Job Title	Registered Practical Nurse, Palliative Care
Reports to	Manager, Interdisciplinary Primary Care and Quality
Incumbent	
Date Issued	August 19, 2026

At Support House, we open doors, minds, and possibilities. We build opportunities, we inspire change, and we transform health care. We believe everyone deserves support.

Support House is directed by our core values. They guide our agency's decisions and actions, unite our staff, define our brand, and inspire our culture. We connect by building meaningful relationships. We put people first by supporting them to direct their own path. We focus on holistic wellness. We foster engagement through designing housing, supports and the system together.

Support House offers supportive housing options, primary care, community outreach, peer support and building system capacity.

Diversity, Equity, and Inclusion

Support House is committed to leveraging diverse backgrounds, experiences, and perspectives of our employees in order to provide services to an equally diverse community and encourages applications from all qualified candidates.

The main purpose of this position

The Registered Practical Nurse (RPN), Palliative Care Focus, is a core clinical member of the Burlington Palliative Care Outreach Team (PCOT). PCOT is a collaborative, interdisciplinary team that supports patients who require a palliative approach to care in the community. The RPN supports the team through a combination of clinical triage, team coordination, and system navigation.

This role serves as a key point of contact for patients, caregivers, physicians, community agencies, and healthcare providers, facilitating access to coordinated palliative care services and supporting continuity of care across health and social service systems.

Operating within a relationship-centered, person-centered, and home-first model of care, the RPN contributes to integrated care delivery, supports community-based palliative care, and strengthens collaboration across the broader health system.

Responsibilities

Clinical Triage & Referral Coordination

- Serve as the initial point of contact for patients, families, physicians, community agencies, and referral partners accessing palliative care services.
- Receive, review, process, and manage referrals within the Electronic Medical Record (EMR) system.

- Conduct clinical triage of referrals to assess urgency and facilitate timely access to appropriate services.
- Ensure all information required for clinical consultation and care planning is available and complete.
- Redirect or refer patients and caregivers to appropriate services and supports when indicated.
- Coordinate consultations and appointments with physicians, interdisciplinary team members, community providers, and healthcare partners.
- Identify and escalate urgent patient care concerns and clinical issues to appropriate providers.

Patient & Family Assessment, Navigation and Support

- Meet with patients and caregivers in home, community, clinic, virtual, or telephone settings as appropriate.
- Conduct comprehensive assessments of patient and caregiver medical, psychosocial, practical, and support needs.
- Identify barriers to care and collaborate with interdisciplinary team members to develop appropriate care plans.
- Provide education regarding palliative care services, care options, disease progression, and available community resources.
- Support patients and caregivers in navigating healthcare, social service, and community systems.
- Facilitate warm referrals and connections to community supports, caregiver supports, grief and bereavement services, housing supports, and other relevant resources.
- Advocate on behalf of patients and caregivers experiencing barriers to accessing care or services.
- Complete follow-up communication with patients and caregivers to ensure care needs have been addressed and service connections have been successful.

Interdisciplinary Collaboration

- Collaborate closely with physicians, nurses, Ontario Health atHome, home care providers, community agencies, hospices, and other system partners.
- Coordinate communication among members of a patient's circle of care.
- Support care transitions between hospital, home, hospice, clinic, and community settings.
- Participate in interdisciplinary rounds, case conferences, team meetings, and care planning discussions.
- Facilitate integrated and coordinated care planning aligned with patient goals and preferences.
- Serve as a resource to clinicians, referral partners, and community organizations regarding available services and referral pathways.

Documentation, Data & Quality Practice

- Maintain accurate, timely, and comprehensive documentation within the Electronic Medical Record system.
- Maintain and update patient records, assessments, referrals, follow-up activities, and risk indicators.
- Ensure documentation is shared appropriately with members of the patient's circle of care in accordance with PHIPA and organizational policies.

- Prepare reports and participate in team meetings, rounds, and program activities.
- Collect, monitor, and report on program metrics, service utilization, and quality improvement indicators.
- Support program evaluation, outcome measurement, and reporting requirements.
- Ensure compliance with professional standards, privacy legislation, and organizational policies.

Community Engagement & System Capacity Building

- Build and maintain strong relationships with community organizations, healthcare providers, and referral partners.
- Maintain current knowledge of community resources, support services, and referral pathways.
- Act as a resource for patients, caregivers, providers, and community partners seeking information about available services.
- Support education and awareness activities related to palliative care services and community supports.
- Contribute to initiatives that enhance access, coordination, and integration across health and social care systems.

Quality Improvement & Program Development

- Participate in quality improvement initiatives and program planning activities.
- Identify trends, service gaps, and opportunities to improve patient and caregiver experiences.
- Actively seek opportunities to strengthen care coordination, service delivery, and system integration.
- Contribute to innovative approaches that improve access to community-based palliative care.

Professional Development Work

- Practice in alignment with the College of Nurses of Ontario standards, ethics, and professional guidelines.
- Engage in ongoing learning related to palliative care, symptom management, care coordination, and system navigation.
- Participate in supervision, team debriefs, and professional development activities.
- Apply relationship-centered, person-centered, culturally responsive, anti-oppressive, and equity-focused approaches in all aspects of work.

Personal Development Work

- Engage in reflective practice and maintain professional boundaries.
- Prioritize personal wellness and sustainability while supporting individuals experiencing serious illness, grief, loss, and end-of-life care needs.
- Communicate support needs and participate in wellness-promoting activities.
- Utilize internal and external supports (e.g., EFAP) as needed.

Knowledge and skills necessary to be successful in this role

- Registered Practical Nurse (RPN) in good standing with the College of Nurses of Ontario.
- Minimum 3-5 years of experience in palliative care, community health, home care, hospice care, oncology, or a related healthcare setting.

- Community-based or outpatient palliative care experience preferred.
- Demonstrated knowledge of palliative and end-of-life care principles.
- Knowledge of pain and symptom management.
- Demonstrated experience with case management, care coordination, and care planning.
- Experience conducting clinical triage and supporting individuals with complex medical and psychosocial needs.
- Strong understanding of health, social service, and community support systems.
- Demonstrated ability to work independently and collaboratively within an interprofessional team.
- Excellent interpersonal, communication, conflict resolution, and relationship-building skills.
- Strong organizational skills with the ability to manage multiple priorities in a complex and dynamic environment.
- Proficiency with Electronic Medical Records and Microsoft Office applications, including Word and Excel.
- Knowledge of PHIPA and confidentiality requirements.
- Strong critical thinking, problem-solving, and clinical judgment skills.
- Demonstrated commitment to Equity, Diversity, Inclusion, and anti-oppressive practice.
- Valid driver's license and access to a vehicle required.

Working conditions

- Full-time position (37.5 hours per week), with flexibility required based on program and client needs.
- Primary work location is the Burlington clinic, with regular community-based work throughout Burlington and surrounding communities.
- Work is conducted across clinic, community, home, hospice, hospital, virtual, and outreach settings.
- Occasional evening or weekend work may be required.
- Regular travel is required; a valid driver's license and access to a vehicle is essential.
- Work involves supporting individuals and families experiencing serious illness, grief, bereavement, and end-of-life care needs.
- Support House prioritizes flexibility, collaboration, employee wellness, and work-life balance.