



## JOB DESCRIPTION

**Department:** Home and Community Care  
**Job Title:** Chronic Disease Nurse

### PURPOSE

Under the direction of the Home and Community Care Program Manager, the Chronic Disease Nurse will provide comprehensive Home Care services to clients in accordance with the standards of nursing practices, the philosophy, objectives and policies of Hailika'as Heiltsuk Health Centre Society (HHCS).

### REPORTING STRUCTURE

Reports to the Home and Community Care Program Manager

### DUTIES AND RESPONSIBILITIES

- Provide comprehensive home care nursing services and performs sanctioned transfer of medical functions (i.e dispensing medications), to clients using a problem-solving approach to facilitate individualized nursing care to client of the Home and Community Care Program
- Follow-up and provide nursing services to the newly diagnosed and unstable diabetics
- Admit client to home care nursing services via referral from nursing services, physician, and community
- Assess the clients' and families physical and psychological needs
- Identify supports available to clients such as OT, PT, CNIB, mental health workers, and etc.
- Develop nursing care plan including individual client needs, support systems, nursing intervention and resources required
- Assess, plan, implement, document and evaluate care to ensure a coordinated holistic approach which best meets the needs of the client
- Provide support to the Elders Nurse when requested in relation to clients' care
- Guides and supports the use of diabetes self care equipment such as home glucose monitors and injection devices
- Ensures that diabetes equipment is working properly by testing, calibrating and troubleshooting
- Assist client to achieve their optimum level of health in situations of normal health, illness, injury, or through the palliative phase
- Advocate the dignity and self-respect of clients
- Promote the autonomy of clients and help them to express their health needs and values to obtain appropriate information and services
- Safeguard the trust of clients that information learned in the context of a professional relationship is shared outside the health care team only with the client's permission or as legally required
- Apply and promote principles of equity and fairness to assist clients in receiving unbiased treatment and a share of health services and resources proportionate to their needs
- Act in a manner consistent with their professional code of ethics, responsibilities, and standards of practice



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- Make decisions regarding client management and facilitates referrals to other health care professional to ensure early diagnosis and prompt intervention in the therapeutic and disease process
- Promote safe and healthy environments in homes
- Participate in committees and research projects related to the Home and Community Care Program with approval of the Coordinator.
- Provides specialized care to enhance client treatment and education
- Initiation of continuous glucose monitoring system and knowledge/interpretation of the results
- Specialized diabetes foot/wound assessment and treatment
- Develop, facilitate, implement and modify health promotion activities based on the needs of the client
- Use a holistic approach to facilitate individual learning of clients and their families in relation to client illness or injury (i.e self-care, health promotion, etc.)
- In collaboration with other members of the health care team lead and coordinate that chronic disease management program
- Assess the client for physical and psychological needs, their knowledge of their health, disease process and learning needs
- Facilitate individual learning in relation to client illness or injury
- Research, develop, revise, and evaluate on an ongoing basis, educational resources necessary to support clients
- Participates in program development for specialty program education and teaching
- Perform administrative functions that contribute to the effective functioning of the Home and Community Care Program and enhance program development, delivery and continuity of care
- Assist in planning, development and evaluation of home and community care programs, services, and policies with a focus on continual improvement
- Provide ongoing evaluation of clients' status and program efficiency
- Collect and document demographic and statistical information
- Communicate with other members of the health care team regarding the client's health care to provide continuity of care and promote collaborative efforts directed toward quality client care
- Provide coaching and leadership to peers, students and other members of the health care team to develop skill levels necessary to achieve the standard of care
- Collaborate with nursing colleagues and other members of the health care team to advocate health care environments that are conducive to the ethical practice and to the health and well-being of clients and others in the setting
- Provide orientation to new employees on department specific programs and mandate
- Participates as a member of the Home and Community Care department team
- Actively participates with accreditation and other continuous improvement related activities
- Actively participates with client and staff safety initiatives and activities
- Maintains confidentiality of personal and business information
- Performs all duties and responsibilities in accordance with HHHCS policies
- Performs other duties as required



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## **QUALIFICATIONS**

### **Knowledge, Skills and Abilities (KSAs)**

- Bachelor Degree in Nursing, including or supplemented by training in community health nursing; or graduation from an approved diploma school of nursing plus a university diploma in community health nursing and at least three years' experience as a community health nurse or equivalent combination of education and experience
- Current practicing membership in the College of Registered Nurses of British Columbia is required
- Experience in supervisory/management capacity
- Familiarity with First Nations culture and traditions preferred
- Computer literacy
- Ability to work as a member of a multidisciplinary team
- Ability to adapt nursing practice to local culture and conditions
- Ability to include, involve and support clients and their families in care planning and care provision
- Ability to prepare comprehensive health records
- Ability to communicate effectively.
- Establish and maintain effective interpersonal relationships
- Reliability, professionalism, initiative, and judgment
- Maintain awareness that a nurse holding this position is a role model in the community
- Physical ability to perform the duties of the position
- Valid BC Driver's license
- Criminal Records Check with Vulnerable Sector Search

## **SIGNATURES:**

I have read, understand and accept this job description. I acknowledge that it is my responsibility to seek clarification on any areas that I may have questions.

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Employee Name: (please print)

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Employee Signature:

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Supervisor Signature:

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Date: