Section 8: Diagnostics

Policy 08-001-00……Laboratory Procedures

08-001-01……Collecting Sexual Assault Kits

Policy 08-002-00……Requisitioning Laboratory Studies

Policy 08-003-00……Interpretation of Laboratory Studies

Policy 08-004-00……Post Mortem Samples

08-004-01……Guidelines for Obtaining Post Mortem Samples

08-004-02……Coroner protocol for obtaining fluids

Policy 08-005-00……Acknowledgement of Diagnostic Test Results

08-005-01……Guidelines for Acknowledging Diagnostic Test Results

Policy 08-006-00……Follow-up of Abnormal Diagnostic test results

08-006-01……Guidelines for Following up Abnormal Results

Policy 08-007-00……Removed

08-007-01……Removed

Policy 08-008-00……..Removed

08-008-01……..Removed

08-008-02……..Removed

08-008-03……Removed

08-008-04……Removed

Policy 08-009-00……Radiological Examination of Pregnant Women

08-009-01……Guidelinesfor Radiological Examination of Pregnant Women

Policy 08-010-00……Interpretation of X-Rays

Policy 08-011-00……Removed

Policy 08-012-00……Diagnostic Records

08-012-01……Guidelines for Filing Diagnostic Records

Policy 08-013-00…….Removed

Policy 08-014-00……Preventative Maintenance and Calibration

Policy 08-015-00……Interpretation of ECGs

Policy 08-016-00……Venipuncture

08-016-01……Venipuncture for Blood Specimens

08-016-02……Venipuncture for Blood Cultures

Policy 08-017-00……Unregulated Healthcare Workers Performing Laboratory Procedure

Policy 08-018-00……Performing X-Rays – CHN, NP, BRT

Policy 08-019-00……CHN Initiated X-Ray Requests

08-019-01…… Initiating X-Rays for TB Program

Policy 08-020-00……Troponin Point of Care Tests in Pediatric Patients

Nunavut

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS		
	Community Health Nursing		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Laboratory Procedures		Diagnostics	08-001-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		5
APPLIES TO:			
Community Health Nurses			

POLICY 1:

A Registered Nurse may perform laboratory procedures in the community health centre providing the following conditions are met:

1. **The Department of Health and Social Services (HSS) shall establish and maintain policies which authorize the registered nurse to perform laboratory procedures.**
2. **Criteria exist for the selection of laboratory procedures appropriate for implementation by registered nurses:**
   - **Procedures can be safely conducted in a health centre**
   - **Access to suitable instruction in the procedure exists**
   - **The recommended procedures are cost effective**
3. **Access to laboratory personnel or adequate resources exist where questions arise with regard to laboratory procedures.**
4. **A Government of Nunavut-approved laboratory manual for community health centre procedures is available to all staff in the community health centre.**
5. **HSS establishes and maintains a policy for obtaining post-mortem samples.**

POLICY 2:

Nurses shall perform laboratory procedures in accordance with the Government of Nunavut *Community Health Centre Laboratory Manual.*

PRINCIPLES:

- Safe implementation of laboratory procedures is of primary importance to ensure quality client care.
- Nurses must practice within their own level of competence. When aspects of care are beyond his/her level of competence, he/she must seek additional information or knowledge, seek help from their supervisor or a competent practitioner and/or request a different work assignment. In the meantime, nurses must provide care until another nurse is available to do so.
- The employer can identify individual expectation or restrictions and is then responsible to ensure competency for the expected procedure(s) by providing education and practical experience as necessary.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 05-009-00	Transferred Health Functions
Policy 05-010-00	Competency for Transferred Health Functions
Guideline 08-001-01	Laboratory Procedure Guidelines
Policy 08-002-00	Requisitioning Laboratory Studies
Policy 08-004-00	Post Mortem Samples
Guideline08-004-01	Collecting Post Mortem Samples

Government of Nunavut *Community Health Centre Laboratory Manual*

REFERENCES:

Canadian Nurses Association (2002). *Code of Ethics for Registered Nurses: Safe, Competent, and Ethical Care*. CNA: Ottawa.

Registered Nurses Association of the Northwest Territories and Nunavut (2007). *Bylaw: Dispensing, Compounding and Packaging Drugs*. RNANTNU: Yellowknife.

Government of Nunavut *Community Health Centre Laboratory Manual*.

GUIDELINES 08-001-01

Collecting Sexual Assaults Kits

A timely, well done medical forensic examination can potentially validate and address sexual A timely, well done medical forensic examination can potentially validate and address sexual assault clients' concerns, minimize the trauma they may experience, and promote their healing. It can also increase the likelihood that evidence collected will aid in a criminal case investigation.

1. The *Sexual Assault Kit* is a forensic packaging system that contains:
   - Specific instructions on collecting the physical and trace biological evidence from a particular case.
   - Containers in which to place all the collected physical and trace biological evidence.
   - Instructions on packaging and documenting evidence.
   - Procedure on maintaining the chain of custody.

2. The *Sexual Assault Kit* is provided by the RCMP. Once the Kit is completed, it will be seized by the RCMP as an exhibit in regards to the criminal investigation.

3. The chain of custody shall be maintained from the time the examination is initiated until the collected physical evidence is handed over to the RCMP. The physical evidence collected during the examination must be closely regulated and controlled to maintain accurate continuity and accountability of exhibits and property. All collected specimens must never be left unattended, including being left in the examination room in the presence of the client.

4. After collection, the seized physical evidence is the responsibility of the RCMP.

5. The Registered Nurse examiner shall follow the protocols and guidelines of the Department of Health and Social Services and RCMP *Sexual Assault Kits.*

6. Every effort must be made to contact the RCMP in advance of using the RCMP Sexual Assault Kit. In the event there is no RCMP officer in the community, contact the RCMP detachment responsible for the community.

Coordinated Approach:

- A coordinated, multidisciplinary approach to conducting the exam provides victims with access to comprehensive immediate care and helps minimize trauma they may experience.

- Addressing client's needs may include: evaluating and treating injuries; conducting prompt exams; providing support, crisis intervention, and advocacy; providing prophylaxis against sexually transmitted infections and referrals; assessing reproductive health issues; and providing follow-up contact/care.

- Addressing justice system needs may include obtaining a history of the assault; documenting exam findings; properly collecting, handling and preserving evidence; and interpreting/analyzing findings, and providing factual and expert opinions.

Victim-Centred Care:

- Victim-centered care is paramount to the success of the exam process. Response to the victims should be timely, appropriate, sensitive and respectful.
- Give clients of sexual assault priority as emergency cases and respond in a timely manner. Provide as much privacy as possible.
- Recognize that the medical forensic exam is an interactive process that must be adapted to the needs and circumstances of each client.
- Be respectful of cultural beliefs which may influence/affect a victim and/or the exam process.
- Understand the importance of victim support services within the exam process. Victim service providers/advocates typically offer victims support, crisis intervention, information and referrals, and advocacy to ensure that victims' interests are represented, their wishes respected, and their rights upheld. Victims have the right to accept or decline victim support services.
- Accommodate victims' request for responders of a specific gender as much as staffing limitations permit.
- Prior to starting the exam and before each procedure, describe what is entailed and its purpose to the client (Provide interpreting services as need to ensure information is accurately conveyed). Respect the client's right to decline any part of the exam.
- After the exam, provide the client with the opportunity to wash, change clothes, get food or drinks, and make needed phone calls.

Confidentiality:

- Maintain confidentiality in accordance with territorial and federal policies and legislation.

Informed Consent:

- Clients should understand the full nature of their consent to each exam procedure. The client must be presented with relevant information to make an informed decision to accept or decline a procedure.
- If a procedure is declined, the client should be aware of the impact of declining the procedure with the client's reasons for declining being documented

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 05-010-00	Competency for Transferred Health Functions
Policy 06-001-00	Confidentiality

REFERENCES:

Government of Canada (2006). Royal Canadian Mounted Police, Operational Manual. Ottawa, ON.

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:**
Requisitioning Laboratory Studies		Diagnostics	08-002-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		2
APPLIES TO:			
Community Health Nurses			

POLICY 1:

Registered Nurses working as a community health nurse may initiate laboratory studies as per the First Nations and Inuit Health Branch *Clinical Practice Guidelines for Nurses in Primary Care, Pediatric Clinical Practice Guidelines for Nurses in Primary Care,* other territorial / national guidelines and/or in consultation with a physician or nurse practitioner.

POLICY 2:

The name of the person ordering the laboratory tests shall ensure his/her name is entered on the lab requisition form. Only the person's name that is ordering the test should be entered. Do not include a physician's name when the physician did not specifically order that test.

PRINCIPLES:

- To make efficient use of the visiting specialist / family physician, relevant laboratory studies should be initiated prior to the physician referral, so the results available at the time of consultation.
- The practitioner must only order laboratory studies which are clinically indicated and are recommended by territorial or national clinical guidelines.
- The nurse ordering any tests is responsible and accountable for reviewing and following up the lab results.

REFERENCES:

First Nations and Inuit Health Branch. (2000). *Clinical Practice Guidelines for Nurses in Primary Care.* Ottawa, ON.

First Nations and Inuit Health Branch. (2001). *Pediatric Clinical Practice Guidelines for Nurses in Primary Care.* Ottawa, ON.

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:**
Interpretation of Laboratory Studies		Diagnostics	08-003-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		1
APPLIES TO:			
Community Health Nurses			

POLICY:

Registered nurses working in community health centers may interpret basic laboratory studies (e.g. culture and sensitivity results, ova and parasite results, viral studies, pregnancy tests) in order to initiate necessary interventions in a timely fashion.

PRINCIPLES:

- Nurses with specialized competence have the required knowledge to interpret basic laboratory results in order to initiate treatment in accordance with drug and treatment protocols and within the Department of Health and Social Services (HSS) policy.
- Nurses without specialized competence shall have access to resources for the interpretation of laboratory results.

REFERENCES:

Canadian Diabetes Association. (2008). *Clinical Practice Guidelines.* Toronto, ON.

First Nations and Inuit Health Branch. (2000). *Clinical Practice Guidelines for Nurses in Primary Care.* Ottawa, ON.

First Nations and Inuit Health Branch. (2001). *Pediatric Clinical Practice Guidelines for Nurses in Primary Care.* Ottawa, ON.

Government of the Northwest Territories Department of Health and Social Services. (1999). *Communicable Disease Manual.* Yellowknife, NT.

Public Health Agency of Canada (2006). Canadian Guidelines on Sexually Transmitted Infections. Ottawa, ON.

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

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS	
	Community Health Nursing	
TITLE:	**SECTION:**	**POLICY NUMBER:**
Post Mortem Samples	Diagnostics	08-004-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018 / February 2021		4
APPLIES TO:		
Community Health Nurses		

POLICY:

Collecting post mortem samples is the responsibility of the Coroner. However, in accordance with the *Coroners Act* and the *Coroners Forms Regulations,* the Coroner may authorize the Registered Nurse to collect post mortem samples. The Coroner will use Form 11 of the schedule to authorize the nurse to obtain the samples.

PRINCIPLES:

Collecting post mortem samples is the responsibility of the Coroner's office and not Health and Social Services. Therefore, if the nurse does not feel comfortable or confident in obtaining post mortem samples, he/she will not be compelled to do so.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 05-007-00	Nursing Practice - Employee Responsibilities
Guideline 08-004-01	Guidelines for obtaining post mortem samples
Reference Sheet 08-004-02	Coroner's Protocol for Obtaining Post Mortem Samples

REFERENCES:

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

Consolidation of Coroners Forms Regulations R.R.N.W.T. 1990, c.C-19, as amended by R-092-92.

Government of Nunavut. *Community Health Centre Laboratory Manual*.

GUIDELINES 08-004-01

Collecting Post Mortem Samples:

1. It is the usual protocol of the Nunavut Chief Coroner's Office to request fluid samples be taken in cases where an autopsy will not be performed.

2. The coroner may request the assistance of a registered nurse to obtain samples. Authorization to take the samples will be given to the registered nurse by the coroner in the form of an *"Authorization to Take Sample of Bodily Fluids"* document. This document *(Consolidation of Coroners Forms Regulations* R.R.N.W.T. 1990, c.C-19, as amended by R-092-92, Form 11) is signed and dated by the coroner.

3. Fluid samples are taken as per the Office of the Chief Coroner Protocol *Body Fluid Collection* using standard precautions.

4. Equipment used should reflect the site and amount of body fluids needed according to the Office of the Chief Coroner Protocol *Body Fluid Collection.*

5. The body fluid samples are forwarded to the appropriate examination laboratory as per the direction of the coroner.

6. The registered nurse shall ensure the coroner has provided an *"Authorization to Examine Sample of Bodily Fluids" (Consolidation of Coroners Forms Regulations* R.R.N.W.T. 1990, c.C-19, as amended by R-092-92, Form 12) which shall accompany the samples to the appropriate examination laboratory. This completed form authorizes the toxicologist to perform the required tests.

RELATED POLICES, GUIDELINES AND LEGISLATION:

Policy 05-007-00	Nursing Practice - Employee Responsibilities
Policy 08-004-00	Post Mortem Samples
Reference Sheet 08-004-02	Coroner's Protocol for Collecting Body Fluids Post Mortem

REFERENCES:

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

Consolidation of Coroners Forms Regulations R.R.N.W.T. 1990, c.C-19, as amended by R-092-92.

Dynacare Kasper Medical Laboratories. (2004). *Directory of Services.* Edmonton, AB.

Office of the Chief Coroner (n.d.). *Body Fluid Collection***.**

GUIDELINES 08-004-02

Coroners Protocol for Fluid Collection Post Mortem

Body Fluid Collection Post Mortem

Blood Collection:

1. Do NOT swab area with alcohol.
2. Use the 16 gauge, 1 ½ inch needle for neck region
3. Can also be performed in femoral vein. (Use 16 gauge, 1 ½ inch needle)
4. Extract minimum of 10 ml of blood (50 ml is the preferred amount).
5. Provide samples in at least one (1) gray and/or plain red stopper tubes.
6. Do NOT separate blood phases.

Urine Collection:

1. Do NOT swab with alcohol.
2. Use 15 gauge, 3 ½ inch needle to puncture the bladder.
3. Extract sufficient amount to fill at least 1 gray stopper tube.
4. Place remainder of urine in sterile urine container.
   (Obtaining a urine sample may also be attempted with the use of a catheter if desired)

Vitreous Collection:

1. Do NOT swab with alcohol.
2. Use 16 gauge, 1 ½ inch needle.
3. Insert through the lateral surface of the globe near the outside corner of the eye.
4. Extract the clear vitreous fluid, approximately 2-3 cc per eye
5. Place in a plain red stopper tube. If no red top tubes available, then may use grey

Toxicology Testing:

1. Blood samples are used primarily for the testing of ethanol.
2. Drug use is difficult to detect in blood samples.
3. Urine and/or vitreous samples must be taken to test for common recreational drug use and medications.
4. Ethanol can also be detected in urine and vitreous fluid
5. If you wish to test for a specific drug or medication, you must identify the substance to be tested for.

All toxicology samples are to be sent to:

Dynacare Kasper Medical Laboratories
#200, 10150-102 St.
Edmonton, AB
T5J 5E2
Phone: 1-800-661-9876
Fax: (780) 452-8488

Note: A completed copy of the "Authorization to Examine Sample of Bodily Fluids" must accompany the samples to Dynacare Kasper.

REFERENCES:

Office of the Chief Coroner (n.d.). *Body Fluid Collection*.

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:**
Acknowledgement of Diagnostic Test Results		Diagnostics	08-005-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
July 21, 2021	July 2023	08-005-00 and 08-005-01	2
APPLIES TO:			
Health Care Provider			

1. **BACKGROUND:**
   Diagnostic tests provide essential information about client health. Diagnostic tests results can be received by fax, email or verbally.
   While Community Health Nurses (CHNs) are responsible to acknowledge and follow up the results of tests that they have ordered, the Supervisor of Health Programs (SCHP) or delegate in health centres where services are suspended is accountable for health care delivery in the health centre they supervise. As such, they are the initial reviewers of test results and must take this opportunity to provide direction as necessary and to ensure that follow up is occurring in a timely way.
   This process ensures that the SCHP is aware of any potential for high-risk situations and can provide appropriate oversight.

2. **POLICY:**
   2.1 The Department of Health (Health) requires acknowledgement of all results of diagnostic tests performed on clients.
   2.2 The SCHP or delegate is the first reviewer of all diagnostic tests.

3. **PRINCIPLES:**
   3.1 The health care provider (HCP)ordering or receiving order for any test(s) is responsible for reviewing and following up the diagnostic test results.
   3.2 The SCHP or delegate is accountable for the overall health care delivery in their community.

4. **DEFINITIONS**:
   Diagnostic tests: Refers to blood and body fluid tests, Pap smears, imaging tests or any other tests ordered by a clinician.

   Health Care Provider: Refers to Community Health Nurses, Public Health Nurses, Licensed Practical Nurses, Nurse Practitioners, Registered Psychiatric Nurses, Home Care Nurses, Physicians, Advanced Care Paramedics, and Primary Care Paramedics.

5. **PROCEDURE:**
   5.1 When the diagnostic test report is first received in the health centre, the office support staff (receptionist, clerk interpreter or records clerk) or HCP will stamp the date that the report was received.
   5.2 The SCHP or delegate is responsible to ensure to maintain a verified manual specimen and result tracking process, please refer to policy 08-005-02 Laboratory Specimen/Result Tracking

Policy.

5.3 All reports of diagnostic testing will be placed in an area designated by the SCHP or delegate for review.

5.4 The SCHP or delegate will initial all reports with the date reviewed and provide written comments for any follow-up that may be required, for example, "Please book urgent appointment", "Please follow up with Community Physician" etc.

5.5 The SCHP will note the initials of the ordering clinician or delegate prior to distributing.

5.6 The SCHP will distribute the test results to the ordering or delegated HCP.

5.7 The ordering or delegated HCP will initial and date each test report when received, reviewed and provide brief written commentary regarding follow-up, e.g., "Follow-up booked", "referred to physician" etc. Additionally, all follow-up interventions must be documented in the client's record.

5.8 As soon as possible, the office support staff will file all hard copy results of diagnostic testing in the medical record under the appropriate section.

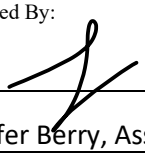
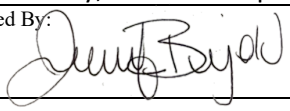
5.9 All verbally reported test results will be documented in the clients' medical record and the HCP will read back to the individual reporting the results to verify accuracy. The entry must also include the name of the person reporting the results, their reporting location (e.g., reporting lab) and their professional designation.

5.10 The clinician/HCP receiving the verbal test results will contact the on call, site physician or Nurse Practitioner (NP) to report any critical or significantly abnormal diagnostic test results.

5.11 All communications or attempts to communicate with the physician/NP shall be documented in the client's medical record. Documentation will include date and time contacted, name of physician/NP, reason for notification, physician/NP response and action taken and/or orders received.

6. RELATED POLICIES:

08-005-02 LAB SPECIMEN TRACKING
08-006-00 FOLLOW-UP OF ABNORMAL DIAGNOSTIC TEST RESULTS
08-006-01 GUIDELINES FOR FOLLOWING UP ABNORMAL RESULTS

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: Francois De Wet, Chief Medical Officer	Date:

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

TITLE:		SECTION:	POLICY NUMBER:
Laboratory Specimen/Result Tracking (for tests ordered on paper requisitions)		DIAGNOSTICS	08-005-02
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
May 1, 2021	May 1, 2024	N/A	7
APPLIES TO:			
Nurse Practitioners, Registered Nurses, and Licensed Practical Nurses			

1. **BACKGROUND:**

The Department is moving toward having all lab tests ordered and resulted electronically. While this process is being developed, interim measures are required to ensure that every lab specimen collected at a community health centre can be accounted for, is tracked, resulted and reviewed. This policy outlines the requirements for manual tracking of investigations not entered or resulted into the electronic medical record. These typically include laboratory tests sent out of community for processing through out-of-Territory, contracted lab service.

2. **POLICY:**

2.1 It is the policy of the Department of Health to require laboratory specimen tracking and result receipt confirmation for all specimens collected at community health centres. The Supervisor of Community Health Programs (SCHP) is responsible and accountable to ensure this process takes place at each health centre by a regulated health professional such as a Nurse Practitioner (NP), Registered Nurse (RN) and/or a Licensed Practical Nurse (LPN).
2.2 Community health centres that order laboratory tests on a paper requisition, are required to maintain a verified manual specimen and result tracking process.

3. **PRINCIPLES:**
3.1 Laboratory specimen and result tracking is a very important aspect of patient safety. Every lab specimen collected from a patient must be subject to a process that ensures it arrived at the testing location and results were reported and reviewed by the most responsible provider (MRP).
3.2 This policy is not applicable to the Qikiqtani General Hospital, Kivalliq Health Centre in Rankin Inlet, and the Kitikmeot Regional Health Centre in Cambridge Bay because there is a regional laboratory on-site.

4. **DEFINITIONS:**

4.1 Most Responsible Provider (MRP) – The term refers to the physician, nurse practitioner, community health nurse, or other regulated healthcare professional, who has overall responsibility for directing and coordinating the care and management of a patient at a specific point in time.

4.2 Verified Manual Specimen and Result Tracking Process – A process that allows every specimen collected from a patient to be recorded, tracked and monitored to ensure that it was received by the testing laboratory and a result was received for clinical review by the MRP.

4.3 Blood Work Binder/Filing System – An organizational system used to store laboratory requisitions for specimens that have not been collected. Staff will commonly use this binder to reference when determining if/when patients should be contacted to have their specimen collected.

4.4 Outstanding Lab Specimen Binder/Filing System – An organizational system used to store laboratory requisitions after the specimen(s) are collected and remain there until all results for tests requested on the requisition have been received.

5. GUIDELINE:

5.1 To aid the implementation of a manual lab specimen and result tracking system, health centres are recommended to use the pre-approved procedure shown in Section 6 of this document. This procedure may be used without approval of the DAC.

5.2 It is recognized that community health centres may have existing procedures in place to track lab specimens and results. In these cases, the Supervisor of Community Health Programs (SCHP) must describe those procedures using the form contained in "Appendix A: Specimen/Result Tracking Process Template" of this document. The completed form must be submitted to the Chair of the Diagnostic Advisory Committee (DAC). The DAC will review the completed form for compliance with this policy or other applicable industry standards and will recommend approval, or changes to the proposed process, prior to submitting it to the Chief Nursing Officer for final approval.

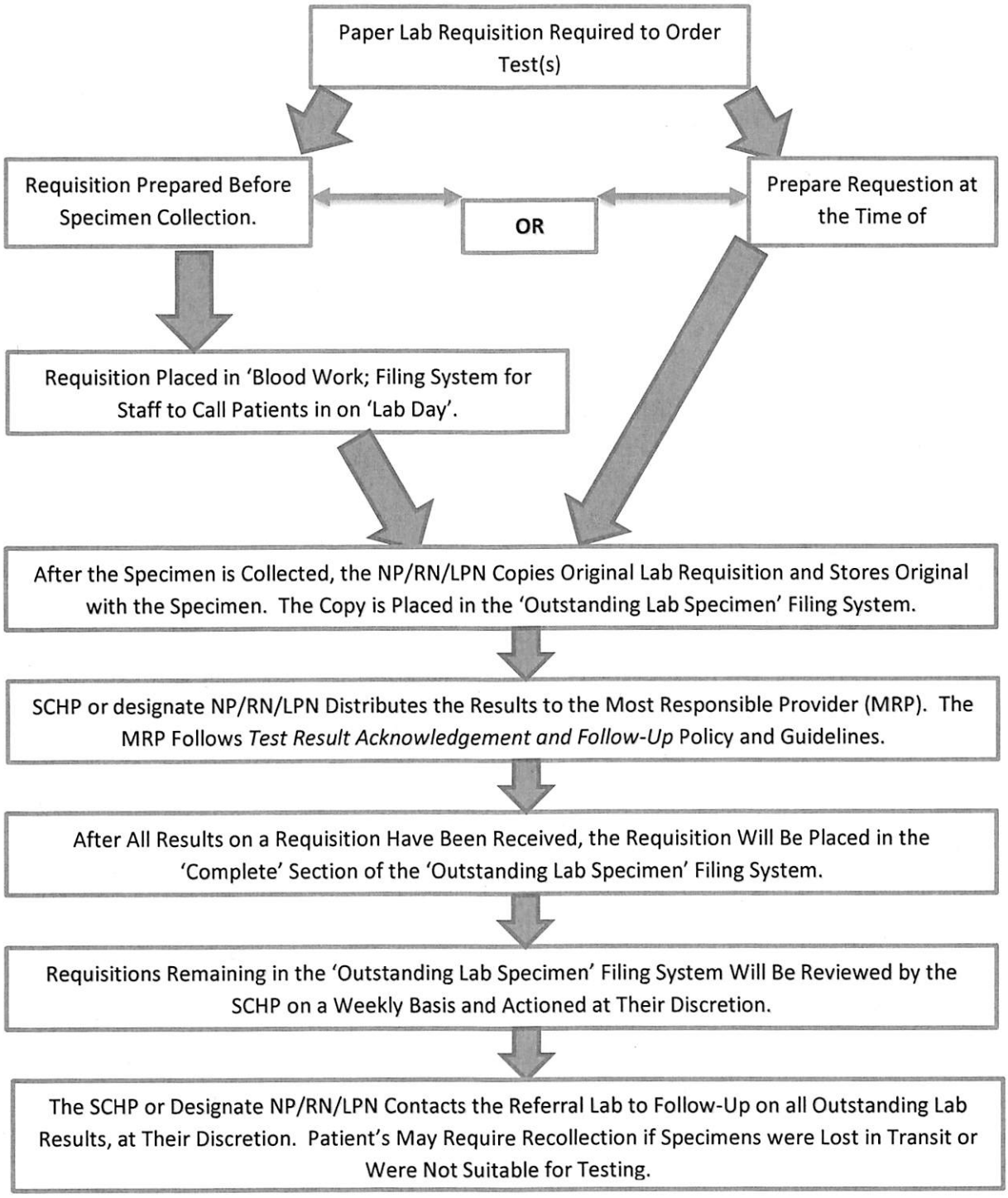
5.3 All health centres that do not submit a health centre specific manual lab specimen and result tracking procedure to DAC for approval, must implement the pre-approved procedure in Section 6 of this document.

6. **PRE-APPROVED PROCEDURE:**

ALL LAB SPECIMENS SENT USING A PAPER LAB REQUISITION FORM REQUIRE MANUAL SPECIMEN TRACKING

THIS PROCEDURE DOES NOT APPLY WHEN TESTS ARE ORDERED AND RESULTED IN MEDITECH

SPECIMEN/RESULT TRACKING PROCEDURE OVERVIEW



SPECIMEN/RESULT TRACKING DETAILED PROCEDURE

Step	Procedure		Rationale
1	**Option 1: Lab requisitions prepared prior to specimen collection.** Lab paper requisitions are placed in a 'Blood Work' binder/filing system for staff to call patients in on 'lab day'.	**Option 2: Lab requisitions prepared at time of specimen collection.**	**Option 1:** A current process already in place in many community health centres to ensure patients are reminded to come in for lab specimen collection.
2	Once specimen has been collected, NP/RN/LPN photocopy the original requisition, place it with the appropriately stored specimen and a copy in the 'Outstanding Lab Specimen' binder/filing system.		**NEW:** Outstanding Lab Specimen Binder. Allows for one location for all outstanding lab specimens sent with paper requisitions. **Important Note:** Only when a specimen is collected and prepared for send out is the photocopied lab requisition placed in the Outstanding Lab Specimen Binder. This prevents following up for lab specimens that were never collected.
3	When lab results are received at the Community Health Centre and date/time stamped, the SCHP or designate NP/RN/LPN matches the results with the photocopied lab requisitions in the 'Outstanding Lab Specimen' binder/filing system and crosses off each completed lab test. The requisition will REMAIN in the outstanding section of the binder until ALL tests on listed on the requisition are resulted.		Refer to CHN Administration Manual Policy/Guideline 08-005-00/01 Acknowledgement of Diagnostic Test Results. More than one report may be received on a specimen due to different test orders and/or preliminary verses completed lab reports.
4	All test results are sent to the SCHP or designate NP/RN/LPN for distribution to the most responsible provider (MRP) for follow up as required.		Refer to CHN Administration Manual Policy/Guideline 08-005-00/01 Acknowledgement of Diagnostic Test Results and Policy/Guideline 08-006-00/01 Follow up of Diagnostic Test Results
5	Once all lab results for that requisition have been received, the photocopied requisition may be moved to the 'Complete' section of the 'Outstanding Lab Specimen' binder/filing system.		Once all results are accounted for the photocopy is retained for one year.

6	Requisitions remaining in the 'Outstanding Lab Specimen" binder/filing system to be reviewed by the SCHP on a weekly basis and actioned at their discretion.	
7	The SCHP or designate NP/RN/LPN contacts the referral lab to follow up on all outstanding lab results, at their discretion.	The patient may require re-collection if specimens was lost in transit or was not suitable for testing.

7. Related Policies, Protocols and Legislation:

Policy 08-005-00 Acknowledgement of Diagnostic Test Results
Guideline 08-005-01 Guidelines for Acknowledging Diagnostic Tests
Policy 08-006-00 Follow up of Diagnostic Test Results
guideline 08-006-01 Guidelines for Follow up of Diagnostic Test Results
Transportation of Dangerous Goods Regulations
Procedure for Lab Sample Collection And Labelling

8. References:

World Health Organization (WHO) – *Laboratory Quality Standards and Their Implementation* (2011) https://www.who.int/medical_devices/publications/lab_quality_standards/en/

Accreditation Canada - *Biomedical Laboratory Services*. Section 25.4: Samples are traceable from collection into final processing, including handling, storage, use and disposal. Accreditation Canada. www.healthstandards.org In effect: January 1, 2019

Approved By:	Date: May 05, 2021
Jennifer Berry, Assistant Deputy Minister, Operations, Department of Health	
Approved By:	Date: May 1, 2021
Jenifer Bujold, a/Chief Nursing Officer	

APPENDIX A: SPECIMEN/RESULT TRACKING PROCESS TEMPLATE

Step	Procedure	Rationale
1		*Describe when lab requisitions are completed (i.e. at time of collection or after a patient visit but before they arrive for specimen collection).* *Are completed requisitions stored for future reference? If so, how and where are they stored and for what purpose?*
2		*After a lab requisition is completed and a specimen is collected, describe the process used to record that the required specimen(s) have been sent to a referral lab.*
3		**Refer to CHN Administration Manual Policy/Guideline 08-005-00/01 Acknowledgement of Diagnostic Test Results.** *Describe the process used to confirm the date/time that referred out lab test results were received and are recorded.* *Describe the process used to ensure that all individual tests requested on a lab requisition have been completed and results received.* *More than one report may be received on a specimen due to different test orders and/or preliminary verses completed lab reports. If not done so already, please describe the process used to address this issue.*

Step	Procedure	Rationale
4		**Refer to CHN Administration Manual Policy/Guideline 08-005-00/01 Acknowledgement of Diagnostic Test Results and Policy/Guideline 08-006-00/01 Follow up of Diagnostic Test Results** *Describe how test results are received at your health centre and how they are distributed to the MRP (most responsible provider).*
5		*Describe the process used to confirm that all requested tests on a requisition have had results returned to the health centre.* Note: Once all results are accounted for, a copy of the requisition should be retained for one year. **This allows for evidence to be available if the process is subject to an audit.**
6		*Describe the process of how outstanding lab results are flagged for follow-up and what is the frequency at which this is checked.*
7		*Describe the process used to follow-up on outstanding lab results.* *Describe what actions are taken if outstanding test results cannot be retrieved.*

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS		
	Community Health Nursing		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Follow-Up of Abnormal Diagnostic Test Results		Diagnostics	08-006-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		2
APPLIES TO:			
Community Health Nurses			

POLICY:

The nurse will promptly discuss all abnormal test results with the client and an appropriate follow up plan initiated. All communication or attempts to communicate with the client shall be documented in the client's medical record.

PRINCIPLES

- Healthy communities: people are responsible and accountable for their own well being
- Simplicity and Unity: developing programs and services which are fair, understandable and easy to access and that will encourage public participation and create accountability
- Self-reliance: residents receive every opportunity to benefit from the health services provided to Nunavummiut
- The nurse ordering any tests is responsible and accountable for reviewing and following up the lab results.

REFERENCES:

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

GUIDELINES 08-006-01

Follow-up Abnormal Results

1. When diagnostic test results are ordered, the client will be advised to contact their nurse for the results of the diagnostic tests. Follow-up appointments may be arranged in advance according to the client's condition or circumstances.

2. In the event that a result is abnormal, the Registered Nurse shall promptly notify the client. All follow-up actions will be documented in the client record, including the details of the telephone contact with the client.

3. The nurse shall attempt to reach the client initially by telephone. In the event the client could not be reached after three attempts by phone, an appointment card shall be delivered to the client requesting a follow-up appointment at the health centre.

4. If there continues to be no response from the client, a letter will be sent to the client in English and in Inuktitut or Inuinnaqtun (if English is not his/her first language) indicating an abnormal test result and any follow-up actions required.

5. All communications or attempts to communicate with the client shall be documented in the client's medical record.

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

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS	
	Community Health Nursing	
TITLE:	**SECTION:**	**POLICY NUMBER:**
Radiological Examination of Pregnant Women	Diagnostics	08-009-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018 / February 2021		2
APPLIES TO:		
Community Health Nurses		

POLICY:

All staff members employed in the community health centre shall ensure that all reasonable steps are taken to protect an unborn child during radiological exams.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 08-007-00	X-rays
Guidelines 08-009-01	Radiological Examination of Pregnant Women
Policy 08-013-00	Radiation Monitoring System

REFERENCES:

American College of Radiology & The Radiological Society of North America. *Radiology Info: The radiology information resource for patients.*

GUIDELINES 08-009-01

Radiological Examination of Pregnant Women

1. All female clients will be asked if they may be pregnant prior to any radiological examination. Signs translated in all official languages should also be posted in the x-ray room requesting that potentially pregnant women inform the technologist.

2. The client's last menstrual period should be recorded on the x-ray requisition form and verified by the x-ray technician / assistant. If the client is unsure of last menstrual dates and cannot rule out pregnancy, then a urine pregnancy test shall be performed.

3. If a client is known to be pregnant:
   - The on call physician shall be consulted to discuss a plan of care
   - A written informed consent is required in the event that a radiological exam is clinically essential.
   - A non-abdominal/non-pelvic radiological exam is performed using client protective shielding to the abdominal area.

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:**
Interpretation of X-Rays	Diagnostics	08-010-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018 / February 2021		1
APPLIES TO:		
Community Health Nurses		

POLICY:

Registered nurses working in the community health centers may provide a preliminary assessment of basic X-ray examinations. All radiological studies undertaken shall be forwarded to a radiologist. A copy of the radiologist's report shall subsequently be filed on the client's health record after reviewed by the ordering Registered Nurse.

PRINCIPLES:

- While registered nurses may make preliminary assessment of an X-ray, it is the responsibility of a radiologist to make a final interpretation.
- It is the responsibility of the registered nurse to consult with a physician in a timely manner when something abnormal is seen on the preliminary assessment of an X-ray or from the radiologists report.
- It is the responsibility of the registered nurse to ensure that x-ray studies are forwarded to a radiologist in a timely manner.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 08-007-00	X-rays
Policy 08-013-00	Radiation Monitoring System

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:**
Diagnostic Records		Diagnostics	08-012-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		2
APPLIES TO:			
Community Health Nurses			

POLICY:

Each client having an x-ray or ultrasound examination shall have an index card maintained in the health centre's diagnostics index filing system. The index card shall contain a permanent Radiology number and shall be filed accordingly.

Each index card shall contain the following information:

1. **Client's name**
2. **Address**
3. **Health Care Plan number**
4. **Date of Birth**
5. **Health centre chart number**
6. **Radiology number**
7. **Date and type of each examination performed**

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Guideline 08-012-01 Guidelines for filing diagnostic records

GUIDELINES 08-012-01

Filing Diagnostic Records:

1. Each x-ray study shall be placed in a 14.5 x 17.5 filing envelope along with a copy of the official Radiologist interpretation of the exam.

2. Each ultrasound study shall be placed in a file folder along with a copy of the radiologist interpretation of the exam.

3. All exams, for a single client, shall be placed in a master file for storage. The master file shall contain information regarding client identification, date and type of exam.

4. The master file shall be filed numerically according to radiology number issued on the index card to aid in the retrieval of studies.

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:**
Preventative Maintenance and Calibration		Diagnostics	08-014-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		1
APPLIES TO:			
Community Health Nurses			

POLICY:

Preventative maintenance checks of all Diagnostic Imaging equipment shall be performed on a routine basis as indicated by in-house quality control testing and any contractual agreements with the supplier.

Equipment calibrations are performed by the supplier during regular preventative maintenance checks.

PRINCIPLES:

- Preventative maintenance ensures proper functioning of equipment and minimizes the impact of daily operations.

REFERENCES:

QGH Policy *Preventative Maintenance and Equipment Calibration*

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:**
Interpretation of ECGs		Diagnostics	08-015-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		1
APPLIES TO:			
Community Health Nurses			

POLICY:

Registered nurses working in the community health centers may provide a preliminary assessment of ECG tracings. All ECG tracings shall be forwarded to a designated specialist. A copy of the specialist's report shall subsequently be filed on the client's health record after reviewed by the ordering Registered Nurse.

PRINCIPLES:

- While registered nurses may make preliminary assessment of an ECG, it is the responsibility of a specialist to make a final interpretation.
- It is the responsibility of the registered nurse to consult with a physician in a timely manner when something abnormal is seen on the preliminary assessment of an ECG or from the specialist's report.
- It is the responsibility of the registered nurse to ensure all ECG studies are forwarded to the designated specialist in a timely manner.

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:**
Venipuncture	Diagnostics	08-016-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018 / February 2021		7
APPLIES TO:		
Community Health Nurses		

POLICY:

A nurse is authorized to perform venipuncture for blood procurement as a result of a direct physician order or transferred function.

If unable to obtain blood after two venipuncture attempts, where possible, another nurse/physician should be consulted for assistance. Avoid using the lower extremities for peripheral venipuncture.

DEFINITIONS:

Peripheral venipuncture is a procedure performed for the purposes of obtaining blood for analysis, culture and sensitivity and transfusion medicine.

PRINCIPLES:

- Collecting and requisitioning blood specimens will be guided by the policies and procedures of the *Health Centre Laboratory Manual*.
- Venipuncture requires special competence and shall not be delegated to unregulated healthcare workers unless directed by the Regional Director and the duty is included in the worker's job description.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 08-001-00 Laboratory Procedures
Policy 08-002-00 Requisitioning Laboratory Studies
Policy 08-004-00 Post Mortem Samples
Government of Nunavut *Health Centre Laboratory Manual*

GUIDELINES 08-016-01

Venipuncture for Blood Specimens

Considerations:

1. Mislabelling or wrong client identity can have fatal adverse outcomes.

2. Prolonged application of the tourniquet may make samples unsuitable for some biochemical or haematological tests. If it is necessary to leave the tourniquet on for more than 1 to 2 minutes, release it and re-apply.

3. Never attempt venipuncture in the arm when arteriovenous fistula/graft is present, or when a mastectomy has been performed on the same side.

4. Under filling a vacutainer tubes can affect the test results. All tubes should be filled to the extent the vacuum allows.

5. Therapeutic drug levels are normally drawn pre-dose with the time of draw documented on both the lab form and the client's health record.

    a. If drawing a post drug level, document the start and finish time of the drug administration in the health record, as well as the time in which blood is drawn.

    b. Follow the Health Centre Lab Manual for detailed instructions on therapeutic drug levels.

6. Indicate on the requisition if the blood was drawn from below an IV site and what solution was infusing.

7. If venipuncture is unsuccessful, discard the needle and use a new one.

8. The antecubital fossa is the preferred site for blood procurement.

9. Blood samples should be collected as per order of draw: blood cultures, non-additive tubes, coagulation/citrate tubes, additive tubes, EDTA (lavender top) tubes.

10. Check the expiry date on all tubes and blood cultures prior to drawing blood.

11. All vacutainer tubes must be mixed seven to ten times with gentle inversion to ensure sufficient mixing.

Venipuncture for Blood Procurement

Equipment:

- Blood tube holder
- Blood collecting tubes as required
- Requisitions and identification labels (if available)
- Non-sterile gloves
- Winged Blood Collection Set (21G/23G) or Safety Collection Needle
- Alcohol swab
- Tourniquet
- 2x2 gauze/cotton ball
- Sharps container
- Plastic specimen bag
- Tape (optional)

Procedure:

1. Explain the procedure to the client.

2. Confirm the client's identity by ensuring that the client's identifier information matches the requisitions, labels and tubes exactly.

3. Assemble equipment.

4. Perform hand hygiene.

5. Position the client comfortably and ensure that the arm is supported.

6. Apply the tourniquet approximately 5-10 cm above the selected venipuncture site. To avoid pinching the skin, the tourniquet may be applied over the client's clothing.

7. Select the vein; glove.

8. Thoroughly cleanse the area with an alcohol swab. Allow to air dry. Do not re-palpate.

9. Select the appropriate tube and rest it in the tube holder.

10. Immobilize the vein and inform the patient of your intent to insert the needle.

11. Insert the needle with bevel up at a 15-30 degree angle and penetrate the skin in a single, smooth motion (non-traumatic insertion technique). With the winged blood collection set, blood will be seen in the tubing if successful. Push the blood collecting tube(s) onto the rubber-tipped needle and allow the tube(s) to fill.

12. If venipuncture is unsuccessful, gently palpate the needle tip position in relation to the vein. Without removing the needle and depending on client tolerance, attempt to access the vein by making necessary adjustments. If unsuccessful, terminate the procedure.

13. Release tourniquet when last tube is filled and pull the blood tube off the rubber tipped needle.

14. Withdraw the needle at the same angle as insertion. Apply gentle pressure over the venipuncture site with a dry cotton ball/gauze for approximately 1-2 minutes. Securing with tape is optional.

15. Do not bend the client's arm as this can increase the risk of subcutaneous bleeding.

16. Dispose of the needle and holder as one unit immediately into sharps container.

17. Remove any blood droplets from the tube stopper with an alcohol swab. Gently invert any additive tubes as per the procedures contained within the *Health Centre Laboratory Manual*. Remove gloves.

18. Label each tube individually (clearly print client information on the tubes if labels are not available) and complete the requisitions (date, time, and signature). Verify labelled tubes against the requisition(s).

19. Place tube(s) into plastic specimen bag(s) and affix requisition(s).

20. Ensure specimens are stored and sent to the laboratory according to the policies and procedures contained within the *Health Centre Laboratory Manual*.

Paediatric Considerations:

- Explain procedure to child at developmentally appropriate age
- Only use restraints when the risk outweighs not using a restraint. Consider an alternative method first, and document the method.
- When performing venipuncture on children, you need to explore a variety of sources for vein access: scalp, antecubital fossa, saphenous, and hand veins.
- Application of EMLA cream may be ordered to reduce pain in infants and young children
- Vacutainers are not recommended in children under 2 years of age due to possible vein collapse with their use.

Unexpected Outcomes:

1. Hematoma forms at venipuncture site
   Intervention:
   Apply pressure
   Monitor client for pain and discomfort
2. Bleeding at site continues
   Intervention:
   Apply pressure to site
   Instruct client to apply pressure
   Monitor client
   Notify physician if bleeding persists
3. Signs and symptoms of infection at venipuncture site occur.
   Intervention:
   Swab site for C&S and treat according to clinical guidelines or physician order
   Apply moist heat to site

4. Client becomes dizzy or faints during venipuncture
   Intervention:
   Assist client into chair or bed
   Lower client's head between knees
   Remain with client
5. Laboratory tests reveal abnormal blood constituents
   Intervention:
   Notify physician

REFERENCES:

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

Weinstein, S. (2007). *Plumer's Principles and Practice of Intravenous Therapy* 8th Ed. Philadelphia:

Lippincott.

Government of Nunavut *Health Centre Laboratory Manual*

GUIDELINES 08-016-02

Venipuncture for Blood Cultures

Considerations:

1. For Adults: Two sets of blood cultures should always be drawn even if blood culture "x 1" is ordered. Each set will be a separate venipuncture from a separate site. The first set will consist of one aerobic and one anaerobic bottle. The second set will consist of only one aerobic bottle. The volume of blood to be collected is important. Mark the labels 10 ml above the growth medium to indicate the level of blood to be added. The sets may be drawn one after the other.

2. Neonatal and Paediatric blood cultures should be drawn in the Peds plus bottle. Do not collect two sets of cultures as indicated for adults.
   Optimal volume per bottle for Neonates: 1-1.5ml of blood
   Optimal volume per bottle for Pediatric: 1-5ml of blood

3. Unless endocarditis is suspected there is no need for a third set. With suspected endocarditis, the third set will consist of only one aerobic bottle. The first, second, and third set should each be drawn 30-60 minutes apart.

4. It is recommended that no more than three sets of blood cultures be drawn on any one client in a twenty four-hour period.

5. Blood cultures are not to be drawn from central venous lines unless ordered by a physician.

6. Each bottle must have its own client label. When placing a patient label on the bottle, do not cover the bar code or the bottom of the bottle.

Equipment:

- Blood culture bottles (verify expiry date)
- Requisition and identification labels (per set)
- Non-sterile gloves
- Winged Blood Collection Set or Safety Collection Needle
- Blood Collection Set with Male Adapter (holder for culture bottles)
- Chlorhexidine Alcohol swab
- Alcohol swab
- Tourniquet
- 2x2 gauze/cotton ball
- Sharps container
- Plastic specimen bag
- Tape (optional)

Procedure:

1. Refer to Procedure steps 1 through 7 as described in Guideline 08-016-01: Venipuncture for Blood Collection.

2. If using Winged Blood Collection Set, connect butterfly needle to blood collection set ensuring no contamination of equipment occurs.

3. Lines denoting 5 ml increments are present on the culture bottle labels. Mark the labels 10 ml above the growth medium to indicate the level of blood to be added.

4. Snap off the cap(s) from the culture bottle(s) and cleanse rubber stopper with an alcohol swab.

5. Apply the tourniquet approximately 5-10 cm above the selected venipuncture site. To avoid pinching the skin, the tourniquet may be applied over the client's clothing.

6. Select the vein; glove.

7. Thoroughly cleanse area with alcohol/ chlorhexidine swab. Allow to air dry. Do not re-palpate.

8. Perform the venipuncture in the usual manner.

9. Firmly push the aerobic culture bottle first onto the rubber tipped needle and allow10 mls of blood to be drawn into the bottle. Do not allow the vacuum to draw more than this amount.

10. Follow with the second bottle (if appropriate) and allow approximately 10 mls of blood to be drawn into the bottle. Remove the spike from the bottle.

11. Remove the tourniquet and the needle from the vein and with one hand press shield over needle until it locks into place. Apply gentle pressure over the venipuncture site with a dry cotton ball/gauze for approximately 1-2 minutes. Securing with tape is optional.

12. Dispose of the needle and holder as one unit immediately into sharps container

13. Label each bottle individually but do not cover the bar code or the bottom of the bottle. The label may be applied around the bottom 1/3 of the bottle. Complete the requisition including the time the culture is taken and verify the labelled bottles against the requisition.

14. Invert bottles 8-10 times.
15. Place tube(s) into plastic specimen bag(s) and affix requisition(s).
16. Ensure specimens are stored and sent to the laboratory as outlined in the policies and procedures of the *Health Centre Laboratory Manual*.

Pediatric Considerations:

- Explain procedure to child at developmentally appropriate age
- Only use restraints when the risk outweighs not using a restraint. Consider an alternative method first, and document the method.
- When performing venipuncture on children, you need to explore a variety of sources for vein access: scalp, antecubital fossa, saphenous, and hand veins.
- Application of EMLA cream may be ordered to reduce pain in infants and young children
- Vacutainers are not recommended in children under 2 years of age due to possible vein collapse with their use.

REFERENCES:

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

Weinstein, S. (2007). *Plumer's Principles and Practice of Intravenous Therapy* 8th Ed. Philadelphia: Lippincott.

Government of Nunavut *Health Centre Laboratory Manual*

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:**
Unregulated Healthcare Workers Performing Laboratory Procedures		Diagnostics	08-017-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
July 15,2021	July 2022	08-017-00	8

APPLIES TO:
Nurses: Community Health Nurses, Home and Community Care Nurses, Nurse Practitioners This policy does not apply to Iqaluit Health Services, Kivalliq Regional Health Centre and Kitikmeot Regional Health Centre

1. BACKGROUND:

The Department of Health (Health) employs both regulated and unregulated healthcare workers to deliver healthcare services to Nunavummiut. In specific situations certain specific tasks may be delegated by a Registered Nurse (RN) to an unregulated healthcare worker.

2. POLICY:

2.1 Unregulated healthcare workers, who have completed the required additional training and have demonstrated competence in performing point of care testing (POCT) may perform the following laboratory procedures:

- Urinalysis using the Clinitek machine only
- Urine Pregnancy Tests
- Hemocue Tests (Haemoglobin) in populations 12 years and older.
- Glucometer Tests (Glucose) in populations 12 years and older
- COVID-19 Point of Care Testing (POCT) if the unregulated healthcare worker has successfully completed ADM Operations approved training.

2.2 These procedures will be performed under the direction and supervision of the RN who delegates the task in accordance with the Health Centre Laboratory Manual and all applicable point of care testing policies.

2.2.1 The nurse who delegates POCT tasks 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.

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

3. PRINCIPLES:

3.1 Collecting and requisitioning laboratory specimens will be guided by the policies and procedures of the *Health Centre Laboratory Manual* and applicable point of care testing policies.

4. PROCEDURES:

4.1 Before delegating any POCT tasks to an unregulated healthcare worker, the nurse must determine if the unregulated healthcare worker has successfully completed the approved training and competency checklist.

4.2 The nurse is responsible to communicate the following considerations to the unregulated healthcare worker prior to performing POCT tasks.

- Seeking guidance and support as needed to safely perform the delegated task or activity;
- Knowing which tasks can be delegated as outlined in section 2.1;
- 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.

4.3 The Nurse delegates the POCT task to the unregulated worker through both verbal and in writing on the "POCT Request and Result" form (refer appendix A).

4.4 The unregulated health care worker will ensure that the POCT task is within their ability to perform it (outlined in section 2.1).

4.5 The unregulated worker will perform this task only if they are competent to complete it and will ask for guidance and support if needed.

4.6 Upon completing this task, the unregulated worker will document the results on "POCT Request and Result" form (refer to Appendix A) and hand this to the nurse.

5. TRAINING

5.1 All unregulated healthcare workers performing POCT tasks will undergo specified training with the POCT territorial coordinator.

5.2 Once the unregulated healthcare worker completes the above training, they will than need to demonstrate their competency by completing the "Laboratory Point of Care Staff Competency Checklist" (refer to Appendix B).

6. 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, Mental Health Workers, Maternal Care Workers, or students training in a health profession.

7. RELATED POLICIES, PROTOCOLS AND LEGISLATION:

Policy 07-009-00 Unregulated Healthcare Workers: Employer's responsibilities
Policy 07-010-00 Unregulated Healthcare Workers: Nurses' responsibilities
Policy 07-011-00 Unregulated Healthcare Workers: Employee's responsibilities
Policy 08-001-00 Laboratory Procedures
Policy 08-002-00 Requisitioning Laboratory Studies
Government of Nunavut Health Centre Laboratory Manual

8. APPENDIX

Appendix A: POCT Request and Results Form

Appendix B: Laboratory Point of Care Staff Competency Checklist

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

APPENDIX A

POCT REQUEST AND RESULT

Patient Identifiers or affix label here.

Patient Name: _____ Date of request: _____

Patient Health Card number: _____ Requested by: _____

Patient Date of Birth: _____

Date and time of POCT: _____ POCT performed by: _____

Check POCT requested	POCT Test Requested	POCT result	Units
	Whole blood Hemoglobin		g/L
	Whole blood Glucose		mmol/L
	Pregnancy test urine / serum	POS / NEG	Onboard QC acceptable Yes / No
	Clinitek urinalysis		Attach printout
	ID NOW Covid 19 Nasal swab	POS / NEG /Invalid	Presumptive Result

APPENDIX B

CLINITEK URINALYSIS DEVICE STAFF PATIENT PRACTICAL

The trainee must be able to perform the following duties on adults on three separate occasions.

Must be at an acceptable level before independent patient testing may occur:

- 2 or more Unacceptable results in a failing grade.
- 3 or more Needs Improvement results in a failing grade.

A = Acceptable

NI = Needs Improvement

U = Unacceptable

Learner's name: _____ Health Centre: _____

Level 1 QC: _____ Level 2 QC: _____

Date of completion: _____ Trainer's name: _____

Learner has successfully passed the Clinitek Urinalysis device practical. Trainer's signature: _____

	Criteria for Evaluation	A	NI	U
1.	Demonstrates how to perform cleaning: between samples, weekly and monthly.			
2.	Acknowledges not to wipe the calibrator white bar (monthly cleaning) with anything but gauze and distilled water.			
3.	States when to perform quality control samples.			
4.	Correctly dips the test strip into the patient's sample.			
5.	Loads the testing strip correctly on the Clinitek testing table.			
6.	Performs the Urinalysis test according to the operational procedure.			
7.	Practices good safety techniques.			
8.	Recognizes when to ask for assistance.			
9.	Correctly attaches the patient's Clinitek printout results to the correct patient requisition.			

HEMOCUE HEMOGLOBIN DEVICE STAFF PATIENT PRACTICAL

The trainee must be able to perform the following duties on adults on three separate occasions.

Must be at an acceptable level before independent patient testing may occur:

- 2 or more Unacceptable results in a failing grade.
- 3 or more Needs Improvement results in a failing grade.

A = Acceptable

NI = Needs Improvement

U = Unacceptable

Learner's name: _____ Health Centre: _____

Quality control sample completed: Level 1: _____ Level 2: _____ Level 3: ____

Date of completion: _____ Trainer's name: _____

Learner has successfully passed the HemoCue Hemoglobin device practical, including capillary sample collection. Trainer's signature: _____

	Criteria for Evaluation	A	NI	U
1.	Performs the quality control samples correctly.			
2.	Demonstrates how to clean the device using the HemoCue cleaner swab.			
3.	Correctly selects equipment needed for patient hemoglobin testing.			
4.	Identifies appropriate puncture site.			
5.	Prepares collection site correctly.			
6.	Loads the microcuvette correctly with whole blood or control sample.			
7.	Performs the Hemoglobin test according to the operational procedure.			
8.	Practices good safety techniques, including correctly disposing of sharps.			
9.	Recognizes when to ask for assistance.			
10.	Correctly enters the Hemoglobin result on the POCT requisition.			

GLUCOMETER STAFF PATIENT PRACTICAL

The trainee must be able to perform the following duties on adults on three separate occasions.

Must be at an acceptable level before independent patient testing may occur:

- 2 or more Unacceptable results in a failing grade.
- 3 or more Needs Improvement results in a failing grade.

A = Acceptable

NI = Needs Improvement

U = Unacceptable

Learner's name: _____ Health Centre: _____

Level 1/ LO QC completed: _____ Level 3/ HI QC completed: _____

Date of completion: _____ Trainer's name: _____

Learner has successfully passed the Glucometer practical, including capillary sample collection.

Trainer's signature: _____

	Criteria for Evaluation	A	NI	U
1.	Performs quality control samples correctly.			
2.	Identifies correct storage of testing strips and quality control material.			
3.	Identifies appropriate puncture site.			
4.	List appropriate samples for patient testing.			
5.	Acknowledges open expiry dates for the test strips and quality control material.			
6.	Applies the blood sample to the testing strip correctly.			
7.	Performs the glucose test according to the operational procedure.			
8.	Practices good safety techniques, including correctly disposing of sharps and biohazards.			
9.	Recognizes when to ask for assistance.			
10.	Correctly enters the glucose result on the POCT requisition.			

PREGNANCY KIT STAFF PATIENT PRACTICAL

The trainee must be able to perform the following tests on three adult samples on three separate occasions.

Must be at an acceptable level before independent patient testing may occur:

- 2 or more Unacceptable results in a failing grade.
- 3 or more Needs Improvement results in a failing grade.

A = Acceptable
NI = Needs Improvement
U = Unacceptable

Learner's name: _____ Health Centre: _____
Negative QC completed: _____ Positive QC completed: _____
Date of completion: _____ Trainer's name: _____

Learner has successfully passed the Pregnancy kit testing and correct receiving and handling of patient sample.
Trainer's signature: _____

	Criteria for Evaluation	A	NI	U
1.	Identifies the patient correctly.			
2.	State storage requirements of the pregnancy kits and quality control material.			
3.	Acknowledges correct sample type for testing.			
4.	Adds the appropriate amount of sample to the pregnancy test.			
5.	Sets the timer for the correct time and reads the test at the correct time.			
6.	Checks the control line on the test to ensure test is valid.			
7.	Performs the Pregnancy test according to the operational procedure.			
8.	Practices good safety techniques.			
9.	Recognizes when to ask for assistance.			
10.	Correctly enters the pregnancy result on the POCT requisition.			

ABBOTT ID NOW STAFF PATIENT PRACTICAL

The learner must perform a successful negative and positive QC swab and collection/testing of a patient nasal swab to complete training.

Must be at an acceptable level before independent testing may occur:

- 2 or more Unacceptable results in a failing grade.
- 3 or more Needs Improvement results in a failing grade.

A = Acceptable

NI = Needs Improvement

U = Unacceptable

Learner's name: _____ Health Centre: _____

Negative QC swab completed: _____ Positive QC swab completed: _____

Date of completion: _____ Trainer's name: _____

Learner has successfully passed the Abbott ID NOW analyzer practical.

Trainer's signature: _____

	Criteria for Evaluation	A	NI	U
1.	Demonstrates the correct way to put on and remove personal protective equipment needed for sample collection and testing.			
2.	Performs the ID NOW analyzer cleaning correctly.			
3.	Identifies correct storage of analyzer kits.			
4.	Acknowledges risks of contamination of analyzer and kit components.			
5.	Performs the ID NOW testing according to the operational procedure.			
6.	Disposes the kit components and patient swab correctly in the biohazard garbage.			
7.	List appropriate samples for patient testing.			
8.	Practices good safety techniques.			
9.	Recognizes when to ask for assistance.			
10.	Correctly enters the ID NOW results as directed.			

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS Community Health Nursing	
TITLE:	**SECTION:**	**POLICY NUMBER:**
Performing X-Rays – CHN, NP and BRT	Diagnostics	08-018-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
August 21, 2020 / August 2023	08-007-00 / 08-008-00 / 08-011-00 / 08-013-00	
APPLIES TO:		
All Community Health Staff and Physicians		

1. **BACKGROUND:**

Basic radiography services are considered an essential part of the basic health care services that must be available in each community. As it is not feasible to have a certified medical radiation technologist in every community, Community Health Nurses, Nurse Practitioners and Basic Radiography Technicians are delegated the authority to perform basic radiography exams under the circumstances outlined in this policy. Quality assurance practices are established in each region to ensure safe operation of equipment and limit unnecessary patient and staff exposure to radiation.

2. **POLICY:**

A limited range of x-ray procedures may be performed in the community health centre setting under specific conditions by authorized personnel:

2.1 Authorized staff to perform x-ray procedures in the health centre setting:

i. Certified Medical Radiation Technologist (MRT)
ii. Community Health Nurses (CHN) and Nurse Practitioners (NP) who have successfully completed a program of instruction on x-ray procedures
iii. Staff member who has completed the Basic Radiology Technician (BRT) training program (or similar GN approved training program)

2.2 Authorized radiological examinations which can be performed by the CHN, NP and BRT:

i. Chest (including ribs)
ii. Extremities (excluding hips)

2.3 Authorized providers for ordering x-rays:

i. Pregnant Women: A Physician or NP order is required to initiate X-rays for any reason.
ii. Chest x-rays: Children < 6 years of age group require a physician or NP order; the only exception is for TB surveillance. X-rays are only to be ordered when they are anticipated to have a direct and significant impact on the immediate management of the case. The practitioner must be aware that due to the equipment and resources available in the health centre setting, the films may be suboptimal, and care must be exercised in using them for clinical decision making. When required, the patient may be transferred to an appropriate referral site for the x-ray, where an MRT and proper equipment are available to support quality imaging.
iii. Chest x-rays for TB Surveillance: CHNs and Public Health Nurses (PHN) may initiate a chest x-ray without a Physician or NP order; the exception would be for pregnant clients. ***NOTE: PHNs are not authorized to PERFORM the x-ray.***
iv. Extremity x-rays: CHNs may initiate extremity x-rays, regardless of age, without a Physician or NP order; the exception would be for pregnant clients. X-rays are only to be

ordered when they are anticipated to have a direct and significant impact on the immediate management of the case. The practitioner must be aware that due to the equipment and resources available in the health centre setting, the films may be suboptimal, and care must be exercised in using them for clinical decision making. When required, the patient may be transferred to an appropriate referral site for the x-ray, where an MRT and proper equipment are available to support quality imaging.
NOTE: FNIHB guidelines list the indications for physician consultation when suspecting a fracture: A physician must be consulted for all known or suspected fractures. The x-ray image must be transmitted to the physician. Do not wait for report confirmation.

2.4 Each health centre is required to participate in Health Canada's Radiation Monitoring Program through National Dosimetry Services and maintain an x-ray log-book.

3. PRINCIPLES:

3.1 X-ray procedures may be performed in a health centre when the result is anticipated to have a direct and significant impact on the management of the case.

3.2 Safe implementation of X-ray procedures is critical to ensure quality client care and safety is maintained. The CHN, NP and BRT will have access to appropriate radiology resources:

i. Radiology personnel when questions regarding X-ray procedures exist
ii. An X-ray manual in each community health centre

4. DEFINITIONS:

4.1 *Requesting an X-ray*:

i. Authorized provider stated in Policy statement 2.3 completes an x-ray requisition.
NOTE: only the name of the provider directly ordering the x-ray is to be entered on the requisition. Do not enter the MD or NP name if a verbal or written order was not directly received; otherwise, enter the name of the CHN who initiated the request as per the medical directive: CHN initiated x-rays.

4.2 *Women of Childbearing Age:*

i. Pregnancy status must be verified prior to imaging for all female clients of childbearing age.
ii. If the client is unsure of the date of the last menstrual cycle, the CHN or NP shall be notified and a urine pregnancy test obtained prior to imaging.
iii. A physician or NP order is required for initiating x-rays on pregnant women.

4.3 *Fulfilling an x-ray request*:

i. CHN, NP and BRT are delegated the authority to perform a limited range of x-ray procedures. When the client requires an x-ray test not listed in policy statement 2.2, the patient will require transfer to another facility where the test can be performed – physician consultation is required to facilitate travel.

Practice Point: If a patient had the same procedure performed previously, reviewing the exposure technique documented in the log-book for that patient may help achieve good image quality and reduce the need for repeat exposures.

ii. X-ray procedures will be performed in accordance with legislation, policies and procedures outlined by the technician's regulatory body and the Department of Health.

4.4 Protective and proper positioning equipment must be used for all x-ray procedures (e.g. lead aprons, pigg-o-stat equipment).

4.5 When the BRT, NP or CHN are unsure of what equipment or positioning is required, they

must consult an MRT, as per established regional consultation protocols.

4.6 All x-rays are to be sent to the radiologist as per established regional operating procedures.

4.7 *Poor Image Quality:*

If the quality of the x-ray image is deemed to be inadequate for safe interpretation:

i. Pediatric patients: **Do not repeat the x-ray before consulting the physician**. If the physician requests the x-ray be repeated, consult an MRT prior to repeating exposure for guidance on how to improve image quality.

ii. Adult patients: The x-ray may be repeated one time only without physician consultation; however, the MRT must still be consulted first before repeating the exam.

4.8 *Following up on x-ray results:*

i. The nurse initiating any test is responsible and accountable for reviewing and following up the diagnostic test results, as per CHN Manual Policies: Interpretation of X-Rays, Acknowledgement of Diagnostic Test Results, and Follow up of Abnormal Diagnostic Test Results.

ii. The MD/NP is responsible and accountable for reviewing and following up on diagnostic test results initiated by him/herself.

4.9 *Documentation:*

i. It is the responsibility of the staff member performing the x-ray to ensure all mandatory information is recorded in the log-book, on the requisition and on the film or digital image.

ii. The following information is to be recorded in the log-book:

- Date
- Radiology number
- Client Name
- Number of examinations performed
- Number of films used
- Type of examination
- Patient measurement
- Focal field distance (i.e. distance from tube to film)
- Patient position (i.e. supine, upright, semi-upright, AP/PA)
- Exposure factor used
- Referring community health centre (if applicable)
- Name of person who took the x-ray

4.10 *Dosimetry:*

i. It is mandated by federal law that all practitioners who are exposed to x-ray radiation be monitored for radiation exposure. Every employee who participates in the process of taking x-rays must be registered with the National Dosimetry Service.

ii. Each health care worker who performs x-ray procedures shall be assigned a radiation monitor badge. The badge is to be worn at all times when working in the clinical area and should not be worn outside of the immediate area. When not in use, all badges are securely stored in the x-ray area where it will not be exposed to radiation.

iii. Each health centre shall retain a minimum of 2 badges assigned to visitors which are to be utilized by relief staff.

iv. The Supervisor of Community Health Programs (SCHP) or designate will collect all badges on a quarterly basis and replace the monitoring disks as assigned by the Radiation Protection Bureau.

v. All used and un-used disks for each quarter will be forwarded immediately to the

Radiation Protection Bureau.

vi. Returned reports form the Radiation Protection Bureau should be retained on file at the health centre for two years.

NOTE: If a CHN, NP, or BRT is pregnant, s(he) should inform the SCHP so that appropriate precautions can be taken to limit the exposure to radiation.

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

Appendix A: Guidelines for X-ray Instruction for CHNs and NPs
Appendix B: Guidelines on Safe Use of a Pigg-O-Stat
CHN Manual Policy: Radiation Monitoring System
CHN Manual Policy: Nurse-Initiated X-rays
CHN Manual Policy: Acknowledgement of Diagnostic Test Results
CHN Manual Policy: Follow-up of Abnormal Diagnostic Test Results
CHN Manual Policy: Interpretation of X-rays

6. **REFERENCES:**

Health Canada. (2008). National Dosimety Services. Retrieved from https://www.hcsc.gc.ca/ewh-semt/occup-travail/radiation/dosim/index_e.html

Approved By:	Date:
	Dec 10, 2020
Jennifer Berry, Assistant Deputy Minister, Operations – Department of Health	
Approved By:	Date:
	Mar 08, 2021
Jenifer Bujold, A/ Chief Nursing Officer	
Approved By:	Date:
Dr. Francois de Wet, Medical Chief of Staff, on behalf of the Medical Advisory Committee	

Background: Performing X-ray procedures is not part of the RN scope of practice and instruction is not included in the basic nursing program curriculum. Therefore, each CHN responsible for performing x-ray procedures must attend a program of instruction. The following guideline outlines the X-ray instruction that the CHN and NP shall receive during orientation. This includes, but is not limited to:

1. Care and use of equipment, including quality assurance practices
2. Underlying principles
3. Special considerations
4. Performance of X-rays
    - Loading film
    - Exposing film
    - Developing film
    - Anatomical positioning (including proper use of pigg-o-stat equipment)
5. Processor Training
6. Identification, handling, and forwarding of X-rays for radiological interpretation
7. Preliminary assessment of films
8. Radiation protection and monitoring systems
9. Safety Measures
    - *lead aprons*
    - *lead spot blockers*
      lead gloves
    - *lead gonad screen*
      lead screen
    - *lead collar*
    - *coning*
    - *logbook*
    - *dosette*

REFERENCES:

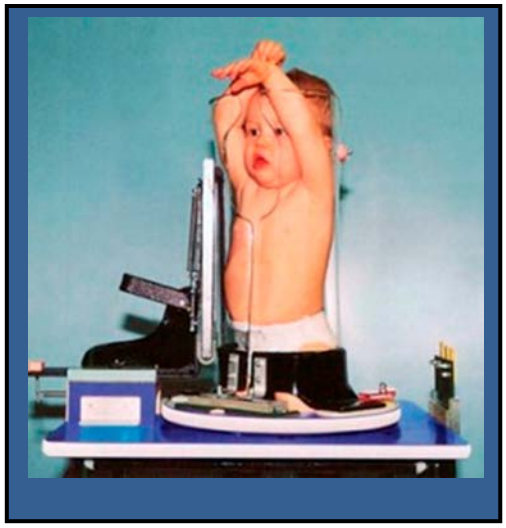
Health Canada. (2008). National Dosimetry Services from http://www.hc-sc.gc.ca/ewh-semt/occup-travail/radiation/dosim/ index_e.html

Health Canada. (1999). *X-Ray Equipment in Medical Diagnosis Part A: Recommended Safety Procedures for Installation and Use - Safety Code 20A.*

APPENDIX B: Guidelines on the Use of Pigg-o-stat

The Pigg-o-stat is to be used for pediatric clients who require immobilization during x-ray examinations.

1. Prepare x-ray machine controls, position and film.
2. Remove the child's clothing, except for the diaper.
3. Open the supports on the Pigg-o-stat immobilizer (like opening a book).
4. Adjust the seat to the lowest level possible so the child's mouth is at the level of the opening in the front.
5. Place the child on the seat and instruct someone (may be the parent) to hold the child's arms in a vertical position touching the ears. The arms should firmly immobilize the head.
6. Then adjust the supports firmly against the child and fasten locks on the base and leather straps at the top.
7. Re-adjust the child if he/she is not in a perfectly erect position.



8. The child must be completely immobilized before letting go of the arms and head. If it is required for the parent to remain with the child during the test, he/she must be given appropriate protective equipment.
9. Avoid using device for children who are too large.
10. Adjust film to the proper height and in contact with supports.
11. Remove child from the immobilizer.
12. Disinfect after each use.

Note: Use care to avoid hard blows or dropping the supports.

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS Community Health Nursing	
TITLE: **Nurse-Initiated X-Ray Requests**	**SECTION:** Diagnostics	**POLICY NUMBER:** 08-019-00
EFFECTIVE DATE: August 21, 2020	**REVIEW DUE:** August 2023	**REPLACES NUMBER:** 08-007-00 / 08-008-00
NUMBER OF PAGES: 6		
APPLIES TO: Community Health Nurses, Public Health Nurses		

1. **BACKGROUND:**
   X-rays can provide valuable information to help differentiate a client's diagnosis; assess the clinical response to treatment; or rule out a potential diagnosis that would require further consultation out of the community. This policy provides an authorizing mechanism for Community Health Nurses and Public Health Nurses to initiate orders for basic radiography exams under the circumstances outlined in this policy.

2. **MEDICAL DIRECTIVE:**
   2.1 The following client condition(s) apply, when initiating x-rays:
   i. Traumatic injuries of the extremities or clavicles when the x-rays are anticipated to have a direct and significant impact on the immediate management of the case; or
   ii. Routine screening chest x-ray under TB surveillance protocols; or
   iii. Diagnostic chest x-ray in periods of acute illness, as directed by the First Nations and Inuit Health Branch (FNIHB) Clinical Practice Guidelines or Department of Health (DH) protocols.

   2.2 Based on these conditions, Community Health Nurses (CHN) may:
   i. Initiate a chest x-ray without a direct Physician or Nurse Practitioner (NP) order for children 6 years of age and older; or
   ii. Initiate an extremity x-ray without a direct Physician or NP order, regardless of age.
   iii. Initiate a chest x-ray regardless of age without a direct Physician or NP order in accordance with the Department of Health TB surveillance protocols as outlined in Policy 08-019-01 Initiating X-rays for TB Program.

   2.3 Public Health Nurses (PHN) may:
   i. Initiate a chest x-ray regardless of age without a direct Physician or NP order in accordance with the Department of Health TB surveillance protocols as outlined in Policy 08-019-01 Initiating X-rays for TB Program.

   PRACTICE NOTE: Due to the equipment and resources variances in the health centre setting, x-rays may be suboptimal, and care must be exercised in using them for clinical decision making.

3. **RECIPIENT PATIENTS:**
   Patients in Community Health Centre and Public Health Settings

4. **CONTRAINDICATIONS TO THIS MEDICAL DIRECTIVE:**
   Consult the Physician or NP before initiating an x-ray when any of the following conditions exist:
   i. Patient is < 6 years of age and requires a chest x-ray, for non-TB related presentation.
   ii. Patient is suspected or known to be pregnant.
   iii. The nurse cannot confirm all conditions of this directive have been met.
   iv. The patient's history or physical exam does not match the criteria set forth in a corresponding DH

protocol or FNIHB clinical practice guideline.

v. The x-ray test is not recommended as part of the diagnostic investigation within the FNIHB guideline or DH protocol, or the guideline recommends physician consultation first.

5. AUTHORIZED IMPLEMENTERS:

5.1 Community Health Nurses or Supervisors of Community Health Programs 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.

5.2 Public Health Nurses who possess the knowledge, skill, and judgement to do so. The PHN is required to demonstrate competency to implement this medical directive through the standard orientation process.

5.3 Sub delegation is not permitted to another health care provider or staff.

6. PRINCIPLES:

6.1 CHNs and PHNs are expected to practice within their own level of competence and seek guidance from their supervisor, physician or NP as needed.

6.2 Guidelines do not replace clinical judgement. Management decisions must be individualized.

6.3 Children and fetuses are more radiosensitive and thus require additional consultation.

6.4 The *Ottawa Knee Rules* and the *Ottawa Ankle Rules* allow nurses to be more selective and efficient in their use of radiography for clients with acute knee and acute ankle injuries.

7. DEFINITIONS

7.1 Nurse: Refers to Community Health Nurse, Supervisor of Community Health Programs, or Public Health Nurse.

8. PROCEDURE:

8.1 The nurse conducts a comprehensive history and physical assessment.

8.2 The nurse is responsible for determining if the conditions of this directive have been met before enacting it. If the findings of the initial assessment suggest an x-ray is warranted for diagnostic determination or guiding treatment decisions, the nurse will reference the corresponding FNIHB clinical practice guideline or DH protocol to verify whether a specific x-ray test is recommended. Algorithm in *Figure 1* provides guidance to the nurse when determining if the medical directive is appropriate to enact.

8.3 The guidelines included in the appendices of this policy are approved references to assist the nurse in the decision-making process for acute injuries. These include:

i. The Ottawa Ankle and Foot Rules
ii. The Ottawa Knee Rules

8.4 The CHN will explain the procedure to the client and/or family, including any potential adverse outcomes. Obtain verbal consent.

8.5 Complete all required fields on the x-ray requisition (enter in Meditech where available):

i. Client identifiers
ii. Reasons for requesting the x-ray exam (clinical findings and initial differential diagnoses)
iii. Ensure the name of the nurse who is initiating the x-ray is clearly stated as the ordering provider. Do not include the MD or NP name if a direct order was not obtained.

8.6 The nurse ordering an x-ray test is accountable for providing timely follow up of test results, in accordance with CHN Manual Policies: 08-010-00 *Interpretation of X-rays*; 08-005-00 *Acknowledgement of Diagnostic Test Results;* and 08-006-00 *Follow up of Abnormal Diagnostic Test Results*.

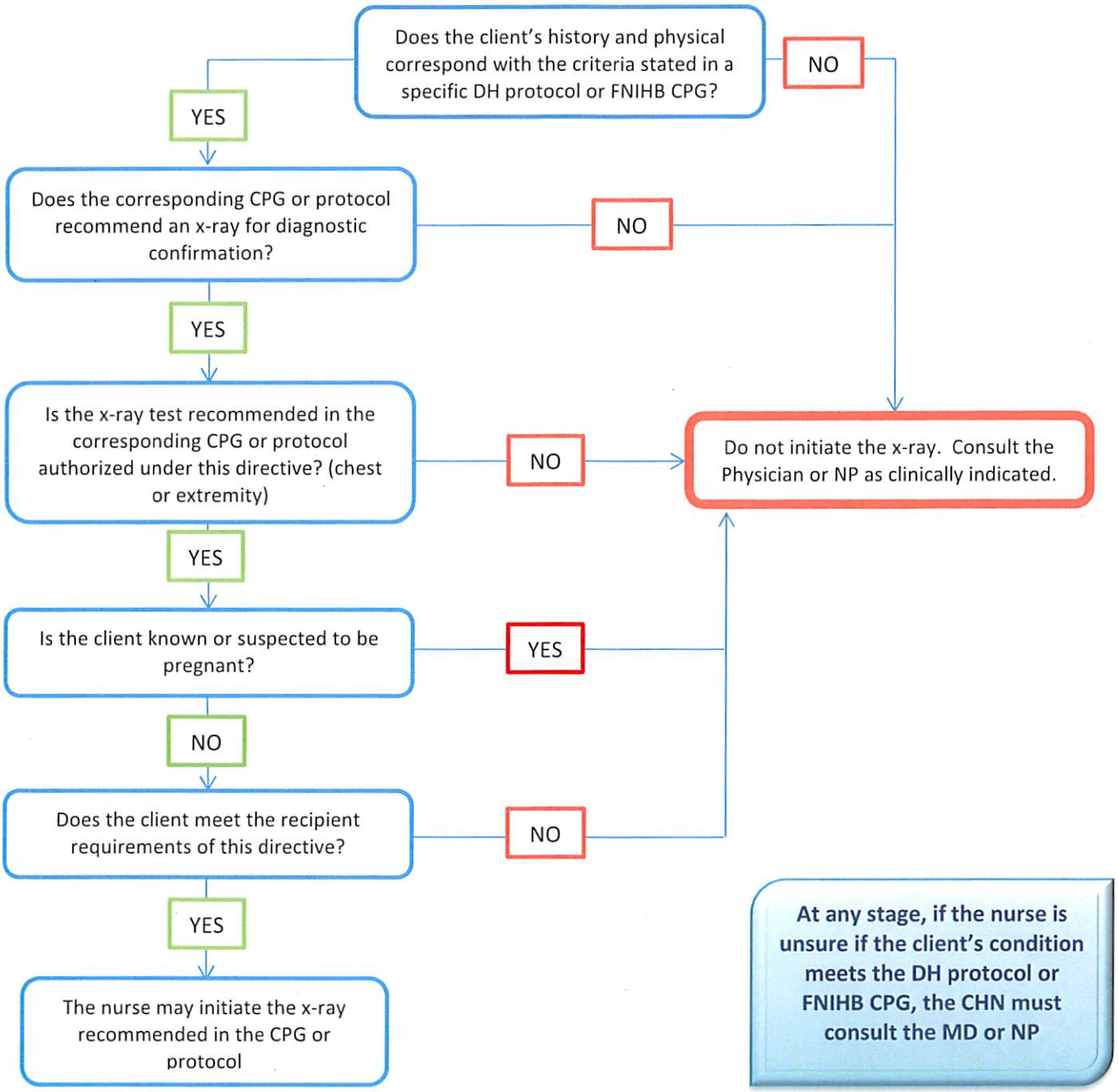
Note: The MD on call must be consulted when there is an urgent need for an x-ray to be read. The MD must be consulted in the event of a known or **suspected** fracture. For greater clarity, the MD must be consulted before the x-ray report is available.

8.7 At minimum, the following must be documented in the client's health record:

i. The client history and physical assessment findings
ii. The x-ray test ordered
iii. The indication / rationale for requesting the x-ray. The nurse must cite the Medical Directive Name PLUS the CPG or protocol used in enacting this medical directive.

Example: "PA/LAT chest x-ray ordered as per FNIHB CPG: Community Acquired Pneumonia under the CHN Initiated X-rays Medical Directive.

FIGURE 1: Algorithm for Assessing Appropriateness of the Medical Directive



9. Related Policies, Protocols and Legislation:

Appendix A: Ottawa Ankle and Foot Rules
Appendix B: Ottawa Knee Rules

Community Health Nursing Manual:	08-018-00 Performing X-rays
Community Health Nursing Manual:	08-010-00 Interpretation of X-rays
Community Health Nursing Manual:	08-019-01 Initiating X-rays for TB Program
Community Health Nursing Manual:	08-005-00 Acknowledgement of Diagnostic Test Results
Community Health Nursing Manual:	08-006-00 Follow up of Abnormal Diagnostic Test Results
Community Health Nursing Manual:	08-009-00 Radiographical Examination of Pregnant Women
Community Health Nursing Manual:	06-008-00 Documentation Standards Policy
Community Health Nursing Manual:	05-009-00 Transferred Functions Policy

FNIHB Clinical Practice Guidelines for Nurses in Primary Care
FNIHB Pediatric Clinical Practice Guidelines
Government of Nunavut TB Manual

10. References

Health Canada (2011). *First Nations and Inuit Health Branch Pediatric Clinical Practice Guidelines for Nurses in Primary Care*.

Government of Nunavut. Tuberculosis Manual.

Stiell, I.G., Wells, G. A., Hoag, R. H., Sivilotti, M. L., Cacciotti, T. F., Verbeek, P. R., et al. (1997). Implementation of the Ottawa Knee Rule for the use of radiography in acute knee injuries. *JAMA 278(23),* 2075-2079.

Stiell. I., Wells, G., Laupacis, A., Brison, R., Verbeek, P., Vandernheen, K. et al. (1995). Multicentre trial to introduce the Ottawa ankle rules for use of radiography in acute ankle injuries. *BMJ 311,* 594-597.

CNO (2014). Reference Document: Legislation and Regulation. RHPA: Scope of Practice, Controlled Acts Model.

Approved By:	Date:
Jennifer Berry, Assistant Deputy Minister, Operations – Department of Health	Dec 10, 2020
Approved By:	Date:
Jenifer Bujold, A/ Chief Nursing Officer	Mar 08, 2021
Approved By:	Date:
Dr. Francois de Wet, Medical Chief of Staff, on behalf of the Medical Advisory Committee	

PRINCIPLES

- Ottawa Ankle and Foot Rules are applied to acute ankle injuries with the intention of reducing the excessive use of ankle x-rays.
- Fractures are diagnosed in only 7% to 36% of ankle injuries, even though most clients undergo a radiographic evaluation. Decreasing excessive radiographs would decrease client exposure to radiation and health care costs.
- Rules can only be applied to clients who are alert and are able to appropriately communicate their pain.

OTTAWA ANKLE RULES

A series of ankle x-ray films is required only if there is any pain in the malleolar zone **and** any of these findings:

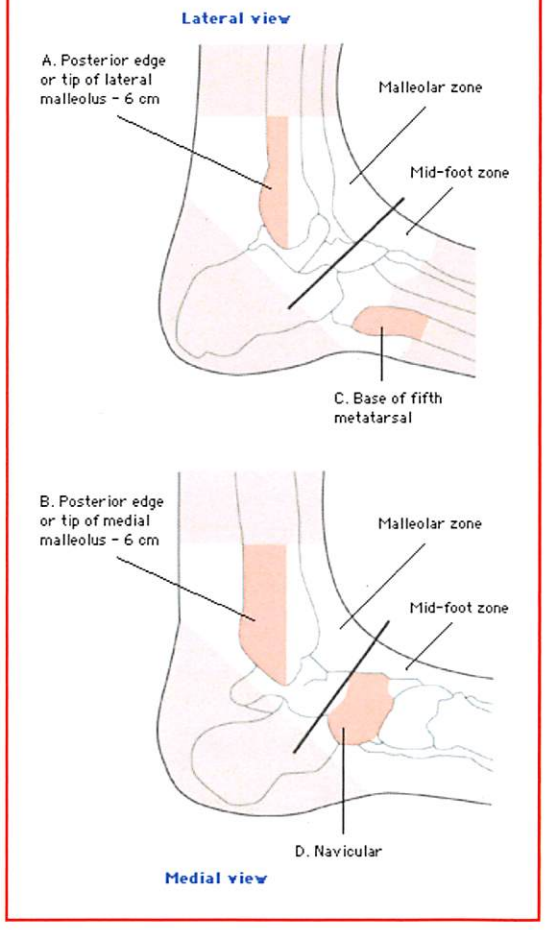
The client has pain near the malleoli, **and** if any of the following are true:

1. Bone tenderness at posterior edge or tip of lateral malleolus (identified as ***A*** on the figure below)
2. Bone tenderness at Posterior edge or tip of medial malleolus (identified as ***B*** on the figure below)
3. Inability to bear weight both immediately and in the emergency department.

OTTAWA FOOT RULES

A series of foot x-ray films is required only if there is any pain in mid-foot zone **and** any of these findings:

1. Bone tenderness at the base of the fifth metatarsal (identified as ***C*** on the figure below)
2. Bone tenderness on the navicular bone (identified as ***D*** on the figure below)
3. Inability to bear weight both immediately and in the emergency department.



Ottawa ankle rules†

Ankle films:
A series of ankle x ray films is required only if there is any pain in malleolar zone and any of these findings:

- Bone tenderness at A
- Bone tenderness at B
- Inability to bear weight both immediately and in the emergency department

Foot films:
A series of foot x ray films is required only if there is any pain in mid-foot zone and any of these findings:

- Bone tenderness at C
- Bone tenderness at D
- Inability to bear weight both immediately and in the emergency department

†Modified from Stiell, IG, McKnight, RD, Greenberg, GH, et al, JAMA 1994; 271:827.

APPENDIX B: Ottawa Knee Rules

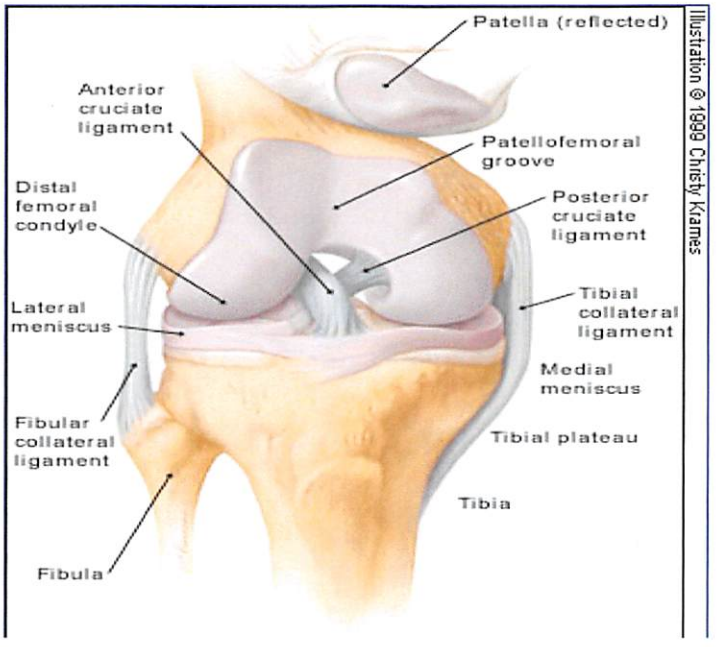
PRINCIPLES

- Ottawa Knee Rules are applied to acute knee injuries with the intention of reducing the excessive use of knee x-rays, by assisting the nurse or physician in the decision to use radiography.
- Decreasing excessive radiographs would decrease client exposure to radiation and health care costs.
- Rules can only be applied to clients who are alert and are able to appropriately communicate their pain.

OTTAWA KNEE RULES

A knee x-ray series is only required for knee injury patients with **any** of these findings:

1. Age 55 or older; **OR**
2. Isolated tenderness of patella (no bone tenderness of knee other than patella); **OR**
3. Tenderness of the head of fibula; **OR**
4. Inability to flex to 90˚; **OR**
5. Inability to bear weight both immediately and in the emergency department for 4 steps (unable to transfer weight twice onto each lower limb regardless of limping)



Department of Health Government of Nunavut		NURSING POLICY, PROCEDURE AND PROTOCOLS Community Health Nursing	
TITLE:		**SECTION:**	**POLICY NUMBER:**
Initiating X-Rays for TB Program		Diagnostics	08-019-01
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
August 21, 2020	August 2023		5
APPLIES TO:			
Community Health Centres			

1. **BACKGROUND:**

X-rays are a vital tool used to screen for and diagnose pulmonary tuberculosis (TB) infections, as well as addressing the patient's clinical response to TB treatment. The Department of Health maintains two policies (08-018-00 and 08-019-00) which outline who is authorized to initiate an x-ray request and who is authorized to perform x-ray procedures in the health centre setting. Through these policies, Community Health Nurses (CHNs) are delegated the authority to initiate x-ray requests without a Physician or Nurse Practitioner (NP) order, but only with very strict parameters. As well, these policies permit CHNs, NPs, and Basic Radiology Technicians (BRT) to perform radiological procedures under specific guidelines.

The strict parameters set out in these medical guidelines were defined such that patient safety risks would be minimized, essential services would remain available in each community, and overall quality assurance of this activity could be easily monitored by the Department of Health. Although these policies remain relevant for general health centre use, they do present challenges when utilized in community-wide TB screening programs, which are primarily staffed with nurses working under the Public Health Nurse job description. This policy provides an authorizing mechanism for Public Health Nurses to additionally initiate orders for basic radiography exams under the community-wide TB screening program as outlined in this policy.

2. **MEDICAL DIRECTIVE:**

2.1 Community Health Nurses, Supervisors of Community Health Programs, and Public Health Nurses may initiate a chest x-ray request without a direct Physician or Nurse Practitioner (NP) order in accordance with the Department of Health TB surveillance protocols for:

- i. Patients of all ages who are being screened for TB disease as part of the Community-Wide TB Screening Program, or
- ii. Patients of all ages who are being monitored in follow-up for TB disease as part of the Community-Wide TB Screening Program, or
- iii. Patients of all ages, in the community health centre setting, who are being investigated and monitored for TB, in accordance with the Department of Health, TB Manual guidelines.

2.2 CHNs and PHNs are not authorized to initiate x-rays for patients who are pregnant; MD or NP order is required.

Practice Note: The practitioner must be aware, that due to the equipment and resources available in the health centre setting, the films may be suboptimal, and care must be exercised in using them for clinical decision making.

3. **RECIPIENT PATIENTS:**
Patients of all ages.

4. **CONTRAINDICATIONS TO THIS MEDICAL DIRECTIVE:**
Consult the Physician or NP before initiating an x-ray when any of the conditions exist:
   i. Patient is known or suspected to be pregnant.
   ii. The CHN/PHN cannot confirm all the conditions of this directive have been met.
   iii. The patient's history of physical exam does not match the criteria set forth in the Department of Health TB manual and protocols.
   iv. The x-ray test is not recommended as part of the diagnostic investigation as stated within the Department of Health TB Manual and protocols, or the protocols recommend physician consultation first.
   v. **The CHN/PHN must verify the date of the last chest x-ray and consult the physician if the x-ray was taken within a month of the proposed x-ray.**

5. **AUTHORIZED IMPLEMENTERS:**
   5.1 Community Health Nurses, Supervisors of Community Health Programs, and Public Health Nurses who possess the knowledge, skill and judgement to do so and are following Department of Health TB Manual protocols. Demonstrated competency is required to implement this medical directive through the standard orientation process.
   5.2 Sub delegation is not permitted to another health care provider or staff.

6. **DEFINITIONS:**
Nurse: Refers to Community Health Nurse, Supervisor of Community Health Programs, and Public Health Nurse.

7. **PRINCIPLES:**
   7.1 Nurses are expected to practice within their own level of competence and seek guidance from their supervisor, physician, or NP as needed.
   7.2 Guidelines do not replace clinical judgement. Management decisions must be individualized.
   7.3 Children and fetuses are more radiosensitive and thus require special consideration.

8. **PROCEDURE:**
   8.1 The nurse conducts a comprehensive history and physical assessment to determine if the conditions of this directive have been met. If the findings of the initial assessment suggest an x-ray is warranted as per the TB Manual, a chest x-ray may be initiated. Algorithm in *Figure 1* provides guidance to the nurse when determining if the medical directive is appropriate to enact.
   8.2 The nurse will explain the procedure to the patient and/or family, including any potential adverse outcomes. Obtain verbal consent.
   8.3 Complete all required fields on the x-ray requisition (enter in Meditech when available):
      i. Patient identifiers.
      ii. Reasons for requesting the x-ray exam (clinical findings and initial differential diagnoses).
      iii. Ensure the name of the nurse who is initiating the x-ray is clearly stated as the ordering provider. Do not include the MD or NP name if a direct order was not obtained.
   8.4 The nurse ordering an x-ray test is accountable for providing timely follow-up of test results,

in accordance with CHN Manual policies: *Interpretation of X-Rays; Acknowledgement of Diagnostic Test Results;* and *Follow up of Abnormal Test Results.*

Note: The Physician On-Call must be consulted when there is an urgent need for an x-ray to be read.

8.5 At minimum, the following must be documented in the patient's health record:

i. The patient history and physical assessment findings.

ii. The x-ray test ordered and the medical directive name.
For example: "PA/LAT chest x-ray ordered as per 'X-rays for TB Screening' policy."

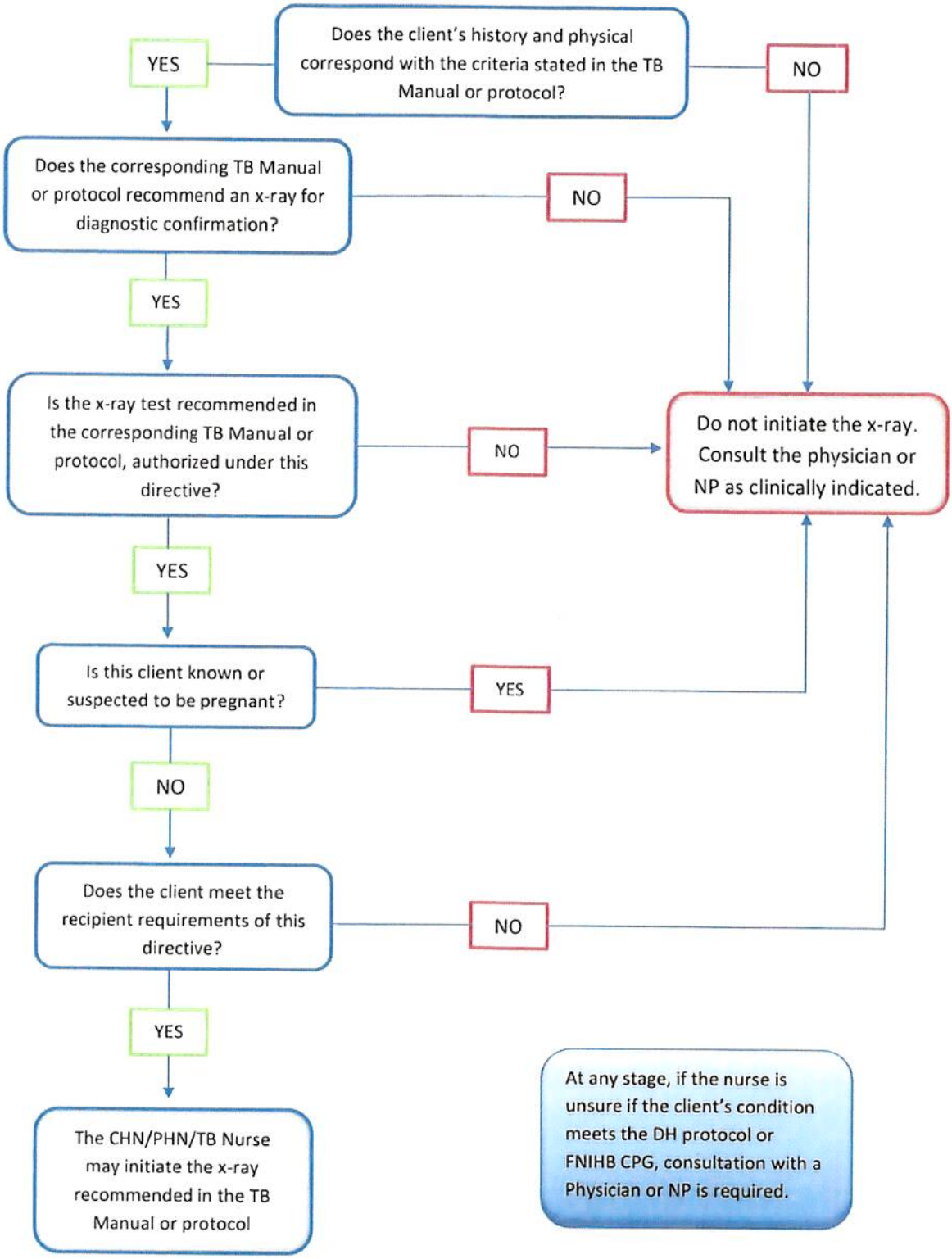
9. Related Policies, Protocols, and Legislation:

Community Health Nursing Manual: 08-019-00 Nurse Initiated X-ray Requests
Community Health Nursing Manual: 08-018-00 Performing X-rays
Community Health Nursing Manual: 08-010-00 Interpretation of X-rays
Community Health Nursing Manual: 08-005-00 Acknowledgement of Diagnostic Test Results
Community Health Nursing Manual: 08-006-00 Follow up of Abnormal Diagnostic Test Results
Community Health Nursing Manual: 08-009-00 Radiographical Examination of Pregnant Women
Community Health Nursing Manual: 06-008-00 Documentation Standards Policy
Community Health Nursing Manual: 05-009-00 Transferred Functions Policy
FNIHB Clinical Practice Guidelines for Nurses in Primary Care
FNIHB Pediatric Clinical Practice Guidelines
Government of Nunavut TB Manual

10. References:

Government of Nunavut. Tuberculosis Manual.
Steill, I.G., Wells, G.A., Hoag, R.H., Sivilotti, M.L., Cacciotti, T.F., Verbeek, P.R., et al. (1997).
CNO (2014). Reference document: Legislation and Regulation. RHPA: Scope of Practice, Controlled Acts Model.

Figure 1: Algorithm for Assessing Appropriateness of the Medical Directive



Approved By:	Date:
Dr. Michael Patterson, Chief Public Health Officer – Department of Health	
Approved By	Date: September 8, 2020
Monique Skinner, Chief Nursing Officer	

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS Community Health Nursing	
TITLE:	**SECTION:**	**POLICY NUMBER:**
Troponin Point of Care Tests in Pediatric Patients	Diagnostics	08-020-00 ~~08-010-00~~
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
January 11, 2018 / January 2020		1
APPLIES TO:		
All Health Centre Staff		

1. **BACKGROUND:**

Chest pain is a commonly encountered problem in children and adolescents. Literature consistently describes the prevalence of chest pain due to cardiac pathology as being relatively low- approximately 1-5%.

Nunavut health centres are equipped with qualitative point of care Troponin I Kits, which are a valuable tool in assessing adults presenting with chest pain in the community setting. Conversely, in the pediatric population, the utility of using point of care Troponin tests as a routine tool for assessing chest pain is much lower. This is due to the low incidence of ischemic cardiac events in children and adolescent patients, and not due to the test kits themselves.

2. **POLICY:**

Community Health Nurses require a Physician or Nurse Practitioner order before performing both qualitative and quantitative point of care Troponin tests in the pediatric population, ages 0-18 years.

3. **PRINCIPLES:**

3.1 The Department of Health is dedicated to providing excellent care to patients of all ages, which is rooted in evidence-informed practice.

3.2 Health care providers demonstrate resource stewardship by using resources wisely and thoughtfully. Ordering tests 'just in case' has the potential to cause more harm than good. In cases with high number of false positives, pursuing additional investigations can cause unnecessary costs, increased anxiety for patients, and even harm to patients.

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

5. CHN Policy: 08-002-00 *Requisitioning Laboratory Studies*
   CHN Policy: 08-006-00 *Follow-up of Abnormal Diagnostic Test Results*

Approved By: Colleen Stockley	Date: Jan. 10/18
Colleen Stockley, Deputy Minister – Department of Health	
Approved By:	Date: January 12, 2018
Jennifer Berry, Chief Nursing Officer	

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS Community Health Nursing	
TITLE:	**SECTION:**	**POLICY NUMBER:**
i-STAT Point of Care Testing in Community Health Centres	Diagnostics	08-021-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
May 28, 2021 / May 28, 2024	N/A	4
APPLIES TO:		
Community Health Centres		

1. **BACKGROUND:**
   1.1. The Department of Health (Health) is aware of the limited capacity for diagnostic and medical testing that is available in each of the communities of Nunavut. In order to increase the capacity for testing at each community-based health centre, Point of Care Testing (POCT) has been introduced.
   1.2. The i-STAT device is a POCT unit which enables clinical staff to perform certain crucial diagnostic tests in the absence of laboratory services. The use of POCT units such as i-STAT has been approved by the Medical Advisory Committee (MAC) and the Diagnostic Advisory Committee (DAC).

2. **POLICY:**
   2.1. i-STAT POCT is primarily used for patients with emergent, urgent, and/or resuscitative presentations.
   2.2. All clinical staff are required to complete specified training and demonstrate competency prior to using i-STAT POCT.
   2.3. i-STAT POCT may be initiated by Community Health Nurses (CHN) if the test is indicated within Department of Health clinical guidelines or First Nations Inuit Health Branch (FNIHB) Guidelines in patient presentations requiring resuscitative, emergent and/or urgent situations. Following **ALL** i-STAT POCT, the CHN is required to consult a physician or NP on the patient's clinical presentation and i-STAT POCT results.
   2.4. All Registered Nurses (RN) not working within the expanded scope or Licensed Practical Nurses (LPN) are not authorized to initiate i-STAT unless ordered by a physician or NP.
      2.4.1. In the event of a critical emergency with limited CHNs, an RN or LPN may complete the iSTAT at the direction of the CHN as this is seen as a team unit working together. An order must be obtained from a physician or NP as soon as possible.
   2.5. The i-STAT may be initiated for time sensitive situations such as INR monitoring for patients who require Warfarin titration, however, this requires a physician or NP to provide a standing order in the patient's plan of care.

3. **PRINCIPLES:**

3.1. Health and FNIHB Guidelines clearly state the circumstances in which a Physician or NP consultation is required; this includes but is not limited to, resuscitative, emergent, and most urgent patient presentations.

3.1.1. CHNs are permitted to initiate i-STAT POCT if the test is indicated in Health and FNIHB Guidelines.

3.1.2. Guidelines do not replace clinical judgement. Management decisions must be individualised.

3.1.3. Clinicians are expected to practice within their own level of competence and seek guidance from their supervisor, physician, or NP as needed.

4. **DEFINITIONS:**

4.1. **Clinicians**: Community Health Nurses, Registered Nurses, Licensed Practical Nurses, Nurse Practitioners, and Physicians

4.2. **Point of Care Test**: Diagnostic test performed outside a laboratory environment

4.3. **Resuscitative**: Threats to life or limb; imminently requiring intervention

4.4. **Urgent**: Potential threat to life, limb, or function; rapid intervention required

4.5. **Emergent**: Conditions with the potential to progress to a serious problem

5. **PROCEDURE:**

5.1 Prior to using i-STAT POCT clinical staff are required to complete training and gain competency in the proper use of the device, including quality control measures outlined in the POCT Operational Procedures Manual.

5.2 All tests performed with the i-STAT device must be acknowledged and have the results recorded in the patient's electronic medical record. A specific section for POCT resulting/recording is built into the Electronic Medical Record (Meditech).

5.3 Abnormal POCT results will be communicated to Physician or NP in a timely manner.

5.4 Ongoing evaluation on the effectiveness of the i-STAT device will be completed as outlined in Appendix A.

5.4.1 The i-STAT POCT Evaluation Log found in Appendix A is added to the existing Health Centre Quality Control Log.

5.4.2 An entry into the i-STAT POCT Evaluation Log is completed by the clinician initiating the POCT. No client identifiers are recorded to maintain patient confidentiality.

5.4.3 The i-STAT POCT Evaluation Log is emailed or faxed monthly to the Territorial POCT Coordinator or designate, along with the Quality Control Log

5.5 The POCT Operational Procedures Manual is available in each health centre in hard copy, with most up to date versions uploaded by the Territorial POCT Coordinator, onto a Government of Nunavut approved electronic platform.

5.6 Quality control testing is to be performed following the most up to date operational procedure.

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

6.1. Community Health Nursing Manual: 08-001-00 Laboratory Procedures

6.2. Community Health Nursing Manual: 08-003-00 Interpretation of Laboratory Studies

6.3. Community Health Nursing Manual: 08-005-00 Acknowledgement of Diagnostic Test Results

6.4. Community Health Nursing Manual: 08-006-00 Follow-Up of Abnormal Diagnostic Test Results

7. **REFERENCES**:

CSMLS. (2016). Point of Care Testing. Retrieved from: https://csmls.org/csmls/media/documents/position_statements/Point-of-Care-Testing_EN062016.pdf

Canadian Association of Emergency Physicians (CAEP). (2012). The Canadian trigae and acuity scale: Combined adult/paediatric educational program. Retrieved from: http://ctas-phctas.ca/wp-content/uploads/2018/05/participant_manual_v2.5b_november_2013_0.pdf

Approved By:	Date:
Jennifer Berry, Assistant Deputy Minister – Department of Health	May 31 / 2021
Approved By:	Date:
Jenifer Bujold, Acting Chief Nursing Officer	May 30, 2021
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: 2021.05.31 09:07:34 -04'00'	Date:
Francois de Wet, Chief of Staff	

Appendix A: i-STAT POCT Evaluation Log

****To be completed for each client presentation when i-STAT POCT utilized****

****Maintain Confidentiality; Avoid Entering Client Identifiers****

Health Centre: _____

Month/Year: _____

Date/Time:_____ **Cartridge(s) used:** ☐ Chem 8 ☐ PT/INR ☐ EG7 ☐ cTnI

Client Age Range: ☐ Pediatric ☐ Adult (18-55) ☐Elder (55+)

Indication for i-STAT POCT:_____

Outcome of i-STAT POCT (check atleast one and comment):

- ☐ Contributed to the decision for Medivac that would not have otherwise been considered
- ☐ Contributed to the decision for Schedivac that would not have otherwise been considered
- ☐ Prevented a Medivac
- ☐ Treatments/therapies initiated/adjusted according to POCT result
- ☐ No change to care plan based on i-STAT use

Comments:

Date/Time:_____ **Cartridge(s) used:** ☐ Chem 8 ☐ PT/INR ☐ EG7 ☐ cTnI

Indication for i-STAT POCT:_____

Client Age Range: ☐ Pediatric ☐ Adult (18-55) ☐Elder (55+)

Outcome of i-STAT POCT (check atleast one and comment):

- ☐ Contributed to the decision for Medivac that would not have otherwise been considered
- ☐ Contributed to the decision for Schedivac that would not have otherwise been considered
- ☐ Prevented a Medivac
- ☐ Treatments/therapies initiated/adjusted according to POCT result
- ☐ No change to care plan based on i-STAT use

Comments:

Department of Health Government of Nunavut	**Medical Directives and Delegation** **Community Health Nursing**	
TITLE:	**SECTION:**	**POLICY NUMBER:**
Paramedic Initiation of Point of Care Testing Medical Directive	Nursing Practice	08-022-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
July 21, 2021 / July 2022	NEW	6
APPLIES TO:		
Primary Care Paramedics, Advanced Care Paramedics		

1. BACKGROUND:

The Department of Health (DH) recognises the need to provide additional healthcare support to communities impacted by Community Health Centre (CHC) critical nursing staff shortages that may have a significant impact on patient safety and access to care for Nunavuimmut.

The Department of Health (Health) is aware of the limited capacity for diagnostic and medical testing that is available in each of the communities of Nunavut. In order to increase the capacity for testing at each community health centre, Point of Care Testing (POCT) has been introduced.

This medical directive provides an authorizing mechanism for both Primary Care Paramedics (PCP) and Advanced Care Paramedics (ACP) to initiate certain POCT under specific circumstances listed in section 2.

2. MEDICAL DIRECTIVE AND/OR DELEGATED PROCEDURE:

2.1 All presentations and POCT results outlined in 2.3 – 2.11 require a follow up consultation with a physician or NP where the POCT results are communicated.

2.2 The PCP or ACP may perform urine analysis (either by the urine dip stick or the Clinitek machine) for pregnancy patients presenting for routine pre-natal visits as part of their role assisting with pre-appointment work up.

2.2.1 All results will be written on POCT Results Form (see appendix A) and submitted to the clinician (CHN/NP/Midwife) who will be seeing the patient.

2.3 The ACP may perform urine analysis (either by the urine dip stick or the Clinitek machine) for patients presenting with dysuria, urgency, or increased frequency in voiding.

2.4 The PCP or ACP may perform INR POCT for patients on coumadin requiring scheduled titration based on INR levels.

2.4.1 The PCP and ACP are not allowed to follow the scheduled coumadin dosing table and must receive orders from the Physician or NP.

2.5 The ACP may perform a rapid strep test for patients presenting with a sore throat whose strep score is 2 or greater (refer to Appendix B for the strep score calculator).

2.6 The PCP or ACP may perform a urine pregnancy test for any female patient requesting a pregnancy test.

2.7 The ACP may perform a urine pregnancy test for any female presenting with abdomen/ lower back pain or vaginal bleeding where the etiology of pregnancy abnormalities must be ruled out.

2.8 The PCP or ACP may perform glucometer POCT for any clinical manifestations of hypoglycemia (I.e. change in mentation, decreased level of consciousness, seizure, etc.) or hyperglycemia (poly-uria/dypsia/phagia, acetone breath, weakness, change in mentation, DKA, HHS, etc)

2.9 The PCP or ACP may perform the Hemocue POCT in situations of trauma; hypovolemic shock; significant bleeding; known or suspected GI/internal bleeding; known or suspected anemia.

2.10 The PCP or ACP may perform a urine drug toxicology POCT for suspected drug use relating to clinical presentations of decreased level of consciousness, seizures or changes in mentation.

2.11 The ACP may perform Troponin iSTAT POCT for any patient presenting with chest pain or cardiac ischemic associated symptoms where the etiology of myocardial infarct must be ruled out.

2.11.1 A Physician or NP must be consulted prior to performing Troponin POCT in pediatric populations aged 0-18. Refer to the Troponin Point of Care Tests in Pediatric Patients Policy # 08-020-00

2.12 The PCP or ACP may perform COVID-19 POCT following the recommended guidelines in the GN Department of Health Communicable Disease Manual COVID-19 protocol, the COVID-19 Laboratory Testing Authority (Policy #07-034-00), and other Nunavut COVID-19 laboratory guidance documents (e.g. IDNow Protocol) - provided competency training is completed as outlined below.

3. PRINCIPALS

3.1 PCPs and ACPs must adhere to the consultation process after initiating all POCT and results must be communicated to an physician or NP in a timely fashion.

3.2 PCPs and ACPs are expected to practice within their own level of competency and scope of practice and are to seek guidance from their supervisor, physician or NP when needed.

3.3 PCPs and ACPs cannot subdelegate any POCT task and must strictly adhere to the conditions outlined in section 2.

3.4 PCPs and ACPs will follow the decision-making tree in Appendix C when initiating POCT

4. PROCEDURES:

5.1 Prior to using POCT PCPs and ACPs are required to complete training and gain competency in the proper use of the device, including quality control measures outlined in the POCT Operational Procedures Manual.

5.2 Prior to initiating POCT, the PCP or ACP must ensure that the specific circumstances (outlined in section 2) are met and match to the specific POCT being initiated.

5.3 All situations where the PCP or ACP initiate POCT require a consultation to the physician or NP and communicate the results.

a. Exception applies to PCPs or ACPs performing urine analysis for the purpose of pre-visit prenatal clinics in which the results are communicated to the clinician (CHN/NP/Midwife) overseeing that prenatal.

5.4 The POCT Operational Procedures Manual is available in each health centre in hard copy, with most up to date versions uploaded by the Territorial POCT Coordinator, onto a Government of Nunavut approved electronic platform.

5.5 Quality control testing is to be performed following the most up to date operational procedure.

5. DEFINITIONS:

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.

6. DOCUMENTATION:

6.1 In addition to following the Government of Nunavut documentation standards, when POCT is initiated the PCP or ACP must appropriately document the following in the patient's medical records:

- Outline the clinical criteria in section 2 which allowed authorization to complete the specified POCT.
- Chart the results of the POCT.
- Chart the name and designation of the physician or NP who the results were communicated to.
- Chart the diagnosis made by the consulting physician or NP along with the plan of care.
- 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.

7. 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 07-040-00 Primary Care and Advanced Care Paramedic Medical Directive
Policy 08-001-00 Laboratory Procedures
Policy 08-003-00 Interpretation of Laboratory Studies
Policy 08-005-00 Acknowledgement of Diagnostic Test Results
Policy 08-006-00 Follow-Up of Abnormal Diagnostic Test Results
Policy 08-020-00 Troponin Point of Care Tests in Pediatric Patients Policy

8. APPENDIXES:

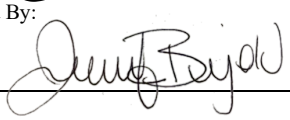
APPENDIX A: Point of Care Testing Results Form
APPENDIX B: Strep Throat Score Calculator
APPENDIX C: Decision-Making Model for Performing Additional Functions and Transferred Functions

9. 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

10. APPROVALS:

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	
Approved By:	Date:
Dr. Francois de Wet, Medical Chief of Staff, on behalf of the Medical Advisory Committee	

APPENDIX B: POINT OF CARE TESTING RESULTS FORM

Patient Identifiers or affix label here.

Patient Name: _____ Date of request: _____

Patient Health Card number: _____ Requested by: _____

Patient Date of Birth: _____

Date and time of POCT: _____ POCT performed by: _____

Urinalysis (urine dip or via Clinitek)	POCT result
Urine Specific Gravity	
Urine PH	
Hematuria	
Proteinuria	
Glycosuria	
Ketonuria	
Nitrates	
Leukocytes	
Bilirubin	

APPENDIX B: STREP SCORE CALCULATOR

Criteria	Score
Temperature of 38.0 degrees Celsius or greater	+1
Absence of a cough	+1
Swollen or tender anterior cervical lymph nodes	+1
Tonsillar swelling or exudate	+1
Age 3-14	+1
Age 15-44	0
Age 45 or older	-1

APPENDIX C: PRIMARY AND ADVANCED CARE PARAMEDIC DECISION-MAKING MODEL FOR PERFORMING ADDITIONAL FUNCTIONS AND TRANSFERRED FUNCTIONS