The Supervisor, Home & Community Care under the direction of the Manager, Home Community Care provides nursing and support services to the elderly, chronically ill, and disabled clients throughout the life cycle to enable them to stay in their homes and to promote participation in activities of daily living.

The Supervisor, Home & Community Care ensures the delivery of quality nursing and support services to clients in their home settings, assisting them to function at their optimum level and remain independent of institutional based care services. This enables clients to remain contributing members of their communities. The provision of professional community home care to clients is done in accordance with established standards of nursing practice, the philosophy and objectives of the Department of Health and Social Services.

The Supervisor, Home & Community Care is responsible:
1. To assess the status of clients who have been admitted or re-admitted to the Home Care Program;
2. To develop and modify a client care plans based on the assessed needs of the individual;
3. To implement the client care plan;
4. To evaluate the extent to which the individual’s health needs are being met;
5. To maintain records for clients;
6. To supervise Home & Community Care Support Workers;
7. To participate as a member of the Home Care Team.

The incumbent should have:
• Bachelors’ degree in Nursing or Nursing Diploma
• Two (2) years of recent related nursing experience
• Knowledge of current trends in health promotion/disease prevention practices and programs and Palliative Care.
• Well-developed skills in order to communicate/teach effectively on an individual or group basis within a cross-cultural setting.
• Basic CPR and annual re-certification required to maintain skill level
• Eligible for registration with RNANT/NU
  . Valid driver’s license – Class 4
  . Knowledge of Inuit language, communities and culture is an asset.

This position is included in the Nunavut Employee’s Union and has a salary of $90,734 to $102,941 per annum with a Northern Allowance of $26,345

Subsidized housing is available.

For full-time, permanent nurses, Recruitment Bonuses include: $5,000 upon start date, $5,000 at 18 months of service and $10,000 at 30 months of service. Other bonuses include a $9,000+ Annual Special Allowance and a $375 Monthly Retention Bonus totaling $4,500 per year.

Reference #: 10-04-415-003PL
Closing Date: May 13, 2011
Contact: Department of Health and Social Services
Government of Nunavut,
P.O. Box 83, Cambridge Bay, NU, X0B 0C0
Att: Patricia Lear, HR Officer - Nursing
Voice Mail: (867) 983-4083
Fax: (867) 983-4004  E-mail: plear@gov.nu.ca

- We will contact only those candidates selected for interviews.
- Candidates must clearly identify their eligibility in order to receive priority consideration under the Nunavut Priority Hiring Policy.
- Job descriptions may be obtained by fax.
- Equivalencies will be considered.
1. IDENTIFICATION

<table>
<thead>
<tr>
<th>Position No.</th>
<th>Job Title</th>
<th>Supervisor’s Position</th>
<th>Fin. Code</th>
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</thead>
<tbody>
<tr>
<td>10-10145</td>
<td>Supervisor Home &amp; Community Care</td>
<td>Manager Home &amp; Community Care</td>
<td>10270/01/44/415</td>
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<td>1025405/04</td>
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</tbody>
</table>

Department: Health and Social Services
Division/Region: Kitikmeot Region
Community: Gjoa Haven
Location: Gjoa Haven

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, the Supervisor Home & Community Care provides nursing and support services to the elderly, chronically ill and disabled clients throughout the life cycle to enable them to stay in their homes and to promote optimal level of functioning in activities of daily living.

3. SCOPE

Describe in what way the position contributes to and impacts on the organization.

The Supervisor Home & Community Care ensures the delivery of quality case management nursing and support services to clients in their home setting assisting them to function at their optimum level and remain independent of institutional based care services which enables them to remain contributing members of their communities.

4. RESPONSIBILITIES

Describe major responsibilities and target accomplishments expected of the position. For a management position, indicate the subordinate position(s) through which objectives are accomplished.

1. Assesses the status of clients who have been admitted or re-admitted to the Homecare Program by:
   - Reviewing the Homecare referral form
   - Completing and reviewing the Homecare assessment record
   - Reviewing the clinic file and/or medical record if indicated
   - Reviewing client status with other services if appropriate
   - Developing rapport with the client and family ensuring privacy and confidentiality
   - Obtaining further information from the client and family in the form of a client history
   - Completing a physical examination
   - Completing the general assessment form and client care plan
   - Interpreting data to determine actual problems/needs
   - Assessing own ability to meet the client's needs
   - Obtaining additional information on subsequent visits, entering any other client problems on the client's record

2. 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

May, 2010
GOVERNMENT OF NU

Formulating a plan of care to achieve expected outcomes, 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 individual and family

Initiating referrals to consultants, other agencies and/or support services where indicated

Planning for discharge if the client’s final goal is a return to independence and responsibility for their own needs and care

Revising the client care plan in response to changes in the individual’s status or to adjust to the individual’s response to care

3. Implements the client care plan by:

- Organizing daily assignments, setting priorities based on individual and overall needs of the clients
- Planning nursing visits to conserve time and energy
- Travelling to each home as scheduled, utilizing the Homecare vehicle as available
- Providing individual care that reflects the priorities established in the plan of care
- Performing appropriate nursing interventions to meet individual needs
- Providing care in surroundings of privacy and providing for the safety and well being of the individual
- Carrying out the nursing portion of the prescribed medical regime
- Ensuring that clients have prescribed medications and/or treatment supplies
- Involving the individual and family whenever possible in the provision of nursing care and in the promotion and maintenance of health
- Providing routine follow-up for specific conditions as recommended by interdisciplinary team members
- Delegating appropriate activities to the Home & Community Care Representative and Home & Community Care Workers
- Reporting and recording accurately and appropriately

4. Evaluates the extent to which the individual's health needs are being met by:

- Assessing the effect of the care provided in terms of goals set and in terms of the individual’s needs
- Modifying the client care plan as required

5. Maintains records for clients by:

- Entering daily each visit and time spent in nursing care of the client on the Home Care Activity Log Form
- 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 daily for each visit any relevant observations and nursing actions on the progress notes or flow chart on the client’s file
- Charting medications prepared for clients on the medication sheet or client’s file
- Completing as indicated progress reports to advise physicians and other services of any change in the individual’s health status or of the individual’s response to services provided
- Noting and acting on any change in orders on the progress report
- Completing discharge reports as required

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6. Supervises 3 staff located in Kugaaruk by:
- Scheduling service time and duties for Home & Community Care Workers
- Providing training and mentorship to Home & Community Care Workers
- Addressing identified issues to ensure professional conduct of Home & Community Care Workers
- Evaluating and reports Home & Community Care Workers performance
- Administering progressive discipline to employees as required

7. Participates as a member of the Home care team by:
- Attending team meetings and monthly staff meetings
- Assisting in setting overall goals for clients and in establishing priorities for services
- Contributing to the development of an ongoing plan for overall care
- Providing information to the team on the existing and potential needs of the clients, evaluating care plans and assisting in reassessment for Homecare Record and care plan
- Providing verbally and in writing information to the client’s physician and other service providers
- Maintaining a high level of professional competency, growth and development
- Other duties as assigned/required

5. KNOWLEDGE, SKILLS AND ABILITIES
Describe the level of knowledge, experience and abilities that are required for satisfactory job performance.
- Diploma or BScN
- Current or eligible for RNA NT/NU registration
- Valid class 4 driver’s license
- Two years experience in a related position
- Excellent assessment skills
- Ability to work in a cross cultural setting
- Ability to work independently
- Ability to work in a multidisciplinary team

6. WORKING CONDITIONS

Physical Demands
Indicate the nature of physical demands and the frequency and duration of occurrences leading to physical fatigue.
- Position 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 disrupt regular work schedules and travel requirements.
- 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 to make judgements through touch, smell, sight and hearing, and judge speed and accuracy.

3
May, 2010
Mental Demands

Indicate conditions that may lead to mental or emotional fatigue.

- Heavy workload demands and conflicting priorities may lead to stress.
- May be necessary to work with clients in emotional states.

7. CERTIFICATION

<table>
<thead>
<tr>
<th>Employee Signature</th>
<th>Regional Director</th>
</tr>
</thead>
<tbody>
<tr>
<td>Printed Name</td>
<td>Supervisor Title</td>
</tr>
<tr>
<td>Date</td>
<td>Supervisor Signature</td>
</tr>
<tr>
<td>I certify that I have read and understand the responsibilities assigned to this position.</td>
<td>Date</td>
</tr>
<tr>
<td></td>
<td>I certify that this job description is an accurate description of the responsibilities assigned to the position.</td>
</tr>
</tbody>
</table>

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".