



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 regional diversity.

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 effectively 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 communication 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