IDENTIFICATION

Department	Position Title	
Northwest Territories Health and Social Services Authority	Diabetes Nurse Educator - LPN	
Position Number	**Community**	**Division/Region**
48-9509	Yellowknife	Primary Care/Yellowknife

PURPOSE OF THE POSITION

The Diabetes Nurse Educator – Licensed Practical Nurse (LPN) is responsible for providing leadership and expertise in the prevention and management of diabetes and its complications in the Northwest Territories.

In collaboration with the Northwest Territories Health and Social Services Authority (NTHSSA) Diabetes Educator, Dietitian, the incumbent designs, develops, delivers, evaluates and advises on education, care and treatment approaches for individuals, groups, regional health authorities and territorial organizations who are dealing with Diabetes. The Diabetes Nurse Educator works closely with the relevant client care team to ensure a full scope of Diabetes services is available to clients.

Work is performed in accordance with established standards from Diabetes Canada (Diabetes Canada Clinical Practice Guidelines) and the philosophy and objectives of NTHSSA to ensure that the clients' care, treatment and educational needs are met.

SCOPE

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-indigenous persons. Health and social services include 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) and Hay River Health and Social Services Agency (HRHSSA) operate under separate boards, 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 NTHSSA.

Under the direction of the Minister of Health and Social Services, transformation strategy, NTHSSA administers all primary care, public health, home care and general physician services throughout Yellowknife, Dettah and Ndilo, as well as all regional health and social services delivered in Fort Resolution and Łutselk'e. NTHSSA provides and supports the delivery of community-based health and social services to adults and children in order to enhance the health and well-being of communities through excellence, accountability and respect for regional diversity.

Building off the results and momentum of System Transformation, the strategic renewal effort has now begun a process of Primary Health Care Reform to shift the system and its care models towards a team and relationship-based approach that is driven through public participation, community feedback, and data, and built upon a foundation of trust and cultural safety. Using a community development approach, we are changing the way we work with people and communities, at every level of the health and social services system, to enable public participation in priority setting, planning, and design that integrates the social determinants of health.

The Diabetes Education Program at NTHSSA is a Diabetes referral centre for a culturally diverse population of the Northwest Territories. NTHSSA provides diabetes prevention education and treatment services to adults and children (both directly and indirectly through the client's care team) in order to restore health with dignity.

Self-management is a core value of the program, and the Diabetes Nurse Educator works with clients to achieve self-management of their own health and well-being.

The incumbent provides services in Yellowknife to patients/clients in the NTHSSA catchment area, in person and through telemedicine. The incumbent travels to other regions for outreach clinics and to build local capacity. Services are provided in both one-to-one and small group format. Outreach programs and support may also be offered twice a year in the Tłı̨chǫ and in other regions on a request basis if needed.

The incumbent determines the nursing management, education programming, resources and teaching methods required to treat and/or to support adults diagnosed with diabetes and its complications, and the prevention of diabetes in high-risk groups.

As a member of a multidisciplinary team the incumbent works with other health and social

service providers, community health centre staff, indigenous organizations, local businesses, community groups and the Department of Health and Social Services (DHSS) to promote healthy lifestyle choices, and the development and delivery of community programs. The position has an impact on reducing health care expenditures that result from the complications of the disease.

As a member of a multidisciplinary team, the incumbent provides direct patient care which includes independently making day-to-day decisions regarding therapeutic treatment, education and care plans for individuals. The incumbent facilitates communication between the patient/client and health care professionals. Health care providers in the catchment area regularly contact the incumbent for advice on diabetes care and treatment. Along with the Diabetes Educator - Dietitian, the incumbent advises and makes recommendations to the Department of Health and Social Services, and to allied health workers and physicians in regional health authorities on diabetes programming and patient care issues.

The incumbent is located in Yellowknife and reports directly to Nurse in Charge, Primary Care.

The incumbent is based in Yellowknife, seeing individuals or groups who are seeking diabetes care. They may travel to a community to plan, deliver and evaluate services. The incumbent fields telephone requests from patients/clients, health care workers, including physicians, teachers, nurses and students, and participates in meetings of community groups working on diabetes and related health issues.

RESPONSIBILITIES

1. **Develops, coordinates, implements and evaluates programs using a patient-centered, integrated service delivery approach. Services may be provided in the diabetes centre in Yellowknife or in a satellite community. Telemedicine is used whenever possible to expand reach of services.**
   - Assists/leads communities with assessment of community issues on the management of pre-diabetes, diabetes and its complications, with a focus on cardiovascular and kidney diseases.
   - Determines priorities, goals, objectives, approaches and solutions for community needs.
   - Coordinates, researches, designs, delivers and evaluates services to facilitate learning, based on the principles of adult education in relation to diabetes self-care.
   - Facilitates community ownership and leadership in diabetes education by working with multidisciplinary community-based groups to increase their capacity to improve the health of their community members.
   - Determines which resources and teaching methods are appropriate and effective, while recognizing and respecting individual, social and cultural differences.

- Reviews and revises community diabetes education plans annually in collaboration with community members and health workers.
- Ensures that policies and standards of diabetes care follow the Diabetes Canada Clinical Practice Guidelines.
- Develops, revises and implements data-gathering tools for diabetes related activities.
- Participates in, and advises national and territorial committees, task forces and research projects related to diabetes care in the Northwest Territories as requested.

2. Provides direct patient care and education to clients to facilitate the adoption of healthy lifestyle related behaviors for the prevention and management of diabetes and its complications (cardiovascular, eye, kidney and nerve diseases)

- Determines which resources and teaching methods are appropriate and effective while recognizing and respecting individual, social and cultural differences. This includes conducting and evaluating physical assessment, and psycho-social screening, lifestyle assessment
- Obtains orders for (or uses a medical directive to order) regular laboratory diagnostics according to clinical guidelines, and assists with/arranges the collection of specimens for laboratory analysis.
- Reviews laboratory diagnostics results with client and arranges follow-up with the appropriate practitioner as required.
- Documents all medications/treatments, assessment data, plan of care, interventions and patient/client responses or outcomes in a timely manner.
- Guides and supports the use of diabetes self-care equipment such as home blood glucose monitors, insulin pumps and injection devices.
- Ensures that diabetes equipment (e.g. blood glucose monitor) is working properly by testing, calibrating and troubleshooting.
- Researches, reviews, interprets and disseminates current diabetes information and best practices through workshops and counseling/training sessions.
- Speaks to individuals and groups about diabetes care and prevention.
- Applies principles of adult education to daily practice and follows the most recent Standards of Diabetes Education in Canada.
- Carries out foot assessments and foot/wound care either by direct care or by consultation.
- Promotes the autonomy of adults living with diabetes and helps them to express their health needs and values to obtain appropriate information and services.
- Advocates and promotes principles of equity and fairness to assist patients/ clients in receiving unbiased treatment and education and a share of health services and resources proportionate to their needs.
- Acts in a manner consistent with the professional code of ethics, responsibilities and standards of practice.

- Communicates with other members of the health care team regarding the health care of adult diabetic clients to provide continuity of care and promote collaborative efforts directed toward quality patient care. This may be done in writing, by telephone, by TeleHealth or in person.

3. **Supports knowledge and skill development opportunities for health care providers, including physicians, nurses, dietitians, pharmacists and lay workers in diabetes management.**
   - Researches, develops, delivers and evaluates training for health care providers within NTHSSA to ensure they understand the best practices to care for their patients/clients living with diabetes. This may be conducted through workshops, and/or in-service education using a train-the-trainer approach.
   - Leads and coaches peers, students and other members of the health care team to develop skill levels necessary to achieve the Standards of Care.
   - Directs care plan changes. As a consultant, the incumbent instructs health care providers on how to assess and recognize significant differences between actual and expected responses of patients/clients to treatment.
   - Collaborates with colleagues to advocate for health care environments and public policy which support the health and well-being of patients/ clients.
   - Orientates new employees, community nurses and nursing students to the DEP services.
   - Participates in committees, task forces and research projects related to the following aspects of diabetes: advocacy, education, care, treatment and research.

4. **Provides specialized care to enhance patient/client treatment and education.**
   - Monitors and interprets patient/client progress by using the DCA 2000+ AlC and ACR analyzer (glycated hemoglobin and albumin creatinine ratio) if equipment is available and perform continuous quality control in accordance with NTHSSA Laboratory standards.
   - In collaboration with the DEP or Area Medical Director, initiates and instructs insulin pump therapy and ongoing management. Certification is required.
   - In collaboration with the DEP or Area Medical Director initiates and instructs continuous glucose monitoring systems and interpret the results. Certification is required.
   - Provides specialized diabetes foot/wound assessment and treatment. Certification is required.

5. **Facilitate, support and promote a culture of teamwork.**
   - Receives and shares information, opinions, concerns and feedback in a positive manner.
   - Works collaboratively to build rapport and create supportive relationships with team members, both within primary care and across the organization.
   - Develops a supportive rapport with individuals and their families to facilitate collaborative relationships with other integrated team members.

- Determines the most appropriate, effective and efficient mode of communication among interdisciplinary team members in accordance with identified policies and procedures.
- Coordinates and participates in formal and informal case conferences to share appropriate information concerning individual concerns or progress and to utilize the team's skills and resources in the most efficient and effective manner.
- Contributes to a strengths-based team environment, and supports team colleagues.
- Collaborates proactively with all integrated and interdisciplinary team members utilizing a client centered approach to facilitate and maximize healthcare outcomes.
- Communicates with other members of the health care team to provide continuity of care and promotes collaborative efforts directed toward quality patient care.

WORKING CONDITIONS

Physical Demands

Concentrated time spent at computer or desk.
(Daily- 20-60 minutes - Moderate)

Lifting heavy objects such as test equipment, boxes of materials while travelling or conducting education sessions.
(Weekly - 20-30 minutes - High)

Awkward positions for foot care assessments.
(Weekly- 20-30 minutes - High)

Awkward positions for foot care.
(Two days/week, six 1-hour appointments – High)

Environmental Conditions

Exposure to body fluids: blood and urine (due to collection of test specimens) (Weekly- 20-30 minutes - High)

Exposure to fungus (due to foot care duties) (Weekly- 20-30 minutes - High)

Travel to regions and communities in small aircraft and over ice roads in adverse weather conditions. (delays in travel - Twice Monthly - Several hours Moderate)

Exposure to contagious diseases at work place and when travelling to communities (Health Centres specifically)
(Daily- Several hours - High)

Sensory Demands

Exposure to loud noise levels when travelling to communities by plane (6 times/year - Several Hours - High)

Work in windowless office, classroom and examination room (Daily- Daily- Low)

Mental Demands

Disruption of personal life due to travel and irregular hours (3-4 times/year - Several days - Moderate)

Exposure to emotionally disturbing experiences. Educator is required to remain calm, controlled and professional despite the situation(s)

(Daily/Weekly/ Monthly - Variable - Low)

Lack of control over the work load with frequent interruptions that may lead to mental fatigue or stress

(Daily- Variable - Moderate)

KNOWLEDGE, SKILLS AND ABILITIES

- Knowledge of diabetes and capacity to share this information with patients, health care professionals and the public on individual and group basis.
- Knowledge/practice competency of use and quality control management of the DCA 2000+ Al C ACR analyzer. Certification is required.
- Knowledge of, and ability to apply principles of adult education in order to develop, deliver and evaluate subject-specific education sessions.
- Knowledge of, and an ability to apply, standard nursing processes (assessment, planning, interpretation, implementation and evaluation) and current nursing practice to ensure that the patients' physical, emotional, psycho-social, spiritual and educational needs are met.
- Knowledge and application of the Diabetes Canada, Clinical Practice Guidelines for the Prevention and Treatment of Diabetes in Canada.
- Knowledge and practice of the Standards of Diabetes Education in Canada.
- Knowledge/practice competency of insulin pumps. Certification is required.
- Knowledge/practice competency of continuous glucose monitoring system. Certification is required.
- 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.
- Knowledge of, and an ability to network, resources within and without NTHSSA (e.g. community health nurses, physicians, homecare, etc.) in order to consult on patients/clients and their families.

- Knowledge and application relating to protection of privacy and confidentiality; ability to keep personal and medical information private and confidential at all times.
- Knowledge of, and ability to operate, computer applications (electronic health records, electronic mail, internet, word processing, database, spreadsheets).
- Skilled in phlebotomy with an understanding of the Stanton Laboratory system. Certification is required.
- Ability to instruct patients/clients and their families about appropriate diabetes self-care activities.
- Ability to advocate for patients/clients and families living with diabetes.
- Ability to operate and/or use standard medical equipment (such as, but not limited to thermometers, sphygmomanometers, blood glucose monitors, sharps, insulin injection devices, etc.).
- Ability and comfort in delivering services using telemedicine technology such as TeleHealth.
- Ability to commit to actively upholding and consistently practicing personal diversity, inclusion and cultural awareness, as well as safety and sensitivity approaches in the workplace.

Typically, the above qualifications would be attained by:

The successful completion of a Licensed Practical Nurse (LPN) Program. Three years' recent nursing experience in an acute or ambulatory setting is required.

Equivalent combinations of education and experience will be considered.

ADDITIONAL REQUIREMENTS

Eligible for registration with the Government of the Northwest Territories-Department of Health and Social Services.

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

Within the Yellowknife Region, all LPNs must be able to acquire, within a reasonable time frame, and remain current in, mandatory certifications specific to the role and working environment as outlined in their orientation. This includes, but is not limited to:

- Heart and Stroke Foundation of Canada Basic Life Support
- Nonviolent Crisis Intervention
- Privacy and Confidentiality training
- Infection, Prevention and Control (IPAC) training
- Education Program for Immunization Competency (EPIC)
- Point of Care Testing certifications
- Training as required to meet Accreditation Canada standards

Within the Diabetes Education Program, the incumbent must be able to acquire, within a suitable period of time, not exceeding two years, and remain current in, the following:

- Working knowledge of insulin injection devices.
- Working knowledge of a variety of home blood glucose monitoring devices
- Certification of the continuous monitoring system
- Ability to use the DCA 2000+ analyzer and quality control management
- Certification in insulin pump use
- Canadian Diabetes Association Certification as a Diabetes Educator

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