CHANESE LAMBERT

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To Human Resources**,**

With a passion for the nursing profession, the motivation to succeed, strong interpersonal and communication skills, and a talent in handling stresses well, I believe I have the strong leadership skills to make a difference for your organization.

Some of the key talents that I can bring to your organization include:

- Strong team leadership, relationship building, critical thinking and management skills
- Commitment to providing the highest level of client and family centered care
- Superior oral and written communication skills
- Demonstrated organization, time management, and problem solving skills
- A passion for making a difference in the lives of clients and their families

Now, I would like to put my drive, energy and experience to work for your team. To help you discover a little about who I am and what I have done I have enclosed a resume. As you review it, I hope a central point stands out: I do excel when I am accountable for results managers and clients can see.

Words on paper do not replace face-to-face conversation - I would welcome a personal interview to discuss my qualifications in detail. I offer the necessary experience; dedication and personal qualities to serve as an excellent team member in assisting your organization to reach its objectives.

Thank you for your consideration. I look forward to our conversation.

Sincerely,

Chanese Lambert

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Performance Summary/Professional Profile

13 years + of extensive community nursing experience combined with administration oversight and staff leadership, resulting in high-performing community/home/long-term care and acute care capacities with exceptional quality and service standards.

Develops and executes programs to improve productivity, profitability, and effectiveness with a focus on patient care. Collaborates as part of cross-functional teams to meet the needs of patients in demanding environments. Ability to elicit, interpret and evaluate information from patients and other sources and draw conclusions to develop treatment and care plans. Evaluates patient responses to planned interventions and modifies interventions in collaboration with the interprofessional team to achieve established goals. Addresses emergency situations and implements appropriate therapeutic interventions. Possesses excellent critical thinking and organizational skills to provide emergency, urgent and routine health care. Demonstrates effective oral and written communication skills and health teaching skills to deal effectively with staff and clients. Applies a solution-oriented approach to resolve conflict, manage staff and work with strategic partners to achieve optimal results.

Software Skills: Microsoft Office (i.e., Microsoft Windows, MS Office Suite, MS Project), Point Click Care, CHRIS, interRAI HC/CA, HPG, and ConnectingOntario, Meditech, Picis Clinical Solutions, CritiCall, WTIS

Management Competencies

- Staff Training & Development
- Strategic Partnership Cultivation & Management
- Regulatory Compliance
- Policy Development
- Expense Control & Budget Management
- Complex Problem Solving
- Strategic Planning & Execution
- Case Management
- Interpersonal Communications

Clinical Competencies

- Post-surgical care & wound management
- Safe medication administration via various routes
- Skilled in IV therapy: peripheral and central lines
- Foley catheter care, respiratory therapy & ventilator management
- Older adults with depression, dementia and/or delirium
- Diabetes care & education
- Clients & families with mental health and addiction issues

Professional Experience

South West Home and Community Care Support Services
Community Care Coordinator *April 2024 - present*

- Maintains a caseload of up to 100 + clients within the London-Middlesex County
- Responsible for the planning, funding, coordinating and delivering home and community care services to citizens across the city, in partnership with: Hospitals, Community Support Services, Long-term Care, Mental Health and Addictions Services, and Community Health Centres
- Conduct phone and face to face assessments with clients and service providers to address urgent care needs and/or concerns navigating through the complexities of the healthcare environment
- Determines eligibility adjudication and coordination of OHIP-funded homecare services and long-term Care placements with clients
- Transition and link clients to community resources including home making and nursing services, home visiting family health teams, foot care, shopping and community social work services
- Collaborate and network with community resources to establish trusting relationships to safely discharge extremely complex clients

St. Joseph's HealthCare - London
Coordinator, Specialized Geriatrics Services *September 2023 - April 2024*

- Responsible for recruitment, selection, development, and performance management for multiple teams
- Share accountability for achieving program targets, managing risks, improving quality and safety advancing outcomes
- Management of unionized staff with multiple collective agreements
- Participate and Lead Hospital wide initiatives to improve patient care
- Supports the day to day operations, proving leadership to a multi-disciplinary and inter-professional team
- Problem solve and collaborate with patients and families

William Osler Health System - Etobicoke General Hospital
Clinical Services Manager, Seniors Health *February 2022 – August 2023*
Interim Assistant Clinical Services Manager, Seniors Health *July 2021 – February 2022*

- Responsible for recruitment, selection, development, and performance management for multiple teams
- Accountability for achieving program targets, managing risks, improving quality and safety advancing outcomes
- Management of unionized staff with multiple collective agreements
- Participate and Lead Hospital wide initiatives to improve patient care such as the implementation of the world's first acute care unit adopting the Butterfly Model Approach
- Supports the day to day operations, proving leadership to a multi-disciplinary and inter-professional team
- Problem solve and collaborate with patients and families

Transitional Care Coordinator *July 2018 – July 2021*

- Maintains a caseload of up to 28+ clients for their transitions and discharge plans on a General Medicine, Palliative Care unit and Reactivation Care Unit
- Responsible for the planning, and coordinating care plans for hospital discharges and safe transitions for clients into the community or institutional settings
- Problem solve and collaborate within an interdisciplinary team to navigate complex discharges
- Transition and link clients to community resources including home making and nursing services, home visiting family health teams, foot care, transportation, home meal delivery, shopping and community social work services
- Collaborate and network with community resources to establish trusting relationships to safely discharge extremely complex clients
- Coordinate and facilitate meetings within an interdisciplinary team with clients and families to identify both short and long term goals
- Provides leadership and collaboration with team members on projects to improve team processes and day-to-day functions

Brant Community Healthcare System
Navigator *January 2019 – July 2020*

- Facilitates inter-facility transitions and repatriations for clients locally and internationally
- Responsible for identifying and addressing barriers to client transitions within the hospital
- Leads engagement of members of the inter-professional team and community partners to identify strategies and action plans to remove barriers to transitions of care
- Collaborate with teams to effectively manage Bed flow Utilization tools to ensure timely client transitions

Toronto Central Local Health Integration Network:
Hospital Care Coordinator *April 2017 – July 2018*
Community Care Coordinator *June 2014 - April 2017*
ALC Transitions Coordinator *March 2013 - June 2014*
Urgent Care Coordinator *Aug. 2011 - March 2013*

- Maintains a caseload of up to 100 + clients for core of the City of Toronto, with its edges reaching out into Scarborough, North York and Etobicoke.

- Responsible for the planning, funding, coordinating and delivering home and community care services to citizens across the city, in partnership with: Hospitals, Community Support Services, Long-term Care, Mental Health and Addictions Services, and Community Health Centres
- Conduct phone assessments with clients and service providers to address urgent care needs and/or concerns navigating through the complexities of the health care environment
- Determines eligibility adjudication and coordination of OHIP-funded homecare services and long-term Care placements with clients in specialized units including Amputee Rehabilitation, Neurorehabilitation, Tuberculosis Treatment, Chronic Assisted Ventilator Care, Respiratory rehabilitation and Complex Continuing Care. Averaged 80 referrals per month.
- Problem solved and collaborated within an interdisciplinary team to navigate complex discharges
- Managed and triaged referrals in a timely manner to ensure clients' return home with appropriate services
- Transition and link clients to community resources including home making and nursing services, home visiting family health teams, foot care, shopping and community social work services
- Collaborate and network with community resources to establish trusting relationships to safely discharge extremely complex clients
- Reassess clients after a transitional period at a behavioural support unit within a long-term care setting to determine eligibility for traditional long-term care facilities
- Attend meetings with external stakeholders to provide recommendations to transition clients to the most appropriate place of care
- Supervises, motivates and trains assigned new Coordinators, ensuring effective teamwork, high standards of work quality and organizational performance, continuous learning and encourages innovation in others

Villa Forum Long Term Care Home
Nurse Manager *May 2011 – November 2011*

- Supervises the day to day operation of all assigned staff including the scheduling/replacement, assigning and reviewing of work. Monitors and evaluates staff performance, hears grievances and recommends/conducts disciplinary action when necessary in consultation with manager, while on shift. Manages labour relations issues, staff development, Occupational Health & Safety, and Quality Assurance in accordance to legislations/organizational policies
- Assesses, plan, implement and evaluate individualized care to meet the residents' physical and emotional needs. Ensure resident care plan is initiated in collaboration with other members of the multidisciplinary team.
- Communicate with relatives regarding the care and condition of respective residents as required.
- In conjunction with the Health and Wellness Manager, participates in discharge planning, consultation, and/or transfer of residents.
- As required, provide direct resident care and participate in resident teaching.
- Encourage active participation by residents in all therapy programs and recreational activities.
- Assist in the development and maintenance of an appropriate plan of care for each resident.
- Liaise with attending physicians, psychiatrists, consultants, social workers, clergy, relatives or responsible persons, nursing, dietary, activity staff, etc. to ensure effective resident care is provided;
- Manages any crisis situation, investigates accidents and ensures appropriate medical care is provided and reports any incidents. Resolves problems with clients with focus on client growth and empowerment and promotes life skills
- Procure and administer medications including all injections and narcotics;
- Participate in the orientation, on-the-job training and in-servicing of nursing staff as required;
- As required, requisition and receive supplies.

Community Visiting Nurse, **VHA Home Health Care** *March 2015 – September 2015*
Community Visiting Nurse, **Spectrum Health Care** *September 2010 – May 2011*

- Primary nurse serving clients throughout Bolton/Caledon/Durham communities
- Perform routine nursing duties in accordance with company policies and procedures and Standards of Nursing Practice as defined by the provincial regulating body; perform specialized nursing procedures
- Conduct in-home assessments and reassessments for personal support clients adhering to all funder standards
- Demonstrate knowledge of Adult Personal Support and Homemaking Services provided under a contract with the LHIN
- Demonstrate an understanding of acute/chronic physical and mental health conditions in the senior population and knowledge of medical terminology, personal care practices and infection prevention and control processes
- Develop service plans in collaboration with the client/caregiver and provide on-going case management regarding client service provision for all the personal support program

- Support compliance with LHIN standards and contractual service provision including the completion of administrative tasks
- Maintain up to date client records that supports tracking and organizational data entry requirements
- Liaise with physicians, social work, VHA, LHIN and referral source staff, clients and/or caregivers as needed for overall service planning, program operation and development
- Possess excellent knowledge of program evaluation, risk management, change management and quality improvement strategies
- Promote health and safety practices throughout the organization following health and safety procedures
- Ensure clients are receiving quality service according to the agency's Quality Assurance Standards

Education & Professional Credentials

Bachelor of Science in Nursing (BScN) | York University – Toronto ON

Valid Ontario Driver's License | Current standing with the College of Nurses of Ontario, CNO #10435861 | Fundamentals of Hospice Palliative Care | P.I.E.C.E.S. Learning & Development Model