

Job Posting

Position Title: Nurse Practitioner (NP) – GAIN Community

Employment Status: Permanent part-time

Position Status: This is a Bargaining Unit position. All terms and conditions of the collective bargaining agreement apply.

Job Posting Deadline for Internal Candidates: September 4, 2024, at 5:00pm

Salary Range: Annualized salary range \$60,559.50 - \$62,958.00, (prorated based on a 0.5FTE) commensurate on skills and experience, plus participation in HOOPP.

Hours of Work/Schedule: 17.5 hours a week

Position Reports to: Senior Manager, Integrated Care and Experience

Primary Location: Oshawa (with flexibility to transition to/work at other DCHC sites as required).

Organization

Durham Community Health Centre (DCHC) is a registered, charitable organization that provides integrated, accessible, and equitable community-based primary care, wellness services, and health education to Durham community members who face multiple barriers to their health and well-being.

DCHC also provides equity-based programs and services that focus on priority populations such as Indigenous, Black, the 2SLGBTQI Community, Newcomers to Canada, Seniors, and Unattached patients (i.e., those without a family doctor), to name a few. DCHC ensures Durham community members receive not only sick care, but preventive care as well.

At DCHC, we are a team-based interprofessional group of staff including physicians, nurse practitioners, nurses, counselors, dietitians, outreach workers, medical secretaries, and other administrative staff. We always place every client at the centre of our approach to care, based on their needs. We address these needs through integrated clinical and wellness care and health education.

It's an exciting time to be joining DCHC, while we are embarking on an energizing path with a focus on making our biggest impact yet on local health care by diversifying, expanding, and leveraging our Strategic Plan, Theory of Change, Brand, Client Stories and Resources.

DCHC's 2023 – 2026 Strategic Goals

- Drive Program and Service Integration and Client Experience Across All that DCHC Does
- Evolve Program Offerings to Improve Health Equity and Meet the Needs of DCHC's Priority Populations
- Establish DCHC as a System Advocate and Champion for Equity
- Enhance DCHC's Brand and Awareness Across Durham Region
- Become an Employer of Choice with a Focus on Recruitment, Retention, and Development

Position Overview

As part of the Chronic Disease Management, Clinical Services Team, this position is also a specific member of the GAIN Geriatric Community Team within the Agency, and part of the broader Geriatric Assessment Intervention Network. In this position, the Nurse Practitioner will be primarily responsible for clients referred to the GAIN Community Team. The client population will be elderly or frail clients who have been identified through direct referrals from the community-by-community family physicians or through indirect referrals such as through hospital Emergency department(s) in the Durham region. The Nurse Practitioner is responsible for conducting client assessments and providing direct support and expertise to GAIN clients, during community home visits and in-office clinical visits. The primary focus of this role will be to conduct community home visits.

Working as a collaborative member of the inter-professional team, the Nurse Practitioner (NP) functions in an expanded role demonstrating a high level of autonomy and expert skill to formulate clinical decisions and appropriately manage acute/chronic illness and wellness promotion for adults and seniors.

The Nurse Practitioner also provides clinical oversight of the team, in support of the manager's directives for the unit's service delivery objectives and regulatory management requirements. The NP leads the provision of comprehensive geriatric services in the GAIN (Geriatric Assessment and Intervention Network) Clinic, an exciting model of Geriatric Outpatient Care that employs inter-professional comprehensive geriatric assessment in the management of frail seniors. The NP provides direct patient care focusing on health promotion, maximizing patient safety and function to support frail seniors living at home. *This position is ideal for a Nurse Practitioner with a passion for geriatric care.* Hours will require flexibility and will include evening work and may include weekend work. The successful candidate will be required to provide proof of liability coverage.

Key Responsibilities:

Clinical Practice:

- Utilizes and demonstrates a comprehensive theoretical knowledge base and advanced level of clinical competence in caring for acute medical and continuing care clients. This involves collecting and interpreting data about the health of the client to determine a medical diagnosis and treat complex problems. The role involves being responsible for the care of the client with the support of collaborating physicians.
- Provides comprehensive geriatric assessments of clients. Assessment activities, include conducting client interviews and comprehensive physical examinations; assessing psychosocial, cultural, and ethnic factors affecting client needs; identifying and ordering required diagnostic tests and procedures, within scope of practice and medical directives/protocols and practice guidelines; collecting and reviewing comprehensive client health data. Additional elements from a comprehensive geriatric assessment may compliment assessments in a standardized format.
- Provides direct patient care focusing on health promotion and maximizing clients' safety and function to support frail seniors living at home.

- Develops and implements goals and treatment intervention for complex case situations or specialized problems to inform integrative care plan with GAIN Community Team.
- Implements the comprehensive plan of care in conjunction with the client that includes prescribing medications and changing dosages, ordering interventions, treatments, and procedures within the scope of NP practice and medical directives; directs the delivery of client care as per the care plan; plays a coordinating role by liaising with other services and team members, as required to coordinate the interdisciplinary plan of care and facilitate the efficient movement of the client through the healthcare system; facilitates communicating the plan of care to the client/family and members of the healthcare team.
- Monitors clients' goals and outcomes and initiates the planning process.
- Participates in case presentation, discussion, and review in a team format.
- Provides outreach assessment/case management services in one or more areas within the program catchment area.
- Prepares comprehensive reports to referral parties on the client and maintains documentation of the mental health chart until the client is discharged. Documentation for case management cases will necessarily include client goals and outcomes.

Administration:

- Initiates and participates in program planning activities within the GAIN team and under the direction of the manager.
- Participates in formal and informal program evaluation to monitor client needs and requests, as a basis for ongoing program planning.
- Participates in team consultation with colleagues as required.
- Liaises with relevant healthcare/hospital services/programs and with the community as a consultant/resource.
- Ensures consistency of program development with the Agency's Mission, Vision and Values.
- Responsible for professional development relevant to the delivery of NP services.
- Maintains statistical records related to practice. This includes recording workload statistics in accordance with program policies and as outlined in established workload measurement protocols.
- Maintains flex time to accommodate department needs.
- Participates in committees.

Other duties within scope of duties include:

Consult/Knowledge Transfer/Support

- Assists, as assigned, in the orientation and training of new GAIN staff.
- Designs and participates in the organization and implementation of strategies to teach staff from other disciplines on the GAIN Community team, about functional assessments.
- Collaborates with other GAIN colleagues in establishing goals and its delivery.
- Maintains a knowledge and information level conducive to competent functioning in areas of assignment. Methods may include personal study, journal clubs, attendance at conference/seminars or formal course work, etc.

- Consults regularly with team members (internal and external) concerning relevant psychosocial management of clients.
- Provides advice and information to relevant team members / partners as it relates to identification, treatment and evaluation of frail elderly client concerns.
- Consults regularly with local agencies or community resources concerning resource development and program planning which is pertinent to GAIN clients and/or the frail, elderly population.

Key Qualifications

- Baccalaureate in nursing or equivalent from an accredited university (Master's degree in nursing preferred) RN with Extended Class required.
- Nurse Practitioner certification through an accredited institution.
- Current Certificate of Competence with the College of Nurses of Ontario. Geriatric training and certification such as P.I.E.C.E.S., Montessori and G.P.A. assets.
- Familiarity with Comprehensive Geriatric Assessment and related tools
- Minimum 3-5 years related clinical and/or management experience, preferably in a community health care setting or combination of community and hospital or public health settings considered an asset.
- Skills/experience to fulfill major functions of the role including wellness care, assessment, and diagnosis.
- Proven ability to coordinate care collaboratively with other interdisciplinary team members as well as to effectively function independently with clients.
- Demonstrated ability to relate therapeutically with clients. Includes strong negotiation and conflict resolution skills.
- Facilitation skills for education and promotion of health programs.
- Demonstrated leadership in the advancement of clinical practice and the achievement of program goals.
- Demonstrated use of theory and research/evidence based outcomes in practice.
- Must have valid driver's license.

Full vaccination against COVID-19 is mandatory for this position (Durham CHC will however adhere to its duty to accommodate those who are unable to be fully vaccinated for a reason related to a human right protected ground).

Application Process:

1. If you are interested in being considered for this position, please submit a cover letter and resume outlining your qualifications and expectations by email to recruiting@durhamchc.ca. This position will remain posted until filled.

2. While we thank all applicants for their interest in applying, only those qualified and considered for an interview will be contacted. All applicant submissions will be kept on file for six months, for future consideration.
3. All applicants are encouraged to provide a valid email address for communication purposes. Applicants may receive written correspondence regarding this job posting directly to the email address provided on their resume. As an applicant, it is your responsibility to ensure that you check your email regularly.
4. All positions are subject to the successful completion of the following pre-employment conditions for all external hires: Reference Checks; and Criminal Background checks (including Vulnerable Sector Screening).

Durham Community Health Centre is committed to complying with all applicable standards as set out in the Accessibility for Ontarians with Disabilities Act, 2005 (AODA), the provisions of the Ontario Human Rights Code, and any other applicable legislation. Accessibility: If you have accessibility needs and require alternate formats or other accommodations, please contact Human Resources at 905-723-0036, or by email to recruiting@durhamchc.ca. **Durham Community Health Centre, and staff are dedicated to creating an inclusive environment that welcomes diversity.**

