

Community Nurse Consultant Service (CNCS)

The Community Nurse Consultant Service (CNCS) is available for Community Living disABILITY Services (CLDS) participants and CLDS Service Providers through referral by the CLDS Service Provider, Primary Care Provider or Community Services Worker (CSW). As more individuals with complex medical needs are supported in the community, it is critical that individuals and their supporting agencies have access to professional nurses who specialize in care provision, assessment, and training for persons with intellectual disabilities.

What is CNCS?

- ▶ CNCS is a provincial team consisting of nursing (RN/RPN/LPN) and administrative support.
- ▶ CNCS will facilitate assessments and training for participants and their support network regarding care provision for both acute and chronic conditions and assist individuals with intellectual disabilities to develop health care plans that can be carried out in community.
- ▶ CNCS provides a community-based health service that promotes integration and stabilization of adults living with an intellectual disability.

What does CNCS do?

- ▶ Develop and maintain specific Individual Health Care Plans created in collaboration with the individual, parent/guardian, service provider, CSW, primary care provider, and relevant medical/community supports, which focuses on the individual's health needs, outcomes and interventions.
- ▶ Ensure timely nursing assessments for individuals in their home environment (including health assessments, pain assessments, mobility assessments, behavioural assessments, etc.).
- ▶ Provide nursing intervention to support the individual's health care needs and promote aging in place.
- ▶ Communicate challenges or changes to the individual's health status or health care plan to appropriate personnel (e.g., case manager, administrators, direct care workers) within the community program.
- ▶ As required, consult with appropriate health care professions (e.g., physician, dietitian, occupational therapist, speech language pathologist, Community Living Psychiatric Services (CLPS), etc.) to ensure a holistic approach to care.
- ▶ Complete comprehensive health history reviews for physician/specialist.
- ▶ As requested, attend appointments, and interpret information from physicians and specialists.



- ▶ Prevent hospital admissions by providing preventive care and reducing the need for trips to emergency.
- ▶ Participate in the hospital discharge planning process for the individual, ensuring timely return to their home environment by developing written care plans related to change in needs and providing education as required.
- ▶ Participate in interdisciplinary meetings regarding the individual.
- ▶ Provide nurse case management follow up for individuals at higher risk due to ongoing complex health issues.
- ▶ Direct questions regarding programming to the appropriate staff person in the community program.
- ▶ Communicate learning needs regarding the individual's health care to the community agency.

Who can be referred to CNCS?

- ▶ Adults living with an intellectual disability who are participants of CLDS.
- ▶ Children living with an intellectual disability who are aging out of Children's disABILITY Services and into the CLDS program.
- ▶ A referral must be submitted by a CLDS Service Provider/Primary Care Physician/or CSW.

Contact Information

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