



Puuk^winkpanač
Walking in Togetherness

Job Description

Diabetes Nurse Lead

POSITION	Diabetes Nurse Leader	FTE	Full-time, 1.0 FTE (37.5 hrs/wk)
CLINIC SITES	Hesquiaht, Ahousaht, Tla-o-qui-aht, Toquaht, and Ucluelet	HOURLY RATE	

ORGANIZATION SUMMARY

The Vancouver Island West Coast Primary Care Initiative Health Society (“**WCPCI**”) is a non-profit organization located on the west coast of Vancouver Island, offering culturally safe and community-centred primary health care services that address the health and social needs of Indigenous, Metis and Inuit people residing in the Central Region Nuu-chah-nulth Communities.

ʔuuk^winkpanač means “*Walking in Togetherness*” in the Nuu-chah-nulth language. We prioritize a holistic approach to healthcare that honors the traditional wellness of the Nuu-chah-nulth communities in the central region. We shake hands with both Western and traditional medicines in health and wellness services.

WORK LOCATION

The WCPCI’s registered office is located at 700 Wya Road, hitac’u, BC, with a satellite office located at #36 – 1971 Harbour Drive, Ucluelet, BC. The team works remotely from home offices and mobile care team members travel to the communities of ʕaaḥuusʔath (Ahousaht), λaʔuuk^{wi}ʔath (Tla-o-qui-aht), ḥiškwiiʔath (Hesquiaht), tʔuk^waaʔath (Toquaht), and Yuuṭuʔitʔath (Ucluelet) to work in the primary health care centres and within the communities, as applicable.

POSITION SUMMARY

The Diabetes Nurse Leader is a key member of the healthcare team, providing expert clinical care, education, and leadership in diabetes management. This role integrates direct person-centered care, program development, healthcare provider training, and advocacy for culturally safe, person-centered services. The Diabetes Nurse Leader also plays a crucial role in guiding and mentoring healthcare professionals while advancing equitable access to quality diabetes care.



PRINCIPAL DUTIES AND RESPONSIBILITIES

1. Leadership and Mentorship

- Leads and mentors' healthcare providers in best practices for diabetes care.
- Develops and delivers diabetes education and care with a strengths-based approach.
- Provides clinical consultation and guidance on complex diabetes cases.
- Supports policy development and protocol implementation for diabetes management.
- Engages in quality improvement initiatives to enhance care delivery.
- Represents the organization in professional networks, advocacy efforts, and community partnerships.
- Participates in committees, research, and policy advocacy for diabetes care improvements.

2. Diabetes Program Development and Community Support

- Develops, implements, and evaluates culturally appropriate diabetes programs.
- Leads community assessments to identify and address diabetes-related health concerns.
- Promotes community-led diabetes initiatives and supports capacity-building efforts.
- Ensures alignment with Diabetes Canada Clinical Practice Guidelines and supports data collection tools for program evaluation and quality improvement.

3. Direct Person Diabetes Education, Care and Support

- Educates individuals and communities about diabetes prevention, early detection, self-management, and living well with diabetes.
- Applies evidence-based strategies to support self-care and living well with diabetes.
- Advocates for equitable access to resources, healthcare and services.
- Uses point-of-care testing (e.g., A1C and ACR analyzers) to monitor diabetes management.
- Supports diabetes self-management, including medication management, treatments, and glucose monitoring systems.
- Conducts wholistic assessments, including health and medication history, physical exams, and psychosocial screenings.
- Provides culturally safe, trauma-informed care that respects individuals' values, beliefs, and lived experiences.



- Monitors, assesses, and documents health status, ordering and interpreting diagnostic tests, coordinating follow-ups with healthcare providers, as needed.
- Coordinates foot and wound care, ensuring appropriate interventions and referrals.
- Collaborates with individuals, families, and healthcare teams to develop and implement care plans.

Ensures accurate documentation and communication to support continuity of care.

4. Teamwork and Collaboration

- Receives and shares information, opinions, concerns, and feedback in a positive and constructive manner.
- Works collaboratively to build rapport and create supportive relationships with team members across the organization and within the region, as applicable.
- Develops a supportive rapport with individuals and their families to facilitate person-centered care.
- Determines the most appropriate, effective, and efficient mode of communication among interdisciplinary team members in alignment with organizational policies and procedures.
- Coordinates and participates in formal and informal case conferences to enhance care planning and service integration.
- Contributes to a strengths-based team environment and actively supports colleagues.
- Collaborates proactively with all integrated and interdisciplinary team members using a person-centered approach to optimize healthcare outcomes.
- Communicates effectively with other members of the healthcare team to ensure continuity of care and promote collaborative, high-quality services.
- Collaborates across organisations to coordinate care and development of service delivery including but not limited to Uut ustuk yuu (Traditional Wellness), Island Health, Nuu-chah-nulth Tribal Council and First Nations Health Authority
- Collaborates with the inter-disciplinary health team, Traditional Healers, elders, families, and community resources as needed to support client identified goals, as appropriate.
- Collaborates with First Nation health leaders to identify and address gaps, barriers and challenges of service delivery and offer solutions.



5. Professional Development and Cultural Safety

- Champions cultural safety and humility in all aspects of care.
- Works to infuse Cultural ceremony, tradition and customs into and around related duties where appropriate and as needed.
- Maintains competency through ongoing education, training, and best practice updates.
- Adheres to organizational principles and values in service delivery.
- Performs other related duties as assigned.

JOB SPECIFICATIONS

Education

- Bachelor's Degree in Nursing

Regulatory Registration

Current Practicing Registration with British Columbia College of Nurses and Midwives

Occupational Certification

- Current license or eligibility for licensure with British Columbia College of Nurses and Midwives (BCCNM)
- Certification as a Certified Diabetes Educator (CDE) by the Canadian Diabetes Educator Certification Board is an asset

Experience

- Minimum of three (3) years of experience as a registered nurse providing clinical practice support in primary care or community and/or public health or acute care, ambulatory care and/or outpatient centers
- Experience working with people with diabetes is an asset
- Experience working with Indigenous people and communities is an asset



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Knowledge and Skills

- Knowledge of First Nations cultural principles and protocols, with the ability to apply them in professional settings.
 - Knowledge of First Nations cultures and backgrounds, including how cultural factors influence communication, attitudes, and approaches to health.
 - Knowledge of the Social Determinants of Health and their effects on the health status of First Nations populations.
 - Knowledge of diabetes, including its biological, social, and medical aspects.
 - Knowledge of primary care, community, and public health models and concepts.
 - Knowledge of the roles and scopes of practice of other healthcare discipline.
 - Ability to provide nursing leadership, services and care, in alignment with the FNHA Regional Diabetes Strategy, to the Nuuchahnulth cultural family, including its citizens and communities.
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HOW TO APPLY

Please send a cover letter and resume to the attention of Suzanne Williams, Director of Operations at suzanne.williams@westcoastpci.ca.

CLOSING DATE

This position will remain posted until filled.