Section 6: Communications

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS **Community Health Nursing**		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Confidentiality		Communications	06-001-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		4
APPLIES TO:			
Community Health Nurses			

POLICY:

Client information shall be collected, accessed or disclosed only by authorized individuals in accordance with relevant policies, procedures and legislation. Personal, family and community information obtained in the context of a professional relationship is considered confidential and shall be respected, communicated and maintained in a manner that safeguards privacy.

Personal employee information shall not be released externally or internally without approval from the employee unless authorized by a collective agreement, legislation, or a Government of Nunavut Human Resources policy.

Immediate supervisors shall educate all new employees on methods of safeguarding information and necessary authorizations for the collection, use and disclosure of personal or health information. All employees will be required to sign an *Oath of Office and Secrecy* (See HR Manual) form.

PRINCIPLES:

Every individual has a basic need for privacy and a legal right to have control over the collection, use, access and disclosure of their personal information.

When health services are required, access to confidential information in the workplace occurs intentionally on a "need to know" basis among members of the health care team. Breaches of confidentiality occur when personal information is accessed without a "need to know" or disclosed without proper authorization.

Health centre staff will not abuse their access to information by accessing health records, including their own, a family member's or any other person's, for purposes inconsistent with their professional obligations.

Potential exists in all health facility premises for inadvertent breaches of confidentiality due to physical layout and space constraints. Staff must exercise care at all times to avoid a breach of confidentiality.

Any questions about the release of information should be referred to the immediate supervisor. The Access to Information and Protection of Privacy (ATIPP) Coordinator for the Department of Health and Social Services may be consulted as required.

Proper keeping and handling of health records shall be in accordance with Nunavut's *Access to Information and Protection of Privacy Act*. (S.N.W.T. 1994, c. 20, enacted for Nunavut).

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Guideline 06-001-01 Confidentiality Guidelines

Canadian Nurses Association (2008) *Code of Ethics for Registered Nurses.* Ottawa, ON.

Nunavut Human Resource Manual *Oath of Office and Secrecy.*

REFERENCES:

Canadian Nurses Association (2008) *Code of Ethics for Registered Nurses.* Ottawa: On

Canadian Nurses Association (2001). Privacy of Personal Health Information Position Statement. Ottawa, ON.

Government of Nunavut (n.d.) *Human Resource Manual*: *Oath of Office and Secrecy.*

Nunavut Access to Information and Protection of Privacy Act S.N.W.T. 1994, c.20, enacted for Nunavut pursuant to the Nunavut Act, S.C. 1993, c.28.

Nunavut Nursing Act (S.Nu. 2003, c.17).

GUIDELINES 06-001-01

Much of the information health centre staff comes in contact with daily is considered confidential and may be generated from the health record, the computer system, reports, hospital correspondence, conversations, and normal daily operations.

Registered nurses collect, use and disclose health information on a need-to-know basis with the highest degree of anonymity possible and in accordance with privacy laws.

When the registered nurse is required to disclose information for a particular purpose, he/she is only to disclose the amount of information necessary for that purpose and to inform only those necessary. Under no circumstances may the aforementioned resources be accessed for personal or non-work related activities.

Suggestions for ensuring privacy and confidentiality is maintained include, but not limited to:

Verbal Communications

Client information should not be discussed where others can overhear the conversation, e.g. in hallways, on elevators, in the employee lounge, on any form of public transportation, and social events.

The Registered Nurse will ensure discussions of clinical cases are respectful and does not identify those persons receiving care unless appropriate.

Dictation of client information should occur in locations where others cannot overhear.

Written Information

Confidential papers, reports and computer printouts should be kept in secure areas and shall never be left overnight in an unlocked clinic room.

Client's health records to be closed when not in use or when the practitioner needs to leave the examination room.

Confidential papers should be picked up as soon as possible from copiers, mailboxes, conference room tables and other publicly accessible locations.

Confidential papers should be appropriately disposed of, e.g. shredded or deposited into the designated recycling and confidential containers.

Fax machines are the least controllable technology when one transmits client information. Please refer to Policy 06-002-00 Transmission of Health Information by Facsimile.

Computerized Information

Protecting your computer access is important to maintain privacy, confidentiality and your accountability for access to our systems. Please refer to Department of Community and Government Services *Acceptable Email & Internet Usage Policy*

Employee Conduct

Staff members with access to information about clients, employees, or business matters may only obtain information that is necessary for their job functions. Regardless of the format in which this information is obtained, i.e. verbal, written, or electronic, it must be treated with the same level of confidentiality.

Policy 06-002-00 Transmission of Health Information by Facsimile
Guideline 06-002-01 Guidelines for Transmitting Information by Facsimile
Canadian Nurses Association (2008) *Code of Ethics for Registered Nurses.* Ottawa: On

Department of Community and Government Services *Acceptable Email & Internet Usage Policy*

Government of Nunavut Human Resource Manual *Oath of Office and Secrecy.*

Approved by:	Effective Date:
11 FEB 2011 **Chief Nursing Officer** **Date**	April 1, 2011
February 11, 2011 **Deputy Minister of Health and Social Services** **Date**	

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS
	Community Health Nursing

TITLE:		**SECTION:**	**POLICY NUMBER:**
Transmission of Health Information by Facsimile		Communications	06-002-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		2
APPLIES TO:			
Community Health Nurses			

POLICY:

Health information shall be transmitted by FAX only when required for urgent or emergent care. The sender of the information shall be responsible for ensuring security of the health information being transmitted.

DEFINITIONS:

Health Information: any identifiable individual's healthcare services related data.

Staff: includes all employees, physicians, volunteers, students, researchers and contractors.

PRINCIPLES:

Fax machines present the opportunity for rapid transmission of both written and graphic information which can facilitate health care in urgent or emergent situations. However, the mode of transmission also makes this information vulnerable to interception by non-authorized individuals, posing risk to the client's right to privacy.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Guideline 06-002-01 Guidelines for Transmitting Information by Facsimile

GUIDELINES 06-002-01

1. The FAX machine shall be located in a secure area where it can be monitored and used by authorized persons only. Machine security features should be utilized; such as activity confirmation reports, key locks, and confidential mail boxes.

2. Use discrimination in determining the selection and number of documents to be transmitted. In most cases it is not necessary to transmit the entire health record. Only information which is immediately necessary for the continuity of client care shall be transmitted.

3. The sender of the information shall be responsible for ensuring security of the health information being transmitted.

4. Senders must take utmost care to assure the accuracy of FAX numbers dialed. Use automatic dialing features for frequently dialed numbers to eliminate the possibility of incorrect dialing. Use visual check on the FAX machine to assure that the correct number was dialed.

5. The sender shall transmit a covering letter to accompany the health information. The letter shall contain the following:
   a) Name, address and phone number of the sender
   b) Name, address and fax number of the receiving party
   c) Number of pages transmitted
   d) Notice that the accompanying information is confidential.

6. The sender shall seek confirmation of receipt of the transmission.

7. Photocopying of transmitted documents received may be required if they are to be included in the clients' permanent health record. Some FAX machines do not use bond paper; therefore, transmitted documents are not suitable for long term storage.

8. An authorization for release of information transmitted by FAX shall be acceptable, provided the original authorization is forwarded by mail and that the authorization meets all criteria for validity.

Approved by:	Effective Date:
11 FEB 2011 **Chief Nursing Officer** **Date**	April 1, 2011
February 11, 2011 **Deputy Minister of Health and Social Services** **Date**	

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS
	Community Health Nursing

TITLE:		SECTION:	POLICY NUMBER:
Release of Information		Communications	06-003-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		3

APPLIES TO:
Community Health Nurses

POLICY

Client information collected and used by the health centre for client care, epidemiological studies, research, education and quality assurance will be released in accordance with the law and in the best interests of the client, health centre and other health care professionals.

All health centre staff, students and volunteers must adhere to the following guidelines regarding release of health information. Failure to comply is considered to be a breach of confidentiality.

DEFINITIONS:

Client Information is information in all media (paper, film, electronic, etc.) about an identifiable person that relates to their previous, current and future health and which is generated during the course of providing health services.

De-Identified Client Information is information that is in statistical format only, without any identifying client information.

PRINCIPLES:

Every individual has a basic need for privacy and a legal right to have control over the collection, use, access and disclosure of their personal information.

When health services are required, access to confidential information in the workplace occurs intentionally on a "need to know" basis among members of the health care team. Breaches of confidentiality occur when personal information is accessed without a "need to know" or disclosed without proper authorization.

Any questions about the release of information should be referred to the immediate supervisor. The Access to Information and Protection of Privacy (ATIPP) Coordinator for the Department of Health and Social Services may be consulted as required.

Proper keeping and handling of health records shall be in accordance with Nunavut's *Access to Information and Protection of Privacy Act*. (S.N.W.T. 1994, c. 20, enacted for Nunavut).

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 06-001-00	Confidentiality
Guidelines 06-001-01	Confidentiality
Policy 06-002-00	Transmission of Health Information by Facsimile
Guidelines 06-002-01	Transmission of Health Information by Facsimile
Guidelines 06-003-01	Guidelines for the Release of Information
Policy 06-004-00	Intra-Departmental Release of Information
Policy 06-005-00	RCMP Investigations

GUIDELINES 06-003-01

INTERNAL RELEASE OF HEALTH INFORMATION

All staff of the Department of Health and Social Services and volunteers shall maintain complete confidentiality by recognizing that all information about a client in any form, is confidential and to be safeguarded.

Access to client information extends to all health-related information that health centre staff and volunteers learn through the duties of their employment. They shall only share client information with other internal authorized staff which is considered essential for care, epidemiological studies, research, education and continuous quality improvement. They will also ensure that the sharing of information is in the best interest of the client and that the recipient is qualified in every respect to receive the information.

Client Information may be released internally between health centres for the purpose of continued client care and in accordance with Policy 06-004-00 Intra-Departmental Release of Information.

EXTERNAL RELEASE OF CLIENT INFORMATION

Client information will only be released when a valid consent form is received. However, in some circumstances, information may be externally released without a signed consent:

- Requests from Territorial / Provincial hospital insurance agencies (e.g. T.H.I.S., O.H.I.P)
- Requests from Workers Safety and Compensation Commission (WSCC) for information related to WSCC claims
- Requests from a Coroner or from a Court of Law

When client consent is required, a Department of Health and Social Services' Release of Information Form must be used for the purpose of documentation and appropriately signed by the client or substitute decision maker.

A client consent form is considered valid when it includes the following: Name and Address of the client; Name and Address of the recipient; Description of information to be released; Signature of client or Substitute Decision Maker and; Date of Request.

Client information may never be released in it's original form. It must be duplicated. Original radiology films may be released for client care purposes only, otherwise they must be duplicated.
Note: On presentation of a search warrant or at the request of a coroner, it may be demanded that original documentation be provided, in which case the health centre must comply.

Client Information may be released via fax, and in accordance with Policy 06-002-00 Transmission of Health Information by Facsimile.

A permanent record of the release of client information must be kept, including name and address of requestor, information released, and date released. The record may be stored as part of the permanent client health record.

RELEASE OF INFORMATION TO THE RCMP

Client information may be released to the RCMP according to Policy 06-005-00

RELEASE OF INFORMATION FOR EXTERNAL DATABASE REPORTING

Aggregate client information may be released for external database reporting without prior consent of the client when the client information is de-identified.

Only external database systems approved by the Department of Health and Social Services will receive de-identified client information.

Approved by:	Effective Date:
11 FEB 2011 **Chief Nursing Officer** **Date**	April 1, 2011
February 11, 2011 **Deputy Minister of Health and Social Services** **Date**	

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS **Community Health Nursing**		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Intra-Departmental Release of Information		Communications	06-004-00
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February 10, 2018	February 2021		2
APPLIES TO:			
Community Health Nurses			

POLICY:

For the purposes of immediate and direct client care, client information may be transferred from one health centre to another via facsimile or internal mail without signed authorisation from the client.

PRINCIPLES:

Every individual has a basic need for privacy and a legal right to have control over the collection, use, access and disclosure of their personal information.

When health services are required, access to confidential information in the workplace occurs intentionally on a "need to know" basis among members of the health care team. Breaches of confidentiality occur when personal information is accessed without a "need to know" or disclosed without proper authorization.

Any questions about the release of information should be referred to the immediate supervisor. The Access to Information and Protection of Privacy (ATIPP) Coordinator for the Department of Health and Social Services may be consulted as required.

Proper keeping and handling of health records shall be in accordance with Nunavut's *Access to Information and Protection of Privacy Act*. (S.N.W.T. 1994, c. 20, enacted for Nunavut).

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 06-001-00	Confidentiality
Guidelines 06-001-01	Confidentiality
Policy 06-002-00	Transmission of Health Information by Facsimile
Guidelines 06-002-01	Transmission of Health Information by Facsimile
Policy 06-003-00	Release of Information
Guidelines 06-003-01	Guidelines for the Release of Information
Guidelines 06-004-01	Intra-Departmental Guidelines for the Release of Information

GUIDELINES 06-004-01

The following guidelines will apply:

- Those releasing client information have the authority to do so.
- The intended release is in the best interest of the client.
- The recipient is qualified in every respect to receive the information.
- The recipient can and will manage the information with the same degree of protection and security.

If a request for disclosure of client information from an internal source seems unusual, it must be directed to the Supervisor of Health Programs or the ATIPP Coordinator for Health and Social Services.

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February 11, 2011 **Deputy Minister of Health and Social Services** **Date**	

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS
	Community Health Nursing

TITLE:		**SECTION:**	**POLICY NUMBER:**
RCMP Investigations		Communications	06-005-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		3
APPLIES TO:			
Community Health Nurses			

POLICY:

Department of Health and Social Services` (HSS) staff shall not disclose client information to the police without the consent of the client, unless required by law to do so by a *search warrant, subpoena,* or *order for production* requesting specific client information.

POLICY:

Upon presentation of a *search warrant, subpoena,* or *order for production*, HSS staff must consult the HSS ATIPP Coordinator before releasing any information or taking any other action.

PRINCIPLES:

Department of Health and Social Services` staff must maintain client confidentiality under existing legislation, policies and pursuant to the Registered Nurses Association of Northwest Territories and Nunavut regulations.

Inappropriate disclosure of client health information may expose HSS and its staff to civil liability for breach of confidentiality, and may result in charges of professional misconduct for the health care professional.

Cooperating and assisting RCMP officers in their investigations must be balanced against the clients` right to privacy and the right to confidentiality of their health information.

DEFINITIONS:

A **Subpoena or Summons to Witness** is a legal document that compels a named individual to attend a court of law to give evidence in a civil or criminal proceeding.

A **Search Warrant** is a legal document that provides authorization for an RCMP officer to obtain evidence, such as clients` health records, belongings and specimen samples, as part of an investigation.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 06-001-00	Confidentiality
Guidelines 06-001-01	Confidentiality
Policy 06-003-00	Release of Information
Guidelines 06-003-01	Guidelines for the Release of Information
Guidelines 06-005-01	Guidelines for RCMP Investigations
Template 06-005-02	Law Enforcement Disclosure Form
Template 06-005-03	Letter to RCMP to Disclose Client Information

GUIDELINE 06-005-01

RCMP INVESTIGATIONS

1. The HSS ATIPP Coordinator must be contacted in all situations that involve client health information and the RCMP.

2. Health centre staff approached by an RCMP officer to disclose client information should advise and consult with their supervisor and the HSS ATIPP Coordinator regarding the request. All requests for release of a client`s health record must be directed to the Territorial HSS ATIPP Coordinator for processing.

3. Health centre staff must do whatever is necessary to respond to a search warrant, subpoena, summons to witness, or other court process. Staff must ask to see the warrant, or other legal documents to verify the legal request and confirm the scope of information and/or objects being requested. Most subpoenas and warrants have a time limit in which the department must respond. This allows for consultation with the HSS ATIPP Coordinator.

4. If the health centre is not given a search warrant, subpoena, court order, or summons to witness; the nurse should not release any client information or health records to the RCMP officer unless the client consents to the release of information.

5. Health centre staff must not interfere with or obstruct an RCMP officer in the exercise of his/her duties. This obligation is especially important if a client has been arrested. Health centre staff must assist the officer if they request assistance in effecting an arrest or to keep the peace. However, if the RCMP officer's activities interfere with the safety of clients or the efficient operation of the health centre, the SHP may insist that the RCMP officer activities be reasonably modified.

6. If a client is under arrest, the property or belongings that are in their possession, including any foreign bodies removed, may be taken by the RCMP without the client`s consent. Staff should obtain written confirmation of the arrest from the RCMP, including the officer's name and badge number. Client information, including the client`s health record and any test results, remain confidential despite a client being under arrest.

7. Health centre staff should never undertake medical tests or treatments solely at the request of an RCMP officer unless the client`s consent has been obtained. The process of handling and labelling of client specimens, from the moment they are drawn/obtained from the client until the results are posted to the health record, is very important and must be clearly documented in the health record.

8. Documentation should be made of all interactions with the RCMP officer. Notes in the health record should include what property has been released and the authority (e.g., search warrant) by which it was released. In such a situation, documentation indicating the officer's name and badge number must be entered on the client`s health record.

Approved by:	Effective Date:
11 FEB 2011 **Chief Nursing Officer** **Date**	April 1, 2011
February 11, 2011 **Deputy Minister of Health and Social Services** **Date**	

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS
	Community Health Nursing

TITLE:		SECTION:	POLICY NUMBER:
Health Records Management		Communications	06-006-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		2

APPLIES TO:
Community Health Nurses

POLICY:

The Department of Health and Social Services shall ensure that policies exist for the management of active and inactive health records and shall be in accordance with Canadian Council on Health Services Accreditation (CCHSA) standards. The health record policies shall address:

- **Completion of health records**
- **Security of health records**
- **Confidentiality of health records**
- **Release of health record information**
- **Removal of health records from agency**
- **Retrieving and filing health records**
- **Retention/disposal of health records**
- **Access to health records**
    - **by resident health care professionals**
    - **by visiting health care professionals**
    - **by clients**
    - **by others**

Where a health records department does not exist, nurses shall abide by existing Department of Health and Social Services policies to guide management of health records. Health records shall not be destroyed or otherwise disposed of without prior approval from the designated authority within the Health Records department.

DEFINITIONS:

Health Record: a compilation of pertinent facts on a client's health history, including all past and present medical conditions/illnesses/treatments, with emphasis on the specific events affecting the client during any episode of care. All healthcare professionals providing care create the pertinent facts documented in a client's health record. Health records may be paper or electronic documents such as electronic health records, faxes, e-mails, audio or videotapes, or images. (College of Registered Nurses of Nova Scotia, 2005)

Completion of Health Records: the method of required completion of the health record to ensure continuity of client care. (Canadian Health Information Management Association [CHIMA], 2006)

PRINCIPLES:

Health records are confidential and legal.

Timely record completion is required for the mandatory coding of clinical information to the Canadian Institute for Health Care Information (CIHI).
The purposes of the health record are to:

- Communicate health information
- Provide continuity of care
- Demonstrate accountability
- Provide information supporting the quality assurance process
- Facilitate education and research
- Facilitate the legal process
- Facilitate financial reimbursement (CHIMA, 2006)

Where facilities do not have a health records department it is essential that policies exist to ensure the proper keeping and handling of health records in accordance with Nunavut's *Access to Information and Protection of Privacy Act* (ATIPP). (S.N.W.T. 1994, c. 20, enacted for Nunavut).

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 06-001-00	Confidentiality
Guideline 06-001-01	Confidentiality
Policy 06-008-00	Documentation

Nunavut *Access to Information and Protection of Privacy Act* (1994). S.N.W.T. 1994, C. 20, enacted for Nunavut pursuant to the Nunavut Act, S.C. 1993, c.28.

REFERENCES:

Nunavut *Access to Information and Protection of Privacy Act* S.N.W.T. 1994, c.20, enacted for Nunavut pursuant to the Nunavut Act, S.C. 1993, c.28.

Canadian Council on Health Services Accreditation (2007). *Patient/Client Safety Goals and Required Organizational Practices. (Patient Safety Area 2: Communication).Ottawa,* ON.

Canadian Institute for Health Care Information (2007). *Canadian Coding Standards for ICD-10.* Ottawa, ON.

College of Registered Nurses of Nova Scotia (2005). *Documentation Guidelines for Registered Nurses.* Halifax, NS.

Approved by:	Effective Date:
11 FEB 2011 Chief Nursing Officer — Date	April 1, 2011
February 11, 2011 Deputy Minister of Health and Social Services — Date	

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS	
	Community Health Nursing	
TITLE:	**SECTION:**	**POLICY NUMBER:**
Health Record Control	Communications	06-007-00
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APPLIES TO:		
Community Health Nurses		

POLICY:

When a chart is removed from the filing system in the health centre, an "OUT-guide" shall be placed in its place. A sign out sheet shall be completed and inserted into the "OUT-guide" to identify which staff member signed out the chart and the date.

Client records must be kept secured at all times. At the end of a scheduled shift, all health records must be returned to the locked health records area.

Client records shall not be removed from the health centre clinic except in extenuating circumstances whereby authorization has been received from the Health Records Manager, Supervisor of Health Programs or Director of Health Programs.

PRINCIPLES:

Every client health record file should be readily accessible and available.

Health records must be safeguarded from avoidable loss and breach of confidentiality.

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11 FEB 2011	April 1, 2011
Chief Nursing Officer **Date**	
February 11, 2011	
Deputy Minister of Health and Social Services **Date**	

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS
	Community Health Nursing

TITLE:		**SECTION:**	**POLICY NUMBER:**
Documentation Standard		Communications	06-008-00
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February 10, 2018	February 2021		5
APPLIES TO:			
Community Health Nurses			

POLICY:

Each health professional shall be responsible for preparation of complete, accurate and legible health records in a timely manner in accordance with requirements of relevant legislation, policies, rules and accepted standards.

Nurses must abide by all professional standards, legislation, Department of Health and Social Services policies and accreditation standards with regard to the manner in which documentation is to be done.

DEFINITIONS:

Documentation - refers to charts, charting, recording, nurses' notes, progress notes. Documentation is written or electronically generated information about a client that describes the care (observations, assessment, planning, intervention and evaluation) or service provided to that client. (College of Registered Nurses of Nova Scotia [CRNNS], 2005)

PRINCIPLES:

Health Professionals are accountable for meeting professional documentation standards and are responsible to comply with and follow agency documentation policies and procedures. Proper and thorough documentation is a nurse's best dense in a legal proceeding (Canadian Nurses Protective Society [CNPS], 2007; CRNNS, 2005).

Characteristics of quality documentation:

- Factual
- Accurate
- Complete
- Current (timely)
- Organized

Documentation is necessary for:

- Communication between health care providers
- Meeting legislative requirements
- Quality improvement
- Research
- Legal proof or evidence of the actual health care provided or not provided (CNPS, 2007).

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 06-006-00	Health Records Management
Guidelines 06-008-01	Documentation Standard Guidelines
Policy 06-009-00	Documentation Format
Guidelines 06-009-01	SOAP Documentation Guidelines

REFERENCES:

Canadian Council on Health Services Accreditation (2007). *Patient/Client Safety Goals and Required Organizational Practices. (Patient Safety Area 2: Communication).* Ottawa, ON.

Canadian Nurses Protective Society. (2007). *Quality Documentation: Your Best Defense. Info Law: A Legal Information Sheet for Nurses.* Canadian Nurses Protective Society: Ottawa, ON.

College of Nurses of Ontario. (2005). *Practice Standard: Documentation*. College of Nurses of Ontario: Toronto, ON.

College of Registered Nurses of Nova Scotia (2005). *Documentation Guidelines for Registered Nurses.*

Registered Nurses association of the Northwest Territories and Nunavut (RNANT/NU). *Standards of Practice for Registered Nurses: Professional Responsibility and Accountability.* RNANTNU: Yellowknife, NT.

GUIDELINES 06-008-01

The client's health record must be concise, comprehensive and objective. Clinically, it provides a permanent record of the client's health care status and activities. The record acts as a communication tool between health professionals involved in the client's care. The record is also an important tool for audit and continuous quality improvement purposes.

Client health records may undergo legal scrutiny for a variety of reasons, commonly, criminal proceedings, child protection proceedings, lawsuits in professional negligence, and professional disciplinary proceedings.

The following charting guidelines have been adopted from a variety of sources.

1. Detail and frequency of recording

This will be determined by the complexity and acuity of the client's health problem; the degree of risk presented by the client and/or his condition; and by the medical/nursing interventions administered.

Nurses must use their best judgment when deciding the amount of detail and the frequency of his/her chart entries; however, a general rule may be applied - the more acutely ill the client, the greater the detail and frequency required. Additional factors may be considered in determining the extent of detail to include in an entry, such as the possibility of the record being used as evidence in criminal proceedings.

2. Record chronologically

Failure to record entries chronologically may result in miscommunication or misinterpretation of significant client data and potentially result in injury to the client. Failure to record events in chronological order may also cast suspicion on the accuracy of the record during legal proceedings and thus question the credibility of the health professional and the health record.

Entries are made on every line of the record. If any line or portion of a line is not used for that entry, a single line shall be drawn through each gap to eliminate the possibility of an entry being made out of chronological order. If a "late entry" is made out of chronological order, it should be clearly marked as such.

3. Record contemporaneously

Events should be recorded as soon as reasonably possible after they occur, particularly when the client's condition is more acute, emergent and/or complex. Documenting the event as soon as possible improves the quality and accuracy of the record and thus admissibility of the health record during court proceedings. Entries must be made within 24 hours of the event occurring.

Failure to record contemporaneously may lead to inaccurate recall of events, errors and/or omissions. The credibility of both the nurse and health record may be questioned in the event of legal proceedings.

4. Record accurately

An accurate entry not only refers to the absence of errors, but also refers to entries which are clearly stated and without ambiguity.

5. Record concisely

Only essential information should be recorded to enable information to be retrieved quickly from the record when needed and avoid sifting through extraneous, irrelevant material. Verbosity can result in pertinent information being overlooked.

"Negative" or "absent findings" are not necessarily irrelevant or extraneous. Negative or absent findings should be included in the documentation when they are relevant to the differential diagnoses. In some instances, the courts have determined that the failure to record that a task was performed despite a negative finding, inferred that it was not performed.

To help the decision-making about whether to document negative or absent findings, the nurse should ask whether the failure to record a negative finding meets the standard of the reasonable, prudent nurse of similar background and experience in like circumstances. For example, given the condition of the client, is the "negative" finding of sufficient importance that a reasonable, prudent nurse would record it, to reflect that a potentially significant differential diagnosis was considered and ruled out?

6. Record factually

Recording is based on accurately perceived data obtained from a variety of sources, such as observation, inspection, palpation, auscultation. Verbal cues or statements made by a client may also be recorded into the entry; however, avoid assumptions or inferences about client statements. The data should be described in quantitative terms wherever possible to reduce the bias injected into the recorded entry.

7. Entries should be made by the individual having personal knowledge of the event(s) recorded.

All entries should be made by the health professional who has witnessed the event being recorded to reduce the risk of inaccurate documentation. The credibility of the health record may also be called into question during legal proceedings if the entry was made by someone who did not witness the event and could not attest to the truth of the information.

8. Sign or initial all entries

Signatures (accompanied with recorder's designation) and initials should be easily identifiable. Whenever initials are used, the corresponding full signature must also be indicated on the record, to assist in identifying the person making the entry. If signatures are illegible, the name should also be printed.

9. Terminology, abbreviations and systems of reporting should be uniform

Uniform terminology, abbreviations, and systems of reporting should be used by all personnel in the facility and in the territory. Consistency and uniformity eliminates misinterpretation of recorded data and potential risks of injury to the client.

10. Note any consultations

The date and time of any nurse-initiated consultations should be noted, showing timely reporting of any abnormal findings, medical direction given, and action taken. All verbal physician orders to prescribe, modify, or discontinue treatment should be clearly recorded. Whenever physician orders are verbally verified for accuracy, this discussion should also be clearly documented in the record.

11. Document refusal of treatment/discharge against advice

The Nurse must request that the client or client's family sign the GN approved form for refusal of treatment/discharge against medical advice. In additional to this form being completed by the client, the nurse must also document: the circumstances of the refusal, the information provided to the client/family about the potential consequences of refusal of treatment, any additional client teaching done, any treatment or medication provided, and reasons to seek medical attention.

12. Correct errors openly

If an error is made in the entry, do not attempt to erase, remove, or obliterate the erroneous entry. A single line must be drawn through the incorrect word(s) and initial the correction. The corrected entry should then be made according to the aforementioned documentation standards.

All entries must be made in non-erasable pens, never pencils. If electronic records are used, the "cut and paste" function should not be used to organize entries into chronological order.

13. Document in Ink

All entries are to be made in blue or black ink only. Pencil should never be used in the client health record or on the immunization cards.

REFERENCES:

Canadian Nurses Protective Society. (2007). *Quality Documentation: Your Best Defense. Info Law: A Legal Information Sheet for Nurses.* Canadian Nurses Protective Society: Ottawa, ON.

College of Nurses of Ontario. (2005). *Practice Standard: Documentation.* CNO: Toronto, ON.

Pharmacy & Therapeutics. (2002). Nunavut *Controlled Substances Policy and Procedures.* Iqaluit, NU.

Approved by:	Effective Date:
11 FEB 2011 **Chief Nursing Officer** **Date**	April 1, 2011
February 11, 2011 **Deputy Minister of Health and Social Services** **Date**	

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS
	Community Health Nursing

TITLE:		**SECTION:**	**POLICY NUMBER:**
Documentation Format		Communications	06-009-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		4
APPLIES TO:			
Community Health Nurses			

POLICY:

The Department of Health and Social Services (HSS) shall employ a standard format for recording client care. Registered Nurses working in a community health centre, as standard format, will employ the principles of SOAP charting with each clinical encounter with a client, unless a Government of Nunavut approved form is available, or the clinical situation is not conducive to SOAP charting (e.g. charting during an emergency).

DEFINITIONS:

Documentation – refers to charts, charting, recording, nurses' notes, and progress notes. Documentation is written or electronically generated information about a client that describes the care (observations, assessment, planning, intervention and evaluation) or service provided to that client. (College of Registered Nurses of Nova Scotia: [CRNNS], 2005)

PRINCIPLES:

- Documentation fundamentally communicates the client's perspective on his/her own health and well-being, the care provided, the effect of care and the continuity of care. All health care providers need ongoing access to client information to provide safe and effective care and treatment. (CNO, 2005)
- Each health professional is responsible for his/her own charting; however, standardizing the format used for documenting the event(s) promotes quality assurance by reducing errors. It also allows information to be organized in such a way that it presents a clear picture of the client's needs, the nurse's actions and the client's response. (CRNNS, 2005)
- Quality documentation is a nurse's best defense in a legal proceeding. (Canadian Nurse Protective Society [CNPS], 2007)

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 06-006-00	Health Records Management
Policy 06-008-00	Documentation Standards
Guideline 06-008-01	Documentation Standard Guidelines
Guideline 06-009-01	SOAP Documentation Guidelines

REFERENCES:

Canadian Council on Health Services Accreditation (2007). *Patient/Client Safety Goals and Required Organizational Practices*. (*Patient Safety Area 2 Communication*). Ottawa, ON.

College of Nurses of Ontario (2005). *Practice Standard: Documentation.* Ottawa, ON.

College of Registered Nurses of Nova Scotia (2005). *Documentation Guidelines for Registered Nurses.*

Canadian Nurses Protective Society. (2007). *Quality Documentation: Your Best Defense. InfoLaw: A Legal Information Sheet for Nurses.* Canadian Nurses Protective Society: Ottawa, ON.

Registered Nurses association of the Northwest Territories and Nunavut (RNANT/NU). *Standards of Practice for Registered Nurses: Professional Responsibility and Accountability.* Yellowknife, NT.

GUIDELINES 06-009-01

SOAP charting is the standard format to be used by all registered nurses working in a community health centre. SOAP charting employs a problem-oriented approach
The information collected is organized as follows:

S = SUBJECTIVE DATA

Information the client gives you, voluntarily or in response to questioning, about his/her self and his/her condition or illness. This information is organized by:

- Chief complaint (to be stated in client's exact words)
- History of presenting illness
- Review of systems
- Past health history
- Family History
- Social History

O = OBJECTIVE DATA

Facts and measurable observations obtained by observation, inspection, palpation, percussion, and auscultation. The objective data is generally organized by:

- General appearance
- Vital signs
- Physical exam findings
- Laboratory and other Diagnostic test results
- Consult reports

A = ASSESSMENT

Appraisal statement of the client's current condition, including:

- Diagnosis (medical and/or nursing)
- Differential diagnosis

P = PLAN

Care plan for the client. The plan of care is generally documented as:

- Education provided to the client and/or family
- Care and treatment provided during the clinic visit
- Medications prescribed and/or dispensed
- Follow-up plans and referrals

Evaluation of the care plan is documented as:

- Did the plan work?
- What changes to the care plan were made, if any?

REFERENCES:

College of Nurses of Ontario (2005). *Practice Standard: Documentation.* Ottawa, ON.

College of Registered Nurses of Nova Scotia (2005). *Documentation Guidelines for Registered Nurses.* Halifax, NS.

Approved by: 11 FEB 2011 **Chief Nursing Officer** **Date**	Effective Date: April 1, 2011
February 11, 2011 **Deputy Minister of Health and Social Services** **Date**	

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS
	Community Health Nursing

TITLE:		**SECTION:**	**POLICY NUMBER:**
Date and Time Sequence		Communications	06-010-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		1
APPLIES TO:			
Community Health Nurses			

POLICY 1:

The Department of Health and Social Services (HSS) shall employ a standardized date and time sequence. The standard date sequencing will be yyyy-mm-dd. For example, 2011-04-01 is April 1st 2011.

On renewal or review of forms or systems, wherever possible, the approved date/time sequencing should be introduced if not already employed

POLICY 2:

The Department of Health and Social Services shall employ the standard notation for time of the day, which is hh:mm:ss. HSS staff shall document the time using the twenty-four (24) hour clock format.

PRINCIPLES:

There are numerous sequences for date and time notation. Using a standard date and time sequence, HSS will promote safety, prevention of error and clarity.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 06-008-00 Documentation Standard
Guidelines 06-008-01 Documentation Standard Guidelines
Policy 06-009-00 Documentation Format

Approved by:	Effective Date:
11 FEB 2011 **Chief Nursing Officer** **Date**	April 1, 2011
February 11, 2011 **Deputy Minister of Health and Social Services** **Date**	

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS		
	Community Health Nursing		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Email Consultation		Communications	06-011-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		1
APPLIES TO:			
Community Health Nurses			

POLICY:

The Government of Nunavut provides a secure network for the transmission and receipt of email by physicians and nurses. However, care providers may access their email on secure work-based networks or less secure web-based applications for email use.

Email consultation shall be governed by the *Government of Nunavut Acceptable Email Use Policy*, The Archives Act and The Access to Information and Protection of Privacy Act. The privacy and confidentiality of client information must be safeguarded at all times.

PRINCIPLES:

Email is an essential tool for the transfer of client information between health care providers for the purposes of consultation and referral.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 06-001-00	Confidentiality
Guideline 06-001-01	Confidentiality Guidelines
Policy	*Government of Nunavut Acceptable Email Use Policy*

Approved by:	Effective Date:
11 FEB 2011	
Chief Nursing Officer **Date**	April 1, 2011
February 11, 2011	
Deputy Minister of Health and Social Services **Date**	

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS	
	Community Health Nursing	
TITLE:	**SECTION:**	**POLICY NUMBER:**
Forms Management	Communications	06-012-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018 / February 2021		1
APPLIES TO:		
Community Health Nurses		

POLICY:

The Department of Health and Social Services shall use standardized forms in its health centres. All forms must be approved by the Chief Nursing Officer and Executive Management Committee, in consultation with a delegate from the Health Records department.

DEFINITIONS:

Form is defined as any information or communication vehicle with pre-printed information requiring the insertion of additional data either manually or computerised.

PRINCIPLES:

All forms will display the Government of Nunavut logo; the form title; and form number

Additional requirements for all clinical forms to be used in client records include: a 3.5 X 2 inch plaque area for client information; 5/8 inch margin on left or top edge; and a maximum 8.5 X 11 paper size.

Approved by:	Effective Date:
11 FEB 2011	
Chief Nursing Officer — Date	
February 11, 2011	April 1, 2011
Deputy Minister of Health and Social Services — Date	

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS
	Community Health Nursing

TITLE:		**SECTION:**	**POLICY NUMBER:**
Interpreter Services		Communications	06-013-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		5
APPLIES TO:			
Community Health Nurses			

POLICY 1:

The health centre staff shall do its utmost to offer healthcare services in the client's primary language

The practitioner shall utilize interpreter services during the following types of encounters/procedures, including, but not limited to:

- **Providing emergency medical services;**
- **Obtaining medical histories;**
- **Explaining any diagnosis and plan for medical treatment;**
- **Discussing any mental health issues or concerns (preferably not a family member);**
- **Explaining any change in regimen or condition**
- **Explaining any medical procedures, tests or surgical interventions**
- **Explaining client rights and responsibilities**
- **Explaining the use of restraints or seclusion**
- **Obtaining informed consent**
- **Providing medication instructions and explanation of potential side effects**
- **Explaining discharge plans**
- **Discussing issues at client and family care conferences and/or health education sessions**
- **Discussing Advance Directives**
- **Discussing end-of-life decisions**
- **Obtaining financial and insurance information**

POLICY 2:

The name of the person interpreting for the client must be documented in the client's health record. If a friend or family member is interpreting for the client, her/his relationship to the client (i.e., wife, friend) must also be documented.

POLICY 3:

The Department of Health and Social Services shall establish a process for ongoing training, monitoring and evaluating the interpreter's competencies.

PRINCIPLES:

- HSS ensures that unilingual clients and their families are able to effectively communicate their medical history and condition; understand the healthcare provider's assessment of their medical condition and treatment options.
- Interpreter services are essential to the provision of quality client care in Nunavut.
- Supports the principles of Inuit Qaujimajatuqangit and guiding principles of Tamapta
- Nurses are responsible for assessing client understanding of the information provided, whether it is done directly or indirectly through the interpreter
- Necessary emergency care should not be withheld pending the arrival of interpreter services.
- All necessary after hours contact numbers for the health centre's Clerk Interpreters shall be available to the nurse-on-call.

REFERENCES:

College of Nurses of Ontario (2004). *Practice Guideline: Culturally Sensitive Care*. CNO: Toronto.

Government of Nunavut. *Tamapta*. GN: Iqaluit.

Inuit Language Protection Act S.Nu. 2008, c.17

U.S. Department of Health and Human Services, Office of Minority Health, National Standards for Culturally and Linguistically Appropriate Services in Health Care, March 2001

GUIDELINES 06-013-01

1. Upon presentation to the health centre, language needs shall be determined for all clients:

    - The client shall be asked if he/she speaks and/or understands English.

    - If the client answers "no", the client shall be asked in what language he/she prefers to receive his/her medical services and in what language he/she prefers to receive written materials.

    - When a client self-identifies as not being fluent in English, the client's primary language shall be documented in the client's health records.

    - The name of the person who interprets for the client shall be documented in the health record. The relationship of the interpreter to the client should also be documented if a friend or family provides this service.

2. Acceptable methods for the provision of interpreter services include, but are not limited to, the following:

    - In-person interpreting

    - Telephone-based interpreting

    - Videoconferencing interpreting

3. The following shall be taken into consideration when determining the appropriate method for the delivery of interpreter services:

    - The critical nature of the clinical interaction

    - Availability of specific and qualified in-person interpreters

4. All signs posted within the health centre must be translated in all four official languages.

5. Every effort must be made to have all vital documents translated in the official languages. The translation of other facility written materials into Inuktitut and Inuinnaqtun, as required. The department of Culture, Language, Elders and Youth (CLEY) should be consulted.

6. Vital documents that are not available in a written translation shall be verbally translated to the client. The provision of oral translation of all vital documents to clients shall be documented.

Confidentiality

Interpreters need to recognize that, by virtue of their role, they are gaining access to personal health information that must be protected. The nurse should inform the client that confidential information is shared only within the healthcare team.

GUIDELINES 06-013-02

1. Seek the client's consent to use an interpreter or any other arrangement for communication.

2. Before using an interpreter, attempt to identify factors that may influence the accuracy of the translation, such as differences in dialect, religion, gender, age, social status, etc.

3. Explain to the interpreter the importance of repeating everything the client and the health provider say, without omissions, summary or judgements. The interpreter's role is to be the voice of the client.

4. The interpreter may have valuable cultural or familial insight. Ask the interpreter to share these insights but ask him/her to identify them as their insights and not as facts or the client's beliefs.

5. Explain to the client and interpreter that confidentiality will be maintained. Family members and friends, in particular, need to realize the role of interpreter needs to be separated from personal roles.

6. Talk to the client and not the interpreter. Maintain eye contact as appropriate. Looking at the client directly reinforces that the communication is between the provider and the client, assisted by the interpreter. This also allows the provider to assess the non-verbal reactions and responses.

7. Speak in simple terms. Avoid jargon or slang.

8. Give the information to the interpreter in short sentences and ask him/her to relay the information after each sentence. Interpreters have to remember and translate everything that they hear.

9. If during an interpretation you sense that a bigger exchange is taking place than what is being relayed to you, ask the interpreter to explain what is being said. The interpreter may be providing information that is appropriate, but you should ensure that important information is not missed.

10. Ask the interpreter to explain to the client any discussion between the interpreter and the nurse. The client should be aware of what is being discussed.

11. Write down key points, directions, appointment times and any other material that has numbers or can easily be confused or forgotten. Giving the client a written record prevents the interpreter from having to rely entirely on memory

12. Ask the client to repeat, in his/her own words, the information you have given. Remind the interpreter to relay everything that the client says.

13. Ask the interpreter if there was anything about the interaction that made it difficult to interpret. This will allow you to assess the overall quality of the interaction.

REFERENCE:

College of Nurses of Ontario (2004). *Practice Guideline: Culturally Sensitive Care*. CNO: Toronto.

Approved by:	Effective Date:
11 FEB 2011 **Chief Nursing Officer** **Date**	April 1, 2011
February 11, 2011 **Deputy Minister of Health and Social Services** **Date**	

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS
	Community Health Nursing

TITLE:		**SECTION:**	**POLICY NUMBER:**
Telephone Communication		Communications	06-014-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		4
APPLIES TO:			
Community Health Nurses			

POLICY 1:

The health centre telephone is answered promptly in a caring and professional manner, meeting the needs of the caller.

POLICY 2:

All staff responsible for answering telephones within the health centre shall be familiar with identifying emergency telephone calls and the process for handling emergency calls.

POLICY 3:

All staff members shall return client's telephone calls in a timely manner.

PRINCIPLES:

- The telephone often provides the first point of contact with health services for clients.
- How a telephone call is handled can have important legal implications as well as an impact on client care and health.

Canadian Nurses Protective Society (2002). *Info Law a Legal Information Sheet for Nurses: Telephone advice.* Ottawa, ON.

GUIDELINES 06-014-01

INITIAL TELEPHONE CONTACT WITH FRONT DESK / RECEPTIONIST STAFF

1. Answer phone promptly; identify the health centre and your name
2. Politely request caller's name.
   Ensure you do not breach confidentiality – use either the client's first name or surname.
3. Establish the nature of enquiry
   Listen carefully to the caller to determine why they are calling. Ask further questions until you have enough information to direct the call or take action based on the call.

ON HOLD

If you must place the caller on hold, politely inform them and promptly address their call. If the caller has been waiting on hold for more than 1 minute, explain the progress of their call and suggest the relevant staff member call the client back.

TAKING A MESSAGE

1. Ask the caller if you may take a message
2. Record the following message details on the carbon copy message pad:
   - Caller name
   - Client name
   - Time of call
   - Reason for call
   - Return phone number and the most convenient time to call
3. Advise the caller that the nurse / physician will return the call as soon as possible.
4. Retrieve the client's health record, attach the phone message to the file and give to the appropriate nurse / physician
5. Check the message pad at the end of the day to ensure all messages have been attended.

DISCLOSURE OF TEST RESULTS/ TREATMENT ADVICE

No test results are to be disclosed by anyone other than the nurse or physician.
No staff member other than a nurse or physician shall provide treatment advice

DISTRESSED OR ABUSIVE CALLERS

Answer distressed callers in a calm and helpful manner, repeating where possible what they have said and deal empathetically with their concerns.
Advise abusive callers about the "zero tolerance" policy and that they can only be served if the abusive behaviour stops. If the caller continues to be abusive, the staff member shall calmly advise the caller they can no longer serve them and hang up. The supervisor must be promptly notified of the situation.

CONFIDENTIALITY

1. Confidentiality is maintained for all telephone calls
2. A phone conversation that is likely to involve confidential information should not to be taken at the front desk.
3. When this is not possible, strategies are taken to minimize the possibility of the conversation being overheard by the clients in the waiting room. These include, but are not limited to:
   a) Lowering the tone of your voice;
   b) Lowering your head or turning your back to the waiting room;
   c) Ensuring that during the conversation all identifying information is not disclosed

AFTER HOURS

Ensure the answering machine is turned on at lunch and after hours. The message must be provided in English AND Inuktitut/ Inuinnaqtun (depending on the community) and include the emergency contact number for the nurse on call.

GUIDELINES 06-014-02

EMERGENCY (ALL AGES): CLIENT ADVISED TO COME TO THE HEALTH CENTRE IMMEDIATELY. IF ALREADY PRESENT, THE CLIENT MUST BE REFERRED IMMEDIATELY TO THE NURSE ON CALL.

- Person has "just been in an accident"
- Person collapsed
- Unconscious
- Seizures
- Any breathing difficulty (client reported or witnessed)
- Severe distress including chest pain or indigestion
- Severe and uncontrolled bleeding
- Looks or feels very unwell
- Suspected poisoning or overdose

URGENT: REFER PROMPTLY TO THE NURSE ON CALL.

- Severe abdominal pain
- Eye injury or severe pain
- Hemorrhage in pregnancy
- Urine retention in elderly males
- Allergic reaction – itchy rash, tongue swelling, breathing difficulties
- Physical or emotional distress
- Persistent vomiting and diarrhea (Infants less than 1 years old)

SOON: REFER TO NURSE ON CALL AND ENSURE THE CALL IS RETURNED WITHIN 1 HOUR

- Persistent vomiting and diarrhea (children over the age of 1 and adults)
- Severe earache
- Persistent high fever
- Severe headache

APPOINTMENT TODAY: IF THERE ARE NO APPOINTMENTS AVAILABLE FOR TODAY, REFER THE TELEPHONE CALL TO THE NURSE ON CALL.

- Cold
- Sore throat
- Chest infection
- Urinary infection
- Foreign body (eye / ear / nose)

APPOINTMENT NEXT DAY:

- Chronic Illness
- Repeat prescriptions
- Vaccinations
- Completion of forms
- Non-urgent conditions or concerns

Approved by:	Effective Date:
11 FEB 2011 Chief Nursing Officer Date	April 1, 2011
February 11, 2011 Deputy Minister of Health and Social Services Date	

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS **Community Health Nursing**		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Missed or Cancelled Appointments		Communications	06-015-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		2
APPLIES TO:			
Community Health Nurses			

POLICY 1:

Nurses shall be notified about clients cancelling or not arriving for a scheduled appointment.

PRINCIPLES:

When the nurse is informed of any missed or cancelled appointments, he/she can follow up appropriately to ensure continuity of care is maintained.

POLICY 2:

Nurses shall ensure that all missed appointments are documented in the client's chart.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Guideline 06-015-01 Guidelines for handling missed or cancelled appointments

GUIDELINE 06-015-01

Appointment Book:

1. Always advise clients when making an appointment to call the health centre as early as possible to cancel or re-schedule the appointment if they decide they are unable to attend the appointment.
2. Follow-up appointments arranged by the nurse or physician is indicated by the use of an asterisk (*) beside the client's name.
3. Indicate in the appointment book any cancellations or "No Show". The method by which these missed appointments are indicated in the book may vary with each health centre. The Supervisor of Health Programs shall establish a standardized procedure for such action. (For example, any cancellations or "no show" appointments are marked at the bottom of the appointment book each day)
4. The clerk interpreter or receptionist shall document in the client's chart "No show for appointment" or "appointment cancelled as per client's request". Additional details may also be documented if available.
5. The clerk or receptionist will provide the nurse or physician with the health records for all the clients who cancelled or missed their appointments.
6. The Nurse or physician will indicate in the health record all follow-up actions required (if any).

Approved by:	Effective Date:
11 FEB 2011 **Chief Nursing Officer** **Date**	April 1, 2011
February 11, 2011 **Deputy Minister of Health and Social Services** **Date**	

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS
	Community Health Nursing

TITLE:		**SECTION:**	**POLICY NUMBER:**
Child Welfare		Communications	06-016-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		5
APPLIES TO:			
Community Health Nurses			

POLICY:

The Department of Health and Social Services (HSS) will respond to child welfare concerns as mandated under the Nunavut *Child and Family Services Act*.

The mandatory reporting requirements of the *Child and Family Services Act* requires that every person who believes on reasonable grounds that any child has suffered or that there is a risk that a child is likely to suffer abuse or neglect, as outlined in 7 (3) of the *Child and Family Services Act*, must report the information to the Child Protection Worker.

If a Child Protection Worker is not available, then the HSS staff will report to a peace officer or other authorized person.

DEFINITIONS:

Abuse means neglect or emotional, psychological, physical or sexual abuse.

Child means a person who is or, in the absence of evidence to the contrary, appears to be under the age of 16 years.

PRINCIPLES:

HSS promotes the best interests, protection and well-being of children.

Children are entitled to protection from abuse and harm and from the threat of abuse and harm.

No action shall be taken against a person for reporting information in accordance with the *Child and Family Services Act* unless it was done with malicious intent.

The duty to report child welfare concerns applies even though the information may be confidential or privileged.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Guideline 06-016-01 Guidelines for Reporting Child Welfare Concerns

Child and Family Services Act, S.N.W.T. 1998, c.34, as enacted for Nunavut, pursuant to the *Nunavut Act*

Access to Information and Protection of Privacy Act

REFERENCES:

Canadian Nurses Association (2008) *Code of Ethics for Registered Nurses.* Ottawa, ON.

Child and Family Services Act, S.N.W.T. 1998, c.34, as enacted for Nunavut, pursuant to the *Nunavut Act*

GUIDELINE 06-016-01

Procedure for Reporting to the Child Protection Worker

1. **If there is reasonable grounds to suspect an incident whereby a child has suffered, or there is a risk that a child is likely to suffer abuse or neglect (specifically any of the matters listed in subsection 7(3) of the Nunavut *Child and Family Services Act*), the following actions are required:**

   a) The health care team must ensure care and safety for the child.
   b) Each member of the health care team (e.g. Nurse, Physician, etc.) who suspects a child is in need of protection must report the suspicion to the Child Protection Worker, as soon as possible. The duty to report applies even though the information may be confidential or privileged.
   c) It is best practice to identify oneself when reporting; however, there is an option to remain anonymous.
   d) This duty to report may not be delegated to another person.
   e) Advise the appropriate health care team members that a report has been made.

2. **A person is required under the *Child and Family Services Act* to report the suspected abuse/neglect and disclosure of personal information to the Child Protection Worker (in most instances the Child Protection Worker will be the Social Worker) is authorized in two circumstances:**

   a) to assist the Child Protection Worker in carrying out its statutory duties; and
   b) where disclosure is necessary to eliminate or reduce significant risk of serious bodily harm to a child.

3. **Each health care provider who reports to the Child Protection Worker must document what was witnessed, reported and/or suspected in the client's health record.**

   a) Documentation in the health record is evidence of the care provided, demonstrates that each member of the health care team has fulfilled their obligation to report and may be considered evidence in legal proceedings.

4. **Discuss with the Social Worker on duty how to inform and who is the most appropriate person to communicate with the parents or person having charge of the child that a report has been made to child protection services.**

5. **Health care workers, who are uncertain as to the legal requirements and their obligations related to reporting abuse or neglect of children, or the investigation thereof, may consult with the Supervisor of Health Programs and/or the Social Worker.**
   Should they require further assistance, contact the ATIPP coordinator, and/or Director of Health Programs.

The Child and Family Services Act outlines the circumstances in which suspected abuse or neglect must be reported to the Child Protection Worker. These include, but are not limited to:

a) the child has suffered physical harm inflicted by the child's parent or caused by the parent's unwillingness or inability to care and provide for or supervise and protect the child adequately;

b) there is a substantial risk that the child will suffer physical harm inflicted by the child's parent or caused by the parent's unwillingness or inability to care and provide for or supervise and protect the child adequately;

c) the child has been sexually molested or sexually exploited by the child's parent or by another person where the child's parent knew or should have known of the possibility of sexual molestation or sexual exploitation and was unwilling or unable to protect the child;

d) there is a substantial risk that the child will be sexually molested or sexually exploited by the child's parent or by another person where the child's parent knows or should know of the possibility of sexual molestation or sexual exploitation and is unwilling or unable to protect the child;

e) the child has demonstrated severe anxiety, depression, withdrawal, self-destructive behaviour, or aggressive behaviour towards others, or any other severe behaviour that is consistent with the child having suffered emotional harm, and the child's parent does not provide, or refuses or is unavailable or unable to consent to the provision of, services, treatment or healing processes to remedy or alleviate the harm;

f) there is a substantial risk that the child will suffer emotional harm of the kind described in paragraph (e) and the child's parent does not provide, or refuses or is unavailable or unable to consent to the provision of, services, treatment or healing processes to prevent the harm;

g) the child suffers from a mental, emotional or developmental condition that, if not remedied, could seriously impair the child's development and the child's parent does not provide, or refuses or is unavailable or unable to consent to the provision of, services, treatment or healing processes to remedy or alleviate the condition;

h) the child's health or emotional or mental well-being has been harmed by the child's use of alcohol, drugs, solvents or similar substances and the child's parent is unavailable, unable or unwilling to properly care for the child;

i) there is a substantial risk that the child's health or emotional or mental well-being will be harmed by the child's use of alcohol, drugs, solvents or similar substances and the child's parent is unavailable, unable or unwilling to properly care for the child;

j) the child requires medical treatment to cure, prevent or alleviate serious physical harm or serious physical suffering and the child's parent does not provide, or refuses or is unavailable or unable to consent to the provision of, the treatment;

k) the child suffers from malnutrition of a degree that, if not immediately remedied, could seriously impair the child's growth or development or result in permanent injury or death;

l) the child has been abandoned by the child's parent without the child's parent having made adequate provision for the child's care or custody and the child's extended family has not made adequate provision for the child's care or custody;

m) the child's parents have died without making adequate provision for the child's care or custody and the child's extended family has not made adequate provision for the child's care or custody;

n) the child's parent is unavailable or unable or unwilling to properly care for the child and the child's extended family has not made adequate provision for the child's care; or

o) the child is less than 12 years of age and has killed or seriously injured another person or has persisted in injuring others or causing damage to the property of others, and services, treatment or healing processes are necessary to prevent a recurrence and the child's parent does not provide or refuses or is unavailable or unable to consent to the provision of, the services, treatment or healing processes.
(Nunavut *Child and Family Services Act*)

Approved by:	Effective Date:
11 FEB 2011 **Chief Nursing Officer** **Date**	April 1, 2011
February 11, 2011 **Deputy Minister of Health and Social Services** **Date**	

Appendix 1 – Morning Report Flow Chart

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS Community Health Nursing		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Morning Report		Nursing Practice	06-017-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
August 2, 2020	August 2023		5
APPLIES TO:			
All Health Centre Staff			

1. **BACKGROUND:**

1.1 The Department of Health (Health) recognises that clear communication and information sharing practices are integral to the effective delivery of healthcare services. Health upholds all process related to the handling of confidential information including Personal Health Information (PHI).

1.2 The Morning Report offers the healthcare service providers and health centre staff the opportunity to come together, discuss issues, and plan for the future.

2. **POLICY:**

2.1 The Morning Report is a mandatory daily meeting which will take place at the beginning of each work day.

2.2 The Morning Report will be attended by all staff working at the health centre that day as well as all associated healthcare providers, such as midwives, community physicians and community health representatives (CHRs).

2.3 The Morning Report will be led by the Supervisor of Community Health Programs (SCHP) or designate in the event that the SCHP cannot attend.

2.4 The Morning Report will consist of two sections, the first is operational, the second is clinical. The operational section should take roughly five minutes. The total meeting time should not exceed 30 minutes to ensure that clients are not kept waiting.

2.5 The operational section of the report requires the attendance of all health centre staff. During the operational section no PHI or other information related to any client will be shared. Discussions will focus solely on the operations of the health centre.

2.6 The clinical section of the Morning Report must be attended by Community Health Nurses (CHNs) and Nurse Practitioners (NPs) and the Community Physician working at the health centre. All other staff will be dismissed from the meeting by the SCHP prior to beginning the clinical section of the meeting. The Mental Health Nurse (MHN)/Registered Psychiatric Nurse (RPN), Public Health Nurse (PHN), Licenced Practical Nurse (LPN), Home Care Nurse (HCN), Visiting Specialists, Paraprofessionals, and/or Midwives will be invited to attend the

clinical portion of the meeting **only if** they have specific clinical matters which must be discussed with the clinical team. These discussions will take place first, after which these clinicians will be dismissed. There will be no discussion of any PHI during the first section of the clinical portion of the meeting. The second section of the meeting will only be attended by CHNs and the Community Physician.

2.7 The SCHP bears ultimate responsibility for upholding professional standards during the Morning Report and will discourage any unnecessary commentary or personal opinions from attending staff.

3 PRINCIPLES:

3.1 Morning Report is a mandatory meeting which helps to ensure effective communication and information sharing leading to better operational efficiency for health centre staff.

3.2 Morning Report provides the opportunity for clinical collaboration to ensure optimal care is being provided to clients.

3.3 PHI and any other confidential, sensitive, or privileged information will only be shared during the clinical section of the Morning Report. The clinical section of the Morning Report will be attended exclusively by the health centre's CHNs, Community Physicians and NPs with invitation to PHN, LPN, HCN, MHN/RPN, Paraprofessionals, and Midwifery only when required to discuss specific clinical matters which must be brought to the attention of all CHNs.

4 DEFINITIONS:

4.1 Personal Health Information/Protected Health Information (PHI):

Health information collected or maintained in any format concerning the health of an individual, living or deceased which includes any of the following information:

a) Information about a pathogen with which an individual is infected or to which the individual has been exposed
b) Information about other health conditions to which an individual is subject
c) Information about health services provided to an individual
d) Information about the individual's health care history
e) Information that is collected in the course of, or incidental to, the provision of health services to an individual
f) Information in respect of the examination or testing of and individual or on referral from a health care professional
g) An identifying number, symbol or other particular assigned to an individual in respect of health services or health information.

4.2 Clinicians: Regulated Health Professionals

Appendix 1 – Morning Report Flow Chart

5 **GUIDELINE: 06-017-01**

5.1 The SCHP will start the Morning Report at 08:30 or the beginning of the work day, whichever comes first.

5.2 The SCHP will take attendance and record any absentees.

5.3 The SCHP will remind everyone that the first section of the Morning Report is operational, and that no PHI or other privileged, personal, or confidential information will be shared.

5.4 The SCHP will assign quality assurance testing to staff to be completed during Morning Report.

5.5 The SCHP will provide an opportunity to front desk staff, housekeepers, and caretakers, in turn to provide updates or express concerns.

5.6 SCHP will request input from the Midwives, MHN/RPN, PHN, HCN, Specialists, Paraprofessionals, and LPN in turn, regarding any updates which they have regarding operations.

5.6.1 After providing updates, theses clinicians will indicate if they have a clinical matter to present during the clinical portion of the meeting.

5.7 The SCHP will request updates from CHRs regarding programming and events of that day and any upcoming programmes or events which may impact health centre operations.

5.8 SCHP will disseminate any recent, relevant information or communications as they relate to health centre operations, including policy updates and answer questions about them.

5.9 The SCHP will adjourn the first section of the meeting, dismissing all staff except for CHNs, NPs and Community Physicians. All other clinicians will be invited to stay only if they have a specific clinical matter that requires discussion with the entire team.

5.10 After all non-clinical staff have departed the SCHP will invite the Midwives, LPNs, PHN, Specialists, Paraprofessionals, and MHN/RPNs to present their matter each in turn. Once these updates are complete, these clinicians will be dismissed.

5.11 All presentations will be focussed on the clinical matters. Sharing of PHI will be limited to only those details which absolutely must be shared.

5.12 The SCHP will invite the On-Call Nurse from the previous night to present those clients who will require follow-up, who are of particular concern such as clients who are presenting with the same complaint for the third time, or who are awaiting transport to another location of care.

5.13 The SCHP will ask the nurses if there are any cases which require discussion between the nurse, the SCHP and/or physician and schedule an appropriate time to discuss the case.

5.14 The SCHP is responsible to update any clinician not present with information presented during this time that pertains to them. This should be done as soon as possible after report is adjourned.

5.15 The SCHP will adjourn the meeting, the total meeting time should not exceed 30 minutes

6. REFERENCES:

Public Health Act of Nunavut

Approved By:	Date: Dec 10 2020
Jennifer Berry, Assistant Deputy Minister, Health Operations	
Approved By:	Date: Jan 7, 2021
Jenifer Bujold, A/ Chief Nursing Officer	

Appendix 1 – Morning Report Flow Chart