Hay River Health & Social Services Authority I Administration des services de santé et des services sociaux de Hay River
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Job Description

IDENTIFICATION

Position Number	*Position Title*	
U-20-31, U-22-31	**Foot Care/Home Care LPN**	
Department	***Position Reports To***	***Site***
Continuing Care	**Supervisor, Home Care**	**Náydı Kų́ę́**

PURPOSE OF THE POSITION

The Foot Care/Home Care Licensed Practical Nurse provides comprehensive, quality advanced foot care, educationand nursing services to clients of all ages, often in the clients' homes.

The overall result expected is cost-effective client centered nursing care focusing on preventative health education and maintaining the health of clients after acute illness, injury or surgery.

Furthermore, the purpose of this position is to provide advanced foot care assessments and treatments of the ailments of the foot, as well as providing ongoing care and education to help maintain lower limb health using specialized tools and procedures.

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 Ku ę́. 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; 23 Long Term Care beds and 2 respite bed; Supportive Living Campus, a Territorial campus providing 11 permanent beds and 1 respite bed; 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.

This position reports to the Home Care Supervisor and provides service to clients in Hay River, the Hay River Dene Reserve and Enterprise. The incumbent also provides services to clients of other health boards who are temporarily relocated to Hay River. Referrals are received from various sources (physicians, hospital units, acute and rehabilitation units, other health and social services agencies, and from the general public). A written referral from a physician is preferred.

The incumbent is a member of a multi-disciplinary team, who provides direct care to clients, acts as a client advocate, facilitating communication between the client, family and all health care professionals.

The LPN uses the Nursing Process (assessment, planning, implementation and evaluation) within the framework of standards of practice of the Licensed Practical Nurse of the NWT; the policies and procedures of the HRHSSA and the philosophy and objectives of the NWT Coordinated Home Care Program/VON Foot Care Guidelines, to promote optimal, cost effective, client centered nursing care, focused on restoring and maintaining the health of clients with chronic disease, acute illness, or after illness or surgery. Furthermore, the Foot Care/Home Care LPN is involved in monitoring and maintaining the health of clients with chronic illness and disability, providing palliative care and assisting clients to achieve and maintain personal independence, and coordinating appropriate services for clients.

The LPN has responsibility and accountability for foot care of clients with chronic disease, and for the nursing care of short-term and long-term clients; making daily, weekly or monthly visits as determined by client acuity and need. During a typical day the incumbent will see 6-8 clients.

The LPN independently and in collaboration with a Home Care RN and the client identifies, assesses and sets priorities for the health needs of the client. The LPN plans appropriate interventions with the client, their family, physician, other health care professionals and community agencies. Knowledge of available resources within the community allows appropriate referrals to be made on behalf of clients.

The incumbent provides a broad range of nursing care based on the identified needs of the client and adapted to the home setting. The nurse evaluates the outcomes of care by a variety of parameters (such as cost, time, client satisfaction, benefit, client's health status).

The problem solving, decision making and nursing care that the nurse provides have the effect of improving the client’s level of health and then maintaining the health status in partnership with the client, family and community throughout the life cycle.

RESPONSIBILITIES

1. Provides comprehensive foot care services to persons assessed to have advanced foot care needs, in accordance with the NWT Coordinated Home Care Program Standards and Procedures, HRHSSA Standards and Procedures, and VON Foot Care Guidelines promoting the clients independence and responsibility in order to assist in the protection, restoration and promotion of foot health and mobility.

- Using independent decision making and judgement in order to identify needs and provide care that maximizes the use of available resources;
- Assessing client's feet and lower limbs, recording client's medical history and any background information pertinent to the proper care of the feet;
- Developing an individualized foot care plan in cooperation with the client, based on identified needs;
- Performs ongoing assessments, education and teaching to clients
- Facilitates the Advanced Foot Care Program and oversees the scheduling of clients
- Performs specialized tasks such as ankle brachial index (ABI), toe brachial pressure index (TBPI), dremmeling, offloading pressure ulcers, and complex wound care.
- Performing basic and advanced foot care functions as required by NWT and HRHSSA standards, encouraging independence and self-responsibility by the client at all times;
- Reassessing the clients needs on an ongoing basis and continuously modifying the care plan to accurately reflect the clients needs;
- Under the direction of the Home Care Supervisor or Home Care RN, provides other medical treatments and services as required to maintain continuity of client care. These may include: taking a blood pressure, weight, vital signs, blood sugar, dressing change, venipuncture, provide oxygen therapy;
- Recommending referrals to consultants and other health care agencies as needed;
- Working collaboratively with the Diabetes Team and other health care team members in the design and implementation of the overall care plan as necessary;
- Respecting the privacy, safety and well-being of the client when providing care;
- Maintaining confidentiality of all client related information at all times.

2. Provides 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 clients of the Home Care Program.

- Assess the client’s and family’s physical and psychological needs, and available support systems as well as any other factors that will serve to provide a clear picture of the client's needs;
- Based on the assessment, develop a Nursing Care Plan to include individual client needs, support systems, nursing intervention and resources required;
- Prepare a list of equipment and supplies that will assist in the care giving process;
- Give feedback to the client, family and referral source as to the exact nature of the service offered and what the client and family responsibilities are in the care;
- Promote safe and healthy home environment for the client by ensuring that all equipment used in care is properly maintained, serviced, cleaned and sterilized;
- Participate in staff meetings and client case conferences as related to the Home Care program.

3. Develop a holistic care plan using professional judgment, experience and creativity, in order that the most important needs are met first using the available resources.

- Set priorities and establish goals of care that address the health needs and preferences of the client and family, and consider the home setting and cultural context. Client input is encouraged and emphasized;
- Anticipate clients needs and confirm this with the client and family;
- Make adjustments to care plans as needed, as goals are reached, and annually on long term clients;
- Include discharge planning in care plans when appropriate;

- Establish a working relationship with the multi-disciplinary team (Registered Nurses, physician, physiotherapist, occupational therapist, speech language pathologist, mental health and addictions counsellorss, dietitian, diabetes nurse educator, orthoptist, podiatrist, wound care specialist, social workers, acute care and community health nurses) and other care providers and agencies involved in client care;
- Review care practices and incorporate current evidence-based clinical practices based on new research;
- Evaluate the overall care plan to ensure outcomes are being met on a continuous basis;
- Utilize and edit a computerized care plan when appropriate.

4. Implement the care plan following established policies, procedures and practices of the organization, and the established standards of a licensed practical nurse in order to ensure the provision of safe and professional service.

- Apply the nursing process of assessment, planning, implementation and evaluation when developing the care plan, providing direct client care and implementing disease prevention strategies;
- Assist the client in ensuring they have prescribed medication when indicated, and treatment supplies and equipment as necessary;
- Make appropriate, independent decisions in unanticipated unstable situations;
- Delegate appropriate treatment activities to family, support staff and volunteers;
- Encourage and support clients, and their families, in their efforts to be responsible for promoting, maintaining and enhancing their health;
- Assist when necessary with client's personal care;
- Foster a positive working relationship with clients and their families, other services providers and community agencies;
- Advocate on behalf of clients. This involves assisting clients to obtain services, resources and fair processes, or lobbying for the development of services and programs to address unmet client needs.

5. Document care by providing a written plan of care to aid communication and to meet legal requirements.

- Obtain a client consent/contract;
- Maintain a chart for each client, following the CCAP (community care assessment plan) format, which includes a statement of the client's needs, the type and frequency of the service to be provided, the goals of the plan, the date the service will commence, referrals to be made to other programs or community resources, any appropriate traditional knowledge and the role and responsibility of the client and the family, and day programming, palliative care, acute care, rehabilitation, respite care or other community based services as appropriate;
- Record each visit and any observations;
- Maintain a central filing system for home care clients;
- Record daily the number of visits, the time spent with the client, and type of service provided in order to provide statistical data for the department;
- Document on MediPatient and EMR as indicated;
- Handle all information as confidential.

6. Collaborate as a member of the multi-disciplinary team in order that services are neither duplicated nor missed and that information can be shared for the benefit of the client and family.

- Frequently makes decisions about the most appropriate, effective and efficient mode of communication among interdisciplinary team members;
- Initiate and participate in case conferences to share pertinent information concerning client concerns or progress;
- Enable client and family to have an understanding of how caregivers work together with them to reach goals set;
- Educate team members as to the services and role of the various caregivers involved in the care of the client;
- Participate in discharge planning with team members.

7. Contribute to own professional development and the development of the Home Care program in order that the highest standards are reached and that the program continues to offer services that are both cost efficient and effective.

- Further own education and personal development by: attending in-services, conducting self directed studies, pursuing professional development activities and reviewing current literature;
- Prepare and deliver health education material to other health care professionals, community groups, or the public;
- Participate in program needs assessments, and the gathering and recording of statistical data relevant to program operations;
- Participate in the Diabetes focus groups to provide education on foot health;
- Assist with orientation, support and guidance of new HRHSSA employees and volunteers in the area of Foot Care and Home Care Nursing;
- Participate in Continuous Quality Improvement activities such as chart audits, client satisfaction surveys, and accreditation;
- Attend and participate in staff meetings and multi-disciplinary team meetings to exchange information;
- Maintain membership or liaison with Nursing organizations, social, health and other groups.

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 shares 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 that each and every client is seen as a unique individual.
- 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:

- Knowledge of current Nursing Theory and foot care/home care practices and regulations, including standards and procedures of the HRHSSA, NWT Coordinated Home Care standard and Procedure Manual, Canadian Immunization Standards, and VON Foot Care Guidelines.
  - Knowledge of the effects of chronic disease, the treatment, complications and indications in medical care, especially as it pertains to foot care.
- Ability to perform venipuncture within the clients' homes
- Knowledge and skills to assess ankle brachial index (ABI), toe brachial pressure index (TBPI), dremmeling, offloading pressure ulcers, and care and maintenance of complex wounds
- Computer literacy skills are required. Good working knowledge of schedulers, electronic information system, word processing, and excel
- Ability to review and understand practitioner notes and diagnostic reports
- Ability to provide training and perform assessment using specialist equipment tools and techniques
- Sensitive to geographical and cultural needs of the regions and understand how community and culture impact the delivery of health care services.
- Knowledge of and an ability to apply Licensed Practical Nursing processes (assessment, planning, implementation, and evaluation).
- Ability to perform basic and advanced foot care skills, as well as ability to react appropriately in an emergency situation.
- Must possess current Basic Cardiac Life Support with annual re-certification.
- An ability to be self directed, meet deadlines, prioritize own workload and manage several tasks at once.
- An ability to communicate effectively orally and in writing.
- An ability to perform pharmacy skills such as dispensing of medications under approved polices.
- Ability to provide ongoing assessments and education/teaching to clients in the Advanced Foot Care Program

- Knowledge and ability to provide and support clients and family members with end of life care, as well as ongoing support through bereavement.
- Ability to teach and communicate effectively with clients and colleagues in order to understand and respond to client needs, and promote the program delivery services to clients, family and the community.
- Must possess a current Class 5 driver's license in order to provide home visits to clients.
- ○ Active registration with the NWT LPN Registrar, Dept. of Health & Social Services GNWT.
- Must be able to acquire within a reasonable time frame and remain current with the Non-Violent Crisis Intervention certification.

This level of knowledge is commonly acquired through the successful completion of a Licensed Practical Nursing Certificate, Advanced Footcare course and two years of recent LPN experience in a medical, surgical, Home Care or Community Health environment.

WORKING CONDITIONS

Physical Demands

There are many physical demands required by the incumbent such as: daily carrying heavy, bulky supplies and containers when traveling in and out of buildings and to client's homes**,** bending**,** kneeling frequently during provision of care, frequent repetitive motions (e.g. filing client's nails), transferring, lifting and positioning of clients often in settings where ideal body mechanics and lifting techniques cannot be used. The incumbent is on a daily basis exposed to temperature extremes in the work environment. Prolonged sitting at a computer/desk and keyboard and repetitive hand and arm movements may result in neck, back, shoulder, wrist, or hand strain. These activities are done daily in moderate intensity and may occur throughout the day.

Environmental Demands:

The incumbent works in a health setting and is therefore exposed daily to communicable diseases, biohazardous waste, body fluids and hazardous supplies such as contaminated sharps. Travel in adverse weather conditions may be required to make their home visits. The incumbent may be exposed to dog bites, falls, car accidents and verbal and physical assaults when performing the home visit. May be exposed to allergens (i.e.; cigarette smoke, cat/dog hair, dust) during the home visits. These environmental demands occur daily, in moderate intensity and in variable durations throughout the day.

Sensory Demands

The incumbent operates various pieces of equipment: thermometer, BP monitors needles and syringes, otoscope, ophthalmoscope, hemoglobinometer, pulmoaide nebulizer, oxygen concentrator, portable oxygen equipment, pulse oximeters and glucose monitoring equipment, and various foot care tools. With some of this equipment noise may be a factor. The senses of hearing, smelling, touching and focused listening are used when completing client assessments and evaluations. The frequency of these demands is daily with variable duration and moderate to high intensity.

Mental Demands

On a daily basis the incumbent may be required to care for clients that may be aggressive, intoxicated, potentially abusive and volatile. As well as clients that may be angry and difficult to work with when assistance may not be easily accessible. The nurse is required to enter an unfamiliar environment, such as a client's home, which may pose a threat to his/her safety. The incumbent is often exposed to clients with complex needs and emotionally disturbing experiences and histories of trauma**.** May be required to care for clients that are dying and provide support and assistance to their families. Providing palliative care is very mentally and emotionally demanding, the intensity is high and duration of care is variable depending on the client's and family's needs. The incumbent is expected to remain calm, controlled, and professional regardless of the situation and demonstrate care and compassion to the client, family and other members of the health team. On a regular basis, the nurse works alone in unpredictable conditions.

Daily the incumbent is required to be flexible and must reprioritize work duties depending on unpredictability and fluctuations of clinical situations in the home**.** Work demands such as entering data in the computer, charting, reviewing care plans, completing audits and work assessments may require long periods of intense concentration. The incumbent is often expected to provide health information to clients who have cognitive and mental impairments, poor reading and writing skills and language barriers. The difficulty in recruiting qualified staff leads to mental anguish, stress and fatigue as a result of the increased workload.

CERTIFICATION

Position Number: U-20-31

_____ 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.

_____ _____

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.

April 2011 reports to change
September 2012 – scope and position role in client safety added
December 2020 – logo, scope, commitment statement, editorial
June 2022 – update of scope of practice, knowledge and skills added, editorial