CommunityCare
NORTHUMBERLAND

Job Posting

Hospice Clinical Navigator - Community Team
Full Time (35 hours/week)
Internal and External

The Navigator will be responsible for coordinating and navigating both clinical and supportive care for clients with a life limiting illness and their families. The Navigator both supports and provides a continuum of care approach from the diagnosis of a life-threatening illness through bereavement. The Navigator collaborates with primary care providers and other community services in the implementation of shared-care plans through the provision of assessment, referral and access to palliative care, grief/bereavement and supportive care services.

Key Accountabilities:

Clinical

1. Provides client-centred care; ensuring shared care team is aware of need for and meaning of a client-centred approach
2. Promotes a continuum of care model through community setting and through a setting of the client's choice (home, hospital or hospice)
3. Provides leadership and influences clinical standard-setting, quality improvement and change management, facilitating the development and implementation of care pathways
4. Performs formal, standardized holistic clinical assessment and intervention, assessing client and family needs in assigned jurisdictions
5. Connects and coordinates care and service for clients and families, providing information, support and guidance in decision-making
6. Works with client, family, hospital and community providers to facilitate transitions of care and service supports across multiple settings of care (i.e. hospice, hospital, retirement home)
7. Advocates for clients and families and intervenes within scope of practice on client and family's behalf

Administrative

1. Documents, tracks and prioritizes care requests to ensure all clients/families receive timely response, including follow-up calls to clients/families to ensure care needs are being and have been met
2. Completes regular and timely documentation and statistical records
3. Manages client files, ensuring information is up-to-date at all times
4. Assists with and attends community palliative rounds meetings
5. Notifies team members and updates files when situations change including the death of a client to ensure bereavement services are in place
6. Adheres to all statistical collection and reporting system requirements of the organization and funders

Liaison Role

1. Collaborates with hospital Clinical Resource Nurse, inpatient hospital units, and LHIN Care Coordinators/NP to develop a plan of care for transitioning clients with an advance life threatening illness into community palliative care
2. Collaborates and communicates through formal and informal case conferencing with health providers and the shared care team to determine appropriate strategies to achieve client focused outcomes
3. Assists in the coordination, prioritization and navigation of all incoming calls to internal and external community resources, including sharing information, scheduling initial home visits, providing guidance/direction to community resources, ensuring team members are up-to-date on client and family care at all times
4. Liaise with LHINS, community agencies, clinics, pharmacies and family physicians with regards to reports and service requests
5. Provides for a culture of sharing, openness, education and mentoring to other team members and non-palliative trained professionals, students and volunteers
6. Facilitates an environment and attitude where values and beliefs regarding shared care coordination are clearly articulated
7. Works with partners in the need identification and delivery of palliative care education

Key Qualifications:

1. Registered Nurse in good standing with College of Nurses Ontario with proof of Professional Liability Protection.
2. Completed palliative education. For example, CNA certification in Hospice Palliative Care, CAPCE, Fundamentals of Palliative Care, LEAP or equivalent educational courses in another jurisdiction
3. Demonstrated progressive experience in hospice palliative care
4. Progressive experience working in a community nursing environment
5. Experience in a leadership, administration, and care coordination role
6. Demonstrates respectful, courteous, caring attitude in all interactions
7. Solid experience in care planning and communicating with multiple providers
8. Prove history of working well within an interdisciplinary team Exceptional critical thinking and problem solving skills
9. Proven leadership abilities with effective verbal, non-verbal and oral communication skills
10. Administrative skills with computer proficiency and accuracy for all documentation and record keeping, and attention to detail
11. Valid driver's license and ability to travel throughout Northumberland County for home visits and meetings
12. Adheres to all standards, practices, policies and procedures regarding privacy and confidentiality of information, and ethical practices as set forth by employer, regulating College and HPCO
13. Other skills include conflict management and problem solving skills where issues may be sensitive

Interested candidates should submit their resume to careers@commcare.ca by 4:00 pm Thursday, September 15, 2022.

Please indicate Hospice Clinical Navigator in the subject line.

Community Care Northumberland *is a non-profit, multi-service, volunteer-based community support organization serving residents of Northumberland County.*
www.commcare.ca

Ed's House Northumberland Hospice Care Centre acts as a centralized 'hub' for CCN's interdisciplinary hospice services team by providing caregiver support, palliative outreach and education, health system navigation and grief and bereavement support in addition to resident hospice care.
www.northumberlandhospice.ca

In accordance with the Accessibility for Ontarians with Disabilities Act (AODA), CCN will provide accommodation in all parts of the hiring process as required, upon request from applicants.