Position Description
Care Partner

Position title	Care Partner
Program	Package Support
Responsible to	• Package Support Program Leader • Manager Aged & Disability • General Manager Health, Aged & Disability • Chief Executive Officer
Direct reports	• Nil
Award	Community Health Centre (Stand Alone Services) Social and Community Service Employees Multi Enterprise Agreement 2022

Position summary

The Care Partner is the designated care manager under the Support at Home Program, responsible for delivering care management activities that enable older people to live safely and independently at home. Working within a rights-based, person-centred framework, the Care Partner collaborates with participants, their supporters, and interdisciplinary teams to coordinate tailored, responsive and inclusive support.

Care Partners function as relationship-based care managers who provide ongoing planning, monitoring, service coordination, and education—with a strong focus on wellness, reablement, and culturally safe care.

They play a key role in planning and overseeing care service delivery across all support streams, including the Restorative Care Pathway, End-of-Life Pathway, and Assistive Technology and Home Modifications (AT-HM), and work closely with clinically qualified Care Partners when a participant's needs require advanced clinical input or complex care planning.

The program area team also provides supports to consumers of Linkages and Support for Carers and other funded programs as required.

Key responsibilities

1. Care Planning and Coordination

- Collaborate with participants to develop individualised care plans within 28 days of service commencement, ensuring alignment with the Notice of Decision, formal aged care assessment, and approved Support Plan.
- Incorporate the participant's goals, service preferences, cultural needs, risk factors, and AT-HM requirements into their care plan.
- Establish and update quarterly budgets, ensuring participants understand their available services and financial responsibilities.

2. Collaboration with Clinically Qualified Care Partners

- Work as part of a team-based model, escalating care planning and clinical decisions to a clinically qualified Care Partner (e.g., Registered Nurse, Social Worker, Allied Health Professional) where the participant's needs exceed general care management scope.
- For participants on the End-of-Life Pathway or those with Classification Level 6+, collaborate on advanced care planning, clinical assessments, and oversight of palliative supports.
- In the Restorative Care Pathway, support short-term reablement goals while clinically qualified Care Partners lead allied health coordination and outcome evaluation.
- Ensure care plans reflect clinical advice and monitor implementation of recommended clinical interventions (e.g., wound care, mobility equipment, medication support).

3. Pathway-Specific Coordination

- **Restorative Care Pathway**: Coordinate supports to achieve short-term reablement goals, integrate care with allied health, and support discharge planning from hospital or short-term programs.
- **End-of-Life Pathway**: Ensure care is aligned with palliative goals, advance care plans are in place, and that the participant's dignity, comfort and wishes are prioritised.
- **AT-HM Pathway**: Manage service coordination and education related to approved Assistive Technology (AT) or Home Modifications (HM); support participants with safe integration of AT into daily routines.

4. Monitoring, Review and Risk Management

- Review care notes and service delivery data; proactively identify and address emerging risks or changes in participant needs.
- Conduct at least monthly care management activities and schedule formal care plan reviews at least annually or as required by program triggers.
- Support participants to undergo Support Plan Reviews or reassessments via My Aged Care, where appropriate.

5. Financial and Budget Oversight

- Collaborate with participants to plan and manage individualised budgets in line with their classification and support needs.
- Monitor spending to prevent underspends and overspends, and align resource allocation with changing needs, including temporary increases during illness or recovery.
- Liaise with service providers for efficient and appropriate use of resources, especially for AT-HM, clinical, or specialist services.

6. Relationship Management and Communication

- Build meaningful relationships with participants and their supporters to understand goals, preferences, and life circumstances.
- Communicate effectively with internal and external stakeholders, including GPs, allied health professionals, palliative care providers, and service coordinators.
- Facilitate or participate in case conferences, ensuring care plans reflect shared decision-making and supported risk-taking.

7. Empowerment and Education

- Promote participant choice and autonomy in service decisions, including supported decision-making and self-management models.
- Provide education on aged care navigation, Assistive Technology use, clinical warning signs, wellness, and health literacy.
- Offer resources and guidance to informal carers and supporters, including during Restorative and End-of-Life pathways.

8. Documentation and Compliance

- Maintain accurate, timely care notes and ensure documentation supports outcomes under the Strengthened Aged Care Quality Standards, particularly Standard 3 (Care and Services) and Outcome 5.1 (Clinical Governance).
- Ensure care management claims comply with Support at Home business rules, including exclusion of administrative, rostering or travel tasks.

9. Other

- Collaborate with the Client and Community Connector in the provision of activities and education and promote awareness of the program to the community and other service providers, using a community development approach such as information displays and sessions.
- Provide supervision and support to students as required.

- Participate in GCH Supervision program (Including accessing External Clinical Supervision as required)
- Other duties commensurate with current skills and experience as agreed with the Program Leader, Manager, General Manager, or the Chief Executive Officer.

Key selection criteria

Qualifications

- Diploma-level qualification in Community Services, Aged Care, Case Management, or equivalent experience
- Demonstrated experience in care coordination, case management or similar roles in aged care, health, or disability services.

Mandatory

- Solid understanding of the Support at Home Program, Strengthened Aged Care Quality Standards, and aged care rights
- Competence in interpreting clinical guidance and escalating appropriately
- Strong communication, empathy and cultural competence
- Skilled in using care management or CRM systems
- Ability to work collaboratively with key stakeholders to determine areas of collaboration and develop a solution approach.

Desirable

- Demonstrated experience in all aspects of case management including comprehensive assessment, planning, provision and evaluation of services for frail elderly, people with dementia and their carers, and people with culturally and linguistically diverse backgrounds.
- Experience working with people with dementia, complex ageing-related conditions, or palliative needs.
- Experience in working with aged and/or younger disabled people, people with mental illness and their carers within a community setting, as well as an appreciation for and understanding of the presenting issues for people who are aged or have a disability, particularly within the rural environment.
- Demonstrated experience in risk management in a caring context, including appropriately identifying and responding to changes in consumer needs and condition.
- Highly developed analytical skills and the ability to apply these skills in case management.
- High level communication, influencing, liaison, negotiation and mediation skills.
- Formal training in trauma-informed care, cultural safety, or restorative practice.
- Familiarity with My Aged Care portals and digital case management systems.

Demonstrated skills and experience:

- Demonstrated attention to detail with well-developed administrative and organisational skills to effectively manage high volumes of work and determine priorities, meet targets and deadlines.
- Ability to maintain confidentiality at all times.
- Demonstrated knowledge and application of computer software, including Microsoft Office and the Internet.
- High level verbal and written communication skills that enable effective and appropriate communication with a broad range of people at all levels.
- Demonstrated ability to contribute to positive workplace culture and practices.

Program and Guidance References

- Support at Home Program Manual – March 2025
- Strengthened Aged Care Quality Standards (2025)
- New Aged Care Act Summary

Performance Indicators

- Timely and responsive care planning and review
- Participant satisfaction and achievement of individual goals
- Compliance with monthly activity and annual review requirements
- Positive collaboration with clinically qualified colleagues and care teams
- Documentation and budget management aligned with program expectations

Quality, Health & Safety

- Act in a way that maintains physical and psychological health and safety for self and others.
- Adhere to safe work practices relevant to the role.
- Promptly report issues that might put self or others at risk, including incidents and near misses, and respond appropriately to risks and reports from others when appropriate to do so.
- Is kind to self and others.
- Contribute to workplace safety and reduction of workplace injuries.
- Ensure team members, consumers/participants and visitors are safe, and accurately report any incidents, hazards and near misses in a timely and professional manner.
- Work at all times within a culture of continuous quality improvement.

Personal attributes

- Empowering
- Professional
- Inclusive
- Courageous
- Compassionate

Licences and registrations

- Current National police check
- Current Employee Working with Children Check
- Victorian driver licence
- Aged Care Worker Screening Check (est. commencement date mid 2026)

Please note: These checks are a standard part of our employment process at Grampians Community Health. If the results of these checks are not aligned with the requirements of the role, we may reconsider the offer of employment.

Required training

- MARAM Brief and Intermediate
- Internal online courses as required

Position Description last updated and approved by CEO **November 2025**