Government of
Northwest Territories

IDENTIFICATION

Department	Position Title	
Northwest Territories Health and Social Services Authority	Transitional Care Planner	
Position Number(s)	**Community**	**Division/Region(s)**
17-14616	Yellowknife	Mental Health Services & Extended Care / Stanton

PURPOSE OF THE POSITION

Reporting to the Clinical Social Worker & Team Leader, the Transitional Care Planner provides advanced liaison and discharge planning support for all patients receiving services from Stanton Territorial Hospital as required. The incumbent will be responsible for ensuring that the health care and social needs of complex clients are met through intake, case management, discharge planning, and client advocacy activities. The Transitional Care Planner will complete an assessment of client needs, make appropriate referrals and follow up to ensure that the client returns to their community in a timely, safe and organized manner. The incumbent will assist in the development and revision of policies and procedures related to transitional care planning practices under the NTHSSA.

SCOPE

The Northwest Territories Health and Social Services Authority (NTHSSA) is the single provider of all health and social services in the Northwest Territories (NWT), with the exception of Hay River and Tłı̨chǫ regions, covering 1.2 million square kilometers and serving approximately 43,000 people, including First Nations, Inuit, Metis, and non-aboriginals. Health and social services includes the full range of primary, secondary and tertiary health services and social services including family services, protection services, care placements, mental health, addictions, and developmental activities, delivered by more than 1,400 health and social services staff.

While the Tłı̨chǫ Community Services Agency (TCSA) will operate under a separate board and Hay River Health and Social Services Agency (HRHSSA) will in the interim, the NTHSSA will set clinical standards, procedures, guidelines and monitoring for the entire Northwest Territories. Service Agreements will be established with these boards to identify performance

requirements and adherence to clinical standards, procedures, guidelines and policies as established by the NTHSSA.

Under the direction of the Minister of Health and Social Services, the NTHSSA is established to move toward one integrated delivery system as part of the government's transformation strategy.

Stanton Territorial Hospital (STH) is a referral centre for the approximately 43,000 residents of the North West Territories and approximately 6000 residents of the Kitikmeot Region, Nunavut. All patients receiving in-patient care require assistance with transitional care planning and support back into the community.

The Transitional Care Planner works is part of a Transitional Care Planning team consisting of a Clinical Social Worker & Team Leader, 2 Transitional Care Planners and 1 Clinical Social Worker. The incumbent is part of the health care team, working alongside all Practitioners and Allied Health care providers to address the unique needs of clients and their families. The incumbent collaborates with Community Partners and all Government Departments to establish an individualized plan of care for each client, ensuring they receive the support they need in order to attain their best level of health and wellness possible in the context of their environment.

RESPONSIBILITIES

1. **Provides Assessment and transitional care planning needs to clients with complex case management and/or discharge planning needs.**

   Main Activities:
   - Reviews and triages referrals from members of the multi-disciplinary team.
   - Assesses patient and family needs in conjunction with the multi-disciplinary team.
   - Works with high risk clients who are dealing with multiple complex social issues (homelessness, poverty, corrections, mental health, FASD, addictions, etc.)
   - Facilitates patient/family planning meetings to support the development and implementation of plans and processes to meet the patient needs.
   - Ensures NWT/NU communities are updated on a regular basis with the status of referred individuals.
   - Assesses the client's medical, functional, spiritual, cultural and psychosocial needs to facilitate their transition through the continuum of care.
   - Ensures the appropriate referral and handover of case management to community agencies.
   - Provides ongoing follow up to evaluate the effectiveness of client interventions, and to take such steps as necessary to improve effectiveness.
   - Reviews complex issues/cases and safety concerns, requiring clinical guidance and support, with the Clinical Social Worker & Team Leader.
   - Ensures effective coordination of transitional care planning needs for all patients referred.

- Advocates for the needs of clients and their families, and ensures that community resources are responsive to their needs. Informs Management, and COO about gaps in services and or service barriers or other barriers that impact the ability of clients and their families from having their needs met.
- Provides recommended solutions to Team Leader, Manager, and Senior Management with regard to opportunities to improve support and assistance to patients and their families.
- Appropriately reports incidents, using the approved risk management system.

2. **Coordinates transitional planning for complex or high risk clients and their families to facilitate their successful transition back into the community.**

   Main Activities;
   - Assesses the emotional, psychosocial and environmental needs of the client and coordinates necessary resources to meet their needs.
   - Engages in best practices in the safe and effective care with all clients and their families.
   - Collaborates/consults with multi-disciplinary teams, community agencies, other centres, the client, their family and their support system to plan discharge from the hospital.
   - Ensures that community resources are appropriately advised of the client and family needs and that they are able to respond appropriately.
   - Evaluates the effectiveness of transitional planning in conjunction with clients and their families.
   - Develops a comprehensive understanding of community resources, the services they provide and referral processes.
   - Analyzes the strength and capabilities of community resources to ensure that they are appropriately matched with the needs of patients and their families.
   - Develops implements and coordinates specialized supports for individuals with complex needs and service providers who support these individuals (Government Departments, Non-Government Organizations (NGO), Boarding Homes, etc.)
   - Establishes strong and cohesive relationships with all community resources to ensure the best interests of clients and their families are met.
   - Intervenes on behalf of the client and organization to reduce admission, avoidable emergency room visit and unnecessary hospital admissions.
   - Participates and supports initiatives to effect social change for the overall benefit of people in the community.
   - Establishes partnerships with appropriate community resources to develop ways to more effectively respond to and meet client and family needs.

3. **Performs administrative duties in consultation and collaboration with the Transitional Care Team**
   - Maintains workload statistics.
   - Provides reports as requested.

- Works in collaboration with the Transitional Care Planning Team, and under the under the direction of the Clinical Social Worker & Team Leader and Manager, Mental Health Services and Extended Care Unit.
- Maintains clear, accurate and up to date documentation reflecting ongoing client status and transitional care planning in accordance to established charting standards.
- Maintains client confidentiality at all times.

WORKING CONDITIONS

Physical Demands

The position works directly with clients who are dealing with multiple complex issues across all departments. Due to the type of work there may be threats of physical confrontation with those who are high risk or dealing with mental health issues.

Environmental Conditions

The incumbent will engage directly with clients. They will be required to assess, provide supports, develop a plan of care, set goals and work within a multidisciplinary team to provide daily discharge and transitional care planning. The incumbent will provide transitional care management to clients with multiple complex issues, including homelessness, mental health, child and family services, criminal matters and income insecurity. There is a risk of exposure to communicable disease and the unpredictability and nature of clientele may pose a health and safety risk. (e.g. tuberculosis, mental health, addictions, cognitive challenges, trauma) These may occur every workday with variable duration and intensity depending on the census/workload.

Sensory Demands

The incumbent must always use combined senses of sight, touch, smell and hearing to maintain an awareness of their working environment to prevent potentially disruptive and dangerous incidents from occurring (i.e. mental health issues, signs of impairment, substance use can increase safety risk) as they are working daily with multiple complex needs clients who are dealing with social issues (homelessness, addictions, mental health, child and family services, income support).

Mental Demands

The incumbent will be required to interact with high risk clients who have the potential to be agitated and are dealing with multiple complex social issues (homelessness, poverty, mental health, addictions, etc.). The incumbent will work directly with high need clients and will frequently be exposed to information of trauma, dysfunctional family situations, homelessness, violence and mental health. The potential for mental stress is significant. Potential exposure to hostile and unpredictable behavior poses a safety risk.

The incumbent must also deal with high rate of staff turnover, staff shortages and inexperienced staff, which may result in lack of control over discharge planning and/or fluctuating levels of competence. The incumbent is required to be innovative and motivated

in the area of continuing education to encourage professional growth.

The incumbents may be exposed to death/dying and other emotionally disturbing experiences. The Transitional Care Planner is expected to remain calm, controlled and professional, regardless of the situation and demonstrate compassionate care to the client, family and other members of the health care team.

There is uncertainty in knowing what to expect while at work. There is legitimate concern about being responsible for the lives of clients and their families, risk of assault and unknown and predictable situations.

KNOWLEDGE, SKILLS AND ABILITIES

- Excellent oral, written and electronic communication skills as well as the ability to adapt communication styles to accommodate different needs with tact and diplomacy
- Knowledge of professional and legal components of client care practices.
- Knowledge of the Canadian Standards of Discharge Planning and knowledge of physical and behavioral sciences are required in order to provide competent discharge planning care to clients and their families.
- The Transitional Care Planner needs to be sensitive to the geographical/cultural impact on the delivery of health care.
- An ability to educate clients and their families (where applicable) on appropriate resources to meet their needs.
- Knowledge of education principles related to adult learners in order to develop and deliver subject specific training and development.
- Knowledge of and ability to operate word processing applications (i.e. Microsoft Word, Excel) in the completion of training materials and presentations.
- Knowledge of and an ability to network resources within and outside Stanton (i.e. Social Services, Public Health) in order to ensure support of clients and their families.

Typically, the above qualifications would be attained by:

This level of knowledge is most commonly acquired through a Bachelor's Degree in a Healthcare related profession (nursing, social work) with 2 years of direct health care experience or a Masters level in Occupational Therapy. Equivalencies will be considered. Proven ability to coordinate care services and have experience working in a cross-cultural environment. Proven leadership experience with effective communication skills required.

ADDITIONAL REQUIREMENTS

Stanton Territorial Hospital Requirements

The Transitional Care Planner must be eligible for registration with the RNANT/NU or other professional associations and have successfully completed a criminal record check.

Within the Stanton Region, the Transitional Care Planner must be able to acquire within a reasonable time frame (6 months) and remain current the following mandatory

certifications:

- Non-Violent Crisis Intervention
- WHMIS
- Fire Training

Position Security (check one)

☐ No criminal records check required
☐ Position of Trust – criminal records check required
☒ Highly sensitive position – requires verification of identity and a criminal records check

French language (check one if applicable)

☐ French required (must identify required level below)
Level required for this Designated Position is:
ORAL EXPRESSION AND COMPREHENSION
Basic (B) ☐ Intermediate (I) ☐ Advanced (A) ☐
READING COMPREHENSION:
Basic (B) ☐ Intermediate (I) ☐ Advanced (A) ☐
WRITING SKILLS:
Basic (B) ☐ Intermediate (I) ☐ Advanced (A) ☐
☐ French preferred

Aboriginal language: To choose a language, click here.

☐ Required
☐ Preferred