Section 7: Nursing Practice

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS		
	Community Health Nursing		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Community Health Nursing		Nursing Practice	07-001-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		3
APPLIES TO:			
Community Health Nurses			

POLICY 1:

Registered nurses who are employed by the Department of Health and Social Services to provide health care and related services shall be responsible for:

- **Registering with Registered Nurses Association of the Northwest Territories and Nunavut (RNANT/NU) as prescribed by the Nunavut *Nursing Act* (*S.Nu. 2003, c.17)*.**
- **Maintaining a good standing of his/her registration with Registered Nurses Association of the Northwest Territories and Nunavut (RNANT/NU) as prescribed by the Nunavut *Nursing Act* (*S.Nu. 2003, c.17)*.**
- **Shall be responsible for maintaining a safe level of practice and shall be aware that no statement of policy by a professional association or any employing agency relieves the responsibility for the nurse's own acts.**
- **Shall practice within the policies, procedures, guidelines and protocols of their employing agency and within professional standards and code of ethics.**
- **Are responsible for clarifying employer performance expectations and familiarizing themselves with how nursing is practiced within the Government of Nunavut.**

POLICY 2:

The Department of Health and Social Services shall ensure that all Registered Nurses are successfully registered with RNANT/NU prior to commencement of the nurse's orientation and placement.

PRINCIPLES:

RNANT/NU sets the minimum standards of practice for registered nurses, gives guidance to registrants, employers, and educators, and provides information for the general public as evidence of basic expectations for all registered nurses. Registration with RNANT/NU is a legal requirement to safeguard client care and maintain competency of practice.

Through the Nunavut *Nursing Act* (*S.Nu. 2003, c.17)* registered nurses are held accountable for upholding the standards of practice and code of ethics as set out by RNANT/NU.

Scope of practice is a continuum of learning and development. Performing a nursing function responsibly requires an understanding of the theory behind the function, the manual skill to perform the function, and the judgment when it is to be performed.

Nurses must practice within their own level of competence. When aspects of care are beyond the level of the nurse's competence, the nurse must seek additional information or knowledge, seek help from a supervisor or a competent practitioner, and/or request a different work assignment. In the interim, the nurse shall provide reasonable care within her/his level of competency until another nurse is available to do so.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 05-006-00	Employer Responsibilities
Policy 05-007-00	Employee Responsibilities
Policy 05-008-00	Nursing Practice- Additional Nursing Function
Guideline 05-008-01	Developing a Policy for Additional Nursing Functions
Guideline 05-008-02	Performing Additional Nursing Functions
Reference 05-008-03	Decision making Model for Performing Additional Nursing Functions and Delegated Medical Functions
Policy 05-009-00	Transferred Functions
Guideline 05-009-01	Policy Guidelines for Transferred Functions
Guideline 05-009-02	Parameters for Performing Transferred Functions

REFERENCES:

Alberta Association of Registered Nurses, Alberta Health Authorities, Alberta Medical Association, & College of Physicians and Surgeons of Alberta. (1987). *Joint Statement: Nursing Practice.* Edmonton, AB: Alberta Association of Registered Nurses.

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

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

Registered Nurses Association of Northwest Territories and Nunavut (2004). *Guidelines for Nursing Practice Decisions*. Yellowknife: RNANTNU

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:
Basic Nursing Procedures		Nursing Practice	07-002-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		1
APPLIES TO:			
Community Health Nurses			

POLICY 1:

Registered nurses are required to be knowledgeable and skilful in the implementation of basic nursing procedures.

POLICY 2:

Registered Nurses shall refer to the textbook *Clinical Nursing Skills and Techniques 7th edition* (Perry and Potter, 2010) for instruction on basic nursing skill procedures.

PRINCIPLES:

Ability to perform basic nursing procedures and follow protocols is expected of a registered nurse. Additional nursing and delegated medical functions require the development of specialized competence.

Related Policies, Guidelines and Legislation:

Policy 07-003-00 Nursing Skill Certification

REFERENCES:

Perry, A. G. and Potter, P.A. (2010). *Clinical Nursing Skills and Techniques 7th ed*. Mosby.

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:**
Nursing Skills Certification		Nursing Practice	07-003-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		3
APPLIES TO:			
Community Health Nurses			

POLICY:

The Department of Health and Social Services shall develop and/or adopt a process for Registered Nurses to develop competence in specialized nursing functions or transferred functions from other professions. This certification program shall incorporate the following elements:

1. **Competency standards are identified**
2. **Provisions are made for the specialized function to be practiced often enough to maintain competence**
3. **Protocols are established for safe implementation**
4. **Instructional programs conform to national standards and include:**
    a. **Knowledge of underlying principles**
    b. **Possible complications or risks**
    c. **Conditions under which it may be performed**
    d. **Supervised practice**
    e. **Method to demonstrate competence**
5. **Provisions are maintained for the review and recertification of the specialized function**
6. **Offers a record of certification**

PRINCIPLES:

- Utilization of the same format for all certification programs is an important element for continuous quality improvement programs.

- Certification validates your nursing specialty knowledge.

RELATED POLICIES, GUIDELINES AND LEGISLATION
Guidelines 07-003-01 Skills Recommended for Certification

REFERENCES:
Registered Nurses Association of the Northwest Territories and Nunavut (1992). *Guidelines for Nursing Practice Decisions*. RNANTNU: Yellowknife.

GUIDELINES 07-003-01

Certification is recommended for, but not limited to, the following skills/functions:

- Administration of Anti-Neoplastic Agents
- Advanced Cardiac Life Support
- Endo Tracheal Intubation
- Neonatal Resuscitation Program
- CPR Level C
- Basic Trauma Life Support / Trauma Nursing Core Course
- Pediatric Advanced Life Support or Emergency Nurses Pediatric Course
- ALARM – Advances in Labour and Risk Management course or other emergency obstetrical courses
- Arterial puncture (where possible)
- Basic Cardiac Life Support
- Cardiac Defibrillation
- Cardiac Monitoring and Interpretation
- Cast Application
- Electronic Fetal Monitoring
- Immunizations
- Phlebotomy
- Intrauterine Contraceptive Device removal
- Intravenous Therapy
- Accessing and maintaining umbilical lines
- X-ray Equipment Operation
- WHMIS
- Transportation of Dangerous Goods
- Suicide Intervention training
- Breastfeeding

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 05-006-00	Community Health Nursing Practice — Employer Responsibilities
Policy 05-007-00	Community Health Nursing Practice — Employee Responsibilities

PRINCIPLES:

- The need for certification is easily documented and substantiated.
- Establishing certification processes for these skills/functions should not pose operational hardship. Consistent certification processes for specialized nursing skills enhances client care and promotes continuous quality improvement.

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:**
Chief Medical Officer of Health		Nursing Practice	07-004-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		1
APPLIES TO:			
Community Health Nurses			

POLICY

Registered Nurses are expected to follow public health policies and protocols as sanctioned by the Chief Medical Officer of Health (CMOH) or Deputy Chief Medical Officer of Health (DCMOH).

PRINCIPLES

The CMOH is responsible for determining policies and protocols for public health functions in Nunavut.

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: **Nunavut Immunization Certification**	**SECTION:** Nursing Practice	**POLICY NUMBER:** 07-005-00
EFFECTIVE DATE: June 15, 2021	**REVIEW DUE:** June 15, 2023	**REPLACES NUMBER:** 07-005-00 (July 1 2018)
NUMBER OF PAGES: 4		
APPLIES TO: Registered Nurses, Licensed Practical Nurses, Nurse Practitioners, Registered Midwives		

1. BACKGROUND:

The goal of the Nunavut Immunization Certification process is to provide an ongoing, standardized education for all healthcare workers involved in the administration of immunizations and TB skin tests. The education modules have been developed in accordance with the Nunavut policies and procedures, the Nunavut Immunization Schedules, the Canadian Immunization Guide (CIG), and the Public Health Agency of Canada (PHAC) immunization competencies.

Although many nurses or midwives might not administer the full array of vaccines as part of their regular practice, they will need the requisite knowledge and skill base to answer questions regarding vaccines and immunization schedules. Additionally, these healthcare professionals should be prepared to assist with any mass immunization clinics in the event of a pandemic, health emergency, or as part of annual influenza activities.

2. POLICY:

All immunization providers must be certified to give publicly funded immunizations in Nunavut. This is a transferred health function from the office of the Chief Public Health Officer (CPHO). Therefore, all registered nurses, nurse practitioners, licensed practical nurses, and midwives who provide publicly funded immunizations and/or perform tuberculosis skin tests (TSTs) are required to successfully complete the Nunavut immunization certification program. This process must be complete before any unsupervised immunizations or TSTs are given.

Immunization certification consists of the completion of an online exam and an immunization skills checklist. The online exam includes a review of 6 education modules and a 75-question multiple-choice exam. The passing grade for the exam is 80% and exam writers will have 3 chances to successfully achieve a passing grade. A certificate will be emailed to the immunization provider. The immunization skills checklist (Appendix A) was developed as a resource for immunization providers to have an ongoing assessment of their competence in providing immunizations in Nunavut. This checklist should be completed with initial certification, then every 3 years with recertification. This is a shared responsibility of both the immunization provider and their supervisor/manager. The original copies of both the certificate and skills checklist are filed in the immunization provider HR file and copies are provided to the immunization provider.

Recertification should be completed every 3 years. The recertification process includes completing the immunization skills checklist as well as writing the online exam. The recertification process is the responsibility of both the immunization provider and their supervisor/manager.

3. PRINCIPLES:

The Registered Nurses Association of the Northwest Territories and Nunavut (RNANT/NU) highlights that continuing competence is essential to professional nursing practice and that "*competence* is continually maintained and acquired through reflective practice, lifelong learning, and integration of learning into nursing practice" (RNANT/NU, 2010).

4. PROTOCOL:

Registered Nurses, Licensed Practical Nurses, Nurse Practitioners and Midwives are governed by their respective professional associations and by Government of Nunavut regulations. The following table outlines the population parameters for each group of certified immunizers.

Profession	Population Parameters
Registered Nurses	May provide immunizations and TSTs (plant and read) to **all populations** as per: o Routine and catch-up immunization schedules o Specific vaccine protocols o Or as directed by the office of the CMOH (e.g. outbreak situation).
Registered Midwives	May provide immunizations to **infants and women of reproductive age** as per: o Routine and catch-up immunization schedules o Specific vaccine protocols
Licensed Practical Nurses	May provide immunizations and TSTs (plant and read) to **all populations** as per: o Routine and catch-up immunization schedules o Specific vaccine protocols o Or as directed by the office of the CMOH (e.g. outbreak situation).
Nurse Practitioners	May order/give vaccines as per professional regulations. May provide immunizations and TSTs (plant and read) to **all populations** as per: o Routine and catch-up immunization schedules o Specific vaccine protocols o Or as directed by the office of the CMOH (e.g. outbreak situation).

The following table outlines the specific roles and responsibilities of immunization providers and other supporting staff within the Nunavut Immunization program.

Profession/Title	Roles/Responsibilities
Registered Nurse Licensed Practical Nurse Registered Midwife Nurse Practitioner Agency nurse	• Complete initial online education modules and exam. • Complete initial skills checklist and review with supervisor/manager/agency. • Complete skills checklist every 3 years. • Complete immunization exam every 3 years.
Supervisor/Manager Agency supervisors	• Ensure that all new staff are oriented to the immunization policy. • Review initial skills checklist and support learning opportunities for staff. Refer to educators/proficient peer immunizers as needed. • Review skills checklist with immunization providers and ensure staff are current on certification. The skills checklist can also be reviewed by an educator or experienced colleague.
Nurse Educators	• Complete initial online education modules and exam. • Complete initial skills checklist and review with supervisor/manager • Complete skills checklist every 3 years. • Complete immunization exam every 3 years. • Support staff to become proficient in immunization skills.
Regional CDC	• Complete immunization certification and remain up to date as per guidelines for registered nurses (as above). • Available as resource for immunization related questions/concerns. • Communicate questions/concerns to Territorial CDC/CMOH.
Territorial CDC/CMOH	• Complete immunization certification and remain up to date as per guidelines for registered nurses (as above). • Maintain database of certified individuals in Nunavut and report to CMOH as requested. • Update immunization education modules and exam as evidence-based practice/vaccine guidelines change. • Address any questions/concerns brought forward by Regional CDC. • Review policy as outlined

5. REFERENCES:

Nunavut Midwifery Profession Practice Regulations (2010). *SCHEDULE E- DRUGS AND SUBSTANCES.*

Public Health Agency of Canada (2008). *Immunization Competencies for Health Professionals.* Retrieved from: http://www.phac-aspc.gc.ca/im/pdf/ichp-cips-eng.pdf

Registered Nurses Association of Northwest Territories and Nunavut (2010). *Scope of Practice for Registered Nurses.* Retrieved from: https://rnantnu.ca/sites/default/files/Scope-of-Practice-for-Registered-Nurses.pdf

Approved By:	Date:
Jennifer Berry, Assistant Deputy Minister - Operations	June 15, 2021
Approved By:	Date:
Michael Patterson, Chief Public Health Officer	June 22/21
Approved By:	Date:
Jenifer Bujold, Chief Nursing Officer	June 15, 2021

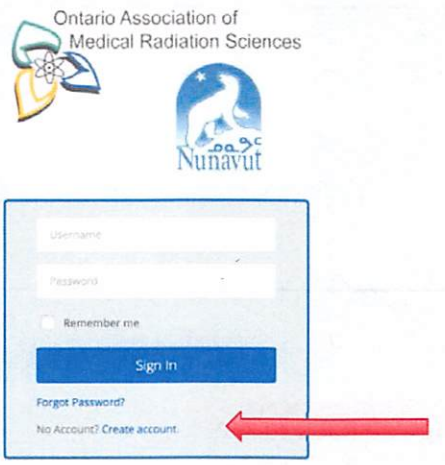
Nunavut Immunization Certification Process

Step 1

Go to: https://nunavuthealth.skillbuilder.co/sign-in

Step 2:

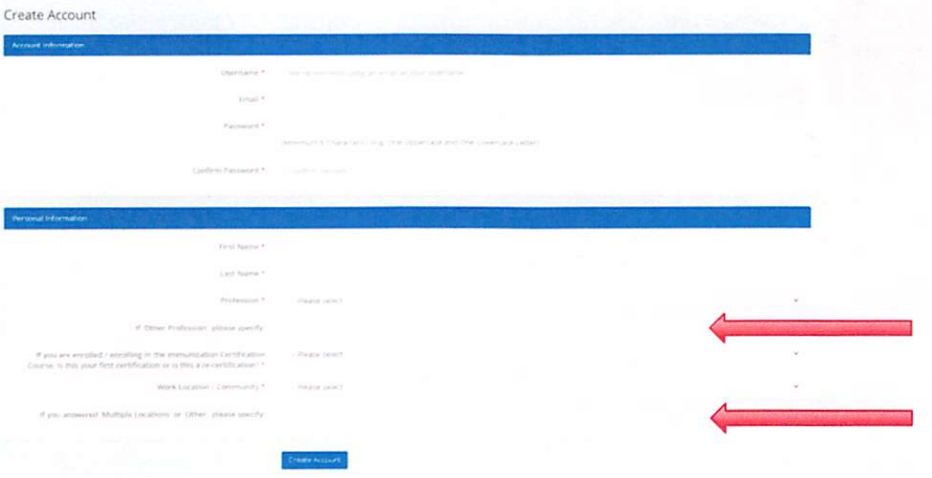
Click on "Create account"



Step 3:

Fill in the boxes with your answers and press "Create Account".

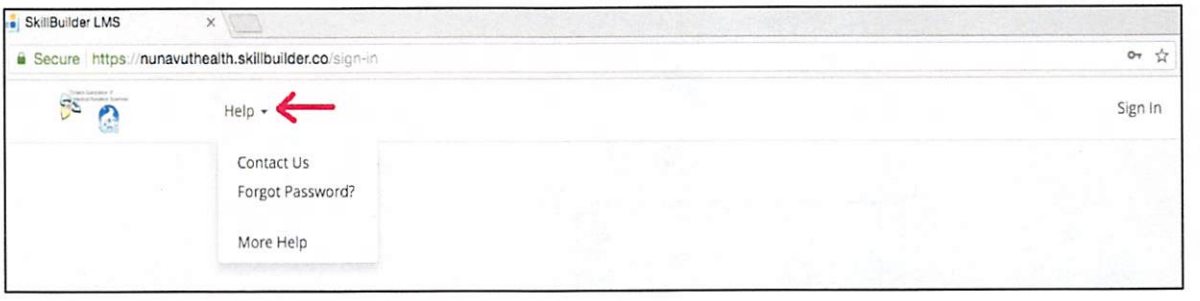
All questions marked with * are mandatory. If you've answered "Other", "Multiple Locations" or "Not Applicable" to any of the questions, please specify in the correct boxes below:



Step 4:

Follow prompts to check your email and confirm your account. You will receive an email from **SkillBuilder Notifications** [notifications@skillbuilder.co] with the subject heading "**Account Created - Verify Account**".
If the email is not in your inbox, check your "Junk E-mail" or "Spam" folder.
In the email, click on the link: Verify Your Account

***Please note** - if you have any issues related to the online platform, you can contact the administrators directly using the help function on website.



Step 5:

Clicking on the link above will bring you back to the https://nunavuthealth.skillbuilder.co/sign-in website.
Now you can Log in using the Username and Password you created.

Step 6:

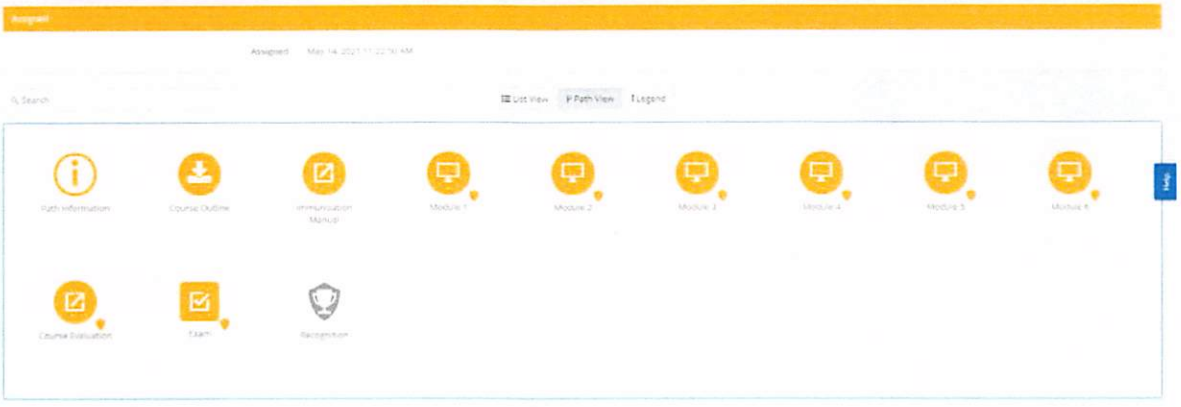
Once logged in, you will be in the "My Dashboard" portion of the website. Click on the "My Learning Paths" circle:

Step 7:

From there you will see the **Immunization Certification Course 2021**. Click on the course.

Step 8:

Review the course outline for learning objectives on the 6 education modules. There is also a link to the Nunavut Immunization Manual online. You will notice that the icons are in yellow until the item has been completed, when they turn green.



Step 9:

Review each of the 6 learning modules. Once completed, each module will turn from yellow to green. All 6 modules must be green in order for the course to be considered completed.

Step 10:

Complete the exam. Once complete, the exam will be automatically scored. Review all incorrect questions which include a rationale for the correct answer. If you are unsuccessful on the exam, please review the course content and try again.

Step 11:

Complete the course evaluation online.

Step 12:

The course is complete! Download your certificate by clicking on the "Recognition" tab. Keep a copy for your files and provide a copy to your supervisor to be kept in your HR file.

Step 13:

Review and complete the Skills Checklist (Appendix A). Keep a copy for your files and provide a copy to your supervisor to be kept in your HR file.

Administration of Non-publicly Funded Vaccine in Nunavut

Background:
In addition to publicly funded vaccines in Nunavut, nurses may be asked to administer non-publicly funded vaccines ordered by nurse practitioners (NPs) and/or physicians. These vaccines could be recommended for specific health conditions, travel, or upon the request of the recipient themselves. These vaccines can be important in providing protection against specific vaccine preventable diseases; Nunavummiut should be able to access and privately pay for the vaccines.

Policy:
Nurses may administer non-publicly funded vaccines ordered by NPs and physicians, in accordance with the vaccine's prescribed route, dose, and schedule (for vaccine series).

All non-publicly funded vaccines must be purchased privately by the patient from a pharmacy; publicly funded vaccine stock in the health center should not be used.

Definition:
Nurse – For the purpose of this policy, nurse refers to Registered Nurses and Licensed Practical Nurses.

Procedure:

1. Patient to order and pay for the vaccine directly from the pharmacy
2. It is important for the nurse to provide education that the vaccine should be transported and stored within recommended cold-chain temperatures.
3. All vaccines administered should be documented as outlined in section 3.4 of the Nunavut Immunization Manual. As there may not be a specific protocol for every vaccine available for private purchase, the following resources can be utilized to guide the nurse in reviewing precautions, contraindications, recommended scheduling, and post-vaccine health education.
    1. Canadian Immunization Guide (evergreen edition): https://www.canada.ca/en/public-health/services/canadian-immunization-guide.html
    2. Vaccine package inserts
    3. Specific vaccine product monographs can be found for all approved drugs in Canada online at: https://health-products.canada.ca/dpd-bdpp/index-eng.jsp

Examples of non-publicly funded vaccines that nurses may be requested to administer include:

- Hepatitis A vaccine

- Shingles vaccine
- Meningococcal vaccine
- Japanese Encephalitis vaccine
- Typhoid
- Rabies

Any additional questions about the administration of non-publicly funded vaccines can be directed to the regional CDC.

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Department of Health
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Ministère de la Santé

Appendix A: Immunization Skills Checklist

Review the following skills checklist. Immunization providers should complete at time of hire/onboarding and every 3 years (with exam). The original copy is filed in the immunization provider HR file and a copy is provided to the immunization provider.

The checklist should be reviewed with supervisor or delegate (including educators and peers who are at a proficient skill level).

The plan of action identifies what further steps the immunization provider should complete to further develop the skill(s).

A tentative date for the next review will be agreed upon and signed by both the immunization provider and supervisor.

Competency and Associated Skills	Self-assessment			Supervisor or Delegate	
	Aware	Knowledgeable	Proficient	Reviewed (initial)	Plan of Action
Obtaining Informed Consent					
• Reviews benefits, common expected reactions, and potential adverse reactions.					
• Proper documentation of informed consent.					
Client assessment					
• Reviews immunization card.					
• Client screening for contraindications.					
Understanding and maintaining cold chain					
• Demonstrates understanding of vaccine fridge monitor and vaccine transport.					
Preparation of Vaccines					
• Correct vaccine preparation with aseptic technique.					
• Ensures anaphylaxis kit is up to date and available. • Reviews steps for management of anaphylaxis.					

Aware = Basic level of mastery of the competency, in which individuals are able to identify the concept or skill but have a limited ability to perform the skill.
Knowledgeable = Intermediate level of mastery of the competency, in which individuals are able to apply and describe the skill.
Proficient = Advanced level of mastery of the competency, in which individuals are able to synthesize, critique, or teach the skill.

Competency and Associated Skills	Self-assessment			Supervisor or Delegate	
	Aware	Knowledgeable	Proficient	Reviewed (initial)	Plan of Action
The 7 Rights of medication administration					
• Right patient					
• Right medication (vaccine)					
• Right dose					
• Right route					
• Right time (in accordance with NU schedule and minimum spacing guidelines)					
• Right documentation					
• Right reason					
Practical demonstration of the following skills using correct positioning/restraint techniques, landmarking, and correct needle size (once per skill).					
• Intramuscular Injection - Infant					
• Intramuscular injection – child/adult					
• Subcutaneous injection					
• Intradermal injection					
Post-immunization Client education					
• Reviews vaccine after care guidelines.					
• Plan/schedule the next immunization appointment.					
Tuberculin Skin Testing (TST)					
• Understand the indications, contraindications and when to defer TST.					
• Successfully demonstrate the administration and reading of TSTs.					
• Ability to interpret TST results based on TB program standards.					

Immunization provider name (printed) and signature

Date signed

Supervisor/delegate signature

Date of next planned review

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS **Community Health Nursing**		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Unregulated Healthcare Workers – Employer Responsibilities		Nursing Practice	07-009-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
July 21, 2021	July 2023	N/A	3
APPLIES TO:			
Community Health Nurses, Home and Community Care Nurses, Psychiatric Nurses, Nurse Practitioners, Licensed Practical Nurses, Public Health Nurses			

1. BACKGROUND:

1.1 The Department of Health (Health) acts as an employer for regulated and unregulated healthcare providers and workers in Nunavut.

1.2 As an employer of regulated and unregulated healthcare providers and workers Health has the responsibility of providing direction on the roles and responsibilities of their employees.

2. POLICY:

2.1 Health will clearly describe the core competencies, educational requirements, roles, and responsibilities for the practice of Unregulated Healthcare Workers in health centres, long-term care facilities, and other locations where Health employs Unregulated Healthcare Workers.

2.2 Health will identify the roles, responsibilities, and accountability of the nurses involved with assigning and delegating tasks to Unregulated Healthcare Workers. Nurses have a professional responsibility to delegate appropriately to other members of the healthcare team and must receive training and direction from Health for delegating and assigning specific tasks to Unregulated Healthcare Workers

3. PRINCIPLES:

3.1 The responsibility for the practice of a nurse cannot be delegated to anyone who not a nurse. Under certain specific conditions a nurse may delegate selected tasks for a specific client to an unregulated healthcare worker provided the unregulated healthcare worker is competent and authorized to perform the task.

3.2 Unregulated healthcare workers are a valuable resource and must receive sufficient training, supervision, and support from Health.

3.3 Health and the unregulated healthcare workers share accountability with the nurse for safe and correct delegation of healthcare tasks.

3.4 Shortages of regulated healthcare providers, a shift in care settings from acute to home and community, an aging population, and a high financial burden of healthcare service delivery in Nunavut have resulted in healthcare teams increasingly relying on unregulated healthcare workers.

3.5 When healthcare providers operate as a team, workloads, wait times, and client outcomes and satisfaction all improve.

4. DEFINITIONS:

Unregulated Healthcare Workers: It is an umbrella term used to describe care providers who provide a form of health service and are not registered or licensed by a regulatory body. Unregulated Healthcare Workers carry numerous position titles and may include, but are not limited to: Community Health Representatives, Home and Community Care Workers, Continuing Care Workers, Personal Care Workers, Mental Health Workers, Maternal Care Workers, Life Skills Workers, family members, or students training in a health profession.

5. RELATED POLICIES, PROTOCOLS AND LEGISLATION:

Policy 07-010-00	Working with Unregulated Healthcare Workers: Nurse Responsibilities
Guideline 07-010-01	Working with Unregulated Healthcare Workers
Guideline 07-010-02	Deciding to Teach or Delegate a Procedure
Policy 07-011-00	Working with Unregulated Healthcare Workers: Worker's Responsibilities

6. REFERENCES:

Canadian Nurses Association (2009). *Increasing Use of Unregulated Health Workers.*

Canadian Nurses Association (2008). *Unregulated Health Workers: A Canadian and global perspective. Ottawa: CNA*

Canadian Nurses Association (2008). *Valuing Health-Care Team Members: Working with unregulated health workers.* Ottawa: CNA

Canadian Nurses Association (2003). *Position Statement: Staffing decision for the delivery of safe nursing care.* CNA: Ottawa.

College of Registered Nurses of British Columbia (2005). *Practice Standard for Registered Nurses and Nurse Practitioners: Delegating Tasks to Unregulated Care Providers.* Vancouver: CRNBC.

College and Association of Registered Nurses of Alberta (2005). *Standards for Supervision of Nursing Students and Undergraduate Nursing Employees Providing Client Care.* CARNA: Edmonton.

College of Nurses of Ontario (2005). *Practice Guideline: Utilization of unregulated care providers.* CNO: Toronto.

Government of Nova Scotia (2006). *Principles and Guidelines: A framework for continuing care assistants in acute care.* Government of Nova Scotia Health: Halifax.

Approved By:	Date: July 21, 2021
Jennifer Berry, Assistant Deputy Minister for Operations – Department of Health	
Approved By:	Date: July 21, 2021
Jennifer Bujold, Chief Nursing Officer	

Department of Health Government of Nunavut	**NURSING POLICY, PROCEDURE AND PROTOCOLS** **Community Health Nursing**		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Unregulated Healthcare Workers –Nurse Responsibilities		Nursing Practice	07-010-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
July 21, 2021	July 2022	07-010-00 and 07-010-01	8
APPLIES TO:			
Community Health Nurses, Home and Community Care Nurses, Psychiatric Nurses, Public Health Nurses, Licensed Practical Nurses, Nurse Practitioners.			

1. BACKGROUND:

1.1 The Department of Health (Health) is an employer of both regulated and unregulated healthcare workers.

1.2 In certain specific situations a nurse may delegate a specific healthcare task or activity for a specific client to an unregulated healthcare worker provided the unregulated healthcare worker is qualified and competent to perform the delegated task.

2. POLICY:

2.1 A nurse may delegate selected tasks to unregulated healthcare workers. The delegated tasks must not include the practice of nursing or the nursing process.

2.2 The nurse who delegates a task will continue to be responsible for the overall assessment, determination of client status, care planning, interventions, and care evaluation when tasks are delegated to an unregulated healthcare worker.

2.3 Before delegating any task to an unregulated healthcare worker, the nurse must ascertain if the unregulated healthcare worker has the required knowledge, skills, and abilities to perform the task which is to be delegated.

2.4 The nurse who delegates client related tasks or activities to an unregulated healthcare worker is accountable for the health and safety of the clients and must ensure that the worker has the required competence to safely perform the task or activity. For clarity the nurse cannot delegate any task or activity to an unregulated healthcare worker who is not qualified and competent to perform the delegated task or activity.

2.5 The unregulated healthcare worker is specifically responsible and accountable for:

- Seeking guidance and support as needed to safely perform the delegated task or activity;
- Knowing which tasks can be delegated as described in their roles, responsibilities, and scope of practice;
- Not performing any delegated tasks until authorized by the nurse;
- Performing the delegated task as they have been trained to do; and

- Reporting to the nurse responsible for delegating the task or activity.
- Compliance with all established departmental policies, procedures and guidelines and to work within the scope of practice defined in their job description.

2.6. The nurse is responsible to communicate this policy in its entirety, and in particular section 2.5, to the Unregulated Healthcare Worker to whom the task has been delegated.

3 PRINCIPLES:

3.1 The responsibility for the practice of a nurse cannot be delegated to someone who is not a nurse. Some tasks carried out by nurses are not in themselves the practice of nursing and therefore, under specific conditions, the task may be delegated to an Unregulated Healthcare Worker.

3.2 Unregulated Healthcare Workers are valuable resources and may give the nurse the opportunity to expand their services to a larger population.

3.3 Unregulated care workers share accountability with the nurse for safe delegation.

4 DEFINITIONS:

Unregulated Healthcare Workers: It is an umbrella term used to describe care providers who provide a form of health service and are not registered or licensed by a regulatory body. Unregulated Healthcare Workers carry numerous position titles and may include, but are not limited to: Community Health Representatives, Home and Community Care Workers, Personal Care Aides, Continuing Care Workers, Mental Health Workers, Maternal Care Workers, family members, or students training in a health profession.

5 RELATED POLICIES, PROTOCOLS AND LEGISLATION:

Policy 07-009-00	Working with Unregulated Healthcare Workers: Employer Responsibilities
Guideline 07-010-01	Working with Unregulated Healthcare Workers
Guideline 07-010-02	Deciding to Teach or Delegate a Procedure
Policy 07-011-00	Working with Unregulated Healthcare Workers: Worker's Responsibilities

6 REFERENCES:

Canadian Nurses Association (2009). *Increasing Use of Unregulated Health Workers.*

Canadian Nurses Association (2008). *Unregulated Health Workers: A Canadian and global perspective. Ottawa: CNA*

Canadian Nurses Association (2008). *Valuing Health-Care Team Members: Working with unregulated health workers.* Ottawa: CNA

Canadian Nurses Association (2003). *Position Statement: Staffing decision for the delivery of safe nursing care.* CNA: Ottawa.

College of Registered Nurses of British Columbia (2005). *Practice Standard for Registered Nurses and Nurse Practitioners: Delegating Tasks to Unregulated Care Providers.* Vancouver: CRNBC.

College and Association of Registered Nurses of Alberta (2005). *Standards for Supervision of Nursing Students and Undergraduate Nursing Employees Providing Client Care.* CARNA: Edmonton.

College of Nurses of Ontario (2005). *Practice Guideline: Utilization of unregulated care providers.* CNO: Toronto.
Government of Nova Scotia (2006). *Principles and Guidelines: A framework for continuing care assistants in acute care.* Government of Nova Scotia Health: Halifax.

GUIDELINES 07-010-01

TEACHING A PROCEDURE TO AN UNREGULATED HEALTHCARE WORKER

The Registered Nurse may teach a procedure to an Unregulated Healthcare Worker when the delegating nurse:

1. Has the knowledge, skill, and judgment to perform the procedure competently.
2. Has the additional knowledge, skill, and judgment to teach the procedure.
3. Accepts accountability for the decision to teach the procedure after considering the risks and benefits.
4. Has determined that the unregulated healthcare worker has acquired the knowledge, skill and judgment to perform the procedure safely, effectively and ethically.
5. Teaches the procedure to an unregulated healthcare worker who will perform the procedure.
6. Evaluates the continuing competence of the Unregulated Healthcare worker to perform the procedure.

DELEGATING A PROCEDURE TO AN UNREGULATED HEALTHCARE WORKER

A Registered Nurse may delegate a procedure to an Unregulated Healthcare worker when the delegating nurse:

1. Has the knowledge, skill and judgment to perform the procedure competently;
2. Has the additional knowledge, skill and judgment to delegate the procedure;
3. Accepts sole accountability for the decision to delegate the procedure after considering the following:
    - The known risks and benefits to the client(s) of performing the procedure;
    - The predictability of the outcomes of performing the procedure;
    - The safeguards and resources available in the situation; and
    - Other factors specific to the client(s) or the setting.
4. Has determined that the unregulated healthcare worker has acquired the knowledge, skill and judgment to perform the procedure;
5. Delegates the procedure to an unregulated healthcare worker who will perform the procedure; and
6. Evaluates the continuing competence of the unregulated healthcare worker to perform the procedure.

ASSIGNING ACTIVITIES, TASKS AND FUNCTIONS TO UNREGULATED HEALTHCARE WORKERS

The employer is responsible and accountable for:

1. Developing the role descriptions which clearly describe the tasks that can be assigned to an Unregulated Healthcare Worker.
2. Ensuring the Unregulated Healthcare Worker has received appropriate training and must supplement this training if needed.
3. The Registered Nurse who assigns activities and tasks to the Unregulated Healthcare Worker is responsible and accountable for:

- Ongoing assessment, care planning and evaluation of the clients' needs and health status.
- Determining the needs of the clients before assigning tasks to the Unregulated Healthcare Worker.
- Assigning only those tasks which fall within the Unregulated Healthcare Worker scope of work.
- Knowing the worker is competent to meet the needs of the clients.
- Establishing parameters for performing the procedure and providing guidance as needed.
- Intervening when the worker's competence to perform the assigned procedure(s) is questioned

SUPERVISING THE UNREGULATED HEALTHCARE WORKER

The Registered Nurse who supervises the activities of the Unregulated Healthcare Worker is responsible for:

1. Knowing the worker is competent to meet to perform the assigned task(s).
2. Verifying the worker understands the conditions and parameters for performing a procedure
3. Providing the appropriate degree of direct or indirect supervision, based on the client's condition, the nature of the procedure, the resources available in the setting and the degree of competence of the worker
4. Intervening in a procedure, when necessary

ACTIVITIES SUITABLE FOR DELEGATION TO UNREGULATED HEALTHCARE WORKERS

The Registered Nurse may delegate the following tasks to Unregulated Healthcare Workers subsequent to providing sufficient training and ensuring that the Unregulated Healthcare Worker is competent to perform the task. This list provides guidance and is not exhaustive; other tasks may also be delegated.

- Heights and weights – adult, child, infant
- Head circumference - infant
- Vital signs – adult
- Vital signs – pediatric (age 6 years and older)
- Visual acuity – child, adult
- Point of care testing:
    - Pregnancy tests
    - Urine testing using Clinitek
    - Capillary hemoglobin using the Hemocue machine in populations 12 years and older.
    - Random or fasting glucose using a glucometer in populations 12 years and older.
    - COVID-19 POCT if unregulated healthcare worker has successfully completed ADM Operations approved training.

DEFINITIONS

Unregulated Healthcare Workers: It is an umbrella term used to describe care providers who provide a form of health service and are not registered or licensed by a regulatory body. Unregulated Healthcare Workers carry numerous position titles and may include, but are not limited to: Community Health Representatives, Home and Community Care Workers, Personal Care Aides, Continuing Care Workers, Mental Health Workers, Maternal Care Workers, family members, or students training in a health profession.

Delegation: Delegation is a process where the Registered Nurse transfers the responsibility for the performance of a task to an unregulated Healthcare Worker or another regulated health professional yet retains accountability for the outcome (Federation of Health Regulatory Colleges of Ontario, 2007).

Delegation may be client-specific and not a general authorization to perform the task, as the delegated task must be determined to be in the client's best interest.

Assignment: Assignment refers to distributing care, activities, tasks and functions that are within the worker's scope of practice or description of duties defined by the employer.

Supervision: Supervising refers to activities of monitoring and directing the activities of Unregulated Healthcare Workers and does not refer to ongoing managerial responsibilities. Supervision may be direct or indirect.

LIABILITY

Each member of the team must be assured that colleagues have the skill and competencies needed to carry out assigned tasks.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 07-009-00	Working with Unregulated Healthcare Workers: Employer Responsibilities
Policy 07-010-00	Working with Unregulated Healthcare Workers: Nurse Responsibilities
Guideline 07-010-02	Deciding to Teach or Delegate a Procedure
Policy 07-011-00	Working with Unregulated Healthcare Workers: Worker's Responsibilities

REFERENCES:

College and Association of Registered Nurses of Alberta. (2005). *Standards for Supervision of Nursing Students and Undergraduate Nursing Employees Providing Client Care. CARNA:* Edmonton.

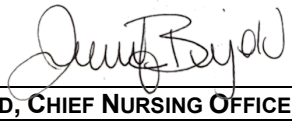
College of Nurses of Ontario (2009). *Practice Guideline: Working with unregulated care providers.* CNO: Toronto.

College of Registered Nurses of British Columbia (2008). *Practice Support: Assigning and delegating to unregulated care providers.* CRNBC: Vancouver.

Pan-Canadian Planning Committee on Unregulated Health Workers (2008). *Valuing Health-Care Team Members: Working with unregulated health workers.* Canadian Nurses Association: Ottawa.

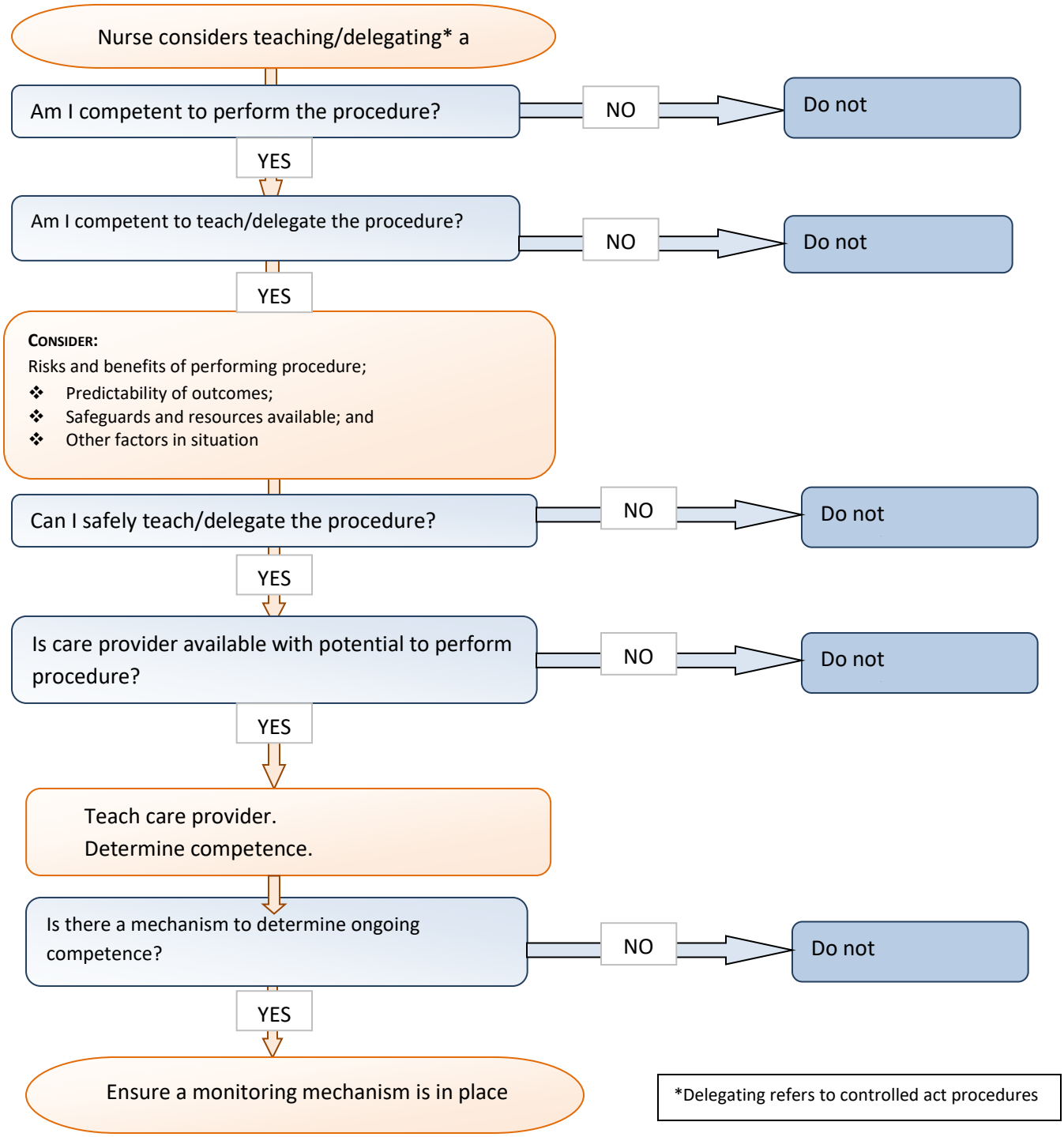
Registered Nurses Association of Northwest Territories and Nunavut (1992). *Guidelines for Nursing Practice Decisions.* RNANTNU: Yellowknife.

Saskatchewan Registered Nurse Association. (2002). *Practice of Nursing: RN Assignment and Delegation.* Regina, SK.

APPROVED BY: 	**DATE:** **JULY 21, 2021**
JENNIFER BERRY, ASSISTANT DEPUTY MINISTER, OPERATIONS	
APPROVED BY: 	**DATE:** July 21, 2021
JENIFER BUJOLD, CHIEF NURSING OFFICER	

DECISION TREE: TEACHING OR DELEGATING THE PERFORMANCE OF A PROCEDURE

DECISION TREE: TEACHING OR DELEGATING THE PERFORMANCE OF A PROCEDURE



Adapted from College of Nurses of Ontario (2009). *Working with Unregulated Care Providers.*

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS		
	Community Health Nursing		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Certification of Death		Nursing Practice	07-012-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		2
APPLIES TO:			
Community Health Nurses			

POLICY:

The medical practitioner who was last in attendance during the last illness of the deceased shall sign the medical certificate in the prescribed form, stating in it the cause of death according to the International List of Causes of Death.

Where a death occurs without attendance by a medical practitioner or where a medical practitioner is not available to complete the medical certificate, the prescribed form shall be completed and signed by the Registered Nurse. The original copy is sent to the office of Registrar General of Vital Statistics where the registrar shall co-sign and certify the form in accordance with the *Vital Statistics Act*.

In circumstances where the coroner has conducted an investigation or held an inquest respecting the death, the coroner shall be responsible for signing the certificate of death.

DEFINITIONS:

Medical Practitioner: Refers to a physician

PRINCIPLES:

- The *Vital Statistics Act (R.S.N.W.T. 1998*, c.17, s.29, as duplicated for Nunavut by s.29 of the *Nunavut Act*, S.C. 1993, c.28) requires that the certificate of death be signed by the medical practitioner last in attendance during the last illness of the deceased or by the coroner where there has been an inquest or inquiry. Where a death occurs without medical attendance, or where a medical practitioner is not available to sign the medical certificate, the Supervisor of Community Health Programs may complete the certificate.

- Due to staffing resources in isolated communities, it is customarily the Registered Nurse who is most likely to complete and sign the Certificate of Death.

- If an autopsy is completed and the pathology and/or autopsy report contains additional information than originally entered on the medical certificate, then the certificate will be amended by Vital Statistics as outlined in the *Vital Statistics Act (R.S.N.W.T. 1998*, c.17, s.29, as duplicated for Nunavut by s.29 of the *Nunavut Act*, S.C. 1993, c.28)

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 07-013-00	Pronouncing a Death
Guideline 07-013-01	Guidelines for Pronouncing a Death
Policy 07-014-00	Reporting a death to the coroner

REFERENCES:

Coroners Act R.S.N.W.T. 1988, c.C-20, as amended by Nunavut Statutes s.Nu.2007, c.15, s.177

Vital Statistics Act (R.S.N.W.T. 1998, c.17, s.29, as duplicated for Nunavut by s.29 of the *Nunavut Act*, S.C. 1993, c.28)

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:**
Pronouncing Death	Nursing Practice	07-013-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018 / February 2021		6
APPLIES TO:		
Community Health Nurses		

POLICY:

In the event of an expected and anticipated death, the Registered Nurse is authorized to pronounce the death of a client. The Nurse shall record the time and date of the death on the client record.

In the event of an unexpected death, the on-call physician shall pronounce the death. If the physician is not available in the community, the Registered Nurse employed as a Community Health Nurse, may pronounce the death. In such circumstances, the on-call physician must be promptly notified.

Pronouncement of death is not a legal entity but rather a declaration that death has occurred as evidenced by absence of pulse, respirations, fixed dilated pupils and no response to painful stimuli.

DEFINITIONS:

Pronouncement of Death: means the determination that death has occurred. It is a legal action based on a physical assessment.

PRINCIPLES:

- The pronouncement of death is not a reserved medical act or a delegated medical function. There are no laws governing the event when death is expected or are there laws defining who is qualified to pronounce death in such circumstances. An unexpected death must be reported to the coroner in accordance with the *Coroners Act* and Policy 07-014-00 *Reporting a Death to the Coroner*.

- In the case of a sudden and/or unexpected death, the RCMP along with the coroner conducts an investigation as defined in the *Coroners Act*. The coroner authorizes an autopsy if necessary. The coroner is the only person who has the authority to order an autopsy without consent.

- Where the death is considered a reportable death as per the *Coroners Act,* the coroner and RCMP are responsible for the body. The responsibility of the community health nurse ends after a pronouncement of death has been made and the details of the case discussed with the coroner or RCMP.

- If a nurse is in doubt of how to proceed, the registered nurse may call the coroner's office in Iqaluit.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 07-012-00	Certification of Death
Guideline 07-013-01	Guidelines for Pronouncing Death
Policy 07-014-00	Reporting a death to the Coroner
Policy 08-004-00	Post Mortem Samples

REFERENCES:

Coroners Act R.S.N.W.T. 1988, c.C-20, as amended by Nunavut Statutes s.Nu.2007, c.15, s.177

Vital Statistics Act (R.S.N.W.T. 1998, c.17, s.29, as duplicated for Nunavut by s.29 of the *Nunavut Act*, S.C. 1993, c.28)

GUIDELINES 07-013-01

Death may be pronounced when the following criteria are met:

1. Client is in cardiac arrest (absence of apical pulse, absence of respirations, fixed and dilated pupils, and no response to painful stimuli)

2. The client was discovered in a state of cardiac arrest AND was not known to be alive in the preceding fifteen (15) minutes. If DO NOT Resuscitate advance directive is present, witness to the arrest does not preclude pronouncement of death.

3. Asystole has been documented in two monitoring leads for at least one (1) minute.

    a. If only an AED is available with single lead capabilities, personnel should note it on client's health record.

    b. Verification of asystole is not necessary if one of the following are present
        i. Death is being pronounced pursuant to a properly executed Do Not Resuscitate advance directive.
        ii. Decomposition of body tissues
        iii. Decapitation
        iv. Incineration
        v. Separation of or massive destruction to heart or brain
        vi. Rigor is present

The client MEETS the criteria for the pronouncement of death:

1. Do not initiate CPR

1. Notify the Supervisor of Community Health Programs and the on-call physician, if not present.

2. Notify a member of the RCMP of all deaths in the community, expected or unexpected. The Coroner shall be promptly notified in accordance with the *Coroners Act*.

3. If the death occurred in the health centre, the Registered Nurse, attending physician, or Supervisor of Community Health Programs will notify the family. If the death occurred in the community and not inside the health centre, the RCMP shall notify the family of the client's death.

4. The Vial Statistics *Registration of Death* form must be completed as per Policy 07-012-00. A photocopy of the completed form is placed in the client's health record. The original is forwarded to Vital Statistics as outlined on the Registration of Death form.

5. Document the pronouncement of death in the client's health record.

Health Record Documentation

The following nursing assessment must be documented in the client's health record:

1. No apical pulse
2. No respiration
3. Pupils fixed / dilated
4. No response to painful stimuli
5. Time the pronouncement of death
6. Name of physician and supervisor notified AND time of notification
7. Name of the coroner notified and time of notification
8. Time the body was transferred to the morgue
9. Name and time next of kin was notified.

Client does NOT meet the criteria for pronouncement of death (e.g. family requests, etc.)

1. Begin Life Support measures
2. Establish contact with Supervisor of Community Health Programs and on-call physician immediately to determine appropriate action. The physician may elect to pronounce death or to administer additional interventions.
3. Proceed accordingly

GUIDELINES 07-013-02

1. When death is pronounced by a Physician or Registered Nurse:

- Pronounce death as per criteria listed in Guideline 07-013-01

- Notify a member of the RCMP, the Coroner and the Director of Health Programs of all deaths in the community, expected or unexpected. The Coroner shall be promptly notified in accordance with the *Coroners Act*.

- Process necessary lab tests as ordered by the physician. If applicable, collect post mortem samples as directed by the Coroner and in accordance with Policy 08-004-00 *Post Mortem Samples*. The Coroner must complete and sign a Form 11 of the schedule in order to authorize a Registered Nurse to obtain post mortem samples. (Note: Collecting post mortem samples is the responsibility of the Coroner's office and therefore, the nurse is not compelled to obtain post mortem samples)

- Provides support to the family

- Complete and sign the Vital Statistics Registration of Death form as per Policy 07-012-00.

- The details of the pronouncement of death, including date and time, must be documented in the client's health record.

2. Nursing staff (may or may not pertain to the nurse who pronounced the death):

- Provide holistic, supportive care to the family based on a comprehensive assessment of wishes and needs.

- Assemble appropriate forms for completion by appropriate members of the team and ensure the forms have been submitted to Vital Statistics as indicated.

- Complete the client's medial record and ensure the following details are included: name of the practitioner who pronounced the death; the time of death; information given to the family about their responsibilities; care of the body; responses of the family; and support given to the family after death.

- Contact other team members as needed to assist in supporting the family and to meet the family's spiritual needs.

- Prepare the body for viewing by family members.
  If the death is a coroner's case with autopsy:
  i. Do not proceed with post mortem care until permission received from coroner.

ii. Do not remove any tubes, drains and catheters, etc. (Tie them off to avoid leakage). The endo-tracheal tube can be removed once placement of the tube is confirmed and documented. Do not send IV bags or drainage bags to the morgue.

- If the family has not yet viewed the body of an infant/child, consider wrapping the young child/infant in warm blankets or place him/her in an incubator before giving to the parents. If this case is a Coroner's case, the Coroner should be consulted first as these actions may compromise evidence.

- Complete lab tests as ordered

- Discuss the family's wishes for preparing the body for the funeral and support their participation in such activities (e.g. dressing the body in client's own clothing).

- A plastic shroud is necessary to meet standards for universal precautions for bodies if there are any potential for fluid leakage. The families may request blankets from home be used as a shroud and is acceptable. The plastic shroud may be applied overtop of the blankets if fluid leakage is anticipated.

- Ensure all personal belongings not accompanying the body are returned to the family and documented in the client's health record. After the family has had an opportunity to complete any death rituals and agreeable to the transfer, contact the Hamlet to notify them that the body is ready for transport to the community morgue.

- Re-stock the clinic room as required

3. <u>Housekeeping:</u>

- Responsible for cleaning the clinic room where the death occurred (if applicable)

- Responsible for sterilization of emergency equipment as required

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:**
Reporting a Death to Coroner	Nursing Practice	07-014-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018 / February 2021		2
APPLIES TO:		
Community Health Nurses		

POLICY 1:

The Registered Nurse shall report a death to the Coroner, in accordance to the *Nunavut Coroners Act*. (R.S.N.W.T. 1998, c. C-20, as amended by Nunavut Statutes S.Nu. 2007, c.15), under the following circumstances:

1. **Occurs as a result of apparent violence, accident, suicide or other apparent cause other than disease, sickness or old age.**

2. **Occurs as a result of apparent negligence, misconduct or malpractice;**

3. **Occurs suddenly and unexpectedly when the deceased was in apparent good health;**

4. **Occurs within 10 days after a medical procedure or while the deceased is under or recovering from anesthesia;**

5. **Occurs as a result of**

    i. **A disease or sickness incurred or contracted by the deceased,**
    ii. **An injury sustained by the deceased, or**
    iii. **An exposure of the deceased to a toxic substance, as a result or in the course of any employment or occupation of the deceased,**

6. **Is a stillbirth that occurs without the presence of a medical practitioner;**

7. **Occurs while the deceased is detained or in custody involuntarily pursuant to law in a jail, lock-up, correctional facility, medical facility or other institution; or**

8. **Occurs while the deceased is detained by or in the custody of a police office.**

POLICY 2:

The client's record is a confidential document and shall only be photocopied for the Coroner when presented with a completed Form H (coroner's authorization form).

PRINCIPLES:

- In the case of a sudden and/or unexpected death, the RCMP along with the coroner conducts an investigation as defined in the *Coroners Act*. The coroner authorizes an autopsy if necessary. The coroner is the only person who has the authority to order an autopsy without consent.

- Where the death is considered a reportable death as per the *Coroners Act,* the coroner and RCMP are responsible for the body. The responsibility of the community health nurse ends after a pronouncement of death has been made and the details of the case discussed with the coroner or RCMP.

- If a nurse is in doubt of how to proceed, the registered nurse may call the coroner's office in Iqaluit.

REFERENCES:

Coroners Act R.S.N.W.T. 1988, c.C-20, as amended by Nunavut Statutes s.Nu.2007, c.15, s.177

GUIDELINE 07-014-01

The Coroner is responsible for completing the forms related to a Coroner's case, as outlined in the Nunavut *Coroner's Act* and *Coroner's Forms Regulations*.

The Coroner's forms which are applicable to the health centre include:

- Form 1: Warrant to Take Possession of the Body
- Form 2: Authorization to Release the Body
- Form 3: Certificate of Coroner Regarding Inquest.
- Form 4: Authorization to Perform Post-Mortem
- Form 5: Authorization to Transport Body out of Nunavut
- Form 11: Authorization to Take a Sample of Bodily Fluids
- Form 12: Authorization to Examine Bodily Fluids

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:
Stillbirth		Nursing Practice	07-015-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		4
APPLIES TO:			
Community Health Nurses			

POLICY:

The Registered Nurse, employed as a Community Health Nurse, shall report and document a stillbirth which occurs within the community in accordance with the *Vital Statistics Act (R.S.N.W.T. 1998*, c.17, s.29, as duplicated for Nunavut by s.29 of the *Nunavut Act*, S.C. 1993, c.28*)* and the *Coroners Act* (R.S.N.W.T. 1988, c.C-20, as amended by Nunavut Statutes s.Nu.2007, c.15, s.177).

The on-call Physician or Registered Nurse shall complete the Stillbirth Certificate in accordance to the *Vital Statistics Act*.

Each Regional office of Health and Social Services shall establish guidelines for the handling of a stillbirth in its respective communities.

DEFINITION:

Stillbirth involves the complete expulsion or extraction of a fetus more than 20 weeks in gestation OR after the fetus attained a weight of 500 grams. After complete expulsion or extraction, the fetus does not show signs of breathing, beating of the heart, pulsations of the umbilical cord or movement of voluntary muscles (*Vital Statistics Act R.S.N.W.T. 1998*, c.17, s.29, as duplicated for Nunavut by s.29 of the *Nunavut Act*, S.C. 1993, c.28)

PRINCIPLES:

- The requirement to report and document is mandated by the *Vital Statistics Act* and the *Coroners Act.*

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Guideline 07-015-01 Guidelines for Handling of a Stillbirth
Guideline 07-015-02 Examination Guidelines for Handling of a Stillbirth

REFERENCES:

Coroners Act R.S.N.W.T. 1988, c.C-20, as amended by Nunavut Statutes s.Nu.2007, c.15, s.177

Vital Statistics Act (R.S.N.W.T. 1998, c.17, s.29, as duplicated for Nunavut by s.29 of the *Nunavut Act*, S.C. 1993, c.28)

GUIDELINES 07-015-01

1. When a stillbirth occurs in the community or in the health centre, the on-call physician and Supervisor of Community Health Programs shall be contacted.

2. Parents or caregivers shall be offered access to support services available in the community.

3. Follow additional Regional Health and Social Services guidelines for the handling of a stillbirth.

4. The Registered Nurse shall notify the Coroner and other community resources as indicated (e.g. Clergy, mental health worker, etc.).

5. The Supervisor of Community Health Programs shall notify the Regional Director of Health and Social Services.

6. The *Registration of Stillbirth Form (Vital Statistics Act*) will be completed by the physician (when available in the community), the Community Health Nurse or the Coroner.

    a. The original copy is sent to the office of Registrar General of Vital Statistics
    b. A photocopy is placed on the mother's chart

7. Complete *Labor and Delivery Record* part 1 and part 2

8. Complete *Newborn Record* part 1

9. If an autopsy is required or ordered by a medical practitioner, the Coroner will assume responsibility for completing required paperwork and arranging transportation of the body.

10. The Burial Permit is issued and completed by the community hamlet.

11. The physician (when available in the community), the Midwife (when available in the community), the Supervisor of Community Health Programs or Community Health Nurse shall discuss the details of any autopsy report with the parents during the six-week post-natal visit. If indicated, a referral can be made to an obstetrician for further consultation.

12. Provide access to Critical Incident Stress Debriefing for health care providers as per Policy 05-005-00— *Critical Incident Stress Management.*

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 05-005-00	Critical Incident Stress Management
Policy 07-014-00	Reporting a Death to Coroner
Policy 07-015-00	Stillbirth
Guideline 07-015-02	Examination Guidelines for a Stillbirth
Policy 08-004-00	Post Mortem Samples

REFERENCES:

Coroners Act R.S.N.W.T. 1988, c.C-20, as amended by Nunavut Statutes s.Nu.2007, c.15, s.177

Vital Statistics Act (R.S.N.W.T. 1998, c.17, s.29, as duplicated for Nunavut by s.29 of the *Nunavut Act*, S.C. 1993, c.28)

GUIDELINES 07-015-02

1. Perform a rapid, superficial examination, noting any abnormalities. The placenta and umbilical cord are examined as part of the initial examination.

2. Notify the Coroner for further direction.

3. Consult the physician regarding maternal care needs.

4. If the parents/caregivers request parental keepsakes (e.g. pictures, footprints or lock of hair), obtain the Coroner's consent prior collecting any keepsakes.

5. Send placenta and cord to pathology (as per HSS laboratory policy and procedure) if autopsy ordered.

REFERENCES:

Coroners Act R.S.N.W.T. 1988, c.C-20, as amended by Nunavut Statutes s.Nu.2007, c.15, s.177

Vital Statistics Act (R.S.N.W.T. 1998, c.17, s.29, as duplicated for Nunavut by s.29 of the *Nunavut Act*, S.C. 1993, c.28)

Leduc, L. (2006). Stillbirth and bereavement: guidelines for stillbirth investigation. *Journal of Obstetrics and Gynecology, 178,* 540-5.

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:**
Advance Directives		Nursing Practice	07-016-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		7
APPLIES TO:			
Community Health Nurses			

POLICY 1:

The Department of Health and Social Services promotes an environment which respects and encourages client self-determination. Clients will be encouraged and assisted to be active participants in the decision making process regarding their care through education, inquiry and assistance as requested.

Clients will be encouraged to communicate their desires in regard to advance directives to their significant others, to allow for guidance of significant others and healthcare providers in following the client's wishes should the client become incapacitated, rendering them unable to make decisions. The existence of an advance directive, or lack thereof, will not determine the client's access to care, treatment and services.

POLICY 2:

In an advance directive, the client may provide guidance as to his/her wishes in certain situations, or may delegate decision making to another individual as permitted by relevant legislation.

The delegated individual must identify themselves through legal transfer of the client's rights/power of attorney. If such an individual has been selected by the client to make treatment decisions, relevant information shall be provided to the representative so that informed healthcare decisions can be made for the client. However, as soon as the client is able to be informed of his/her rights, the Department of Health and Social Services shall provide that information to the client.

POLICY 3:

When the registered nurse or physician discuss advanced care planning with a client/ substitute decision maker/ power of attorney, the practitioner shall use the *Nunavut Care Level Planning* form in addition to documenting the details of the discussion in the client's health record.

DEFINITIONS:

Advance Directives refer to the means used to document and communicate a person's preferences regarding life-sustaining treatment in the event that they become incapable of expressing those wishes themselves. There are two forms:

- *Instruction directive:* commonly referred to as a living will, which details what life-sustaining treatments a person would want or not want in given situations
- *Proxy directive:* which explains who is to make healthcare decisions if the person becomes incompetent

Capability: All adults are presumed to be capable of making health care decisions until there is clear evidence that the adult is incapable of making a clear decision. Capability and incapability is assessed on the client's understanding:

- Of the information being given to him/her
- That the information applies to his/her own situation.

PRINCIPLES:

- Nunavut does not have legislation governing Advance Directives
- Advance Directives encourages an atmosphere of respect and caring and maximizes the client's ability and right to participate in medical decision making.
- Advanced directives promote the ethical value of autonomy. Autonomy is the principle that a person should be free to make his or her own decisions. Individual freedom is the basis for the modern concept of bioethics.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Template 07-016-01	Nunavut Care Level Planning
Policy 07-017-00	Do Not Resuscitate Order

REFERENCES:

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

Canadian Nurses Association (2008). *Position Statement: Providing nursing care at the end of life.* Ottawa, ON.

Canadian Nurses Association (1998). Advance Directives: The Nurse's Role. *Ethics in Practice.*

GUARDIANSHIP AND TRUSTEESHIP (S.N.W.T. 1994,c.29, as as duplicated for Nunavut by s.29 of the *Nunavut Ac*t, S.C. 1993, c.28)

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**	

TEMPLATE 07-016-01

The practitioner discussing advanced care planning with a client must ensure the *Nunavut Care Level Planning* form is completed by the physician/registered nurse, client or substitute decision maker/ power of attorney, and the interpreter (if applicable).

This form is filed in the client's health record. If the client is transferred to a referral site/ hospital, then a copy of this form should accompany the client.

Nunavut Care Level Planning
ᓄᓇᕘᒥ ᐃᓄᑐᖃᕐᓄᑦ ᐸᓇᓱᐊᒐᖅ

Your health care team would like to know how to provide the best care for you and your family. We would like to listen to you.

To provide the best care we need to have a difficult conversation with you and your family. We will only talk about your illnesses with your family with your permission. We would like to talk about what happens when you become sick and may be dying and what forms of care you would like to receive. We would like to know where you would like to receive your care (for example in your home community, Iqaluit, or Ottawa). If possible we would like to provide care at the end of your life with your family with you at home or in Iqaluit.

Thank you for allowing your nurses and doctors to talk about this with you.

If you do not wish to talk about your illness and care please let us know and we will not discuss it with you.

ᐋᓂᐊᖅᑐᓕᕆᓂᕐᒧᑦ ᑲᒪᔨᒋᔭᔅᓯ ᖃᐅᔨᒪᖕᒪᑕ ᖃᓄᖅ ᐊᑲᐅᓂᖅᐹᒃᑯᑦ ᑲᒪᒋᔭᖃᑦᑎᐊᕈᓐᓇᕐᒪᖔᑦ ᐃᓕᖕᓂᒃ ᐃᓚᒋᔭᔅᓯᓐᓂᒡᓗ. ᐃᓕᔅᓯᓐᓂᒃ ᓈᓚᒍᒪᕗᒍᑦ.

ᐊᑲᐅᓛᒃᑯᑦ ᑲᒪᒋᔭᖃᑦᑎᐊᕈᓐᓇᕐᑯᓪᓗᑕ ᐊᔪᕐᓇᖅᑐᒃᑯᑦ ᐅᖃᖃᑎᖃᓇᐊᖅᑲᕐᑕ ᐃᓕᖕᓂᒃ ᐃᓚᒋᔭᔅᓯᓐᓂᒡᓗ. ᐅᖃᐅᓯᖃᑐᐃᓐᓇᕐᓂᐊᖅᑐᒍᑦ ᐋᓂᐊᓇᔭᕐᓂᒃ ᐃᓚᒋᔭᔅᓯᓐᓄᑦ ᐊᖏᕈᑎᖃᓚᐅᖅᑎᓪᓗᑎᑦ. ᐅᖃᐅᓯᖃᕈᒪᒐᑦᑕ ᐋᓂᐊᓕᕋᖓᕕᑦ ᖃᓄᐃᓕᐅᖃᑦᑕᕐᒪᖔᔅᓯ ᑐᖁᐃᓐᓇᓇᐊᖅᑲᕐᓗᑎᓪᓘᓐᓃᑦ ᖃᓄᕐᓗ ᑲᒥᔭᐅᖃᑦᑕᕈᒪᖕᒪᖔᖅᐱᑦ. ᖃᐅᔨᒪᕗᒍᑦ ᓇᓂ ᑲᒥᔭᐅᕙᒪᓇᔭᕐᒪᖔᖅᐱᑦ (ᐅᓇ ᐆᒃᑑᑎᒥᓗᒍ ᓄᓇᔅᓯᓐᓂ, ᐃᖃᓗᖕᓂ, ᐋᑐᕚᒥ ᓘᓐᓃᑦ). ᐊᔪᕐᓇᙱᑉᐸᑦ ᑲᒥᕙᒪᓇᔭᖅᐸᑦᑎᒋᑦ ᐃᓅᓯᖅᐱᑦ ᐃᓱᐊᓄᑦ ᐃᓚᒋᔭᑎᑦ ᐱᖃᑎᒋᓗᒋᑦ ᐊᖏᕐᕋᔅᓯᓐᓂ ᐃᖃᓗᖕᓂᓪᓘᓐᓃᑦ.

ᖁᔭᓐᓇᒦᒃ ᐋᓂᐊᓯᐅᖅᑎᓯᓐᓂᒃ ᓘᒃᑖᓯᓐᓂᓪᓗ ᐱᕕᖃᖅᑎᑦᑎᒐᔅᓯ ᑖᔅᓱᒥᖓ ᐅᖃᐅᓯᖅᑎᓪᓗᑕ ᐃᓕᖕᓄᑦ.

ᐅᖃᐅᓯᖃᕈᒪᙱᒃᑯᕕᑦ ᐋᓂᐊᕐᓂᖅᐱᑦ ᒥᒃᓵᓄᑦ ᑲᒪᒋᔭᐅᔪᓇᐊᕐᓂᕐᓄᓪᓗ ᖃᐅᔨᑎᓐᓂᐊᖅᐸᑦᑎᒍᑦ ᐅᖃᓪᓚᖃᑎᒋᔾᔮᙱᑉᐸᑦᑎᒋᓪᓗ.

Nunavut Care Level Planning

I, ________________________________, would like the following level of care to be provided to me,
ᐅᕙᖓ, ________________________________, ᐃᒫᒃ ᑲᒪᒋᔭᐅᔪᒪᓂᖃᖅᑐᖓ ,

_______ acute medical care, including transport and care in referral hospitals in Southern Canada.
ᐋᖅᑭᒃᑕᐅᓴᕋᐃᑦᑐᒧᑦ, ᐃᓚᖃᓯᐅᑎᓗᒍ ᐃᖏᕐᕋᔾᔪᑎᒋᓂᐊᖅᑕᒃᑲ ᐊᒻᒪᓗ ᑖᒃᑎᓕᐊᕐᕕᖕᓂᓗ ᐋᓐᓂᐊᕐᕕᖕᓂ ᖃᓪᓗᓈᓂ.

________ acute medical care, including transport and care in referral hospitals in Southern Canada, but do not wish CPR/intubation/cardioversion.
ᐋᖅᑭᒃᑕᐅᓴᕋᐃᑦᑐᒧᑦ, ᐃᓚᖃᓯᐅᑎᓗᒍ ᐃᖏᕐᕋᔾᔪᑎᒋᓂᐊᖅᑕᒃᑲ ᐊᒻᒪᓗ ᑖᒃᑎᓕᐊᕐᕕᖕᓂᓗ ᐋᓐᓂᐊᕐᕕᖕᓂ ᖃᓪᓗᓈᓂ, ᑭᓯᐊᓂ ᐋᓐᓂᖅᓵᖅᑎᑕᐅᓇᓱᐊᕈᒪᓂᐊᖏᑦᑐᖓ/ᓱᓪᓗᓕᖅᑐᖅᑕᐅᔪᒪᓇᖓᓗ ᑎᒥᒃᑯᑦ/ᐆᒻᒪᑎᖓ
ᑎᒡᓕᓕᖅᑎᑕᐅᓇᓱᐊᖅᑕᐅᖁᖏᑦᑕᕋᓗ.

________ acute medical care to be provided at Qikiqtani General Hospital only, recognizing that CPR/intubation/cardioversion will not be performed as this will then involve transport to a hospital in Southern Canada. In stabilization and transport to QGH I do not wish CPR/intubation/cardioversion. I may desire transport for medically relevant investigations, but this will be reviewed with my health care team on an individual basis.
ᐋᖅᑭᒃᑕᐅᓴᕋᐃᑦᑐᒧᑦ ᐃᑲᔪᖅᑕᐅᔪᒪᔪᖓ ᕿᑭᖅᑖᓗᑉ ᐋᓐᓂᐊᕐᕕᖓᓐᓂ ᑭᓯᐊᓂ, ᖃᐅᔨᒪᑦᓯᖓᓗ
ᐋᓐᓂᖅᓵᖅᑎᑕᐅᓇᓱᐊᕈᒪᓂᐊᖏᑦᑐᖓ/ᓱᓪᓗᓕᖅᑐᖅᑕᐅᔪᒪᓇᖓᓗ ᑎᒥᒃᑯᑦ/ᐆᒻᒪᑎᖓ
ᑎᒡᓕᓕᖅᑎᑕᐅᓇᓱᐊᖅᑕᐅᖁᖏᑦᑕᕋᓗ
ᖃᐅᔨᒪᒐᒐ ᐊᓯᐊᓄᑦ ᐋᓐᓂᐊᕐᕕᖕᒧᑦ ᐊᒡᔭᖅᑕᐅᔭᓇᐊᖅᑲᕐᓂᐊᕋᒪ ᖃᓪᓗᓈᓄᑦ.
ᖃᓄᐃᒍᓐᓃᔾᔨᒥᑎᑕᐅᓇᓱᐊᖅᑎᓪᓗᖓ ᐊᒡᔭᖅᑕᐅᑎᓪᓗᖓᓗ ᕿᑭᖅᑖᓗᑉ ᐋᓐᓂᐊᕐᕕᐊᓄᑦ ᐆᒻᒪᑎᖓ
ᑎᒡᓕᓕᖅᑎᑦᓯᓇᓱᐊᖅᑕᐅᖁᖏᑦᑕᕋ/ᓱᓪᓗᓕᖅᑐᖅᑕᐅᔪᒪᓇᖓᓗ ᑎᒥᒃᑯᑦ/.
ᐊᒡᔭᖅᑕᐅᖃᑦᑕᕈᒪᓂᐊᖅᑐᖓ ᑎᒥᒐ ᓇᓗᓇᐃᖅᑐᖅᑕᐅᔭᓇᐊᖅᑐᓇᐊᖅᑲᕌᖓᑦ ᓘᒃᑖᓄᑦ, ᑭᓯᐊᓂ
ᑕᒪᓐᓇ ᕿᒥᕐᕈᔭᐅᓂᐊᖅᑐᖅ ᐊᑐᓂ ᐋᓐᓂᐊᖅᑐᓕᕆᔩᒃᑯᓐᓄᑦ.

________ acute medical care to be provided at ____________________ only, recognizing that CPR/intubation/cardioversion will not be performed as this would then involve transport out of my community. I may desire transport for medically relevant investigations, but this will be reviewed with my health care team on an individual basis.
ᐋᖅᑭᒃᑕᐅᓴᕋᐃᑦᑐᒧᑦ ᐃᑲᔪᖅᑕᐅᔪᒪᔪᖓ ᐅᕙᓂ __________________ ᑭᓯᐊᓂ, ᖃᐅᔨᒪᑦᓯᖓᓗ
ᐋᓐᓂᖅᓵᖅᑎᑕᐅᓇᓱᐊᕈᒪᓂᐊᖏᑦᑐᖓ/ᓱᓪᓗᓕᖅᑐᖅᑕᐅᔪᒪᓇᖓᓗ ᑎᒥᒃᑯᑦ/ᐆᒻᒪᑎᖓ
ᑎᒡᓕᓕᖅᑎᑕᐅᓇᓱᐊᖅᑕᐅᖁᖏᑦᑕᕋᓗ ᓄᓇᑦᑎᓐᓂᒃ ᐊᐅᓪᓚᖅᑎᑕᐅᔭᓇᐊᖅᑲᕐᓂᐊᕋᒪ.
ᐊᒡᔭᖅᑕᐅᖃᑦᑕᕈᒪᓂᐊᖅᑐᖓ ᑎᒥᒐ ᓇᓗᓇᐃᖅᑐᖅᑕᐅᔭᓇᐊᖅᑐᓇᐊᖅᑲᕌᖓᑦ ᓘᒃᑖᓄᑦ, ᑭᓯᐊᓂ ᑕᒪᓐᓇ
ᕿᒥᕐᕈᔭᐅᓂᐊᖅᑐᖅ ᐊᑐᓂ ᐋᓐᓂᐊᖅᑐᓕᕆᔩᒃᑯᓐᓄᑦ.

palliative care at ________________________. I realize I have an illness which is terminal and desire quality comfort care at ________________.
I would like my family involved with my care.

________ I do not wish CPR/intubation/cardioversion.
ᐋᓐᓂᐊᖃᖅᑐᓄᑦ ᑲᒪᕆᔭᐅᕕᖕᒦᒧᒪᔪᖕᖓ ________________________. ᖃᐅᔨᒪᔪᖕᖓ
ᐋᖅᑭᒃᑕᐅᔪᓐᓇᖏᑦᑐᒥᑦ ᐋᓐᓂᐊᖃᓕᕐᓂᓐᓄᑦ ᐅᕝᕙᓂᓗ ᑲᒪᕆᔭᐅᔪᒪᑦᓯᐊᖅᑐᖕᖓ ________________.
ᐃᓚᒃᑲ ᐅᕙᓐᓂᒃ ᑲᒪᖃᑕᐅᕐᑯᔭᒃᑲ. ᐃᓅᒍᓐᓃᕐᕕᒃᓴᕋ ᓇᓪᓕᐅᑎᒃᐸᑦ ᐊᒻᒪᓗ ᐆᒻᒪᑎᒐ
ᑎᒡᓕᓕᖅᑎᑕᐅᓇᓱᐊᖅᑕᐅᖁᙱᑦᑕᕋ/ᓱᓪᓗᓕᖅᑐᖅᑕᐅᔪᒪᓇᖕᖓᓗ ᑎᒥᒃᑯᑦ/

I understand I may change my mind at any time and that this will be respected.
ᑐᑭᓯᐅᒪᑦᓯᐊᖅᑐᖕᖓ ᖃᖕᖓᑐᐃᓐᓇᖅ ᑕᒪᓐᓇ ᐊᓯᔾᔨᖅᑕᐅᔪᓐᓇᕐᑯᔪᓐᓇᖅᑕᕋ ᐊᒻᒪᓗ ᑕᒪᓐᓇ ``ᑲᒪᓱᕆᔭᐅᑦᓯᐊᕐᑯᔭᕋ.

Discussed at: ________________________ Date: ________________________
ᐅᖃᐅᓯᐅᔪᖅ ᐅᕙᓂ: ________________________ ᐅᓪᓗᒥ: ________________________

Discussion in Inuuktituit: Y N
ᐅᖃᐅᓯᐅᔪᖅ ᐃᓄᒃᑎᑐᑦ: ᐃᐧ ᐋᒡᒐ

If yes, then interpreter name: _____________________________
ᐊᖏᖅᑕᐅᒍᓂ, ᑑᓴᔨᐅᑉ ᐊᑎᖓ: ____
Signature: ____
ᐊᑎᓕᐅᕈᓯᖓ: ____

Family and others present at discussion:
ᐃᓚᒋᔭᐅᔪᑦ ᐊᓯᖏᓪᓗ ᓈᓚᖃᑕᐅᔪᑦ ᐅᓇ ᐅᖃᐅᓯᐅᑎᓪᓗᒍ:
____
____
____

Signatures:
ᐊᑎᓕᐅᕐᓃᑦ:

____________________________ ______________________ _________________
Patient or POA for personal care | MD or RN discussing care | witness
ᐋᓐᓂᐊᖅᑐᖅ | ᓘᒃᑖᖅ ᒫᓇᖅᓯᓘᓐᓃᑦ ᐅᖃᐅᓯᖃᖅᑐᖅ | ᑕᐅᑐᒃᑐᖅ

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS		
	Community Health Nursing		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Do Not Resuscitate Order		Nursing Practice	07-017-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
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APPLIES TO:			
Community Health Nurses			

POLICY 1:

A Do Not Resuscitate (DNR) order must be ordered by a physician and clearly documented in the client's health record. In the event a physician is not present in the community to document the DNR order in the client's record, a telephone order may be given. The telephone order must be verified by two staff members, one of whom shall be a Registered Nurse.

The attending physician shall discuss the issue of DNR with the client (if capable) or if the client is not capable, with the substitute decision maker/power of attorney (POA). The physician or delegate must make a reasonable attempt to identify a person capable of making decisions on behalf of the client.

The outcome of the discussions with the client / substitute decision maker/ power of attorney leading up to the DNR order shall be recorded on the client's health record. This should include:

- **Client's prognosis, including likelihood of reversing the illness, and agreement on prognosis among consulting physicians;**
- **Discussions of treatment plan and options with the client or substitute decision maker, as well as others on the health care team;**
- **Views of the client, or substitute decision maker, concerned with client's comfort**
- **Signature of the client / substitute decision maker/ POA on the *Nunavut Care Level Planning* form.**

POLICY 2:

Where a previously arranged instruction from the client exists, either as an advanced directive, living will, or written DNR order from another institution, they should be respected, providing the physician is satisfied that:

- **The document is valid;**
- **The elapsed time since the document was drafted is (in the physician's judgment) reasonable,**
- **The client's condition has not undergone enough change to warrant a new decision,**
- **The client's wishes have not changed.**

POLICY 3:

A capable client or substitute decision maker may request that a voluntary DNR order be rescinded at any time. Provided that CPR is medically supportable, such a request must be followed by a written order and an accompanying progress note explaining the change.

DEFINITIONS:

Capability: All adults are presumed to be capable of making health care decisions until there is clear evidence that the adult is incapable of making a clear decision. Capability and incapability is assessed on the Adult's understanding:

- Of the information being given to him/her
- That the information applies to his/her own situation.

DEFINITIONS:

Do Not Resuscitate: means the practitioner will not initiate basic or advanced cardiopulmonary resuscitation such as:

- Chest compression;
- Defibrillation;
- Artificial ventilation;
- Insertion of an oropharyngeal or nasopharyngeal airway;
- Endotracheal intubation;
- Transcutaneous pacing;
- Advanced resuscitation drugs such as, but not limited to, vasopressors, antiarrhythmic agents, and opiod antagonists.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 07-016-00	Advance Directive
Template 07-016-01	Nunavut Care Level Planning Form

REFERENCES:

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

Canadian Nurses Association (2008). *Position Statement: Providing nursing care at the end of life.* Ottawa, ON.

Canadian Nurses Association (1998). Advance Directives: The Nurse's Role. *Ethics in Practice.*

GUARDIANSHIP AND TRUSTEESHIP (S.N.W.T. 1994,c.29, as as duplicated for Nunavut by s.29 of the *Nunavut Ac*t, S.C. 1993, c.28)

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:**
Client Identification for Clinical Care		Nursing Practice	07-018-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
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APPLIES TO:			
Community Health Nurses			

POLICY:

Each health care provider shall ensure that all clients are properly identified prior to any care, treatment or services provided.

PRINCIPLES:

A system for positive identification of all health centre clients fulfills four (4) basic functions:

- Provides positive identification of clients from the time of arrival.
- Provides a positive method of linking clients to their health records and treatment.
- Minimizes the possibility that identifying data can be lost or transferred from one client to another.
- Improves the accuracy of client identification.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Guidelines 07-018-01 Client Identification Strategies

GUIDELINES 07-018-01

1. When a client's health record is created, a client specific identification card to be used with the addressograph imprinter shall also be created. The card shall include the client's full name, facility identification number, health record number, date of birth, and sex. This ID card shall be securely placed in the client's health record. (Addressograph may not be available in smaller centers)

2. All health centre-approved forms and records shall have the client's identifier information entered, preferably via the addressograph imprinter. Otherwise, the information can be entered by hand. The healthcare provider should never make an entry into a client's chart which has not been completely and clearly marked with the client's critical identifying information.

3. Before any procedure is carried out, the healthcare provider shall verify the following two (2) identifiers from the health record or health card to ensure that the right client is being treated:

    - Patient name
    - Patient date of birth

4. Client identification must be confirmed using the two (2) identifier system prior to conducting any healthcare procedures. Procedures may include, but are not limited to:
    - Administration of medication
    - Transfusion of blood or blood components
    - Obtaining blood or other specimens from the patient
      Specimen samples obtained from the patient will be labeled using the two (2) identifier system in the presence of the patient.
    - Performing a treatment
    - Performing a diagnostic test (i.e., diagnostic radiographic study)

5. When health records are pulled, the office support staff (Clerk Interpreter, Receptionist, Records Clerk) shall verify the progress notes and flowsheets are clearly marked with the client's identifier information before delivering the chart to the healthcare provider.

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:**
Transfer of Care Between Colleagues	Nursing Practice	07-019-00

EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
July 21, 2021	July 2024	07-019-00	3

APPLIES TO:
ALL Community Nurses

1. BACKGROUND:

1.1. Transfer of care (handover) involves the transfer of professional responsibility and accountability for some or all aspects of care for a client, or groups of clients, to another person, such as a clinician, nurse, or professional group, on a temporary or permanent basis. Within the Department of Health (Health), this could include transfers from nurse to nurse within a centre, community health nurse (CHN) to flight nurse, CHN to emergency department, or a provider in one facility or service to another (within or outside of Nunavut).

2. POLICY:

2.1. Details about a client's condition, treatment, and plan of care should be communicated thoroughly to the next provider or team and documented clearly.

2.2. A standardised approach to transfer of care is required. Nurses and other providers must formulate the information in their handover according to the "Situation, Background, Assessment, Recommendation (SBAR)" technique.

2.3. The client and their family member(s)/caregiver(s) (with client consent) should be involved in every transfer of care as they are the only constant factors in the care process.

3. PRINCIPLES:

3.1. Effective handover ensures safe and effective coordination and continuity of care.

3.2. Transfer of care should follow a structured format.

3.3. Effective communication (verbal, written, electronic) is fundamental to safe and efficient handover. Errors in communication can result in adverse client outcomes.

3.4. Safe transfer of care requires adequate time, privacy, and a calm environment, free from distraction.

3.5. Clients often need support from their families or caregivers during care transitions.

3.6. Successful transfer of care must account for client factors such as language, culture, wishes for care, and health literacy. Inuit Societal Values and Inuit Qaujimajatuqangit (IQ) principles should underpin client inclusion in transfer of care.

3.7. Comments made during handovers may inadvertently contribute to misdiagnosis or inappropriate treatment because of the influence of cognitive biases and stereotyping.

3.8. Leaders can facilitate safe transfers of care by providing resources and training and by creating embedded organisational awareness of the importance of safe handover.

4. **DEFINITIONS**:

SBAR: A standardised approach to information transfer and handover communication consisting of four categories.

- Situation: Problem, patient's symptoms, patient stability, or level of concern.
- Background: History of presentation, background information.
- Assessment: Assessment and differential diagnosis, where you think things are headed.
- Recommendation: Recommendations and action plan, what you have done, what you would like the other person to do.

CLINICIAN: Regulated healthcare providers – Community Health Nurses, Licensed Practical Nurses, Registered Nurses practising in Mental Health, Registered Psychiatric Nurses, Home and Community Care Nurses, Nurse Practitioners and Physicians.

5. **PROCEDURE:**

5.1. Whenever there is a change in the client's care provider, the following information shall be communicated using the SBAR technique, in a clear and concise report between colleagues, please see Appendix A for SBAR template:

- Name and role of provider handing client over, client's name
- Accurate information regarding diagnosis, investigations and results, consultations, treatments
- Pertinent past medical and surgical history; allergies
- Recent vital signs; input and output (if applicable) and any discrepancies from baseline.
- Recent or anticipated changes in the client's condition; emotional state
- Current medications (drug, dose, frequency, route) and time last given (to include IV infusions); accurate and complete transfer and documentation of medication information (medication reconciliation).
- Any outstanding orders to be processed and/or implemented.
- Plan of care, equipment requirements, follow-up appointments, client teaching
- Presence of any advance directives
- Contact information for the on-call physician
- Contact information for the client (if pertinent to transfer)
- Any other information important to the client's care

5.2. A departing clinician will create a list of all clients receiving ongoing or follow-up care at minimum of two working days before departing the community.

- In the event of an urgent or emergent departure from a community the clinician will develop the list as soon as possible.

5.3. The clinician will meet with the SCHP or immediate supervisor to review the list of clients and determine which clinicians will be taking over the care of each of the client.

- In the event that no other accepting clinicians are available the departing clinician will conduct a handoff of all clients to the SCHP or immediate supervisor.
- The SCHP or immediate supervisor will handoff the clients to another accepting clinician at a later date, until that point the SCHP or the immediate supervisor will be the MRP.

5.4. When and where possible and appropriate the departing clinician will inform the client that their care will be managed by a different clinician

6. **RELATED POLICIES, PROTOCOLS AND LEGISLATION:**
06-017-00 Morning Report

7. **REFERENCES**:
Canadian Medical Protective Association (2021, May 4). Handovers: Transferring care to others. https://www.cmpa-acpm.ca/serve/docs/ela/goodpracticesguide/pages/communication/Handovers/what_is_a_handover-e.html

Merten, H., van Galen, L.S., & Wagner, C. (2017). Safe handover. British Medical Journal. 359, j4328 doi: 10.1136/bmj.j4328

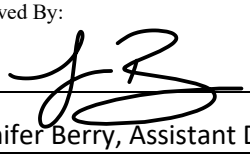
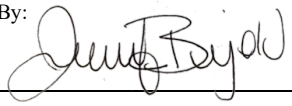
Registered Nurses' Association of Ontario. (2014). Clinical best practice guidelines: Care transitions. Toronto, ON: Author.

Resident Doctors of Canada. (2014). Handover education in Canadian residency programs. Ottawa, ON: Author.

The Royal Children's Hospital Melbourne. (2021, May 4). Nursing clinical handover. https://www.rch.org.au/rchcpg/hospital_clinical_guideline_index/Nursing_clinical_handover/#:~:text=Clinical%20handover%3A%20Transfer%20of%20professional%20responsibility%20and%20accountability,professional%20group%20on%20a%20temporary%20or%20permanent%20basis

University Hospitals of Leicester. (2018). Policy for clinical handover. Leicester, UK: Author.

World Health Organisation. (2011). Patient safety curriculum guide. Malta, Greece: Author.

Approved By: 	Date: July 21, 2021
Jennifer Berry, Assistant Deputy Minister – Department of Health	
Approved By: 	Date: July 21, 2021
Jenifer Bujold, a/Chief Nursing Officer	

APPENDIX A

S	**Situation**: Identify Client and age • Brief history of present illness	
B	**Background**: • Past medical history • Current Medications including dosage, route and frequency • Any IV infusions/antibiotics and when last given • Allergies • Most recent vital signs and any discrepancies from baseline • Pertinent lab results • Other clinical information • Any follow up appointments, teaching etc. • Presence of advance directives	
A	**Assessment**: What is the nurse's assessment of the situation. Differential diagnosis	
R	**Recommendation**: What does the nurse want done	

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS		
	Community Health Nursing		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Conscious Sedation		Nursing Practice	07-020-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		8
APPLIES TO:			
Community Health Nurses			

Conscious sedation is to be performed for those clients who must undergo painful or difficult procedures where cooperation and/or comfort will be difficult or impossible without pharmacologic support.

POLICY:

Only physicians have the authority to administer pharmacologic agents to achieve desired levels of sedation. The physician must be qualified to rescue clients from deep sedation, and must be competent to manage a compromised airway and provide adequate oxygenation and ventilation.

The physician performing the conscious sedation is responsible for reviewing the risks, options and benefits of the selected pharmacologic agents with the client, parent and/or guardian; and documenting the client, parent or guardian's informed consent in the health record.

The registered nurse may be given the responsibility of administration and maintenance of conscious sedation in the presence of and on the order of a physician. The nurse is responsible for verifying that informed consent has been obtained before initiating the procedure for sedation. The nurse will be trained in basic EKG and current BCLS certification. Emergency resuscitation equipment will be readily available.

DEFINITIONS:

Conscious Sedation provides a minimally reduced level of consciousness in which the client retains the ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command.

PRINCIPLES:

- The Registered Nurse must have education, knowledge of medications used and skills to assess, diagnose and intervene in the event of complications. The nurse functions within the limitation of facility policies and scope of practice.

- The nurse is responsible for continuously monitoring the client with assessment findings being documented every five (5) minutes for the first 15 minutes then every fifteen (15) until the procedure is completed.

- Monitoring includes:
  1. Physical assessment
  2. Blood pressure
  3. Heart rate
  4. Respirations (frequency and volume)
  5. Oxygen saturation
  6. Cardiac monitoring
  7. Skin color
  8. Level of consciousness (sedation scale)

- A second Registered Nurse may be required to assist during complex technical procedures or in procedures that are complicated due to the severity of the client's illness.

- The Physician will screen the risk factors for each client by utilizing the American Society of Anesthesiology (ASA) Physical Status Classification (see reference sheet 07-020-02) Clients considered appropriate for moderate and deep sedation in the community health centre are ASA Class I and Class II. Clients who fall into ASA Class III or Class IV present special problems which necessitate a consultation by an anesthesiologist.

- Common agents like midazolam and fentanyl cause dose-related suppression of airway protective reflexes and ventilatory drive; therefore may provoke airway compromise, hypoventilation and hypotension. Clinicians employing these agents should be comfortable with airway management and familiar with the pertinent reversal agents, flumazenil and naloxone.
- In the low doses, ketamine induces dissociative sedation, where airway protective reflexes are preserved, ventilatory response to carbon dioxide is maintained, respirations are generally adequate and the eyes often remain open. Ketamine can, cause adverse effects, including hypersalivation, laryngospasm and apnoea.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Guidelines 07-020-01	Conscious Sedation Guidelines
Reference Sheet 07-020-02	Sedation – Physical Status Classification
Template 07-020-03	Conscious Sedation Record

REFERENCES:

Canadian Society of Gastroenterology Nurses and Associates (n.d.). *Conscious Sedation: Responsibilities of the Registered Nurse Related to Conscious Sedation*.

The Child Health Network for the Greater Toronto Area (2002). *Practice Guideline: Management of Children Receiving Conscious or Deep Sedation.*

Urbain, Ip and Anurag Saincher (2000). Safety of Pediatric Procedural Sedation in a Canadian Emergency Department. *Canadian Journal of Emergency Medicine.2*(1): 15-20.

GUIDELINES 07-020-01

Conscious Sedation Guidelines

1. The physician assesses the risk factors for each client using the American Society of Anesthesiology (ASA) Physical Status Classification (see reference sheet 07-020-02) Clients considered appropriate for moderate and deep sedation in the community health centre are ASA Class I and Class II.

2. The attending physician explains to the client and caregiver(s) the need for the procedure, the effects of medications being used, and the associated risks. Verbal consent is obtained.

3. The client is placed on NPO status. The registered nurse documents a pre-sedation assessment on the *Conscious Sedation Record* (Template07-020-03)

   Physical and baseline assessment parameters include, but are not limited to:

   - Level of consciousness
   - Anxiety level
   - Vital signs, including temperature
   - Skin color and condition
   - Sensory defects
   - Current medications and allergies
   - Relevant medical surgical history
   - Client perceptions regarding procedure and moderate sedation

4. The client is connected to an ECG monitor, oxygen saturation monitor and automated blood pressure monitor. Oxygen is applied by mask or nasal cannula.

5. The resuscitation cart is brought to the bedside. Oral airway, bag-valve-mask, suction, and reversal drugs are made immediately available.

6. IV access is established. Fluid type and rate is determined by the physician.

7. Medications are administered. The choice of agent and route of administration is at the discretion of the attending physician.

8. Vital signs are recorded every five (5) minutes for the first 15 minutes then are performed every fifteen (15) minutes until the client meets the discharge criteria. One-to-one nursing care is maintained during the monitoring period.

9. Untoward reactions or sudden/significant changes in monitoring parameters should be immediately reported to the physician.

Conscious Sedation Guidelines (cont'd)

10. Post procedure, the client should be place in the recovery position until fully awake.

11. Clients should continue to be monitored for a minimum of one (1) hour post procedure with vital signs recorded every 15-30 minutes. Readiness for discharge is assessed according to the discharge criteria key (see *Conscious Sedation Record*). Clients must achieve a score of 7 prior to discharge.

12. The entire procedure is documented on the *Conscious Sedation Record*.

13. Written and verbal after-care instructions are given to the client's caregiver prior to discharge and documented in the client's health record.

EQUIPMENT

- Oxygen and nasal cannula
- Suction
- Emergency crash cart with defibrillator
- Cardiac monitor
- Pulse oximeter
- Blood pressure monitor

EMERGENCY INTERVENTIONS

Initiate emergency interventions when the following client conditions are identified:

1. **Decreased Oxygen Saturation** < 94% (or based on individual baseline oxygen saturation) with minimal respiratory distress that does not return to baseline
   - Look, listen and feel
   - Assess colour and chest wall movement
   - Check for proper placement of oxygen saturation probe
   - Check airway patency and reposition (airway/jaw holding) if necessary
   - Apply oxygen by facemask at 100 %, and notify M.D.

2. **Dyspnea or Cyanosis**
   - Determine patency of airway and reposition, suction if necessary
   - Apply oxygen per mask or ambu-bag at highest concentration (e.g., 100%)
   - Notify M.D.
   - Call additional nursing or medical staff for assistance if condition does not improve

3. **Inability to Maintain Patient Airway Related to Copious Secretions**
   - Suction patient
   - Oral airway
   - Notify physician

4. **Laryngospasm**
   - Determine airway patency
   - Reposition, head tilt/chin lift, jaw thrust
   - Apply oxygen per mask at 100% when airway patent
   - Provide artificial ventilation with a bag and mask if necessary
   - Call physician and additional nursing staff STAT, anticipate intubation

5. **Respiratory Depression**
   - Reposition airway, head tilt/chin lift, jaw thrust
   - Ventilate with ambu-bag using 100% oxygen
   - If no response, call additional nursing and medical staff and initiate advanced life support measures
   - Anticipate use of reversal agent

6. **Symptomatic Bradycardia**
   - Ensure patent airway
   - Ventilate with ambu-bag with 100% oxygen
   - If not corrected or leads to asystole, initiate CPR and advanced life support measures

7. **Excessive Sedation**
   - Inability to rouse easily
   - Support airway by jaw holding and bagging if no air exchange
   - Notify physician STAT

8. **Persistent Agitation**
   - Paradoxical response
   - If client is agitated remain at bedside and constantly assess airway and level of consciousness, protect client from injury
   - Notify physician (e.g., possibility of using a reversal agent)

REFERENCES:

Canadian Society of Gastroenterology Nurses and Associates (n.d.). *Conscious Sedation: Responsibilities of the Registered Nurse Related to Conscious Sedation*.

The Child Health Network for the Greater Toronto Area (2002). *Practice Guideline: Management of Children Receiving Conscious or Deep Sedation.*

Urbain, Ip and Anurag Saincher (2000). Safety of Pediatric Procedural Sedation in a Canadian Emergency Department. *Canadian Journal of Emergency Medicine.2*(1): 15-20.

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**	

REFERENCE SHEET 07-020-02

The Physician will screen the risk factors for each client by utilizing the American Society of Anesthesiology (ASA) Physical Status Classification. Clients considered appropriate for moderate and deep sedation in the community health centre are ASA Class I and Class II. Clients who fall into ASA Class III or Class IV present special problems which necessitate a consultation by a member of the Anesthesia Department.

ASA PHYSICAL STATUS CLASSIFICATION:

Class I	No organic, physiologic, biochemical or psychiatric disturbance. Normal, healthy client.
Class II	Mild systemic disturbance; may or may not be related to reason for surgery. (Examples: controlled hypertension, controlled diabetes mellitus)
Class III	Severe systemic disturbance, but not incapacitating. (Examples: heart disease, poorly controlled hypertension)
Class IV	Life threatening systemic disturbance. (Examples: congestive heart failure, persistent angina pectoris)
Class V	Moribund client. Little chance for survival. (Examples: uncontrolled bleeding, ruptured abdominal aortic aneurysm)
Class E	Client requires emergency procedure. (Examples: appendectomy, D&C for uncontrolled bleeding)

REFERENCES:

Canadian Society of Gastroenterology Nurses and Associates (n.d.). *Conscious Sedation: Responsibilities of the Registered Nurse Related to Conscious Sedation*.

Urbain, Ip and Anurag Saincher (2000). Safety of Pediatric Procedural Sedation in a Canadian Emergency Department. *Canadian Journal of Emergency Medicine.2*(1): 15-20.

TEMPLATE 07-020-03

When conscious sedation procedure is to be performed in the community health centre, the *Conscious Sedation Record* shall be used to document the event. Once the form is completed, the form shall be filed in the client's health record.

Adopted from:

Urbain, Ip and Anurag Saincher (2000). Safety of Pediatric Procedural Sedation in a Canadian Emergency Department. *Canadian Journal of Emergency Medicine.2*(1): 15-20.

CONSCIOUS SEDATION RECORD

GUIDELINES: (Initials)

1. _____ Client is NPO
2. _____ Client weight is obtained
3. _____ Baseline TPR and BP done
4. _____ Baseline oxygen saturation done
5. _____ Oral airway, bagging unit, oxygen, suction, pulse oximeter done
6. _____ Crash cart with cardiac monitor is readily available
7. _____ Vital signs post procedure:
   Q 5 minutes for 15 minutes
   Q 15 minutes for 45 minutes or until meets discharge criteria
8. _____ Discharge criteria are met prior to criteria

Procedure: _____

Time Begin:_____ Time End:_____

PRE-SEDATION ASSESSMENT

Airway	Breathing	Colour	Skin	Vital Signs	Oxygen Rate	IV access
□ Own □ Mask □ _____	□ Nasal □ Normal □ Shallow □ Rapid □ Laboured	□ Normal □ Pale □ _____	□ Moist □ Warm □ Dry □ Cool	BP_____ HR_____ RR_____ O2 Sat_____ T _____	□ N/A □ Cannula □ Mask □ _____ Flow:_____ Time started:_____ Discontinued:_____	□ N/A □ Saline Lock □ Peripheral IV Site_____ Solution_____ Time started:_____ Discontinued:_____

VITAL SIGNS: DURING AND POST PROCEDURE

Time									
BP									
HR									
RR									
O2 Sat									

MEDICATION

TIME	Medication	Dose	Route	Initials

DISCHARGE CRITERIA

Activity								
Breathing								
Circulation								
Consciousness								
Total Scores								

COMMENTS: (Document pre-procedure information given to client/parent)

DISCHARGE CRITERIA KEY

1. **ACTIVITY**
   0 = Unable to lift head or move extremities Voluntarily or on command
   1 = Lifts head spontaneously & moves extremities voluntarily or on command
2. BREATHING
   0 = Apneic
   1 = Dyspnea or shallow, irregular breathing
   2 = Able to breathe deeply and cough on command
3. CIRCULATION
   0 = Systolic BP < 80mmHg
   1 = Systolic BP > 100mmHg
   2 = Systolic BP within normal limits for client
4. CONSCIOUSNESS
   0 = Not responding, or responding only to painful stimuli
   1 = Responds to Verbal stimuli but falls asleep readily

	2 = Awake, alert and oriented to time, person, place (child to name, parent) **TOTAL SCORE PRIOR TO DISCHARGE MUST BE SEVEN**
Verbal/written discharge instructions given to: □Client □ Parent/guardian □ Other Initials:	Signature:_____ Initials:_____ Signature:_____ Initials:_____

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

TITLE:		SECTION:	POLICY NUMBER:
Restraints		Nursing Practice	07-021-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		2
APPLIES TO:			
Community Health Nurses			

POLICY:

Any physical or chemical restraint will be used as a last resort and for the shortest time possible. Alternatives to restraints should be considered prior to restraint use. A physician must be consulted prior to the use of restraints.

PRINCIPLES:

A policy of least restraint is threefold:

- Alternatives will be explored before a restraint is used.
- In the event that alternatives have not been successful in eliminating/reducing risk factors, the least restrictive type of restraint will be used.
- The restraint will be applied for the shortest period of time.

DEFINITION:

Restraint refers to any mechanical, chemical, environmental or physical measures used to limit the activity or control the behaviour of a person or a portion of their body. (AARN Position Statement [Mar 2003]

Physical/Mechanical Restraints are the use of a device or an appliance that restricts or limits freedom of movement. (I.e. vest restraints, lap belts, pelvic restraints, mittens, and geriatric chairs with locked trays.)

Environmental Restraint involves the use of the environment, including seclusion to or in a time out room, to involuntarily confine a person and to restrict freedom of movement.

Chemical Restraint includes:

a) The use of a psychopharmologic drug not required to treat medical symptoms, for any purpose of discipline or convenience.
b) A pharmacological intervention intended to control, inhibit or restrict a person's behaviour.
c) The therapeutic use of any pharmacological interventions with the purpose of providing treatment for mental health or associated behaviour is not considered a restraint.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Alberta Association of Registered Nurses (2003). *Position Statement: The use of restraints in client care settings.*

Perry and Potter, 6th edition (2006), p.85-93

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:
Clients on Continuous Observation		Nursing Practice	07-022-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		4
APPLIES TO:			
Community Health Nurses			

POLICY:

Clients who are at risk to harm themselves or others may be placed on Continuous Observation. Continuous Observation may be conducted by a nurse, psychiatric nurse, mental health worker or other delegated to unregulated healthcare worker (e.g. clerk interpreter).

When an application for involuntary admission has been completed under the Mental Health Act, the client will be placed on continuous observation.

Assistance from the RCMP may be requested if there is a potential threat or actual threat to the safety of the client and/or health centre staff.

DEFINITIONS:

Continuous Observation means the client is observed by staff or other designated personnel and is in sight at all times, including while in the washroom.

Unregulated staff includes, but not limited to, clerk interpreter, maternity care worker, mental health worker, home care worker and health care aid.

Form 1: is a Medical Practitioner's Order for a Psychiatric Assessment (Mental Health Act, Sec. 8), where detention is for the purpose of an assessment. Completed by a Medical Practitioner who must assess the person being formed. Authorizes detention for 48 hours.

Form 3: is a detention for the purpose of assessment (Mental Health Act, Sec.9). A Form 3 is completed by a Justice of the Peace or Territorial Court Judge. It authorizes detention by a peace officer for 7 days and authorizes detention for 48 hours for an assessment.

Form 4: is an affidavit (Mental Health Act, Sec. 9; 19.3; 23.2; 26, 26.1;49.1) which accompanies any application to court. The applicant signs the corresponding application. The form must accompany the person to court to be filed and served on interested parties before the hearing.

Form 5: Statement by a psychologist, peace officer, nurse, psychiatric nurse, mental health worker, or other person i.e. family member etc. (Mental Health Act, Sec.10; 11; 12). This relates to the circumstances surrounding apprehension for assessment. The person who signs is the person who arranges to have the detainee seen by a medical practitioner or a hospital. It is to be completed when delivering custody of an apprehended person.

Form 6: Application of Involuntary Admission (Mental Health Act, Sec. 13; 14) when the client poses a danger to self or to others. It is also used to request transfer to another province/territory. **This is the form most frequently used by QGH and when there is physician in the community.** A Form 6 can only be completed by a Medical Practitioner who has performed an assessment or an examination; and must be completed within 24hrs of that assessment. This form authorizes detention for 48 hours while the application is being processed

Form 7: Certificate of Involuntary admission (Mental Health Act, Sec. 16) which authorizes detention because the person poses a danger to self or to others. The form is completed by a Delegate for the Minister within 24 hours of receipt of a completed Form 6. A 72 hour detention can be ordered for the purpose of a second assessment and a 48 hour detention in unusual circumstances. Once a Form 7 has been issued, detention may be authorized for up to two weeks.

Form 8: Certificate of transfer (Mental Health Act, Sec.19). This form authorizes the transfer of a client to a hospital outside of Nunavut.

Form 25: Notice of Detention to the Client and Substitute Consent Giver (Mental Health Act, Sec. 35.2; 18). This is a notice of any decision to detain and of the rights, including the right to review. The form is signed by the attending healthcare practitioner, which includes a psychiatric nurse or a community health nurse. It must be completed and conveyed within 48 hours of an assessment / examination and immediately after the Certificate of Involuntary Admission, a Certificate of Transfer or a Certificate of Renewal has been issued.

PRINCIPLES:

Under the original interpretation of the Mental Health Act (1993), a health centre may assume the role of a 'hospital' while an involuntary client is awaiting transfer to an accepting facility.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Guideline 07-022-01 Provisions of Care for Clients on Continuous Monitoring

REFERENCES:

Rights and Responsibilities: Mental Health and the Law 2002.

Jones, J., Martin, W., Nigel, W. (2000). Psychiatric inpatients' experience of nursing observation a United Kingdom perspective. Journal of Psychosocial Nursing 38(12) 10-20.

Boyd, M A., Nihart, M A., Psychiatric Nursing: Contemporary practice. Lippincott New York.

GUIDELINE 07-022-01

NURSING ALERTS:

- The client will at no time be left alone following the decision for continuous observation
- Do not leave medications at the client's beside under any circumstances.
- Ensure that all oral medications administered are swallowed.
- The physician's order for continuous observation will be reassessed daily, in the event the client is unable to travel out of the community (e.g. no flights due to inclement weather).
- All clients who are on continuous observation will remain in the examination room until the order for continuous observation is discontinued or the client is medivaced from the community.
- The client is not allowed any items brought into the health centre by visitors unless they have been approved by health centre nursing staff.
- The flight nurse, in consultation with the attending health centre nurse will determine the level of risk associated with on-flight procedures prior to departure from the health centre. The flight team will be responsible for accessing additional personnel for the flight (e.g. RCMP escort) or retrieving additional medication orders if the client is assessed to be moderate to high risk for injury or violence.

GUIDELINES:

1. Advise the Supervisor of Community Health Programs of the physician's order for continuous observation. If there is a Registered Psychiatric Nurse in the community, he/she should also be consulted to discuss further treatment options.

2. Remove all clients' belongings and sharps, including the client's luggage. Ensure the client's environment is free of potentially harmful objects.

3. Document in the client's health record all belongings which have been removed and the methods in which the belongings/valuables have been secured. The type of observation must also be documented in the client's health record.

2. Assign a staff member to the client until the client is discharged to the medivac team.

1. The attending nurse will instruct the staff member about any client restrictions, visitor privileges and/or precautions to be taken. The staff member will also be instructed not to leave the client until he/she is relieved by another staff member.

2. Immediately inform the health care team when the client on continuous observation attempts to leave the health centre.

3. Call RCMP if assistance is required.

4. Ensure the health care team informs the client of the limitations imposed.

GUIDELINE 07-022-02

Guidelines for Unregulated Staff - Caring for a Clients under Continuous Observation

"Continuous observation" means that you see the client at all times. This includes when the client uses the washroom.

Guidelines:

- The Registered Nurse (RN) will give you a brief report when you arrive. This private and confidential information will help you carry out your duties. It is never to be discussed with people not involved in the client's care.
- You must be within 3 meters of the client at all times.
- The client needs an environment of low stimulation. This means things like loud music and talking are to be avoided.
- Avoid talking about issues that may upset the client.
- The client must stay in the clinic room, unless otherwise instructed by the RN.
- Keep the curtains around the bed open, even if the client is sleeping. Make sure you see the client's head above the bed linens.
- Use the emergency bell/alarm in the clinic room if you require immediate help. The RN will show you how it works if you are unsure.
- Never discuss your personal issues with the client. Listen but do not give advice.
- Do not get side tracked from your duties. Avoid getting into long talks with other clients or staff.
- Call the RN if the client needs to use the washroom and you and the client are of the opposite sex. This will help protect the client's modesty.
- Make a mental note of things like the client's appearance, facial expressions, speech, mood, activity level, reaction to others, and appetite. Report all concerns or observations as they happen to the client's Nurse.
- Remain with the client until your replacement arrives for breaks and at the end of your shift. Do not leave the client alone in the care of family or friends.

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:**
Non-Urgent Evacuation of Obstetrical Clients		Nursing Practice	07-023-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		2
APPLIES TO:			
Community Health Nurses			

POLICY 1:

In communities without obstetrical services, all prenatal clients shall be transported to the nearest community which offers obstetrical services for delivery of their infant. The gestational time for evacuation will depend on:

1. **Level of pregnancy risk assessment;**
2. **History of current pregnancy;**
3. **Geographical location of the home community to the nearest facility with obstetrical services and factors such as availability of scheduled flights;**

POLICY 2:

The medical travel arrangements and approval of escorts will be in accordance with the *Nunavut Client Travel Policy*.

PRINCIPLES:

- Labour and delivery, while a natural event, is not without risk.
- Registered nurses work with the client to develop an acceptable care plan and to transfer care to an appropriate care provider.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Nunavut Client Travel Policy
07-023-01 Obstetrical Clients Refusing to Travel

GUIDELINES 07-023-01

In special circumstances where the pregnant woman refuses to travel out of her community for the delivery of her baby, the following guidelines should be applied:

1. Explore the woman's feelings and reasoning for refusing to travel out of the community for delivery. If the woman and/or family identify a specific reason preventing her from traveling out of the community (e.g. no child care for her other siblings), assist the woman in finding a solution, so she would be able to travel. Involve other team members, such as social services, as appropriate and as authorized by the woman.

2. Notify the physician and/or midwife involved in the obstetrical care of the woman.

3. If the woman continues to refuse to travel for confinement, advise the woman of the risks of delivering in the community. This should be done without coercion or threats. The nurse must be cognizant and respectful of the woman's rights.

    a. The nurse should also educate the woman on the obstetrical background and experience of the attending nurses and midwives (if applicable).

    b. The woman must be asked to sign a release of responsibility / or against medical advice form.

4. The woman should be offered weekly prenatal visits until delivered.

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:
Home Visits – Planned		Nursing Practice	07-024-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		3
APPLIES TO:			
Community Health Nurses			

POLICY:

Health care services will be available to all community members, including those who are unable to access the health centre due to illness or mobility constraints.

PRINCIPLES:

- The safety and security of health and social services' (HSS) employees is of paramount importance.
- HSS adheres to the Government of Nunavut's Zero Tolerance Policy on violence in the workplace which includes all health facilities.
- Health care professionals are considered in the workplace during home visits that are performed as part of a plan of health care.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 05-003-00 Risk Management
Policy 05-004-00 Risk Management Incident Reporting
Policy 05-029-00 Violence in the Workplace
Policy 05-030-00 Motor Vehicles
Guideline 07-024-01 Guidelines for Planned Home Visits
Guideline 07-024-02 Guidelines for Safe Home Visits
Zero Tolerance Policy from the *Human Resources Manual*

GUIDELINE 07-024-01

PROCEDURE

1. Community members who have known illness or medical conditions and are unable to attend to the health centre will be referred to the Home and Community Care Program (HCC)

2. If the client is not accepted into the HCC program, a staff member from the HCC program will notify the practitioner who made the original referral.

3. In communities where there is no Home Care Nurse (HCN), and the health services required in the home are beyond the scope of the Home and Community Care Worker (HCCW), every effort will be made for the client to be seen at the health centre by a CHN.

4. If the client refuses to attend the health centre and the CHN determines that a home visit is not required, all reasons why the home visit was not completed and any attempts to seek alternative means of access or support to attend at the home must be documented in the client's health centre health record.

5. If the client is unable to attend at the health centre and a planned home visit is required, the home visit will be determined by the nature of the illness and the interventions required.

6. The decision to home visit is determined by the client's condition, existing external conditions, including safety of the situation, resources available and the professional judgment of the health care professional with respect to the intervention required and frequency.

7. Every effort should be made to have the client attend at the health centre

8. If during the home visit, the CHN has any concerns about their own safety DO NOT ENTER or if concerns or doubts arise during the visits LEAVE IMMEDIATELY. Do not worry about leaving supplies, equipments or anything behind, your safety is most important.

   The health care professional will NOT attend a home/site when it is determined to be UNSAFE.

9. The details of the home visit must be documented in the client's health centre health record, as per Policy 06-008-00 Documentation Standards and Policy 06-009-00 Documentation Format.

GUIDELINE 07-024-02

PLAN A SAFE VISIT

- Before your visit, enquire about pets, children, other potential visitors, etc.
- Always inform the Supervisor of Community Health Programs or other colleague that you are conducting a home visit; the time you expect to arrive and leave the residence.
- Discuss any potential dangers
- Request a partner if you feel one is necessary

PERSONAL SAFETY DURING THE VISIT

- Present yourself in a calm and confident manner
- Before entering be aware of your surroundings. If you have any concerns about your safety do not enter.
- If there are dogs or other pets which concern you, be assertive and decline providing a service until they are secured and pose no threat to you
- Avoid the kitchen (potential weapons – knives, pans, hot water, etc.)
- Do not sit if the client stands. If you sit, do so in a hard-backed chair. You can get up faster from a firm chair than a soft sofa.
- If possible, do not remove your shoes or bring a pair of indoor shoes to wear.
- Be aware of your surroundings – watch for dangerous objects
- Recognize the first signs of a change in your client's behaviour or the behaviour of others in the home. Assess the client's appearance, routine of daily living, how he or she spends the day, and any other outstanding characteristics.
- Know where doors/exits are for an escape route, and try to keep between your client and the route to safety.
- Carry a communication device (cell phone, radio phone, etc.)
- Notify the SCHP or other colleague of your return to the health centre.

HOME VISIT DO'S AND DON'TS

DO:

- Appear confident and in control
- Follow the client (do not let them follow you)
- Stand to the side of the client
- Leave the environment if your instincts tell you to
- Leave the home if the client or visitor asks you to leave
- Treat the client with respect and dignity.
- Follow up on a staff member who has not reported back at a scheduled time after conducting a home visit.
- Report any unusual incidents to the SCHP as soon as possible

DON'T:

- Don't appear fearful - it promotes the victim syndrome
- Don't enter the client's home if your instincts say not to
- Don't stand face to face with a client (it makes you vulnerable to attack)
- Don't complete a home visit where someone (a client, client's visitors or family members) is intoxicated, or abusive
- Don't complete a home visit with someone (a client, client's visitors or family members) who is inappropriately dressed, or where sexual comments and innuendoes are made or pornography is viewed in your presence.

REFERENCES

Health Care Health & Safety Association of Ontario; Ontario Workplace Safety and Insurance Board (2003)*Health and Safety in the Home Care Environment*.

Winnipeg Police Service Community Relations Unit (2009). *Professional Home Visitors.*

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:**
Home Visits – Unplanned and Urgent		Nursing Practice	07-025-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		3
APPLIES TO:			
Community Health Nurses			

POLICY:

Health care will be accessible to all community members, including those who are unable to access the health centre due to illness or mobility constraints.

PRINCIPLES:

- The safety and security of health and social services' (HSS) employees is of paramount importance.
- HSS adheres to the Government of Nunavut's Zero Tolerance Policy on violence in the workplace which includes all health facilities.
- Health care professionals are considered in the workplace during home visits that are performed as part of a plan of health care.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 05-003-00 Risk Management
Policy 05-004-00 Risk Management Incident Reporting
Policy 05-029-00 Violence in the Workplace
Policy 05-030-00 Motor Vehicles
Guideline 07-024-01 Guidelines for Planned Home Visits
Guideline 07-024-02 Guidelines for Safe Home Visits
Zero Tolerance Policy from the *Human Resources Manual*

GUIDELINE 07-025-01

PROCEDURE

For after-hours assessments or emergencies, the nurse on call (NOC) will be contacted.

1. Every effort must be made to transport the client to the health centre for further assessment.

2. All available means of the client's accessibility to health care needs to be explored when a client cannot come to the health centre.

3. Unplanned home visits need to be assessed on an individual basis.

4. The decision to attend an unplanned home or site visit is determined through a process of:

    a. Contacting the client and obtaining as much information about the client and location – full name, address, phone number, other people living in the residence;

    b. Assessing the client's condition and possible risk factors (who is in the house, listen for background noise, known domestic violence, criminal involvement/substance abuse/unstable mental illness) through telephone or radio contact. If the residence or client is known to be dangerous DO NOT ATTEND.

    c. Speaking directly with the client is preferable but not always possible;

    d. Anticipating and determining the health intervention that may be required, its timing, and urgency in obtaining health care.

    e. Assessing potential for a life threatening health condition(s) where a delay in seeking alternative transportation modes to the health centre can cause further harm.

    f. Determining if the mechanism of transport for the client requires the expertise of a health professional prior to moving (e.g. spinal immobilization).

    g. Assessing the capacity of the client to attend a the health centre; existing external conditions that may impede the client's ability to attend to the health centre (e.g. COPD exacerbated by cold weather, etc)

5. If the situation in the home or at the site is assessed to be unsafe to attend at the home / site and in the clinical decision of the health professional the client requires urgent access to health care, alternative means of access or support to attend at the home or transport to the health centre must be explored. (e.g. accompanied by RCMP, Bylaw Officer, Social Worker). **The practitioner will NOT attend a home/site when it is determined to be UNSAFE.**

6. If the health concern has been determined to be non life threatening, and does not require the expertise of a health care professional for transportation concerns (e.g. spinal immobilization) the client must attend at the health centre for assessment.

7. If the situation in the home or at the site is assessed to be safe and of an emergent nature, the NOC responding to the call will:

    a. During clinic hours: Inform the Supervisor of Community Health Programs (SCHP) about the exact location of the unplanned home visit; telephone number at the location; type of telecommunication system that will be taken with them to the home/site; the reason for attending at the home/site, and the estimated length of stay at the location.
    Inform the SCHP upon safe return back to the health centre.

    b. After clinic hours: Inform the second NOC / or other colleague about the exact location of the unplanned home visit; telephone number at the location; type of telecommunication system that will be taken with them to the home/site; the reason for attending at the home/site, and the estimated length of stay at the location.
    Inform the second NOC or other colleague upon safe return back to the health centre.

8. The nurse attending the home visit must take a means of communicating with the health centre or outside help (e.g. cell phone, satellite phone, radio phone, etc.)

9. The second NOC or colleague who was notified of the unplanned home visit should make contact with the NOC at set time intervals (e.g. every 20 minutes) until they have been notified of the safe return of the NOC back to the health centre.

10. If the NOC has not returned to the health centre and the second NOC or colleague is unsuccessful in contacting the NOC on the home visit, the second NOC will immediately contact:

    a. SCHP
    b. RCMP as directed by the SCHP or other standard procedures established for that health centre.

11. If during the home visit, the nurse has any concerns about their own safety DO NOT ENTER or if concerns or doubts arise during the visits LEAVE IMMEDIATELY. Do not worry about leaving supplies, equipments or anything behind, your safety is most important.

12. All contact with the client, family or contact person through telephone / radio conversations or home visits must be documented in the client's health centre health record.

13. If a home visit was not completed, all contact with the client, family or contact person must be documented in the client's health record, as well as the reasons why the visit was not completed and any attempts to seek alternative means of access or support.

14. If a home visit was completed, details of the home visit must be documented in the client's health centre health record, as per Policy 06-008-00 Documentation Standards and 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:**
Emergency Land Medivacs		Nursing Practice	07-026-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		3
APPLIES TO:			
Community Health Nurses			

POLICY 1:

Health care will be accessible to all community members, including those who are ill or injured on the land. Search and Rescue (SAR) shall be notified by the Nurse-on-Call (NOC) or Supervisor of Health Programs (SHP) of any person who is known to be ill or injured on the land.

POLICY 2:

The on call physician shall determine whether an emergency land medivac is warranted. The NOC may authorize a medivac if a physician is unavailable and after consultation with the SHP.

POLICY 3:

A nurse or physician may volunteer to attend an emergency land medivac if appropriate and if the health centre can continue to operate safely in the absence of that health care practitioner. As a volunteer, the nurse will not be insured and will not be covered for workers compensation benefits through their employment. Employees will however be covered under Workers Compensation and Safety Commission, in case of an accident, through an agreement with Nunavut Emergency Management.

PRINCIPLES:

- Each Hamlet has its own Search and Rescue Team (SAR). For each distress call out on the land for a lost, ill or injured person, the SAR notifies the Nunavut Emergency Measures in Iqaluit (for advice and coordination) and sometimes the RCMP. The contact number is 867-979-6262.
- The *Emergency Medical Aid Act* (1998) states that the RN, MD or volunteer are not liable except for gross negligence while a) rendering emergency first aid assistance and b) rendering emergency medical services or first aid assistance outside the hospital or other place having adequate medical facilities and equipment.
- It is not mandatory for a health care practitioner to attend emergency land medivacs.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Guideline 07-026-01 Guidelines for Emergency Land Medivacs
Nunavut *Emergency Medical Aid Act*

REFERENCES:

Department of Health and Social Services (2002). *Emergency Land Medivacs*.

Nunavut *Emergency Medical Aid Act*

- Each Hamlet has its own Search and Rescue Team (SAR). For each distress call out on the land for a lost, ill or injured person, the SAR notifies the Nunavut Emergency Management (NEM) in Iqaluit (for advice and coordination) and sometimes the RCMP. The contact number is 867-979-6262.

- If the person is ill or injured, the SAR notifies the Health Center. If the Health Center is notified first of the illness, the SAR should be notified by the Health Center.

- The Nurse-on-call (NOC) may communicate with the ill or injured person by CB or satellite telephone to assess the problem and provide advice.

Medivac

1. If a medivac is required, the NOC contacts the physician-on-call (as per usual health centre procedure) to discuss the situation and the person's condition.

2. Based on the information provided by the NOC, the physician will determine the urgency of the medical condition and whether a medivac is warranted. The physician will advise NEM regarding the medical urgency.

3. NEM will provide the physician with the details of the conditions for travel, time frames and available transport to the health centre. The physician and NEM will then make a joint decision regarding the appropriate mode of transportation. NEM is responsible for arranging the transportation.

4. The physician will be responsible for making clinical decisions regarding the urgency of evacuation and not the primary logistical decisions surrounding the evacuation.

5. The NOC may authorize a medivac if a physician is unavailable and after consultation with the SHP.

6. If an air medivac is required, the NEM makes arrangements for the transportation and not medical travel. Emergency land medivacs, by air, land and sea, are paid by the Department of Health and Social Services. NEM already has the authorization number for payment.

7. If a nurse, physician or community member volunteers to accompany the medivac (by air, land or sea) they are covered under NEM's agreement with Worker's Safety and Compensation Commission and the Federal Government for their safety. Note it is not mandatory for a nurse or physician to attend the medivac. The health care practitioner may attend if appropriate and if the health centre can continue to operate safely in the absence of that health care practitioner.

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:**
Certificate of Illness		Nursing Practice	07-027-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		2
APPLIES TO:			
Community Health Nurses			

POLICY 1:

Community Health Nurses may provide certificates of illness or "sick notes" to clients who present to the health centre provided that the patient has been seen and assessed by nursing staff.

POLICY 2:

During exceptional circumstances, the need for an assessment can be superseded by a directive from the department through the Deputy Minister, Assistant Deputy Minister, Chief Medical Officer, Director of Medical Affairs or Chief Nursing Officer.

PRINCIPLES:

- The nurse issuing the certificate of illness or sick note must base the content of the letter upon their assessment of the patient.
- Should a patient not require a certificate of illness after their first presentation to the health centre, and subsequently returns with the same signs and symptoms, the practitioner may note in the sick note previous clinic visits related to this immediate illness from the contents of the patient's chart.
- Sick notes may not be back dated when completed. The sick note may only document the day the patient was seen in the health centre and any further time directed as "off" for the purposes of the treatment plan. A nurse may not provide a sick note for any "sick days" incurred before the client presents to the health centre.
- All sick notes must be legibly written and contain the patient's full name and date of birth. The nurse authoring the letter must clearly sign their name and designation (RN) on the letter or note.
- A copy of all certificates of illness should be filled in the patient's chart.
- In some exceptional circumstances such as an outbreak of respiratory disease, the Department may issue a directive requesting patients not to present to the health centre for sick notes. Under these rare circumstances, a community health nurse may issue a certificate of illness without seeing the patient.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 06-001-00	Confidentiality
Policy 06-006-00	Health Records Management
Policy 06-008-00	Documentation Standards
Guideline 06-008-01	Documentation Standard Guidelines
Policy 06-009-00	Documentation Format

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	Medical Directives and Delegation Tuberculosis (TB) Programming	
TITLE:	**SECTION:**	**POLICY NUMBER:**
LPN Medical Directive: TB program	Nursing Practice	07-028-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
October 2017 / October 2020		8
APPLIES TO:		
All Department of Health staff		

1. **BACKGROUND:**

The Department of Health, Professional Practice Unit acts as the regulator for Licensed Practical Nurses (LPN) in Nunavut, as authorized through legislation. This unit is responsible for setting the standards and scope of practice for LPNs working in the territory. The Department of Health has adopted the Scope of Practice and Practice Standards from the College of Licensed Practical Nurses of Alberta, which provides the foundation for LPN practice in Nunavut. The training received through Canadian LPN educational programs, coupled with the LPN practice standards, prepare LPNs to carry out the functions required to administer communicable disease programming in the territory.

This policy provides an authorizing mechanism in which LPNs may perform duties, within the context of the Tuberculosis (TB) program, which are sanctioned to another regulated health care professional (e.g. physician, nurse practitioner, public health nurse (PHN), TB nurse (TBN) and pharmacist) without a direct order from that health care professional with the purpose of supporting safe and efficient delivery of local TB programs. LPNs are not to be assigned to work independently in TB programs; rather, LPNs are to be assigned to work collaboratively with a local registered nurse (RN) trained in TB and public health programs (i.e. PHNs or TBNs).

The LPN will be operationally supervised by the SCHP; however, overall TB program leadership is the responsibility of the PHN/TBN. The PHN/TBN and LPN work collaboratively with the RCDC team to provide timely screening and control of TB in the territory. LPNs have a role in supporting patients on DOT, ensuring safe administration and monitoring of patients on TB program while working collaboratively with the DOT worker and the PHN/TBN and implementing delegated tasks from the PHN/TB in contact investigations.

2. **MEDICAL DIRECTIVE:**

2.1 SCREENING AND TESTING:

2.1.1 LPNs may perform tuberculin skin test (TST) without a direct Physician (MD) or Nurse Practitioner (NP) order for children over 5 years of age, as directed by the patient screening criteria TB Testing Flowcharts described in the *TB Manual*.
LPNs are authorized to perform tuberculin skin tests only after they have received TST training and meet the required TST competencies.

2.1.2 LPNS, working in the TB program, may initiate sputum test requisitions without a direct MD or NP order for the purpose of screening, diagnostic testing, or monitoring as outlined in the *TB Manual*.

2.1.3 Patients meeting the criteria outlined in the *TB Manual* for needing a chest x-ray or blood work, for the purpose of screening, diagnostic testing or monitoring, will be

referred to the PHN/TBN for initiation of the x-ray and blood work requisitions.
NOTE: When a PHN/TBN is not available in the community, the LPN may consult the CHN/SCHP for the required test requisitions; however, the CHN/SCHP must have completed the GN TB Training program.

2.1.4 LPNs working in the TB program may perform clinical procedures related to the collection of sputum specimens as directed by the *TB Manual* and in accordance with relevant GN Lab Manuals and GN policies and procedures.

2.2 DIAGNOSIS:

2.2.1 LPNs are authorized to read a TST result after receiving TST training and meeting the required TST competencies. All abnormal results are to be reported immediately to the PHN/TBN or SCHP and Regional Communicable Disease Coordinator (RCDC), as per established local TB program protocols.

2.2.2 All abnormal test results are to be reported to the PHN/TBN, RCDC, and/or TB MD, as per established local TB program protocols.

2.2.3 LPNs are not authorized to make medical diagnoses. Once a diagnosis is confirmed, the PHN/TBN (or CHN/SCHP when a PHN/TBN is not available) will review the diagnosis with the patient and provide support and follow-up as per established local TB program protocols and per the Nunavut TB Manual.

2.3 TREATMENT:

2.3.1 It is within the LPN scope of practice to administer TB drug therapy, once an order has been received from the TB MD. The LPN is not authorized to initiate drug therapy without such direct order.

3. LEGISLATIVE AND REGULATORY SUPPORTING DOCUMENTS:

3.1 Licensed Practical Nurses Act
3.2 Standards of practice
3.3 Scope of practice document
3.4 CNA code of ethics
3.5 Medical professions act

4. AUTHORIZED IMPLEMENTERS:

4.1 LPNs who are assigned to the TB program and possesses the knowledge, skill and judgment to do so. The LPN is required to demonstrate competency to implement this medical directive through the standard TB orientation, training and certification process.

4.2 Sub delegation is not permitted to another regulated or non-regulated health care professional (i.e. to DOT workers in communities).

5. PRINCIPLES:

5.1 LPNs are expected to practice within their own level of competence and seek guidance from PHN/TBN, their supervisor (SCHP), RCDC, CHN, physician and/or NP as needed. Decision making model is included in Appendix A to assist with the decision to perform additional skills and delegated functions. Guidelines set out in the TB manual must be followed.

5.2 As described in the *Licensed Practical Nurses Act*, LPNs are authorized to provide practical nursing services:

(a) Independently, for patients considered stable with predictable outcomes (i.e. Routine screening (school screening/employment screening/walk-ins and low risk contacts); and

(b) Under the guidance or direction of a registered nurse (ie, PHN/TBN, CHN, SCHP, nurse practitioner, medical practitioner or other health care professional) authorized to provide such guidance or direction, for patients considered unstable with unpredictable outcomes.

5.3 In the community health centre settings, the LPN works under the supervision of the SCHP, with support and guidance on the TB program from the PHN/TBN; while the regional TB team provides the specific TB program expertise and guidance to both the LPN and the PHN/TBN. All health center staff including the PHNs, TBNs and LPN report to the SCHP.

5.4 During instances when a PHN/TBN is not available in the community for consultation, the LPN will consult a CHN/SCHP who has completed the GN TB Training program.

5.5 Guidelines do not replace clinical judgement. Management decisions regarding patient care must be individualized.

6. **CONTRAINDICATIONS:**

Consult the PH/TBN, MD, NP, SCHP, or RCDC before enacting this medical directive when any of the following conditions exist:

6.1 The LPN cannot confirm all conditions of this directive and the *TB Manual* have been met.

6.2 The patient's history or physical exam does not match the criteria described in the *TB Manual* for specific investigations, interventions and/or treatment.

6.3 The patient has contraindication to the recommended test, treatment or clinical procedure, as outlined in the *TB Manual*.

6.4 The *TB Manual* recommends physician consultation first.

7. **DEFINITION:**

Practical Nursing Services: means the application of practical nursing theory in the

(a) Assessment of patients;
(b) Collaboration in the development of a nursing plan of care for a patient;
(c) Implementation of a nursing plan of care for a patient; and
(d) Ongoing evaluation of a patient

8. **PROCEDURE:**

Patient Assessment

8.1 For stable, low risk patients, the LPN, as per legislative scope of practice, conducts comprehensive patient history and physical, as per the screening and monitoring guidelines in the *TB Manual*.

(a) The LPN references the *TB Manual* to determine if the conditions of this directive have been met (e.g. the patient's presenting condition meets the screening criteria in the *TB Manual*). The Algorithm in Appendix A provides guidance to the LPN when determining if the medical directive is appropriate to enact.

(b) If the LPN determines the conditions have not been met, or is unsure if the patient's history and physical meets the criteria for screening, diagnostic testing, or monitoring or for complex care then the PHN/TBN, SCHP, RCDC, MD or NP shall be consulted, as per established local TB program protocols.

TST, Lab and Diagnostic Imaging

8.2 *Tuberculin Skin Test*: TST competencies (planting and reading) must be met per NU TB program standards.

(a) When directed by the guidelines in the *TB Manual*, LPNs may perform a tuberculin skin test (TST) without a direct MD or NP order for patients over 5 years of age. PHN/TBN shall be promptly notified for all patients under the age of 5 years of age who require a TST. The LPN is authorized to read TST results in patients of all ages (including children under 5 years of age), as per their scope of practice and training.

(b) The LPN is to promptly report to the PHN/TBN (or CHN/SCHP when a PHN/TBN is not available) all cases where induration is noted – regardless of size. The PHN/TBN will assess the TST result, document findings, and provide guidance to the LPN on reporting and next steps – as per *TB Manual*.

8.3 *Sputum Specimens*:

(a) When directed by the guidelines in the *TB Manual*, LPNs may initiate a requisition for sputum specimens without a direct MD or NP order for patients of all ages.

(b) In conditions where sputum specimens are warranted, the LPN may collect and prepare the specimens as per the procedures outlined in the *TB Manual* and relevant GN Lab Manuals as well as provide all patient collection instructions.

(c) For symptomatic patients, the LPN can collect sputum specimens using airborne precautions and collect specimens for GeneXpert under the advisement of the PHN/TBN and RCDC.

8.4 Chest X-rays:

(a) When a patient requires a chest x-ray, as directed by the *TB Manual*, the LPN will promptly notify the PHN/TBN (or CHN/SCHP when a PHN/TBN is not available in the community), who in turn reviews the case and initiates the x-ray requisition in accordance with the *TB Manual* and *CHN Manual* policy: *CHN Initiating X-Ray Requests.*

(b) The LPN will arrange the x-ray appointment and follow up to confirm the test is completed.

8.5 *Blood Work*:

(a) When a patient requires blood work, as directed by the *TB Manual*, the LPN will promptly notify the PHN/TBN (or CHN/SCHP when a PHN/TBN is not available in the community), who in turn reviews the case and initiates the blood work requisition in accordance with the TB Manual and CHN Manual policy: *Requisitioning Laboratory Studies.*

(b) The LPN will arrange for blood work to be drawn and follow up to confirm test completed. Note: LPNs who completed competency training for phlebotomy can perform blood draws.

8.6 Follow up of Test Results:

(a) The LPN is responsible for receiving and reviewing all lab and diagnostic imaging reports which were generated within the TB program.

(b) The PHN/TBN (or CHN/SCHP) who initiated the lab and x-ray requisitions are also required to review the reports and ensure appropriate follow up care is instituted, as per *TB manual* baseline assessment and routine monitoring guidelines as well as the *CHN Manual* policies: *Acknowledgement of Diagnostic Test Results* and *Follow-up of Abnormal Diagnostic Test results.* The LPN will consult with the ordering PHN/TBN (or CHN/SCHP) once the report is received to ensure each report has been reviewed and direction is provided to the LPN on next steps.

(c) It is not within the role of the LPN to interpret lab and DI results; therefore, all abnormal test results are to be reported promptly to PHN/TBN (or CHN/SCHP when the PHN/TBN is not available) who will report abnormalities to RCDC, as per established local TB program protocols.

Treatment:

8.7 LPN requires a direct TB MD order for the administration of medications, which in most cases will be in the form of a physician prescription. The LPN shall refer to the textbook *Clinical Nursing Skills and Techniques* (Perry and Potter) for instruction on basic nursing medication administration procedures as well as the *Nunavut TB Manual* for guidelines on Direct Observed Therapy.

Note: For medications to be administered by the LPN via Intravenous, intramuscular, intradermal or subcutaneous routes, the LPN must have either (1) completed a post-graduate

medication administration course if the LPN graduated prior to 2001 or (2) have graduated from a Canadian LPN educational program after 2001, whereby the competency training for these medication administration routes were considered part of the basic educational curriculum.

8.8 LPNs are authorized to verify blister packs cross referenced with the current prescription for the DOT workers. It is a shared responsibility between the LPN and PHN/TBN to review all incoming blister packs (BBP) from pharmacy against the prescription orders and verify BBPs are correct by initialling and dating the back of the blister packs, as per Nunavut TB program protocols and outlined in the *Nunavut TB Manual.*

Documentation:

8.9 All patient encounters are to be documented in the patient's chart, using the appropriate forms as described in the *TB Manual (*e.g. DOT medication records and TB Assessment Form).

8.10 All TB documentation is to be submitted to RCDC in accordance with the procedures described in the *TB Manual.*

Contact Investigations and Public Health Follow up

8.11 Contact Investigations and public health follow up are advanced practice nursing skills and the LPN role in contact investigations are to follow up with tasks delegated by a PHN/TBN (or CHN/SCHP when a PHN/TBN is not available in the community) trained in public health contact investigations.

8.12 The LPN can be delegated tasks for following up in contact investigations that include assessing patients who have been identified as high risk by the PHN/TBN and following protocols outlined in the *TB Manual.*

8.13 Patient risk assessments and contact investigation including public health follow up must be overseen by the PHN/TBN (or CHN/SCHP when the PHN/TBN is not available in the community) and in collaboration with RCDC as outline in the *NU TB Manual.*

School Screening

8.14 LPNs will work in collaboration with the PHN/TBN (or CHN/SCHP when the PHN/TBN is not available in the community) in school screening programs. Follow up actions from the screening initiative may be delegated to the LPN by the PHN/TBN; except for collating the data from the school screening program, which will remain the PHN/TBN responsibility.

9. **RELATED POLICIES, PROTOCOLS AND LEGISLATION:**

APPENDIX A: Algorithm for Assessing Appropriateness of the Medical Directive
APPENDIX B: Decision-Making Model Performing Additional Functions & Transferred Functions
Alberta Licensed Practical Nurses Association Standard of Practice Documents
Government of Nunavut TB Manual
Community Health Nursing Manual: Documentation Standards Policy
Community Health Nursing Manual: Transferred Functions
Community Health Nursing Manual: CHN Initiating X-Ray Requests
Community Health Nursing Manual: Requisitioning *Laboratory Studies*
Nunavut Formulary
Licensed Practical Nurses Act

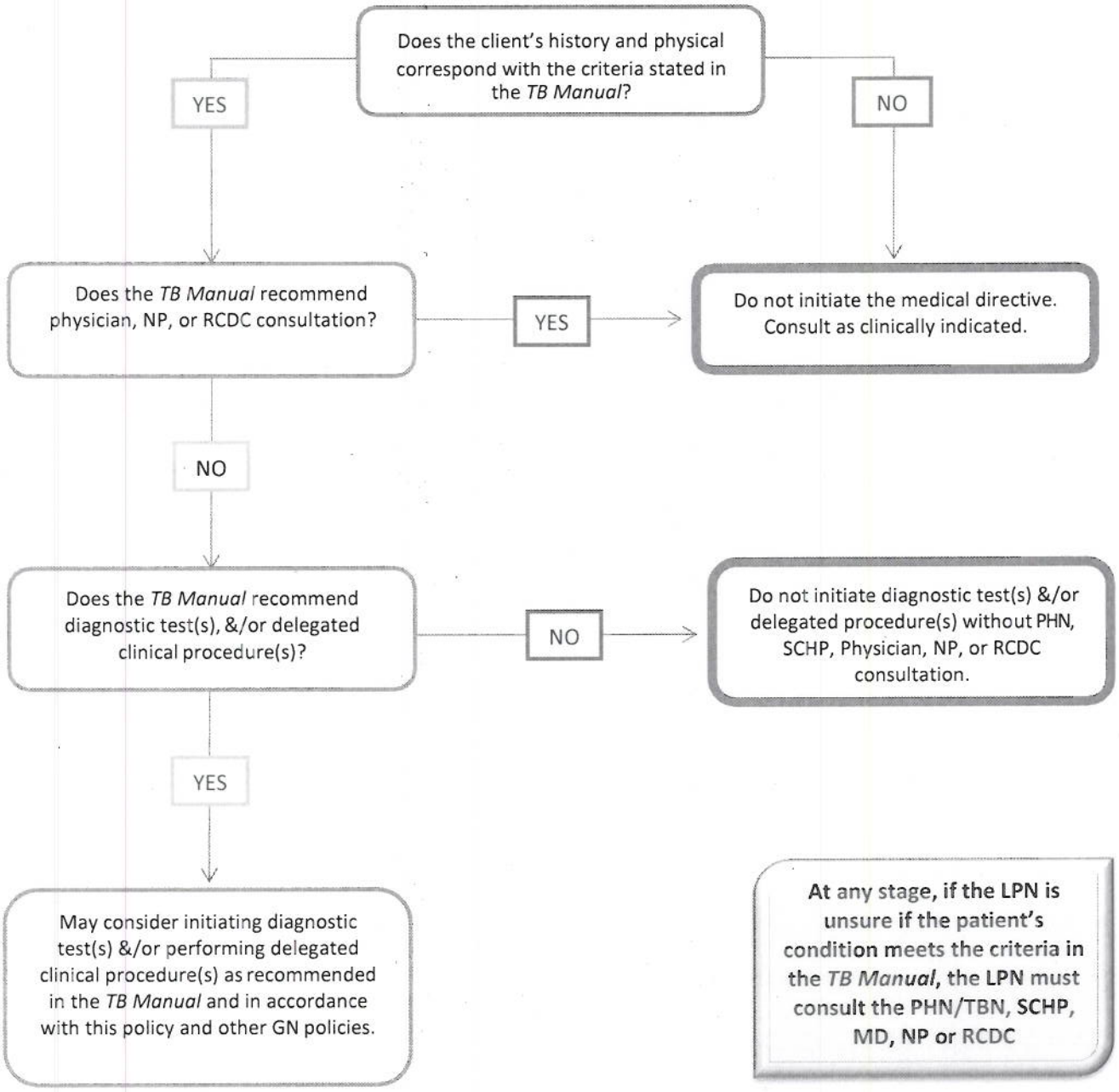
10. **REFERENCES:**

Alberta Licensed Practical Nurses Association Standard of Practice Documents
Government of Nunavut (2010). *Community Health Nursing Standards, Policies and Guidelines*
Government of Nunavut. *Tuberculosis Manual*. (2017)
Licensed Practical Nurses Act

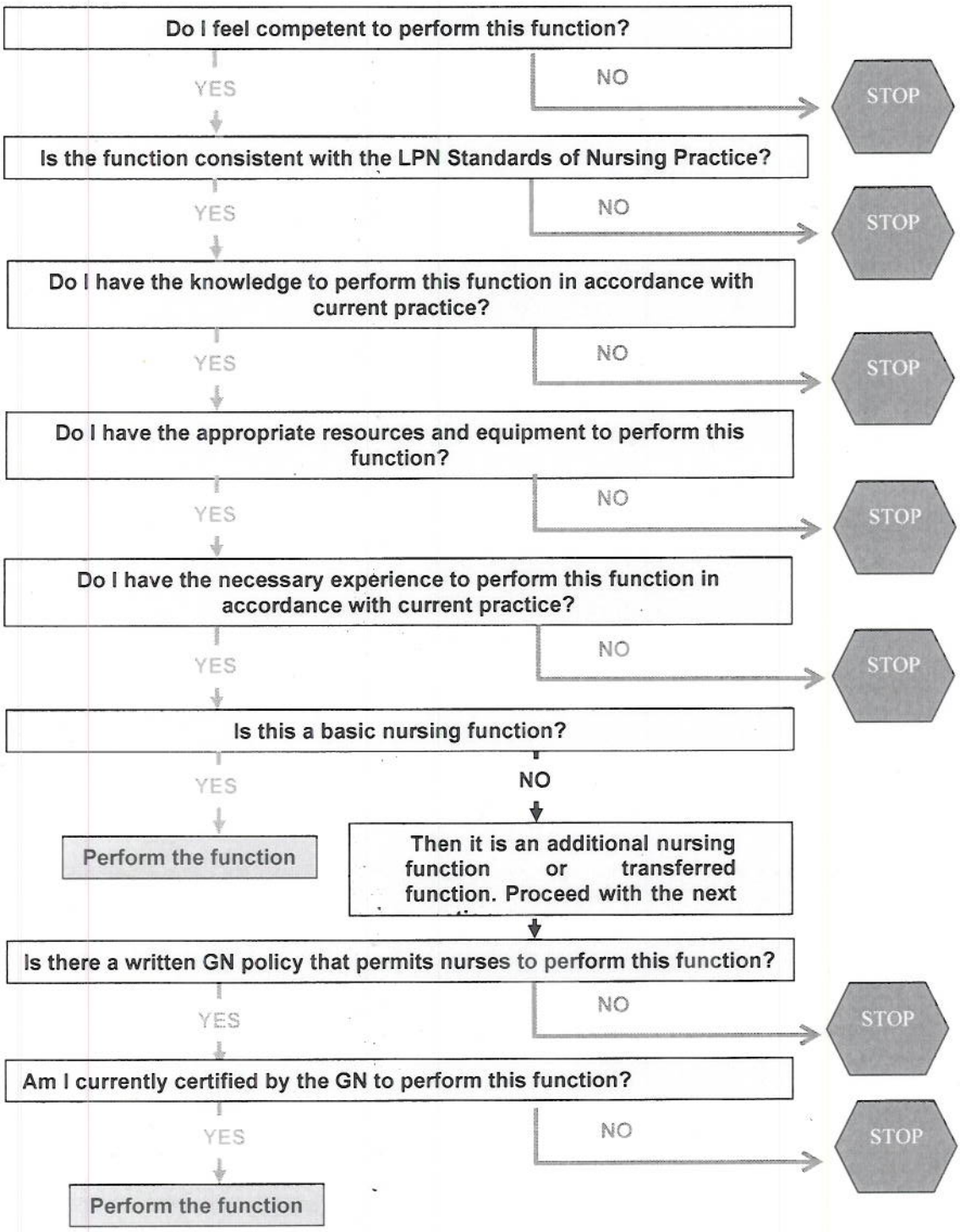
11. **APPROVALS:**

Approved By:	Date: 26-October - 2017
Dr. Kim Barker, Chief Medical Officer of Health – Department of Health	
Approved By:	Date: 26-October - 2017
Jennifer Berry, Chief Nursing Officer	

APPENDIX A: ALGORITHM FOR ASSESSING APPROPRIATENESS OF THE MEDICAL DIRECTIVE



APPENDIX B: DECISION-MAKING MODEL FOR PERFORMING ADDITIONAL FUNCTIONS AND TRANSFERRED FUNCTIONS



Adapted from RNANT/NU (2010). *Scope of Practice for Registered Nurses*, p. 9

Department of Health Government of Nunavut	Title **Infant - Telephone Triage and Infant Assessment (Age 0 – 12 Months)**		
NURSING POLICY, PROCEDURE AND PROTOCOLS		**SECTION:**	**POLICY NUMBER:**
Community Health Nursing		Clinical Practice	07-029-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
August 18, 2017	August 2020	07-006-00 Telephone Triage 07-007-00 Telephone Advice 07-008-00 Acutely Ill Infants	3
APPLIES TO:			
All Community Health Nurses and Nurse Practitioners			

1. BACKGROUND:

Community Health Nurses and Nurse Practitioners provide telephone triage services within the community to assess the severity of the client's symptoms and determine the appropriate plan of care. The health status of infants can quickly deteriorate, lending to the need that all ill infants require full assessments at the Health Centre to determine the infants' health status and appropriate plan of care.

2. POLICY:

ASSESSMENT:

2.1 All infants aged 12 months and under must be fully assessed in the clinic, whether it is during or after regularly scheduled clinic hours.

TELEPHONE TRIAGE:

2.2 Infants aged 12 months and under must be seen in the health centre within one hour of receiving a phone call from the parent/guardian. The timing of the visit to be determined by the urgency of the reported signs and symptoms.

i. If the parent/guardian declines to bring the infant to the health centre at the time of the call, he/she must be (1) offered the opportunity to call the Nurse-on-Call back and (2) offered an appointment at the health centre later that same day or the following calendar day.

2.3 Every telephone call received regarding an infant must be documented on the *Infant Telephone Triage Form* at the time the call is received. The only exception to this policy statement is when the nurse has the infant's chart in his/her possession at the time of the call and the information is written directly into the health record.

3. PRINCIPLES:

3.1 Telephone triage requires the nurse to assess a client's health concern without the advantage of a face-to-face interaction or hands-on inspection. The clinical decisions made by Registered Nurses during telephone triage require complex critical thinking, which shall largely be based on current evidence and best-practices. Nurses must also rely on their communication skills, knowledge of disease processes, and normal growth and development for all age groups in order to accurately understand the client's presenting symptoms.

3.2 All parents/guardians have a right to refuse to bring the infant to the health centre to be assessed. In these situations, the nurse will attempt to obtain as much information as possible over the phone to mitigate the risks associated with not immediately assessing the infant in the clinic.

3.3 The *Infant Telephone Triage Form* is a legal document and must be promptly secured in the health record.

4. DEFINITIONS:

Nurse: For the purpose of this policy, nurse refers to Community Health Nurses and Nurse Practitioners.

Telephone Triage: an assessment over the phone to assess a health condition of a client in order to determine the level of urgency for care and the overall plan of care.

5. PROCEDURE:

Telephone Triage:

5.1 When a call is received from a parent / guardian regarding an infant, the nurse shall use the *Infant Telephone Triage Form* to guide the telephone assessment, determine the urgency, and to record the details of the call.

NOTE: The triage form is only intended to provide guidance for a preliminary evaluation of the infant's health status to determine the urgency of receiving medical care. It is NOT intended to provide guidance for a full infant assessment.

5.2 The nurse will request that the parent/guardian bring the infant to the health centre within one hour of receiving the call. The decision to see the infant immediately versus safely postponing the clinic visit for one hour shall be based on the evaluation of the Infant's Airway, Breathing and Circulation status over the phone.

Note: In the event of a blizzard, safety considerations for the nurse and the client must be carefully evaluated. If the client's condition is determined to be non-urgent and it is not safe to travel to the health centre (e.g. zero visibility), the nurse must notify the SCHP and arrange appropriate follow up care (for example: follow up phone calls with the parent/caregiver at set intervals) until such time that the weather improves (e.g. visibility > 400m) or the client's condition changes and is now determined to be urgent or emergent. Follow local health centre protocols for travelling to the health centre in the event the client's condition is determined to be emergent or urgent, which includes notifying the SCHP of the situation before traveling to the health centre. Whenever the nurse is in doubt about the level of urgency for the client to be seen, the physician and supervisor are to be consulted.

5.3 If the parent/guardian declines to bring the infant to the health center, the nurse shall:

i. Obtain additional information regarding the infant's health status to support the development of an appropriate plan of care;
ii. Document details of the call on the triage form:
   - reason caller declined to attend health centre;
   - health status of the infant;
   - treatment plan;
   - date/time follow up appointment arranged
   - advice on when the parent/guardian should call the nurse on call back; and
   - any other relevant details discussed;
iii. Offer the caller an opportunity to call the nurse on call back at any time;
iv. Arrange an appointment for the infant to be assessed in the health centre later that day or on the next calendar day;
v. Complete, sign and date the *Infant Telephone Triage Form* at the time of the call and place in the infant's health record as soon as it is feasible to do so.

Assessment:

5.4 The assessment of the ill infant shall, at minimum, include ALL of the following:

1.	Undress the child down to his/her diaper.
2.	Address any airway, breathing or circulation issues first.
3.	Perform a full set of vital signs including temperature, heart rate, blood pressure, respiratory rate, oxygen saturation.
4.	Weigh the infant naked at <u>each</u> visit

5. Obtain a comprehensive history including: - past medical history and social history, - medications the infant has received (including antipyretics), - history of presenting illness, focusing on: when the illness started, if it's getting better or worse, if the infant is drinking, and voiding, and if there have been any changes in the level of alertness of the infant.
6. Perform a physical exam with particular focus on: - assessing hydration status (tears when crying, moist mucous membranes), - work of breathing, - fever status, - finding the focus: head and neck examination including looking in both ears and throat, respiratory exam (documenting work of breathing and breath sounds), cardiac exam, abdominal exam, dermatology exam and neurology exam including any signs of nuchal rigidity, and decreased level of consciousness. - Additional diagnostic tests may be required depending on the presenting concerns and initial assessment findings
7. Consult the physician on call for further advice (as per local protocols) for all concerns which arise from the assessment.

6. **RELATED POLICIES, PROTOCOLS AND LEGISLATION:**

Policy 06-001-00	Confidentiality
Policy 06-006-00	Health Records Management
Policy 06-008-00	Documentation Standards
Policy 06-009-00	Documentation Format

7. **REFERENCES :**

American Heart Association (2011) Pediatric Advanced Life Support Provider Manual

Approved By: Colleen Stockley	Date: Aug 18/17
Colleen Stockley, Deputy Minister – Department of Health	
Approved By:	Date: August 18/17
Jennifer Berry, Chief Nursing Officer	

Department of Health Government of Nunavut Policy 07-027-00	TITLE **INFANT TELEPHONE TRIAGE FORM** **Age 0- 12 months**

ALL INFANTS (12 mths of age and younger) MUST BE ASSESSED AT THE HEALTH CENTRE

*** This Form is not to be used as an assessment of the infant but to establish URGENCY whether to see the child at the Health Centre immediately or within ONE hour ***

Name of Caller:	**Date**:	**Time**:	**Phone**:
Relationship of Caller to Patient:		**Location of Caller:**	
Name of Patient:	**Gender:** M / F	**Age**:	
Chief Complaint:			
Known Health Conditions:			

AIRWAY :			**CIRCULATION**		
Is the child breathing?	**Y**	**N**	Colour: ☐ **Normal** ☐ **Pale**		
Noisy Breathing?	**Y**	**N**	Urine Output : # wet diapers? _____ Last wet diaper? _____		
Is it worsening?	**Y**	**N**	Child crying /making tears?	**Y**	**N**
BREATHING			**DISABILITY**		
How is the infant's breathing? ☐ **Normal** ☐ **Fast** ☐ **Difficult**			Is the Child alert?	**Y**	**N**
Any blue colour around lips, hand or feet now?	**Y**	**N**	Responsive?	**Y**	**N**
Any previous episodes of blue colour around lips, hands or feet?	**Y**	**N**	Excessively sleepy?	**Y**	**N**
Using belly muscles while trying to breath?	**Y**	**N**	Irritable?	**Y**	**N**
Is the infant's head moving up & down when trying to breath?	**Y**	**N**	**Any other concerns?**		
Are the infant's nostrils moving in and out when trying to breath?	**Y**	**N**			

ASSESSMENT : Emergency: _____ Urgent (1 hour): _____ To Come to Clinic : Now _____ / within 1 hour_____

Other Comments : ☐ caller agreeable ☐ caller refused (check one)

If caller declines to bring child to health centre within one hour, DOCUMENT all advice given:

_____

_____

_____

_____

_____

_____

Signature of CHN _____ Print Name _____ Date_____ Time _____

COMPLETED FORM MUST be PLACED in Patient's Health Record

Department of Health Government of Nunavut	TITLE **Pediatric and Adult - Telephone Triage**		
NURSING POLICY, PROCEDURE AND PROTOCOLS		**SECTION:**	**POLICY NUMBER:**
Community Health Nursing		Clinical Practice	07-030-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
August 18, 2017	August 2020	07-006-00 Telephone Triage 07-007-00 Telephone Advice	6
APPLIES TO:			
All Community Health Nurses and Nurse Practitioners			

1. BACKGROUND:

Community Health Nurses and Nurse Practitioners provide telephone triage services within the community to assess the severity of the client's symptoms and determine the appropriate plan of care.

2. POLICY:

2.1 All clients who call regarding a health concern will be assessed on an individual basis utilizing the *Pediatric Telephone Triage Form* or the *Adult Telephone Triage Form* to establish the time frame in which the client will be assessed in the Health Centre.

2.2 **The following individuals** shall be offered to be seen at the Health Centre to have their presenting health concern fully assessed in the clinic immediately or within 4 hours based on the urgency of the presenting symptoms from the telephone triage:

1. All clients whose condition is determined to: a. Require resuscitation; b. Be emergent; or c. Be urgent
2. All clients age 65 and older;
3. All pregnant women;
4. All women up to two (2) weeks postpartum;
5. All clients who were discharged in the last 48 hour from a hospital or care facility;
6. All clients who had a surgical procedure under general anaesthetic within the previous ten (10) days
7. All clients who had an endoscopic procedure (gastroscopy or colonoscopy) within the previous three (3) days
8. All clients with complex medical condition(s)
9. All clients who had multiple visits or multiple calls to the Health Centre in the previous seventy-two (72) hours with the same presenting complaint(s)
10. All clients in custody of the RCMP when an Officer contacts the health centre regarding a health concern of a detainee.

2.3 Every telephone call received regarding a presenting health concern is to be documented on the appropriate *Telephone Triage Form* at the time the call is received. The only exception is when the nurse has the client's medical record in his/her possession at the time of the call and the information is written directly into the health record.

3. PRINCIPLES:

3.1 Telephone triage requires the nurse to assess a client's health concern without the advantage of a face-to-face interaction or hands-on inspection. The clinical decisions made by Registered Nurses during telephone triage require complex critical thinking, which shall largely be based on current evidence and best-practices. Nurses must also rely on their communication skills, knowledge of disease processes, and

normal growth and development for all age groups in order to accurately understand the client's presenting symptoms.

3.2 Telephone Advice Guidelines are included in Appendix A and provide examples of strategies to mitigate the risks associated providing advice over the phone.

3.3 All clients have a right to refuse to be seen at the health centre to be assessed. In these situations, the nurse will attempt to obtain as much information as possible over the phone to mitigate the risks associated with not being assessed in the clinic.

3.4 The *Telephone Triage Forms* are legal documents and must be promptly secured in the client's health record.

4. DEFINITIONS:

Nurse: For the purpose of this policy, nurse refers to Community Health Nurses and Nurse Practitioners.

Telephone Triage: an assessment over the phone to assess a health condition of the client in order to determine the level of urgency for care and the overall plan of care.

Resuscitation: When there are conditions that are threats to life or limb or there is an imminent risk of deterioration which requires aggressive interventions (Canadian Triage and Acuity Scale (CTAS, 2007)).
Examples include, but are not limited to (consult another care provider if uncertainly of the acuity status of a client):

- Cardiac arrest
- Active seizures
- Respiratory arrest
- Major trauma (shock)
- Shortness of breath (severe respiratory distress)
- Altered level of consciousness (Glasgow Coma Scale 3-9)
- Severe dehydration in pediatric client

Emergent: When there are conditions that are potential threat to life, limb or function, requiring rapid medical intervention (CTAS, 2007).
Examples include, but are not limited to (consult another care provider if uncertainly of the acuity status of a client):

- Chest pain with cardiac features
- Hypothermia
- Fever (Temperature > 38.5, appears septic; and/or infant less than 3 months with fever >38 C)
- Headache (sudden, severe)
- Bizarre paranoid behavior
- Depression/suicide (attempted suicide, clear plan)
- Chemical exposure to eye
- Shortness of breath (moderate respiratory distress)
- Abdominal pain (severe pain)
- Altered level of consciousness (Glasgow Coma Scale 10-13)
- Moderate dehydration in pediatric client

Urgent: When there are conditions that could potentially progress to a serious problem requiring emergency intervention (CTAS, 2007).
Examples include, but are not limited to (consult another care provider if uncertainly of the acuity status of a client):

- Seizures (resolved, normal level of alertness)
- Diarrhea (uncontrolled bloody diarrhea)
- Active labour; premature rupture of membrane; and/or preterm bleeding after 20 weeks gestation.
- Depression / suicide (suicidal ideation, no plan)
- Shortness of breath (mild respiratory distress)
- Abdominal pain

- Headache (moderate pain 4-7 / 10)
- Chest pain, non cardiac features (other significant chest pain)

5. PROCEDURE:

5.1 When a call is received from a client the nurse shall use the appropriate *Telephone Triage Form* (Pediatrics or Adults) to guide the telephone assessment, determine the urgency, and to record the details of the call.

NOTE: The triage form is only intended to provide guidance for a preliminary evaluation of the client's health status to determine the urgency of receiving medical care. It is NOT intended to provide guidance for a full client assessment.

5.2 After analyzing the assessment information obtained from the telephone triage and noting the **required client populations to be seen listed in policy statement 2.2,** the nurse will determine the appropriate follow up plan:

i. Arrange to see the client at the Health Centre immediately or within four hours of the call; or
ii. Offer an alternate appointment date / time; or
iii. Provide telephone advice only.

Note: In the event of a blizzard, safety considerations for the nurse and the client must be carefully evaluated. If the patient's condition is determined to be non-urgent and it is not safe to travel to the health centre (e.g. zero visibility), the nurse must notify the SCHP and arrange appropriate follow up care (for example: follow up phone calls with the client/parent/caregiver at set intervals) until such time that the weather improves (e.g. visibility > 400m) or the patient's condition changes and is now determined to be urgent or emergent. Follow local health centre protocols for travelling to the health centre in the event the patient's condition is determined to be emergent or urgent, which includes notifying the SCHP of the situation before traveling to the health centre. Whenever the nurse is in doubt about the level of urgency for the patient to be seen, the physician and supervisor are to be consulted.

5.3 When a client declines to come to the health centre or when an alternate date/time has been arranged, the nurse shall:

i. Obtain additional information regarding the client's health status to support the development of an appropriate plan of care;
ii. Offer the caller an opportunity to call the nurse on call back at any time
iii. Counsel the client on when he/she should call the nurse on call back;
iv. Arrange an alternate appointment date/time;
v. Complete, sign and date the *Telephone Triage Form* and secure in client's health record as soon as it is feasible to do so.

5.4 Details of the call are to be documented on the *Telephone Triage Form* at the time the call is received and secured in the client's medical record at the earliest opportunity.

6. RELATED POLICIES, PROTOCOLS AND LEGISLATION:

Appendix A:	Telephone Advice Guidelines
Appendix B:	*Pediatric Telephone Triage Form*
Appendix C:	*Adult Telephone Triage Form*
Policy 06-001-00	Confidentiality
Policy 06-006-00	Health Records Management
Policy 06-008-00	Documentation Standards
Policy 06-009-00	Documentation Format

7. **REFERENCES:**

Canadian Emergency Department (2007). Canadian Triage and Acuity Scale (CTAS).

National Emergency Nurses Affiliation (2002). Position Statement A-1-4.

Approved By: Colleen Stockley	Date: Aug 18/17
Colleen Stockley, Deputy Minister, Department of Health	
Approved By:	Date: August 18/17
Jennifer Berry, Chief Nursing Officer, Department of Health	

Appendix A: Telephone Advice Guidelines

BACKGROUND:
It is within the scope of practice for a Community Health Nurses to provide telephone advice. The Department of Health supports the practice of providing telephone advice to clients by Registered Nurses.

Guidelines:

Common Hazards

The Registered Nurse must be aware of the most common hazards in giving telephone advice and attempt to eliminate these hazards. These include, but are not limited to:

Common Hazards	
▪ Using leading questions	▪ Using medical jargon
▪ Inadequate data collection	▪ Inadequate time to explore client's symptoms
▪ Jumping to conclusions	▪ Stereotyping callers or problems
▪ Failing to talk directly to the client	▪ Accepting client self-diagnosis and second guessing
▪ Overreacting and underreacting	▪ Nurse fatigue
▪ Language barriers	

Documenting Telephone Advice

Documenting the telephone call is a legal and professional obligation for the Registered Nurse who provides telephone advice to a client. The minimum requirements to be included in telephone contact documentation include:

Documentation	
▪ Date and time of the call	▪ Callers name, telephone number and address
▪ Information received from the caller	▪ Advice or information given by the nurse
▪ Referral and follow-up information	▪ Name of the nurse
▪ Client's name if different from caller	

The nurse may document the details of the telephone contact directly into the progress notes of the client's health record if immediately available. If the chart is not immediately available, such as when the nurse on call is fielding telephone calls outside the health centre, the nurse shall document the telephone conversation onto the appropriate *Telephone Triage Form*. At first opportunity, the form must be placed in the client's health record. Until such time, all forms must be kept secure while in the nurse's possession.

Risk Management

Providing telephone advice is a high risk activity. The following risk management strategies are designed for both the employee and employer and intended to reduce the incidence of injury to clients and the risk of potential liability:

Risk Management Strategies	
▪ When in doubt, see the client	▪ If a client calls seeking advice about the same problem more than once in the span of 3 days, then arrange for the client to be seen
▪ After reviewing care advice, ask the caller, "do you feel comfortable with this plan?" if the caller does not, schedule a call back in 1 hour or arrange to see the client. Remember telephone triage is point of entry into the health care system. Do not use triage as a method of limiting access. Instead use it as a method of improving access to primary care.	▪ Encourage callers to call back if the condition worsens. Callers should be given specific reasons to call back. At the least, the nurse should instruct the caller to call back if the "client becomes worse".

Appendix A: Telephone Advice Guidelines

▪ Establish policies and protocols for nursing staff regarding telephone triage and telephone advice	▪ Ensure nurses have appropriate training, skills and experience to provide telephone advice
▪ Establish a policy to protect patient confidentiality	▪ Provide adequate staffing
▪ Develop an appropriate documentation system, including safe management of all records	▪ Follow professional guidelines and standards
▪ Ongoing review and evaluation of protocols for relevancy and accuracy	▪ Conduct routine chart audits
▪ Report and follow-up unusual occurrences	

Communication Device

- Every attempt should be made to talk with clients using a land line.
- There are special circumstances when a land line is not possible, e.g. clients in outpost camps using hand radios and satellite phones.
  - ➢ Clients must be informed that the information discussed may not be confidential as others may be able to hear the conversation.
  - ➢ Obtain only as much information that is required to make a sound clinical judgment
  - ➢ Protect the client's identity and personal information as reasonably possible.

REFERENCES:

Canadian Nurses Association (2007). *Telehealth: The role of the nurse.* Ottawa, ON.

Canadian Nurses Protective Society (2008). *Info Law a Legal Information Sheet for Nurses: Telephone advice.* Ottawa, ON.

College of Nurses of Ontario (2009). *Telephone Practice Guideline*. Toronto, ON

Wilson, B. (2003). Telephone Advice. *Nursing BC, June, 27-28.*

Appendix B: Pediatric Telephone Triage Form

See separate document – note this form must be printed double sided

Appendix C: Adult Telephone Triage Form

See Separate document – note this form must be printed double sided

Department of Health Government of Nunavut Policy 07-030-00	**TITLE** **PEDIATRIC TELEPHONE TRIAGE FORM** **12 months to 12 years of age**

Infants 12 mths or younger TO BE SEEN AT THE HEALTH CENTRE - Use Infant *Telephone Triage Form*

Name of Caller:	**Date**:	**Time**:	**Phone**:
Name of Patient:	**Gender:** M / F	**Age / DOB**:	
Relationship of caller to patient:		**Location of caller:**	
Chief Complaint:			
Known Health Condition(s):			

FEVER:	No Concern ☐		**TRAUMA :**	No Concern ☐	
Temperature (if known): Feels hot ☐			Precipitating event?		
When did fever start?			Time occurred?		
Tylenol ☐ or Advil ☐ given?	**Y**	**N**	Bleeding?	**Y**	**N**
When? How much?			Bruising?	**Y**	**N**
Did it take the fever away?	**Y**	**N**	Swelling?	**Y**	**N**
Seizure activity?	**Y**	**N**	Movement?	**Y**	**N**
Hx of seizures?	**Y**	**N**	Weight Bearing?	**Y**	**N**
Immunization in last 24 hours?	**Y**	**N**	Pain? Intensity of Pain (1-10 Scale):	**Y**	**N**
On antibiotics or just finished? Reason:	**Y**	**N**	Location: Localized ☐ or Referred ☐		
RESPIRATORY :	No Concern ☐		**SKIN/MSK:**	No Concern ☐	
How is their breathing? Normal ☐ Fast ☐ Difficult ☐			Burn ☐ or Laceration ☐ Location:		
Cough?	**Y**	**N**	Rash? Location:	**Y**	**N**
Is it worsening?	**Y**	**N**	Known food related?	**Y**	**N**
Noisy Breathing?	**Y**	**N**	Known Medication related?	**Y**	**N**
Is it worsening?	**Y**	**N**	Itchy?	**Y**	**N**
Any blue colour around lips, hands or feet now?	**Y**	**N**	Colour Change?	**Y**	**N**
Any blue colour around lips, hands or feet before? How many times?	**Y**	**N**	Area warm to touch?	**Y**	**N**
Using belly muscles while trying to breath?	**Y**	**N**	Sensation changes?	**Y**	**N**
Head moving up & down when trying to breath?	**Y**	**N**	Changes to movement?	**Y**	**N**
Nostrils moving in & out when trying to breath?	**Y**	**N**	**GU:**	No Concern ☐	
Activity level:			Burning / Pain with voiding?	**Y**	**N**
Are they able to eat and drink as usual?	**Y**	**N**	Urgency?	**Y**	**N**
# wet diapers today? or # times voided today?			Odour?	**Y**	**N**
Foreign body?	**Y**	**N**	Fever?	**Y**	**N**
Ingested toxin?	**Y**	**N**	# wet diapers? # times voided?		
GI:	No Concern ☐		**NEURO :**	No Concern ☐	
Vomiting? # times in 24 hrs:	**Y**	**N**	Level of Consciousness: Alert ☐ Altered ☐		
Diarrhea? # times in 24 hrs:	**Y**	**N**	Stiff neck?	**Y**	**N**
Pain? Where:	**Y**	**N**	Headache?	**Y**	**N**
Eating / drinking? Usual for child ☐ Less ☐ More ☐			Vomiting? # of times today?	**Y**	**N**
# wet diapers today? or # times voided today?			Child seems floppy?	**Y**	**N**
Foreign body?	**Y**	**N**	Seizures?	**Y**	**N**
Ingested toxin?	**Y**	**N**	History of Seizures?	**Y**	**N**

***** ASSESSMENT CONTINUES ON BACK PAGE *****

Name of Patient:	**Age / DOB**:

Mental Health:					No Concern ☐
Current thoughts of self-harm/ suicide?	**Y**	**N**	Current thoughts of harming another person?	**Y**	**N**
Past thoughts of self-harm / suicide?	**Y**	**N**	Past thoughts of harming another person?	**Y**	**N**
Prior Suicide attempts?	**Y**	**N**	Recent trauma exposure?	**Y**	**N**
Substance use / abuse? Current ☐ Past ☐	**Y**	**N**	Victim of violence / abuse?	**Y**	**N**
School concerns?	**Y**	**N**	Any recent losses?	**Y**	**N**
Ever accessed mental health services?	**Y**	**N**	☐ Family services or ☐ law enforcement involvement?	**Y**	**N**

ASSESSMENT : (0-1hour) _____ Urgent (1-4 hours) _____ Non-urgent _____

Complete the next two sections if the patient is not being seen immediately at the health centre and advice is being provided

PRELIMINARY DIFFERENTIAL DIAGNOSES:

Intervention(s) and Advice Given:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Follow up Plan:

Caller advised to: Come to Clinic: Now ☐ next 4 HRS ☐ Time: _____ in AM ☐ Date / time:_____

(**Refer to *Pediatric and Adult Triage Policy* for list of all clients that must be assessed in clinic within 1-4 hours of the call)**

Additional details:

_____
_____
_____
_____
_____

Other Comments:_____
_____

CALLER'S RESPONSE TO PLAN:

☐ caller agreeable ☐ caller refused (provide additional details if refused)

Signature of CHN _____ Print Name _____ Date_____ Time _____

COMPLETED FORM MUST be PLACED in Patient's Health Record

Department of Health Government of Nunavut Policy 07-030-00	**TITLE** **ADULT TELEPHONE TRIAGE FORM** **Age 12 years and older**

Name of Caller:	**Date**:	**Time**:	**Phone**:
Name of Patient:	**Gender:** M / F	**Age / DOB**:	
Relationship of caller to patient:		**Location of caller:**	
Chief Complaint:			

History of Presenting Illness:

Onset and Duration of the Event: (When did it start? How long has this condition lasted? What was pt doing when it started?)

Severity / Character: (How bothersome is this problem? Does it interfere with daily activities or keep pt up at night? Pt description of symptoms– use pain scale when appropriate)

Is it similar to a past problem? ☐ Y ☐ N If so, what was done at that time?

Location/Radiation: (Is the symptom (e.g. pain) located in a specific place or radiate? Has this changed over time?)

Treatment to Date: (Has pt tried any therapeutic maneuvers? Did it make it better or worse?)

Pace of illness: (Is the problem getting better, worse, or staying the same? How quickly or slowly has it been changing?)

Are there any associated symptoms? (Has the pt noticed other symptoms around the same time as the dominant complaint?)

What does the pt think the problem is and/or what he/she is worried it might be?

Why today? (When the cc that has been long standing -Is there something new/different today compared to previous days when present?)

Mental Health: No Concern ☐

Current thoughts of self-harm/ suicide?	**Y**	**N**	Current thoughts of harming another person?	**Y**	**N**
Past thoughts of self-harm / suicide?	**Y**	**N**	Past thoughts of harming another person?	**Y**	**N**
Prior Suicide attempts?	**Y**	**N**	Recent trauma exposure?	**Y**	**N**
Substance use / abuse? Current ☐ Past ☐	**Y**	**N**	Victim of violence / abuse?	**Y**	**N**
☐ School concerns? Or ☐ Job Loss?	**Y**	**N**	Any recent losses?	**Y**	**N**
Homelessness	**Y**	**N**	☐ Family services or ☐ law enforcement involvement?	**Y**	**N**
Ever access mental health services?	**Y**	**N**	Other:		

Current Medications:

Allergy status: ☐ NKDA ☐ Known (specify):

***** ASSESSMENT CONTINUES ON BACK PAGE *****

Name of Patient:	**Age / DOB**:

Relevant Past Medical / Surgical History:

LMP: ☐ N/A ☐ Date: ☐ Post menopausal ☐ Not known ☐ Pregnancy previously confirmed

The following clients are to be seen in the health centre immediately or within 4 hours of the call
(based on the urgency of the presenting symptoms from the telephone triage)

☐ Condition is determined to: ☐ Require resuscitation ☐ Be emergent ☐ Be urgent	☐ ≥ Age 65
☐ Complex medical condition(s)	☐ In RCMP Custody
☐ Pregnant	☐ ≤ Two (2) weeks postpartum
☐ Discharged in the last 48 hour from a hospital or care facility	☐ Had a surgical procedure under general anaesthetic within the previous ten (10) days
☐ Had an endoscopic procedure (gastroscopy or colonoscopy) within the previous three (3) days	☐ Multiple visits or multiple calls to the Health Centre in previous seventy-two (72) hours with the same presenting complaint(s)

Complete the next two sections if the patient is not being seen immediately at the health centre and advice is being provided

PRELIMINARY DIFFERENTIAL DIAGNOSES:

Intervention(s) and Advice Given:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Follow up Plan:

Caller advised to: Come to Clinic: Now ☐ next 4 HRS ☐ Time: _____ in AM ☐ Date / time:_____

Additional details:

_____
_____
_____
_____

Other Comments:_____
_____

CALLER'S RESPONSE TO PLAN:

☐ caller agreeable ☐ caller refused (provide additional details if refused)

Signature of CHN _____ Print Name _____ Date_____ Time _____

COMPLETED FORM MUST be PLACED in Patient's Health Record

Department of Health Government of Nunavut	**Medical Directives and Delegation** **Community Health Nursing**

TITLE:		**SECTION:**	**POLICY NUMBER:**
CHN Expanded Role: Diagnosing, initiating lab and x-ray tests, and initiating drug treatment		Nursing Practice	07-031-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
July 21, 2021	July, 2024	07-031-00	6
APPLIES TO:			
Community Health Nurses			

1. BACKGROUND:

The Legislative Assembly of Nunavut provides the legislative acts that regulate the nursing profession in Nunavut. The Registered Nurses Association of the Northwest Territories and Nunavut (RNANTNU) set the standards and scope of practice for Registered Nurses (RN).

Community Health Nurses (CHN) are RNs who work in an expanded role through the execution of advanced nursing skills and medical directives to assess, diagnose, plan, initiate and evaluate care. This policy provides an authorising mechanism by which CHNs may perform specified duties through Government of Nunavut (GN) polices, clinical guidelines, protocols, and directives (PCGPD) or First Nation Inuit Health Branch (FNIHB) Clinical Practice Guidelines (CPG), Clinical Care Pathways (CCP), & Emergency Clinical Care Pathways (E-CCP) that are within scope of another regulated health care professional, such as physicians and nurse practitioners (NP), without a direct order from that healthcare professional.

2. MEDICAL DIRECTIVE:

2.1 CHNs may (1) formulate and communicate medical diagnoses; (2) initiate lab and x-ray tests; (3) initiate routine comprehensive ultrasound tests for prenatal patients; and (4) perform delegated clinical procedures without a physician or NP order, as directed only by the resources found in *Appendix A*.

3. LEGISLATIVE AND REGULATORY SUPPORTING DOCUMENTS:

3.1 Consolidation of Nursing Act S.N.W.T. 1998, c.38, s.4 (Current to 2011-03-22)
3.2 RNANTNU Standards of Practice (2019)
3.3 RNANTNU Scope of Practice (2019)
3.4 CNA Code of Ethics (2017)
3.5 Consolidation of Medical Profession Act R.S.N.W.T. 1988, c. M-9 (Current to 2006-02-06)

4. AUTHORISED IMPLEMENTERS:

4.1 CHN and Supervisor of Community Health Programs (SCHP) who possess the knowledge, skill, and judgment to do so. The CHN is required to demonstrate competency to implement this medical directive through the standard orientation process.
4.2 Subdelegating or redelegating of a delegated task is explicitly forbidden. CHNs may not subdelegate or redelegate a task that has been delegated to them through this medical directive.

4.2.1 When two or more CHNs are working together toward a common cause, such as an urgent or emergent situation, any of the CHNs involved in the event may complete the ordered task provided the task falls within their scope of work. This is seen as a team working together as opposed to subdelegating or redelegating an order.

4.2.2 If the assistance of another non-regulated or regulated healthcare professional, such as a LPN, and/or Paramedic is required, a physician or NP's order must be in place prior to the completion of the task.

5. PRINCIPLES:

5.1 CHNs must practice within their own level of competence and seek guidance from their supervisor, a physician, or an NP as required. Refer to Appendix B.

5.2 Guidelines do not replace clinical judgment; decisions must be individualised.

5.3 A physician or NP must be consulted before enacting this medical directive when any of the following conditions exist:

5.3.1 The CHN cannot confirm that all conditions of this directive have been met.

5.3.2 The patient's history or physical exam does not match the criteria set forth in a corresponding GN PCGPD or FNIHB CPG, CCP, e-CCP.

5.3.3 The GN PCGPD or FNIHB CPG, CCP, E-CCP recommends physician or NP consultation first.

6. PROCEDURE:

6.1 The process for creating a treatment plan is as follows: The CHN will refer to approved GN PCGPD first; if none are available the CHN will then refer to the FNIHB CPG, CCP or E-CCP; if none are available, the CHN will then consult a physician or NP. See *Appendix B* for Process for Creating Treatment Plan by Community Health Nurse.

6.2 If a medication is indicated, the CHN will then refer to the Nunavut Formulary and may initiate drug therapy without a direct physician or NP order according to the Health Centre Treatment Code found in the formulary. If the CHN is not authorized to initiate medication as indicated in GN PCGPD, or FNIHB CPG, CCP or e-CCP, then they must consult with a physician or NP. See *Appendix B* for Process for Ordering Diagnostics and/or Medications as a Community Health Nurse.

6.3 The CHN may use the approved *Pharmacy Health Centre Reference List* to inform decisions for most up to date treatment plan and medications. This resource list is only to be used to ensure that the treatment being provided is best practice and is supportive to the GN PCGPD or the FNIHB CPG, CCP or E-CCP. If the best practice treatment recommendation does not align with GN PCGPD or the FNIHB CPG, CCP, or E-CCP then you must consult with physician or NP.

6.4 If there is no GN approved PCGPD directing a CHN to initiate a medication, treatment, clinical procedure, lab, x-ray, or ultrasound test, the CHN must consult a physician or NP. See *Appendix B* for Process for Ordering Diagnostics and/or Medications as a Community Health Nurse.

7. DOCUMENTATION:

7.1 When a CHN enacts this medical directive, they must document:

7.1.1 Encouraged to indicate the name and number (when applicable) of the GN PCGPD or FNIHB CPG, CCP, e-CCP, policy, protocol or directive utilised to provide care;

7.1.2 Name and signature, including designation; and

7.1.3 Pertinent information related to the treatment or procedure performed, such as the patient's response, to be documented in accordance with GN and RNANTNU documentation standards.

8. APPENDICES:

APPENDIX A: Resources for CHN Expanded Role

APPENDIX B: Process for Creating Treatment Plan by Community Health Nurse AND Process for Ordering Diagnostics and/or Medications as a Community Health Nurse

9. RELATED POLICIES, PROTOCOLS AND LEGISLATION:

Community Health Nursing Manual
FNIHB Clinical Practice Guidelines for Nurses in Primary Care – Adult
FNIHB Clinical Practice Guidelines for Nurses in Primary Care – Pediatric and Adolescent
FNIHB Clinical Care Pathways and Emergency Clinical Care Pathways
Government of Nunavut TB Manual 2018
Government of Nunavut Communicable Disease Manual 2016
Government of Nunavut Immunization Manual 2017
Government of Nunavut Formulary 2017

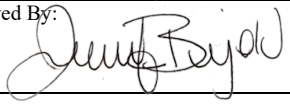
10. REFERENCES:

Registered Nurses Association of the Northwest Territories and Nunavut. (2015, January). *Documentation guidelines.* https://rnantnu.ca/wp-content/uploads/2019/10/Documentation-Guidelines-RNANTNU-Effective-January-19-20151.pdf

Registered Nurses Association of the Northwest Territories and Nunavut. (2019, January). *Scope of practice for registered nurses and nurse practitioners*. https://rnantnu.ca/wp-content/uploads/2019/10/SCOPE-OF-PRACTICE-2019-NEW.pdf

Registered Nurses Association of the Northwest Territories and Nunavut. (2019, January). *Standards of practice for registered nurses and nurse practitioners.* https://rnantnu.ca/wp-content/uploads/2019/10/2019-standards-of-practice.pdf

APPROVALS:

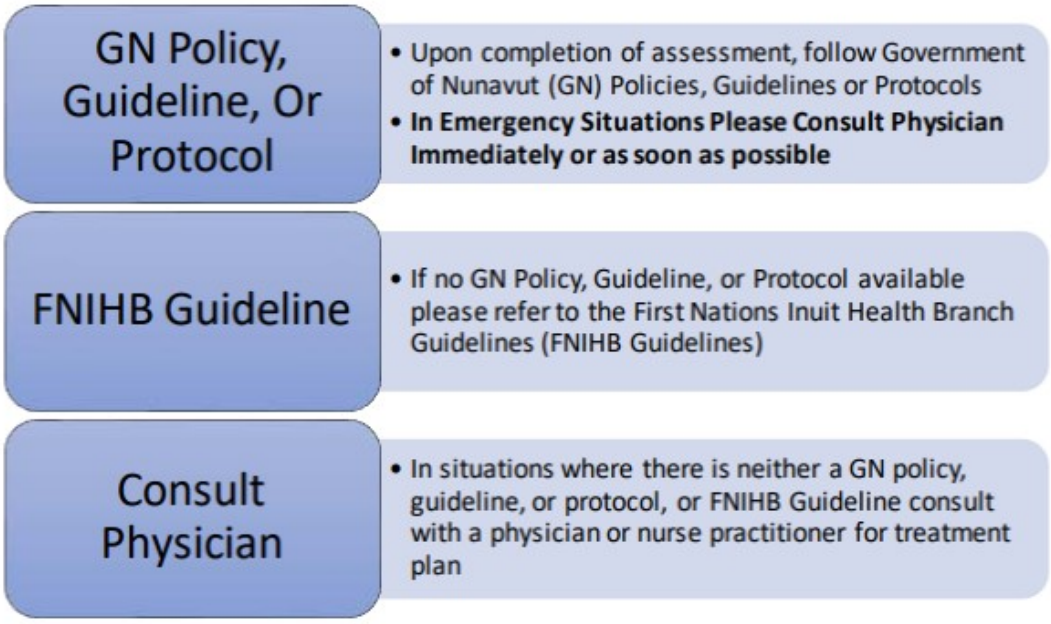
Approved By: 	Date: July 21, 2021
Jennifer Berry, Assistant Deputy Minister Operations – Department of Health	
Approved By: 	Date: July 21, 2021
Jenifer Bujold, Chief Nursing Officer	
Approved By:	Date:
Dr. Francois de Wet, Medical Chief of Staff, on behalf of the Medical Advisory Committee	

APPENDIX A: RESOURCES FOR CHN EXPANDED ROLE

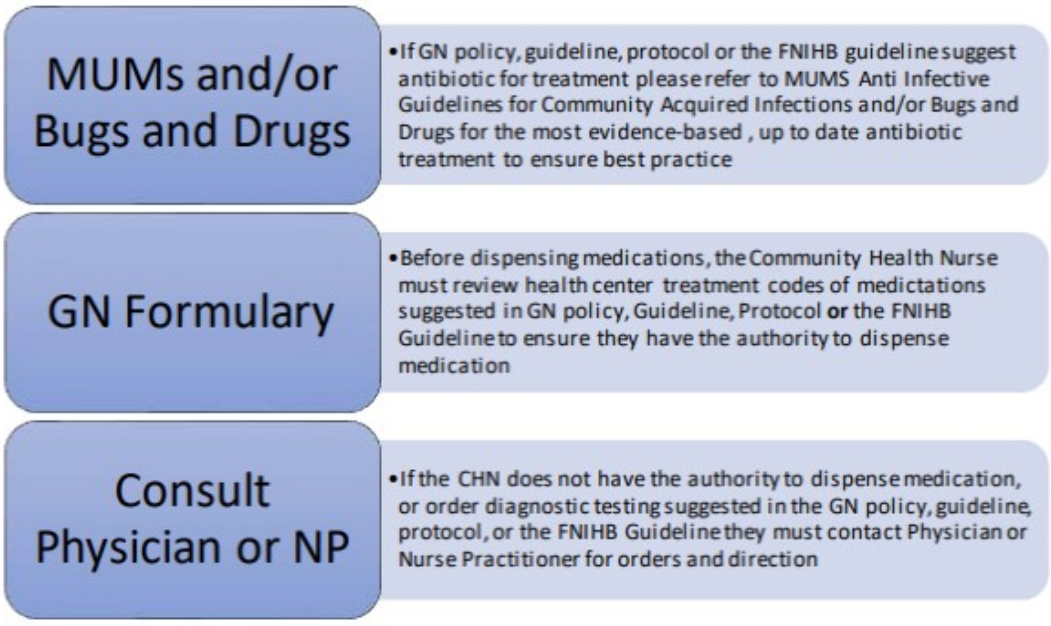
GOVERNMENT OF NUNAVUT (GN) POLICY, CLINICAL GUIDELINE, PROTOCOL OR DIRECTIVE (PCGPD)	FOUND
Community Health Centre Manual	HTTPS://WWW.GOV.NU.CA/HEALTH/INFORMATION/MANUALS-GUIDELINES
Prenatal Record and Guidelines for Completing Prenatal Records	
Well Child Record and Guideline for Completing Well Child	
Communicable Disease Manual	
Influenza Immunization Protocol 2020-2021	
Nunavut Synagis Protocol Manual 2019	
GN Public Health Directive or Protocol issued by the Office of the Chief Public Health Officer and /or Chief Medical Officer	
Other GN approved policies, procedures, screening and management protocols, and medical directives including Cervical Screening Guideline, Protocol for Identifying and Treating Iron Deficiency Anemia in Infants and Young Children, and the Revised Vitamin D Supplementation Protocol November 2014	
Febrile Child Protocol	**MICROSOFT TEAMS-NUNAVUT NURSES EDUCATION OR DOCUMENT MANAGEMENT SYSTEM**
FIRST NATIONS INUI HEALTH BRANCH GUIDELINES (FNIHB)	**FOUND**
FNIHB Clinical Practice Guidelines (CPG) for Nurses in Primary Care – Adult Care	HTTPS://WWW.CANADA.CA/EN/INDIGENOUS-SERVICES-CANADA/SERVICES/FIRST-NATIONS-INUIT-HEALTH/HEALTH-CARE-SERVICES/NURSING/CLINICAL-PRACTICE-GUIDELINES-NURSES-PRIMARY-CARE/ADULT-CARE.HTML
FNIHB Clinical Practice Guidelines (CPG) for Nurses in Primary Care – Pediatric and Adolescent Care	HTTPS://WWW.CANADA.CA/EN/INDIGENOUS-SERVICES-CANADA/SERVICES/FIRST-NATIONS-INUIT-HEALTH/HEALTH-CARE-SERVICES/NURSING/CLINICAL-PRACTICE-GUIDELINES-NURSES-PRIMARY-CARE.HTML
FNIHB integrated adult and pediatric Clinical Care Pathways (CCP) and Emergency Clinical Care Pathways (e-CCPs)	**MICROSOFT TEAMS-NUNAVUT NURSES EDUCATION OR DOCUMENT MANAGEMENT SYSTEM**

APPENDIX B:
PROCESS FOR CREATING TREATMENT PLAN BY COMMUNITY HEALTH NURSE AND PROCESS FOR ORDERING DIAGNOSTICS AND/OR MEDICATIONS AS A COMMUNITY HEALTH NURSE

Process for Creating Treatment Plan by Community Health Nurse



Process for Ordering Diagnostics and/or Medications as a Community Health Nurse



Department of Health Government of Nunavut		Medical Directives and Delegation Public Health Nursing	
TITLE:		**SECTION:**	**POLICY NUMBER:**
Testing, diagnosing, and treating syphilis infections for public health nurses and community health nurses		Nursing Practice	07-032-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
October 1, 2018	October 2020		9
APPLIES TO:			
Public Health Nurses and Community Health Nurses who have completed training as specified in the directive			

1. **BACKGROUND:**

The rates of sexually transmitted infections (including chlamydia, gonorrhea, and syphilis) in Nunavut are higher than the rest of Canada. In particular, the territory has been experiencing a syphilis outbreak since 2012. Prior to that time there were 0-5 cases per year; from 2012 to 2017 there have been approximately 30-120 cases per year.

Public Health Nurses (PHN) and Community Health Nurses (CHN) in the territory can help to decrease the risk of transmission and possible complications of syphilis by supporting prompt diagnosis and treatment of syphilis.

PHNs and CHNs are expected to practice within their own level of competence and consult with their supervisor, a nurse practitioner (NP), or a physician as required. Interviewing cases and contacts and completing a physical assessment are within the RN scope of practice. Drawing blood is also within the RN scope of practice provided the nurse has acquired the appropriate competencies. Diagnosis and treatment are not within the RN regulated scope of practice and therefore, RNs require additional training and a medical directive to perform these functions.

2. **MEDICAL DIRECTIVE AND/OR DELEGATED PROCEDURE:**

This medical directive includes testing (2.1), diagnosing (2.2.), and treating (2.3). Please note that this directive is intended to be used by only a few nurses, with appropriate training and assessment as per this directive, in communities where there is ongoing transmission of syphilis.

Please see Section 6.4.1 Syphilis in the Nunavut Communicable Disease Manual for detailed clinical information.

2.1 **TESTING**: Public Health Nurses (PHN) and Community Health Nurses (CHNs) may order a blood test for syphilis for patients presenting to the clinic without a direct Physician or Nurse Practitioner (NP) order when any of the following conditions in Table 1 are met. In addition to the blood test, they may also collect a swab if clinically indicated; note, there is not darkfield microscopy in the territory but PCR testing may be possible through the National Microbiology Laboratory (NML).

2.1.1 The PHN or CHN may order bloodwork for syphilis, HIV and Hepatitis B without a physician or NP order when testing for *Chlamydia trachomatis* or *Neisseria gonorrhea*, as per recommendations from the *Canadian Guidelines on Sexually Transmitted Infections*.

Table 1: Inclusion Criteria for ordering blood test for syphilis

Syphilis
Female or Male
Lesion (chancre) or rash consistent with syphilis
Generalized symptoms or findings consistent with secondary or tertiary syphilis
Sexual contact with a person with known infection or compatible syndrome
Anyone diagnosed with gonorrhea or chlamydia
Patient self identifies at least 1 risk factor for STIs as outlined in the Government of Nunavut Communicable Disease Manual (GN CD Manual)
Patient request
As part of prenatal screening
Follow-up of individual previously diagnosed with syphilis

Nunavut Communicable Disease Manual, 2013

PRACTICE NOTE: If the patient reports any of the following, consult the MD or NP:

Female: Lower abdominal pain
Abnormal vaginal bleeding
Neurologic findings
Findings consistent with non-primary syphilis
Suspected sexual assault

Male: Testicular or epididymal pain
Neurologic findings
Findings consistent with non-primary syphilis (see Table 2 for more details)
Suspected sexual assault

2.2 **DIAGNOSIS**: PHN or CHN with appropriate training may communicate a diagnosis of syphilis infection or a negative result to the patient when a blood or microscopy test is done for *Treponema pallidum* (syphilis). This can only be done when the PHN or CHN has completed appropriate training as per this directive as the interpretation of syphilis serology and test results is complicated and depends on past exposure and treatment.

Table 2: Clinical manifestations of syphilis based on stage of infection

Syphilis		
Stage	**Incubation period**	**Clinical manifestations**
Primary	3 weeks (3 to 90 days)	Chancre, regional lymphadenopathy
Secondary	2 to 12 weeks (2 weeks to 6 months)	Rash, fever, malaise, lymphadenopathy, mucus lesions, condyloma lata, patchy or diffuse alopecia, meningitis, headaches, uveitis, retinitis
Latent	Early: < 1 year Late: ≥ 1 year	Asymptomatic
Tertiary:		
Cardiovascular syphilis	10 to 30 years	Aortic aneurysm, aortic regurgitation, coronary artery ostial stenosis
Neurosyphilis	<2 years to 20 years	Ranges from asymptomatic to symptomatic with headaches, vertigo, personality changes, dementia, ataxia, presence of Argyll Robertson pupil
Gumma	1 - 46 years (most cases 15 years)	Tissue destruction of any organ; manifestations depend on site involved
Congenital:		

Early	Onset <2 years	2/3 may be asymptomatic; fulminant disseminated infection, mucocutaneous lesions, osteochondritis, anemia, hepatosplenomegaly, neurosyphilis
Late	Persistence >2 years after birth	Interstitial keratitis, lymphadenopathy, hepatosplenomegaly, bone involvement, anemia, Hutchinson's teeth, neurosyphilis

2.3 **TREATMENT**: PHN and CHN may initiate and dispense drug treatment for syphilis without a direct physician or NP order when any of the following conditions in Table 3 apply. The physician or NP must be consulted prior to treatment for all children 16 years of age and younger, all pregnant individuals, and if penicillin-allergic.

Table 3: Inclusion Criteria for Initiating Drug Therapy

Treponema pallidum (syphilis)
A test is positive for syphilis infection as outlined in the diagnostic section of 6.4.1 Syphilis protocol in the Communicable Disease Manual.
Patient reports syndrome compatible with a syphilis infection (without waiting for test results) as outlined in Table 2 of this directive.
Diagnosis of syphilis infection in a sexual partner
Practice Note: Diagnosis of a syndrome according to standard criteria predicts the likelihood that a specific pathogen is present, leading to empiric treatment at the first visit rather than deferring treatment until there is microbiological confirmation (*Canadian Guidelines on Sexually Transmitted Infections,* 2006). The syndromic approach helps in controlling transmission and negative sequelae, particularly in a territory that has variable access to lab testing and variable rates of follow up.

3. Recipient Patients:

3.1 All male and female patients older than 16 years of age may receive counseling, testing, and treatment. The physician or NP must be consulted prior to treatment for all children 16 years of age and younger, all pregnant individuals, and if penicillin-allergic.

4. Authorized Implementers:

4.1 In order to enact this medical directive, the PHN or CHN is required to complete additional training in sexually transmitted infections including syphilis which has been approved by the Chief Medical Officer of Health (CMOH). Current authorized training includes: (1) training at a clinic (e.g. Edmonton, Ottawa, or as determined by CMOH) and (2) review the relevant chapters in the Nunavut Communicable Disease Manual and *the Canadian Guidelines on Sexually Transmitted Infections*. Completion of training will be tracked by the territorial Communicable Disease Consultant. The training will need to be re-certified every 5 years. The office of the CMOH will keep a written list of all those who are authorized implementers and each addition to the list will need to be signed off by the CMOH or DCMOH. In addition, periodic case audits and reviews may be conducted. Individuals using this directive are expected to review any questions with the Regional Communicable Disease Coordinators, and, where necessary, the territorial syphilis consultant.

4.2 See Appendix A for a decision-making flow chart to assist staff in deciding if they have the knowledge, skills, and ability to enact the directive.

4.3 Sub delegation is not permitted to another regulated or non-regulated health care professional who (1) are not listed in the directive/ delegation policy and (2) are not authorized to perform that procedure through other authorizing mechanisms like departmental policies, professional regulation acts and associations.

5. INDICATIONS AND CONTRAINDICATIONS:

The physician or NP must be consulted when any of these conditions exist:

5.1 **GENERAL:**

- 5.1.1 The patient's history or exam findings do not match the criteria stated in this directive
- 5.1.2 The patient reports neurological symptoms or symptoms consistent with secondary or tertiary syphilis as outlined in table 2.

5.2 **TREATMENT** - Specific:

- 5.2.1 The patient is younger than 16 years of age.
- 5.2.2 Patient has a contraindication (to the preferred treatment) as stated in the product monograph or CPS.
- 5.2.3 The nurse is unsure or uncomfortable about providing treatment.
- 5.2.4 The patient is pregnant.
- 5.2.5 The patient is penicillin-allergic.

6. PROCEDURE:

6.1 Prior to implementation of this directive, a patient assessment must be conducted. At minimum, assess: for fever, risk assessment (as outlined in the *Canadian Guidelines on Sexually Transmitted Infections*), history of presenting illness, medical /menstrual / breast feeding and social history, allergy status, current medications, previous STI test results, contact history, and immunization status. For any patient reporting sexual abuse, consult with MD/NP without delay and consider referral to mental health and victim services.

6.2 **TESTING**:

- 6.2.1 When the patient meets the conditions stated in medical directive statement 2.1, the PHN or CHN may order a blood test for syphilis
- 6.2.2 In addition to ordering bloodwork for syphilis, the nurse should consider ordering urine for chlamydia and gonorrhea and bloodwork Hepatitis B and HIV screening, as per *Canadian Guidelines on Sexually Transmitted Infections*.
- 6.2.3 Obtain verbal consent prior to collecting a specimen and initiating drug treatment – ensure the patient understands the mandatory reporting and contact tracing requirements associated with positive results.
- 6.2.4 The specimen is to be collected, labelled, handled, and transported as per relevant GN laboratory and Meditech policy and procedures.
    - Requisitioning through Medi-tech: Enter the PHN or CHN's Personal Identification Number in the signature line and enter the Medical Directive Number, and the PHN or CHN's full name with designation in the Comments field of the requisition module.

- Requisitioning on hard copies of the lab form: Enter the Medical Directive Number and the PHN/CHN's signature on the form.

6.2.5 The PHN/CHN is responsible and accountable for reviewing and following up on lab results once available. Every attempt shall be made to promptly notify the patient of the results once available and if the patient is lost to follow-up and had a positive test result, attempt follow-up by phone at least three times and by mail at least once.

- When HIV and Hepatitis B screening serology was ordered as part of this medical directive, all positive results must be referred to an physician or NP.
- If the PHN or CHN is unsure of the interpretation of any lab result, the regional Communicable Disease Consultant should be consulted.

6.2.6 The PHN/CHN is not authorized, through this medical directive, to assess, diagnose and treat HIV or Hepatitis B and thus physician or NP referral is required upon receipt of positive laboratory results. Consultation with the physician or NP should follow usual consultation practices already established locally.

6.2.7 When a positive syphilis test result is reported, the PHN/CHN will complete and submit the GN *Syphilis Report Form*, conduct case management and contact tracing in compliance with the CMOH-directed protocol in the CD manual and submit the *STI Contact Investigation Form* to the regional Communicable Disease Consultant within one week of diagnosis.

6.2.8 For children 16 years and younger, the physician or NP must be consulted, as there may be additional assessments, swabs and referrals required. NOTE: Mandatory reporting protocols are to be enacted when child abuse is suspected. Refer to *Appendix B: Age of Consent to Sexual Activity*.

6.3 **TREATMENT:**

PRACTICE POINT: For children whereby sexual abuse is suspected, a physician or NP must be consulted prior to initiating drug treatment.

6.3.1 When the patient meets the conditions stated in medical directive statement 2.3, the PHN or CHN may Initiate treatment as outlined in the Syphilis Protocol in section 6.4.1 of the Nunavut Communicable Disease Manual and provide patient information about the potential adverse effects of the prescribed treatment.

6.3.2 Any adverse events will be documented and reported to the physician or NP.

6.4 **COUNSELING:**

6.4.1 The PHN or CHN will provide health counselling information as outlined in the Nunavut Communicable Disease Manual.

6.4.2 Provide information about the conditions in which the patient should seek follow up medical care; and when to return for follow-up syphilis serology.

6.4.3 Offer the Hepatitis B vaccine, if eligible under the GN immunization schedule.

7. DOCUMENTATION:

7.1 The nurse is to document in accordance with RNANT/NU and GN documentation standards. At minimum, the following is to be documented:

7.1.1 The patient assessment findings and care plan;

7.1.2 The specific laboratory test(s), date and time ordered;

7.1.3 Medication treatment initiated and administered (include name of medication, dose, route, time of administration, and amount dispensed)

7.1.4 Patient counselling topics;

7.1.5 All other interventions conducted (including referrals and procedures); and

7.1.6 The Medical Directive Number.

7.2 For lab and other diagnostic test requisitions, the implementer must document the name and number of the directive on the requisition form, as well as the implementer's name as ordering provider.

8. Quality Monitoring:

8.1 Any staff that identifies unintended outcomes arising from implementation of this directive or needs clarification of this directive, are responsible to discuss with their supervisor.

8.2 The Department of Health will maintain a list of authorized implementers and may perform random audits.

9. Related Policies, Protocols and Legislation:

Nunavut Communicable Disease Manual. Chapter 6.4.1 Syphilis.

APPENDICES

Appendix A: Decision-Making Model for Performing Additional Functions and Transferred Functions

Appendix B: For more information on clinical guidance, please see Chapter 6.4.1 Syphilis in the Nunavut Communicable Disease Manual.

DOCUMENTS

- Government of Nunavut (2013). Nunavut Communicable Disease Manual. Chapters: 6.4.1 Syphilis; 6.2.1 Chlamydia; and 6.3.1 Gonorrhea. Available at: https://www.gov.nu.ca/health/information/manuals-guidelines.
- Nunavut Drug Formulary
- GN Community Health Nursing Administration Manual. Policy: Documentation Standards
- GN Community Health Nursing Administration Manual. Policy: Transferred Functions
- GN Community Health Nursing Administration Manual. Policy: Medication Administration – Nursing
- GN Community Health Nursing Administration Manual. Policy: Dispensing Medication
- GN Community Health Nursing Administration Manual. Policy: Laboratory Procedures
- Public Health Agency of Canada (2010). *Canadian Guidelines on Sexually Transmitted Infections* from http://www.phac-aspc.gc.ca/std-mts/sti-its/cgsti-ldcits/index-eng.php#toc
- Health Centre Lab Manual – Regional Specific

10. REFERENCES:

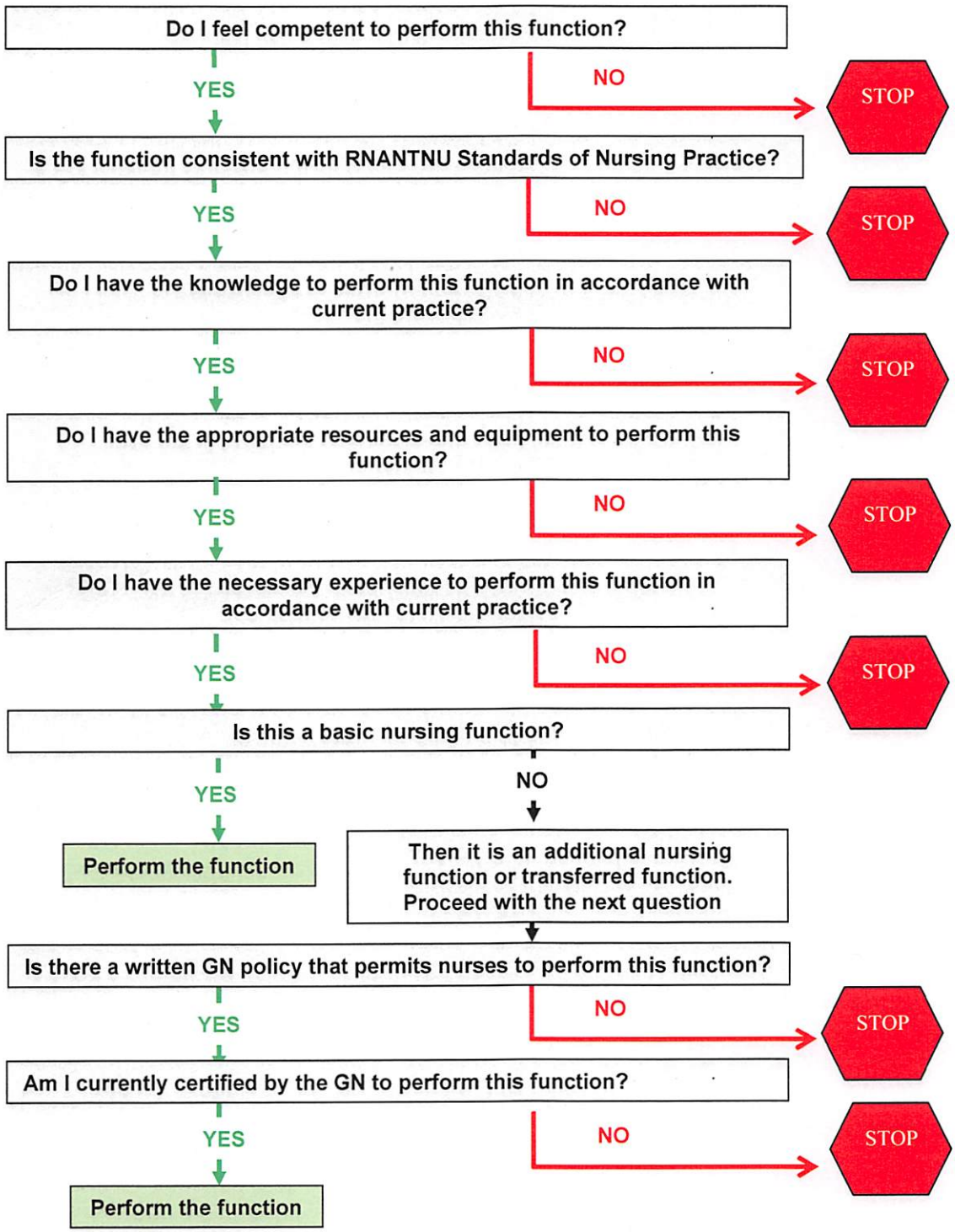
- Government of Nunavut (2013). Nunavut Communicable Disease Manual. Available at: https://www.gov.nu.ca/health/information/manuals-guidelines.
- Government of Nunavut (2010). Community Health Nursing Administration Manual.
- Public Health Agency of Canada (2010). *Canadian Guidelines on Sexually Transmitted Infections*. Available at: http://www.phac-aspc.gc.ca/std-mts/sti-its/cgsti-ldcits/index-eng.php#toc.

11. APPROVALS:

A directive, delegation or procedure may require approval from administrative authorities such as the Medical Advisory Committee.

Approved By:	Date: Nov 30/18
Colleen Stockley, Deputy Minister – Department of Health	
Approved By:	Date: Nov 29, 2018
Jennifer Berry, Chief Nursing Officer	
Approved By:	Date: Dec 3/18
Dr. Michael Patterson, A/Chief Medical Officer of Health	

APPENDIX A: DECISION-MAKING MODEL FOR PERFORMING ADDITIONAL FUNCTIONS AND TRANSFERRED FUNCTIONS



RNANT/NU (2010). *Scope of Practice for Registered Nurses*, p. 9

Appendix B:

For more detailed clinical guidance, please see Chapter 6.4.1 Syphilis protocol in the Nunavut Communicable Disease Manual (last updated in 2018).

It includes a 2-page decision support tool with information on staging, contact tracing, treatment, and follow-up.

Department of Health Government of Nunavut	Medical Directives and Delegation All Health Services	
TITLE:	**SECTION:**	**POLICY NUMBER:**
COVID-19: Nursing Assessment & Advice Protocol	Nursing Practice	07-033-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
March 20, 2020 / March 2023	N/A	
APPLIES TO:		
Registered Nurses and Licensed Practical Nurses		

1. **BACKGROUND:**

COVID-19 is a novel coronavirus that was first detected in Wuhan, China in late 2019. On March 11, 2020, the World Health Organization declared COVID-19 a pandemic. Coronavirus infections are diagnosed through health care professionals in consultation with public health teams and guidance based on symptoms and typically confirmed through laboratory testing. To address the need for urgent public health information, a COVID-19 Telephone Hotline has been developed. The Department of Health *COVID-19 Nursing Assessment & Advice Protocol* is intended to 1) provide standardized health information to the public; and 2) provide an authorizing mechanism for nurses to communicate standardized public health information related to eligibility and direction for COVID-19 screening, self-monitoring, self-isolation, and advice developed through the Chief Public Health Officer.

Guidelines do not replace clinical judgement; management decisions must be individualized. Registered Nurses and Licensed Practical Nurses are expected to practice within their own level of competence and seek guidance as required.

2. **MEDICAL DIRECTIVE AND/OR DELEGATED PROCEDURE:**
   - **2.1 Registered Nurses and Licensed Practical Nurses may determine COVID-19 screening eligibility and coordinate screening for Nunavummiut as outlined in the *COVID-19 Public Health Protocol***
   - **2.2 Registered Nurses and Licensed Practical Nurses may communicate advice related to COVID-19 outlined in the *COVID-19 Pubic Health Protocol***
   - **2.3 Registered Nurses may provide the information and screening listed in 2.1 and 2.2 via telephone interaction.**

3. **DEFINITIONS:**
   - 3.1 *Nurse* refers to registered nurse or licensed practical nurse.
4. **RECIPIENT PATIENTS**
   - 4.1 Nunavummiut of all ages
5. **AUTHORIZED IMPLEMENTERS:**
   - 5.1 Nurses employed by the Department of Health.
   - 5.2 Sub delegation is not permitted to another regulated or non-regulated health care professional who are not listed in this medical directive.
6. **CONTRAINDICATIONS TO THIS MEDICAL DIRECTIVE:**
   - 6.1 Health care workers inquiring about COVID-19 workplace practices must contact the Office of the Chief Public Health Officer (previously referred to as Chief Medical Officer of Health)

directly.

6.2 In the event a client or client caller reports any medical distress, the nurse is required to immediately direct them to seek medical attention in their community and document the advice given.

6.3 For telephone advice, callers not physically located in Nunavut must be advised to contact their local jurisdiction for advice. Registered Nurses' registration provides liability coverage for advice to clients in territory only.

7. **PROTOCOL:**

7.1 Refer to Appendix A for the *COVID-19 Public Health Protocol, including the Persons Under Investigation (PUI) Assessment Form*

8. **DOCUMENTATION:**

8.1 It is the nurse's responsibility to ensure documentation of telephone interaction is recorded in accordance with Department of Health *Documentation Standard*, and completion of the *COVID-19 Persons Under Investigation Assessment Form* including:

i. Date and time of call
ii. Name, telephone number, address of the client
iii. Information received
iv. Advise or information given, guided by the *PUI Assessment Form*
v. Referral and follow-up information
vi. Name and signature of the implementer, including designation
vii. Pertinent information related to call, such as the client's response

9. **RELATED POLICIES, PROTOCOLS AND LEGISLATION:**

Appendix A: COVID-19 Public Health Protocol
CHN Manual Policy: 06-088-00 Documentation Standard

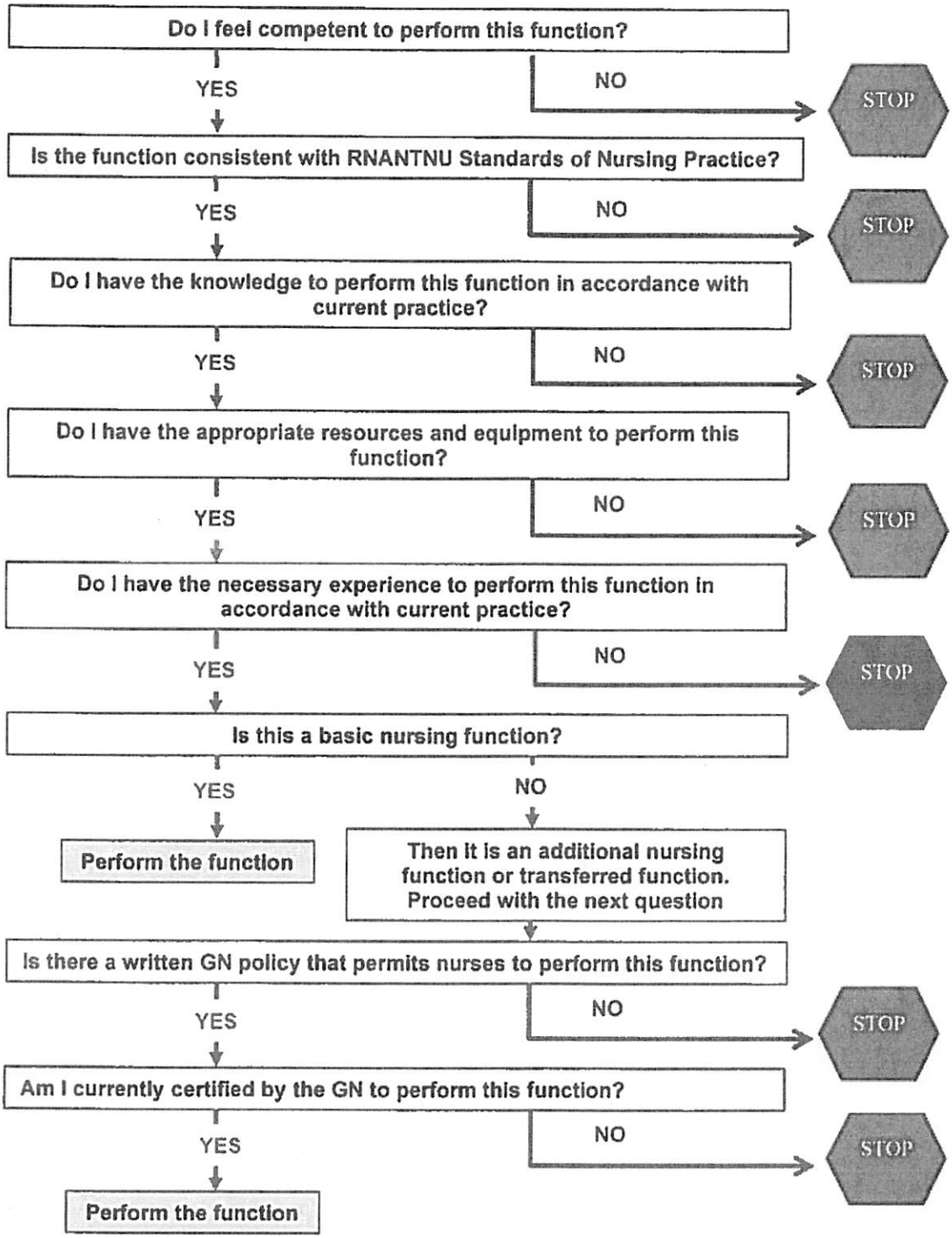
10. **REFERENCES:**

Canadian Nurse's Protective Society. Telephone Advice.
https://www.cnps.ca/index.php?page=111

11. **APPROVAL:**

Approved By: N/A	Date: N/A
Ruby Brown, Deputy Minister – Department of Health	
Approved By: [signature]	Date: March 24/20
Monique Skinner, Chief Nursing Officer	
Approved By: [signature]	Date: March 24/2020
Dr. Michael Patterson, Chief Public Health Officer	

APPENDIX A: DECISION-MAKING MODEL FOR PERFORMING ADDITIONAL FUNCTIONS AND TRANSFERRED FUNCTIONS



RNANT/NU (2010). *Scope of Practice for Registered Nurses*, p. 9

Department of Health Government of Nunavut	Medical Directives and Delegation Community Health Nursing

TITLE:		SECTION:	POLICY NUMBER:
COVID-19 Laboratory Testing Authority		Nursing Practice	07-034-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
June 15, 2021	June 15, 2023	07-034-00	4

APPLIES TO:
Registered Nurses, Licensed Practical Nurses, Respiratory Therapist, Advanced Care Paramedics, Primary Care Paramedics

1. **BACKGROUND:**

As a result of the SARS-CoV-2 (Covid 19) pandemic it is necessary to increase the access of services to Nunavummiut

Covid-19 infections are diagnosed through healthcare professionals in consultation with public health teams, and guidance based on symptoms, typically confirmed through laboratory testing. Through policy 07-031-00, Community Health Nurses (CHNs) are delegated the authority to initiate COVID-19 testing. To improve access to care and lower the risk of transmission, delegation to Healthcare Providers is needed. The *COVID-19 Laboratory Testing Authority* is intended to:

1) provide an authorising mechanism for Healthcare Providers to initiate laboratory testing for COVID-19;

2) provide standardised public health criteria to guide the nurse in their decision to initiate testing; 3) provide a procedural outline; and

4) provide standardised guidance related to follow-up and mandatory reporting.

2. **MEDICAL DIRECTIVE AND/OR DELEGATED PROCEDURE:**

2.1 **CHNs already possess the delegated authority to initiate testing; however, they must follow the additional requirements outlined in this medical directive.**

2.2 **Registered Nurses (RNs) are permitted to initiate testing for COVID-19, according to the *COVID-19 Public Health Protocol* and requirements outlined in this medical directive.**

2.3 **Licensed Practical Nurses (LPNs) are permitted to initiate testing for COVID-19 and must follow the requirements outlined in this medical directive.**

2.4 **Respiratory Therapists (RTs) are permitted to initiate testing for COVID-19 and must follow the requirements outlined in this medical directive.**

2.5 **Advanced Care Paramedics (ACPs) and Primary Care Paramedics (PCPs) are permitted to initiate testing for COVID-19 and must follow the requirement outlined in the medical directive.**

3. **Principles:**

3.1 Healthcare Providers are expected to practice within their own level of competence and seek guidance from their supervisor, physician, or Nurse Practitioner as needed.

3.2 Guidelines do not replace clinical judgement. Management decisions must be individualised.

4. **RECIPIENT PATIENTS:**
   4.1 Nunavummiut of all ages

5. **AUTHORIZED IMPLEMENTERS:**
   5.1 RNs who possess the knowledge, skills, and abilities to initiate the testing.
   5.2 LPNs who possess the knowledge, skills, and abilities to initiate the testing.
   5.3 RTs who possess the knowledge, skills, and abilities to initiate the testing.
   5.4 ACPs and PCPs who posses the knowledge, skills, and abilities to initiate the testing.
   5.5 Sub delegation to initiate a test is **not** permitted to another regulated or non-regulated healthcare professional who (1) are not listed in the directive/ delegation policy and (2) are not authorised to perform that procedure through other authorising mechanisms like departmental policies, professional regulation acts and associations.
   5.6 Healthcare Providers are required to demonstrate competency to implement this medical directive through the standardised orientation process.

6. **INDICATIONS AND CONTRAINDICATIONS:**
   6.1 The medical directive may be enacted when patient's history and symptoms match the testing criteria outlined in the *COVID-19 Public Health Protocol*
   6.2 Healthcare Providers may only initiate testing by means of Nasopharyngeal (NP) swab.
   6.3 RNs, LPNs, RTs, ACPs and PCPs may not give orders to other Healthcare Providers to perform testing, as per scope of practice.

7. **DEFINITIONS:**
   Healthcare Provider: Registered Nurse (RN), Licensed Practical Nurse (LPN), Respiratory Therapist (RT), Advanced Care Paramedics (ACPs) or Primary Care Paramedics (PCPs)

8. **PROCEDURE:**
   8.1 The Healthcare Provider assesses the patient by completing the *Person Under Investigation (PUI) Assessment Form*, outlined in Appendix C of the *COVID-19 Public Health Protocol*
   8.2 The Healthcare Provider determines if COVID-19 testing is indicated through the *COVID-19 Healthcare Provider Flowchart,* outlined in Appendix D of the *COVID-19 Public Health Protocol*
   8.3 If the client meets testing criteria, the Health Care Provider completing the *PUI Assessment Form initiates testing*.
   8.4 **The Healthcare Provider is required to submit the PUI Assessment Form for all patients to the Regional Communicable Disease Coordinator (RCDC) by email when testing is initiated. Forms for those not tested can be sent in batches at the end of the day directly to cdsurveillance@gov.nu.ca. In the case of computer issues, fax the form AND contact RCDC by phone to ensure receipt of information. The RCDC will in turn, forward the form to the Territorial Communicable Disease Specialist (TCDS) and Communicable Disease Surveillance (cdsurveillance@gov.nu.ca) to ensure required outbreak management processes can occur.**
   8.5 The Healthcare Provider will explain the procedure to the client and/or family, including any potential adverse outcomes. Obtain verbal consent.
   8.6 The Healthcare Provider collects the specimen, according to the *COVID-19 Public Health Protocol*, listing the name of the person ordering/initiating the test. When collecting specimens, the approved procedural technique and personal protective equipment requirements must be followed.

8.7 The Healthcare Provider completes all fields on the laboratory requisition (enter in Meditech where available) including, but not limited to:

i. A minimum of 2 patient identifiers.
ii. The name of the clinician initiating/ordering the test, clearly stated as the ordering provider.
iii. Date and time of collection clearly labelled on the specimen and requisition.
iv. Health Centre contact information and initiating/ordering clinician's contact information.

8.8 The RN and the LPN are accountable for providing timely follow-up of test results in accordance with CHN Manual policies *Acknowledgement of Diagnostic Test Results* and *Follow up of Abnormal Diagnostic Test Results*.

8.9 RTs, ACPs, and PCPs are responsible to communicate all test results in a timely manner to their clinical supervisor. The RT, ACP and PCP are not authorized to communicate test results to a patient without consultation first with the clinical supervisor.

8.10 The Healthcare Provider maintains a manual list of all tests they have initiated and are responsible for manually tracking test results. The RCDC will additionally be tracking pending investigations but is not the most responsible practitioner. The RN initiating the test is the most responsible practitioner.

8.11 Reporting suspicious or confirmed cases of COVID-19 to Public Health is mandatory, see COVID-19 Public Health protocol for reporting requirements.

8.12 In the case that the RN's employment ends, the list of investigations initiated must be handed over to the Supervisor of Health Programs and the RCDC to ensure follow-up.

8.13 Health centres, hospitals, screening clinics, or any other health programs are required to manually track COVID-19 specimens if they do not have processes in place to do this through Meditech. This is to ensure specimens are not lost in transit or there are issues that arise with lab processing.

Practice Point: Maintain a manual tracking binder in your facility for COVID-19 laboratory investigations; keep one section for pending requisitions and another section for completed/received results. This will additionally allow for tracking the amount of testing per community.

9. DOCUMENTATION:

9.1 The Health Care Providers must follow the Documentation Standard policy outlined in the CHN Manual

9.2 At minimum, the following must be documented:

i. All related fields within the *COVID-19 Public Health Protocol's, PUI Form*
ii. If patient meets testing criteria, any consultations to initiate and perform the test (NP swab)
iii. Informed consent received from the client and tolerance of the test
iv. Follow-up instructions to the patient
v. Reference to this medical directive
vi. Documentation of communication to RCDC

10. RELATED POLICIES, PROTOCOLS AND LEGISLATION:

Appendix B: COVID-19 Public Health Protocol
https://www.gov.nu.ca/sites/default/files/covid-19_public_health_protocol_v6_2jul2020.pdf
CHN Manual Policy: Acknowledgement of Diagnostic Test Results
CHN Manual Policy: Follow up of Abnormal Diagnostic Test Results

CHN Manual Policy: Documentation Standard
https://www.gov.nu.ca/health/information/manuals-guidelines

11. REFERENCES:

Government of Canada. (2020). https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection.html
World Health Organization. Coronavirus disease. https://www.who.int/emergencies/diseases/novel-coronavirus-2019/events-as-they-happen

12. APPROVALS:

Approved By:	Date: June 15, 2021
Jennifer Berry, Assistant Deputy Minister – Department of Health	
Approved By:	Date: June 15, 2021
Jenifer Bujold, Chief Nursing Officer	
Approved By:	Date: June 22/21
Dr. Michael Patterson, Chief Public Health Officer, on behalf of the Medical Advisory Committee	

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS **Community Health Nursing**		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Escalation of Medical Care		Nursing Practice	07-035-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
21/07/2020	07/2023	N/A	5
APPLIES TO:			
Community Health Nurses, Nurse Practitioners, and Physicians			

1. BACKGROUND:

1.1. The Department of Health (Health) provides patients with care as close to home as possible. When the patient needs exceed the services available at the health centre in their home community, the patient will be transferred to another centre with more robust resources providing that the patient is agreeable.

1.2. To protect the health and wellbeing of patients, limitations are placed on the length of time which a patient may remain at the health centre, and the number of repeat visits without improvement or diagnosis.

2. POLICY:

2.1. The nurse will consult with the community physician or physician on call to arrange patient transfer to an alternate care site whenever a patient has been at a health centre for 4 hours without evidence of clinical improvement. For greater clarity, patients may not be monitored in the health centre for greater than 4 hours. Transferring a patient to another health centre or third-party healthcare provider is done explicitly to allow for timely access to greater resources and supports for investigations, diagnosis, and treatment options.

2.2. A patient who has been seen twice for the same complaint must be seen by a different clinician on the third visit. The third visit will include a complete examination and investigations into alternate diagnoses in addition to a referral to or consultation with a physician or nurse practitioner.

2.3. A patient who has been seen three times for the same complaint **without** an effective treatment plan and/or diagnosis must be sent to a third-party healthcare provider by the most appropriate means of transportation given the patient's condition, including medevac. The transfer of the patient to a third-party healthcare provider is done explicitly to allow for timely access to greater resources and supports for investigations, diagnosis, and/or treatment options. This statement applies to all clinicians regardless of location of care within Nunavut.

3. PRINCIPLES:

3.1. Nunavummiut have a right to access equitable healthcare resources and supports regardless of

their home community. The delivery of these healthcare resources and supports may require travel to another centre.

3.2. Health provides Nunavummiut with care as close to home as possible. To ensure that the priority of receiving care as close to home as possible does not conflict with the need to provide all Nunavummiut with access to equitable healthcare resources and supports, patients may be required to receive evaluation, care, and/or treatment at a location other than their home community. Non-urgent/non-emergent treatment at a location other than a patient's home community will take place only when specific criteria are met as outlined in this policy.

3.3. Patients will be transferred between communities and referral sites using the most appropriate means of transportation given the patient's condition, including medevac.

3.4. To ensure that all Nunavummiut have access to the healthcare resources and supports needed, even in non-urgent/emergent situations, patients may be required to receive care away from home.

4. DEFINITIONS:

4.1. **Clinician:** Refers to Community Health Nurses (CHN), Nurse Practitioners (NP), and Physicians.

4.2. **Non-Urgent:** Non-Urgent refers to conditions that may be acute but non-urgent as well as conditions which may be part of a chronic problem with or without evidence of deterioration.

4.3. **Urgent:** Urgent refers to conditions that could potentially progress to a serious problem requiring emergency interventions.

4.4. **Emergent:** Emergent refers to conditions that are a potential threat to life, limb, or function requiring rapid medical interventions and the use of condition specific controlled medical acts.

4.5. **Consultation:** A deliberation between clinicians in order to seek advice. The clinician initiating the consult remains the Most Responsible Person (MRP).

4.6. **Referral:** A referral is a request from one physician to another to assume responsibility for management of one or more patient either entirely or for a specified problem. A referral may be for a specified time period, until the resolution of a problem, or may be for ongoing care. It is the responsibility of the physician accepting the referral to maintain appropriate and timely communication with the referring physician and to seek approval from the referring physician for treating or referring the patient for any other condition that is not part of the original referral.

5. PROTOCOL:

5.1. Patients who have made three visits to a clinician for the same complaint without improvement or a confirmed diagnosis must be transferred to a third-party healthcare provider for evaluation and/or treatment if determined through consultation with the community physician or physician on call.

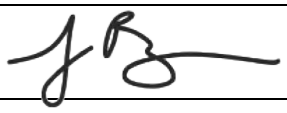
5.1.1. Physicians who have seen the same patient for 3 visits for the same complaint without improvement or a confirmed diagnosis must refer the patient for transfer to a third-party healthcare provider.

5.2. Patients who have been in the health centre for 4 hours without improvement will be transferred to a regional centre or third-party healthcare provider after consultation with a physician.

5.3. Patients who have been treated twice for the same complaint will be re-evaluated by a different clinician on their third visit for the same complaint, regardless of resolution/improvement between visits. A physician or nurse practitioner referral or consultation must be arranged at that time.

6. PRACTICE POINT:

6.1. An underlying mood disorder or other psychiatric origin of the illness, as well as a referral to Mental Health, should be considered for any patient who has been seen twice with vague or non-specific complaints **without** a diagnosis.

Approved By: 	Date: August 31, 2020
Jennifer Berry, Assistant Deputy Minister, Operations, Department of Health	
Approved By: 	Date: August 31, 2020
Monique Skinner, Chief Nursing Officer, Department of Health	
Approved By:	Date:
Francois de Wet, Chief of Staff, Department of Health	

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS Community Health Nursing	
TITLE:	**SECTION:**	**POLICY NUMBER:**
Community Health Centre Protected Code Blue During the COVID-19 Pandemic	Nursing Practice	07-037-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
May 2020 / May 2023	N/A	9
APPLIES TO:		
Community Health Centres		

PLEASE NOTE: This is an emerging pandemic involving a novel virus. As new evidence is released, the information contained within this document may change.

1. **BACKGROUND:**
   The SARS-CoV-2 virus (COVID-19) currently causing a worldwide pandemic is transmitted primarily by droplet and contact means. Certain procedures performed during a code blue, known as 'aerosol-generating medical procedures' (AGMP), are believed to cause both a higher volume of infectious droplets as well as aerosolization of the virus, increasing risk of transmission. This protocol aims to provide specific risk reduction and infection prevention strategies to guide healthcare providers when performing resuscitation.

2. **DEFINITIONS:**
   - **2.1** Code Blue: Cardiopulmonary arrest.
   - **2.2** Aerosol: Small droplet of moisture that may carry microorganisms; may remain suspended in the air for periods of time, allowing inhalation of microorganisms.
   - **2.3** Aerosol-Generating Medical Procedures (AGMP): A procedure with the potential to generate a high volume of respiratory droplets and aerosols. Potential AGMP during a critical patient presentation and resuscitation within the health centre setting may include (but is not limited to):
     - **2.3.1** Nebulizer therapy
     - **2.3.2** High-flow oxygen therapy (nasal prongs at >6L/min)
     - **2.3.3** Open airway suctioning (including deep suctioning of nasopharynx and trachea; not including oral suctioning)
     - **2.3.4** Cardiopulmonary resuscitation (CPR)
       - i. Cardioversion and defibrillation **in the absence of bag-valve mask ventilation (BVM)** are not AGMP
       - ii. Other procedures associated with CPR including chest compressions **with** intubation and manual ventilation, are AGMP
       - iii. Chest compressions alone are not considered an AGMP
     - **2.3.5** Bag-valve mask ventilation
     - **2.3.6** Endotracheal intubation and extubation
     - **2.3.7** Insertion of any advanced airway

2.3.8 Non-invasive ventilation (CPAP, BiPAP)
2.3.9 Needle decompression

3. KEY PRINCIPLES:

3.1 Safety and protection of healthcare providers is priority.
3.2 Additional precautionary measures should be taken when delivering care to patients with suspected respiratory infection.
3.3 During the current pandemic, assume all respiratory and cardiac arrests are COVID-19 positive.
3.4 Ethical principles surrounding resource allocation, staff training, PPE availability and conservation, prognosis, and patient wishes must be taken into consideration.

4. RECIPIENT PATIENTS:

4.1 Patients presenting to the Community Health Centre, requiring resuscitation.

5. POLICY:

5.1 The Community Health Centre must apply the risk reduction and infection prevention strategies listed in 6.0 during a code blue.
5.2 The Community Health Centre must adapt the risk reduction and infection prevention measures outlined in Appendix A: *Community Health Centre Protected Code Blue Practical Guide.*

Note*: It is recognized that the resources and number of healthcare providers involved in a code blue will depend on staffing complement and availability. The roles and responsibilities outlined in Appendix A must be adapted to situation and setting, with emphasis on maintaining risk reduction and infection prevention strategies.*

6.0 RISK REDUCTION & INFECTION PREVENTION STRATEGIES:

6.1 AGMP should be performed in (order of preference):
6.1.1 Negative pressure room
6.1.2 Isolation room with door closed, or
6.1.3 Private room with door closed, or
6.1.4 COVID-19 cohort area, where all healthcare providers are wearing PPE
6.2 In the absence of a negative pressure room, every effort must be made for a code blue resuscitation to be performed in the health centre isolation room with the door closed.
6.3 It is mandatory for healthcare providers to don full Personal Protective Equipment (PPE) for droplet, contact and airborne precautions during a code blue resuscitation.
6.4 An observer should be assigned with donning and doffing of PPE.
6.5 Use disposable equipment when possible.
6.6 Double glove to allow removal of highly contaminated outer gloves.
6.7 Pay attention to limit exposure of contaminated equipment that have come into direct contact with the patient's face or secretions.
6.8 Use a drop bag to isolate highly contaminated equipment after any procedures, prior to disposal/cleaning of room.
6.9 Limit the amount of equipment entering the room to items that are deemed necessary; all supplies in the room are considered contaminated.
6.10 Avoid unnecessary entry/exit of the room by healthcare providers.
6.11 Bag-valve mask ventilation (BVM) is considered a highly aerosolized procedure. If BVM must be performed, use two-person, four-handed technique.

6.12 The door to the room should remained closed as much as possible.

6.13 Utilize a telephone with speaker phone function or baby monitor to communicate with staff outside of the room. This will a) minimize door opening b) aid with documentation; and c) assist with retrieval of equipment.

6.14 The use of personal cell phones is discouraged.

Note: Contact the Regional Director and/or Regional Clinical Educator for direction on isolation room set up.

7.0 PROCEDURAL GUIDE:

Outlined below in Appendix A: Community Health Centre Protected Code Blue Practical Guide.

8.0 RELATED POLICIES, PROTOCOLS AND LEGISLATION:

Department of Health, Qikiqtani General Hospital. April 2020. *Protected Code Blue in adults at Qikiqtani General Hospital during the COVID-19 pandemic.*

Department of Health, Qikiqtani General Hospital. April 2020. *Protected Code Blue in pediatric patients at Qikiqtani General Hospital during the COVID-19 pandemic.*

Community Health Centre Policy 10-003-06 Aerosol-Generating Medical Procedures in Patients with Known or Suspected COVID-19

Community Health Nursing Policy 06-008-00: Documentation Standards

Community Health Nursing Policy 06-008-01: Documentation Standards

Community Health Nursing Policy 10-005-00: Personal Protective Equipment

Department of Health Housekeeping Procedures Manual

9.0 REFERENCES:

1. Tran, K., Cimon, K., Severn, M., Pessoa-Silva, C.L., & Conly, J. (2011). Aerosol-generating procedures and risk of transmission of acute respiratory infections: A systemic review. *Canadian Agency for Drugs and Technologies in Health*. Retrieved from https://www.cadth.ca/media/pdf/M0023_Aerosol_Generating_Procedures_e.pdf

2. The Ottawa Hospital, Department of Critical Care. COVID-19 Quick reference guide. Retrieved from https://www.covidottawa.com/

Approved By:	Date: June 22, 2020
Ruby Brown, Deputy Minister – Department of Health	
Approved By: Monique Skinner Digitally signed by Monique Skinner DN: cn=Monique Skinner, o=Government of Nunavut, ou=Operations, email=mskinner@gov.nu.ca, c=CA Date: 2020.06.22 08:26:24 -06'00'	Date:
Monique Skinner, Chief Nursing Officer	
Approved By:	Date:
Francois de Wet, Chief of Staff – On behalf of the Medical Advisory Committee	

APPENDIX A:

COMMUNITY HEALTH CENTRE PROTECTED CODE BLUE PRACTICAL GUIDE

1. Team Roles & Preparation

Minimize number of people inside room. Roles should be assigned. Consider staffing compliment, job descriptions, and scope of practice.

Ideal Healthcare Providers Inside Room

a) Team Lead MD, 1st responder or most experience provider - may assist with BVM by bagging
b) Nurse x 4 if available

Ideal Healthcare Providers Outside of the Room

c) Nurse – backup in full airborne PPE
d) Nurse – Runner, documenter and PPE Observer if dedicated Observer not available
e) PPE Observer

2. Equipment Preparation

a) Cardiac monitor removed from arrest cart and brought into room
a) Portable suction
b) IV pump as needed
c) Oxygen Tank
d) Back board
e) Preparation Isolation supply of: Airway and Breathing Kit, Circulation Kit & Medication Kit OR Arrest cart outside of the room
f) **ARREST CART (SHOULD) REMAIN OUTSIDE ROOM DURING CODE**
Note: Contact Clinical Nurse Educator for isolation room set up and equipment preparation.

3. Situation Specific Procedure

Healthcare provider who witnesses an adult patient experiencing cardiac arrest, or becoming unresponsive:

a) Check for pulse for no more than 10 seconds
b) Verify code status if possible
c) Alert code blue to team
d) Leave room to properly don Airborne PPE
e) Cover nose and mouth with surgical mask, NRB mask up to 15 L/min, or piece of cloth while awaiting additional personnel
f) Return to room, if defibrillator available, apply pads to patient. If rhythm is shockable, you may deliver a shock, as this is not considered and AGMP
g) Start compressions as soon as 1st responder is in room in full PPE
h) Only ventilate patient with appropriate airway adjunct and when two experienced providers are available. With viral filter attached to BVM, perform 2-Person, 4-hand BVM.
i) Ensure door to room is closed

4. Roles & Responsibilities of Healthcare Providers Inside the Room

Team Lead:

a) Enters room in airborne and contact PPE
b) Assigns roles to team members
c) Obtain clinical history; if no physician present, call regional physician on call
d) Once airway obtained, assist with bagging patient using 2-person, 4-hand technique

First Nurse (Defibrillator/Monitor):

e) Returns to room after donning airborne and contact PPE
f) If cardiac monitor in room already, apply pads; follow ACLS guidelines; defibrillation in the absence of BVM is not an AGMP; therefore, may defibrillate at this point if indicated.
g) Initiate chest compressions if indicated without airway manipulation or BVM
h) Will switch roles with team members at each pulse check as per ACLS guidelines or physician direction, to maintain high quality CPR

Second Nurse (Circulation):

i) Brings Circulation Kit, Medication Kit, back board and cardiac monitor
j) Place backboard to improve compressions
k) Apply pads to patient and deliver a shock if shockable rhythm is present (not considered an AGMP) unless this has already been done by first nurse.
l) Obtain IV access
m) Cycle compressions and airway with first nurse at each pulse check

Third Nurse (Airway):

n) Brings Airway Kit & Breathing Kit
o) If no physician, apply oxygen at 15 L/min with a Non-Rebreather Mask
p) Insert oral airway and initiate 2-person, 4-Hand BVM; Team Lead can perform 'bagging'
q) If physician in community, patient may be intubated at this time; chest compressions are to be paused for intubation. (Note: Community Health Centre Guideline for COVID-19 Intubation is in development).
r) BVM increases aerosolization; use viral HEPA filter if available; use PEEP valve if available and indicated.
s) If using PEEP valve, set at 5 cm H20 and increase as ordered to improve oxygen saturation. Avoid PEEP in hypotensive patients; consult with physician for guidance.
t) Cycles compressions and airway

***Fourth &/or Fifth Nurse*:**

u) Cycles compressions and airway

5. Roles & Responsibilities of Healthcare Providers Outside the Room

Backup Nurse:

a) To don full PPE and wait outside the room to assist if necessary
b) May need to swap out for compressions or airway support

***Runner and PPE observer*:**

c) Retrieve extra equipment/meds as needed (Support staff may act as runner)
d) PPE observer remains outside room; ensures proper donning/doffing of PPE by all individuals entering room and prevents unnecessary personnel from entering or leaving the room
e) Documenter

6. Running the Code Blue

a) The Code Blue to be directed by Physician/Physician On-Call, following standard ACLS Guidelines.
b) Consider inserting an advanced airway if physician available in community (or a healthcare provider who has received training for advanced airway insertion such as LMA, KingLT, or Combitube) to decrease aerosolization in comparison to BVM.
c) Only Rankin Inlet has a ventilator at this time; if patient is intubated or has a supraglottic airway inserted, they require manual ventilation, which is an AGMP. Currently, there is no way to close the circuit in a community health centre setting.
d) If unable to insert advanced airway, the patient should be ventilated with oral or nasal airway and 2-person, 4-hand BVM technique.
e) Consider discontinuation of resuscitation if:
    - No improvement after 1-2 cycles of CPR after definitive airway is established
    - Severe COVID-19 related hypoxia that has deteriorated despite invasive mechanical ventilation.

7. Determining Appropriateness & Duration of Intervention

a) Decision to discontinue efforts is made by physician.
b) With patient historical factors and context of arrest in mind:
    I. Consider holding resuscitation for unwitnessed arrests in adults with suspected/confirmed COVID-19.
    II. Consider discontinuing resuscitation for adults after 1 cycle of CPR once a definitive airway is established with the following rationale:
        i. Purely hypoxic arrests should respond quickly to restoring oxygenation with a definitive airway.
        ii. Chance of survival for asystole and PEA that does not respond quickly to ACLS measures is poor.
        iii. If the patient is suffering from severe and progressive COVID-19 disease, resuscitative efforts are unlikely to change the course of this disease.
        iv. Prolonged resuscitative efforts increase ongoing risk of exposure to all healthcare providers involved in the code.

8. Further Treatments & Investigations

a) Diagnostic imaging should be avoided during code blue for patients with suspected/confirmed COVID-19.
b) Obtaining laboratory specimens should be avoided during code blue for patients with suspected/confirmed COVID-19.
c) Consider empiric needle decompression of chest if pneumothorax suspected (considered to be an AGMP).
d) Extra equipment should not be brought into room such as portable ultrasound, EKG machine if not necessary.

9. Documentation

a) Documentation is low priority, but still important.
b) Healthcare providers involved in the code blue can meet and reasonably recall events for documentation following the code.
c) Documenter, if available, should remain outside the door.
d) Follow Policy 06-008-00 *Documentation Standards* & 06-008-01 *Documentation Standard Guidelines* found in Government of Nunavut Community Health Nursing Manual.

e) Use of speaker function on telephone in isolation room or baby monitor, is suggested.
f)

10. Successful Code Blue During COVID-19 Pandemic

a) If patient has return of spontaneous circulation (ROSC), ongoing management must be provided while maintaining full airborne/contact/droplet precautions until patient is transferred to higher tertiary centre.
b) If ventilator available (closed circuit), patient can be removed from airborne precautions 4 hours after AGMP or resuscitation.
c) Any urgent investigations such as blood work should be carried out by those healthcare providers already in the room, whenever possible.
d) After successful code blue, ALL equipment and medication are to remain in the room for safe disposal and decontamination.
e) Garbage and linen may be removed as per isolation policy in housekeeping manual; however, equipment if possible, should stay in room until patient leaves room.
f) At least one designated RN to remain in room with patient to provide supportive care; may need to be relieved by another team member depending on transport time to higher level care centre.
g) Medevac to be arranged by regional physician; contact RCDC and/or CPHO; ensure transport team aware of precautions.
h) Disposition of patient would be decided by the regional physician on-call.
i) Documentation to be completed by Nurse who was designated to document; maintain documentation outside of room.
j) Once patient leaves, allow 4 hours to elapse before cleaning, according to housekeeping procedure (see Reference List).

11. Termination of Code Blue During COVID-19 Pandemic

a) After unsuccessful code blue, ALL equipment and medication are to remain in room for safe disposal and decontamination.
b) DO NOT extubate patient – leave ambu-bag, filter, and airway, in situ.
c) Housekeeping staff to perform a decontamination and disposal of room, 4 hours after patient removed from room.
d) Careful doffing of PPE must be done for all involved personnel, one at a time, with the designated observer ensuring proper processes followed.
e) If possible, staff involved in resuscitation/code blue should shower and change clothing.

12. Summary of Adjustments to CPR algorithms during COVID-19 pandemic

Reduce Provider exposure

a) Assume all patients are COVID-19 positive during an arrest
b) Don PPE before entering room/scene
c) Limit personnel involved

Prioritize oxygenation and ventilation strategies with lower aerosolization risk

d) Defibrillation can be performed early without airborne precautions for shockable rhythms
e) Before intubation, BVM can be used if it can be performed using 2 Person, 4 Handed approach
f) Viral HEPA Filter to be used
g) Consider passive oxygenation with a facemask as an alternative to bag mask ventilation when not immediately available

h) Intubate early with a cuffed tube, if possible, and connect to mechanical ventilator when able (applies to Rankin Inlet only)
i) Engage the Intubator with the highest chance of first-pass success
j) Pause chest compressions to intubate
k) Consider use of video laryngoscopy or LMA, if available

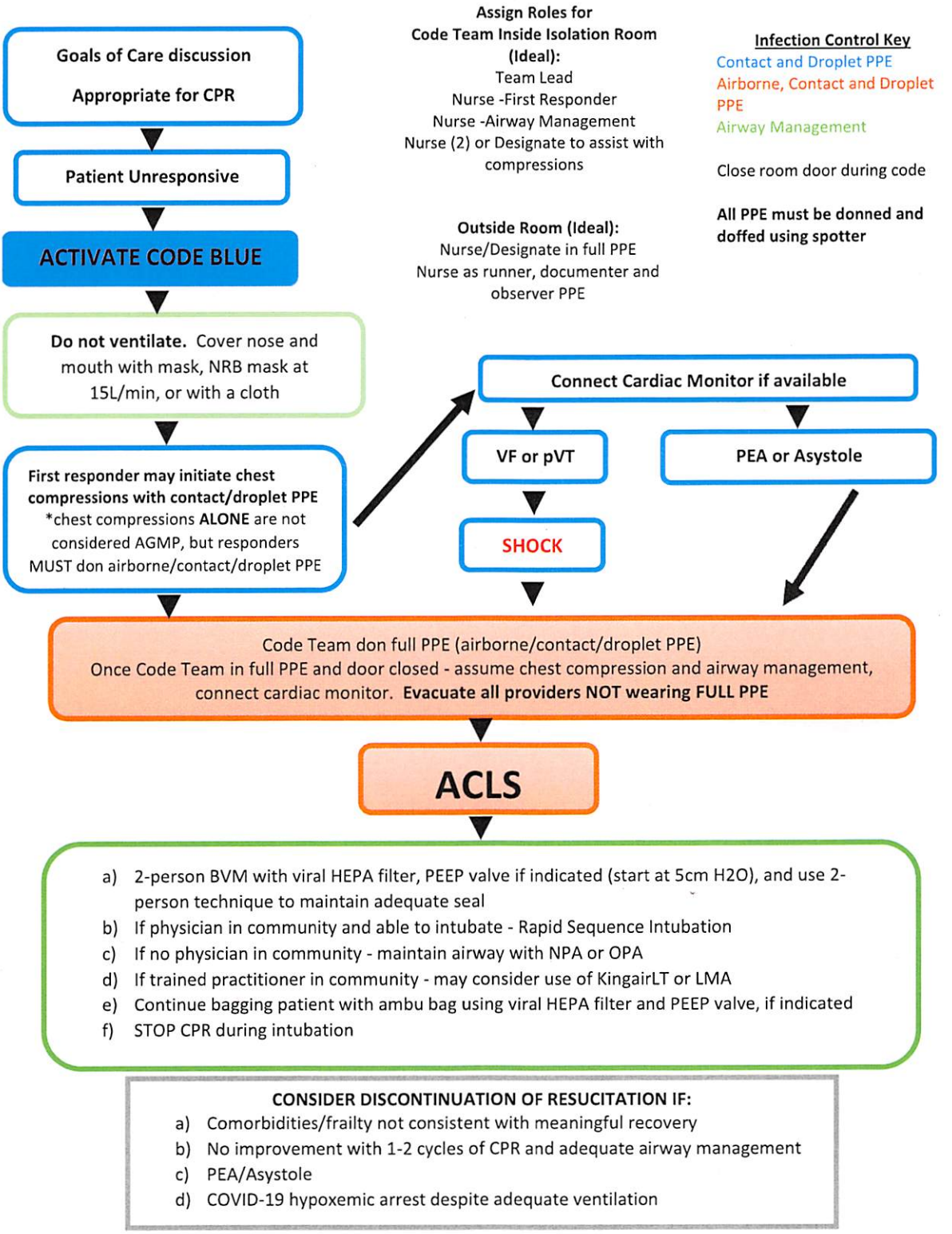
Consider Rescuer Appropriateness

l) Address Goals of Care in early course of illness, when possible
m) Consider discontinuation of CPR following 1-2 cycles with adequate ventilation

Pediatric Considerations

a) Equipment: Broselow Equipment Organizer outside of room – supplies brought in as needed
b) Medication: As directed by Physician
c) Defibrillation: Energy delivery as directed by Physician, based on weight
d) Running the Code Blue: Physician, or Physician on call and according to PALS Guidelines
e) Rescuer Appropriateness: Physician to determine appropriateness and duration of resuscitation

Community Health Centre Protected Code Blue During the COVID-19 Pandemic



Department of Health Government of Nunavut	**Medical Directives and Delegation** **Community Health Nursing**	
TITLE:	**SECTION:**	**POLICY NUMBER:**
COVID-19 Allied Health Provider Notification of Results	Nursing Practice	07-038-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
May 1, 2021 / May 1, 2022		4

APPLIES TO:

Allied Health Care Providers (HCP) – specifically:

- Physiotherapy (PT)
- Occupational Therapy (OT)
- Speech Language Pathology (SLP)
- Audiologist
- Registered Dietician (RD)
- Respiratory Therapist (RT)

1. BACKGROUND:

COVID-19 is a novel coronavirus that was first detected in China in late 2019. On March 11, 2020, the World Health Organization declared COVID-19 a pandemic. Coronavirus infections are diagnosed through health care professionals in consultation with public health teams and guidance based on symptoms, typically confirmed through laboratory testing.

The outbreak response in Nunavut is requiring additional support and involvement of allied HCP. This *COVID-19 Allied Health Provider Notification of Results* directive is intended to 1) provide an authorizing mechanism for allied HCP as defined above to communicate COVID-19 laboratory testing results; 2) provide a procedural outline; and 3) provide standardized guidance related to communicating results, follow-up, and mandatory reporting.

Delegated authority for nurses is through other processes and directives. Community Health Nurses have the delegated authority to initiate COVID-19 testing as per policy 07-031-00. A separate *COVID-19 Laboratory Testing Authority* directive provides an authorizing mechanism for licensed practical nurses and registered nurses to initiate COVID-19 testing as well.

2. MEDICAL DIRECTIVE AND/OR DELEGATED PROCEDURE:

2.1 **The allied HCP can communicate COVID-19 results within specific circumstances as outlined in section 6.**

2.2 **This directive does not cover initiating or ordering testing for COVID-19. Registered Nurses and LPNs are permitted to initiate testing for COVID-19, according to the *COVID-19 Public Health Protocol* and requirements outlined in this medical directive.**

2.3 **This medical directive does not apply to any laboratory results other than for COVID-19 testing.**

3. Principles:

3.1 Allied HCPs are expected to practice withing their own level of competence and seek guidance from their supervisor, physician, or Nurse Practitioner as needed.

3.2 Guidelines do not replace clinical judgement. Management decisions must be individualized.

4. RECIPIENT PATIENTS:

4.1 Nunavummiut of all ages

5. AUTHORIZED IMPLEMENTERS:

5.1 Allied HCPs who possess the knowledge, skills, and abilities to communicate COVID-19 test results, and who possess the the specific training working within the Nunavut Virtual Public Health Nurse (VPHN) program for COVID-19.

5.2 Sub delegation to communicate a test result is **not** permitted to another regulated or non-regulated HCP who (1) are not listed in the directive/ delegation policy and (2) are not authorized to perform that procedure through other authorizing mechanisms like departmental policies, professional regulation acts and associations.

6. INDICATIONS AND CONTRAINDICATIONS:

6.1 The medical directive may be enacted when an allied HCP is working with the VPHN team and is required to communicate a COVID-19 test result to the client. The allied HCP must have completed/received additional training and support to communicate the COVID-19 test result.

7. DEFINITIONS:

Allied Health Care Provider (HCP): Physiotherapy (PT), Occupational Therapy (OT), Speech Language Pathologist (SLP), Audiologist, Registered Dietician (RD), Respiratory Therapist (RT).

8. PROCEDURE:

8.1 HCP onboarded on to VPHN team and Microsoft Teams outbreak-specific space
8.2 HCP receives directive-specific and general training
8.3 Throughout, HCP follows COVID-19 protocol & VPHN Processes
8.4 Assigned calls by VPHN Lead or supervisor via daily assignment sheet
8.5 Buddied with VPHN. If questions or issues arise, they reach out to that individual with questions.
8.6 Check COVID-tracker for laboratory results in yellow for Household assigned
8.7 Call clients as per assignment sheet
8.8 Confirm two patient identifiers when calling to do symptom check and when providing negative laboratory results. Strong education that negative results do not necessarily mean off isolation, still required to isolate.
8.9 Fill out daily monitoring form as per processes. Do not document in Meditech.
8.10 Update the COVID-tracker with date notified of the laboratory result and un-yellow the new lab result on the COVID-tracker
8.11 Strike through each household (HH_ assigned once call completed.

Practice Point: Remember that positives protect but negatives mean nothing beyond that day. Someone with COVID-19 is almost certain to test negative the day after their exposure, even if they're going to go on to develop COVID-19 and be infectious; the timing of the test matters. Even with a negative result, individuals are required to remain on isolation for 14 days after the exposure (longer in households with positive cases with ongoing exposure to someone who is infectious).

1. DOCUMENTATION:

1.1 HCPs must document communication of the results on the Daily Monitoring Form as directed by the VPHN training .

1.2 At minimum, the following must be documented:

i. Date, time, name, and designation of HCP.
ii. Result communicated
iii. Follow-up instructions to the patient
iv. Reference to this medical directive

2. RELATED POLICIES, PROTOCOLS AND LEGISLATION:

APPENDIX A: Decision-Making Model for Performing Additional Functions and Transferred Functions for Nurses (for information)

Appendix B: COVID-19 Public Health Protocol. Available here: https://www.gov.nu.ca/health/information/manuals-guidelines

CHN Manual Policy: Acknowledgement of Diagnostic Test Results
CHN Manual Policy: Follow up of Abnormal Diagnostic Test Results
CHN Manual Policy: Documentation Standard
https://www.gov.nu.ca/health/information/manuals-guidelines

3. REFERENCES:

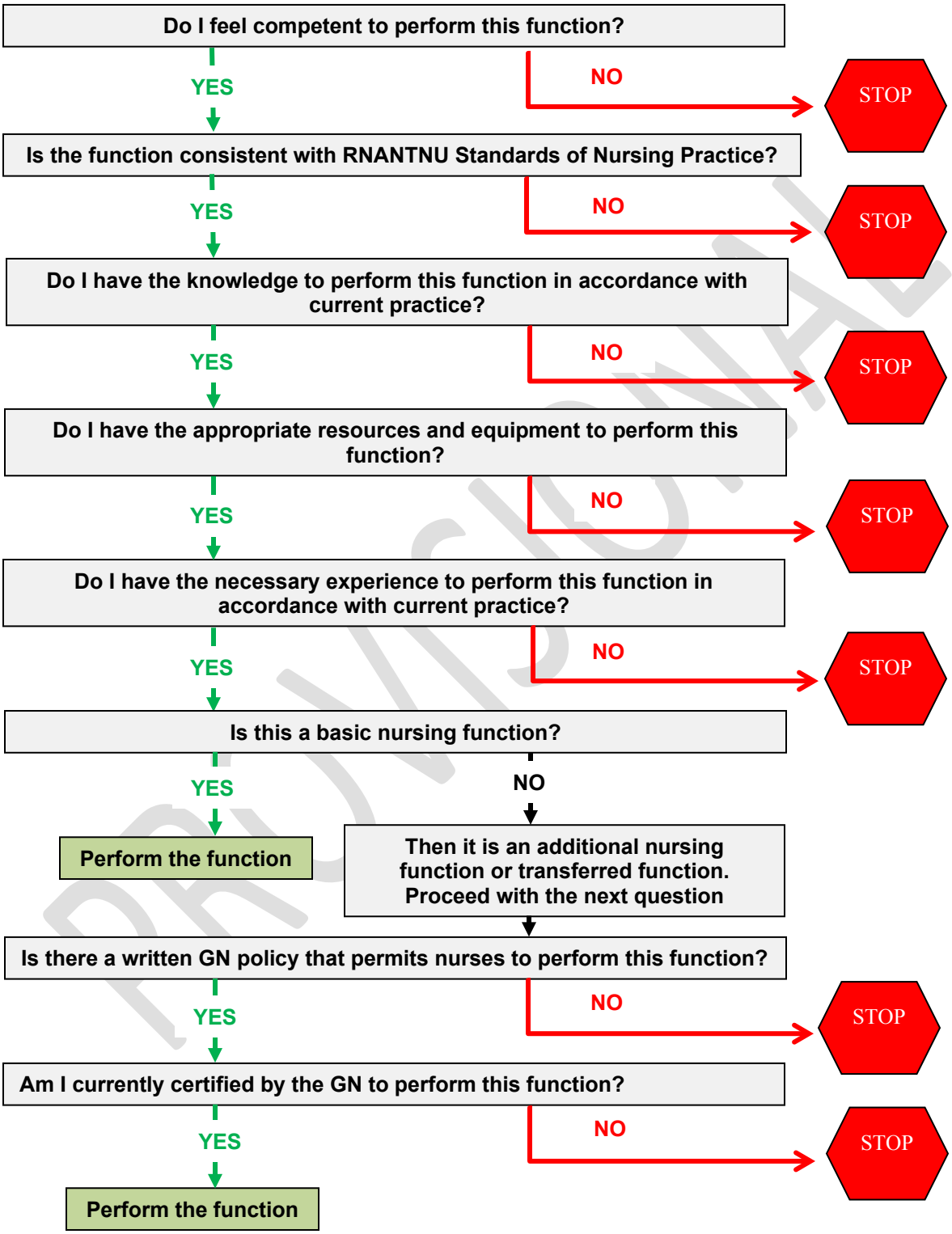
Government of Canada. (2020). https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection.html

World Health Organization. Coronavirus disease. https://www.who.int/emergencies/diseases/novel-coronavirus-2019/events-as-they-happen

4. APPROVALS:

Approved By: 	Date: May 12, 2021
Jen Bujold, Acting Chief Nursing Officer – Department of Health	
Approved By: 	Date: May 12, 2021
Jennifer Berry, ADM Operations – Department of Health	
Approved By:	Date:
Dr. Francois de Wet, Chief of Staff, on behalf of the Medical Advisory Committee	

APPENDIX A: DECISION-MAKING MODEL FOR PERFORMING ADDITIONAL FUNCTIONS AND TRANSFERRED FUNCTIONS



RNANT/NU (2010). *Scope of Practice for Registered Nurses*, p. 9

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS **Community Health Nursing**	
TITLE:	**SECTION:**	**POLICY NUMBER:**
Informed Refusal of Treatment	Nursing Practice	07-039-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
May 1, 2021 / May 1, 2023	N/A	5
APPLIES TO:		
Nurses and Physicians		

1. BACKGROUND:

Adult and Mature Minor Clients have the right to make the informed decision to refuse treatment for themselves, their minor children, or their wards, even if this refusal is contrary to what the clinician believes to be in their best interest. A thorough discussion of the potential consequences of treatment refusal serves to ensure the client comes to an informed decision. Clear documentation of the client encounter serves to protect the clinician and the Government of Nunavut from a medico-legal risk perspective.

2. POLICY:

2.1 Capable Adult and Mature Minor Clients may refuse treatment on their own behalf and on behalf of their minor children or wards, although some restrictions exist.

2.2 The clinician is responsible for assessing the client's capacity to give or refuse consent, explaining the current health situation, the risks and benefits of the proposed treatment, and the consequences of refusing treatment in plain language. Qualified interpreter services must be offered when the client's first language is not English.

3. PRINCIPLES:

3.1 Clients have the right to make informed decisions about their health, including which treatments they accept or refuse. This could include refusing lifesaving treatment.

3.2 Parents, legal guardians, and substitute decision-makers (SDM) may also make the informed decision to refuse treatment on behalf of their child or ward, although some restrictions exist, such as where the child is a mature minor.

3.3 The client or parent/legal guardian/SDM must demonstrate capacity. They must understand the current health situation, benefits and risks of proposed treatment, and the risks of refusing.

3.5 The client has the right to consent, withdraw consent, or refuse treatment at any time.

3.6 The client has the right to consent to some treatments and refuse others. Refusal of one or more treatments does not mean that all care is arrested.

3.7 It is illegal to impose a treatment when a client with capacity has refused, except in emergencies, or circumstances of court-ordered treatments.

3.8 Signing a "Refusal of Medical Treatment Against Advice" form serves only as documentation that a conversation about the consequences of refusing treatment occurred between clinician and client. It does not prevent the client from seeking care or accepting treatment in the future.

4. DEFINITIONS:

4.1 Clinician: Refers to Community Health Nurse (CHN), Public Health Nurse (PHN), Home Care Nurse (HCN), Mental Health Nurse (MHN), Licensed Practical Nurse (LPN), Nurse Practitioner (NP), or physician.
4.2 Treatment: An intervention intended to protect, promote, or improve the health and wellbeing of a client.
4.3 Capacity: Refers to the ability of a person to understand information provided to them, weigh the benefits and risks of different courses of action, come to a decision, communicate this decision, and understand the potential consequences.
4.4 Minor: A person under the age of nineteen.
4.5 Mature Minor: A person under the age of nineteen, who is assessed by the clinician and deemed to be capable of providing consent or refusing treatment. The mature minor exhibits an understanding of the indication for treatment, what the treatment involves, the benefits and risks of accepting treatment, and the risks of refusing treatment.
4.6 Legal Guardian: A non-parent, court-appointed decision-maker for a minor or dependent adult.
4.7 Ward: A minor or dependent adult who has a court-appointed legal guardian.
4.8 Dependent Adult: An adult who lacks the legal capacity to make health care decisions for themselves, including consent or refusal of treatment.
4.9 Substitute Decision-Maker (SDM): A person who is authorized in writing to make health care decisions for another person, when that person is incapable of making such decisions themselves.

5. PROCEDURE:

5.1 Clients must have capacity to understand the consequences of their decision to decline treatment for themselves or their child/ward.
- 5.1.1 Adults are presumed to have capacity unless there is evidence to the contrary.
- 5.1.2 Mature Minors have the same capacity as Adults, unless there is evidence to the contrary.
- 5.1.3 Minors are presumed to be incapable unless there is evidence to the contrary. A Minor's parent or legal guardian is presumed to be capable of giving or refusing consent.
- 5.1.4 The Director of Child and Family Services (or a designate) gives or refuses consent on behalf of minors in care pursuant to the *Child and Family Services Act*.
- 5.1.5 If a clinician has concerns about an individual's capacity, arrangements must be made to further investigate. This could involve referral to a physician or NP.

5.2 A full discussion of the current health situation, proposed treatment, benefits and risks of treatment, and risks of refusing treatment must occur between clinician and client.
    5.2.1 All the client's questions must be answered in a way that they can understand, avoiding the use of medical jargon.
    5.2.2 Qualified interpreter services must be offered when the client's first language is not English.

5.3 The clinician should explore the client's reason for refusal and determine if there is a way to make treatment acceptable to the client.

5.4 The clinician must request that the client sign a "Refusal of Medical Treatment Against Advice" form (located in Appendix A), formally acknowledging their decision to refuse treatment.
    5.4.1 If the client refuses to sign, the clinician will document this.
    5.4.2 The client should be informed that signing this document does not prevent them from receiving alternate available treatments or from accepting proposed treatment later.

5.5 The clinician must review symptoms of deterioration of condition that would necessitate client's return to the health centre, and any other relevant health teaching.

5.6 The clinician must inform the client that they may change their decision at any time.

5.7 In the case of minors:
    5.7.1 If the parent/guardian of a minor refuses treatment on their behalf, the parent/guardian should be asked to sign the "Refusal of Medical Treatment on Behalf of Minor or Dependent Adult Against Advice" form (located in Appendix B).
    5.7.2 If the parent/guardian of a minor refuses treatment on behalf of the minor that the clinician believes to be essential to health and wellbeing, the clinician must consult Family Services. The clinician must notify the parent/guardian of the intended consultation.
    5.7.3 A mature minor who demonstrates understanding of the purpose, benefits, and risks of a proposed treatment may consent, even with parent/guardian refusal.
    5.7.4 Minors should be advised of their right to obtain assistance from the Office of the Representative for Children and Youth.

5.8 In the case of dependent adults:
    5.8.1 If the guardian/substitute decision-maker of a dependent adult refuses treatment on their behalf, the guardian/SDM should be asked to sign the "Refusal of Medical Treatment Against Advice" form.
    5.8.2 If the clinician believes the refused treatment to be essential to the health and wellbeing of the dependent adult, the clinician must consult Family Services. The clinician must notify the guardian/SDM of the intended consultation.
    5.8.3 If the guardian/SDM is not present or able to be immediately contacted, and there exists imminent threat to life, health, or limb, the clinician has a duty to intervene. The guardian/SDM should be contacted as soon as possible, but provision of lifesaving treatment should not be delayed unless where the clinician has reason to believe that the client would not consent to the planned treatment.
    5.8.4 A guardian/SDM cannot consent to certain treatments, such as psychosurgery, electroconvulsive therapy, sterilization that is not medically necessary, or the removal of organs for the purposes of donation or research. If an adult cannot personally give or

refuse consent to any of these treatments, the clinician cannot proceed without obtaining a court order.

5.9 In rare circumstances, disease control measures such as examination, isolation, and quarantine, might be imposed upon a client without their consent. This would only occur pursuant to an Order of the Chief Public Health Officer. The Chief Public Health Officer may seek an apprehension and treatment order from the Court in circumstances where the burden of risk to client and community outweighs the restriction of the client's individual rights and freedoms.

5.10 There may be instances when a treatment is court-ordered, and adherence by the client is compulsory.

5.11 The clinician must document the following:

5.11.1 A description of the client's current health situation and proposed treatment
5.11.2 Client's reason for refusal of treatment, in their own words
5.11.3 A summary of the discussion had with client about benefits of treatment and potential consequences of refusing
5.11.4 Any consultations that occurred with a physician or NP
5.11.5 Treatments accepted by the client
5.11.6 Education provided to client on reasons to return to health centre or hospital
5.11.7 Any planned follow-up appointments
5.11.8 That the client was informed they may choose to accept treatment and return to the health centre or hospital at any time.
5.11.9 A signed "Refusal of Medical Treatment Against Advice" form if client consents to signing. If the client refuses to sign, this should be documented.
5.11.10 Presence of interpreter if interpreter services were used.

5.12 Procedure must be repeated at each subsequent visit for the same health concern if the client continues to exercise their right to refuse treatment.

6. RELATED POLICIES, PROTOCOLS AND LEGISLATION:

Documentation Standard	Policy 06-008-00
Documentation Standard	Guideline 06-008-01
Child Welfare	Policy 06-016-00
Procedure for Reporting to the Child Protection Worker	Guideline 06-16-01
Non-Urgent Evacuation of Obstetrical Clients	Policy 07-023-00
Non-Urgent Evacuation of Obstetrical Clients	Guideline 07-023-01
Interpreter Services	Policy 06-013-00
Interpreter Services Guidelines	Guideline 06-013-01
Public Health Act	

7. REFERENCES:

Canadian Nurses Protective Society. (2018 Jun). *Consent to treatment: The role of the nurse*. Retrieved from: https://cnps.ca/article/consent-to-treatment/

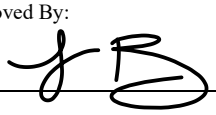
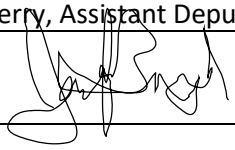
Canadian Medical Protective Association. (2016 Jun). *Consent: A guide for Canadian physicians.* 4th Ed. Retrieved from: https://www.cmpa-acpm.ca/en/advice-publications/handbooks/consent-a-guide-for-canadian-physicians#Informed%20refusal

Canadian Pediatric Society. (2018 Apr 12). *Medical decision-making in pediatrics: Infancy to adolescents.* Retrieved from: https://www.cps.ca/en/documents/position/medical-decision-making-in-paediatrics-infancy-to-adolescence

8. APPENDICES:

A. Refusal of Medical Treatment Against Advice form
B. Refusal of Medical Treatment on Behalf of a Minor or Dependent Adult Against Advice form

9. APPROVALS:

Approved By: 	Date: May 18, 2021
Jennifer Berry, Assistant Deputy Minister – Department of Health	
Approved By: 	Date: May 20, 2021
Jenifer Bujold, Chief Nursing Officer	
Approved By:	Date:
Dr. Francois de Wet, Medical Chief of Staff, on behalf of the Medical Advisory Committee	

Refusal of Medical Treatment Against Advice

Patient Name: ______________________________

Date of Birth: ______________________________

Health Care Number: __________________________

I, ____ acknowledge that I voluntarily refuse the below
patient name

listed medical evaluation and treatment at ____.
hospital/health centre

1. I have been advised by ______________________________________ that medical care on my
healthcare provider

   behalf is necessary, specifically:

   ☐ Diagnostic tests (list): ____
   ____
   ☐ Medical treatments (list): ____
   ____
   ☐ Transfer to another facility (specify): ____
   ____

2. I understand that refusal of this medical care and assistance could be hazardous to my health, and under certain circumstances, lead to disability or death.

3. I have considered the options presented to me, and, having been informed of the potential risks, have decided to refuse medical treatment at this time.

4. If I change my mind, I will return to the hospital or health centre as soon as possible.

5. By signing this form, I release the Government of Nunavut and the treating health care providers of any liability or medical claims resulting from my decision to refuse treatment against medical advice.

In signing, I confirm that I have read and understand this information and the release of liability.

_____	_____	_____
Signature of Patient	**Print Name**	**Date**
_____	_____	_____
Signature of Witness	**Print Name**	**Date**
_____	_____	_____
Signature of Interpreter	**Print Name**	**Date**

☐ I, _____confirm that I have reviewed the information above with
healthcare provider
the above-named patient. The patient refused to sign the Refusal of Medical Treatment Against Advice form.

_____	_____	_____
Signature of Provider	**Print Name**	**Date**
_____	_____	_____
Signature of Witness	**Print Name**	**Date**
_____	_____	_____
Signature of Interpreter	**Print Name**	**Date**

ᐋᓐᓂᐊᕐᕕᖕᒥ ᐃᓱᐊᖅᓴᖅᑕᐅᓂᐊᖅᑐᖅ ᐅᖃᐅᔾᔪᖅᑕᐅᔪᒪᙱᑦᑐᖅ

ᐋᓐᓂᐊᕐᕕᓕᐊᖅᑰᑉ ᐊᑎᖓ: ______________________________

ᐃᓅᖅᕕᖓᑕ ᐅᓪᓗᖓ: ______________________________

ᐋᓐᓂᐊᕕᓕᐊᕈᓐᓇᐅᑖ: ______________________________

ᐅᕙᖓ, ______________________________ ᓇᓗᓇᐃᖅᓯᕗᖓ ᐃᓱᒪᖅᓱᖅᓱᖓ ᐊᑖᓂ ᑎᑎᕋᖅᓯᒪᔪᖅ ᐋᒃᑳᕋᒃᑯ
ᐋᓐᓂᐊᕕᓕᐊᖅᑰᑉ ᐊᑎᖓ

ᐋᓐᓂᐊᕐᕕᖕᒥ ᖃᐅᔨᓴᖅᑕᐅᓂᕐᒧᑦ ᐃᓱᐊᖅᓴᖅᑕᐅᓂᕐᒧᓪᓗ ᐅᕙᓂ ______________________.
ᐋᓐᓂᐊᕕᐊᓗᖕᒥ/ᐋᓐᓂᐊᕕᖕᒥ

1. ᐆᒧᖓ ᐅᖃᐅᔾᔭᐅᖅᑲᐅᕗᖓ ______________________________ ᐋᓐᓂᐊᕕᖕᒥ ᑲᒪᕆᔭᐅᔭᕆᐊᖃᕐᓂᓐᓂᑦ
   ᐃᓱᐊᖅᓴᐃᔨᒧ

   ᐅᓇ ᐱᔾᔪᑎᒋᓗᐊᖅᓱᒍ:

   ☐ ᖃᐅᔨᓴᖅᑕᐅᔭᖅᑐᕐᓗᖓ (ᑎᑎᕋᕐᓗᒍ): ______________________________
   ____
   ☐ ᐋᓐᓂᐊᕐᕕᖕᒥ ᐃᓱᐊᖅᓴᖅᑕᐅᓗᖓ (ᑎᑎᕋᕐᓗᒍ):
   ____
   ____
   ☐ ᐊᓯᐊᓄᑦ ᐋᓐᓂᐊᕕᖕᒧᐊᖅᑕᐅᓗᖓ (ᓇᓗᓇᐃᕐᓗᒍ): ______________________________
   ____

2. ᑐᑭᓯᕙᖓ ᐋᓐᓂᐊᕕᖕᒥ ᑲᒪᔩᔭᐅᔪᒪᙱᒃᑯᒪ ᐃᑲᔪᖅᑕᐅᔪᒪᙱᒃᑯᒪᓗ ᐃᓅᓯᓐᓄᑦ ᐅᓗᕆᐊᓇᕈᓐᓇᕐᒪᑦ, ᖃᓄᐃᓐᓇᕐᓗ ᐱᔾᔪᑎᖃᕐᓗᓂ, ᐊᔪᕈᑎᖃᓕᕈᓐᓇᖅᓱᖓ ᐃᓅᔪᓐᓃᕐᓗᖓᓘᓐᓃᑦ.

3. ᖃᓄᖅᑰᕈᑎᒃᓴᓂᒃ ᐅᕙᓐᓄᑦ ᐅᖃᐅᓯᐅᓚᐅᖅᑐᓂᒃ ᐃᓱᒪᒃᓴᖅᓯᐅᕈᑎᖃᓚᐅᖅᐳᖓ, ᐊᒻᒪᓗ, ᑐᓴᖅᑎᑕᐅᓚᐅᖅᓱᖓ ᐅᓗᕆᐊᓇᑐᐃᓐᓇᕆᐊᓕᖕᓂᒃ, ᒫᓐᓇᐅᔪᖅ ᐋᓂᐊᕕᖕᒥ ᐃᓱᐊᖅᓴᖅᑕᐅᔪᒪᙱᓐᓱᖓ ᐋᖅᑭᒃᓯᕗᖓ.

4. ᐃᓱᒪᒪ ᐊᓯᔾᔨᕈᒃᑯ, ᐋᓐᓂᐊᕕᐊᓗᖕᒧᑦ ᐋᓐᓂᐊᕕᖕᒧᓪᓘᓐᓃᑦ ᐅᑎᕐᓂᐊᖅᐳᖓ ᐊᔪᕈᓐᓃᑐᐊᕈᒪ.

5. ᐅᓇ ᑎᑎᕋᖅᓯᒪᔪᖅ ᐊᑎᓕᐅᕈᒃᑯ, ᓄᓇᕗᑦ ᒐᕙᒪᖓᓄᑦ ᓴᒃᑯᑎᓂᐊᖅᐳᖓ ᐊᒻᒪ ᐃᓱᐊᖅᓴᐃᓂᐊᖅᑐᑦ ᐋᓐᓂᐊᓯᐅᖅᑏᑦ ᖃᓄᐃᓐᓇᖅ ᐸᓯᔭᐅᔪᓐᓇᕐᓂᖏᓐᓂᒃ ᐅᕝᕙᓘᓐᓃᑦ ᐋᓐᓂᐊᕐᕕᖕᒥ ᐊᑭᓕᒃᓴᒥᑦ ᐋᓐᓂᐊᕐᕕᖕᒥ ᐅᖃᐅᔾᔪᖅᑕᐅᔪᒪᙱᓐᓱᖓ ᐋᖅᑭᒃᓯᓂᓐᓄᑦ.

ᐊᑎᓕᐅᕈᒃᑯ, ᓇᓗᓇᐃᖅᓯᔾᔪᖓ ᐅᖃᓕᒫᕐᓂᓐᓂ ᑐᑭᓯᓪᓗᑎᓪᓗ ᑖᒃᑯᐊ ᑎᑎᕋᖅᓯᒪᔪ ᐊᒻᒪ ᓴᒃᑯᑦᑎᔾᔪᖓ ᐸᓯᔭᐅᔪᓐᓇᕐᓂᕐᒥᒃ.

______________________________ ________________________ ____________________

ᐋᓐᓂᐊᕐᕕᓕᐊᖅᑑᑉ ᐊᑎᓕᐅᕈᓯᖓ   ᐊᑏᑦ ᑎᑎᕋᕐᓗᒍ   ᐅᓪᓗᖓ

______________________________ ________________________ ____________________

ᑕᐅᑦᑎᒋᔭᐅᔪᑉ ᐊᑎᓕᐅᕈᓯᖓ   ᐊᑏᑦ ᑎᑎᕋᕐᓗᒍ   ᐅᓪᓗᖓ

______________________________ ________________________ ____________________

ᑐᓵᔨᐅᑉ ᐊᑎᓕᐅᕈᓯᖓ   ᐊᑏᑦ ᑎᑎᕋᕐᓗᒍ   ᐅᓪᓗᖓ

☐ ᐅᕙᖓ, ___________________________________ᓇᓗᓇᐃᖅᓯᔾᔪᖓ ᖁᕝᕙᓂ ᑎᑎᕋᖅᓯᒪᔪᓂᑦ ᕿᒥᕐᕈᖅᑲᑎᒋᖅᑲᐅᓚᒃᑯ
ᐃᓄᐊᖅᓴᐃᔨ
ᖁᕝᕙᓂ ᐊᑎᕐᑲᖅᑐᖅ ᐋᓐᓂᐊᕐᕕᓕᐊᖅᑐᖅ. ᐋᓐᓂᐊᕐᕕᓕᐊᖅᑐᖅ ᐊᑎᓕᐅᕈᒪᖅᑲᐅᙱᑦᑐᖅ ᐋᓐᓂᐊᕕᖕᒥ ᐃᓄᐊᖅᓴᖅᑕᐅᓂᐊᖅᑐᒧᑦ ᐅᖃᐅᔾᔭᖅᑕᐅᔭᒪᙱᔾᔭᑎᒥᒃ.

______________________________ ________________________ ____________________

ᐃᓄᐊᖅᓴᐃᔨᐅᑉ ᐊᑎᓕᐅᕈᓯᖓ   ᐊᑏᑦ ᑎᑎᕋᕐᓗᒍ   ᐅᓪᓗᖓ

______________________________ ________________________ ____________________

ᑕᐅᑦᑎᒋᔭᐅᔪᑉ ᐊᑎᓕᐅᕈᓯᖓ   ᐊᑏᑦ ᑎᑎᕋᕐᓗᒍ   ᐅᓪᓗᖓ

______________________________ ________________________ ____________________

ᑐᓵᔨᐅᑉ ᐊᑎᓕᐅᕈᓯᖓ   ᐊᑏᑦ ᑎᑎᕋᕐᓗᒍ   ᐅᓪᓗᖓ

Qingiyauyuq Aanniarnikkut Havautikhainnik Uqautiyugaluaq

Aan**niaqtuq Atia:**___________________________________

Ublua Inuuvia: ___________________________________

Aaniaqtailinirmun Napaa

Uvanga,____ angigiikhimayunga uvamnik ihumaliuqhimayunga qingiuyunga titiraqhimayut ataani

Aanniaqtuq Atia

titiraqhimayuq havautikhat ihivriuqtauhimayut mamitirutikharnik talvani______________________________

aanniarvit/munarhitkut

1. Uqaudjiuvakhimayunga talvanga ___________________________________havautikhaq munagidjutikhanga talvani piutigiyangani

   munarhi ikayukhimaaqtuq

   talvanga atuquyauyuq, naunaiyattiaqhimayut:

   ☐ Ihivriuqtauhimayut Naunaiyaqhimayut (titiraqhimayut):
   ____
   ____

   ☐ Havautikharnik mamitirutikhat (titiraqhimayut:
   ____
   ____

   ☐ Nuutukhauyuq allanun aanniarvingmun (naunaiqlugu):
   ____
   ____

2. Ilihimayunga qingiyauyunga uminga havautikharnik munagidjutikharnik ikayuutikharnik amingnarmanik inuuhimnun, talvuuna mikhaatigun, ayungnautiqarniaqtunga huirniaqtungaluuniit.

3. Ihumaliuqhimayunga pidjutikharnik aituqtauhimayut uvamnun, naunaiyattiaqhimagama ayungnautiqaqtunik, ihumaliuqhimayut qingiyunga havautikharnik tadjanuaq.

4. Ihumaliuffaarmigumik, utirniaqtunga aanniarvikmun munarhitkununluunii qilaminuaq.

5. Atiliugungni una titiraq, atuquyunga Nunavut Kavamanga havautikharnik munarhitkut akiliktuilimaitun havautikharnik akiliktuilimaitun talvuuna ihumaliuyagiikhimayamnik qingiyaangat havautikharnik talvanga munarhit taaktit uqaudjiyainik.

Atiliugupku, angigiikhimayunga taiguqtaga ilihimayungalu una naunaiyagiikhimayuq tautuktitiyaangat allanun akilirialgiit.

_____ _____ _____

Atiliurvikha Aanniaqtuq **Titirattiarlugu Atiit**
Ublua

_____ _____ _____

Atiliurvia Tautuktup **Titirattiarlugu Atiit** **Ublua**

_____ _____ _____

Atiliuqhimayuq Uqaqtiuyi **Titirattiarlugu Atiit** **Ublua**

☐ Uvanga, _____naunaiyagiikhimayuq ihivriuqpakhimayaga naunaiqhimayut titirat qulaani umingalu

munarhi ikayukhimaaqtuq

qulaani atia aanniaqhimayuq. Aanniaqtum qingiyuq atiliugianganik Qingihimayuq Havautikharnik Havautitugumangituq talvanga Uqaudjihimayunin

titirakhaq.

_____ _____ _____

Atiliuqtangit Munarhi **Titirattiarlugu Atiit** **Ublua**

_____ _____ _____

Atiliurvia Tautuktup **Titirattiarlugu Atiit** **Ublua**

_____ _____ _____

Atiliuqhimayuq Uqaqtiuyi **Titirattiarlugu Atiit** **Ublua**

ᑲᑎᒪᔨᑦ ᓄᓇᕗᑦ ᐱᖃᓐᓇᕐᓂᖅᓄᑦ
Building Nunavut Together
Nunavuliuqatigiingniq
Bâtir le Nunavut ensemble

Refus d'un traitement médical contre avis

Nom du patient : _____

Date de naissance : _____

Numéro d'assurance maladie : _____

Je, _____ reconnais que je refuse volontairement
nom du patient

l'évaluation et le traitement médical énumérés ci-dessous à _____.
l'hôpital/au centre de santé

1. J'ai été informé par _____ que des soins médicaux
fournisseur de soins de santé
sur ma personne sont nécessaires, en particulier :

   ☐ Tests de diagnostic (liste) : _____
   _____
   ☐ Traitements médicaux (liste) : _____
   _____
   ☐ Transfert vers un autre établissement (précisez) : _____
   _____

2. Je comprends que le refus de cette assistance et de ces soins médicaux pourrait être dangereux pour ma santé et, dans certaines circonstances, entraîner une invalidité ou la mort.

3. J'ai examiné les options qui m'ont été présentées et, après avoir été informé des risques, j'ai décidé de refuser tout traitement médical pour le moment.

4. Si je change d'avis, je retournerai à l'hôpital ou au centre de santé dès que possible.

5. En signant ce formulaire, je dégage le gouvernement du Nunavut et les fournisseurs de soins de santé concernés de toute responsabilité ou réclamation médicale résultant de ma décision de refuser un traitement contre avis médical.

En signant la présente, je confirme que j'ai lu et compris ces informations et la décharge de responsabilité.

_____	_____	_____
Signature du patient	**Nom (caractères d'imprimerie)**	**Date**
_____	_____	_____
Signature du témoin	**Nom (caractères d'imprimerie)**	**Date**
_____	_____	_____
Signature de l'interprète	**Nom (caractères d'imprimerie)**	**Date**

☐ Je, _____confirme que j'ai passé en revue les informations
fournisseur de soins de santé
ci-dessus avec le patient susmentionné. Le patient a refusé de signer le Refus de traitement médical contre avis.

Formulaire :

_____	_____	_____
Signature du fournisseur de soins de santé	**Nom (caractères d'imprimerie)**	**Date**
_____	_____	_____
Signature du témoin	**Nom (caractères d'imprimerie)**	**Date**
_____	_____	_____
Signature de l'interprète	**Nom (caractères d'imprimerie)**	**Date**

ᑲᑐᑎᓪᓗᒍ ᓄᓇᕗᑦ ᐱᕈᖅᐸᓪᓚᐊᑎᓪᓗᒍ
Building Nunavut Together
Nunavuliuqatigiingniq
Bâtir le Nunavut ensemble

Refusal of Medical Treatment on Behalf of Minor or Dependent Adult Against Advice

Patient Name: ________________________________

Date of Birth: ________________________________

Health Care Number: ____________________________

I, ____ acknowledge that I voluntarily refuse the below
name of parent, legal guardian or substitute decision maker

listed medical evaluation and treatment at ____ on
hospital/health centre

behalf of ____ , who is:
name of patient

☐ a child younger than 19 years of age for whom I am the custodial parent or legal guardian

☐ a dependent adult of whom I have substitute decision-making authority

1. I have the legal authority to make medical treatment decisions for the above-named person.
2. I have been advised by ______________________________________ that medical care is necessary for the above named person, specifically:
   ☐ Diagnostic tests (list): ____
   ____
   ☐ Medical treatments (list): ____
   ____
   ☐ Transfer to another facility (specify): ____
   ____
3. I understand that refusal of this medical care and assistance could be hazardous to their health, and under certain circumstances, lead to disability or death.
4. I have consulted with the above-named person and their other parent or caregiver (where appropriate; and
5. I have considered the options presented, and, having been informed of the potential risks, have decided to refuse medical treatment for the above-named person at this time.
6. If I change my mind, I will return with the above-named person to the hospital or health centre as soon as possible.
7. I understand that healthcare providers may be required contact the Department of Family Services concerning this matter.

Patient Name:
Date of Birth:
Health Care Number:

8. By signing this form, I release the Government of Nunavut and the treating health care providers of any liability or medical claims resulting from my decision to refuse treatment for the above-named person against medical advice.

In signing, I confirm that I have read and understand this information and the release of liability.

_____	_____	_____
Signature of Parent, Guardian Substitute Decision Maker	**Print Name**	**Date**
_____	_____	_____
Signature of Witness	**Print Name**	**Date**
_____	_____	_____
Signature of Intepreter	**Print Name**	**Date**

☐ I, _____confirm that I have reviewed the information above with
healthcare provider
the above-named parent/guardian/substitute decision maker. The parent/guardian/substitute decision maker refused to sign the Refusal of Medical Treatment Against Advice form.

_____	_____	_____
Signature of Provider	**Print Name**	**Date**
_____	_____	_____
Signature of Witness	**Print Name**	**Date**
_____	_____	_____
Signature of Interpreter	**Print Name**	**Date**

ᐋᓐᓂᐊᕐᕕᖕᒥ ᐃᓗᐊᖅᓴᖅᑕᐅᓂᐊᖅᑐᖅ ᐅᖃᐅᕝᕕᖅᑕᐅᔪᒪᙱᑦᑐᖅ ᕿᒡᒐᖅᑐᖅᓗᒍ ᐅᑭᐅᑭᑦᑐᖅ ᐅᕝᕙᓘᓐᓃᑦ ᕿᑐᙵᒐᓚᐅᔪᖅ ᐃᓐᓇᐅᓪᓗᓂ

ᐋᓐᓂᐊᕙᓕᐊᖅᑑᑉ ᐊᑎᖓ: ______________________________

ᐃᓅᕝᕕᖓᑕ ᐅᓪᓗᖓ: ______________________________

ᐋᓐᓂᐊᕙᓕᐊᕈᓐᓇᐅᑖ: ______________________________

ᐅᕙᖓ, ______________________________ ᓇᓗᓇᐃᖅᓯᕗᖓ ᐃᓱᒪᖅᓱᖅᓗᖓ ᐊᑖᓂ ᑎᑎᕋᖅᓯᒪᔪᖅ ᐋᒃᑳᕋᒃᑯ
ᐊᖓᔪᖅᑳᕆᔭᐅᔪᖅ, ᐸᖅᑭᖏᔭᐅᔪᖅ ᐅᕝᕙᓘᓐᓃᑦ ᐃᓱᒪᓕᐅᕆᔩᐅᖔᖅᑐᖅ

ᐋᓐᓂᐊᕐᕕᖕᒥ ᖃᐅᔨᓴᖅᑕᐅᓂᐊᖅᑐᖅ ᐃᓗᐊᖅᓴᖅᑕᐅᓂᐊᖅᑐᕐᓗ ᐅᕙᓂ ______________________________
ᐋᓐᓂᐊᕙᐊᓗᖕᒥ/ᐋᓐᓂᐊᕕᖕᒥ

ᐆᒥᖓ ᕿᒡᒐᖅᑐᐃᓪᓗᓂ ______________________________ , ᐃᒪᐃᑦᑐᖅ:
ᐋᓐᓂᐊᕙᓕᐊᖅᑑᑉ ᐊᑎᖓ

☐ ᓄᑕᕋᖅ 19 ᑐᖒᓂ ᐅᑭᐅᓕᒃ ᐊᖓᔪᖅᑳᕆᔭᐅᓪᓗᖓ ᐸᖅᑭᖏᔭᐅᓪᓗᖓᓘᓐᓃᑦ

☐ ᕿᑐᙵᒐᓚᐅᔪᖅ ᐃᓐᓇᖅ ᐃᓱᒪᓕᐅᖔᕈᓐᓇᖅᑎᑕᐅᓪᓗᖓ

1. ᐱᔪᓐᓇᐅᑎᖃᖅᐳᖓ ᐋᓐᓂᐊᕐᕕᖕᒥ ᐃᓗᐊᖅᓴᖅᑕᐅᓂᐊᖅᑐᒧᑦ ᐃᓱᒪᓕᐅᕆᔪᓐᓇᖅᓱᖓ ᖁᓚᓂ ᐊᑎᓕᐅᖅᓯᒪᔪᒧᑦ.
2. ᐆᒧᖓ ᐅᖃᐅᔾᔭᐅᓚᐅᖅᐳᖓ ______________________ ᐋᓐᓂᐊᕐᕕᖕᒥ ᑲᒪᒋᔭᐅᔭᕆᐊᖃᕐᒪᑦ ᖁᓚᓂ ᐊᑎᖓ ᑎᑎᕋᖅᓯᒪᔪᖅ, ᐱᔾᔪᑎᒋᓗᐊᖅᓱᒍ:
   ☐ ᖃᐅᔨᓴᖅᑕᐅᔭᖅᑐᕐᓗᓂ (ᑎᑎᕋᕐᓗᒍ): ______________________
   ____
   ☐ ᐋᓐᓂᐊᕐᕕᖕᒥ ᐃᓗᐊᖅᓴᖅᑕᐅᓗᓂ (ᑎᑎᕋᕐᓗᒍ): ______________________
   ____
   ☐ ᐊᓯᐊᓄᑦ ᐋᓐᓂᐊᕕᖕᒧᐊᖅᑕᐅᓗᓂ (ᓇᓗᓇᐃᕐᓗᒍ): ______________________
   ____
3. ᑐᑭᓯᔪᖓ ᐋᓐᓂᐊᕕᖕᒥ ᑲᒪᒋᔭᐅᔪᒪᙱᑉᐸᑦ ᐃᑲᔪᖅᑕᐅᔪᒪᙱᑉᐸᓘᓐᓃᑦ ᐃᓅᓯᖓ ᐅᓗᕆᐊᓇᖅᑑᒥᓕᕈᓐᓇᕐᒪᑦ, ᖃᓄᑐᐃᓐᓇᕐᓗ ᐱᔾᔪᑎᖃᕐᓗᓂ, ᐊᔪᕈᑎᖃᓕᕈᓐᓇᕐᒪᑦ ᐃᓅᔪᓐᓂᕐᓗᓂᓘᓐᓃᑦ.
4. ᐅᖃᖃᑎᒋᓚᐅᖅᐸᕋ ᖁᓚᓂ ᐊᑎᓕᐅᖅᓯᒪᔪᖅ ᐊᓯᖏᓪᓗ ᐊᖓᔪᖅᑳᕆᔭᐅᔪᑦ ᑲᒪᔩᖏᔭᐅᔪᕐᓘᓐᓃᑦ (ᐱᔭᕆᐊᖃᖅᐸᑦ); ᐊᒻᒪᓗ
5. ᖃᓄᖅᑑᕈᑎᒃᓴᓂᒃ ᐅᕙᓐᓄᑦ ᐅᖃᐅᓯᐅᓚᐅᖅᑐᓂᒃ ᐃᓱᒪᒃᓴᖅᓯᐅᕈᑎᖃᓚᐅᖅᐳᖓ, ᐊᒻᒪᓗ, ᑐᓴᖅᑎᑕᐅᓚᐅᖅᓱᖓ ᐅᓗᕆᐊᓇᑐᐃᓐᓇᕆᐊᓕᖓᓂᒃ, ᒫᓐᓇᐅᔪᖅ ᐋᓂᐊᕕᖕᒥ ᐃᓗᐊᖅᓴᖅᑕᐅᔪᒪᙱᖕᓗᓂ ᖁᓚᓂ ᐊᑎᓕᐅᖅᓯᒪᔪᖅ ᐋᖅᑭᒃᓯᕗᖅ.
6. ᐃᓱᒪᒐ ᐊᓯᔾᔨᕈᒃᑯ, ᐋᓐᓂᐊᕕᐊᓗᖕᒧᑦ ᐋᓐᓂᐊᕕᖕᒧᓪᓘᓐᓃᑦ ᖁᓚᓂ ᐊᑎᖃᖅᑐᖅ ᐅᑎᖃᑎᒋᓂᐊᖅᐸᕋ ᐊᔪᕿᓇᕈᓐᓃᑐᐊᖅᐸᑦ.
7. ᑐᑭᓯᔪᖓ ᐋᓂᐊᓯᐅᖅᑏᑦ ᐃᓄᓕᓇᔾᑯᓐᓂ ᑐᓴᖅᑎᑦᑎᔭᓇᐊᖃᑐᐃᓐᓇᓇᐊᖃᖅᑲᑕ ᑕᒪᓐᓇ ᐱᔾᔪᑎᒋᓪᓗᒍ.
8. ᐅᓇ ᑎᑎᕋᖅᓯᒪᔪᖅ ᐊᑎᓕᐅᕈᒃᑯ, ᓄᓇᕗᑦ ᒐᕙᒪᖓᓄᑦ ᓴᒃᑯᑎᓂᐊᖅᐳᖓ ᐊᒻᒪ ᐃᓗᐊᖅᓴᐃᓂᐊᖅᑐᑦ ᐋᓐᓂᐊᓯᐅᖅᑏᑦ ᖃᓄᑐᐃᓐᓇᖅ ᐸᓯᔭᐅᔪᓐᓇᕐᓂᕐᒋᓐᓂᒃ ᐅᕝᕙᓘᓐᓃᑦ ᐋᓐᓂᐊᕐᕕᖕᒥ ᐊᑭᓕᒃᓴᒥᑦ ᐋᖅᑭᒃᓯᓂᓐᓄᑦ ᐋᓐᓂᐊᕐᕕᖕᒥ ᐃᓗᐊᖅᓴᖅᑕᐅᓂᐊᖅᑐᖅ ᐅᖃᐅᔾᔭᖅᑕᐅᔪᒪᙱᕐᓗᓂ ᖁᓚᓂ ᐊᑎᓕᐅᖅᓯᒪᔪᖅ.

ᐋᓐᓂᐊᕕᓕᐊᖅᑑᑉ ᐊᑎᖓ:
ᐃᓘᕝᕕᐊ:
ᐋᓐᓂᐊᕕᓕᐊᕈᓐᓇᐅᑖ;

ᐊᑎᓕᐅᕈᑦᑯ, ᓇᓗᓇᐃᖅᓯᔾᔪᖓ ᐅᖃᓕᒫᕐᓂᖕᓂ ᑐᑭᓯᓪᓗᒋᓪᓗ ᑖᒃᑯᐊ ᑎᑎᕋᖅᓯᒪᔪ ᐊᒻᒪ ᓴᒃᑯᑦᑎᔾᔪᖓ ᐸᓯᔭᐅᔪᓐᓇᕐᓂᕐᒥᒃ.

______________________	______________________	______________________
ᐊᖓᔪᖅᑳᕆᔭᑉ, ᐸᖅᑭᔨᐅᑉ ᐊᑎᓕᐅᕈᓯᖓ ᐃᓱᒪᓕᐅᕆᔨᐅᖕᒫᖅᑐᖅ	ᐊᑏᑦ ᑎᑎᕋᕐᓗᒍ	ᐅᓪᓗᖓ
______________________	______________________	______________________
ᑕᐅᑦᑎᓯᔨᐅᔫᑉ ᐊᑎᓕᐅᕈᓯᖓ	ᐊᑏᑦ ᑎᑎᕋᕐᓗᒍ	ᐅᓪᓗᖓ
______________________	______________________	______________________
ᑑᓵᔨᐅᑉ ᐊᑎᓕᐅᕈᓯᖓ	ᐊᑏᑦ ᑎᑎᕋᕐᓗᒍ	ᐅᓪᓗᖓ

☐ ᐅᕙᖓ, ______________________________ ᓇᓗᓇᐃᖅᓯᔾᔪᖓ ᖁᑕᓂ ᑎᑎᕋᖅᓯᒪᔪᑦ ᕿᒥᕐᕈᖅᑲᐅᓚᑦᑎᒍᑦ
ᐃᓅᐊᖅᓴᐃᔨᒐᓗ
ᖁᑕᓂ ᐊᑎᓕᐅᖅᓯᒪᔪᕐᓗ ᐊᖓᔪᖅᑳᕆᔭᐅᔪᖅ/ᐸᖅᑭᔨᕆᔭᐅᔪᖅ/ᐃᓱᒪᓕᐅᕆᔨᐅᖕᒫᖅᑐᖅ.
ᐊᖓᖅᔪᖅᑳᕆᔭᐅᔪᖅ/ᐸᖅᑭᔨᕆᔭᐅᔪᖅ/ᐃᓱᒪᓕᐅᕆᔨᐅᖕᒫᖅᑐᖅ ᐊᑎᓕᐅᕈᒪᓚᐅᙱᓪᒪᑦ ᐋᓐᓂᐊᕕᖕᒥ ᐃᓅᐊᖅᓴᖅᑕᐅᓂᐊᖅᑐᖅ ᐅᖃᐅᔾᔭᖅᑕᐅᔭᒪᙱᔾᔭᑎᒥᒃ.

______________________	______________________	______________________
ᐃᓅᐊᖅᓴᐃᔨᐅᑉ ᐊᑎᓕᐅᕈᓯᖓ	ᐊᑏᑦ ᑎᑎᕋᕐᓗᒍ	ᐅᓪᓗᖓ
______________________	______________________	______________________
ᑕᐅᑦᑎᓯᔨᐅᔫᑉ ᐊᑎᓕᐅᕈᓯᖓ	ᐊᑏᑦ ᑎᑎᕋᕐᓗᒍ	ᐅᓪᓗᖓ
______________________	______________________	______________________
ᑑᓵᔨᐅᑉ ᐊᑎᓕᐅᕈᓯᖓ	ᐊᑏᑦ ᑎᑎᕋᕐᓗᒍ	ᐅᓪᓗᖓ

Qingiyauyuq Aanniarnikkut Havautikhainnik Iningniungitunik Munagiyauyunikluuniit Iningnirmin talvanga Uqautiyugaluaq

Aanniaqtuq Atia:___________________________________

Ublua Inuuvia: ___________________________________

Aaniaqtailinirmun Napaa

Uvanga,____ angigiikhimayunga uvamnik ihumaliuqhimayunga qingiuyunga titiraqhimayut ataani

Atia angajuqqaaq, munaqtiuyuq allanikluuniit ihumaliuqtiuyuq munagiyainik

titiraqhimayuq havautikhat ihivriuqtauhimayut mamitirutikharnik talvani______________________________ talvuuna

aanniarvit/munarhitkut

pidjutigiplugit ____ tamnauyuq:

Atia Anniaqtup

☐ nutaraq nukakhitqiyaq 19nik ukiuqangituq taima angayuqaanguyunga munaqtiuyungaluuniit

☐ munagihimaaqtaqqut iningniq taima ihumaliuqtiuyunga munagiyamnik

1. Maligaliqinikkut akhurutiqaqtunga aanniaqtun havautikharnik ihumaliuqtukhauyunga atia titiaqhimayunun qulaani.
2. Uqaudjiyauyunga tapfuminga _____________________________________havautikharnik munagidjutikhainik qulaani atia titiraqhimayuq, naunaiyattiaqhimayuq:

   ☐ Ihivriuqtauhimayut Naunaiyaqhimayut (titiraqhimayut):

   ____

   ____

   ☐ Havautikharnik mamitirutikhat (titiraqhimayut:

   ____

   ____

   ☐ Nuutukhauyuq allanun aanniarvingmun (naunaiqlugu):

   ____

   ____
3. Ilihimayunga qingiyauyunga uminga havautikharnik munagidjutikharnik ikayuutikharnik amingnarmanik inuuhimnun, talvuuna mikhaatigun, ayungnautiqarniaqtunga huirniaqtungaluuniit.

Aanniaqtuq Atia:
Ublua Annivia:
Aaniaqtailinirmun Napaa

4. Tutqikhaivakhimayunga tamna qulaani atia titiraqhimayuq inuk aipaitlu angajuqqaangit munaqtiuyutluuniit (ihuaqtumi itukhaq; unalu
5. Ihumaliuqhimayunga pidjutikharnik aituqtauhimayut uvamnun, naunaiyattiaqhimagama ayungnautiqaqtunik, ihumaliuqhimayut qingiyunga havautikharnik qulaani atia inuk titiraqtauhimayuq tadjanuaq.
6. Ihumaliuffaarmigumik, utirniaqtunga qulaani atia inuk titiraqtauhimayuq aanniarvikmun munarhitkununluunii qilaminuaq.
7. Ilihimayunga munarhit tunihimaaqtun munagidjutikharnik hivayagiaqaqtaat Havagviat Inulirijikkut ihumaginikkut una ihumagiyauyumik.

8. Atiliurnikkut una titiraq, aulatitigiaqaqtunga Nunavut Kavamanga munagihimaaqtun munarhitkut kitunikliqaak akiliktauyukharnik havautikharnik akiligiaqaqtunik talvani ihumaliuqhimayuni qingiyuniklu havautikharnik qaangani atia titiraqhimayuq talvanga havautikharnik uqaudjiyukharnik.

Atiliugupku, angigiikhimayunga taiguqtaga ilihimayungalu una naunaiyagiikhimayuq tautuktitiyaangat allanun akilirialgiit.

_____ _____ _____

Atiliurvikha Angajuqqaaq, Munaqtiuyuq Himautauyumin Ihumaliuqnikkut Ihumaliuqtimin Ublua **Titirattiarlugu Atiit**

_____ _____ _____

Atiliurvia Tautuktup **Titirattiarlugu Atiit** **Ublua**

_____ _____ _____

Atiliuqhimayuq Uqaqtiuyi Ublua **Titirattiarlugu Atiit**

☐ Uvanga, _____naunaiyagiikhimayuq ihivriuqpakhimayaga naunaiqhimayut titirat qulaani umingalu

munarhi ikayukhimaaqtuq

Qaangani atiq angajuqqaaq/munaqtiuyuq/himautikhaq ihumaliuqtiuyuq. Tamna

Aanniaqtuq Atia:
Ublua Annivia:
Aaniaqtailinirmun Napaa
angayuqaaq/munati/himautihimayuq ihumaliuqti

ihumaliuqtiuyuq anniaqtum qingiyuq atiliugianganik Qingihimayuq Havautikharnik Havautitugumangituq talvanga Uqaudjihimayunin titiraqharni.

_____	_____	_____
Atiliuqtangit Munarhi	**Titirattiarlugu Atiit**	**Ublua**
_____	_____	_____
Atiliurvia Tautuktup	**Titirattiarlugu Atiit**	**Ublua**
_____	_____	_____
Atiliuqhimayuq Uqaqtiuyi	**Titirattiarlugu Atiit**	
Ublua		

Refus d'un traitement médical au nom d'un mineur ou d'un adulte à charge contre avis

Nom du patient : ___________________________________

Date de naissance : ___________________________________

Numéro d'assurance maladie : ______________________________

Je, ____ reconnais que je refuse volontairement
nom du parent, du tuteur légal ou du mandataire spécial

l'évaluation et le traitement médical énumérés ci-dessous à ___________________________________au
l'hôpital/au centre de santé

nom de ____, qui est :
nom du patient

☐ un enfant âgé de moins de 19 ans dont je suis le parent ayant la garde ou le tuteur légal

☐ un adulte à charge pour lequel je dispose d'un pouvoir de décision au nom d'autrui

1. J'ai l'autorité légale de prendre les décisions relatives au traitement médical de la personne susmentionnée.
2. J'ai été informé par _______________________________________ que des soins médicaux sont nécessaires pour la personne susmentionnée, en particulier :
   ☐ Tests de diagnostic (liste) : ____
   ____
   ☐ Traitements médicaux (liste) : ____
   ____
   ☐ Transfert vers un autre établissement (précisez) : _____________________________________
   ____
3. Je comprends que le refus de cette assistance et de ces soins médicaux pourrait être dangereux pour sa santé et, dans certaines circonstances, entraîner une invalidité ou la mort.
4. J'ai consulté la personne susmentionnée et son autre parent ou fournisseur de soins (le cas échéant).
5. J'ai examiné les options qui ont été présentées et, après avoir été informé des risques, j'ai décidé de refuser tout traitement médical pour la personne susmentionnée pour le moment.
6. Si je change d'avis, je retournerai à l'hôpital ou au centre de santé avec la personne susmentionnée dès que possible.
7. Je comprends que les fournisseurs de soins de santé peuvent être tenus de contacter le ministère des Services à la famille à ce sujet.

Nom du patient :
Date de naissance :
Numéro d'assurance maladie :

8. En signant ce formulaire, je dégage le gouvernement du Nunavut et les fournisseurs de soins de santé concernés de toute responsabilité ou réclamation médicale résultant de ma décision de refuser un traitement pour la personne susmentionnée, et ce, contre avis médical.

En signant la présente, je confirme que j'ai lu et compris ces informations et la décharge de responsabilité.

_____	_____	_____
Signature du parent/tuteur Mandataire spécial	**Nom (caractères d'imprimerie)**	**Date**
_____	_____	_____
Signature du témoin	**Nom (caractères d'imprimerie)**	**Date**
_____	_____	_____
Signature de l'interprète	**Nom (caractères d'imprimerie)**	**Date**

☐ Je, _____confirme que j'ai passé en revue les informations
fournisseur de soins de santé

ci-dessus avec la personne susmentionnée/le tuteur/le mandataire spécial. Le parent/le tuteur/le mandataire spécial a refusé de signer le formulaire de Refus de traitement médical contre avis.

_____	_____	_____
Signature du fournisseur de soins de santé	**Nom (caractères d'imprimerie)**	**Date**
_____	_____	_____
Signature du témoin	**Nom (caractères d'imprimerie)**	**Date**
_____	_____	_____
Signature de l'interprète	**Nom (caractères d'imprimerie)**	**Date**

Department of Health Government of Nunavut	**Medical Directives and Delegation** **Community Health Nursing**	
TITLE:	**SECTION:**	**POLICY NUMBER:**
COVID-19 Allied Health Provider Notification of Results	Nursing Practice	07-040-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
May 1, 2021 / May 1, 2022		4

APPLIES TO:

Allied Health Care Providers (HCP) – specifically:

- Physiotherapy (PT)
- Occupational Therapy (OT)
- Speech Language Pathology (SLP)
- Audiologist
- Registered Dietician (RD)
- Respiratory Therapist (RT)

1. BACKGROUND:

COVID-19 is a novel coronavirus that was first detected in China in late 2019. On March 11, 2020, the World Health Organization declared COVID-19 a pandemic. Coronavirus infections are diagnosed through health care professionals in consultation with public health teams and guidance based on symptoms, typically confirmed through laboratory testing.

The outbreak response in Nunavut is requiring additional support and involvement of allied HCP. This *COVID-19 Allied Health Provider Notification of Results* directive is intended to 1) provide an authorizing mechanism for allied HCP as defined above to communicate COVID-19 laboratory testing results; 2) provide a procedural outline; and 3) provide standardized guidance related to communicating results, follow-up, and mandatory reporting.

Delegated authority for nurses is through other processes and directives. Community Health Nurses have the delegated authority to initiate COVID-19 testing as per policy 07-031-00. A separate *COVID-19 Laboratory Testing Authority* directive provides an authorizing mechanism for licensed practical nurses and registered nurses to initiate COVID-19 testing as well.

2. MEDICAL DIRECTIVE AND/OR DELEGATED PROCEDURE:

2.1 **The allied HCP can communicate COVID-19 results within specific circumstances as outlined in section 6.**

2.2 **This directive does not cover initiating or ordering testing for COVID-19. Registered Nurses and LPNs are permitted to initiate testing for COVID-19, according to the *COVID-19 Public Health Protocol* and requirements outlined in this medical directive.**

2.3 **This medical directive does not apply to any laboratory results other than for COVID-19 testing.**

3. Principles:

3.1 Allied HCPs are expected to practice withing their own level of competence and seek guidance from their supervisor, physician, or Nurse Practitioner as needed.

3.2 Guidelines do not replace clinical judgement. Management decisions must be individualized.

4. RECIPIENT PATIENTS:

4.1 Nunavummiut of all ages

5. AUTHORIZED IMPLEMENTERS:

5.1 Allied HCPs who possess the knowledge, skills, and abilities to communicate COVID-19 test results, and who possess the the specific training working within the Nunavut Virtual Public Health Nurse (VPHN) program for COVID-19.

5.2 Sub delegation to communicate a test result is **not** permitted to another regulated or non-regulated HCP who (1) are not listed in the directive/ delegation policy and (2) are not authorized to perform that procedure through other authorizing mechanisms like departmental policies, professional regulation acts and associations.

6. INDICATIONS AND CONTRAINDICATIONS:

6.1 The medical directive may be enacted when an allied HCP is working with the VPHN team and is required to communicate a COVID-19 test result to the client. The allied HCP must have completed/received additional training and support to communicate the COVID-19 test result.

7. DEFINITIONS:

Allied Health Care Provider (HCP): Physiotherapy (PT), Occupational Therapy (OT), Speech Language Pathologist (SLP), Audiologist, Registered Dietician (RD), Respiratory Therapist (RT).

8. PROCEDURE:

8.1 HCP onboarded on to VPHN team and Microsoft Teams outbreak-specific space
8.2 HCP receives directive-specific and general training
8.3 Throughout, HCP follows COVID-19 protocol & VPHN Processes
8.4 Assigned calls by VPHN Lead or supervisor via daily assignment sheet
8.5 Buddied with VPHN. If questions or issues arise, they reach out to that individual with questions.
8.6 Check COVID-tracker for laboratory results in yellow for Household assigned
8.7 Call clients as per assignment sheet
8.8 Confirm two patient identifiers when calling to do symptom check and when providing negative laboratory results. Strong education that negative results do not necessarily mean off isolation, still required to isolate.
8.9 Fill out daily monitoring form as per processes. Do not document in Meditech.
8.10 Update the COVID-tracker with date notified of the laboratory result and un-yellow the new lab result on the COVID-tracker
8.11 Strike through each household (HH_ assigned once call completed.

Practice Point: Remember that positives protect but negatives mean nothing beyond that day. Someone with COVID-19 is almost certain to test negative the day after their exposure, even if they're going to go on to develop COVID-19 and be infectious; the timing of the test matters. Even with a negative result, individuals are required to remain on isolation for 14 days after the exposure (longer in households with positive cases with ongoing exposure to someone who is infectious).

1. DOCUMENTATION:

1.1 HCPs must document communication of the results on the Daily Monitoring Form as directed by the VPHN training .

1.2 At minimum, the following must be documented:

i. Date, time, name, and designation of HCP.
ii. Result communicated
iii. Follow-up instructions to the patient
iv. Reference to this medical directive

2. RELATED POLICIES, PROTOCOLS AND LEGISLATION:

APPENDIX A: Decision-Making Model for Performing Additional Functions and Transferred Functions for Nurses (for information)

Appendix B: COVID-19 Public Health Protocol. Available here: https://www.gov.nu.ca/health/information/manuals-guidelines

CHN Manual Policy: Acknowledgement of Diagnostic Test Results
CHN Manual Policy: Follow up of Abnormal Diagnostic Test Results
CHN Manual Policy: Documentation Standard
https://www.gov.nu.ca/health/information/manuals-guidelines

3. REFERENCES:

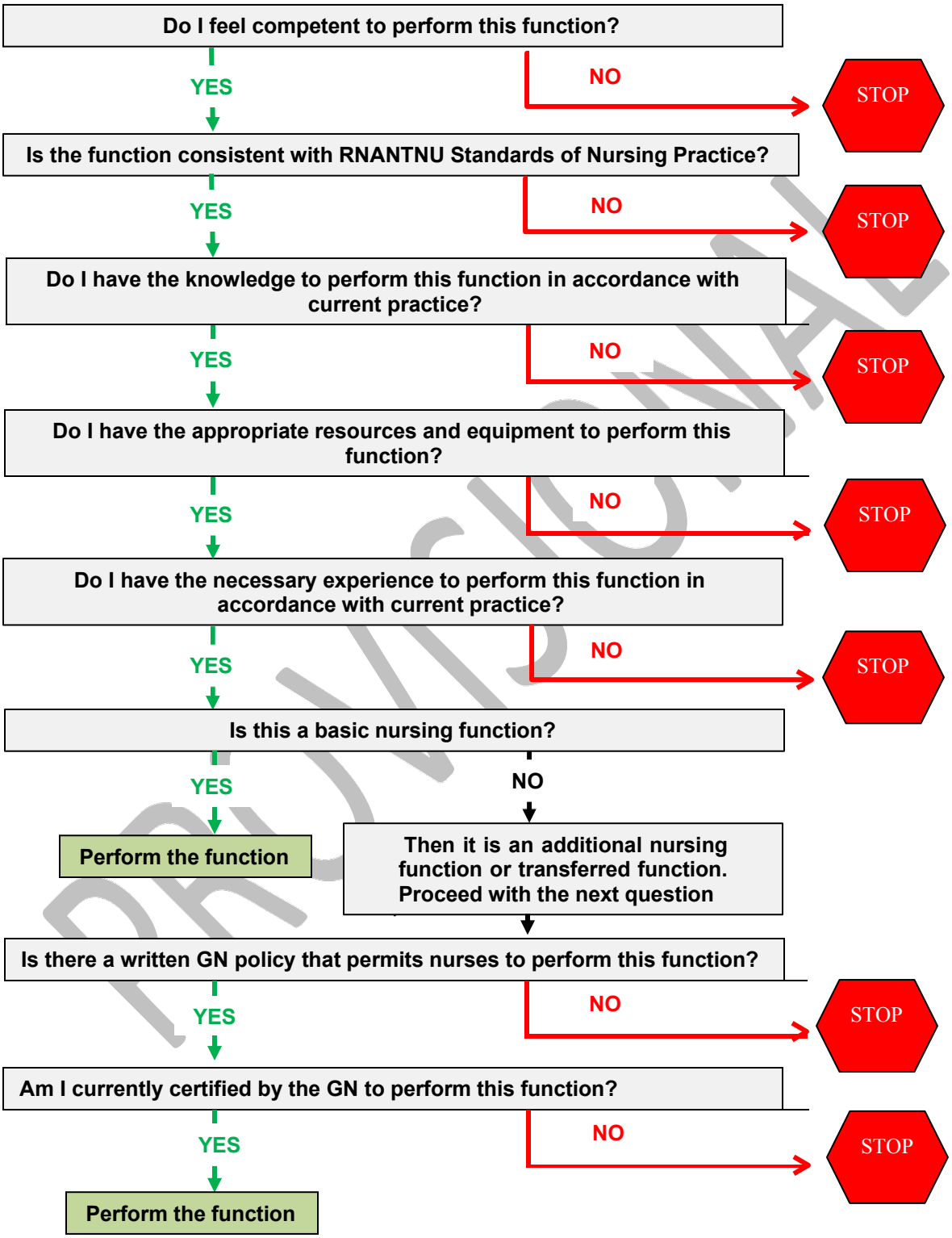
Government of Canada. (2020). https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection.html

World Health Organization. Coronavirus disease. https://www.who.int/emergencies/diseases/novel-coronavirus-2019/events-as-they-happen

4. APPROVALS:

Approved By:	Date: May 12, 2021
Jen Bujold, Acting Chief Nursing Officer – Department of Health	
Approved By:	Date: May 12, 2021
Jennifer Berry, ADM Operations – Department of Health	
Approved By: Digitally signed by Dr Francois de Wet DN: cn=Dr Francois de Wet, o=Government of Nunavut, ou, email=fdewet@gov.nu.ca, c=CA Date: 2021.05.13 11:12:49 -04'00'	Date:
Dr. Francois de Wet, Chief of Staff, on behalf of the Medical Advisory Committee	

APPENDIX A: DECISION-MAKING MODEL FOR PERFORMING ADDITIONAL FUNCTIONS AND TRANSFERRED FUNCTIONS



RNANT/NU (2010). *Scope of Practice for Registered Nurses*, p. 9

Department of Health Government of Nunavut	**Medical Directives and Delegation** **Community Health Nursing**		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Primary Care and Advanced Care Paramedic Medical Directive		Nursing Practice	07-040-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
June 29, 2021	June 29, 2022	**NEW**	12
APPLIES TO:			
Primary Care Paramedics, Advanced Care Paramedics			

1. BACKGROUND:

The Department of Health (Health) recognises the need to provide additional healthcare support to communities affected by Community Health Centre (CHC) critical nursing staff shortages which may otherwise significantly impact access to urgent and emergent clinical services. In honouring Qanuqtuurniq and Piliriqatigiinniq Health has determined that the deployment of Primary Care Paramedics (PCPs) and Advanced Care Paramedics (ACPs) is an effective and efficient solution to meeting the needs of communities impacted by staffing shortages.

PCPs and ACPs will work within the CHC and report to the Supervisor of Community Health Programs (SCHP) or delegate. They will work under the clinical direction of the registered nurse (RN), nurse practitioner (NP) or physician and perform those healthcare activities which they are qualified and authorised to perform in Nunavut.

2. MEDICAL DIRECTIVE AND/OR DELEGATED PROCEDURE:

2.1 PCPs and ACPs are responsible and accountable for seeking guidance and support as needed to safely perform the assigned or delegated tasks. See ***Appendix A*** *for Primary and Advanced Care Paramedic Decision-Making Model for Performing Additional Functions and Transferred Functions*

2.2 PCPs and ACPs may not perform any task which is beyond their scope of practice that is outlined in the *National Occupational Competency Profile for Paramedics* (Oct. 2011) even if it is delegated by a RN, physician, or NP.

2.3 PCPs may not initiate any healthcare activity or task which has not been delegated or assigned by a RN, NP, or physician unless it is within their scope of practice outlined in the *National Occupational Competency Profile for Paramedics (Oct.2011)*

2.4 PCPs and ACPs will follow *Alberta Health Services Medical Control Protocols – (v.4.0) June 1, 2021* (available via app, see reference list) according to their scope of practice in urgent and emergent situations. PCPs and PCPs must further consult with NP or Physician as soon as possible.

2.5 ACPs can follow administration/dispensing of Narcotics as per the *Alberta Health Services Medical Control Protocols – (v.4.0) June 1, 2021* in consultation with physician or NP and must adhere to the narcotic substance handling protocols within the Government of Nunavut Drug Formulary.

2.6 Many of the policies, protocols and guidelines found in the Community Health Nursing (CHN) Manual are relevant for both ACPs and PCPs. ***Appendix B*** outlines policies that are applicable.

2.7 PCPs and ACPs are to adhere to the GN Infection Prevention and Control Manual, and Housekeeping Manual.

2.8 RNs, NPs, or physicians can direct PCPs to engage in any healthcare activities which they are authorised to perform in Nunavut, provided that they have the knowledge, skills, and ability that

is included in ***Appendix C*** *LIST OF PRIMARY AND ADVANCED CARE PARAMEDIC AUTHORISED ACTIVITIES AND SCOPE OF PRACTICE*.

2.9 PCPs and ACPs can administer Post Exposure Prophylactic (PEP) immunizations and COVID-19 vaccines upon completion of the Nunavut Immunization Training Modules and have obtained certification under guidance and direction from a NP or physician. Link for course and test; https://nunavuthealth.skillbuilder.co/sign-in

3. RECIPIENT PATIENTS:

3.1 PCPs and ACPs may provide care and support to any patient at the direction of the SCHP or their designate, RN, Physician and/or NP provided that the care and support required falls within their scope of work.

4. AUTHORIZED IMPLEMENTERS:

4.1 PCPs and ACPs can implement those health care activities they are authorised and qualified to perform in Nunavut according to this medical directive provided they have been given direction to implement those activities by a RN, NP, or physician.

4.2 PCPs and ACPs may not implement any healthcare activity which is beyond their scope of practice.

4.3 PCPs and ACPs are not permitted to subdelegate to another regulated or non-regulated health care professional.

4.4 When two or more Paramedics are working together toward a common cause, such as an urgent or emergent situation, any of the paramedics involved in the event may complete the ordered task provided the task falls within their scope of work.

5. INDICATIONS AND CONTRAINDICATIONS:

5.1 RNs, NPs, or physicians may not delegate any task which could be better performed by an available RN.

5.2 SHPs and RNs cannot subdelegate a task which has been delegated to them from a MD or NP or through medical directives and guidelines.

5.3 PCPs and ACPs will follow the decision-making tree in Appendix A when encountering a task with which they are unfamiliar or uncertain if they are able to perform.

6. DEFINITIONS:

Registered Nurse (RN): Regulated healthcare professional able to work autonomously.

Nurse Practitioner (NP): A Regulated healthcare professional with advanced education and more extensive scope of work.

Community Health Nurse (CHN): A CHN is a RN whose scope of work specifically includes providing healthcare support to individuals, families, and a community. CHNs scope of work is more extensive than that of a RN who works within a specific hospital-based setting.

Primary Care Paramedic (PCP): A licensed healthcare professional scope of work includes assessing the needs of patients and providing medical treatment in emergent, and non-emergent situations. PCPs provide care in out-of-hospital, inter-hospital, and community settings.

Advanced Care Paramedic (ACP): A licensed healthcare professorial who is specialized in advanced care of medical and trauma patients with a focus on advanced cardiac resuscitation. ACPs can provide care in out-of-hospital, inter-hospital, and community settings.

7. PROCEDURE:

7.1 RNs, NPs, or physicians will provide specific direction to a PCP and ACP regarding specific delegated tasks.

7.2 PCPs and ACPs must have sufficient competency to perform the delegated task.

7.3 RNs, NPs, or physicians who are delegating tasks to a PCP or ACP will document what the task was, and to whom it was delegated to.

7.4 PCPs and ACPS must accurately and appropriately document who delegated the task, what task delegated, and outcome in the patient's health record.

8. DOCUMENTATION:

8.1 When healthcare activities are delegated to a PCP or ACP it is necessary to document:

- Name of activities which have been delegated.
- Name of the implementer/delegator, including designation.
- Pertinent information related to the procedure performed, such as the patient's response, to be documented in accordance with department documentation standards.
- PCPs and ACPs must follow Policy 06-008-00 Documentation Standards, Policy 06-008-01 Documentation Standards Guidelines, Policy 06-009-00 Documentation Format, and Policy 06-009-01 SOAP Documentation Guidelines.

9. RELATED POLICIES, PROTOCOLS AND LEGISLATION:

Community Health Nursing (CHN) Manual
https://www.gov.nu.ca/health/information/manuals-guidelines
Policy 06-008-00 Documentation Standards
Policy 06-008-01 Documentation Standards Guidelines
Policy 06-009-00 Documentation Format
Policy 06-009-01 SOAP Documentation Guidelines
Policy 07-034-00 COVID-19 Laboratory Testing Authority
APPENDIX A: Decision-Making Model for Performing Additional Functions and Transferred Functions
APPENDIX B: COMMUNITY HEALTH NURSING POLICIES THAT ARE APPLICABLE TO PCP AND ACPS
APPENDIX C: LIST OF PRIMARY AND ADVANCED CARE PARAMEDIC AUTHORISED ACTIVITIES AND SCOPE OF PRACTICE
APPENDIX D: MEDICATION GUIDELINE FOR PCPS AND ACPS

10. REFERENCES:

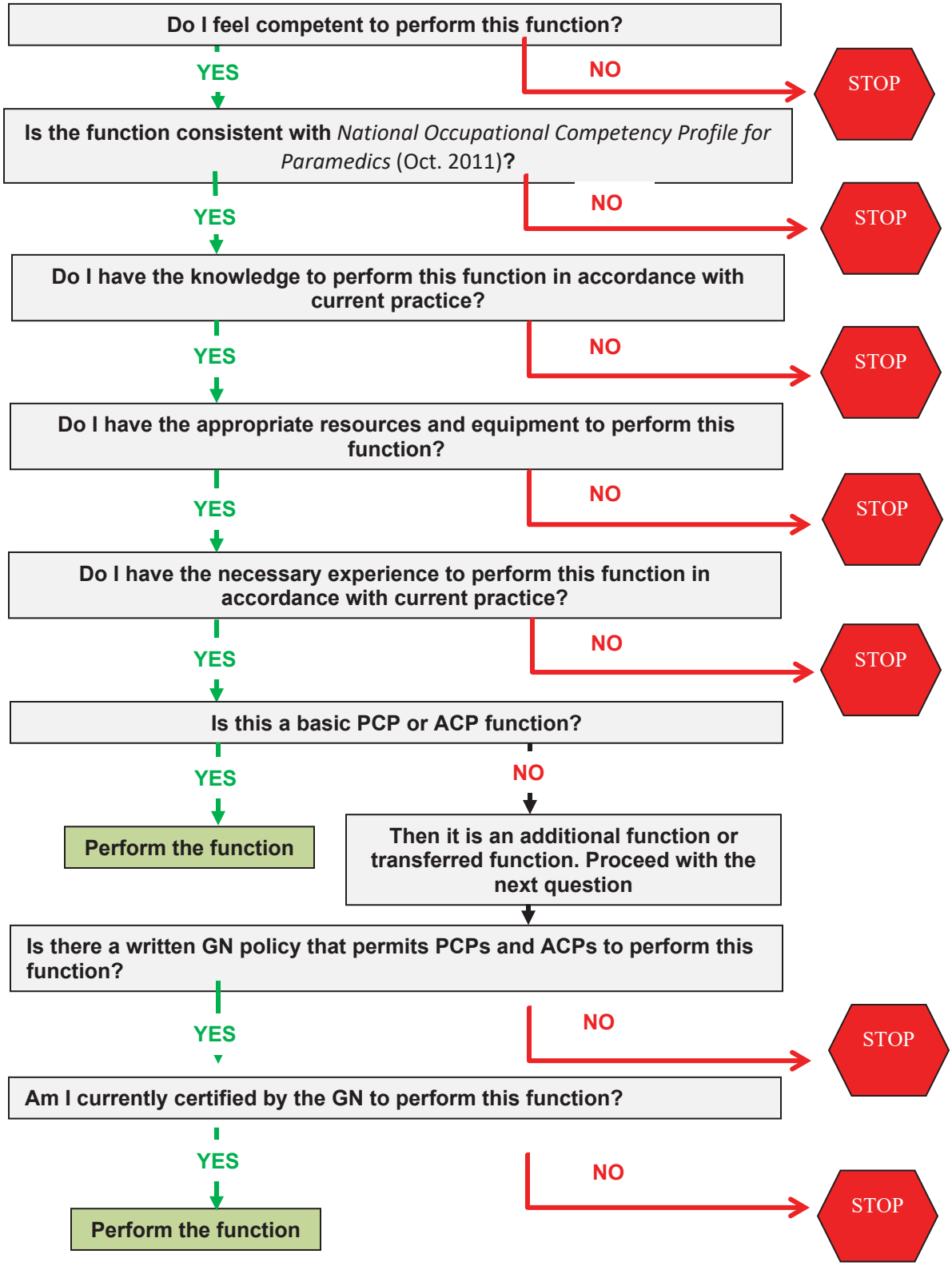
Alberta Health Services Medical Control Protocols – (v.4.0) June 1, 2021
https://ahsems.com/public/AHS/login.jsp

National Occupation Competency Profile for Paramedics, Oct 2011
https://www.paramedic.ca/uploaded/web/documents/2011-10-31-Approved-NOCP-English-Master.pdf

11. APPROVALS:

Approved By: Jennifer Berry	Date: 21-06-29
Jennifer Berry, Assistant Deputy Minister – Department of Health	
Approved By:	Date: June 29, 2021
Jenifer Bujold, a/Chief Nursing Officer	
Approved By: Digitally signed by Dr Francois de Wet DN: cn=Dr Francois de Wet, o=Government of Nunavut, ou, email=fdewet@gov.nu.ca, c=CA Date: 2021.07.02 11:23:53 -04'00'	Date:
Dr. Francois de Wet, Medical Chief of Staff, on behalf of the Medical Advisory Committee	

APPENDIX A: PRIMARY AND ADVANCED CARE PARAMEDIC DECISION-MAKING MODEL FOR PERFORMING ADDITIONAL FUNCTIONS AND TRANSFERRED FUNCTIONS



Appendix B: Policies in Community Health Nursing Manual which apply to Primary and Advanced Care Paramedics

Section 2: Organisation		
Policy Number	Title	Applicable to
02-002-00	Core Community Health Nursing Programs	PCP, ACP
02-003-00	Structural Objectives and Indicators	PCP, ACP
Section 3: Definition of terms		
Entire section applicable to both PCPs and ACPs		
Section 4: Standards		
Policy Number	Title	Applicable to
04-004-00	Health Centre Documentation Audit	PCP, ACP
Section 5: Administration		
Policy Number	Title	Applicable to
05-005-00, 05-005-01	Critical incident stress management and Guideline	PCP, ACP
05-013-00	Orientation	PCP, ACP
05-015-00	Statutes and Legislation	PCP, ACP
05-018-00	Standard Emergency Equipment	PCP, ACP
05-020-00	Equipment Advanced Nursing	PCP, ACP
05-021-00	Occupational Health and Safety	PCP, ACP
05-022-00	Smoke Free Workplace	PCP, ACP
05-023-00	Treating Immediate Family Members	PCP, ACP
05-024-00	Clients in Police Custody	PCP, ACP
05-024-01	Provisions of Care to Clients in Police Custody	PCP, ACP
05-025-00	Gifts	PCP, ACP
05-026-00	Loss of Theft or Property	PCP, ACP
05-027-00	Contacting Clients Through Local Radio	PCP, ACP
05-028-00	Scent-free Workplace	PCP, ACP
05-029-00	Violence in the Workplace	PCP, ACP
05-030-00	Motor Vehicles	PCP, ACP
05-031-00	Fire Response and Evacuation	PCP, ACP
05-034-00	Client Safety Events-Reporting and Management	PCP, ACP
05-035-00	Client Safety Disclosure	PCP, ACP
Section 6: Communication		

Policy Number	Title	Applicable to
06-001-00	Confidentiality	PCP, ACP
06-002-00	Transmission of Health Information by Facsimile	PCP, ACP
06-003-00	Release of Information	PCP, ACP
06-004-00	Intra-Departmental Release of Information	PCP, ACP
06-005-00	RCMP Investigations	PCP, ACP
06-006-00	Health Records Management	PCP, ACP
06-007-00	Health Record Control	PCP, ACP
06-008-00, 06-008-01	Documentation Standard and Guideline	PCP, ACP
06-009-00, 06-009-01	Documentation Format and Guideline	PCP, ACP
06-009-01	Date and Time Sequence	PCP, ACP
06-011-00	Email Consultation	PCP, ACP
06-012-00	Forms Management	PCP, ACP
06-013-00	Interpreter Services	PCP, ACP
06-014-00	Telephone Communication	PCP, ACP
06-015-00	Missed or cancelled appointment	PCP, ACP
06-016-00	Child Welfare	PCP, ACP
06-017-00	Morning Report	PCP, ACP
Section 7: Nursing Practice		
Policy Number	Title	Applicable to
07-005-00	Immunizations: Can administer Post Exposure Prophylactic (PEP) immunizations upon completion of the Nunavut Immunization Training Modules and have obtained certification under guidance and direction from a NP or physician. Link for course and test; https://nunavuthealth.skillbuilder.co/sign-in	PCP, ACP
07-018-00	Client Identification for Clinic Care	PCP, ACP
07-019-00	Transfer of Care between Colleagues	PCP, ACP
07-020-00	Conscious Sedation	ACP
07-021-00	Restraints	PCP, ACP
07-022-00	Clients on Continuous Observation	PCP, ACP
07-023-00	Non-Urgent Evacuation of Obstetrical Clients	ACP
07-024-00	Home Visits Planned	PCP, ACP
07-025-00	Home Visits – Unplanned and Urgent	PCP, ACP
07-028-00	LPN Directive – TB Program	PCP, ACP
07-026-00	Emergency Land Medevacs	PCP, ACP

07-029-00	Infant-Telephone Triage and Infant Assessment (Age 0-12 months) **Can not provide telephone triage, to use as guidance for triage**	PCP, ACP
07-030-00	Pediatric and Adult-Telephone Triage **Can not provide telephone triage, to use as guidance for triage**	PCP, ACP
07-033-00	COVID-19 Nursing assessment and advice protocol	PCP, ACP
07-034-00	COVID-19 Laboratory Testing Authority	PCP, ACP
07-035-00	Escalation of Medical Care	PCP, ACP
07-037-00	Community Health Centre Protected Code Blue During the COVID-19 Pandemic	PCP, ACP
07-039-00	Informed Refusal of Treatment	PCP, ACP done with RN, Physician or NP
Section 8: Diagnostics		
Policy Number	Title	Applicable to:
08-001-00	Laboratory procedures	PCP, ACP
08-002-00	Requisitioning laboratory studies	PCP, ACP
08-004-00	Post Mortum Samples-Under the direction from the coroner	PCP, ACP
08-005-00	Acknowledgement of Diagnostic Test Results	PCP, ACP
08-006-00	Follow-up of Abnormal Diagnostic test results	PCP, ACP consult with Physician/NP
08-015-00	Interpretation of ECGs	ACP
08-016-00	Venipuncture	PCP if trained, ACP
08-021-00	iStat Point of Care Testing in Community Health Centres	PCP, ACP
Section 9: Pharmacy		
Policy Number	Title	Applicable to:
09-001-00	Documentation of Allergies	PCP, ACP
09-003-00	Stock Medications	PCP, ACP
09-005-00	Dispensing Medications-**Excluding policy 2 statement**	PCP, ACP
09-006-00	Administering or Dispensing Pharmaceuticals-Documentation	PCP, ACP
09-007-00	Administering Medications – IM injections	PCP, ACP
09-008-00	Administering Medications – IV Direct	ACP
09-009-00	Administering Medications via Subcutaneous Infusion Set	PCP, ACP
09-010-00	Repackaging Pharmaceuticals	PCP, ACP
09-011-00	Labeling Pharmaceutical Agents	PCP, ACP
09-018-00	Bronchiolitis Management Protocol	ACP
Section 10: Infection Control		
All polices apply to both PCPs and ACPS except: Policy 10-001-00 Communicable Disease Policy 10-001-01 Reportable Communicable diseases		

Section 11: Clinical Procedures		
Policy Number	Title	Applicable to:
11-007-00,	Nasogastric Tube	PCP, ACP
11-007-01	Nasogastric Tube: Nursing Considerations	ACP
11-007-02	Nasogastric Tube: Insertion and Maintenance	PCP may not insert, ACP
11-009-00	Anesthesia: Topical, Local and Digital Nerve Block	ACP
11-010-00	Suturing	ACP if trained
11-011-00	Wound Closure: Skin Adhesive	ACP if trained
11-017-00 To 11-017-08	Plaster Splinting	ACP if trained

APPENDIX C: List of Primary and Advanced Care Paramedic Authorised Activities and Scope of Practice

Assessment and Diagnostics

- Conduct triage in a multiple-patient incident; **this does not include telephone triage**
- Obtain patient history
- Conduct complete physical assessment of those areas of the body they are qualified and competent to examine, demonstrating appropriate use of inspection, palpation, percussion, and auscultation.
- Assess vital signs
- Utilize diagnostic tests
- Conduct Point of Care Testing (POCT) once Government of Nunavut POCT testing training and competencies have been completed; PCPs and ACPs must follow direction from NP or Physician
- ACPs and PCPs are permitted to initiate testing for COVID-19 and must follow the *COVID-19 Laboratory Testing Authority Policy Number 07-034-00*

Therapeutics:

- Maintain patency of upper airway and trachea; explicitly excluding intubation for PCP's and ACPs must consult with NP or Physician prior to advanced airway intervention
- Prepare oxygen delivery devices
- Deliver oxygen and administer manual ventilation
- Utilise ventilation equipment
- Implement measures to maintain hemodynamic stability
- Provide basic care for soft tissue injuries
- ACP can suture with training and competency according to *Policy 11-010-00 Suturing* found in the Community Health Nursing Manual.
- Immobilise actual and suspected fractures
- ACPs can apply plaster splint if training completed, please refer to policy *11-0017-00 Plaster Splinting* found in the Community Health Nursing Manual
- ACPs can administer medications as per *Alberta Health Services Medical Control Protocols – (v.4.0) June 1, 2021* or as directed by NPs or Physicians provided they are competent and qualified to administer the medication
- PCPS can administer medications provided they are competent and qualified to administer the medication and must be directed by a NP or Physician. **Please see *Appendix D** for Medication Guideline for ACPs and PCPs*.
- **NOTE: RNs such as CHNs or SCHPs cannot subdelegate any medication administration or dispensation to a PCP or ACP.**
- Can administer Post Exposure Prophylactic (PEP) immunizations and COVID-19 vaccines (see Policy 07-034-00 COVID-19 Laboratory Testing Authority) upon completion of the Nunavut Immunization Training Modules and have obtained certification under guidance and direction from a NP or physician. Link for course and test; https://nunavuthealth.skillbuilder.co/sign-in

Integration

- Utilise differential diagnostic skills, decision making skills, and psychomotor skills in providing care to patients
- Provide care to meet the needs of unique patient groups
- Conduct ongoing assessments and provide care

Transportation

- Drive ambulance/emergency response vehicle or other vehicle as designated by SCHP for

healthcare delivery services

- ❖ Arrange medical evacuation from Community Health Centre
- ❖ Transfer patient to air ambulance

Health Promotion and Public Safety

- ❖ Integrate professional practice into community care
- ❖ Contribute to public safety through collaboration with rapid response team at the direction of the SCHP
- ❖ Participate in management of chemical, biological, radiological/nuclear, explosive (CBRNE) incident at the direction of the SCHP.

Reference

National Occupation Competency Profile for Paramedics, Oct 2011 (pp.9-13)
https://www.paramedic.ca/uploaded/web/documents/2011-10-31-Approved-NOCP-English-Master.pdf

Appendix D Medication Guideline for PCPs and ACPs

This list is a guideline from the National Occupational Competency Profile for Paramedics (October 2011) that indicates the groups of pharmacologic agents with which it is recommended that Primary and Advanced Care Paramedics be familiar with.

- The administration of any medication for a PCP or ACP must be under direction from a Nurse practitioner or Physician.
- PCPs and ACPs can follow Alberta Health Services Medical Control Protocols – (v.4.0) June 1, 2021.
- The list below is medications that an ACPS may administered under the Medical Control Protocols without physician order and direction in an emergency situation. Consultation with a physician should be obtained as soon as possible.
- ACPs can administer other medications not on the list under direct order of the physician or nurse practitioner.
- PCPs and ACPS that are administering/dispensing medications must have the knowledge, skills, and ability to safely administer medications .

		PCP	ACP
A. Medications affecting the central nervous			
A.1	Opioid Antagonists	X	X
A.2	Anaesthetics		
A.3	Anticonvulsants		X
A.4	Antiparkinsonism Agents		X
A.5	Anxiolytics, Hypnotics and Antagonists		X
A.6	Neuroleptics		X
A.7	Non-narcotic analgesics	X	X
A 8	Opioid Analgesics		X
A 9	Paralytics		
B. Medications affecting the autonomic nervous system.			
B.1	Adrenergic Agonists	X	X
B.2	Adrenergic Antagonists		X
B.3	Cholinergic Agonists		X
B.4	Cholinergic Antagonists		X
B.5	Antihistamines		X
C. Medications affecting the respiratory system.			
C.1	Bronchodilators	X	X
D. Medications affecting the cardiovascular system.			
D.1	Antihypertensive Agents		X
D.2	Cardiac Glycosides		X
D.3	Diuretics		X
D.4	Class 1 Antidysrhythmics		X
D.5	Class 2 Antidysrhythmics		X

D.6	Class 3 Antidysrhythmics		X
D.7	Class 4 Antidysrhythmics		X
D 8	Antianginal Agents	X	X
E. Medications affecting blood clotting mechanisms.			
E.1	Anticoagulants		X
E.2	Thrombolytics		X
E.3	Platelet Inhibitors	X	X
F. Medications affecting the gastrointestinal system.			
F.1	Antiemetics		X
G. Medications affecting labour, delivery and postpartum hemorrhage.			
G.1	Uterotonics		X
G.2	Tocolytics		X
H. Medications used to treat electrolyte and substrate imbalances.			
H.1	Vitamin and Electrolyte Supplements		X
H.2	Antihypoglycemic Agents	X	X
H 3	Insulin		X
I. Medications used to treat / prevent inflammatory responses and infections.			
I.1	Corticosteroids		X
I.2	NSAID		X
I.3	Antibiotics		X
I.4	Immunizations		X
J. Medications used to treat poisoning and overdose.			
J.1	Antidotes or Neutralizing Agents		X

National Occupation Competency Profile for Paramedics, Oct 2011 (pp.171-172)
https://www.paramedic.ca/uploaded/web/documents/2011-10-31-Approved-NOCP-English-Master.pdf