Home Care – Job Descriptions

Government of
Northwest Territories

IDENTIFICATION

Department	Position Title	
Northwest Territories Health and Social Services Authority	Home Care Licensed Practical Nurse	
Position Number(s)	**Community**	**Division/Region(s)**
57-5678	Yellowknife	Continuing Care Services/Yellowknife

PURPOSE OF THE POSITION

The Home Care Clinical Coordinator (CC) works in accordance with relevant current NWT and Canadian legislation, the standards and clinical practice guidelines from the GNWT Department of Health and Social Services, the Registered Nurses Association of the Northwest Territories and Nunavut (RNANT/NU) and the Community Health Nurses of Canada (CHNC). The CC provides services according to the mission, values, strategic plan, administrative directives and standard operating procedures of the Northwest Territories Health and Social Services Authority (NTHSSA) and NTHSSA—Yellowknife Region.

The role of the Home Care LPN is to protect, restore and/or maintain health or provide end of life care for Home Care clients with a broad array of diagnoses across the lifespan and the health-illness continuum, using the principles of primary health care, preventive, curative, maintenance and comfort nursing interventions, education, communication and support for the informal caregiver. The Home Care LPN promotes community wellness through health promotion, prevention, screening and intervention activities.

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.

Located in Yellowknife and reporting to the Regional Manager, Continuing Care Services, the incumbent's scope of practice is similar to a registered nurse with the exceptions of administration of narcotics and the Home Intravenous Therapy Program. The Home Care LPN's experience is beyond the scope of a graduate LPN and the expanded role demands independent thinking, judgment and critical decision-making skills for the delivery and management of nursing care for Home Care clients.

The LPN works independently collaboratively in the community. In comparison to the hospital setting, physicians and other supportive resources are not readily available to the nurse. The LPN models and promotes excellence through the hands on delivery of nursing care to residents of Yellowknife Region. The LPN may be assigned to all of the program areas (Wound Care, Palliative Care, Chronic Care, Foot Care) with the exception of the Home Intravenous Therapy Program. The incumbent independently makes six to eight home visits a day and coordinates the care of 15-25 clients concurrently. It is the incumbent's responsibility to set priorities, develop work plans and manage workloads, while balancing each individual client's need, complexity and acuity.

The LPN initiates, coordinates, manages and evaluates the resources needed to promote the client's maximum level of health and function. Complex procedures and treatments are performed within very unpredictable home environments. The LPN must have the experience, skill, knowledge and confidence to deliver comprehensive nursing services, including palliative care in the home setting, working with the professional care team, the family caregivers and family dynamics. For example, the LPN may organize pastoral and funeral arrangements and support the grieving family at the time of a death in the home. As another example, chronic wounds may be assessed and managed by the LPN.

Appropriate problem-solving and decision-making have a direct impact on improving a client's level of health and maintaining partnerships with the client, family and community. Decisions frequently prevent complications and allow for early intervention, resulting in cost-savings of significant magnitude to the health system as a whole.

The Home Care LPN is an advanced foot care provider who: participates in the development of the foot care program; has input into policies and procedures for the foot care program; develops and delivers a teaching package to teach basic foot care to Home Support Workers. The position supports foot care clients (clients with diabetes and/or poor circulation who are high risk for infection which can lead to gangrene and amputation) and spends 2 days per week performing foot care duties. The remainder of the time the incumbent performs general home care nursing to clients.

The LPN, as part of an inter-disciplinary team, is expected to communicate with a wide variety of health and social service providers within NTHSSA—Yellowknife Region and other regions, pharmacies, community organizations, Southern acute and rehabilitation units, and the general public. Staff is called upon to provide expert advice in their complex and specialized program areas to other health care professionals. The position has the expectation for continuous expansion of the depth and breadth of knowledge and skill.

RESPONSIBILITIES

1. **Provide comprehensive nursing care in the community setting to assist clients in achieving optimum health and quality of life in situations of chronic disease, acute illness, and injury or through the process of dying, using basic and advanced nursing knowledge and skills in one or more specialty areas, including wound care, palliative care or chronic illness.**
    - Assess the client and family's physical, emotional, intellectual and spiritual needs
    - Determine the need for Home Care nursing services and admit or discharge the client as appropriate
    - Identify supports available to the client, such as community organizations, occupational therapy, mental health counseling, etc.
    - Develop a treatment plan that incorporates the client's goals, needs, support systems, treatment and interventions, and the resources required to achieve these goals
    - Make referrals to other health care professionals to ensure early diagnosis and prompt intervention
    - Coordinate the implementation of the care plan Perform nursing interventions and transferred lab or medical functions Provide case management on clients' health related matters Facilitate communication among client, family and other health care providers
    - Use problem-solving skills to overcome obstacles in delivery of client care and enhancement of client independence e.g. transportation, dressing supplies, medication safety
    - Evaluate care on an ongoing basis to determine its effectiveness and appropriateness, and make changes as indicated

2. **Participate in the ongoing development, delivery, evaluation and improvement of Continuing Care Services.**
   - Maintain current expertise in program areas, e.g. wound care, palliative care, chronic disease management
   - Act as a resource for home health knowledge and practice (for example, wound care, palliative care, home intravenous) for health care providers in other communities in the NWT.
   - Participate in meetings within the Department, NTHSSA, Stanton, and with community organizations, as required
   - Under the direction of the Manager, participate in interdisciplinary committees responsible for researching, developing and evaluating programs, including their associated forms, clinical policies and procedures
   - Research, develop, revise and evaluate educational resources necessary to support clients
   - Research, develop and present information for in-service programs within the Continuing Care Services, Yellowknife Region, NTHSSA and other agencies in the community
   - Participate in the advancement of home health nursing practice by acting as a mentor and preceptor for students and new practitioners from Territorial and other Canadian nursing programs
   - Orient new employees to the Continuing Care Services
   - Participate in special projects and research, as requested

3. **Preform administrative functions that contribute to the effective functioning of the Continuing Care Services.**
   - Maintain current Home Care charts with updated information as a legal and communication record
   - Enter statistical information into Health Suite in a timely manner
   - Maintain records related to hours worked, use of personal and office vehicles, services provided to clients without NWT health care coverage and other records as required
   - Collect and document demographic and statistical information

WORKING CONDITIONS

Physical Demands

Carrying supplies and/or equipment, weighing up to 50 pounds, up and down stairs, in and out of vehicles and homes. Assisting clients with ambulation or transfers or providing personal care as needed. Driving, standing or performing client assessment or care while bending and standing in awkward positions or in cramped space for approximately 80% of each working day.

Environmental Conditions

Exposure to unsanitary conditions, cigarette smoke, pets, loud noises, and extremes of heat and cold in the client's home.

Exposure to communicable diseases and infectious organisms, needle stick injuries, blood and body fluid, hazardous materials.

Exposure to all weather conditions including temperatures ranging from -40 to +30, wind, rain and snow, mosquitoes. The incumbent is normally walking outdoors or driving for up to two hours a day and driving in winter conditions for 7 months of the year.

Working alone, on evenings and weekends.

Work environments and situations encountered are unpredictable and must be dealt with independently

Sensory Demands

Maintaining acute cognitive focus while using the combined senses of touch, sight, smell and hearing during assessments and provision of care in an uncontrolled setting Exposure to unpleasant sights, odors and noises.

Mental Demands

Working alone in unpredictable and uncontrolled conditions. Home visits are made alone, so the incumbent must be aware of the risk of verbal or physical assault, and unknown or unpredictable situations

The requirement to "shift gears" frequently during the day, for example administering an intravenous medication to an elderly client and then being present for a death of a child at home shortly after

May experience emotionally disturbing experiences in which the incumbent is expected to remain calm, controlled, professional and demonstrate compassion and team work. The incumbent must be able to think conceptually, yet maintain attention to detail, often at the same time.

Providing expert nursing care and special treatments in homes with poor lighting, frequent interruptions, constant observation and conversation by informal caregivers.

Work pace is controlled by the client and the incumbent must adapt to the client's level of readiness for interventions.

Ongoing reprioritization and reorganization of workload during the work day in response to uncontrollable factors

The incumbent works shift work and occasional on-call may be required which may cause a disruption in lifestyle.

KNOWLEDGE, SKILLS AND ABILITIES

- Knowledge of current nursing practice, primary health care and trends in health promotion and disease prevention
- Knowledge of the nursing process (assessment, planning, implementation and evaluation) to collaborate, develop, coordinate and implement mutually agreed upon care plans, negotiate priorities in care, and support clients to navigate and transition through the continuum of care
- Knowledge of biological, physical and behavioral sciences in order to recognize, interpret and prioritize findings and determine and implement a plan of action based on accepted standards of practice in a community setting
- Knowledge and current expertise in a broad range of areas, including adult education, community-based nursing, working with families, disease processes, long-term care assessment, community resources, wound care and specialized dressings, medications, grief management and pain management
- Knowledge of computer programs including but not limited to: word processing; Health Suite, Internet Explorer, Outlook e-mail, EMR (Wolf electronic medical record system)
- Ability to make informed, pertinent assessments and decisions while working independently in the community
- Ability to act independently to set priorities, develop work plans and manage workload while balancing clients' needs, complexity and acuity
- Ability to be self-directed, meet deadlines and manage several tasks at once.
- Ability to use basic and advanced nursing skills to perform and adapt complex procedures in the home care setting
- Ability to adapt, be flexible and responsive in the safe and appropriate use of various types of equipment, technology and treatments to address the challenging health needs of clients
- Ability to perform pharmacy skills such as dispensing of medications under approved policies
- Ability to work shift work, including days, evenings and weekends
- Ability to communicate in a caring, professional, therapeutic manner at all times with a wide variety of clients, caregivers, and health care providers
- Ability to think calmly and respond therapeutically in emergency situations
- Ability to apply appropriate learning principles to encourage clients, families and others to recognize their capacity for managing their health needs and to participate in their care
- Ability to integrate activities to avoid duplication of service and inappropriate use of resources, both for individual clients and within the nurse's current caseload
- Ability to work in a culturally diverse environment using resources, such as interpreters, appropriately
- Ability to communicate effectively (orally and in writing)
- Ability to operate and/or use medical equipment such as, but not limited to, intravenous pumps and lines, a variety of intravenous access devices,

sphygmomanometer, blood glucose monitor, pulse oximeter, wheel chair, canes, crutches, etc.

Typically, the above qualifications would be attained by:

The successful completion of a Licensed Practical Nursing Certificate with at least 2 years of recent, acute care LPN nursing experience in a medical, surgical, home care or community health environment.

ADDITIONAL REQUIREMENTS

Yellowknife Regional Requirements
Must be eligible for registration with the GNWT Registrar, have completed a satisfactory criminal record check and possess a Class 5 driver's license.

The Home Care LPN must be able to acquire within a reasonable time frame, and remain current with the following training and/or certifications:

- Non-Violent Crisis Intervention
- WHMIS
- Back Care
- NWT Immunization Certificate
- Certification in basic CPR
- Certification in hand hygiene
- Internet and e-mail applications
- Fire/disaster plan for NTHSSA
- Fit Testing
- Glucometer
- Venipuncture
- IM Injections
- Wound / Ostomy Care
- Palliative Care
- Cardiac Teaching

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

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IDENTIFICATION

Department	Position Title	
Northwest Territories Health and Social Services Authority	Home Care Registered Nurse	
Position Number	**Community**	**Division/Region**
48-3358	Yellowknife	Home and Community Care/Yellowknife

PURPOSE

The Home Care Registered Nurse is responsible for providing comprehensive, full spectrum nursing care to clients located in Yellowknife, and neighbouring communities of Dettah and Ndilo, in their home or in the community setting. As well, this position provides palliative and end-of-life care in the community setting, and acts as a healthcare case manager enabling clients to access and navigate health and social services and resources in the community setting.

Through client- and family-centered assessment and evaluation of care needs, the Home Care Registered Nurse enacts Home and Community Care's mission of supporting clients to remain independent in their home, reducing hospital encounters and hospitalizations, and ensuring continuity of care between hospital and the community setting.

SCOPE

The Northwest Territories Health and Social Services Authority (NTHSSA) is the single provider of all health and social services (HSS) 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 HSS staff.

NTHSSA administers all public health, home care, social services and general physician services in the Yellowknife region, and provides and supports the delivery of community based health care services to adults and children in order to enhance the health and wellbeing of communities through excellence, accountability and respect for regional diversity.

Located in Yellowknife, the Home Care Registered Nurse (HCRN) reports to the Manager, Home and Community Care, and provides nursing care based on a co-created care plan with the client and family to support client's individual abilities. The incumbent provides care using knowledge and skill sets in various areas of nursing care, for a broad array of diagnoses and for clients across the lifespan from infant to seniors, as well as advanced knowledge and skill in the Home and Community Care program areas, including: wound and ostomy care, foot care, home intravenous therapy, chronic disease management, and palliative care.

The HCRN provides case management services enabling client access and navigation of Health and Social Services in the community setting and liaises with appropriate allied health providers, primary care and specialist physicians, and other services providers within and outside the NWT to ensure holistic care and continuity of care. Case management of long-term care applications and transition planning for clients is also part of the HCRN's role. HCRNs also provide and coordinate care for clients from Nunavut, usually temporarily residing in Yellowknife boarding homes, and coordinates care for clients returning to the Northwest Territories from medical travel.

As lead case managers, and sole nursing frontline providers of palliative and end-of-life care in the community setting, this position plays a critical role in providing symptom management and caregiver support for clients wishing to live their remaining days in their home. Provision of home-based palliative and end-of-life care supports client's goals of care and supports client autonomy and dignity in their final days. The HCRN provides palliative services from initial referral to end-of-life, through a co-created care plan that empowers family caregivers and offers 24 hour on-call nursing services to assist with client needs in the final days of life. The HCRN also liaises with physicians and allied health professionals (occupational therapy, physiotherapy, speech therapy, etc.) as needed throughout the client's palliative trajectory to ensure holistic provision of care until end-of-life and to ensure supports for the bereaved.

Home and Community Care is the only provider of advanced foot care in the home setting, and provides the majority of foot care services in the community setting through the Home and Community Care clinic office.

The incumbent also provides individualized client and caregiver teaching pertaining to various diagnoses and health concerns, and promotes community wellness through health promotion, prevention, immunization, screening, and intervention activities.

As the frontline care provider for Home and Community Care, Yellowknife Region, the HCRN provides services according to the mission, values, strategic plan, administrative directives, clinical policies, and standard operating procedures of the NTHSSA. The Home Care Registered Nurse provides care in accordance with current applicable NWT and Canadian legislation, standards of nursing practice and clinical practice guidelines from the Government of the Northwest Territories' (GNWT) Department of Health and Social Services (DHSS), the Registered Nurses Association of the Northwest Territories and Nunavut (RNANT/NU) and the Community Health Nurses of Canada (CHNC).

RESPONSIBILITIES

1. **Provide comprehensive nursing care in the community setting to allow clients to remain independent in their home, avoid hospitalization, defer admission to long term care, and to achieve optimal quality of life using basic and advanced nursing knowledge and skills in one or more areas of nursing care, particularly in the following program areas:**

   A) Wound Care: Provide expert-level wound and ostomy care (post-operative, venous and arterial ulcers, diabetic ulcers, pressure injury, etc.) in the home or clinic setting, to ensure skin integrity and wound healing and/or maintenance, minimize risk of infection, and prevent avoidable hospitalizations.
   - Assess wound status, and monitor for infection; liaise with physicians to prevent complications, escalate care as needed.
   - Develop a treatment plan that incorporates the client's goals, needs, support systems, treatment and interventions, and the resources required to achieve these goals.
   - Provide teaching to clients and informal caregivers regarding skin integrity and wound care, including self-care strategies, and lifestyle and postural modifications to support wound healing.
   - Collaborate with other healthcare providers, including occupational therapists and pedorthists to assist with equipment related to wound care and healing e.g. compression stockings, offloading devices, braces, etc.
   - Collaborate with the territorial Nurses Specialized in Wound, Ostomy and Continence (NSWOC) team to care plan for the provision of more complex wound care; seek continuing education and skill building in collaboration with NSWOC as needed to provide optimal wound care.
   - Identify and collaborate with NSWOC and physicians to determine need for compression systems; implement compression systems (e.g. Coban, Ready wraps, Tubigrip, etc.) via direct care, or via teaching with the client and informal supports. Liaise with occupational therapists and pharmacies to establish fit (if needed) and acquire supplies.
   - Liaise with physicians and pharmacies to receive specialized wound dressing supplies; ensuring proper coverage of these under NWT Healthcare or other sources as needed.
   - Evaluate wound status and care plan on an ongoing basis to determine its effectiveness and appropriateness, and make changes as indicated.

   B) Palliative Care: Provide palliative care nursing assessments, education, and interventions for palliative clients of any age, and coordinate services and equipment, to ensure symptom management and to support clients and their families with end of life in the home or community setting.
   - Assess the client and family's physical, emotional, educational, and spiritual needs.

- Develop a palliative care plan that incorporates the client and family's goals of care, support systems, treatment and interventions, and the resources required to achieve these goals; update care plan as applicable throughout the disease trajectory.
- Participate in conversations/discussions and care planning regarding goals of care and advanced care planning in collaboration with the client's physician(s).
- Provide education to clients and their informal caregivers regarding: illness/disease prognosis (if known) and expected trajectory, symptom management strategies, medication teaching and administration, and self-care strategies for the client and informal caregivers.
- Implement and case manage referrals with interdisciplinary allied health professionals (e.g. occupational therapy, physiotherapy, speech therapy, registered dietician, medical social work, etc.); implement interdisciplinary team recommendations into care plan.
- Recommend supports available to the client and family, such as community organizations, mental health counseling, respite services, etc.
- Coordinate with physicians and pharmacies to anticipate availability of symptom management medications, and availability in routes applicable to the client (e.g. switch from oral to injectables at the end of life).
- Anticipate needs to ensure supplies, equipment, and services are available when needed.
- Ensure an appropriate staffing schedule to provide 24 hour on-call nursing and home support services in the final days of life.
- Provide bereavement support to loved ones after a client's passing.
- Support other areas in the NWT in the provision of palliative care.
- Coordinate equipment loan of palliative care bed, and other adaptive equipment as needed.
- Provide post-mortem care, or assist family and informal caregivers with post-mortem care if desiring to participate; provide necessary teaching to facilitate this.
- Coordinate with physician to complete necessary documentation at time of death, and with the funeral director/coroner to arrange removal of the deceased from the home per the client and family's wishes.
- Support clients, physicians and loved ones in the provision of Medical Assistance in Dying (M.A.I.D.) per applicable legislation.
- Liaise with Stanton Hospital, Cancer Navigation Group, and other healthcare and social supports to ensure continuity of care.

C) Foot Care: Provide advanced foot care to clients with various foot disorders who require specialized care in the home or clinic setting, to reduce complications, ensure client comfort and foster independence.

- RNs holding an Advanced Foot Care certificate provide foot care services in the clinic and home setting.
- Provide care for difficult to manage nails and foot disorders in the diabetic and non-diabetic foot.

- Provide advanced assessment of the lower leg and foot
- Teach clients and family self-care of nails, corns, calluses, proper footwear, skin care, fungal infections, offloading, preventative maintenance.
- Instruct, support, and oversee delivery of basic foot care by home support workers in the community.
- Liaise with physicians, diabetic team, occupational therapy, and pedorthists as needed.

D) Home IV Program: Develop a client-specific plan of care with clients, families and referring physician to allow for IV therapy, via peripheral or central lines, in the home or community setting to allow clients to play a greater role in their care, to complete treatments in their home, to resume family, work and school activities, and to shorten hospitalizations when feasible and improve health resource utilization.

- Choose appropriate mode of delivery in consultation with attending physician and pharmacist; IV direct or intermittent.
- Provide written and verbal teaching information for self-administration of medication with the delivery system chosen when feasible for the client, or when informal supports can assist in administration.
- Coordinate with client for regular pick-up, and delivery of medications.
- Provide clients with necessary home IV therapy supplies, including preparation of medications.
- Provide ongoing advice, trouble shooting and support for self-administration of home IV therapy.
- Provide regular and ongoing assessment and maintenance of IV access; restart or resite IV access as necessary or when indicated.
- Provide regular updates to attending physician.
- Provide central line assessment (e.g. PICC line), monitoring, troubleshooting, teaching, and dressing changes.

E) Post-Acute Illness Monitoring and Chronic Disease Management: Conduct wellbeing and acute or chronic disease follow up for Home and Community Care clients requiring ongoing nursing assessments and interventions.

- Complete relevant comprehensive nursing assessments and report findings to most responsible physician (MRP).
- Liaise with primary care or specialist physicians as needed.
- Perform nursing assessments, including vital signs, general or focused assessments, functional assessments, etc.
- Administer oral and parenteral (SC, IM, IV, etc.) as prescribed; includes cytotoxic medications.
- Perform nursing assessment and interventions relating to a wide range of medical devices, including surgical drains and tubes, and catheters (e.g. Pleurex drainage and dressing changes, nephrostomy tube care and dressing changes, suprapubic catheter changes and care, etc.).
- Facilitate communication among client, family, and other health care providers.

- Assist clients and families with medication review, reconciliation, and self-administration strategies; coordinate and collaborate with necessary supports and interdisciplinary providers to assist with medication compliance (e.g. OT cognitive assessments, polypharmacy review, etc.).
- Provide immunizations for home bound clients (e.g. influenza, pneumovax, COVID-19, etc.).
- Perform delegated laboratory test functions (e.g. blood work, urine specimens, swabs etc.) for homebound clients, including collection and delivery to Stanton Hospital Laboratory, and follow-up with ordering physician.
- Provide ongoing individualized education to clients and families to assist them in managing their acute or chronic health conditions.
- Evaluate plan of care and routinely report changes and concerns to most responsible physician and other care providers as applicable.
- Escalate care to higher levels of care when warranted, and coordinate with other care centers to ensure continuity of care (e.g. submit Home Care Summary Report when directing client to hospital Emergency unit for further assessment).

2. **Lead case management and service coordination by collaborating proactively with all Home and Community Care interdisciplinary team members and external service providers using a patient-centered, and problem-solving approach to facilitate access to services and maximize healthcare outcomes.**
   - Determine the need for additional Home and Community Care services based on client and family-centered assessment of abilities and resources (physical, financial, support systems, etc.)
   - Establish and complete appropriate internal interdisciplinary referrals to Home Care disciplines including occupational therapy, physiotherapy, registered dietician, medical social worker or to the foot care program; complete external referrals to community supports/resources.
   - Act as case manager to coordinate interdisciplinary patient care for high risk or complex patients.
   - Use problem-solving skills to overcome obstacles in delivery of client care and enhancement of client independence e.g. transportation, dressing supplies, insurance coverage, medication safety.
   - Assist in organizing and coordinating appointments and services as required; attend appointments with clients as required.
   - Liaise with physicians and pharmacies for best possible medication reconciliation; maintain updated client medication record.
   - Identify other community supports applicable to support clients in the community-setting (e.g. Inclusion NWT, Independent Living Supports, Integrative Case Management, etc.).
   - Assisting clients in the transition from home to long term care; complete the Continuing Care Assessment & Placement (CCAP) package, liaise with client, family, Territorial Admission Committee, LTC facilities until placement - reassessed yearly and as conditions change; case manage client's move to facility once admitted.

- Ensure coordination of care with other health authorities (e.g. Alberta Health Services) and overarching care coordination supports (e.g. Cancer Care Navigation, NWT Medical Travel, Northern Health Services Network, etc.).
- Assist clients in sourcing, obtaining, and funding necessary medical equipment and supplies, including home O2, palliative care equipment, specialized dressings, etc.
- Participate in meetings within the Department, NTHSSA, Stanton, and with community organizations to ensure continuity of care and safe discharge planning.

3. **Participate in the ongoing improvement of Home and Community Care programs and services by advocating for resources and allocations necessary for providing optimal nursing care and participating in process improvement initiatives.**
   - Maintain current expertise in program areas, e.g. wound care, palliative care, home intravenous program, chronic disease management, and general nursing competencies (BLS/CPR, hand hygiene, etc.).
   - Act as a resource for home health knowledge and practice (for example, wound care, palliative care, home intravenous) for health care providers in other communities in the NWT.
   - Develop a supportive rapport with individuals and their families to facilitate collaborative relationships with other interdisciplinary team members.
   - Determine the most appropriate, effective, and efficient mode of communication among interdisciplinary team members in accordance with identified policies and procedures.
   - Collaborate proactively with interdisciplinary team members utilizing a client- and family-centered approach to facilitate and maximize healthcare outcomes.
   - Provide continuity of care and promote collaborative teamwork directed toward quality patient care.
   - Coordinate and participate in formal and informal case conferences to share appropriate information concerning client concerns or progress and to utilize the team's skills and resources in the most efficient and effective manner.
   - Orient new employees to Home and Community Care and participate in the advancement of home health nursing practice by acting as a mentor and preceptor for students and new practitioners from territorial and other Canadian nursing programs.
   - Enter statistical information into Health Suite in a timely manner to track time and resources allocated to each program area.
   - Participate in special projects, committees, task forces, and research projects as related to Home and Community Care.
   - Under the direction of the Manager, participate in interdisciplinary committees responsible for researching, developing, and evaluating programs, including their associated forms, clinical policies and procedures.

WORKING CONDITIONS

The Home Care Registered Nurse works as a shift worker, on a 6-week rotating schedule, that includes mostly eight hour day shifts (0800-1630), one week of evening shifts (1200-2000), and one weekend of 3- twelve hour shifts (0800-2000).

The Home Care Registered Nurse works the majority of hours in client homes providing care (60-80% of work hours), with the remainder spent commuting to homes (10-15% of work hours) and completing necessary case management and documentation (up to 30% of work hours).

Physical Demands

The Home Care Registered Nurse must provide direct client care in their home environment for 60-80% of the workday, which requires substantial physical activity, including:

- Carrying supplies and/or equipment, weighing up to 50 pounds, up and down stairs, in and out of vehicles and homes.
- Assisting clients with ambulation or transfers or providing personal care as needed.
- Driving, standing, or performing client assessments or care while bending, reaching, pulling, and standing in awkward positions or in cramped spaces.

Environmental Conditions

The Home Care Registered Nurse must provide direct client care in their home environment for 60-80% of the day, which can involve:

- Working alone in unpredictable, unsecured, and unpleasant conditions that must be managed independently;
- Exposure to unsanitary conditions, cigarette smoke, pets, loud noises, and extremes of heat and cold in the community and clients homes that may cause discomfort or pose a safety risk;
- Exposure to communicable diseases and infectious organisms, needle stick injuries, blood and bodily fluids, cytotoxic medications and waste, and other hazardous materials.

The Home Care Registered Nurse must drive to client homes and transfer in and out of vehicles, in addition to navigating walkways and stairs that may be unsafe. This involves exposure to all weather conditions including temperatures ranging from -40 to +30, wind, rain, snow, and mosquitoes/bugs. The incumbent is normally walking outdoors or driving for up to two hours a day, in winter conditions for 7 months of the year, and may be called to visit clients outside of Yellowknife city limits, where phone service is limited or not available.

Sensory Demands

The Home Care Registered Nurse spends 60-80% of the day providing direct patient care where the incumbent will be required to maintain acute cognitive focus while using the combined senses of touch, sight, smell and hearing during assessment and provision of care in an uncontrolled setting (i.e. the client's home).

Working within the client home may be extremely distracting and make normal assessment and diagnosis more difficult as these settings may be a distraction for both the incumbent and the client (noise level, family interruptions, pets, visual distractions, etc.). The combined use of senses is critical to all assessments. Providing expert nursing care and special treatments in

homes with poor lighting, frequent interruptions, constant observation, and conversation by informal caregivers requires acute focus and discipline.

Mental Demands

Within the health care setting there is significant lack of control over the work pace, with frequent interruptions. Work pace is controlled by the client and the incumbent must adapt to the client's level of readiness for interventions, while managing the total client load within allotted work time. There is ongoing reprioritization and reorganization of workload during the workday in response to uncontrollable factors.

The requirement to quickly shift nursing care focus during the day, for example administering an intravenous medication to an elderly client, then being present for a death of a child at home shortly after, followed by case management and required charting / documentation. The incumbent must be able to think conceptually, yet maintain attention to detail, often simultaneously.

The incumbent must be mindful that their own independent critical judgement and decision-making may have serious implications for client health and outcomes (e.g. deciding whether a client's clinical status requires higher level of care or if they can continue to be managed in the home and community setting).

The Home Care Registered Nurse encounters unknown or unpredictable situations (i.e. client or visitor under the influence of alcohol/drugs, cognitively impaired etc), as well as uncontrolled conditions such as exposure to death and other emotionally upsetting experiences.

KNOWLEDGE, SKILLS AND ABILITIES

- Knowledge of home and community nursing and nursing sciences to practice and synthesize information from a broad range of theories, models, and frameworks.
- Knowledge of the nursing process to collaborate, develop, coordinate, and implement mutually agreed upon care plans, negotiate priorities in care, and support clients to navigate and transition through the continuum of care.
- Knowledge of biological, physical, and behavioral sciences in order to recognize, interpret and prioritize findings and determine and implement a plan of action based on accepted standards of practice in a community setting.
- Knowledge and current expertise in a broad range of areas, including adult education, community-based nursing, working with families, disease processes, long-term care assessment, community resources, wound care and specialized dressings, medications, grief management and pain management.
- Knowledge of computer programs including but not limited to: word processing; Health Suite, Internet Explorer, Outlook e-mail, EMR (Wolf electronic medical record system).
- Ability to make informed, pertinent assessments and decisions while working independently in the community.

- Ability to act independently to set priorities, develop work plans and manage workload while balancing clients' needs, complexity, and acuity.
- Ability to be self-directed, meet deadlines and manage several tasks at once.
- Ability to use basic and advanced nursing skills to perform and adapt complex procedures in the home care setting.
- Ability to adapt, be flexible and responsive in the safe and appropriate use of various types of equipment, technology, and treatments to address the challenging health needs of clients.
- Ability to communicate in a caring, professional, therapeutic manner at all times with a wide variety of clients, caregivers, and health care providers.
- Ability to think calmly and respond therapeutically in emergency situations.
- Ability to apply appropriate learning principles to encourage clients, families and others to recognize their capacity for managing their health needs and to participate in their care.
- Ability to integrate activities to avoid duplication of service and inappropriate use of resources, for individual clients, within the nurse's current caseload, as well as system-wide.
- Ability to work in a culturally diverse environment using resources, such as interpreters, appropriately; ability to provide care that is culturally-competent, and trauma-informed.
- Ability to communicate effectively (orally and in writing).
- Ability to operate and/or use medical equipment such as, but not limited to, intravenous pumps and lines, a variety of intravenous access devices, sphygmomanometer, blood glucose monitor, pulse oximeter, wheelchair, canes, crutches, etc.

Typically, the above qualifications would be attained by:

A BScN with at least 2 years of recent, acute care nursing experience in a medical, surgical, or in a home care or community health environment.

Knowledge and experience equivalencies will be determined on a case by case basis.

ADDITIONAL REQUIREMENTS

Proof of immunization in keeping with current public health practices is required.

Must be eligible for registration with the RNANT/NU.

Possess a Class 5 driver's license.

Must be able to work shiftwork, including days, evenings and weekends.

Yellowknife Regional Requirements

All Home Care Nurses must be able to acquire within a reasonable time frame, and remain current with the following training and/or certifications:

- Non-Violent Crisis Intervention
- WHMIS

- Proper Body Mechanics
- NWT Immunization Certificate
- Basic CPR-C
- Certification in hand hygiene
- Internet and e-mail applications
- Fire/disaster plan for NTHSSA
- Fit Testing
- Venipuncture
- Sapphire Pump
- Pleurex Drain
- Glucometer
- Home Intravenous Therapy Program
- Education Program Immunization Competencies (EPIC)
- Incident Reporting

As directed by the manager, the incumbent may be required to obtain additional skills and training in areas such as, but not limited to the following:

- Advanced Foot Care
- Wound / Ostomy Care
- Palliative Care/End of Life Care
- Cardiac Teaching

Position Security

☐ 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

Indigenous language: Select language

☐ Required
☐ Preferred

Government of
Northwest Territories

IDENTIFICATION

Department	Position Title	
Northwest Territories Health and Social Services Authority	Home Care Registered Nurse	
Position Number	**Community**	**Division/Region**
48-6414	Yellowknife	Home and Community Care/Yellowknife

PURPOSE

The Home Care Registered Nurse is responsible for providing comprehensive, full spectrum nursing care to clients located in Yellowknife, and neighbouring communities of Dettah and Ndilo, in their home or in the community setting. As well, this position provides palliative and end-of-life care in the community setting, and acts as a healthcare case manager enabling clients to access and navigate health and social services and resources in the community setting.

Through client- and family-centered assessment and evaluation of care needs, the Home Care Registered Nurse enacts Home and Community Care's mission of supporting clients to remain independent in their home, reducing hospital encounters and hospitalizations, and ensuring continuity of care between hospital and the community setting.

SCOPE

The Northwest Territories Health and Social Services Authority (NTHSSA) is the single provider of all health and social services (HSS) 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 HSS staff.

NTHSSA administers all public health, home care, social services and general physician services in the Yellowknife region, and provides and supports the delivery of community based health care services to adults and children in order to enhance the health and wellbeing of communities through excellence, accountability and respect for regional diversity.

Located in Yellowknife, the Home Care Registered Nurse (HCRN) reports to the Manager, Home and Community Care, and provides nursing care based on a co-created care plan with the client and family to support client's individual abilities. The incumbent provides care using knowledge and skill sets in various areas of nursing care, for a broad array of diagnoses and for clients across the lifespan from infant to seniors, as well as advanced knowledge and skill in the Home and Community Care program areas, including: wound and ostomy care, foot care, home intravenous therapy, chronic disease management, and palliative care.

The HCRN provides case management services enabling client access and navigation of Health and Social Services in the community setting and liaises with appropriate allied health providers, primary care and specialist physicians, and other services providers within and outside the NWT to ensure holistic care and continuity of care. Case management of long-term care applications and transition planning for clients is also part of the HCRN's role. HCRNs also provide and coordinate care for clients from Nunavut, usually temporarily residing in Yellowknife boarding homes, and coordinates care for clients returning to the Northwest Territories from medical travel.

As lead case managers, and sole nursing frontline providers of palliative and end-of-life care in the community setting, this position plays a critical role in providing symptom management and caregiver support for clients wishing to live their remaining days in their home. Provision of home-based palliative and end-of-life care supports client's goals of care and supports client autonomy and dignity in their final days. The HCRN provides palliative services from initial referral to end-of-life, through a co-created care plan that empowers family caregivers and offers 24 hour on-call nursing services to assist with client needs in the final days of life. The HCRN also liaises with physicians and allied health professionals (occupational therapy, physiotherapy, speech therapy, etc.) as needed throughout the client's palliative trajectory to ensure holistic provision of care until end-of-life and to ensure supports for the bereaved.

Home and Community Care is the only provider of advanced foot care in the home setting, and provides the majority of foot care services in the community setting through the Home and Community Care clinic office.

The incumbent also provides individualized client and caregiver teaching pertaining to various diagnoses and health concerns, and promotes community wellness through health promotion, prevention, immunization, screening, and intervention activities.

As the frontline care provider for Home and Community Care, Yellowknife Region, the HCRN provides services according to the mission, values, strategic plan, administrative directives, clinical policies, and standard operating procedures of the NTHSSA. The Home Care Registered Nurse provides care in accordance with current applicable NWT and Canadian legislation, standards of nursing practice and clinical practice guidelines from the Government of the Northwest Territories' (GNWT) Department of Health and Social Services (DHSS), the Registered Nurses Association of the Northwest Territories and Nunavut (RNANT/NU) and the Community Health Nurses of Canada (CHNC).

RESPONSIBILITIES

1. **Provide comprehensive nursing care in the community setting to allow clients to remain independent in their home, avoid hospitalization, defer admission to long term care, and to achieve optimal quality of life using basic and advanced nursing knowledge and skills in one or more areas of nursing care, particularly in the following program areas:**

   A) Wound Care: Provide expert-level wound and ostomy care (post-operative, venous and arterial ulcers, diabetic ulcers, pressure injury, etc.) in the home or clinic setting, to ensure skin integrity and wound healing and/or maintenance, minimize risk of infection, and prevent avoidable hospitalizations.
   - Assess wound status, and monitor for infection; liaise with physicians to prevent complications, escalate care as needed.
   - Develop a treatment plan that incorporates the client's goals, needs, support systems, treatment and interventions, and the resources required to achieve these goals.
   - Provide teaching to clients and informal caregivers regarding skin integrity and wound care, including self-care strategies, and lifestyle and postural modifications to support wound healing.
   - Collaborate with other healthcare providers, including occupational therapists and pedorthists to assist with equipment related to wound care and healing e.g. compression stockings, offloading devices, braces, etc.
   - Collaborate with the territorial Nurses Specialized in Wound, Ostomy and Continence (NSWOC) team to care plan for the provision of more complex wound care; seek continuing education and skill building in collaboration with NSWOC as needed to provide optimal wound care.
   - Identify and collaborate with NSWOC and physicians to determine need for compression systems; implement compression systems (e.g. Coban, Ready wraps, Tubigrip, etc.) via direct care, or via teaching with the client and informal supports. Liaise with occupational therapists and pharmacies to establish fit (if needed) and acquire supplies.
   - Liaise with physicians and pharmacies to receive specialized wound dressing supplies; ensuring proper coverage of these under NWT Healthcare or other sources as needed.
   - Evaluate wound status and care plan on an ongoing basis to determine its effectiveness and appropriateness, and make changes as indicated.

   B) Palliative Care: Provide palliative care nursing assessments, education, and interventions for palliative clients of any age, and coordinate services and equipment, to ensure symptom management and to support clients and their families with end of life in the home or community setting.
   - Assess the client and family's physical, emotional, educational, and spiritual needs.

- Develop a palliative care plan that incorporates the client and family's goals of care, support systems, treatment and interventions, and the resources required to achieve these goals; update care plan as applicable throughout the disease trajectory.
- Participate in conversations/discussions and care planning regarding goals of care and advanced care planning in collaboration with the client's physician(s).
- Provide education to clients and their informal caregivers regarding: illness/disease prognosis (if known) and expected trajectory, symptom management strategies, medication teaching and administration, and self-care strategies for the client and informal caregivers.
- Implement and case manage referrals with interdisciplinary allied health professionals (e.g. occupational therapy, physiotherapy, speech therapy, registered dietician, medical social work, etc.); implement interdisciplinary team recommendations into care plan.
- Recommend supports available to the client and family, such as community organizations, mental health counseling, respite services, etc.
- Coordinate with physicians and pharmacies to anticipate availability of symptom management medications, and availability in routes applicable to the client (e.g. switch from oral to injectables at the end of life).
- Anticipate needs to ensure supplies, equipment, and services are available when needed.
- Ensure an appropriate staffing schedule to provide 24 hour on-call nursing and home support services in the final days of life.
- Provide bereavement support to loved ones after a client's passing.
- Support other areas in the NWT in the provision of palliative care.
- Coordinate equipment loan of palliative care bed, and other adaptive equipment as needed.
- Provide post-mortem care, or assist family and informal caregivers with post-mortem care if desiring to participate; provide necessary teaching to facilitate this.
- Coordinate with physician to complete necessary documentation at time of death, and with the funeral director/coroner to arrange removal of the deceased from the home per the client and family's wishes.
- Support clients, physicians and loved ones in the provision of Medical Assistance in Dying (M.A.I.D.) per applicable legislation.
- Liaise with Stanton Hospital, Cancer Navigation Group, and other healthcare and social supports to ensure continuity of care.

C) Foot Care: Provide advanced foot care to clients with various foot disorders who require specialized care in the home or clinic setting, to reduce complications, ensure client comfort and foster independence.

- RNs holding an Advanced Foot Care certificate provide foot care services in the clinic and home setting.
- Provide care for difficult to manage nails and foot disorders in the diabetic and non-diabetic foot.

- Provide advanced assessment of the lower leg and foot
- Teach clients and family self-care of nails, corns, calluses, proper footwear, skin care, fungal infections, offloading, preventative maintenance.
- Instruct, support, and oversee delivery of basic foot care by home support workers in the community.
- Liaise with physicians, diabetic team, occupational therapy, and pedorthists as needed.

D) Home IV Program: Develop a client-specific plan of care with clients, families and referring physician to allow for IV therapy, via peripheral or central lines, in the home or community setting to allow clients to play a greater role in their care, to complete treatments in their home, to resume family, work and school activities, and to shorten hospitalizations when feasible and improve health resource utilization.

- Choose appropriate mode of delivery in consultation with attending physician and pharmacist; IV direct or intermittent.
- Provide written and verbal teaching information for self-administration of medication with the delivery system chosen when feasible for the client, or when informal supports can assist in administration.
- Coordinate with client for regular pick-up, and delivery of medications.
- Provide clients with necessary home IV therapy supplies, including preparation of medications.
- Provide ongoing advice, trouble shooting and support for self-administration of home IV therapy.
- Provide regular and ongoing assessment and maintenance of IV access; restart or resite IV access as necessary or when indicated.
- Provide regular updates to attending physician.
- Provide central line assessment (e.g. PICC line), monitoring, troubleshooting, teaching, and dressing changes.

E) Post-Acute Illness Monitoring and Chronic Disease Management: Conduct wellbeing and acute or chronic disease follow up for Home and Community Care clients requiring ongoing nursing assessments and interventions.

- Complete relevant comprehensive nursing assessments and report findings to most responsible physician (MRP).
- Liaise with primary care or specialist physicians as needed.
- Perform nursing assessments, including vital signs, general or focused assessments, functional assessments, etc.
- Administer oral and parenteral (SC, IM, IV, etc.) as prescribed; includes cytotoxic medications.
- Perform nursing assessment and interventions relating to a wide range of medical devices, including surgical drains and tubes, and catheters (e.g. Pleurex drainage and dressing changes, nephrostomy tube care and dressing changes, suprapubic catheter changes and care, etc.).
- Facilitate communication among client, family, and other health care providers.

- Assist clients and families with medication review, reconciliation, and self-administration strategies; coordinate and collaborate with necessary supports and interdisciplinary providers to assist with medication compliance (e.g. OT cognitive assessments, polypharmacy review, etc.).
- Provide immunizations for home bound clients (e.g. influenza, pneumovax, COVID-19, etc.).
- Perform delegated laboratory test functions (e.g. blood work, urine specimens, swabs etc.) for homebound clients, including collection and delivery to Stanton Hospital Laboratory, and follow-up with ordering physician.
- Provide ongoing individualized education to clients and families to assist them in managing their acute or chronic health conditions.
- Evaluate plan of care and routinely report changes and concerns to most responsible physician and other care providers as applicable.
- Escalate care to higher levels of care when warranted, and coordinate with other care centers to ensure continuity of care (e.g. submit Home Care Summary Report when directing client to hospital Emergency unit for further assessment).

2. **Lead case management and service coordination by collaborating proactively with all Home and Community Care interdisciplinary team members and external service providers using a patient-centered, and problem-solving approach to facilitate access to services and maximize healthcare outcomes.**
   - Determine the need for additional Home and Community Care services based on client and family-centered assessment of abilities and resources (physical, financial, support systems, etc.)
   - Establish and complete appropriate internal interdisciplinary referrals to Home Care disciplines including occupational therapy, physiotherapy, registered dietician, medical social worker or to the foot care program; complete external referrals to community supports/resources.
   - Act as case manager to coordinate interdisciplinary patient care for high risk or complex patients.
   - Use problem-solving skills to overcome obstacles in delivery of client care and enhancement of client independence e.g. transportation, dressing supplies, insurance coverage, medication safety.
   - Assist in organizing and coordinating appointments and services as required; attend appointments with clients as required.
   - Liaise with physicians and pharmacies for best possible medication reconciliation; maintain updated client medication record.
   - Identify other community supports applicable to support clients in the community-setting (e.g. Inclusion NWT, Independent Living Supports, Integrative Case Management, etc.).
   - Assisting clients in the transition from home to long term care; complete the Continuing Care Assessment & Placement (CCAP) package, liaise with client, family, Territorial Admission Committee, LTC facilities until placement - reassessed yearly and as conditions change; case manage client's move to facility once admitted.

- Ensure coordination of care with other health authorities (e.g. Alberta Health Services) and overarching care coordination supports (e.g. Cancer Care Navigation, NWT Medical Travel, Northern Health Services Network, etc.).
- Assist clients in sourcing, obtaining, and funding necessary medical equipment and supplies, including home O2, palliative care equipment, specialized dressings, etc.
- Participate in meetings within the Department, NTHSSA, Stanton, and with community organizations to ensure continuity of care and safe discharge planning.

3. Participate in the ongoing improvement of Home and Community Care programs and services by advocating for resources and allocations necessary for providing optimal nursing care and participating in process improvement initiatives.

- Maintain current expertise in program areas, e.g. wound care, palliative care, home intravenous program, chronic disease management, and general nursing competencies (BLS/CPR, hand hygiene, etc.).
- Act as a resource for home health knowledge and practice (for example, wound care, palliative care, home intravenous) for health care providers in other communities in the NWT.
- Develop a supportive rapport with individuals and their families to facilitate collaborative relationships with other interdisciplinary team members.
- Determine the most appropriate, effective, and efficient mode of communication among interdisciplinary team members in accordance with identified policies and procedures.
- Collaborate proactively with interdisciplinary team members utilizing a client- and family-centered approach to facilitate and maximize healthcare outcomes.
- Provide continuity of care and promote collaborative teamwork directed toward quality patient care.
- Coordinate and participate in formal and informal case conferences to share appropriate information concerning client concerns or progress and to utilize the team's skills and resources in the most efficient and effective manner.
- Orient new employees to Home and Community Care and participate in the advancement of home health nursing practice by acting as a mentor and preceptor for students and new practitioners from territorial and other Canadian nursing programs.
- Enter statistical information into Health Suite in a timely manner to track time and resources allocated to each program area.
- Participate in special projects, committees, task forces, and research projects as related to Home and Community Care.
- Under the direction of the Manager, participate in interdisciplinary committees responsible for researching, developing, and evaluating programs, including their associated forms, clinical policies and procedures.

WORKING CONDITIONS

The Home Care Registered Nurse works as a shift worker, on a 6-week rotating schedule, that includes mostly eight hour day shifts (0800-1630), one week of evening shifts (1200-2000), and one weekend of 3- twelve hour shifts (0800-2000).

The Home Care Registered Nurse works the majority of hours in client homes providing care (60-80% of work hours), with the remainder spent commuting to homes (10-15% of work hours) and completing necessary case management and documentation (up to 30% of work hours).

Physical Demands

The Home Care Registered Nurse must provide direct client care in their home environment for 60-80% of the workday, which requires substantial physical activity, including:

- Carrying supplies and/or equipment, weighing up to 50 pounds, up and down stairs, in and out of vehicles and homes.
- Assisting clients with ambulation or transfers or providing personal care as needed.
- Driving, standing, or performing client assessments or care while bending, reaching, pulling, and standing in awkward positions or in cramped spaces.

Environmental Conditions

The Home Care Registered Nurse must provide direct client care in their home environment for 60-80% of the day, which can involve:

- Working alone in unpredictable, unsecured, and unpleasant conditions that must be managed independently;
- Exposure to unsanitary conditions, cigarette smoke, pets, loud noises, and extremes of heat and cold in the community and clients homes that may cause discomfort or pose a safety risk;
- Exposure to communicable diseases and infectious organisms, needle stick injuries, blood and bodily fluids, cytotoxic medications and waste, and other hazardous materials.

The Home Care Registered Nurse must drive to client homes and transfer in and out of vehicles, in addition to navigating walkways and stairs that may be unsafe. This involves exposure to all weather conditions including temperatures ranging from -40 to +30, wind, rain, snow, and mosquitoes/bugs. The incumbent is normally walking outdoors or driving for up to two hours a day, in winter conditions for 7 months of the year, and may be called to visit clients outside of Yellowknife city limits, where phone service is limited or not available.

Sensory Demands

The Home Care Registered Nurse spends 60-80% of the day providing direct patient care where the incumbent will be required to maintain acute cognitive focus while using the combined senses of touch, sight, smell and hearing during assessment and provision of care in an uncontrolled setting (i.e. the client's home).

Working within the client home may be extremely distracting and make normal assessment and diagnosis more difficult as these settings may be a distraction for both the incumbent and the client (noise level, family interruptions, pets, visual distractions, etc.). The combined use of senses is critical to all assessments. Providing expert nursing care and special treatments in

homes with poor lighting, frequent interruptions, constant observation, and conversation by informal caregivers requires acute focus and discipline.

Mental Demands

Within the health care setting there is significant lack of control over the work pace, with frequent interruptions. Work pace is controlled by the client and the incumbent must adapt to the client's level of readiness for interventions, while managing the total client load within allotted work time. There is ongoing reprioritization and reorganization of workload during the workday in response to uncontrollable factors.

The requirement to quickly shift nursing care focus during the day, for example administering an intravenous medication to an elderly client, then being present for a death of a child at home shortly after, followed by case management and required charting / documentation. The incumbent must be able to think conceptually, yet maintain attention to detail, often simultaneously.

The incumbent must be mindful that their own independent critical judgement and decision-making may have serious implications for client health and outcomes (e.g. deciding whether a client's clinical status requires higher level of care or if they can continue to be managed in the home and community setting).

The Home Care Registered Nurse encounters unknown or unpredictable situations (i.e. client or visitor under the influence of alcohol/drugs, cognitively impaired etc), as well as uncontrolled conditions such as exposure to death and other emotionally upsetting experiences.

KNOWLEDGE, SKILLS AND ABILITIES

- Knowledge of home and community nursing and nursing sciences to practice and synthesize information from a broad range of theories, models, and frameworks.
- Knowledge of the nursing process to collaborate, develop, coordinate, and implement mutually agreed upon care plans, negotiate priorities in care, and support clients to navigate and transition through the continuum of care.
- Knowledge of biological, physical, and behavioral sciences in order to recognize, interpret and prioritize findings and determine and implement a plan of action based on accepted standards of practice in a community setting.
- Knowledge and current expertise in a broad range of areas, including adult education, community-based nursing, working with families, disease processes, long-term care assessment, community resources, wound care and specialized dressings, medications, grief management and pain management.
- Knowledge of computer programs including but not limited to: word processing; Health Suite, Internet Explorer, Outlook e-mail, EMR (Wolf electronic medical record system).
- Ability to make informed, pertinent assessments and decisions while working independently in the community.

- Ability to act independently to set priorities, develop work plans and manage workload while balancing clients' needs, complexity, and acuity.
- Ability to be self-directed, meet deadlines and manage several tasks at once.
- Ability to use basic and advanced nursing skills to perform and adapt complex procedures in the home care setting.
- Ability to adapt, be flexible and responsive in the safe and appropriate use of various types of equipment, technology, and treatments to address the challenging health needs of clients.
- Ability to communicate in a caring, professional, therapeutic manner at all times with a wide variety of clients, caregivers, and health care providers.
- Ability to think calmly and respond therapeutically in emergency situations.
- Ability to apply appropriate learning principles to encourage clients, families and others to recognize their capacity for managing their health needs and to participate in their care.
- Ability to integrate activities to avoid duplication of service and inappropriate use of resources, for individual clients, within the nurse's current caseload, as well as system-wide.
- Ability to work in a culturally diverse environment using resources, such as interpreters, appropriately; ability to provide care that is culturally-competent, and trauma-informed.
- Ability to communicate effectively (orally and in writing).
- Ability to operate and/or use medical equipment such as, but not limited to, intravenous pumps and lines, a variety of intravenous access devices, sphygmomanometer, blood glucose monitor, pulse oximeter, wheelchair, canes, crutches, etc.

Typically, the above qualifications would be attained by:

A BScN with at least 2 years of recent, acute care nursing experience in a medical, surgical, or in a home care or community health environment.

Knowledge and experience equivalencies will be determined on a case by case basis.

ADDITIONAL REQUIREMENTS

Proof of immunization in keeping with current public health practices is required.

Must be eligible for registration with the RNANT/NU.

Possess a Class 5 driver's license.

Must be able to work shiftwork, including days, evenings and weekends.

Yellowknife Regional Requirements

All Home Care Nurses must be able to acquire within a reasonable time frame, and remain current with the following training and/or certifications:

- Non-Violent Crisis Intervention
- WHMIS

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- NWT Immunization Certificate
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- Certification in hand hygiene
- Internet and e-mail applications
- Fire/disaster plan for NTHSSA
- Fit Testing
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- Wound / Ostomy Care
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Position Security

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French language (check one if applicable)

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WRITING SKILLS:
Basic (B) ☐ Intermediate (I) ☐ Advanced (A) ☐
☒ French preferred

Indigenous language: Select language

☐ Required
☐ Preferred

Government of
Northwest Territories

IDENTIFICATION

Department	Position Title	
NWT Health and Social Services Authority	Home Care Medical Social Worker	
Position Number	**Community**	**Division/Region**
48-95065	Yellowknife	Home and Community Care

PURPOSE OF THE POSITION

The role of the Home Care Medical Social Worker (MeSW), is to provide psychosocial assessment, facilitation, advocacy, case coordination and management, and counseling services to high-risk clients of all ages and their families who are encountering psychosocial challenges as a result of illness, disability, injury, and/or hospitalization, as well as those facing chronic, life-limiting and/or terminal illness. The incumbent coordinates community resources and referrals to facilitate health transitioning; long term planning; exchange of information and to expedite the discharge planning process. As lead case manager for long term care applications, the incumbent will provide initial assessment, case management and follow up to clients and families hoping to transition from home to residential care. The incumbent will also be responsible for providing psychosocial support and guidance to HCC staff, and occasionally called upon to support discharge planning.

The position works in accordance within applicable legislation (Social Work Profession Act), standards and guidelines and the philosophy and objectives of the Northwest Territories Health and Social Services Authority.

SCOPE

The Northwest Territories Health and Social Services Authority (NTHSSA) is the single provider of all health and social services (HSS) in the Northwest Territories (NWT), with the exception of Hay River and Tl1chQ regions, covering 1.2 million square kilometers and serving approximately 43,000 people, including First Nations, Inuit, Metis, and non-aboriginals. HSS 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 HSS staff.

NTHSSA administers all public health, home care, social services and general physician services in the Yellowknife region, and provides and supports the delivery of community based health care
services to adults and children in order to enhance the health and wellbeing of communities through excellence, accountability and respect for regionaldiversity.
Located in Yellowknife and reporting to the Manager, Home and Community Care, the incumbent provides community based psychosocial and supportive services as part of an interdisciplinary team ensuring Home and Community Care (HCC) services to clients ranging from pediatric to geriatric in Yellowknife, Ndilo and Dettah.

Psychosocial issues directly impact the health care system by increasing costs and diminishing resources. Coordination of available resources and community access is a valuable service for promoting health and wellness. The MeSW acts to coordinate client needs in collaboration with the client, their family, home care staff, physicians, nurses, counselors, and other health and social services resources within the communities. This position's responsibilities include direct social work and counseling such as crisis intervention. The MeSW collaborates with other HCC staff to provide care to the clients in order to restore or maintain the health of clients after acute/chronic illness, injury or disability, and to deliver comprehensive HCC services that foster a safe, efficient, effective and quality patient experience of services. The incumbent will also occasionally be called upon to co-ordinate the necessary resources and referrals for clients to facilitate the exchange of information and to expedite the discharge planning process.

As a key member providing care to clients within one of HCC's core service areas, home-based palliative and end-of-life care, the incumbent provides palliative/end-of-life psychosocial, supportive care, and caregiver education to clients/families, informal caregivers, staff and community groups as required; engaging the community and helping to build a community of practice to optimize palliative and end-of-life care in the home setting. The incumbent provides consultation to colleagues regarding psychosocial aspects of navigating palliative and end-of- life journeys. The incumbent maintains strong professional links with provincial/territorial psychosocial palliative care practitioners and is aware of national practice standards. The incumbent will also support the coordination of safe, integrated, comprehensive, and individualized care across the palliative/end-of-life care continuum, and will provide and education to clients and their families on advanced care planning, power of attorney, and other logistical/legal proceedings as applicable. The incumbent will exercise professional judgment in the completion of their duties and discussions/actions to be taken on day-to-day matters, based on a complete assessment of client and family readiness and other factors, such as anticipatory grief, etc.

Moreover, the MeSW is responsible to provide psychosocial support to staff including fostering teamwork and team building, promoting and teaching self-care and resilience strategies, as well as critical incident stress debriefing sessions for staff when applicable. Particularly, recognizing the emotional impact of providing palliative/end-of-life care, the incumbent will provide emotional support to HCC colleagues, identifying resources to help prevent caregiver burnout and/or compassion fatigue.

The Medical Social Worker (MeSW) is a sole provider and works independently assisting high-risk clients and their families in a variety of settings i.e. in their homes, or in the hospital. The MeSW must be self-directed and highly motivated; must take initiative to quickly identify issues, plan a course of action, coordinate resources in a timely manner; communicate and collaborate with all stakeholders; and review, revise and evaluate the psychosocial therapeutic plans. The incumbent must have sound knowledge of medical social work theory and practice, and must sound sound problem solving and critical thinking, communication, prioritizing, conflict resolution and decision making skills as well as excellent organizational skills. The incumbent effectively manages their caseload and participates on several multi-disciplinary teams.

RESPONSIBILITIES

1. **Client Assessment: Assess high risk clients and/or family members for psychosocial problems related to their illness, disability, injury or hospitalization and plan, implement, and evaluate interventions which will ensure that the necessary resources are in place for support and follow up.**
    - Provide direct social work and counseling services to clients and families, e.g. grief counseling, mental health assessments, suicide risk assessments, palliative care/end-of-life support and education, logistical/financial counseling, homelessness, resource information and crisis intervention.
    - Assess the client's social and psychosocial status and specific needs in view of their care requirement.
    - Promote effective communication to facilitate information sharing between client, staff, physicians, and other health care providers and outside providers/agencies.
    - Documents client's needs assessment and develops a service plan with projected goals and intervention planning.
    - Consults/collaborates with interdisciplinary HCC team members, health, social, and community agencies regarding client care needs.
    - Work in collaboration with HCC team to provide services to seniors and those living with a disability, in order to advocate for their financial, educational, and personal care needs.
    - Provide ongoing follow up and evaluation to determine efficacy of interventions.

2. **Planning Care: Coordinate client needs, emotional and mental health care and discharge planning, as well as available resources for high-risk clients and their families to facilitate re-integration into the community.**
    - Assess the emotional, psychosocial and environmental needs of the client and coordinate the necessary resources to meet their needs.
    - Collaborate and consult with clients, their families, interdisciplinary teams, community agencies, and other resources to support discharge and follow up.
    - Educate clients and families to develop an understanding of how service providers, client and family work together to reach desired goals.
    - Provide case management and be a liaison to acquire the necessary resources to facilitate a client's successful reintegration into the community.

- Set priorities and establish goals of care that are responsive to the health and social needs and preferences of the client, family, the home setting and cultural context
- Coordinate and prioritize caseload.
- Maintain familiarity of and establish a working relationship with health services, continuing care programs, community counseling program, other health and social services professionals and community/territorial agencies to advise clients and families of available resources.
- Facilitate health transitioning for clients from hospital to home/community. This includes direct social work and counseling related to changes in lifestyle, relationships, physical functioning, employment and financial concerns and emotional-psychological functioning.
- Collaborate/consult with clients and their families, interdisciplinary team members, community resources and other supports to reduce duplication of service and to identify potential gaps in services.
- Initiate and participate in case conferences to share pertinent information concerning client concerns or progress, and to utilize team skills and resources to provide the most efficient and effective service delivery.
- Participate and collaborate in discharge planning with Stanton Territorial Hospital as applicable.
- Review, evaluate and adjust the care plan as goals are met, on a continuous basis and annually on long-term clients.

3. **Provision of Care: Implements plan of care following established policies, procedures and practices of the organization and the Canadian Social Workers Association in order to ensure safe and professional care.**
   - Ensure that available and requested support services outlined in care plan are implemented and evaluated on a case-by-case basis.
   - Provide appropriate, independent interventions in unanticipated, potential volatile, unstable situations.
   - Provide crisis intervention as required.
   - Encourage and support clients and their families to be responsible for advocating, promoting, maintaining and enhancing their health and independence.
   - Foster a positive working relationship with clients and their families, other service providers and community agencies.
   - Advocate on behalf of clients to obtain services, resources, and fair processes, or lobbying for the development of services and programs to address gaps in services.
   - Partner with appropriate community agencies and service providers to develop strategies to address broader community needs.
   - Document a written plan of care and ongoing progress to aid in interdisciplinary communication and to meet legal requirements.

4. **Long-Term Care/Supportive Living/Residential Care Application Case Management: Complete and coordinate assessments, and act as lead case manager for all long-term care/supportive living/residential care applications submitted to Territorial Admissions Committee (TAC)**

- Meet with clients and their families/informal caregivers to complete the Continuing Care Assessment Package (CCAP) for HCC clients/families requesting consideration for higher level care.
- Lead case management for applications during collation of all required documents, and once submitted to TAC to ensure completion of application.
- Identify and complete applications requiring update, and resubmit as required, either according to outline deadlines or change in client status.
- Act as liaison between HCC and TAC.
- Lead HCC interdisciplinary meetings for care collaboration regarding CCAP completion and applications to TAC.
- Report to manager statistics on application acceptance, waitlist, etc.

5. **Palliative and End-of-life Care: Provide psychosocial, educational, and instrument support to clients, their families, and informal caregivers, facing palliative and/or end- of-life diagnoses.**
   - Provide psychosocial support to clients and families, such as therapeutic communication and grief counseling, based on social work principles and scope.
   - Provide supportive and instrumental support to clients and their families/informal caregivers, including referrals within and outside HCC to support their care needs (e.g. personal support work services to support caregiver burnout, etc.).
   - Provide consultation to colleagues regarding psychosocial aspects of navigating palliative and end-of-life journeys.
   - Engage the community and promote building a community of practice to optimize palliative and end-of-life care in the home setting.
   - Maintain strong professional links with provincial/territorial psychosocial palliative care practitioners and awareness of national practice standards.
   - Support the coordination of safe, integrated, comprehensive, and individualized care across the palliative/end-of-life care continuum.
   - Provide education to clients and their families on advanced care planning, power of attorney, and other logistical/legal proceedings as applicable; support completion of such documentation as applicable.
   - Provide services based on an awareness and complete assessment of client and family readiness and other factors, such as anticipatory grief, etc.

6. **Psychosocial Support to Staff: Provide psychosocial support to HCC staff to foster teamwork, team-building, resilience, self-care among HCC employees.**
   - Foster teamwork and team-building by organizing group discussion, activities and supportive discourse among the HCC team.
   - Promote and education staff regarding self-care strategies to prevent/mitigate moral distress, caregiver burnout, and/or compassion fatigue.
   - Support and promote staff resilience.
   - Lead critical incident debriefing sessions after difficult experience (e.g. violence, death of a client, etc.)
   - Research resources to support this as required to support individual or team concerns.

- Provide monthly /as needed in-service education and/or lead team check-ins on monthly/bi-monthly basis.

7. **Professional and Program Development: Contributes to her/his own professional development and the development of the Home Care program in order that the highest standards are reached and the program continues to offer services that are both cost efficient and effective.**
   - Work for the implementation and maintenance of workplace conditions and policies, which are current with the standard of practice of the Social Worker Code of Ethics.
   - Participate in assessment of program development needs; establish policies and review present practices for the Medical Social Worker position.
   - Review strategic planning and provide feedback both for client care and regarding the Medical Social Worker position, i.e. goal setting, program enhancement with all stakeholders.
   - Further own education and personal development.
   - Identify personal educational and training goals annually with Manager, Home and Community Care; collaborate with the Home Care Clinical Coordinator to establish plan to meet these goals.
   - Acts as a social work resource for students, preceptees and new hires to HCC.

WORKING CONDITIONS

Physical Demands

Most of the MeSW's work hours are spent in the Home Care office, where no unusual physical demands exist.

However, the MSW will be require to provide some aspects of assigned duties in client's home environment (may be up to 30-50% of work hours), which may require driving, standing, or performing client assessments or care while bending, reaching, pulling, and standing in awkward positions or in cramped spaces.

Environmental Conditions

Most of the MSW's work hours are spent in the Home Care office, where no unusual environmental demands exist.

However, the MSW may be called upon to see clients in the community independently in client's home environment (up to 30-50% of work hours), which can involve:
Working alone in unpredictable, unsecured, and unpleasant conditions that must be managed independently;

Exposure to unsanitary conditions, cigarette smoke, pets, loud noises, and extremes of heat and cold in the community and clients homes that may cause discomfort or pose a safety risk;
Exposure to communicable diseases and infectious organisms, needle stick injuries, blood and bodily fluids, cytotoxic medications and waste, and other hazardous materials.

As such, the MSW must drive to client homes and transfer in and out of vehicles, in addition to navigating walkways and stairs that may be unsafe. This involves exposure to all weather conditions including temperatures ranging from -40 to +30, wind, rain, snow, and mosquitoes/bugs.

This may also require walking outside, in winter conditions, for 7 months of the year, and may be called to visit clients outside of Yellowknife city limits, where phone service is limited or not available.

The Home Care Medical Social Worker (MeSW) works Monday-Friday, during regular working hours (0800-1630).
The incumbent's day will be divided between direct client care, case management, and staff support duties.

Sensory Demands

Most of the MSW's work hours are spent in the Home Care office, where no unusual sensory demands exist.

This said, the MSW may be called upon to see clients in the community independently in client's home environment (up to 30-50% of work hours), and be required to maintain acute cognitive focus while using the combined senses of touch, sight, smell and hearing during assessment and provision of care in an uncontrolled setting (i.e. the client's home).

Working within the client home may be extremely distracting and make normal assessment and therapeutic communication more difficult as these settings may be a distraction for both the incumbent and the client (noise level, family interruptions, pets, visual distractions, etc.). The combined use of senses is critical to all assessments.

Mental Demands

The incumbent is required to be continuously be motivated and innovative in the area of continuing education and practice to encourage the professional growth of self and others, and to maintain psychosocial fitness to practice in order to provide quality care to clients and staff.

The MSW has the opportunity to develop relationships with the clients of the Home Care Program. The person 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. The MSW is required to support a peaceful and dignified death of those residents that may cause significant emotional stress. This also requires sustained focused attention to verbal and non-verbal communication of potentially volatile, difficult, intoxicated and verbally and/or physically abusive clients. In addition, the incumbent must demonstrate the ability to provide ethical care and maintain appropriate boundaries despite the potential of developing close therapeutic relationships.

While working with clients in their home, and within the health care setting, there is significant lack of control over the work pace, with frequent interruptions. Work pace is controlled by the client and the incumbent must adapt to the client's level of readiness for interventions, while managing the total client load within allotted work time. There is ongoing reprioritization and reorganization of workload during the workday in response to uncontrollable factors and program priorities. The incumbent must be mindful that their own independent critical judgement and decision-making may have serious implications for client health and outcomes (e.g. deciding whether a client's mental or emotional status requires higher level of care or if they can continue to be supported in the home). The MSW may also encounter unknown or unpredictable situations (i.e. client or visitor under the influence of alcohol/drugs, cognitively impaired etc.), as well as uncontrolled conditions such as exposure to death and other emotionally upsetting experiences.

There is a requirement to quickly shift focus during the day, for example providing psychosocial supports to clients, discussing end-of-life with a caregiver, to case managing a LTC application, to debriefing a critical incident with staff. The incumbent must be able to demonstrate flexibility, think conceptually, and maintain attention to detail, often simultaneously.

KNOWLEDGE, SKILLS AND ABILITIES

- Knowledge of healthcare concerns/challenges to identify and address health issues as they impact on the client and their families.
- Knowledge of and an ability to apply psychosocial processes (such as assessment, planning, coordination, facilitation and evaluation).
- Ability to teach and communicate effectively with clients and colleagues of different ages and cultures, using appropriate English language skills, in order to understand and respond to client needs and work together in the client's best interests.
- Strong interpersonal and communication skills to interact with clients, their families, community resources, outside agencies, and other health care professionals.
- Strong communication skills both verbal and written.
- Awareness of the biological, physical and behavioral sciences in order to recognize interpret and prioritize issues and determine and implement a plan of action based on accepted standards of practice.
- Ability to demonstrate flexibility to ensure the effective and efficient use of resources and to maintaining professional peer relationships.
- Ability to function within the interdisciplinary team setting and promote teamwork practices i.e. attendance at morning huddles with other disciplines, staff meetings, and team/case conferences.
- Ability to be self-directed, meet deadlines, prioritize workload, and manage various projects and requests simultaneously.
- Demonstrate sound judgment and creative problem-solving skills, set priorities, make decisions independently while interacting with acute and chronically ill clients with changing needs.
- Excellent listening skills and a non-judgmental attitude.
- Demonstrated knowledge of the community and its resources

- Ability to provide care that is culturally sensitive
- Research, analytical and evaluation skills, ability to communicate effective to obtain required information through investigative and interviewing skills
- Strong communication skills, particularly in the areas of tactfulness, attentive listening, diplomacy and conflict resolution
- Strong interpersonal skills to facilitate effective communicate with other team members, clients, their families, and outside agencies, i.e. public speaking, counseling skills.
- Working knowledge of territorial acts, legislation regarding social services programs
- Ability to interpret and apply acts, regulations, and legislation as applicable
- Ability to operate a desktop computer in order to send and receive electronic mail, compile statistical data and conduct research over the internet.
- Proven ability to work independently and as part of a team
- Excellent time management skills, and ability to meet changing deadlines, as well as competing priorities
- Ability to remain flexible and innovative
- Ability to establish and promote effective relationships between individuals or groups to resolve issues/conflicts impacting clients, families, and/or staff
- Interpersonal skills that facilitate active participation as part of a cross-functional team
- Ability to function and thrive within a multicultural environment
- Demonstrated ability to work with a client base of wide geographical and complex cultural backgrounds

Typically, the above qualifications would be attained by:

A Degree in Social Work plus four (4) years of current clinical practice including social work, counseling, crisis intervention, suicide risk assessments, case conferencing, planning, management with adults, children and families.

ADDITIONAL REQUIREMENTS

Yellowknife Regional Requirements

- Current membership in good standing with a provincial or Canadian Association of Social Workers is required.
- Eligible to be registered as a Social Worker in the NWT.
- Must have completed a satisfactory criminal record check and possess a Class 5 driver's license. Proof of immunization in keeping with current public health practices is required.
- The Home Care Medical Social Worker must be able to acquire within a reasonable time frame, and remain current with the following training and/or certifications:
- Non-Violent Crisis Intervention
- WHMIS
- Basic CPR-C
- Proper Body Mechanics
- Certification in hand hygiene

- Internet and e-mail applications
- Fire/disaster plan for NTHSSA
- Fit Testing
- Privacy and Confidentiality

Assets include:

- Clinical counseling experience
- Further education regarding palliative/end-of-life counseling

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

Indigenous language: Select language

☐ Required
☐ Preferred

Government of
Northwest Territories

IDENTIFICATION

Department	Position Title	
Northwest Territories Health and Social Services Authority	Home Care Clinical Coordinator	
Position Number(s)	**Community**	**Division/Region(s)**
57-12363	Yellowknife	Continuing Care Services/Yellowknife

PURPOSE OF THE POSITION

The Home Care Clinical Coordinator (CC) works in accordance with relevant current NWT and Canadian legislation, the standards and clinical practice guidelines from the GNWT Department of Health and Social Services, the Registered Nurses Association of the Northwest Territories and Nunavut (RNANT/NU) and the Community Health Nurses of Canada (CHNC). The CC provides services according to the mission, values, strategic plan, administrative directives and standard operating procedures of the Northwest Territories Health and Social Services Authority (NTHSSA) and NTHSSA—Yellowknife Region.

The Home Care Clinical Coordinator leads the coordination of nursing services under the direction of the Regional Manager, Continuing Care and in coordination with the Continuing Care staff in Yellowknife Region to provide quality nursing care to Home Care clients. The Home Care Clinical Coordinator monitors, assesses and improves comprehensive client care and ensures nurses' educational needs within Continuing Care are met. The Home Care Clinical Coordinator evaluates nursing interventions in a systematic and continuous manner by measuring their effect on clients, families and staff. The Home Care Clinical Coordinator contributes to the quality of the work environment by identifying needs, issues, solutions and actively participating in the team and organization.

The incumbent provides comprehensive community based nursing services to residents of Yellowknife Region. The role of the Home Care Clinical Coordinator is to protect, restore and/or maintain health or provide end of life care for Home Care clients with a broad array of diagnoses across the lifespan and the health-illness continuum, using the principles of primary health care, preventative, curative, maintenance and comfort nursing interventions, education, communication and support for the informal caregiver. The Home Care Clinical

Coordinator promotes community wellness through health promotion, prevention, screening and intervention activities.

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.

The Northwest Territories Health and Social Services Authority (NTHSSA)—Yellowknife Region administers all public health, home care and Primary Care services and social services delivered in Yellowknife Region. The NTHSSA provides and supports the delivery of community based health care services to adults and children in order to enhance the health and well-being of communities through excellence, accountability and respect for regional diversity.

Located in Yellowknife and reporting to the Regional Manager, Continuing Care Services, the Home Care Clinical Coordinator is responsible for coordinating quality nursing care within HCC and the educational needs of the Registered Nurses, Licensed Practical Nurses and Home Support Workers. The incumbent develops and delivers appropriate training, arranges for external training, develops and revises policies and procedures to meet current standards of practice as appropriate and ensures nurse staffing level meets client acuity needs.

The Home Care Clinical Coordinator is a registered nurse with advanced education and experience beyond the scope of a graduate nurse. This expanded role of the position demands independent thinking, judgment and excellent critical decision-making and organizational skills for the delivery and management of nursing care for Home Care clients.

The Home Care Clinical Coordinator works independently and collaboratively in the

community. In comparison to the hospital setting, physicians and other supportive resources are not readily available to the nurse. The Home Care Clinical Coordinator models and promotes excellence through the hands on delivery of nursing care to residents of Yellowknife Region. The Home Care Clinical Coordinator is assigned to all of the program teams (Wound Care, Palliative Care, Chronic Care, Foot Care and Home Intravenous Therapy). The incumbent independently makes 2 - 3 home visits a day and coordinates client care concurrently. It is the incumbent's responsibility to set priorities, develop work plans and manage workloads, while balancing individual clients' needs complexity and acuity.

As part of an inter-disciplinary team, the Home Care Clinical Coordinator is expected to communicate with a wide variety of health and social service providers within NTHSSA and other health boards, pharmacies, community organizations, Southern acute and rehabilitation units, and the general public. The Home Care Clinical Coordinator provides expert advice in nursing program areas to other health care professionals. The position has the expectation for continuous expansion of the depth and breadth of knowledge and skill.

RESPONSIBILITIES

1. **Monitor the quality of nursing care within the Home and Community Care (H&CC) programs and identify education requirements of H&CC nursing staff to effectively address the physical, psychosocial, emotional, spiritual and educational needs of clients.**
   - Conduct audits on the delivery of nursing services by individual nurses, identify learning needs, collaboratively develop nurse specific learning plans and facilitate the delivery of education identified within the specific learning plans
   - Conduct assessments to determine nursing group learning requirements and arrange for the delivery of appropriate education
   - Coordinate/provide consultations to NTHSSA—Yellowknife Region programs and external agencies
   - Implement policies and procedures related to nursing services within Continuing Care Services in collaboration with the Manager and staff

2. **Promote a quality practice environment by coordinating the staff and organizing the resources necessary for safe, competent and ethical nursing care.**
   - Provide coaching and leadership to peers, students and other members of the health care team to develop skill levels necessary to achieve a competent standard of care
   - Act as a resource for home health knowledge and practice for health care providers in other communities in the NWT
   - Develop and facilitate the delivery of a nursing orientation program
   - Provide education sessions within Continuing Care Services
   - Collaborate with nurses, peers and other members of the health care team to advocate health care environments that are conducive to ethical practice and to the health and well-being of clients and staff

- Participate on committees, task forces, and approved research projects as related to Continuing Care Services
- Advocate on behalf of clients: assist clients to obtain services, resources and fair processes, lobby for the development of services and programs to address unmet client needs
- Maintain the confidentiality of staff and client information
- Apply and promote principles of equity and fairness to assist clients in receiving unbiased treatment and a share of health services and resources proportionate to their needs
- Evaluate community health programs on a continuing basis for appropriateness and effectiveness, and modify as needed

3. **Develop, facilitate, implements and modifies health promotion activities and services based on the needs of the client.**
   - Use a holistic approach to facilitate individual learning of clients and their families in relation to client illness or injury (i.e. self-care, health promotion, etc.)
   - Assess the client for physical and psychological needs, their knowledge of their health, disease process and learning needs
   - Facilitate individual learning in relation to client illness or injury
   - Research, develop, revise and evaluate on an ongoing basis, educational resources necessary to support clients
   - Participate in program development for specialty program education and teaching
   - Provide health promotion presentations and opportunities at various sites (i.e. schools, senior fair) on various health related topics such as diabetic education and foot care

4. **Provide comprehensive nursing care in the community setting to assist clients in achieving optimum health and quality of life in situations of chronic disease, acute illness, and injury or through the process of dying, using basic and advanced nursing knowledge and skills in one or more specialty areas, including wound care, palliative care, home intravenous therapy, or chronic illness.**
   - Assess the client and family's physical, emotional, intellectual and spiritual needs
   - Determine the need for Home Care nursing services and admit or discharge the client as appropriate
   - Identify supports available to the client, such as community organizations, occupational therapy, mental health counseling, etc.
   - Develop a treatment plan that incorporates the client's goals, needs, support systems, treatment and interventions, and the resources required to achieve these goals
   - Make referrals to other health care professionals to ensure early diagnosis and prompt intervention
   - Coordinate the implementation of the care plan
   - Perform nursing interventions and transferred lab or medical functions
   - Provide case management on clients' health related matters
   - Facilitate communication among client, family and other health care providers

- Use problem-solving skills to overcome obstacles in delivery of client care and enhancement of client independence e.g. transportation, dressing supplies, medication safety
- Evaluate care on an ongoing basis to determine its effectiveness and appropriateness, and make changes as indicated

5. Participate in the ongoing development, delivery, evaluation and improvement of Continuing Care Services

- Maintain current expertise in program areas, e.g. wound care, palliative care, home intravenous program, chronic disease management
- Act as a resource for home health knowledge and practice (for example, wound care, palliative care, home intravenous) for health care providers in other communities in the NWT
- Participate in meetings within the Department, NTHSSA, Stanton, and with community organizations, as required
- Under the direction of the Manager, participate in interdisciplinary committees responsible for researching, developing and evaluating programs, including their associated forms, clinical policies and procedures
- Research, develop, revise and evaluate educational resources necessary to support clients
- Research, develop and present information for in-service programs within the Home and Community Care Program, NTHSSA—Yellowknife Region and other agencies in the community
- Participate in the advancement of home health nursing practice by acting as a mentor and preceptor for students and new practitioners from Territorial and other Canadian nursing programs
- Orient new employees to the NTHSSA—Yellowknife Region Continuing Care Services
- Participate in special projects and approved research, as requested

6. Perform administrative functions that contribute to the effective functioning of the Continuing Care Services.

- Maintain current Home Care charts with updated information as a legal and communication record
- Enter statistical information into Health Suite in a timely manner
- Maintain records related to hours worked, use of personal and office vehicles, services provided to clients without NWT health care coverage and other records as required
- Collect and document demographic and statistical information
- Act as Nurse-in-Charge during evening and weekend shifts which can include resolving staffing issues and functional supervision of Home Support Workers

7. Assist the Regional Manager, Continuing Care, with the day-to-day administration and functioning of Home Care Services.

- Monitor nursing staff patterns and organize the necessary human resources to meet staffing requirements (i.e. regular scheduling, calling in nurses to cover illnesses, approval of leave etc.)

- Ensure that the stock of unit supplies is adequate and arrange for the ordering of supplies as required
- Collect and interpret unit statistics

WORKING CONDITIONS

Physical Demands

Carrying supplies and/or equipment, weighing up to 50 pounds, up and down stairs, in and out of vehicles and homes.

Assisting clients with ambulation or transfers or providing personal care as needed.

Driving, standing or performing client assessment or care while bending and standing in awkward positions or in cramped space for approximately 50% of each working day.

Environmental Conditions

Exposure to unsanitary conditions, cigarette smoke, pets, loud noises, and extremes of heat and cold in the client's home.

Exposure to communicable diseases and infectious organisms, needle stick injuries, blood and body fluid, hazardous materials.

Exposure to all weather conditions including temperatures ranging from -40 to +30, wind, rain and snow, mosquitoes. The incumbent is normally walking outdoors or driving for up to two hours a day and driving in winter conditions for 7 months of the year.

Working alone, on evenings and weekends.

Work environments and situations encountered are unpredictable and must be dealt with independently.

Sensory Demands

Maintaining acute cognitive focus while using the combined senses of touch, sight, smell and hearing during assessments and provision of care in an uncontrolled setting.

Exposure to unpleasant sights, odors and noises.

Mental Demands

Is required to be motivated and innovative in the area of continuing education and practice to encourage the professional growth of self and others.

Working alone in unpredictable and uncontrolled conditions.

Home visits are made alone, so the incumbent must be aware of the risk of verbal or physical assault, and unknown or unpredictable situations.

The requirement to " shift gears" frequently during the day, for example administering an intravenous medication to an elderly client and then being present for a death of a child at home shortly after.

May experience emotionally disturbing experiences in which the incumbent is expected to remain calm, controlled, professional and demonstrate compassion and team work.
The incumbent must be able to think conceptually, yet maintain attention to detail, often at the same time.

Providing expert nursing care and special treatments in homes with poor lighting, frequent interruptions, constant observation and conversation by informal caregivers.
Work pace is controlled by the client and the incumbent must adapt to the client's level of readiness for interventions.

Ongoing reprioritization and reorganization of workload during the work day in response to uncontrollable factors.

The incumbent works shift work and occasional on-call which may impact lifestyle.

KNOWLEDGE, SKILLS AND ABILITIES

- Knowledge of education principles related to adult learners in order to develop and deliver subject specific training and development
- Knowledge of home and community nursing and nursing sciences to practice and synthesize information from a broad range of theories, models and frameworks
- Knowledge of the nursing process to collaborate, develop, coordinate and implement mutually agreed upon care plans, negotiate priorities in care, and support clients to navigate and transition through the continuum of care
- Knowledge of biological, physical and behavioral sciences in order to recognize, interpret and prioritize findings and determine and implement a plan of action based on accepted standards of practice in a community setting
- Knowledge and current expertise in a broad range of areas, including adult education, community-based nursing, working with families, disease processes, long-term care assessment, community resources, wound care and specialized dressings, medications, grief management and pain management
- Knowledge of computer programs including but not limited to: word processing; Health Suite, Internet Explorer, Outlook e-mail, EMR (Wolf electronic medical record system) Ability to make informed, pertinent assessments and decisions while working independently in the community
- Ability to act independently to set priorities, develop work plans and manage workload while balancing clients' needs, complexity and acuity Ability to be self-directed, meet deadlines and manage several tasks at once Ability to use basic and advanced nursing skills to perform and adapt complex procedures in the home care setting

- Ability to adapt, be flexible and responsive in the safe and appropriate use of various types of equipment, technology and treatments to address the challenging health needs of clients
- Ability to communicate in a caring, professional, therapeutic manner at all times with a wide variety of clients, caregivers, and health care providers Ability to think calmly and respond therapeutically in emergency situations Ability to apply appropriate learning principles to encourage clients, families and others to recognize their capacity for managing their health needs and to participate in their care
- Ability to integrate activities to avoid duplication of service and inappropriate use of resources, both for individual clients and within the nurse's current caseload Ability to work in a culturally diverse environment using resources, such as interpreters, appropriately
- Ability to communicate effectively (orally and in writing)
- Ability to operate and/or use medical equipment such as, but not limited to, intravenous pumps and lines, a variety of intravenous access devices, sphygmomanometer, blood glucose monitor, pulse oximeter, wheel chair, canes, crutches, etc.

Typically, the above qualifications would be attained by:

The successful completion of a BScN or BN degree program with at least 5 years of recent, acute care nursing experience in a medical, surgical, home care or community health environment with one year experience in program coordination.

ADDITIONAL REQUIREMENTS

Yellowknife Regional Requirements
Must be eligible for registration with the RNANT/NU, have completed a satisfactory criminal record check and possess a Class 5 driver's license. Must be able to work shift work, including days, evenings and weekends.

The Home Care Clinical Coordinator must be able to acquire within a reasonable time frame, and remain current with the following training and/or certifications:

- Non-Violent Crisis Intervention
- WHMIS
- Back Care
- NWT Immunization Certificate,
- Certification in basic CPR
- Certification in hand hygiene
- Internet and e-mail applications
- Fire/disaster plan for NTHSSA
- Fit Testing
- Venipuncture
- Glucometer
- Home Intravenous Therapy Program

The Home Care Clinical Coordinator may be required to obtain additional skills training in areas such as but not limited to the following, as directed by the supervisor:

- Advanced Foot Care
- Wound/Ostomy Care
- Palliative Care
- Cardiac Teaching

Other courses/certifications offered by the Canadian Nursing Association which would be considered an asset (i.e. Palliative Care Course, Gerontology)

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