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

- 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