1. IDENTIFICATION

Position No.	Job Title	Supervisor's Position
See Appendix A	Supervisor Home & Community Care	**See Appendix A**

Department	Division/Region	Community	Location
Health	See Appendix	See Appendix A	See Appendix A

Freebalance Coding:	See Appendix A

2. PURPOSE

Main reason why the position exists, within what context and what the overall end result is.
Under the direction of the Manager Home & Community Care and in collaboration with the Supervisor of Health Programs (SHP) and the Community Health Nurses (CHN), the Supervisor Home & Community Care (SHCC) provides nursing care and support services to the general population throughout the life cycle to enable them to stay in their homes and to promote the optimal level of functioning in activities of daily living. The SHCC also supervises, trains, and provides direction to the Home & Community Care (HCC) staff in assigned communities.

3. SCOPE

Describe the impact the position has on the area in which it works, or if it impacts other departments, the government as a whole, or the public directly or indirectly. How does the position impact those groups/individuals, the organization and/or budgets? What is the magnitude of that impact?
The SHCC ensures the delivery of quality case management, nursing, and support services to clients in their home setting and other community settings, assisting them to function at their optimum level and to remain independent of institutional-based care services. The SHCC supervises, trains, and manages HCC staff in assigned communities.

4. RESPONSIBILITIES

Describe major responsibilities and target accomplishments expected of the position. List the responsibilities that have the greatest impact on the organization first and describe them in a way that answers *why* the duties of the position are being performed. For a supervisory or management position, indicate the subordinate position(s) through which objectives are accomplished.
Assesses the status of clients who have been admitted or re-admitted to the Home & Community Care (HCC) program by: • Reviewing the home care referral form; • Reviewing the clinic file and/or medical record if indicated; • Reviewing client status with other service providers if appropriate; • Completing a physical examination; • Interpreting data to determine actual problems/needs; • Obtaining further information from the client and family in the form of a client history; • Completing and reviewing the home care assessment form and client care plan;

- Developing a rapport with the client and family while ensuring privacy and confidentiality; and
- Obtaining additional information on subsequent visits and entering any other relevant information on the client's record.

Develops and modifies a client care plan based on the assessed needs of the individual and the prescribed medical regimes by:

- Setting priorities in planning care;
- Formulating a plan of care to achieve expected outcomes by writing objectives and long-term goals that are realistic and feasible in terms of resources, time, material, people, and cultural relevancy;
- Identifying appropriate actions that will provide for continuity of care, an individualized teaching plan, and the involvement of the client and family;
- Planning for discharge, as part of expected outcomes, if the client's final goal is a return to independence and responsibility for their own needs and care; and
- Revising the client care plan in response to changes in the client's status or to adjust to the client's response to care.

Implements the client care plan by:

- Organizing daily assignments and setting priorities based on individual and overall needs of the clients;
- Carrying out the nursing portion of the prescribed medical regime;
- Planning nursing visits to conserve time and energy;
- Travelling to client's home or other community settings as scheduled or to other communities as assigned;
- Providing individual care that reflects the priorities established in the client care plan;
- Performing appropriate nursing interventions to meet the client's assessed needs (i.e. IV therapy, central lines i.e. PICC lines);
- Providing care in private surroundings and providing for the safety and well-being of the client;
- Reviewing the client's medications, compliance with care plan, and need for supplies;
- Involving the client and family whenever possible in the provision of nursing care and the promotion and maintenance of health;
- Providing routine follow-up care for specific conditions as recommended by interdisciplinary team members;
- Delegating appropriate activities to the Home & Community Care Workers (HCCW); and
- Communicating, reporting, and recording accurately and appropriately.

Evaluates the extent to which the client's health needs are being met by:

- Assessing the effect of the care provided in terms of the client's care plan, established goals, and with respect to the client's assessed needs;
- Collaborating with the SHP and CHN in care plan for Chronic Disease Clinic (CDC) clients and following existing CDC guidelines;
- Reassessing the client's needs at predetermined intervals; and
- Modifying the client care plan as required.

Maintains records for clients by:

- Documenting each visit and time spent providing nursing care to the client in the HCC Activity Log form after each visit;
- Maintaining a chart for each client that may include a referral, assessment record, client care plan, progress notes, medication and/or treatment sheet, flow charts, progress reports, and other related information/letters;

- Recording, for each visit, any relevant observations and nursing actions in the progress notes and flow chart on the client's file;
- Completing, as indicated, progress reports to advise physicians and other service providers of any change in the client's health status or the client's response to services provided;
- Processing any change in orders, identifying these changes on the progress report, and informing other service providers of the changes; and
- Completing discharge reports as required.

Supervises HCCRs and/or HCCWs by:

- Participates in hiring, and performance management as required;
- Providing orientation, ongoing training, and mentorship to HCCWs;
- Scheduling service time and duties for the HCCWs;
- Addressing identified issues to ensure professional conduct of HCCWs; and
- Evaluating and reporting HCCWs performance on an annual basis and recommending progressive discipline as required.

Participates as a member of the HCC team by:

- Attending health care team meetings regularly;
- Organizing and leading monthly HCC staff meetings with HCCWs;
- Assisting in setting overall goals for clients and establishing priorities for services;
- Contributing to the development of an ongoing plan for overall care;
- Communicating information to the health care team on the existing and potential needs of clients;
- Evaluating care plans, reassessing the client's needs at predetermined intervals, and adapting the client care plan as required;
- Discharging clients according to their client care plan;
- Communicating, verbally and in writing, information to the client's physician and other service providers as required;
- Participating in training required to fulfill necessary client care plan requirements; and
- Maintaining a high level of professional competency, growth, and development.

Performing other duties as assigned/required. Performs administrative functions by:

- Participating in the hiring process for HCC staff as required;
- Participating in the orientation, training, support, and guidance of HCCWs;
- Conducting performance reviews for all HCC staff on an annual basis;
- Delegating work assignments to appropriate HCC staff (e.g., HCCW);
- Ensuring regular maintenance checks of medical equipment are completed as per protocol;
- Responding to personal, telephone, or written inquiries from clients, administration, physicians, and the general public in a timely manner, as per GN policy;
- Performing delegated administrative functions, preparing reports, processing correspondence and reports, requisitions, and processing and receiving supplies and equipment;
- Maintaining client and administrative records in a concise, accurate, and confidential manner within professional and legal guidelines, and scope of practice;
- Following worksite safety and security rules as per GN's Workplace Wellness Program and the Occupational Health and Safety guidelines;

- Planning for and assisting with physician, specialist, and regional staff visits as required;
- Developing and maintaining good working relationships (e.g. team building) with other agencies, the community, colleagues, and supervisor; and
- Participating in continuous Quality Improvement (QI) and risk management activities.
- Adapting and incorporating Inuit Societal Values with healthcare service delivery by;
- Respecting others, advocate for equity and social improvement, involvement with the community and activities, be innovative and resourceful.

5. KNOWLEDGE, SKILLS AND ABILITIES

Describe the level of knowledge, experience and abilities that are required for satisfactory job performance.
Knowledge identifies the acquired information or concepts that relate to a specific discipline. *Skills* describe acquired measurable behaviours and may cover manual aspects required to do a job. *Abilities* describe natural talents or developed proficiencies required to do the job.
These requirements are in reference to the *job*, not the incumbent performing the job.

Contextual Knowledge

- Theories, principles and practices of Home and Community Nursing Care
- Principles of working in a cross cultural setting
- Knowledge of community dynamics as it pertains to health care

Skills and Abilities

- Ability to work in a cross cultural setting
- Excellent assessment skills
- Excellent communication skills
- Ability to teach/persuade effectively to individuals or groups
- Ability to work in a multi-disciplinary team

Qualification for this position is normally gained through a Bachelor of Science in Nursing or a Diploma in Nursing with 5 years of nursing experience. A minimum of 1 year supervisory experience and 1 year of related home and community care are also required for this position. Current CANNN registration or eligibility to register is required. Candidates must possess a valid driver's license. Current CPR certification is required. Assets for this position are; knowledge of Inuit Culture, wound care, diabetes care, palliative care, specialized foot care, peripheral intravenous (PIV) and central intravenous (IV) access, exceptions can be made for Nunavummiut and or graduates of the Nunavut Arctic College, Northern Nursing Education Program.

The ability to speak more than 1 of Nunavut's Official Languages would be considered an asset.

This is a highly sensitive position. Criminal Record and Vulnerable Sector checks required.

6. WORKING CONDITIONS

List the unavoidable, externally imposed conditions under which the work must be performed and which create hardship for the incumbent. Express frequency, duration and intensity of each occurrence in measurable time (e.g. every day, two or three times a week, 5 hours a day).

Physical Demands

Indicate the nature of physical demands and the frequency and duration of occurrences leading to physical fatigue or physical stress.
• Requires full mobility in the community in all types of weather conditions. • Requires the ability to lift and transport heavy objects.

Environmental Conditions

Indicate the nature of adverse environmental conditions to which the jobholder is exposed, and the frequency and duration of exposures. Include conditions that increase the risk of accident, ill health, or physical discomfort.
• Required to provide services in severe winter weather conditions. • Seasonal low-light levels.

Sensory Demands

Indicate the nature of demands on the jobholder's senses. These demands can be in the form of making judgements to discern something through touch, smell, sight, and/or hearing. It may include concentrated levels of attention to details though one or more of the incumbents' senses.
• Requires the use of all five senses. • Exposure to blood and body fluids – risk can be minimized through use of universal precautions. • Exposure to animals while on home visits. • Exposure to emotionally difficult or potentially violent situations on home visits. • Exposure to clients with contagious conditions - risk can be minimized by maintaining immunization status and using infection control measures. • Exposure to hazardous substances – risk can be minimized with application of WHMIS knowledge.

Mental Demands

Indicate conditions within the job that may lead to mental or emotional fatigue that would increase the risk of such things as tension or anxiety.
• Heavy workload demands and conflicting priorities may lead to stress. • Required to work with clients in various emotional states.

7. CERTIFICATION

Employee Signature	Supervisor Title
Printed Name	Supervisor Signature
Date:	Date
I certify that I have read and understand the responsibilities assigned to this position.	I certify that this job description is an accurate description of the responsibilities assigned to the position.
Deputy Head Signature	
Date	
I approve the delegation of the responsibilities outlined herein within the context of the attached organizational structure.	

8. ORGANIZATION CHART

Please attach Organizational Chart indicating incumbent's position, peer positions, subordinate positions (if any) and supervisor position.

"The above statements are intended to describe the general nature and level of work being performed by the incumbent of this job. They are not intended to be an exhaustive list of all responsibilities and activities required of this position".

9. Appendix A – List of Positions and Corresponding Information

Community	Position	Supervisor	Freebalance Code
Arviat	10-10269	10-10072	10270-01-3-300-1025405-04
Baker Lake	10-14058	10-10072	10270-01-3-305-1025405-04
Cambridge Bay	10-10151	10-09810	10270-01-4-410-1025405-04
Kinngait	10-10146	10-10044	10270-01-2-210-1025405-04
Coral Harbour	10-10268	10-10072	10270-01-3-315-1025405-04
Gjoa Haven	10-10148	10-09810	10270-01-4-415-1025405-04
Igloolik	10-10143	10-10044	10270-01-2-230-1025405-04
Kugaaruk	10-10149	10-09810	10270-01-4-425-1025405-04
Kugluktuk	10-10150	10-09810	10270-01-4-420-1025405-04
Naujaat	10-10352	10-10072	10270-01-3-325-1025405-04
Pangnirtung	10-10147	10-10044	10270-01-2-250-1025405-04
Pond Inlet	10-10145	10-10044	10270-01-2-255-1025405-04
Rankin Inlet	10-10364	10-10072	10270-01-3-320-1025405-04
Taloyoak	10-10152	10-09810	10270-01-4-430-1025405-04