Employee Name: ___________________________________________________________Employee #: ____________________________________________

**MAIN FUNCTION:**

Assures the delivery of quality care through responsible management of cases assigned, and coordination of service provided by all health team members.

**SUPERVISED BY:** CLINICAL MANAGER

**SUPERVISES DIRECTLY:** Home Health Aides

**QUALIFICATIONS:**

1. Registered Nurse, licensed in the state of practice.
2. Graduate of an accredited and approved nursing program as indicated by school transcript or diploma.
4. Have a criminal background check completed.
5. Hold current CPR certification if providing care to pediatric clients. Effective November 10, 2003, current CPR certification is also required for adult care nurses assigned to clients with tracheostomies or mechanical ventilation.* (Required by May 15, 2004 if hired prior to Nov. 10, 2003). **NOTE:** State regulation and/or office specific policy may exceed this requirement.

**RESPONSIBILITIES:**

<table>
<thead>
<tr>
<th>RATING</th>
<th>RESPONSIBILITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>______</td>
<td>Makes initial evaluation visit to new admissions and determines eligibility based on Agency criteria.</td>
</tr>
<tr>
<td>______</td>
<td>Develops and initiates the Plan of Care in conjunction with the physician’s orders and through assessment of patient needs, condition and environment and consultation with other health team members and Clinical Manager.</td>
</tr>
<tr>
<td>______</td>
<td>Regularly re-evaluates patient needs and revises Care Plan to meet patient’s assessed needs.</td>
</tr>
<tr>
<td>______</td>
<td>Consults regularly with patient’s physician to assure current and accurate Plan of Treatment for patient’s care.</td>
</tr>
<tr>
<td>______</td>
<td>Observes and reports to physician and other personal changes in patient’s needs and condition.</td>
</tr>
<tr>
<td>______</td>
<td>Provides those services requiring specialized nursing skill and initiates appropriate preventative and rehabilitative nursing procedures in accordance with Agency policies.</td>
</tr>
<tr>
<td>______</td>
<td>Understands and follows safety and infection control policies and practices.</td>
</tr>
<tr>
<td>______</td>
<td>Prepares clinical and progress notes and observes prescribed procedures for documentation, charting and planning.</td>
</tr>
<tr>
<td>______</td>
<td>Assumes responsibility for care given by Home Health Aide assigned for supervision and teaching.</td>
</tr>
<tr>
<td>______</td>
<td>Counsels the patient and family in meeting nursing and related needs and interprets services of the Agency to patient and family.</td>
</tr>
<tr>
<td>______</td>
<td>Completes reports as scheduled for coordination of care, Home Health Aide supervision, periodic review of patient progress, supervisory conferences and Record Review Committee.</td>
</tr>
</tbody>
</table>
MEDICARE STAFF NURSE - FIELD

12. Schedules work load for maximum efficiency in field and office. _______

13. Meets requirements of employment track, as applicable. _______

14. Confers regularly with other health team members to maintain effective coordination of patient care. _______

15. Covers nursing needs of Agency caseload on weekends and holidays on a rotating basis with other staff nurses. _______

16. Participates in staff in-service programs. _______

17. Maintains a current knowledge of the nursing profession by participation in formal education programs, conferences, workshops and professional organizations. _______

18. Utilizes counseling techniques to activate and motivate patient during period of adjustment. _______

19. Demonstrates competence in performing the following skills, as applicable:
   - Waived testing, i.e. glucometer and PT/INR (demonstrated in home or lab). _______
   - ________________________________________________________________________ _______
   - ________________________________________________________________________ _______

20. Other responsibilities, as required:
    ________________________________________________________________________ _______
    ________________________________________________________________________ _______
    ________________________________________________________________________ _______

Goals achieved from prior year evaluation?  
☐ Yes  ☐ No  ☐ N/A (if employed less than one year)

Comments:
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Goal(s) for upcoming year / Additional Comments:
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Date annual home visit observation completed: __________________________
Date annual skills competency evaluation completed (if different than above) ___________________

Clinical Manager Signature ___________________________________________ Date ______________________

RATING KEY:
5: Very Much Above Standard  2: Below Standard - Needs Improvement
4: Above Standard           1: Very Much Below Standard
3: Meets Standard          N/A: Not Applicable
EMPLOYEE SECTION: Please complete section below. You may indicate (N/A) if you have no further comment. Please remember to sign and date below. If you are reviewing/completing the evaluation off-site, please return the entire evaluation to your supervisor by _________________. A copy will be provided to you upon request.

Employee Response to Evaluation / Goals proposed: _______________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

________________________            ______________________
Employee Signature                 Employee #           Date

Reviewed by _________________________
Client Services Manager or Clinical Manager Signature           Date