Clinical Nurse Job Description-Dual Role
Community Health and Home Care Nurse

Reporting to: The successful candidate reports directly to the Clinical Lead. This position is temporary part-time. The candidate will work 4 days per week, 7.5 hours per day, onsite at the Splatsin Health Centre. Hours will be between 8:30am – 4:30pm Monday to Friday, with a half hour unpaid lunch.

Position Summary: Working within the context of the client-centered, family focused vision and goals of the Splatsin Clinical Care Program the FNHA Home and Community Care Program/Community Health Program and in accordance with CRNBC Standards of Practice, the ideal candidate combines her/his health sciences knowledge with assessment, supervisory and clinical nursing skills to effectively assess and coordinate client care for the Home and Continuing Care/Community Health Programs.

Qualifications:
- Member in good standing of the College of Registered Nurses of British Columbia (CRNBC)
- Preferred qualifications Baccalaureate degree in nursing from a Canadian University or recognized equivalent
- Experience working in First Nation communities, particularly within the Home and Community Care/Community Health program
- Valid Class 5 Driver’s License and clean Driver’s Abstract.
- Successful Criminal Record Check

Knowledge, Skills, and Abilities:
- Knowledge and understanding of the history of First Nation communities in Canada and the current health and social issues
- Knowledge and understanding of the Indigenous social determinants of health
- Excellent written and interpersonal communication skills and the ability to work effectively with a variety of people and circumstances
- Ability to teach, facilitate learning and transform health programs
- Self-directed with demonstrated organizational skills
- Practice from a trauma-informed perspective at all times
- Actively engages in self-reflectivity and cultural safety at all times
- Ability to model, promote, and maintain professionalism and confidentiality

Responsibilities:
Home and Community Care
• Coordinates clinical care services in such a way to meet the needs of the clients while encouraging independence, family and community support

• Identifies community members requiring nursing care support

• Completes a structured home care client assessment that includes ongoing re-assessment and determines client need and service allocation

• Develops client centered care plans

• Implements the care plan to provide in-home personal care/home management/family care services in collaboration with the Home Support Worker

• Provides mentoring, direction, guidance, support and supervision to the Home Support Worker

• Provides in-home direct nursing care as required

• Adheres to infection-control guidelines

• Maintains client confidentiality and ensures that all records are stored securely

• Provides clients and family caregivers with health information as required through demonstrations and informal teaching sessions

• Participates in case management and family conferences as appropriate

• Maintains nursing skills through attendance at workshops, conferences, in-service and staff meeting, in addition to reading current literature and evidence-based principles

• Ensures that clients admitted to the Home and Community Care Program have access to medical supplies and equipment

• Maintains professional support and consultation to ensure the program is delivered in a safe effective manner

• Establishes internal and external linkages with other professionals and community resources

**Community Health Nursing Program**

• Identify needs and provide health services in homes, clinics, schools, and offices, to individuals or groups by:

• Providing treatment and arranging referral where necessary

• Preventing illness, e.g., immunization

• Teaching treatment procedures and care techniques to client and family
• Using epidemiological methods to trace and identify index case contacts and source of infection, e.g., Hepatitis, Tuberculosis, communicable diseases

• Providing support and follow up for compliance to treatment

• Maintaining report and record system

• Referring community members to appropriate agencies and/or physicians