. d) Links patients with the most appropriate institutional or community resources. e) Provides ongoing assessment, monitoring, early interventions and education in collaboration with APRN's and physicians to prevent acute exacerbation. 	<p>1 2 3</p>

<ul style="list-style-type: none"> f) Uses a shared information source to maintain appropriate documentation of health services. g) Conducts telephonic follow up as needed for patient assessment and equipment evaluation. h) Provides telemonitoring satisfaction survey to assess program services. i) Conducts discharge home visit for patients transitioning out of telemonitoring program. j) Provides bereavement follow up as needed. 	
<p>4. Assumes responsibility for maintaining own current competency file.</p> <ul style="list-style-type: none"> a. BCLS expires_____ b. ACLS expires_____ c. Net Learning completed_____ d. HCCS completed_____ e. Health Screen completed_____ 	1 2 3
TOTAL POINTS: / NUMBER OF FUNCTIONS: =	