Hay River Health & Social Services Authority | Administration des services de santé et des services sociaux de Hay River
37911 MacKenzie Highway | 37911, route MacKenzie
Hay River, NT X0E 0R6

Job Description

IDENTIFICATION

Position Number	*Position Title*	
U-06-39-DNE-3601	**Diabetes Program Coordinator**	
Department	***Position Reports To***	***Site***
Home Care Enhancement	**Supervisor of Home Care**	Náydı Kų́ę́

PURPOSE OF THE POSITION

The Diabetes Program Coordinator is the lead certified diabetes educator (CDE) and a registered nurse (RN). The Diabetes Program Coordinator provides clinical expertise and acts as a resource to clients, families, schools and health care providers regarding diabetes management. Using the nursing process (assessment, planning, implementation and evaluation) the incumbent, in collaboration with the client, practitioner, registered dietitian (RD) and other members of the multi-disciplinary care team, will develop a learner-centered education program and plan of care.

The Diabetes Program Coordinator is responsible for the design, implementation, facilitation and evaluation of the diabetes program to meet the individual and group learning needs. The incumbent will provide counseling to clients and families. The Diabetes Program Coordinator will also develop and present diabetes education sessions to schools, agencies and the community. The Diabetes Program Coordinator works within the established standards of nursing practice, standards of the Canadian Diabetes Association and Standards for Diabetes Education in Canada (2014). Care is coordinated in accordance with Diabetes Canada Clinical Practice Guidelines (2018).

SCOPE

This position may be located at one of the Hay River Health & Social Services Authority (HRHSSA) locations. They include the Hay River Regional Health Center (HRRHC), the Gensen Building, Woodland Manor, Supportive Living Services and/or Náydı Kų́ę́ . The HRHSSA is an accredited, integrated health authority that provides the following services:19 acute inpatient beds

(14 Community Support Beds, 1 Family Suite (Palliative), 2 Secure Rooms, 2 Observation beds), Emergency and Ambulatory Care, including dialysis and endoscopy; Midwifery Care and Delivery; 25 Long Term Care beds; Supportive Living Campus, a Territorial campus providing 11 permanent residences; Diagnostic Services (Diagnostic Imaging, Ultrasound, Mammography); Laboratory; Medical and Specialty Clinics including Diabetes programming; Social Programs (Community Counselling, Healthy Families and Child and Family Services) Community Health and Home Care, Rehabilitation which include Physiotherapy, Occupational Therapy and Speech Language Pathology; and a full range of Support Services.

Services are provided to clients in Hay River, K'atl'odeeche First Nation Reserve, Enterprise, and Kakisa. The incumbent also provides services to clients of other Health Authorities who are temporarily located to Hay River, those who are referred from other Health Authorities or visiting from another province. Referrals are received from various sources (physicians, acute care units, other health and service agencies, and from the public).

The Diabetes Program Coordinator provides collaborative care and education to clients, families, groups and the community. The Diabetes Program Coordinator will provide leadership to healthcare providers and the community regarding health promotion, prevention, screening and active management of diabetes. The incumbent will develop, implement, facilitate and evaluate educational plans based on individual and group learning needs. A key component of this process is to empower clients and their family to make healthy choices, to improve diabetes self-management.

RESPONSIBILITIES

1. Provides clinical expertise and acts as a resource to clients and health care providers in the HRHSSA and outside agencies regarding diabetes management

Main Activities:

- Works as the lead of the multi-disciplinary team to achieve client outcomes;
- Counsels clients and family members on diabetes, management, prevention, complications and management of complications;
- Diabetes Program Coordinator is responsible for updating clients, family and staff on new CDA CPG, changes in targets, new recommendations and new research;
- Leads case management for approximately 300 clients, coordinating client-centered-care with involvement from the client, practitioner, RD and other allied health care providers. This includes ordering and reviewing lab results, assessing the client, developing individualized care plans;
- The Diabetes Program Coordinator provides comprehensive medication reviews, educates clients on medication management and makes recommendations to treatment plans in accordance with CDA CPG 2018;
- Works independently making advanced assessments/decision regarding holding or adjusting medications that are causing side effects;
- Independently assesses client for readiness and need for insulin. Provides initial teaching for those starting insulin or GLP injection. Coordinates and completes necessary follow-up with assessments, education, medication adjustment, assessing for hypoglycemia and prevention;

- Provides direction, information and technical guidance to professional and nonprofessional individuals through consultation, in-services, workshops and newsletters, and on an as needed basis;
- Maintains a resource library of education reference material for clients, family members, support persons and health care providers;
- Researches, develops and evaluates on an ongoing basis, educational resources necessary to support individual clients, communities, health care providers;
- Develops health promotion and educational materials;
- Acts as a contact for internal or external sources needing information regarding diabetes program or reports;
- Responsible for ordering supplies for diabetes program (Eg. Insulin, injection pens, glucometers, strips, lancets, control solution, pen-tip samples, literature resources) and ensuring all resources are up to date.

2. Develops a learner-centered education program and plan of care in collaboration with a multi-disciplinary team

Main Activities:

- Assesses the physical, psycho-social, cultural and learning needs of clients with Type 1, Type 2, Gestational diabetes and Prediabetes and develops individualized care plans;
- Responsible for reviewing, evaluating and updating individualized care plans with clients according to Diabetes Canada CPG;
- Responsible for assessing and coordinating appointments as needed for clients with NP's or physicians via Diabetes Clinics;
- Responsible for ordering initial complication screening blood work for all new clients admitted to the Diabetes Program;
- Responsible for ordering follow-up blood work every three months for those clients actively followed in the Diabetes Program and makes frequent independent decisions on need for repeating blood work sooner or additional blood work depending on results and treatment plan;
- Independently provides advanced assessments during office appointments regarding risk of microvascular and macrovascular complications, makes recommendations accordingly and arranges for referral to doctor or specialist as necessary;
- Independently makes advanced decisions for example holding medications or need for urgent medication start or insulin start depending on assessment, symptoms, client safety and risks, then discusses with practitioner as able to;
- Works closely with the Specialty Clinic to help coordinate follow-up appointments and arrange blood work prior to appointments;
- Works closely with Renal Program (nephrology), Internal Medicine and OB/GYN, attends specialist appointments for those with Type 1, Type 2 or Gestational Diabetes who are actively followed in the Diabetes Program;
- In collaboration with the prescriber, completes insulin education, initiation, evaluation and adjustment;
- Sets priorities and establishes goals of care that address the health needs and preferences of the client and family, and consider the home setting and cultural

context;
- Promotes self-management and enables clients to take charge of their health;
- Works with Homecare, Long Term Care, SLS and Inpatients as a consultant and resource for their clients with diabetes on an as needed basis;
- Responsible for updating EMR problem list, medication list, allergy list and demographics for those followed in the diabetes program;
- Triages and initiates referrals to specialist in priority of urgency via Diabetes Clinic;
- Provides ongoing assessments and management according to consult letters specific to each client;
- In collaboration with the Home Care / Foot Care LPN, provides annual foot assessments to clients followed in the diabetes program.

3. Designs, implements, facilitate and evaluate the Diabetes Program to meet the needs of the public

Main Activities:

- Ensures program maintains Diabetes Education Standards for Recognition;
- Plans, implements and evaluates educational plans that consider individual and group learning needs for both clients and their families/support persons;
- Uses a holistic approach to diabetes management, working collaboratively with clients, their families/support persons, and other members of the multi-disciplinary care team;
- Develops, evaluates and revises programs and educational materials, ensuring information is current, evidence-based, culturally sensitive and appropriate;
- Completes program audits and regular review of services;
- Collects monthly stats and completes departmental reports;
- Maintains up-to-date Diabetes Program database.

4. Collaborates as the lead member of the multi-disciplinary team

Main Activities:

- Makes frequent decisions about the most appropriate, effective and efficient mode of communication among inter-disciplinary team members;
- Attends Specialty Clinic appointments in Hay River for those actively followed in the Diabetes Program, as required;
- Works closely with Medical clinic to ensure appropriate follow-up and avoid duplicate appointments;
- Works closely with the Laboratory regarding diabetes blood work;
- Responsible for initiating, maintaining, evaluating and updating Diabetes Laboratory Standing Orders;
- Initiates and participates in case conferences to share pertinent information concerning client concerns or progress;
- Participates in Long term Care case conferences for Diabetes residents as needed;
- Educates team members as to the services and roles of the various care givers involved in the care of the client;
- Organizes and participates in Diabetes Clinics with the physician or NP.

5. Contributes to professional development and the development of the Diabetes Program so that the highest standards are reached and the program continues to offer information that is current and evidence-based and services that are effective and timely.

Main Activities:

- Furthers own education and development;
- Prepares and presents information to other health care professionals, community groups and the public;
- Assists with gathering, recording and evaluating statistical data relevant to program operation;
- Accesses additional program funds, materials and equipment through writing of proposals;
- Participates in quality assurance activities;
- Maintains membership or liaison with nursing organizations and other groups and follows practice and standards of the RNANT/NU and current Diabetes Canada Guidelines;
- Assists in the development of policies and procedures specific to the Diabetes Program.

POSITION ROLE IN CLIENT & STAFF SAFETY:

The HRHSSA is committed to creating a culture of safety throughout the organization. A culture of safety is necessary to provide optimal care to our clients, and a healthy workplace for staff. An organization with a culture of safety is characterized by several elements:

- Client-centered care;
- Healthy workplace;
- Open communication; and a
- Blame-free and accountable environment.

All staff throughout the organization share the responsibility for client and staff safety by:

- Demonstrating a commitment to safety;
- Complying with safety policies, procedures and best practices;
- Identifying and reporting safety issues; and
- Participating in safety initiatives.

Commitment to client centered care

Recognizing that our clients are the experts for their own lives, the Hay River Health & Social Services Authority (HRHSSA) is committed to support our clients as leaders to accomplish the goals that they have set out for us in their personal care. The (HRHSSA) will endeavor to provide client centered care through the following:

- Involving clients in their care by reducing barriers that may inhibit our ability to help them.
- Providing a culture that will ensure clients have a voice and participate in their own personal care.

- Empowering clients through improving client satisfaction, enhancing the quality of care and ultimately the quality of life for our clients.
- Focusing on the experience of the client from their perspective and listening to their needs.
- Fostering collaboration between the client and organization by working together to achieve our goals.
- Providing continuous dialogue with the clients to ensure individualized, client centered care.
- Ensuring staff are provided with the training and tools required to complete the best job possible.

Criminal Record Check

Employment with the Hay River Health & Social Services Authority is contingent on providing a satisfactory criminal record check including the vulnerable sector check to the Human Resources Office prior to the official start date of a position.

KNOWLEDGE, SKILLS AND ABILITIES

- Excellent critical thinking skills, program planning and organization skills
- Excellent interpersonal and communication skills, oral and written
- Self-directed, reliable, organized, and ability to triage multiple tasks
- Cultural sensitivity and inclusivity
- Strong understanding of pharmacology, diabetes labs and chronic disease management
- Knowledge of current nursing theory, client care practices and regulations, including standards and procedures of the HRHSSA and RNNT/NU
- Knowledgeable of Diabetes Canada Clinical Practice Guidelines (2018)
- Knowledge of basic diabetes foot care and ability to perform diabetes foot assessments
- Ability to develop, deliver and evaluate individualized educational programs
- Knowledge of the community and available resources
- Computer skills and ability to write reports, proposals and review budgets

These skills, abilities and knowledge are commonly acquired through a Baccalaureate degree in Nursing, with a minimum of three years registered nursing experience with demonstrated knowledge, skills and ability in the area of diabetes education. Incumbent must possess a current Class 5 driver's license for home visits and community education. Active registration with the NWTRNA and basic CPR with annual certification is mandatory. Must be willing to work toward being a Certified Diabetes Educator, and have completed within a year of employment

WORKING CONDITIONS

Physical Demand

Demand	Frequency	Duration	Intensity
Standing for prolonged periods of time during provision of care and treatment	Daily	20-30%	moderate

Prolonged sitting at desk, computer and keyboard	Daily	50-70%	moderate to high
Temperature extremes in work environment	Daily	10-30%	low to moderate

Environmental Conditions

Demand	Frequency	Duration	Intensity
Exposure to hazardous substances	Daily	10-30%	Moderate
Exposure to communicable diseases	Daily	10-30%	Moderate
Exposure to needle stick injuries	Daily	10-30%	Moderate
Travel in adverse weather conditions to make home visits, do presentations and workshops	Varies	10-30%	Moderate
Exposure to allergens (i.e., dog/cat hair, dust, smoke)	Varies	10-40%	Moderate to High

Sensory Demands

Demands	Frequency	Durations	Intensity
Focused assessment and observation activities when evaluating clients and developing care plans.	Daily	50-70%	Moderate to High
Language barriers and physical and cognitive impairments in clients.	Daily	20-30%	Moderate to high
Operating various pieces of mechanical equipment: audiovisual aids and providing technical troubleshooting	Daily	20-30%	Moderate
Tabulating, auditing, inspecting and proofreading data and entering data into the computer.	Daily	30-40%	Moderate to High

Mental Demands

Demands	Frequency	Durations	Intensity
Providing care to clients who may be angry, potentially abusive and volatile.	Daily	20-30%	Moderate to high
Incumbent is required to be motivated and innovative in the area of providing continuing client and family education	Daily	50-60%	Moderate to high
Exposure to clients with complex needs	Daily	40-50%	Moderate to high

Fluctuating workload depending on unpredictability of client's clinical situations.	Daily	20-30%	Moderate
Concentrated attention to detail for prolonged periods of time when data entering information into computer, preparing reports and updating files	Daily	20-40%	Moderate

CERTIFICATION

Position Number: U-06-39-DNE-3601

_____ Employee Signature _____ Printed Name _____ Date I certify that I have read and understand the responsibilities assigned to this position.	_____ Supervisor Title _____ Supervisor Signature _____ Date I certify that this job description is an accurate description of the responsibilities assigned to the position.

_____ 17 March 2021

Director/Chief Executive Officer Signature Date

I approve the delegation of the responsibilities outlined herein within the context of the attached organizational structure.

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

Revised: July 31, 2002
Editorial changes – February 2005
Revised August 2010
April 2011 reports to
Sept.2011 Scope 2011
Editorial changes – August 2013
Scope, editorial – Jan 2017
Name, editorial – Jun 2017
Reports to, scope, editorial changes - March 2021
Location of Worksite 2022