

# SHP Manual

DEPARTMENT OF HEALTH

VERSION 1, APRIL 1<sup>ST</sup>, 2023

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## FORWARD FROM JEN BERRY, ASSISTANT DEPUTY MINISTER OPERATIONS

The Department of Health pledged a commitment to strengthening its nursing workforce when it published the *Roadmap to Strengthen the Nunavut Nursing Workforce (2021-2026)*. The strategic pillars within the roadmap are intended to support the personal and professional development of nurses within a healthy, supportive work environment that both attracts and retains qualified and engaged nurses. This new *Supervisor of Health Programs Manual* reflects the dedication to meeting the roadmap goals.

The Supervisor of Health Programs (SHP) has extensive responsibilities for managing a full suite of primary health care and emergency care services in the community. SHPs require enhanced knowledge, skills, and abilities to support health care teams achieve healthcare excellence, while also meeting individual, family and community needs. This manual is intended to support new and seasoned SHPs by providing guidance on the management of the day-to-day functions expected within the role. It also aims to standardize the operational procedures of community health centres to facilitate staff mobility between communities in a safe and effective manner.

I would like to thank the Operations team for dedicating their time and offering their expertise, wisdom and experience to create Nunavut's first *Supervisor of Health Programs Manual*.



Jennifer Berry MN, NP-PHC, BScN

Assistant Deputy Minister Operations  
Department of Health, Government of Nunavut

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## ABBREVIATIONS

Please note in the document, the Director of Health Programs will be referred to as “Director.”

ADM: Assistant Deputy Minister	AEFI: Adverse Events Following Immunisation
ATA: Agency Task Authorisation	ATIPP: Access To Information and Protection of Privacy Act
AWOL: Absent Without Leave	BPGs: Best Practice Guidelines
BRT: Basic Radiology Technician	CGS: Community and Government Services
CHN: Community Health Nurse	CHR: Community Health Representatives
CMOH: Chief Medical Officer of Health	CPHO: Chief Public Health Officer
CQI: Continuous Quality Improvement	CRC: Criminal Record Check
CSA: Casual Staffing Action	DAC: Diagnostic Advisory Committee
ED&T: Economic Development & Tourism	ED: Executive Director. In this document, this refers to the Executive Director of Health for the region
EHB: Extended Health Benefits	ENT: Ear, Nose and Throat Specialist
GN: Government of Nunavut	GPO: Group Purchasing Organization
HPV: Human Papilloma Virus	HR: Human Resources
iEHR: interoperable Electronic Health Record	IPAC: Infection Prevention and Control
IR: Internal Requisition	KIS: Kivalliq Inuit Services
LCA: Local Contact Authority	LPN: Licensed Practical Nurse
MOA: Memorandum of Agreement	MRP: Most Responsible Person
NEU: Nunavut Employee Union	NIHB: Non-insured Health Benefits
NP: Nurse Practitioner	NRP: Nursing Resource Program
O&M: Operations and Maintenance	OHSNI: Ottawa Health Services Network
OOT: Out of Territory	OPR: Office of Patient Relations
P&T: Pharmacy and Therapeutics	PE: Performance Evaluation, sometimes used interchangeable with PR Performance Review
PHN: Public Health Nurse	PR: Performance Review, sometimes used interchangeable with PE Performance Evaluation
QC: Quality Control	QRM: Quality and Risk Management
RCDC: Regional Communicable Disease Coordinator	RCDC: Regional Communicable Disease Coordinator
RCMP: Royal Canadian Mounted Police	RESA: Relief Employee Staffing Action
RFP: Request for Proposal	RNANTNU: Registered Nurses Association of the Northwest Territories and Nunavut
RNAO: Registered Nurses Association of Ontario	RSN: Requisition for Supplies and Services Number
SAO: Senior Administrative Officer	SBAR: Situation, Background, Assessment, Recommendation
SHP: Supervisor of Health Programs. Formerly known as SCHK Supervisor Community Health Programs	SSR: Specimen Signature Record
TB: Tuberculosis	TPC: Territorial Procurement Committee
WSSC: Workers Safety and Compensation Commission	

## TIPS FOR NAVIGATING A PDF DOCUMENT USING TABLE ON CONTENTS AND BOOKMARKS

### Table of Contents

This document has a table of contents page i to viii. This feature does more than displaying the page numbers for headings as you can also jump to the section with a click.

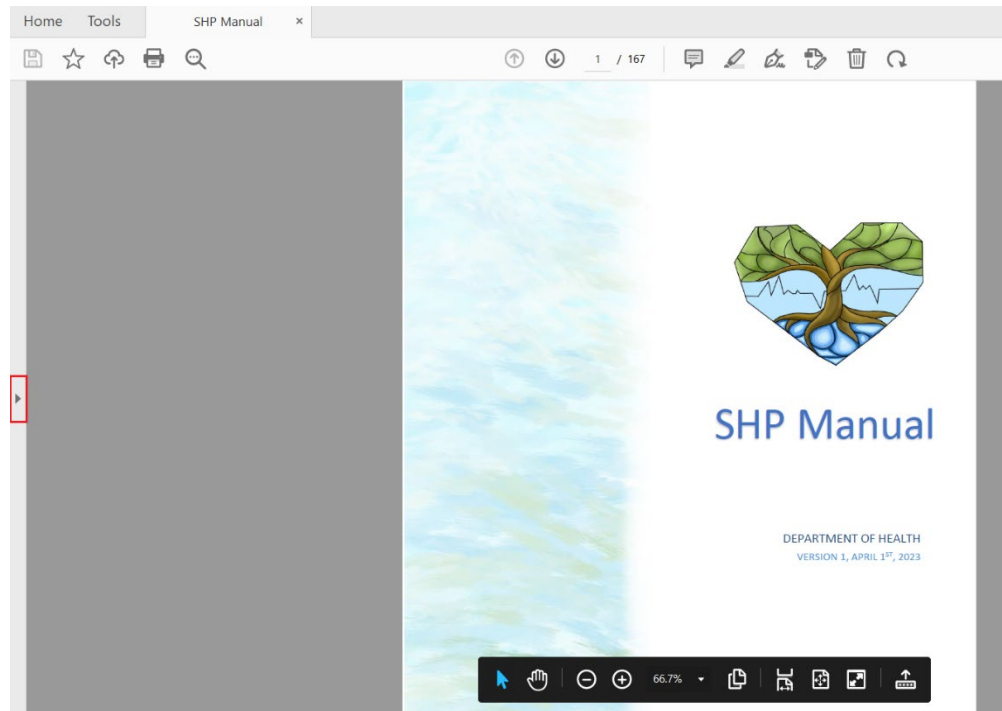
1. Hover over the heading name and click. This will jump you to the page.

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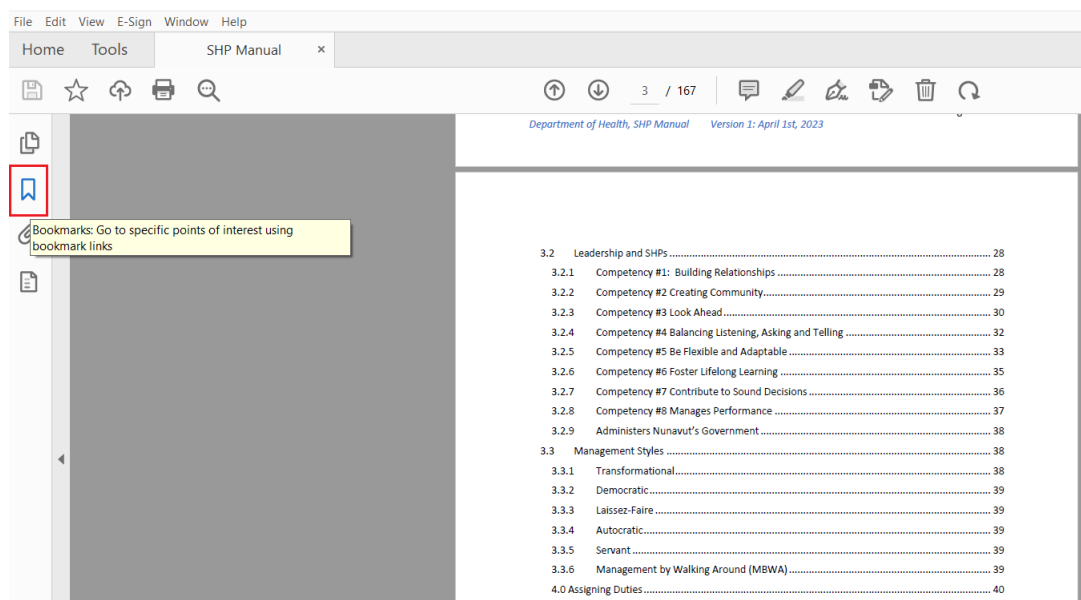
## Navigating Using PDF Bookmarks

Each heading listed in the Table of Contents is also a bookmark in this document. Bookmarks can be viewed on a side pane, and you can jump around the document using the bookmarks for easy navigation.

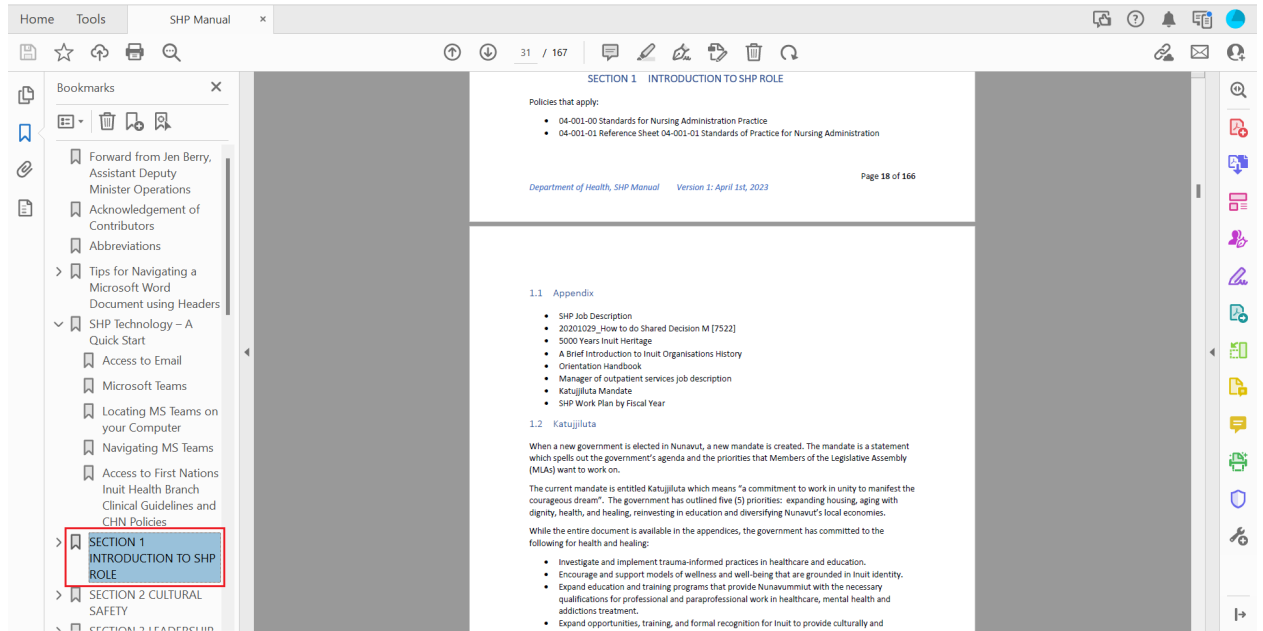
1. The left side pane may be open when you open this document, if so, please skip this step. Open the side pane by selecting the small triangle arrow on the left middle of your window



2. Once the side pane is open, you will see four icons. Select the Bookmark icon.



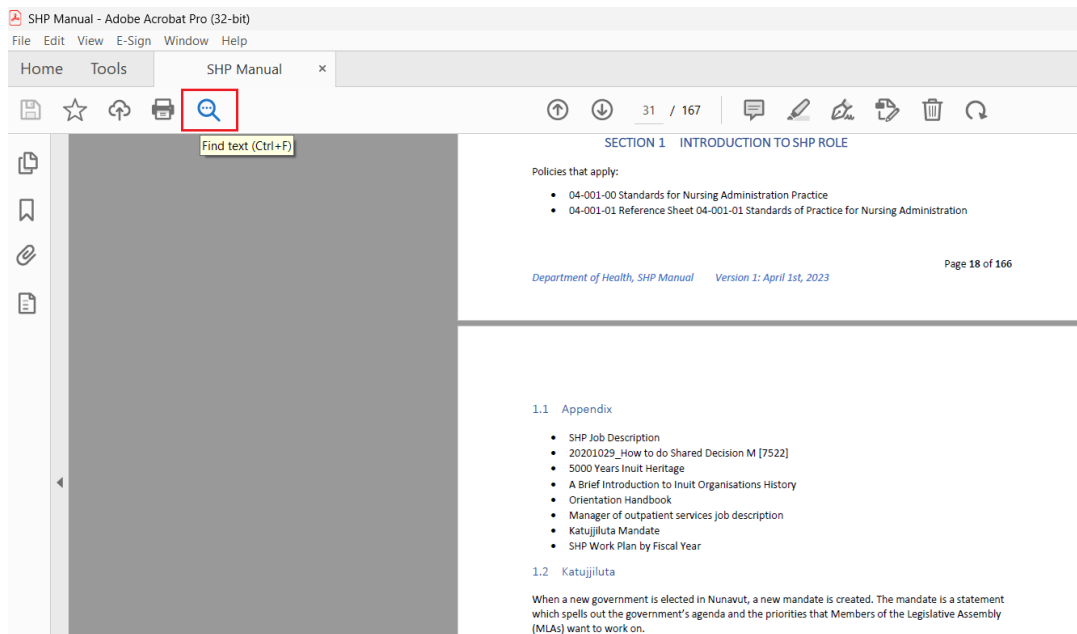
3. Selecting this will change the side pane to display all the bookmarked headings. Select any heading to jump to that page.



## Search and “Find”

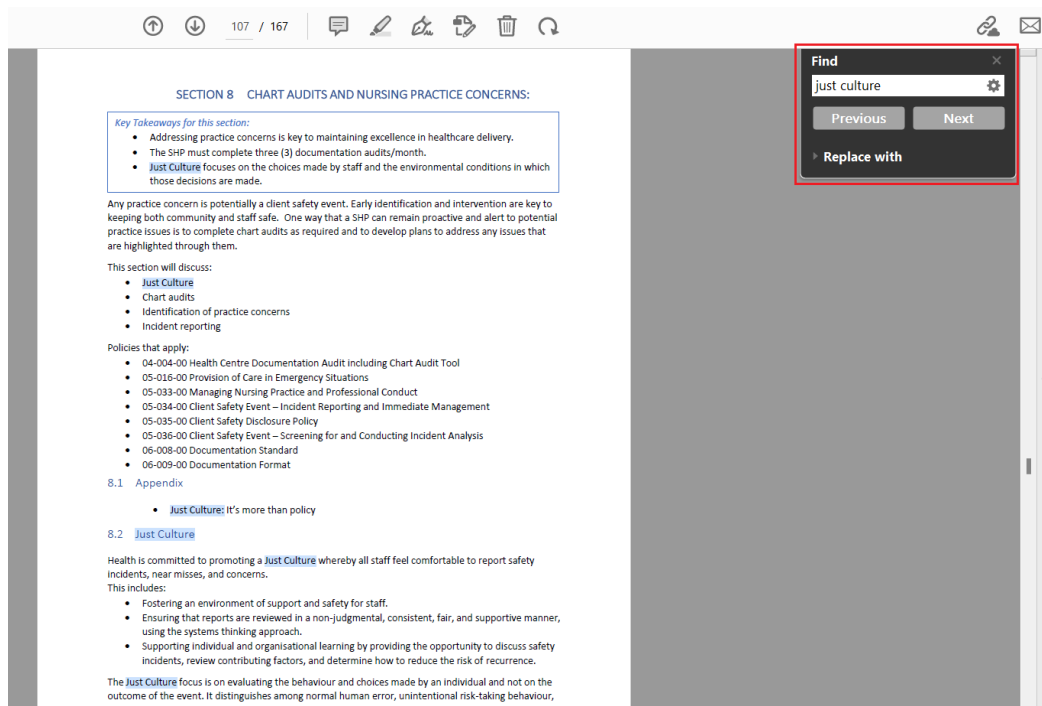
Searching the document for specific keywords can be very helpful.

1. To search a document for a word or phrase, you need to open the “Find” window. To open this window, you can use the keyboard shortcut pressing the “ctrl” key at the same time as the “f” key while in the document. You can also open this window by selecting the magnifying glass icon on the top left-hand side of the document.





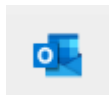
2. Once the Find window is opened, you can enter your phrase or keyword and select enter. You will be jumped to the first instance of that phrase or keyword, and you can select Next to be jumped to the next instance and so on. The phrase or keyword is highlighted through the document.



## SHP TECHNOLOGY – A QUICK START

### *Access to Email*

The SHP’s email platform is on Microsoft Outlook. This program can be identified with the below icon on your desktop, taskbar or in your programs.



If you do not have access to this program, please contact Help Desk.

If you are having an issue or would like more on the features of this program, please find support at: [Outlook help & learning - Microsoft Support](#)

### *Microsoft Teams*

The SHP role will rely on the use of the tool Microsoft Teams (MS Teams). This tool is a business communication platform that includes file sharing, calendar, text-based communication, and video calling functions.

Upon hire, you should be provided access to MS Teams. If you do not have access at this time, please contact Help Desk.



MS Teams is a huge program. For the sake of this quick start guide, we cannot go into all features here. This walk through will focus on core features to help you get started with the program. If you are having an issue or would like more on the features of this program, please find support at: [Microsoft Teams help & learning - Microsoft Support](#)

### Locating MS Teams on your Computer

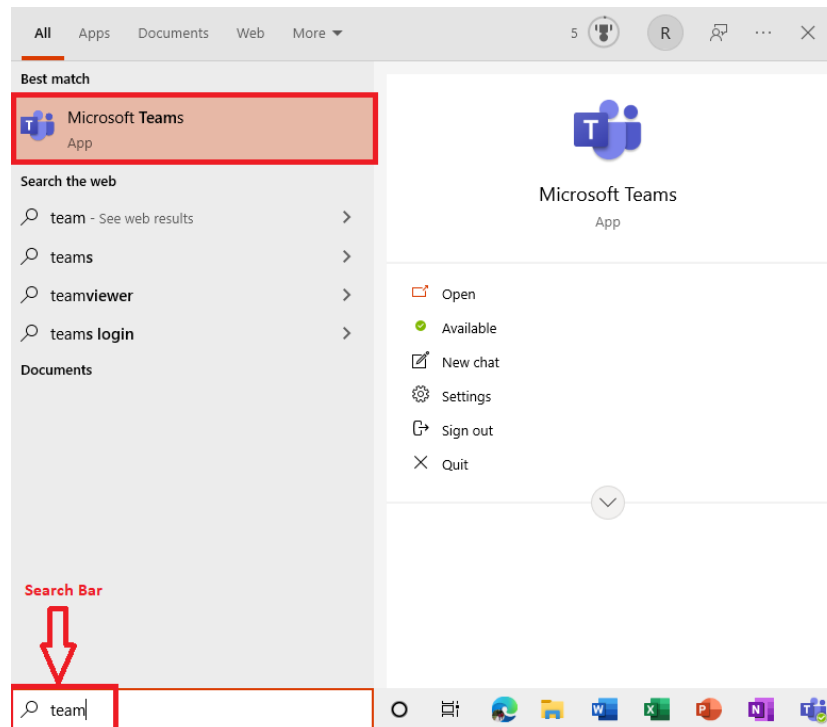
The MS Teams Icon may be found on your toolbar:



Or desktop icon:



If neither of these have been added to the computer, you can search your applications for MS Teams (note this easy search shown below is only available on computers running operating systems Windows 11 and above):

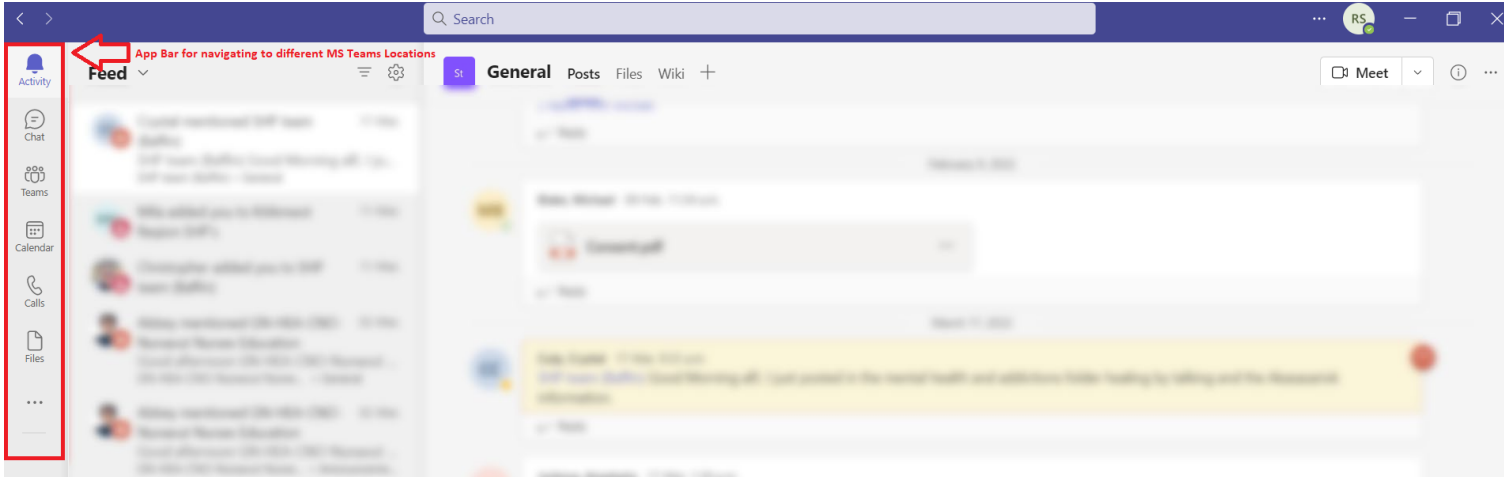


This section will provide a *brief* guide to using this tool to get you started. Helpdesk also provides some MS teams training which you should utilize as well.

## Navigating MS Teams

### App Bar


MS Teams has most aspects on navigation located on the left-hand panel called the App Bar.

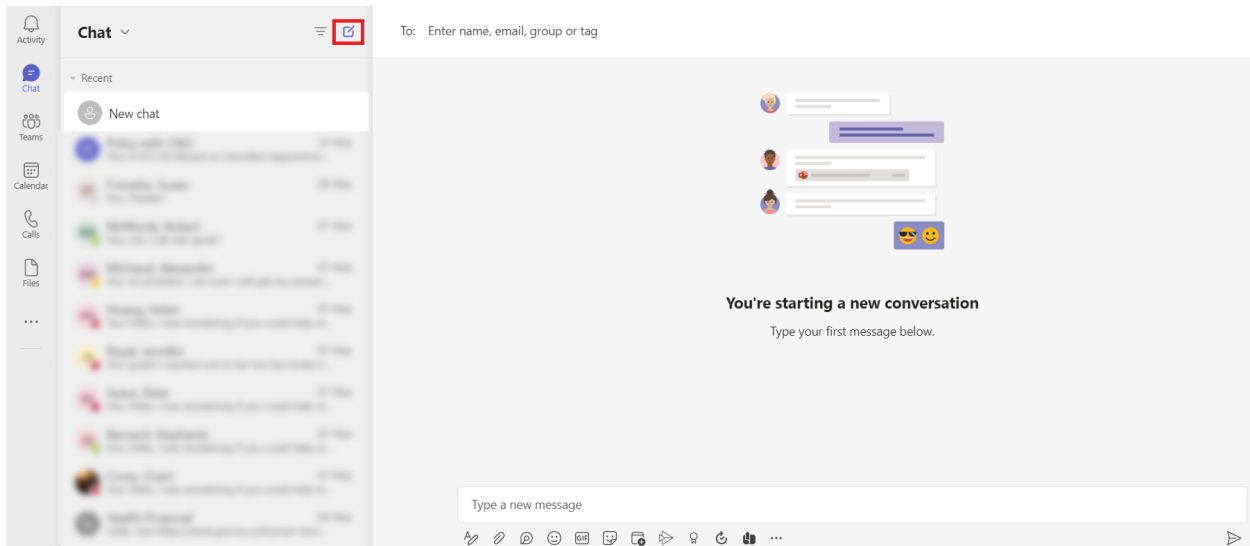


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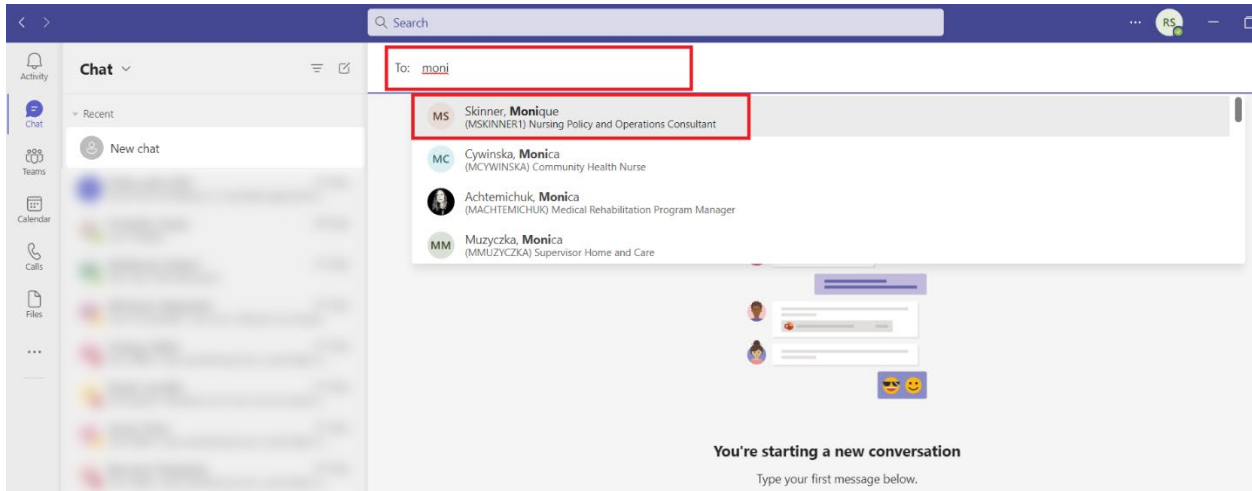
### Chat

MS Teams allows you to chat with any team members that are on the platform.

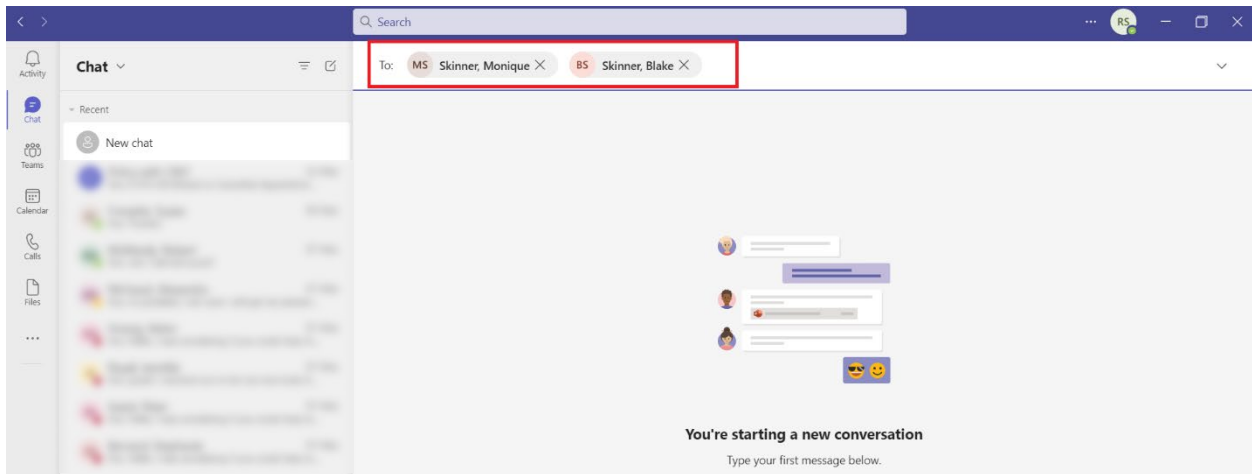
1. You can start a new chat by selecting the  button to the right of "Chat."



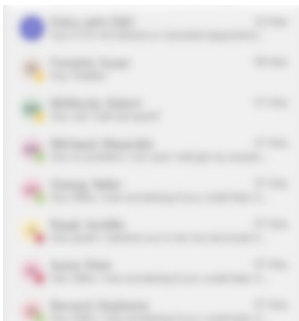
- This opens a dialogue window where you can start typing the name of the person you wish to chat with

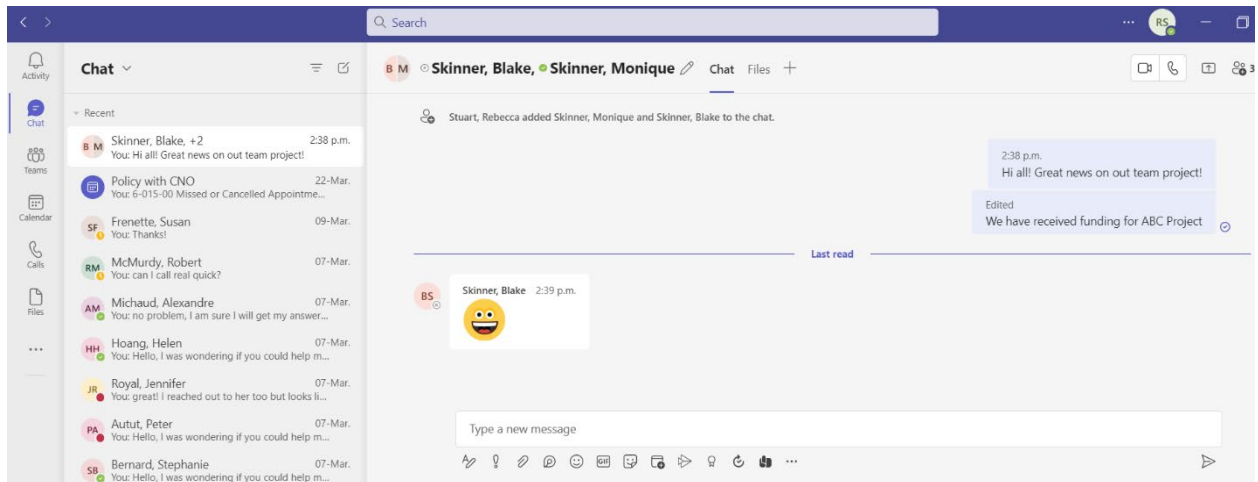


- You can add multiple people to the chat.



- Start typing in the next window at the bottom of the screen. Press “enter” or select the button to send the message to the chat attendees.





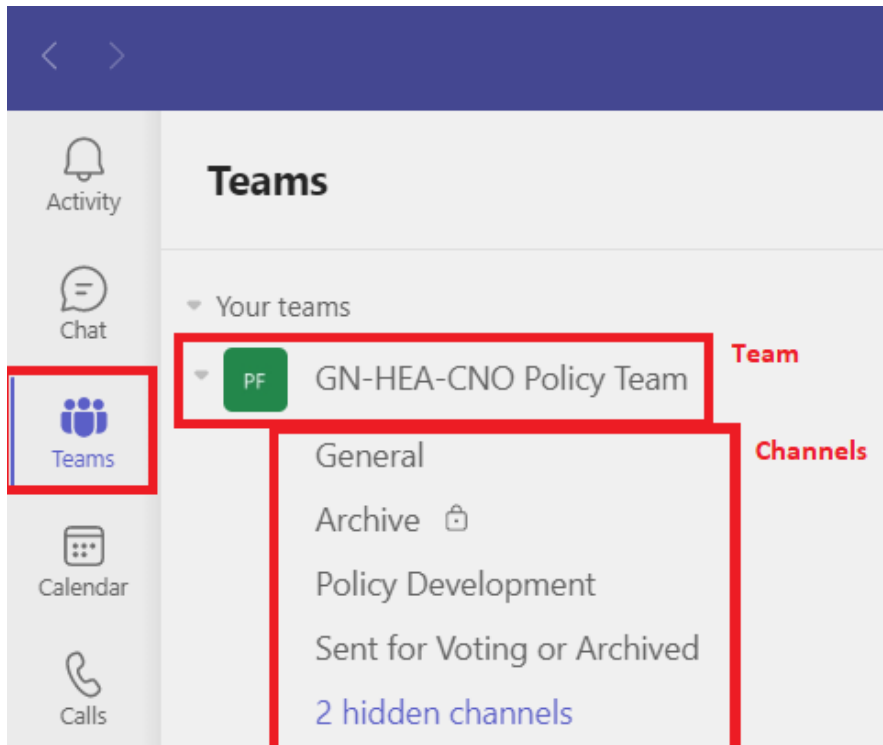
## Teams and Channels

Terminology can get confusing with Teams. This program is called Teams, and has many features, one of which is also called Teams. For this document and clarity, the program will be referred to as “MS Teams,” while the feature will be referred to as “Teams”.

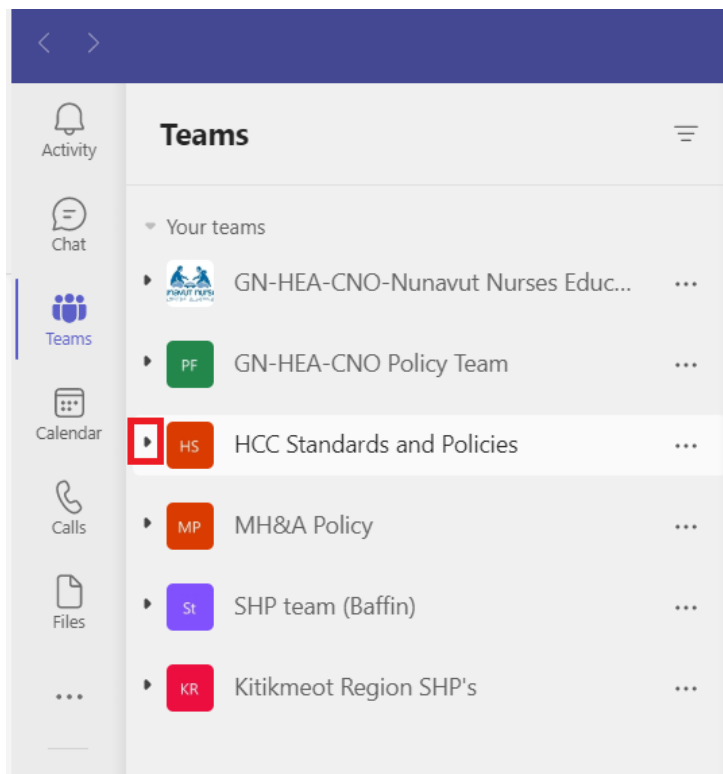
Teams is a virtual grouping of people, basically a virtual *team* of people. How teams are organized is up to your organization to set and administer. A channel appears below the team and can be organized to be based on a specific topic, project or department.

From the app bar, selecting “Teams”, you will see all the teams ***you have been added to***. If there is a Team you believe you should be a part of, contact your administrator.

For more information about Teams and Channels, [please review this article](#).



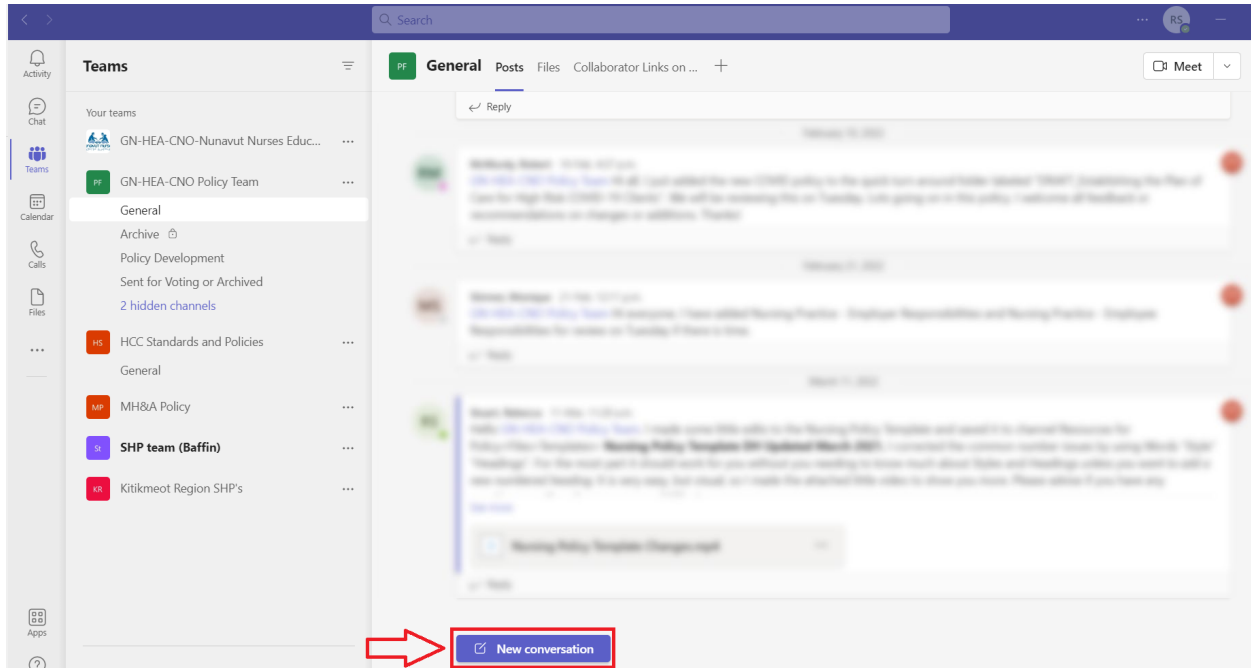
Sometimes the channels are collapsed and require you to select the triangle adjacent to the team name to see them.



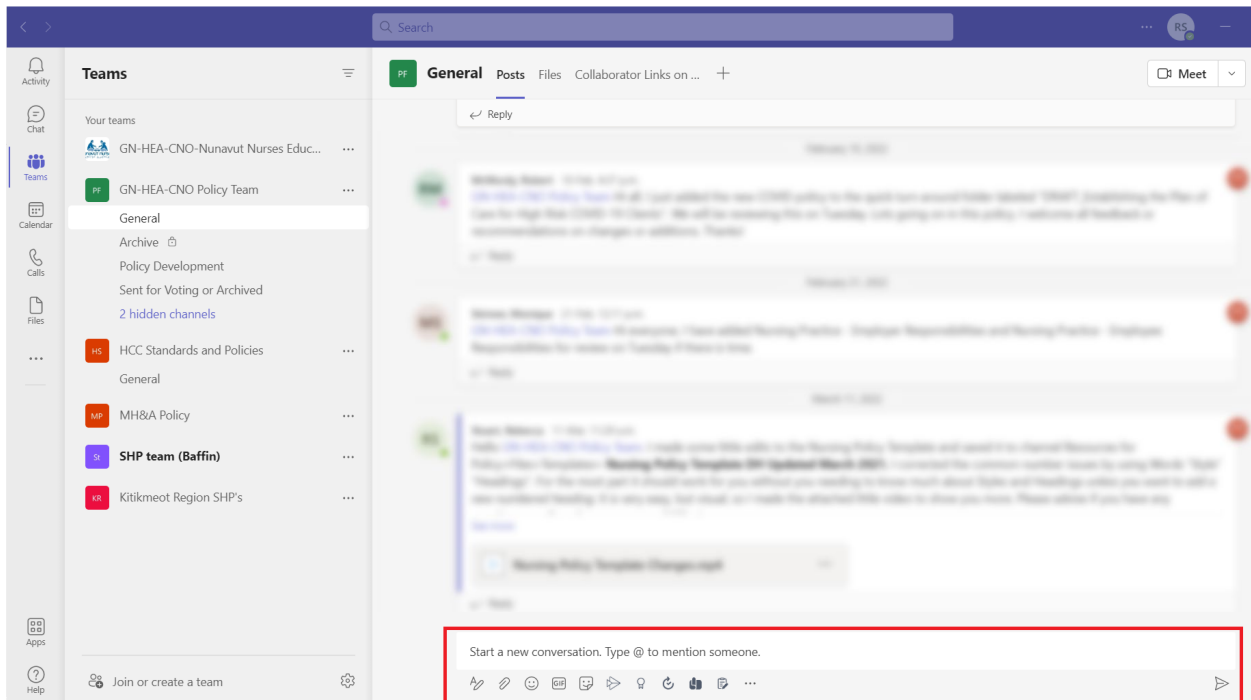
In the channels, you can have conversations with the team by adding a “New Conversation” or reacting and responding to conversations already started.

### Starting a “New Conversation”

In a Teams channel you can send a message to the team by selecting “New Conversation”.

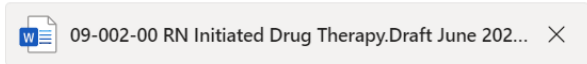


This will open a window where you can type your message and attach files.



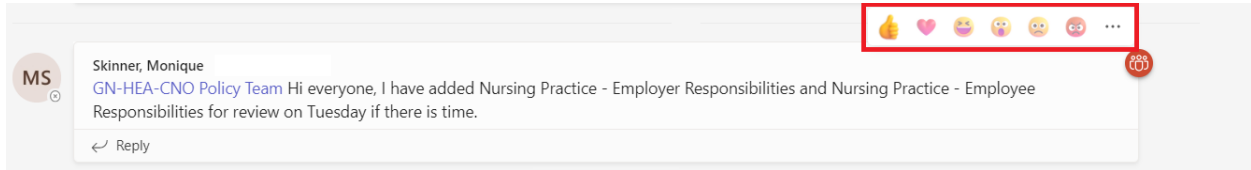
To send the message to the team, press Enter or select the arrow to the right of the message.

Hi Team, please take a look at this policy for review!

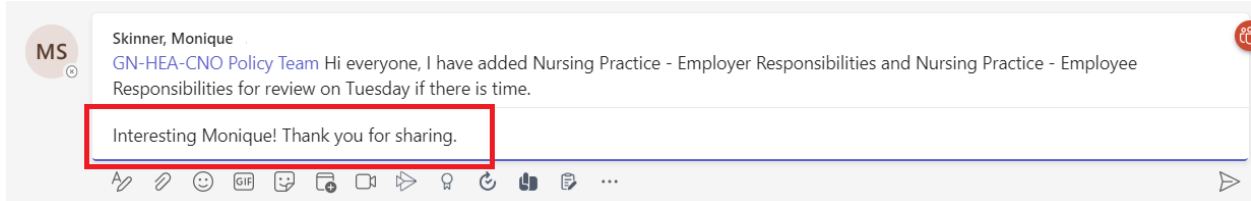
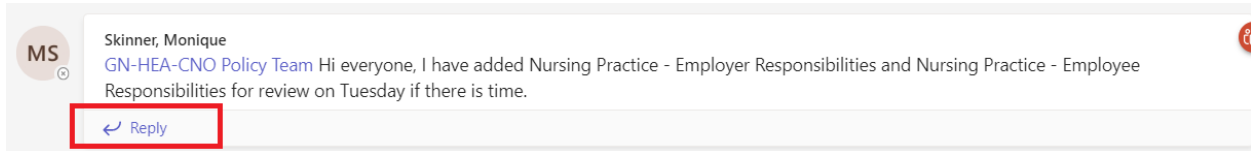


### Reacting and Responding to Conversations

In a conversation in a team’s channel, you can react and/or respond to messages. To reach, when you hover over the message, a box with emoji options will appear.



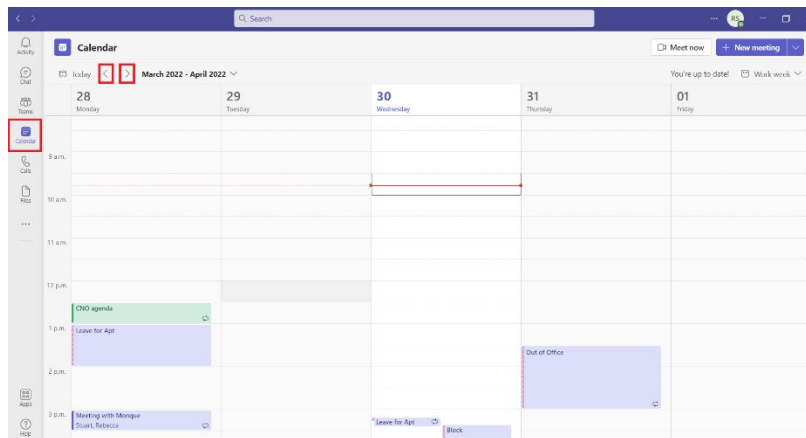
To respond directly to the messages, select the “reply” button and start typing.



### Calendar

MS Teams Calendar syncs automatically with the Outlook calendar; meetings you are invited to through Outlook will appear in your MS Teams calendar.

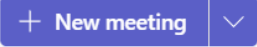
You can navigate though the workweek by using the   arrows.

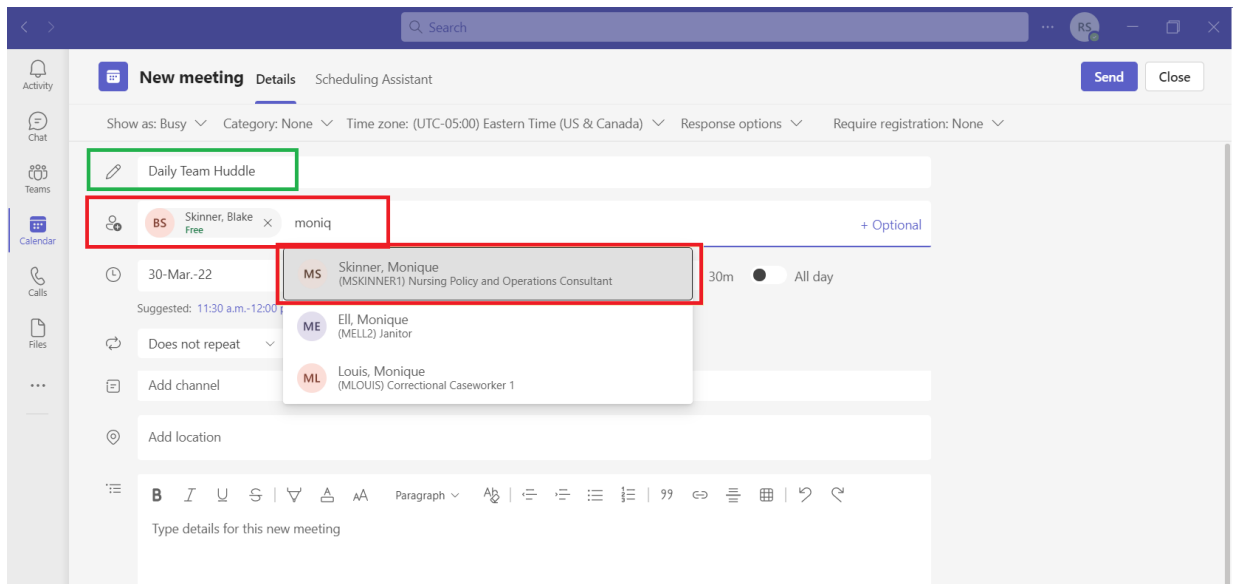


You may also wish to change the view from workweek to “day” or “week” by selecting



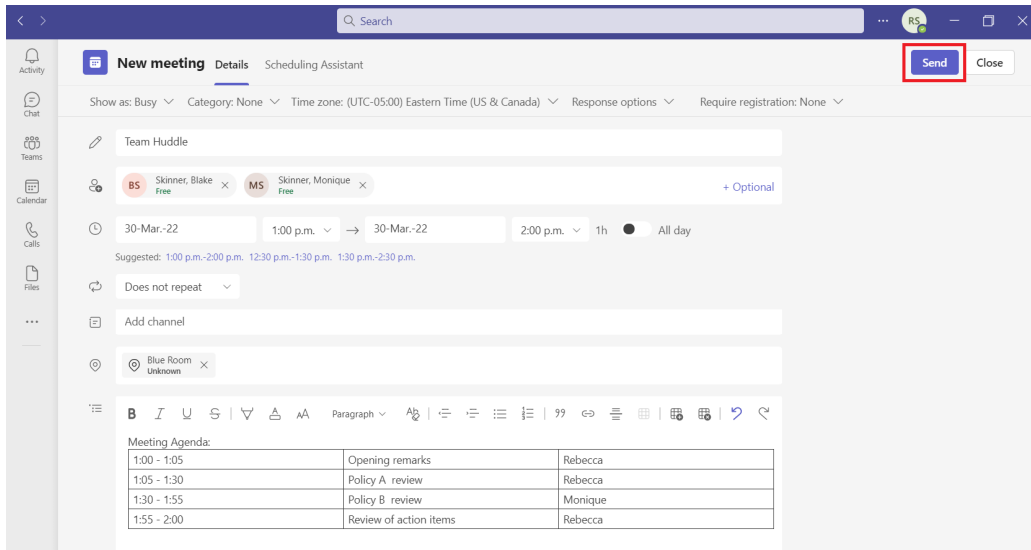
You can also add meetings directly into your MS Teams Calendar and invite attendees to a meeting.

1. Click on the Calendar location at the time you would like to schedule a meeting or select  located in the right side of the header.
2. This opens a window where you can add meeting information.
3. The “Add attendees” field can be left blank to put a reminder to yourself in the calendar. To add attendees, start typing their name in the “Add required attendees” location and select the name of the desired attendee.



4. Fill out or ensure time and date are correct to what you wish.
5. **Note:** you can add a meeting to a channel. This will cause the meeting to appear on the channel, but it will also *automatically invite everyone in the channel to the meeting*. Please ensure this is what you would like to do before entering anything into the “Add channel” field. This field can be left blank.
6. Once all required fields are complete, select “Send” to complete the meeting invite.

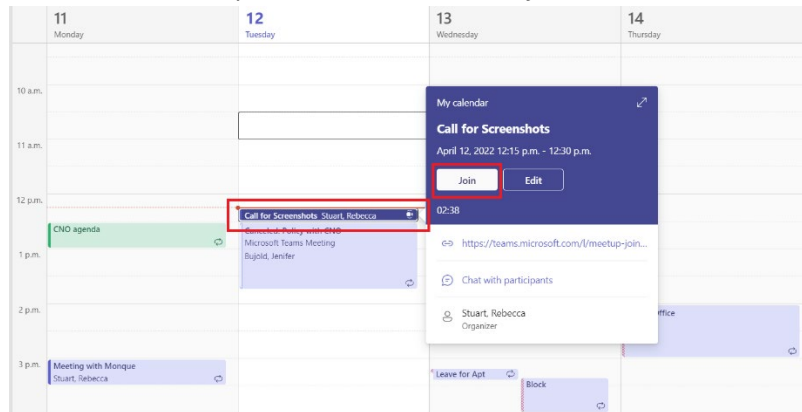




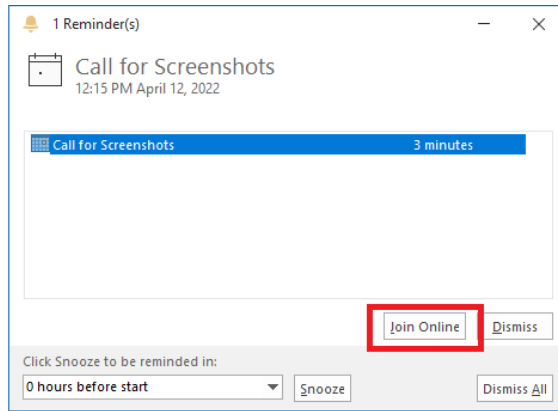
### Accepting Video call Meeting

If a Video call meeting has been accepted, there several ways to join this meeting.

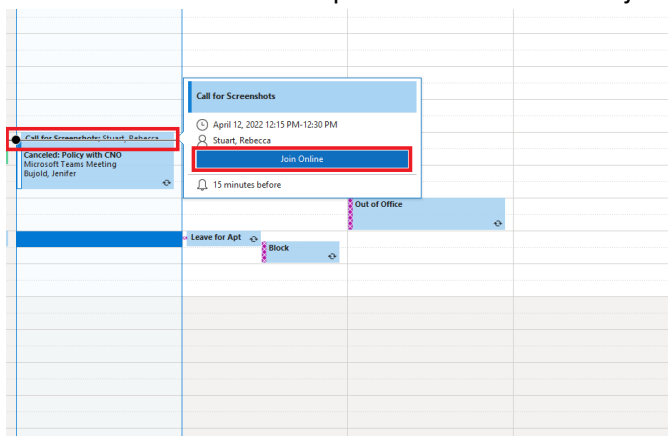
1. From the Teams calendar, you can select the meeting. From the pop-up, selecting “Join Online” will open MS Teams and navigate you to the meeting confirmation screen. See the below “Calls” section in this document from step “5” forward to how to join the call.



2. From Outlook, you will receive a reminder for the event. Selecting “Join Online” will open MS Teams and navigate you to the meeting confirmation screen. See the below “Calls” section in this document from step “5” forward to how to join the call.



- From the Outlook calendar, you can select the meeting. From the pop-up, selecting “Join Online” will open MS Teams and navigate you to the meeting confirmation screen. See the below “Calls” section in this document from step “5” forward to how to join the call.



## Calls

You can connect to a video and/or audio-only call with any team members using MS Teams in the organization. Calling in MS Teams requires an internet connection. All GN issued laptops should have a webcam and microphone installed, but your first time using these features on MS Teams, the system will ask you for permission to use the microphone and/or camera. Please provide this permission.

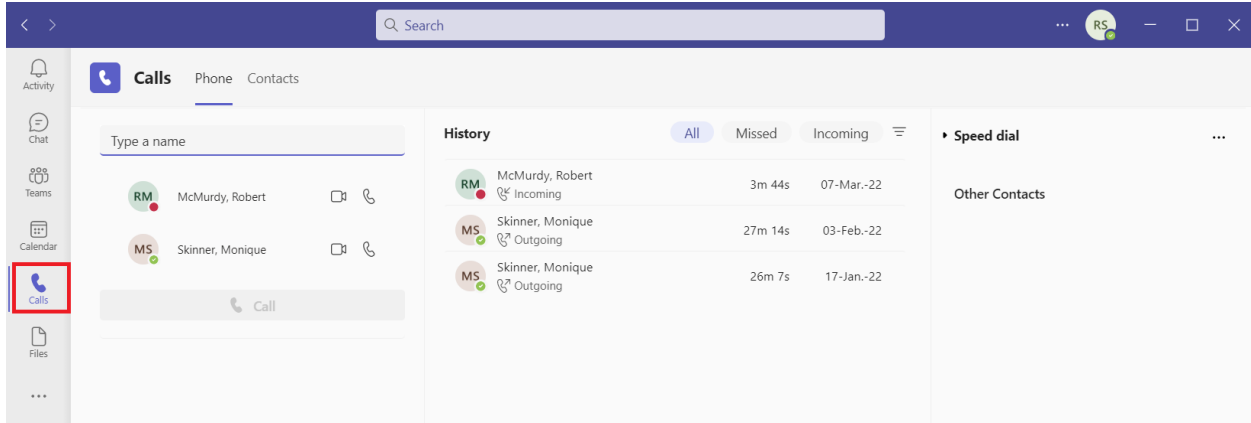
When making calls, it is highly recommended that you have a head set that connects to your computer so that you can clearly hear the audio from the call. These headsets have a better-quality microphone than the laptop, so that call participants can clearly hear you. If you do not have a headset, please contact your Director to order one. The Director may have ordering information or may contact Health IT for it. Using a headset also decreases background noise that may be picked up from your end of the call which will improve the call experience for all. It is also highly recommended that *you take or make any calls from a quiet place*. SHPs should have access to an office or a quiet room to take the call.

As calling is a core function of MS Teams, there are several ways to make calls in MS Teams. We will Review calling from the Calls button in the App Bar, Joining calls from the Calendar, the *Meet Now* Function and from Organizational Contacts.

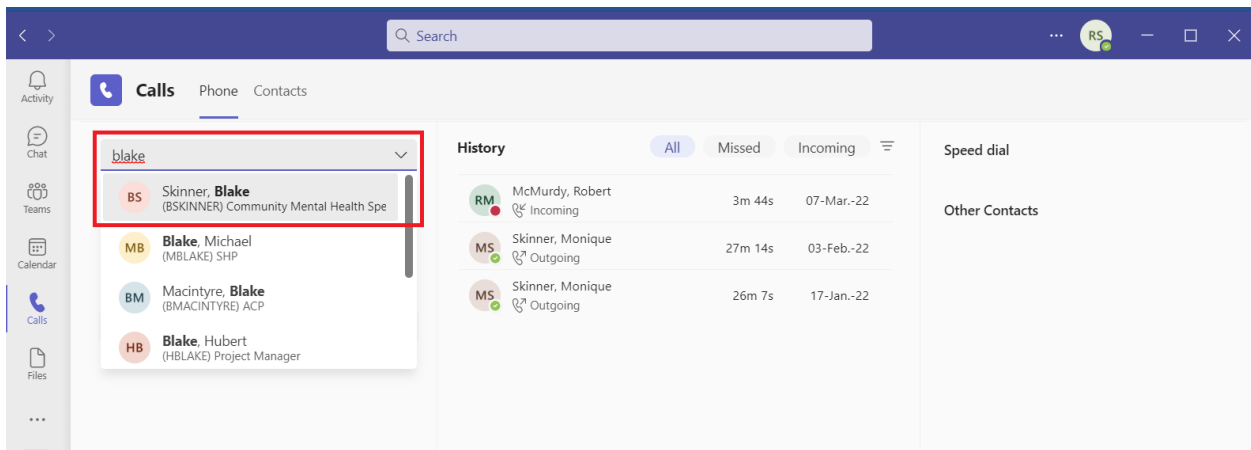
For more about calling in MS Teams please [review this article](#).

### The Calls Button in the App Bar

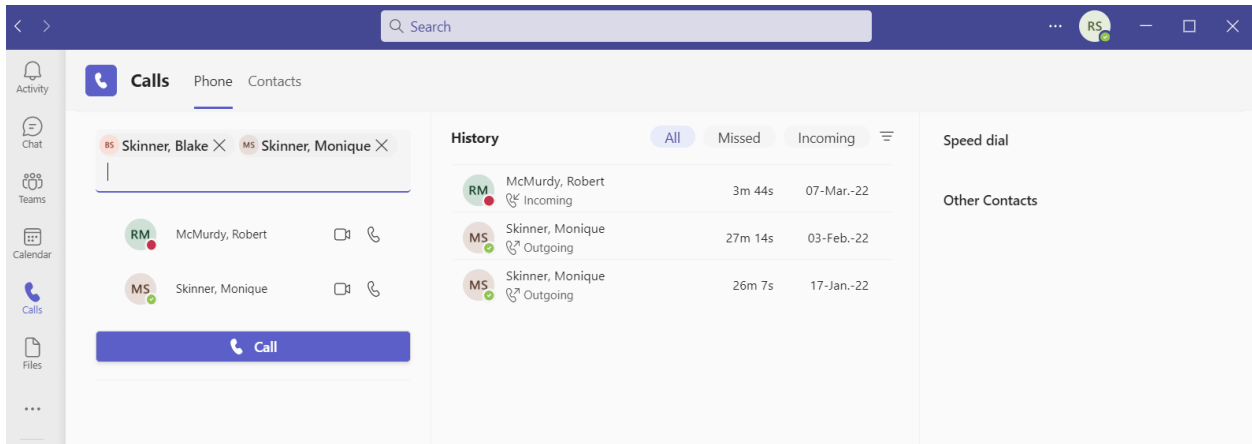
1. In the App Bar, select Calls.



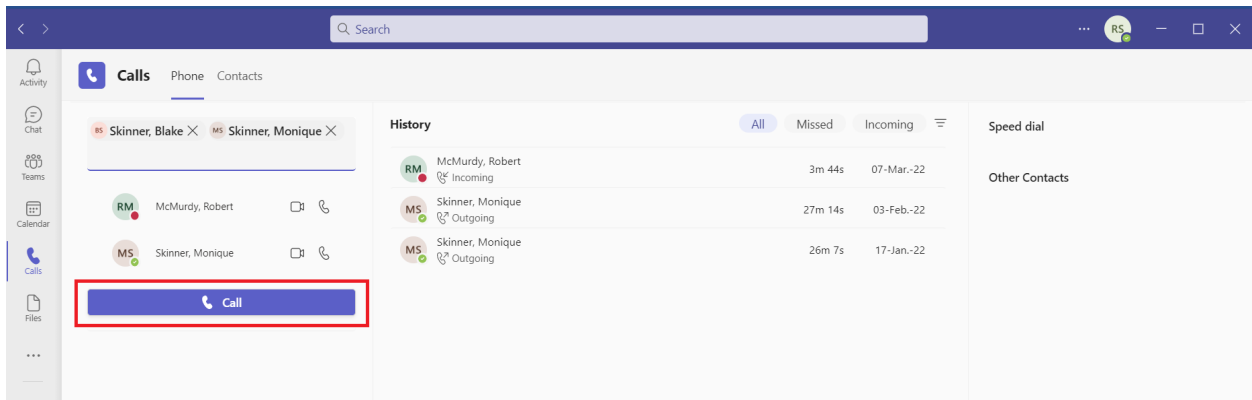
2. From this window, you can see your call history, set up speed dial and other features.
3. To make a new call, start typing the name of the person you would like to call in the "Type a name" window

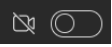


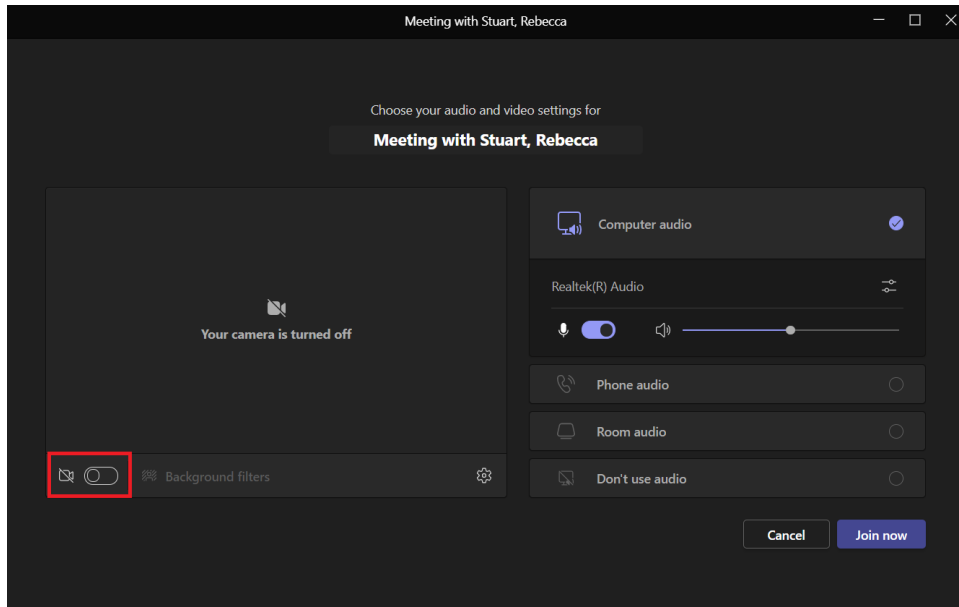
- a. You can add multiple people to the call.





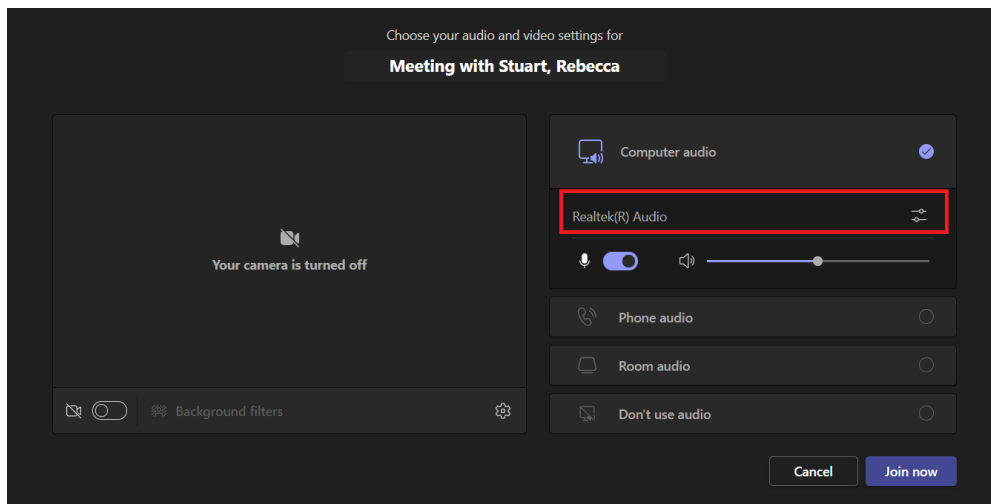
4. Once you have selected a name(s), the “Call” button will appear. Press this button to move to a confirmations screen before the call is started.



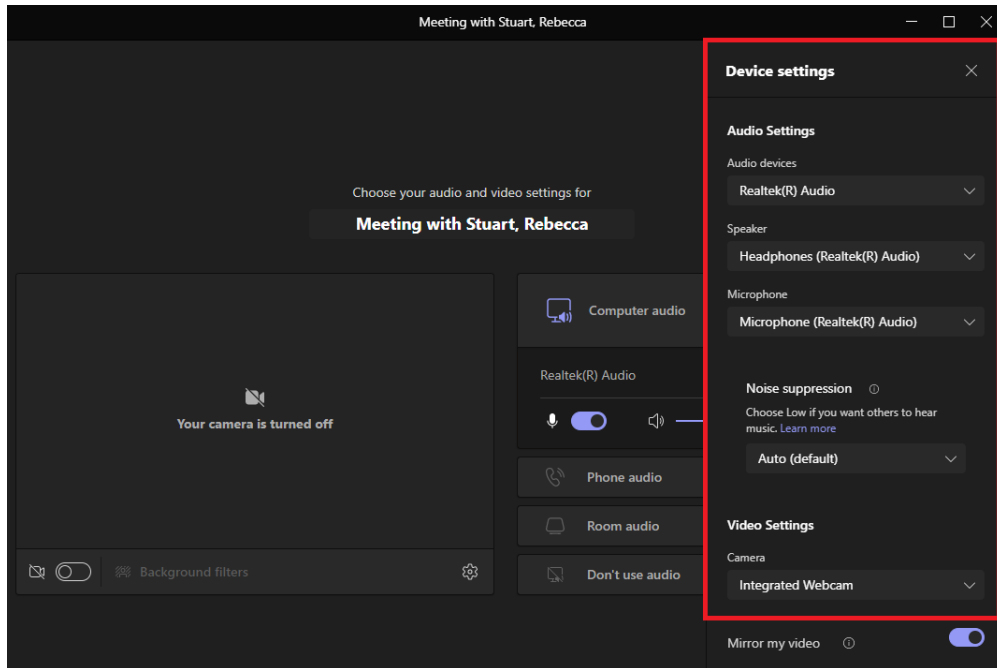
5. This confirmation screen allows you to confirm your audio and visual settings before calling the other participants. There are more settings here than we can discuss in detail; we will review how to turn on and off your camera, mute and unmute and check audio settings. For more information, please review: [MS Teams Meeting Support](#)
  - a. In the screenshot below, this screen is indicating that the Camera is **off**. Selecting the slider adjacent to the camera button  will turn on the camera. It is dependent on the type of call and your preferences as to whether you wish to have your camera on or off. You are able to turn it on or off once the call has begun.



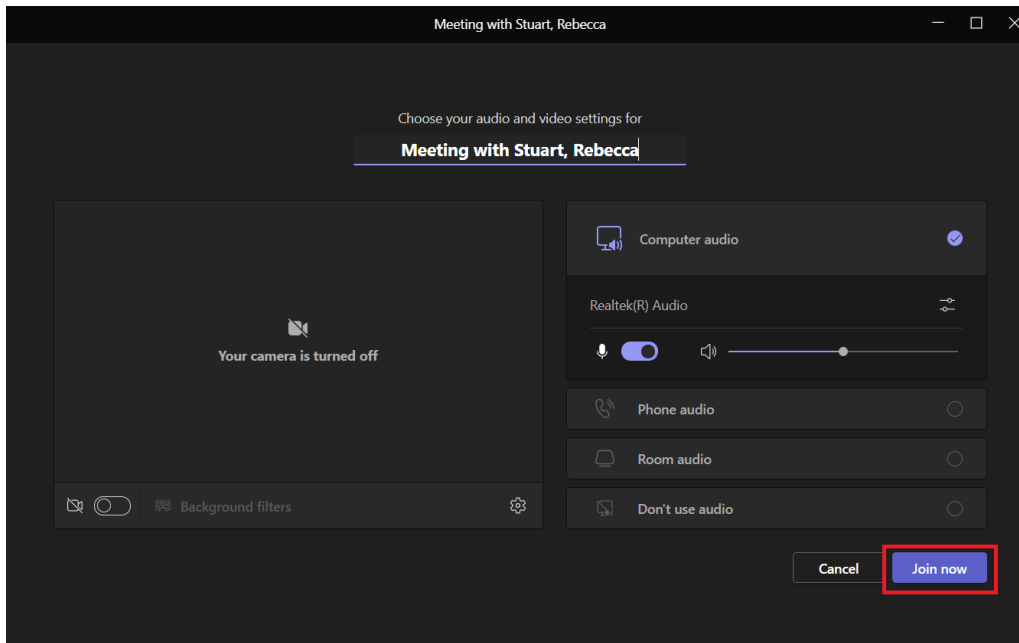
- a. In the screenshot below, the screen is indicating the microphone is **on**. Selecting slider adjacent to the Microphone button  will turn the microphone off. It is dependent on the type of call and your preferences as to whether you wish to start the call with your microphone on or off. You are able to turn it on or off once the call has begun.
- b. In the screenshot below the audio input (microphone) has defaulted to Realtek® Audio. To change audio input device, click on  adjacent to the audio input.



- c. This will open the Device Settings side menu where you can alter audio settings.

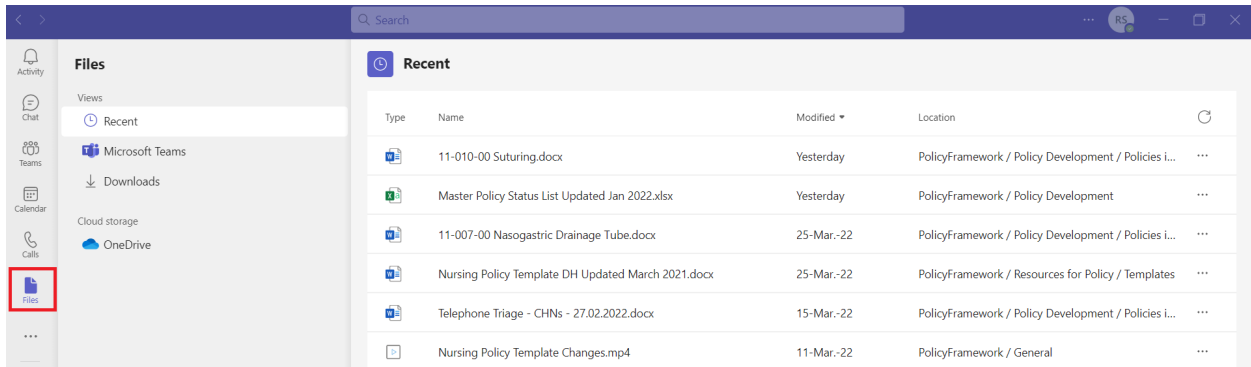


6. Once you are ready to join the call, select the **Join now** button.

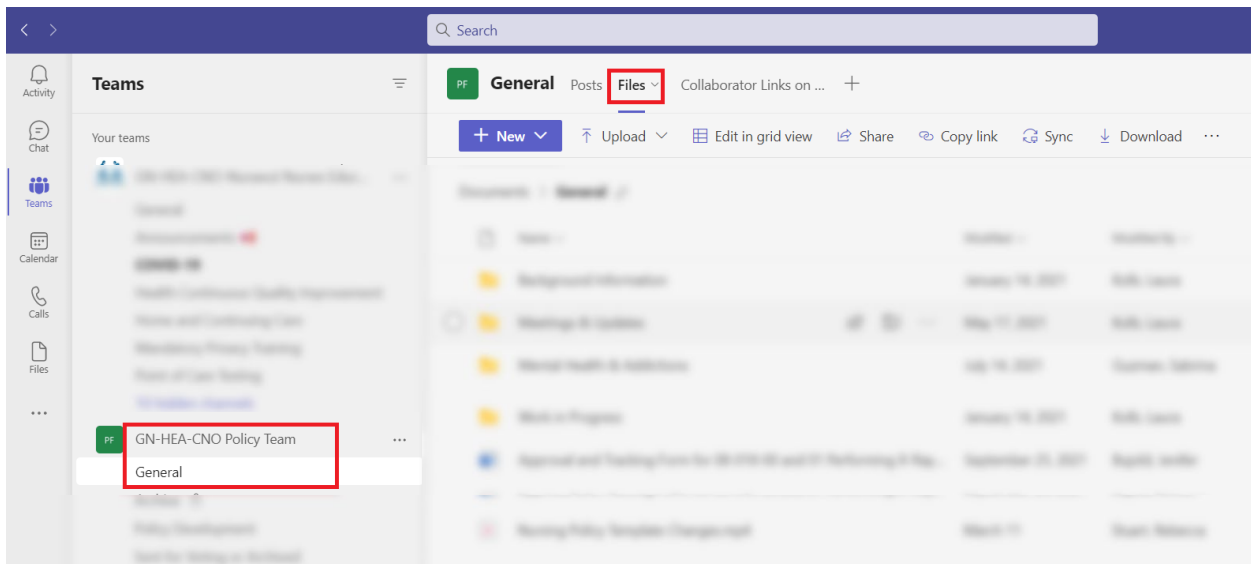


## Files

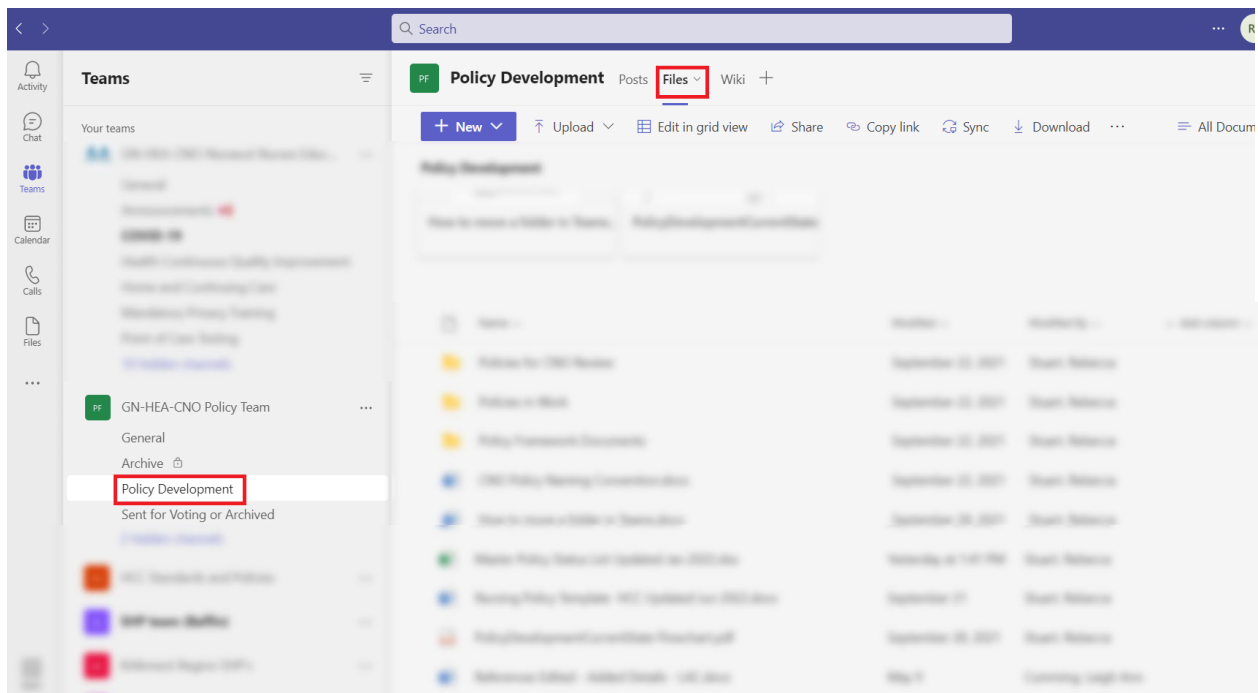
The files section of the App Bar shows recent files accessed by you.



Files can also be found in Teams by selecting the Teams General Tab, then the “Files” tab:



Files can also be found in Channels by selecting the Channel, then the “Files” tab:



## Access to First Nations Inuit Health Branch Clinical Guidelines and CHN Policies

Access to FNIHB guidelines has changed. The new website is [www.onehealth.ca/ab/CPG](http://www.onehealth.ca/ab/CPG).

The username for all regions is **Nursing**.

The password for all regions is **National**.

As this information may change over time, any updates will be provided by the CNO Education team.

Their team is GN-Hea-CNO-Nunavut Nurses Education.

Access can be provided by contacting an educator.

Reminder that hard copy editions of the FNIHB Guidelines are now outdated.

Policies and procedures are available at <https://www.gov.nu.ca/health/information/manuals-guidelines>.

There may be a hardcopy Policy and Procedure Manual in the health centre. The SHP should not rely on this manual; it is unlikely that it has been kept up to date.

## SECTION 1 INTRODUCTION TO SHP ROLE

Policies that apply:

- 04-001-00 Standards for Nursing Administration Practice
- 04-001-01 Reference Sheet 04-001-01 Standards of Practice for Nursing Administration



## 1.1 Appendix

- SHP Job Description
- 20201029\_How to do Shared Decision M [7522]
- 5000 Years Inuit Heritage
- A Brief Introduction to Inuit Organisations History
- Orientation Handbook
- Manager of outpatient services job description
- Katujjiluta Mandate
- SHP Work Plan by Fiscal Year

## 1.2 Katujjiluta

When a new government is elected in Nunavut, a new mandate is created. The mandate is a statement which spells out the government's agenda and the priorities that Members of the Legislative Assembly (MLAs) want to work on.

The current mandate is entitled Katujjiluta which means "a commitment to work in unity to manifest the courageous dream". The government has outlined five (5) priorities: expanding housing, aging with dignity, health, and healing, reinvesting in education and diversifying Nunavut's local economies.

While the entire document is available in the appendices, the government has committed to the following for health and healing:

- Investigate and implement trauma-informed practices in healthcare and education.
- Encourage and support models of wellness and well-being that are grounded in Inuit identity.
- Expand education and training programs that provide Nunavummiut with the necessary qualifications for professional and paraprofessional work in healthcare, mental health and addictions treatment.
- Expand opportunities, training, and formal recognition for Inuit to provide culturally and linguistically relevant mental health and well-being programs and services.
- Engage and recognize more Elders and other community members as advisors, local counsellors for Inuit, and in programming on the land.
- Promote and provide long-term funding to support and expand effective models for community-led programs and services.

## 1.3 Mission, Vision, Values and Principles

### *Our Mission:*

Through collaboration, innovation, and integration of Inuit Qaujimajatuqangit, we will provide excellent healthcare services that empower Nunavummiut to live healthy lives.

### *Our Vision:*

Healthy Nunavummiut

### *Our Principles:*

- Inuuqatigiitsiarniq: Respecting others, relationships and caring for people.
- Tunnganarniq: Fostering good spirits by being open, welcoming, and inclusive.
- Pijitsirniq: Serving and providing for family and/or community.
- Aajiiqatigiinniq: Decision making through discussion and consensus.
- Pilimmaksarniq/Pijariuqsarniq: Development of skills through observation, mentoring, practice, and effort.
- Piliriqatigiinniq/Ikajuqtiigiinniq: Working together for a common cause.
- Qanuqtuurniq: Being innovative and resourceful.
- Avatittinnikkamatsiarniq: Respect and care for the land, animals, and the environment.

#### *Our Values:*

- **Integrity** – in everything we do, we are honest and fair in our dealings with clients and employees.
- **Service** – we will continue to improve our services by becoming more effective, prompt, courteous and accessible.
- **Harmony** – we can only achieve our vision through unified leadership and working together with the communities and stakeholders we serve.
- **Respect** – for every individual. Our clients are served with respect, dignity, courtesy and understanding. Our employees are recognised in a professional manner.

## 1.4 Purpose of Manual

The regional Departments of Health function as a team to provide a high standard of care to the residents of Nunavut. The role of the Regional staff is to provide direction, support, and act as a resource to the staff in the communities. This manual provides an additional reference which supports the daily activities of the Supervisor of Health Programs (SHP) in their role and to document the parameters of the SHP's duties. The manual also promotes the standardisation of operations across Nunavut. Standardising operations between communities facilitates the movement of staff from one community to another when necessary and ensures a consistent level of healthcare is being maintained throughout the territory.

The manual will be reviewed and updated regularly as policies, operations, and procedures change. As the SHP you are required to be familiar with the current operational policies, procedures, and guidelines, especially when returning from an extended period away or when newly appointed (either acting, short/contract, or long term) to the position.

### 1.4.1 Purpose of the SHP

The position exists to ensure effective leadership and management of the health center.

The position ensures the provision of professional community health nursing care to clients in accordance with established standards of nursing practice and the philosophy and objectives of the Department of Health. The SHP supports the provision of quality community health programming.

The position promotes optimal health in the community and ensures continuity of care. The incumbent will administer a comprehensive community health program in conjunction with other members of the

healthcare team. The position is also responsible for stimulating a healthy awareness at the levels of prevention (i.e., primary – health promotion and specific protection against diseases; secondary - early diagnosis and prompt treatment intervention in the disease process; tertiary – rehabilitative activities). This position provides local leadership to front-line health workers to assure cohesion of the community teams.

This is the senior position in the health center, which has responsibility for managing and providing direct clinical and administrative supervision and training for all direct reports at various levels of qualification.

Please review the full SHP *Job Description* located in the appendix.

#### 1.4.2 SHP Workplan

It is advisable for the SHP to plan the year's work. A SHP workplan is included in the appendix for this purpose.

The workplan begins on April 1, the beginning of the fiscal year for the GN.

The first tab indicates the timing of all of the yearly deadlines.

The second tab provides a checklist for all of the duties that must be completed weekly, bi-weekly, etc.

A workplan will help the SHP stay on track to ensure that all duties are completed.

## SECTION 2 CULTURAL SAFETY

### 2.1 Cultural safety and Privilege

The United Nations Declaration on the Rights of Indigenous Peoples, Article 23, states that “indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.” Article 24 states that “indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals, and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.” (United Nations, 2007)

The declaration was adopted by the Government of Canada on June 21, 2021, through the *United Nations Declaration on the Rights of Indigenous Peoples Act*.

Cultural safety is in alignment with the UN Declaration and expands the concept of patient-centred care through the examination of self that places the caregiver and client as partners rather than the helpers and those needing help. Cultural safety is well aligned with trust-based therapeutic relationships. To build trust, the client must feel comfortable being themselves, and that they will in no way experience judgment or discrimination.

Cultural safety goes beyond the concept of cultural sensitivity to analyzing power imbalances, institutional discrimination, colonisation, and colonial relationships as they apply to health care. (National Aboriginal Health Organization (NAHO), 2008)

There is discomfort in examining our own power and privilege and the extent that it might impact our attitudes towards ourselves and our clients. It involves listening to others, examining our own privilege, and asking questions about who might be excluded or adversely affected by our work. Here is a list composed by Peggy McIntosh who authored a seminal article about privilege in the 1980’s. Reflect on these privileges and whether they are true for us and whether our clients can say the same.

1. I can, if I wish, arrange to be in the company of people of my race most of the time.
2. If I should need to move, I can be pretty sure of renting or purchasing housing in an area which I can afford and in which I would want to live.
3. I can be pretty sure that my neighbors in such a location will be neutral or pleasant to me.
4. I can go shopping alone most of the time, pretty well assured that I will not be followed or harassed.
5. I can turn on the television or open to the front page of the paper and see people of my race widely represented.

6. When I am told about our national heritage or about “civilization,” I am shown that people of my color made it what it is.
7. I can be sure that my children will be given curricular materials that testify to the existence of their race.
8. If I want to, I can be pretty sure of finding a publisher for this piece on white privilege.
9. I can go into a music shop and count on finding the music of my race represented, into a supermarket and find the staple foods that fit with my cultural traditions, into a hairdresser’s shop and find someone who can cut my hair.
10. Whether I use checks, credit cards or cash, I can count on my skin color not to work against the appearance of financial reliability.
11. I can arrange to protect my children most of the time from people who might not like them.
12. I can swear, or dress in second- hand clothes, or not answer letters, without having people attribute these choices to the bad morals, the poverty, or the illiteracy of my race.
13. I can speak in public to a powerful male group without putting my race on trial.
14. I can do well in a challenging situation without being called a credit to my race.
15. I am never asked to speak for all the people of my racial group.
16. I can remain oblivious of the language and customs of persons of color who constitute the world’s majority without feeling in my culture any penalty for such oblivion.
17. I can criticize our government and talk about how much I fear its policies and behavior without being seen as a cultural outsider.
18. I can be pretty sure that if I ask to talk to “the person in charge,” I will be facing a person of my race.
19. If a traffic cop pulls me over or if the IRS audits my tax return, I can be sure I haven’t been singled out because of my race.
20. I can easily buy posters, postcards, picture books, greeting cards, dolls, toys, and children’s magazines featuring people of my race.
21. I can go home from most meetings of organizations I belong to feeling somewhat tied in, rather than isolated, out-of-place, outnumbered, unheard, held at a distance, or feared.
22. I can take a job with an affirmative action employer without having co-workers on the job suspect that I got it because of race.
23. I can choose public accommodations without fearing that people of my race cannot get in or will be mistreated in the places I have chosen.
24. I can be sure that if I need legal or medical help, my race will not work against me.
25. If my day, week, or year is going badly, I need not ask of each negative episode or situation whether it has racial overtones.
26. I can choose blemish cover or bandages in “flesh” color and have them more less match my skin.

(McIntosh, 1989)

## 2.2 The Nurse-Patient Relationship in Relation to Privilege

In the nurse-patient relationship, nurses hold a position of power by virtue of having:

- Professional knowledge and skills that patients rely on for their well-being.
- More authority and influence in the health care system.
- Access to patients' bodies (for example when performing physical exams).
- Access to patient's personal health information. (College of Nurses of Ontario, 2020)

**Entry level competencies for nurses practicing in Nunavut can be found:** [626-Entry-Level Competencies 2019.pdf \(rnantnu.ca\)](#)

Relevant sections include:

**1.4** Adapts practice in response to the spiritual beliefs and cultural practices of clients.

**2.5** Identifies the influence of personal values, beliefs and positional power on clients and the healthcare team and acts to reduce bias and influences.

**6.1** Acquires knowledge of the Calls to Action of the Truth and Reconciliation Commission of Canada.

**6.7** Acts to support **culturally safe** practice environments.

**7.3** Advocates for the use of Indigenous health knowledge and healing practices in collaboration with Indigenous healers and Elders, consistent with the Calls to Action of the Truth and Reconciliation Commission of Canada.

**7.14** Uses knowledge of health disparities and inequities to optimize health outcomes for all clients.

**9.3** Engages in self-reflection to interact from a place of **cultural humility** and create **culturally safe** environments where clients perceive respect for their unique health care practices, preferences, and decisions. (Registered Nurses Association of the Northwest Territories and Nunavut, 2020)

### 2.2.1 Cultural Safety

Cultural Safety is the “effective nursing practice of a person or family from another culture and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability.

The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which

diminishes, demeans, or disempowers the cultural identity and well being of the individual.” (Nursing Council of New Zealand, 2011)

Culture informs the way we interact with and view each other and the world around us.

Unsafe cultural practice makes the client feel less than a whole person simply because they do not share the same culture as the nurse.

### 2.2.2 Cultural Humility

Cultural humility is defined as a process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another’s experience. (First Nations Health Authority, 2019).

In order to foster trust in a traumatized population, nurses in Nunavut are most effective if they practise in a culturally safe manner. This means that they must examine both their own privilege and the power dynamics between themselves and the people they serve.

Dominant cultures often view their methods as ‘the right way’ of doing things which can leave the non-dominant culture feeling invalidated and inferior.

It is not possible to come to a complete understanding of cultural safety without reflecting on the origins of the trauma experienced by indigenous peoples in this country.

### 2.2.3 Colonialism

“Traditionally, becoming self-reliant was a core purpose of becoming a human being, yet self-reliance is not easily accomplished in a world where there is limited access to the tools and materials you need. It is almost impossible in a world where systems assume that you are not able to become self-reliant without intervention. Jaypeetee Arnakak describes this system as a “moral hazard” because the social safety net provided for Inuit by the government was based on a number of false assumptions, mainly stemming from the view that Inuit were “unable” to be self-reliant and basically required “rescuing” (Nunavut Tunngavik Incorporated, 2002).

Working from these assumptions resulted in social policies that have created what he describes as ‘the unvoiced power dynamics of dependency’ which is “unhealthy and unsustainable.” He goes on to point out that traditional Inuit society was based on a practice of interdependency which provided an “organic economic framework.” By ignoring this reality and systematically devaluing and dismantling it, the strengths of interdependency and interconnectedness within Inuit society have been replaced by increasing numbers of Inuit who are *inunnguinnigittuq* or have not been made to become able.” (Tagalik, 2010)

#### 2.2.4 Residential Schools

The goal of traditional Inuit child-rearing was to ensure that every child would become able/enabled/capable so that they could be assured of living a good life – where the child would have sufficient proper attitude and ability to be able to contribute to working for the common good, helping others and making improvements for those to come. Children were nurtured and encouraged. Their specific skills and abilities were noticed and encouraged by the adults responsible for them. (Tagalik, 2010)

Juxtapose this childhood with the one experienced by a child attending residential school. The child in residential school was given a number – the way they were most often addressed – and an English name. The child was punished if they spoke their own language and may not have been fluent in English. They were isolated, cut off from their culture, their home, their family. They were often subject to harsh physical punishment and sexual abuse. They might be separated from their siblings or cousins who were also in attendance at the school. When they returned to their families, often after a period of years, they were strangers. Imagine this happening in generation after generation. How would parenting skills be affected?

#### 2.2.5 Sixties Scoop

As the residential schools began to close in the 1960's, Family Services, at first federally, and then provincially, began removing children from homes they considered to be either inadequate or unsafe. The number of indigenous children in foster care grew exponentially. Many of these children were fostered or adopted to white families.

These children, often suffering the effects of their own parents' attendance at residential schools, faced a further loss of culture, loss of family and community life and cemented in the minds of both children and the country at large that indigenous families were not capable of looking after children.

#### 2.2.6 Indian Hospitals

Indigenous people diagnosed with tuberculosis were often sent to 'Indian' hospitals in the south. While originally, these hospitals were funded by religious groups, the Government of Canada aggressively expanded the system after the Second World War and by 1960, owned 22 hospitals across the country.

These hospitals provided racially segregated care to First Nations and Inuit. Inuit were often kept for years at a time because of the belief that they could not manage at home. The hospitals were underfunded and poorly staffed. The hospitals also provided opportunities for medical experimentation, often without the patient's consent. Indigenous patients had no choice in the matter. In 1953, the Indian Act was amended to include the *Indian Health Regulations* that made it a crime for Indigenous people to refuse to see a doctor, to refuse to go to hospital, and to leave hospital before discharge. (The Canadian Encyclopedia, 2017)



Those who died in Indian hospitals were buried at the nearest cemetery in unmarked graves.

Elders, in particular, may have a deep mistrust of hospitals and hospital staff as a result and will have passed this mistrust on to their families.

### 2.2.7 Intergenerational Survivor

“**Intergenerational Survivor**” refers to any individual who has been affected by the intergenerational dysfunction created by the experience of attending residential school; this includes those who have been abused by persons who are Survivors or victims of survivors and, more generally, those who inhabit dysfunctional communities whose roots lie in the fracturing of family and community wrought by the generations of children who were separated from their families. In the early 1990’s, an estimated 287,350 intergenerational survivors were living across Canada, both on and off reserves. (Legacy of Hope Foundation, 2001)

These traumas have continued to impact Indigenous people past the closure of schools and the end of the Sixties scoop.

As healthcare providers, practising in a culturally safe manner begins by assessing our own attitudes and biases and recognizing our privilege. It means recognising our own positions of power and working to level the playing field by giving our clients a voice, by advocating for them and by acknowledging and encouraging their strengths as well as their challenges. Cultural safety results in healthcare provision that meets client needs in a way that is congruent with client wishes.

## 2.3 Further Reading

The University of Victoria offers 3 modules on Cultural Safety which are free to the public and excellent resources. The websites are below.

<https://web2.uvcs.uvic.ca/courses/csafety/mod1/index.htm>

<https://web2.uvcs.uvic.ca/courses/csafety/mod2/glossary.htm#culture>

<https://web2.uvcs.uvic.ca/courses/csafety/mod3/index.htm>

## SECTION 3 LEADERSHIP AND DELEGATION

### *Key Takeaways for this section:*

- SHPs are leaders in the health centre and in the community.
- Understanding their own leadership style and acknowledging both their strengths and challenges will assist the SHPs in establishing themselves in the role.

### 3.1 Appendix

- GN Leadership Competency Model

### 3.2 Leadership and SHPs

The Government of Nunavut (GN) has developed a Leadership Framework and Competency Model in accordance with best practices in Canadian public administration, based on recent research. It is grounded in the Inuit system of values and behaviours.

The competency model is a set of competencies that relate to a role or group of roles. It focuses on a small set of competencies that differentiate a high-performing leader.

The complete *GN Leadership Framework and Competency Model* is included in the appendices.

The GN Competency Model focuses on eight behavioural competencies and three technical competencies.

The sections below are taken directly from the competency model but focused on the attributes necessary for the success of SHPs.

#### 3.2.1 Competency #1: Building Relationships

Our leaders understand that collaborative relationships help everyone to achieve common goals. They foster relationships with individuals, teams, other departments, external partners, and other levels of government.

As a manager, the SHP collaborates to achieve objectives:

- Understands GN structures and relationships.
- Develops and manages respectful relationships with colleagues, clients, and program stakeholders.
- Develops and manages business relationships with suppliers and service providers.
- Participates effectively in cross-division and cross-department processes, working groups and training.
- Builds deep and lasting work relationships with colleagues, including mentors.

#### *Proficient SHPs:*

- Identify opportunities where working in collaboration with others within and across networks can bring added benefits.
- Create opportunities to bring individuals and groups together to achieve goals.

- Promote the sharing of information and resources.
- Actively seek the views of others.

#### *Examples of Effectively Building Relationships*

- Actively seeking and reflecting on client and clinician views.
- Attending and observing multidisciplinary team meetings.
- Contributing to discussions on developing care pathways.
- Making presentations at conferences, meetings, or workshops, uni-disciplinary or multidisciplinary, internally, and externally.
- Creating links with clients, clinicians, interagency committee, and hamlet council to develop services jointly.

#### *Examples of Ineffectively Building Relationships*

- Provides direction that is either insufficient or overly prescriptive and controlling.
- Limits access to information beyond the requirements of discretion and policy.
- Disregards pertinent information provided from team, client, or Department.
- Operates independently without reference to the wider system of knowledge and experience.
- Working in silos without reference to health centers in the region.

### 3.2.2 Competency #2 Creating Community

Our leaders create an open, welcoming work environment where a diverse workforce can develop trust, feel a sense of belonging, and contribute effectively. They understand and respect differences.

As a manager, the SHP fosters inclusiveness:

- Creates a work environment that welcomes, supports, and respects everyone.
- Develops a personal understanding of Inuit and other cultures to understand employees' needs.
- Relates effectively to people with diverse values, cultures, abilities and/or personalities.
- Makes use of complementary strengths so all can contribute.
- Demonstrates availability, approachability, and fairness so that employees feel comfortable in discussing work-related matters.

#### *Proficient SHPs:*

- Listen to others and recognise different perspectives.
- Empathise and consider the needs and feelings of others.
- Communicate effectively with individuals and groups, and act as a positive role model.
- Gain and maintain trust and support of colleagues, both internal and external.
- Incorporate Inuit principles such as consensus building in interactions with others.
- Provide encouragement, and the opportunity for people to engage in decision-making and to challenge constructively.
- Respect, value and acknowledge the roles, contributions, and expertise of others.
- Employ strategies to manage conflict of interests and differences of opinion.
- Keep the focus of contribution on delivering and improving services to clients.

#### *Examples of Effectively Creating Community*

- Encouraging participation of all staff within multidisciplinary, interagency, and organizational team meetings.
- Collaborating with others in projects.
- Collaborating with local networks to develop the local networks of understanding.
- When conflict arises, works with the team members to discuss, and cooperatively work through the conflict.
- Providing the means and climate for colleagues to raise issues or concerns.
- Encouraging participation from other staff within clinical case reviews and enabling all present to learn about each other's contributions.
- Inviting and encouraging feedback from clients and providing feedback to clients, relatives, and clinicians.
- Listening to the views of staff and clients/service users, relatives or clinicians and their representatives about potential for improvement.

#### *Examples of Ineffectively Creating Community*

- Fails to listen to concerns from team members.
- Leaves staff to work through changes on their own or gives inadequate time to acknowledge concerns.
- Withholds information from team and fails to communicate changes and updates.
- Shows favouritism or bias.
- Fails to consider the input of others when inclusiveness and engagement are key to team performance and morale.
- Creates a work environment where feedback is discouraged.
- Ignores conflict in the team.
- Does not access available resources such as Patient Relations and Employee Relations.

### 3.2.3 Competency #3 Look Ahead

Effective leaders think beyond their immediate jobs. They use 'big picture' thinking to look ahead, set strategic direction and make plans to guide people and generate action.

As a manager, the SHP contributes to setting direction:

- Is aware of trends, issues and opportunities affecting Nunavut and its people.
- Thinks ahead 3 – 10 years for the program and/or division.
- Translates strategies into program and/or division work plans that can be executed.
- Aligns work with the goals and priorities of the department.
- Helps people to understand how work contributes to achieving departmental goals and meeting the needs of Nunavummiut.
- Anticipates and addresses issues.

#### *Proficient SHPs:*

- Support plans for services that are part of the strategy for the wider healthcare system.
- Gather feedback from clients, service users and colleagues to help develop plans.
- Contribute their expertise to planning processes.
- Appraise options in terms of benefits and risks.

- Demonstrate awareness of the political, social, technical, economic, organisational, and professional environment.
- Understand and interpret relevant legislation and accountability frameworks.
- Anticipate and prepare for the future by scanning for ideas, best practice and emerging trends that will have an impact on health outcomes.
- Develop and communicate aspirations.
- Use appropriate methods to gather data and information.
- Carry out analysis against an evidence-based criterion set.
- Use information to challenge existing practices and processes.
- Influence others to use knowledge and evidence to achieve best practice.
- Participate in and contribute to organisational decision-making processes.
- Act in a manner consistent with the values and priorities of their organisation and profession.
- Educate and inform key people who influence and make decisions.
- Contribute their unique perspective to team, department, system, and organisational decisions.

#### *Examples of Effectively Looking Ahead*

- As a member of a management team, contributing to the development of business and service plans.
- Accessing sources of information from inside and outside of the organisation, including client feedback, to inform plans for service improvement.
- Contributing to the development of organisational and professional body responses to emerging health policy.
- Completes health center program planning such as public health, pre-natal, quality checks and resource planning.
- Taking part in opportunities to learn about the healthcare system, GN policy environment, organisation, and structures.
- Seeking routes to influence departmental policy to improve local healthcare delivery.
- Critically analysing appropriate information and data to determine trends.
- Using and interpreting departmental performance data and information to debate services within multidisciplinary team meetings.
- Using audit outcomes to challenge current practice and develop consistent, reliable care.
- Contributing to decisions using evidence about the running of the service as part of a multidisciplinary team.
- Advising management colleagues by providing a clinical perspective on service developments and the implications for clients.
- Taking responsibility for ensuring appropriate and effective decision-making processes are in place.

#### *Examples of Ineffectively Looking Ahead*

- Fails to include or assess critical inputs in project planning.
- Places personal goals ahead of plans for service from the Department of Health and does not complete pre-planning such as resource planning.
- Fails to act on prior agenda action items.
- Does not incorporate or model Inuit Societal Values within the health centre.

- Does not participate in interagency meetings in community.
- Does not develop relationship with hamlet staff in order to improve services to community.
- Gathers information from the internet without checking sources.
- Makes process changes without evidence of change being needed, or without evidence the change will help with situation.
- Applying self knowledge without collaborative input or taking organizational situation into account.
- Abdicates decision-making responsibilities to other levels.
- Argues against or impedes decisions made by the organization.
- Makes decisions without input from staff and lacking collaboration with the team.
- Makes rash or impulsive decisions without consideration of consequences.

### 3.2.4 Competency #4 Balancing Listening, Asking and Telling

GN leaders are effective two-way communicators. They express themselves clearly so that information is understood. They listen actively and ask questions to develop their understanding of others.

As a manager, the SHP communicates clearly and directly:

- Providing information or direction when needed.
- Communicates clearly and directly within the division and with program stakeholders.
- Understands the audience and their needs, perspectives and interests when communicating.
- Is aware of own assumptions.
- Asks questions to understand others' points of view and the reasons behind them.
- Responds to a speaker's ideas and concerns rather than the person's communication style.

#### *Proficient SHPs:*

- Uphold personal and professional ethics and values, considering the values of the organisation and respecting the culture, beliefs, and abilities of individuals.
- Communicate effectively with individuals, appreciating their social, cultural, religious, and ethnic backgrounds and their age, gender, and abilities.
- Value, respect and promote equality and diversity.
- Take appropriate action if ethics and values are compromised.
- Listen to others and recognise different perspectives.
- Empathise and consider the needs and feelings of others.
- Communicate effectively with individuals and groups, and act as a positive role model.
- Gain and maintain trust and support of colleagues, both internal and external.
- Incorporate Inuit principles such as consensus building in interactions with others.

#### *Examples of Effective Balancing Listening, Asking and Telling*

- Taking part in ethics discussions to appreciate a client's perspective.
- Identifying incompetent or suboptimal practice, investigating, and taking corrective action.
- Ensuring that professional values and ethics are considered in management decisions.
- Actively seeking and reflecting on client and clinician views.
- Attending and participating in multidisciplinary team meetings.

- Contributing to discussions on developing care pathways.
- Creating links with clients, clinicians, interagency committee, and hamlet council to develop services jointly.
- Encouraging participation of all staff within multidisciplinary, interagency, and organizational team meetings.
- Collaborating with others in projects.
- Collaborating with local networks to develop mutual understanding.

#### *Examples of Ineffective Balancing Listening, Asking and Telling*

- Imposes their own personal views onto staff and clients over the needs of the community and directives from the Department of Health.
- Is insensitive to, or unaware of, the diverse needs, aspirations and capabilities of team members.
- Mistreats others and takes advantage of the authority vested in the position.
- Does not take action to address situations of wrongdoing.
- Attributes failures to individuals or previous administrations.
- Provides direction that is either insufficient or overly prescriptive and controlling.
- Limits access to information beyond the requirements of discretion and policy.
- Disregards pertinent information provided from team, client, or Department.
- Operates independently without reference to the wider system of knowledge and experience.
- Works in silo without reference to health centers in the region.
- Fails to listen to concerns from team members.
- Leaves staff to work through changes on their own or gives inadequate time to acknowledge concerns.
- Withholds information from team and fails to communicate changes and updates.
- Shows favouritism or bias.

### 3.2.5 Competency #5 Be Flexible and Adaptable

Leaders demonstrate the willingness and ability to work effectively in a variety of situations. They are resourceful and can adapt their approach to respond to changing requirements. They are resilient under stress.

As a manager, the SHP promotes adaptability:

- Helps to implement new practices based on an identified change in policy or program.
- Supports employees to implement new practices.
- Prioritizes their own activities effectively in response to changing demands.
- Looks at challenges from multiple perspectives.
- Creates a work environment that promotes flexibility in the team.
- Leads change in the unit or division with confidence and a positive attitude.

#### *Proficient SHPs:*

- Manage the impact of their emotions on their behaviour with consideration of the impact on others.
- Are reliable in meeting their responsibilities and commitments to consistently high standards.

- Ensure that their plans and actions are flexible and take account of the needs and work patterns of others.
- Plan their workload and activities to fulfil work requirements and commitments, without compromising their own health.
- Obtain and act on client, clinician and service user feedback and experiences.
- Assess and analyse processes using up-to-date improvement methodologies.
- Identify healthcare improvements and create solutions through collaborative working.
- Appraise options, and plan and take action to implement and evaluate improvements.
- Question the status quo.
- Act as a positive role model for innovation.
- Encourage dialogue and debate with a wide range of people.
- Develop creative solutions to transform services and care.
- Model the change expected.
- Articulate the need for change and its impact on people and services.
- Promote changes leading to systems redesign.
- Motivate and focus a group to accomplish change.

#### *Examples of Effective Flexibility and Adaptability*

- Liaising with colleagues in the planning and implementation of changes and identifying areas for improvement.
- Contributing to the development of systems which help them, and others manage their time and workload more effectively.
- Overcoming disappointing findings from a client survey and working on positive ways of addressing issues.
- Developing and implementing a learning plan for an identified area of development.
- Evaluating the outcome of changes following clinical audits or other audit activity.
- Using proven improvement techniques to develop service improvement proposals.
- Supporting colleagues to evaluate and audit the outcomes of healthcare improvement projects.
- Creating and promoting opportunities for colleagues and clients/service users and their representatives to generate, discuss and openly debate ideas for improvement and change, encouraging them to feel safe to challenge existing practices.
- Using multidisciplinary team, client feedback and other settings to debate and question current systems and practices.
- Identifying areas for improvement and initiating appropriate projects or developing them with others.
- Systematically appraising and evolving current practice, systems, and processes.
- Testing the feasibility of implementing changes with clients, colleagues, and staff.
- With senior colleagues, reviewing client satisfaction information to develop strategies for implementing and managing innovative solutions within the organisation.
- Presenting the arguments for change to colleagues, addressing concerns and risks.
- Recognising when change processes have not met their stated goals and reflecting on the reasons for this.

#### *Examples of Ineffective Flexibility and Adaptability*



- Allows own stress to interfere with team efforts.
- Remains inflexible and stays committed to a single outcome.
- Continues to accept additional work despite workload threshold being reached and quality beginning to suffer.
- Allows day-to-day issues to obstruct critical long-term planning.
- Disregards client and clinician feedback.
- Changes are implemented haphazardly without evaluation.
- Overlooks issues and information that may hinder the implementation of key aspects of the vision.
- Focuses on process at the expense of results.
- Focuses and blames their own negative evaluations on others.
- Creates an environment that reinforces the status quo and discourages discussion.
- Does not support colleagues to discuss issues and opportunities for improvement.
- Implements change in an unstructured way causing confusion about priorities and timelines.
- Poor communication skills lead to a lack of collaboration with stakeholders such as schools and hamlets.
- Does not complete appropriate specialist and resource planning for specialist clinics.
- Does not support change by continuing with status quo.
- Actively voices unconstructive criticism regarding changes being implemented.
- Does not advocate for changes that could improve client care.
- Does not incorporate quality focused principles to enact change.
- Does not act as a change agent to streamline service delivery.

### 3.2.6 Competency #6 Foster Lifelong Learning

Strong leaders learn continuously. They set goals for themselves and others. They take action to grow personally and to develop others in support of the GN's strategic goals.

As a manager, the SHP focuses on developing others:

- Discusses development needs and career plans with direct reports.
- Identifies ways to meet own and others' development needs.
- Helps people to understand and apply what they have learned in courses and through on-the-job experience.
- Gently pushes and supports others to go beyond their comfort zone in order to grow.
- Allows people to make mistakes so they can learn from them.
- Regularly assesses the talent in the unit.

#### *Proficient SHPs:*

- Actively seek opportunities and challenges for personal learning and development.
- Acknowledge mistakes and treat them as learning opportunities.
- Participate in continuing professional development activities.
- Change their behaviour in the light of feedback and reflection.
- Provide guidance and direction for others, using the skills of team members effectively.

- Review the performance of the team members to ensure that planned service outcomes are met.
- Support team members to develop their roles and responsibilities.
- Support others to provide good client care and better services.

#### *Examples of Effective Fostering Lifelong Learning*

- Seeking opportunities to learn from other professionals in everyday practice or through formal opportunities.
- Reviewing own practice against peers and best practice examples.
- Undertaking a management and/or leadership development programme.
- Undertaking benchmarking activities to identify best practice.
- Teaching, coaching, and mentoring others, including junior staff, students, and other disciplines.
- Delegating work to more junior staff.
- Managing the performance of staff within an area of responsibility, undertaking challenging conversations with colleagues whose actions have been associated with poor performance and taking appropriate action, including disciplinary action, where necessary.
- Creating new learning opportunities to develop staff.
- Liaising with Chief Nursing Officer and stakeholders in learning and orientation plans.

#### *Examples of Ineffective Fostering Lifelong Learning*

- Avoids opportunities for development and growth.
- Does not support invitations to training.
- Disregards latest research in scope of work.
- Reluctant to take part in organizational Professional Development Opportunities.
- Is unaware of team members' skills and strengths, causing them to be under utilized.
- Allows under- performing team members to continue in job with no feedback or course correction.
- Avoids uncomfortable discussions regarding performance gaps.

### 3.2.7 Competency #7 Contribute to Sound Decisions

Effective leaders involve others in determining the wisest and most appropriate decision according to the situation. They build consensus by listening, demonstrating respect, and facilitating open dialogue.

As a manager, the SHP includes others in decision-making:

- Invites input from others and is open to receiving it.
- Develops and expresses a thoughtful point of view.
- Is willing to change their own point of view.
- Involves subject matter experts to improve the quality of data.
- Bases decisions on data, facts, evidence, and observation.
- Communicates decisions and the reasons behind them.
- Understands how decisions affect Nunavummiut and other interested parties.

#### *Proficient SHPs:*

- Participate in and contribute to organisational decision-making processes.

- Act in a manner consistent with the values and priorities of their organisation and profession.
- Educate and inform key people who influence and make decisions.
- Contribute their unique perspective to team, department, system, and organisational decisions.
- Test and evaluate new service options.
- Standardise and promote innovative approaches.
- Overcome barriers to implementation.
- Formally and informally disseminate good practice.

#### *Examples of Effectively Contributing to Sound Decisions*

- Contributing to decisions using evidence about the running of the service as part of a multidisciplinary team.
- Advising management colleagues by providing a clinical perspective on service developments and the implications for clients.
- Taking responsibility for ensuring appropriate and effective decision-making processes are in place.
- Evaluating change options in terms of their impact on services and people.
- Designing outcome measures for services.
- Presenting the results of clinical audit and research to audiences outside their immediate specialty.

#### *Examples of Ineffectively Contributing to Sound Decisions*

- Abdicates decision-making responsibilities to other levels.
- Argues against or impedes decisions made by the organization.
- Makes decisions without input from staff and lacking collaboration with the team.
- Makes rash or impulsive decisions without consideration of consequences.
- Resists change even when existing methods are inadequate.
- Gives up at first obstacle to change.
- Makes decisions with a focus on self-satisfaction instead of service satisfaction; “if it works for me, then we are good”.

### 3.2.8 Competency #8 Manages Performance

Leaders hold themselves and others accountable for doing excellent work and achieving results. They provide clear expectations, give feedback on performance, and recognize everyone’s contribution.

- Assigns work based on clear goals and realistic expectations.
- Takes personal responsibility for fulfilling own commitments.
- Addresses issues of performance and productivity in a timely way.
- Provides regular, constructive feedback to staff members.
- Expresses patience and is encouraging to create a safe and trusting environment.
- Provides coaching for individual and group success.
- Recognizes hard work and achievements in a timely way.

#### *Proficient SHPs:*

- Analyse information from a range of sources about performance.
- Take action to improve performance.

- Take responsibility for tackling difficult issues.
- Build learning from experience into future plans.

#### *Examples of Effective Performance Management*

- Taking part in discussions with senior managers to develop understanding of future service plans.
- Communicating progress against targets and plans and ensuring that colleagues take personal responsibility for outcomes.
- Informing the dialogue around the introduction or amendment of locally set performance targets.
- Makes use of learning plans and makes work planning goals.
- Uses GN and other learning material for all staff.
- Completes chart audits and pharmacy audits in a regular and timely manner.

#### *Examples of Ineffective Performance Management*

- Does not conduct regular performance reviews with team.
- Takes no action when a staff conflict is brought to their attention.
- Does not ensure that delegated work has been completed.
- Does not prioritize workload in order to ensure critical tasks are completed in a timely manner.
- Failure to see the operational consequences and safety concerns from unsatisfactory audits.

### 3.2.9 Administers Nunavut's Government

Leaders are effective public administrators. They understand and comply with GN policies and practices related to managing people, finances, and government programs and services.

The three **technical competencies** described below pertain to all levels of staff.

#1 Managing People through understanding, interpretation and implementation of Human Resource policies and procedures.

#2 Managing Finances and Procurement by understanding, interpreting, and applying GN policies for managing finances and procurement.

#3 Managing Programs and Services by understanding and applying guidelines for GN programs.

## 3.3 Management Styles

This section will provide a brief introduction to management styles. It is important for the SHP to reflect on the attributes that they bring to their role and to understand their own strengths and challenges.

Most SHPs will demonstrate more than one style of management, pivoting to accommodate the needs of both the staff and situation.

### 3.3.1 Transformational

Transformational leadership is a management style that motivates employees to take ownership for their roles and perform beyond expectations. They lead by example.

The Registered Nurses Association of Ontario (RNAO) has developed a booklet on Best Practice Guidelines for Developing and Sustaining Nursing Leadership available at <https://rnao.ca/bpg/guidelines/developing-and-sustaining-nursing-leadership>.

The Best Practice Guidelines (BPGs) propose five practices of transformational leaders:

- Building relationships and trust.
- Creating an empowering work environment.
- Creating a culture that supports knowledge development and integration.
- Leading and sustaining change.
- Balancing the complexities of the system, managing competing values and priorities.

### 3.3.2 Democratic

Democratic leadership welcomes and encourages input and communication from the team when making decisions. Relationships are highly valued. This management style works well with experienced staff, but caution should be used when most staff are new to the health centre.

### 3.3.3 Laissez-Faire

This type of leadership is referred to as ‘hands-off’ approach and is most often seen in new or inexperienced leaders. They allow the team to function as they prefer without strong supervision. This is not the best style of management in health centres with the constant change in staffing. It does work well, however, with a very experienced staff who are comfortable with their autonomy.

### 3.3.4 Autocratic

This is an extremely ‘hands-on’ type of leadership where the manager makes decisions without the input of the team and may withhold information from the team in general. This is very effective in emergency when rapid decisions are necessary but does not promote trust or communication and can be detrimental to building collegial relationships with staff.

### 3.3.5 Servant

Servant leadership refers to leaders who influence and motivate others by building relationships and developing the skills of individual team members. This type of management works well in developing staff.

(American Association of Nurse Assessment Coordination)

### 3.3.6 Management by Walking Around (MBWA)

MBWA is not strictly a management style, but rather, a management practice. It expands on an open-door policy by encouraging managers to spend time with their staff in informal conversations. The conversations should be relaxed and unstructured. The manager listens more than talks, giving the staff member undivided attention. Listening actively helps staff members to be open and honest. Recognise good work and share the successes. This style has been attempted in a few hospitals; its success depends on the manager following through with resolving problems that occur.

## 4.0 Assigning Duties

Policies that apply:

- 05-008-00 Additional Nursing Functions
- 05-009-00 Transferred Functions
- 05-010-00 Competency for Transferred Functions
- 07-009-00 Unregulated Healthcare Workers – Employer Responsibilities
- 07-010-00 Working with Unregulated Healthcare Workers – Nurse Responsibilities
- 08-017-00 Unregulated Healthcare Workers Performing Laboratory Procedures

Delegation is a word commonly used in health centres to describe the assignment of duties. Transferred functions and delegated authority are other terms which refer to delegation.

For greater clarity, delegation is a formal process where a skill or function not in the basic scope of practice of the healthcare provider is transferred from another profession through policy and/or medical directive. Delegation is the responsibility of the Department of Health, senior nursing administration, and the profession from which the function is transferred.

An example of this is the ability that CHNs have to diagnose illness and initiate diagnostic testing. These are delegated functions transferred through medical directive and policy.

SHPs do not delegate (even if they use this term); when they give another team member a job or task, they are assigning a duty.

The SHP or CHN cannot assign duties that require nursing judgment or any aspect of the nursing process: assessment, planning, implementation, or evaluation.

CHNs have an expanded scope of practice. Some unregulated healthcare workers have also been delegated skills that are outside of their basic scope of practice, such as clerks who perform basic radiology functions. Public Health Nurses also have the ability to initiate x-rays for TB and the ability to treat sexually transmitted infections. LPNs can now immunise children under the age of 5. These are all examples of delegated functions supported by policy or directive.

The SHP may share the authority to assign duties with another CHN or with a Public Health Nurse in the assignment of duties to Community Health Representatives. The SHP retains **responsibility** for the assigned duties. **For greater clarity**, this means that the SHP cannot assign duties without following up to ensure that the job was completed and is correct. If the duty has not been completed as required, the SHP must resolve the issue – either by assisting the staff member, providing further instruction, or training, or re-assigning the job. The SHP may use the performance review system to address resistance to or non-completion of assigned duties. The performance review system is discussed in [8.2 Performance Evaluations](#)

While the SHP is responsible for all healthcare delivered in the community, the number of duties to be accomplished on a daily basis can be daunting. Many of these duties can be assigned to other team

members. An effective leader will build the capacity of their team, ensuring all team members are working to their full scope.

Assignment of duties is not only a necessary tool in the SHP's toolbox, but also an art – in recognising, coaching, and mentoring increased skill in the team. By trusting your team and accepting that you can't do it all, you'll accomplish more as a group than you could have ever accomplished alone.

#### *Five Rights of Task Assignment:*

1. **Right Task:** the SHP determines that the task can be assigned to a member of the team. The SHP needs to be aware of and consider any policies which may impact the assignment.
2. **Right Circumstance:** The task being assigned matches the team member's competency and level of supervision required. The SHP cannot assume that the team member knows how to accomplish the task. This is important for both clinical and community staff.
3. **Right Person:** The SHP considers the skills and abilities of individual personnel in making decisions about assignment of tasks and implements remedies when performance is below standard.
4. **Right Communication:** The SHP communicates specifically what, how, and by when, assigned tasks are to be accomplished. Communication includes the purpose and goal of the task.
5. **Right Supervision:** The SHP monitors and evaluates the performance of the assigned task, intervenes if necessary and provides feedback to the team member.

#### *Some commonly assigned duties:*

- Month End Reports - the completion of these summaries is often assigned to front desk clerical staff. The Month End Report is currently undergoing changes and may, eventually be removed from SHP responsibilities. At this time, however, it is important to ask for direction from the Director of Health Programs regarding current submissions.
- Monitoring of the transient units may be assigned to housekeepers.
- Caretakers may be responsible for shipping laboratory specimens.
- Follow up of consult notes or abnormal lab results may be assigned to casual or agency CHNs if the CHN who originated the work is away from the community.
- Public Health Programs such as Communicable Disease or Well Child should be assigned to full time staff but may be assigned to CHNs on contract in the community when full-time staff members are away. For greater clarity – it is important that full-time staff remain in control of this important programming.
- On call schedule can be assigned to a full-time CHN.
- Point of care testing quality checks and submission of results can be assigned to an LPN, a CHN or a community staff member who has been successfully trained.
- Ordering of stock items can be assigned to the caretaker, LPN or to a CHN.
- Ordering of pharmacy stock can be assigned to an LPN or CHN.
- Weekly checks of crash cart, birthing carts etc. can be assigned to an LPN but should also be assigned to CHNs on a rotational basis so that they are comfortable with finding items when they are needed.

- Collecting payroll sheets and documents may be assigned to front desk staff or administrative assistants.
- Processing physician orders may be assigned to a CHN or LPN.
- Drawing lab specimens on a lab draw day can be assigned to an LPN who has been trained in phlebotomy.

## SECTION 4 THE DAY BEGINS

### *Key Takeaways for this section:*

- Understand and follow the Chain of Command.
- Request approval from other managers when requesting assistance from one of their staff members.
- Understanding and following the Morning Report Policy will set the tone for how staff interact about community members and between colleagues.
- If QC is not performed, the POC equipment may lock out and care will be delayed.
- Effective communication with clerical staff will provide supportive direction and improve access to care.
- Tracking referrals helps prevent loss of clients to follow-up.
- Organisation is key to effective stewardship of the health centre.

This section will cover the daily health centre duties. Other than Morning Report, the SHP is free to organise the day to suit themselves. Some SHPs dive directly into paperwork while others walk through the clinic to check on workflow and to greet community members in the waiting room. The listing and explanation of duties is not, therefore, in chronological order but does cover what generally happens in the clinic on a daily basis.

Policies that apply:

- 05-001-00 Laboratory Procedures
- 005-016-00 Provision of Care in Emergency Situations
- 06-014-00 Telephone Communication
- 06-015-00 Missed or Cancelled Appointments
- 06-017-00 Morning Report
- 07-009-00 Unregulated Healthcare Workers – Employer Responsibilities
- 07-009-00 Unregulated Healthcare Workers – Employer Responsibilities
- 07-010-00 Unregulated Healthcare Workers – Nurse Responsibilities
- 07-010-00 Unregulated Healthcare Workers – Nurse Responsibilities
- 07-035-00 Escalation of Medical Care
- 08-0015-00 ECGs
- 08-002-00 Requisitioning Laboratory Studies
- 08-003-00 Interpretation of Laboratory Studies
- 08-005-00 Acknowledgement of Diagnostic Test Results
- 08-005-02 Lab Specimen Result Tracking
- 08-006-00 Follow-up of Abnormal Diagnostic Test Results
- 08-017-00 Unregulated Healthcare Workers Performing Laboratory Procedure.



- 08-017-00 Unregulated Healthcare Workers Performing Laboratory Procedures
- 08-020-00 Troponin Point of Care Tests in Pediatric Patients
- 08-021-00 iStat Point of Care Testing in Community Health Centres
- 08-022-00 Paramedic Initiation of Point of Care Testing Medical Directive
- 10-006-00 Housekeeping
- 10-007-00 Handling of Used Equipment and Supplies
- 10-008-00 Clean and Disinfect
- 10-009-00 Sharps

#### References:

*Housekeeping Manual* is in hard copy in health centres and available online at

<https://www.gov.nu.ca/health/information/manuals-guidelines>.

*Infection Prevention and Control Manual* is in hard copy in health centres and available online at

<https://www.gov.nu.ca/health/information/manuals-guidelines>.

Collective Agreement between the Nunavut Employees Union and the Minister Responsible for the Public Service Act available at <https://www.gov.nu.ca/finance/information/collective-agreements>.

Human Resources Manual Section 1200 Hours of Work and Overtime available at

<https://gov.nu.ca/human-resources/information/human-resources-manual>.

## 4.1 Appendix

- Policy 06-017-00 Morning Report
- Approved POCT and QC Expectations
- QC Monthly Checklist
- SHP Medical Travel Flowchart
- eHealth Projects Service Request Form
- GN Employee Medical Travel Guidelines

## 4.2 Organisational Chart and Chain of Command

The SHPs in all communities outside of Cambridge Bay and Rankin Inlet report to a Director of Health Programs. The SHPs in Cambridge Bay and Rankin Inlet are titled Managers of Outpatient Services and report to the Directors of the Regional Health Centres in those communities. Functionally, however, these positions are SHPs, and this manual refers to them as well.

Regional Directors of Health Programs (Director) report to the Executive Director (ED) of the Region. The ED reports to the Assistant Deputy Minister (ADM) for Operations for the Department of Health. The ADM reports to the Deputy Minister. The Deputy Minister reports directly to the Minister of Health.

Not everyone in the health centre reports to the SHP. Home care nurses, for example, report to the Regional Manager of Home and Community Care. Mental Health staff reports to the Regional Manager of Mental Health and Addictions.

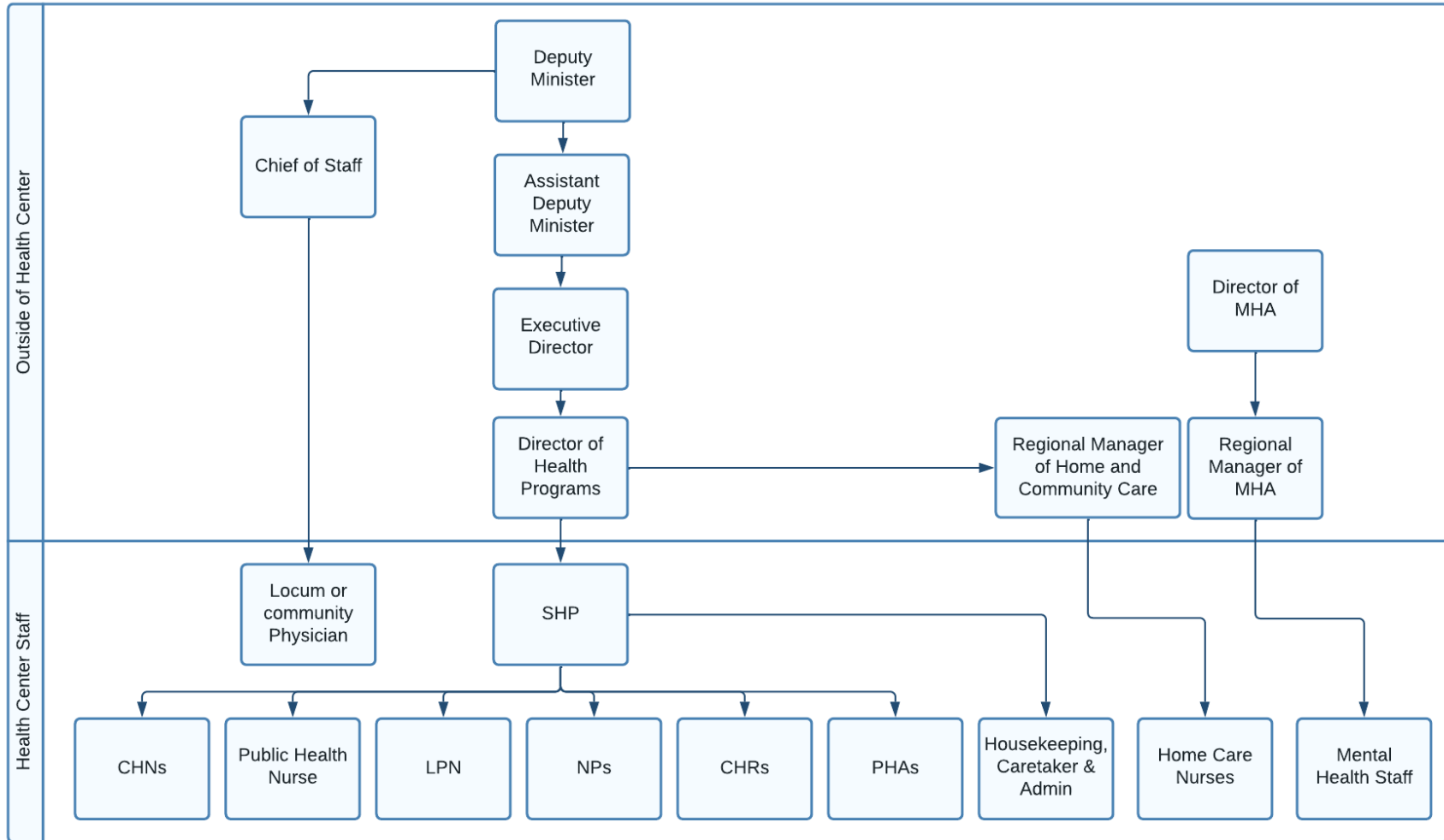
Locum or community physicians report to the Chief of Staff in Iqaluit who reports to the Deputy Minister.

Before asking a team member, who reports elsewhere, to undertake a task in the health centre, the SHP should consult with their manager. This promotes transparency and respect and supports relationships.

It is important to understand the reporting structure and to respect it by maintaining congenial and effective relationships and communication with other managers within the department.

The SHP has direct authority over the Community Health Nurses (CHNs), Public Health Nurses, Licensed Practical Nurses (LPNs), Nurse Practitioners (NPs), Community Health Representatives (CHRs), Public Health Assistants (PHAs), housekeeping, caretaking, and administrative staff in the health centre. Some health centres have a Supervisor of Administrative Services who serves as the supervisor for housekeeping, caretakers, and administrative staff and can support the logistics of maintaining health centre operations.

HEALTH SIMPLIFIED CENTER ORGANIZATIONAL CHART



## 4.3 Initial Duties

### 4.3.1 Administrative Overtime

The health centre day generally begins at 08:30 and ends at 17:00 although there may be some variation in these hours for some communities. Regardless, the workday is 8.5 hours with 1 (one) hour off for lunch, giving 7.5 hours of functional work time.

Many SHPs come to work early to complete some necessary tasks before the day begins. This is considered to be administrative overtime and requires permission of the Director. The overtime pre-authorisation form is available on the *GN Intranet*. This form should be signed by the Director prior to the work being done, however, that arrangement is flexible between the SHP and the Director. The same applies to staying late to complete tasks.

Obtaining pre-authorisation provides transparency to the Department of Finance.

SHPs must also provide pre-authorisation for administrative overtime for any health centre staff who need to stay after hours to complete tasks. While this is not necessary for the mandatory, clinical overtime provided by the CHNs on a rotational basis, it does refer to overtime claimed for activities such as updating population health programs and for completion of charts.

It is the SHP's responsibility to ensure that the pre-authorized tasks are necessary and completed. There are times when it is more important to ensure that the CHN has sufficient rest and downtime than to keep a program up to date. This is especially true in times of short staffing when the CHN is doing more overtime (OT) than usual.

The signed pre-authorisation permissions are submitted to the Regional Office every two weeks along with the overtime claims.

### 4.3.2 Health Centre Keys

All of the professional healthcare staff in the health centres have keys to the health centre. They are given keys because they are on call or may need to access the health centre during off hours.

In some communities, there may be an administrative staff member who starts work before the health centre opens. This staff member usually has a key.

Security staff may have keys.

Keeping track of the keys and ensuring that they are returned when casual or agency staff leave the community is the responsibility of the SHP. The SHP can do this in a number of ways – keeping a sign out binder, keeping an electronic log etc. The SHP must implement a system of documenting and tracking who has which keys, but the exact nature is at the discretion of the SHP.

If a nurse leaves the community with the keys, the SHP can have a new key cut by the Facility Maintainer or the Housing Department. The SHP should request that the nurse return the keys via registered mail at their own expense.

Loss of keys may present a security risk, and, in such cases, it is recommended to have the locks changed. The SHP should advise the Director if this happens and complete an incident report for submission to the MEDITECH QRM module. The Facility Maintainer is responsible to complete the work. The maintainer may request that a work order be submitted to Community and Government Services (CGS).

Community and Government Services is responsible for completing minor, routine repairs to the health centres in Nunavut. They do this through the Facility or Settlement Maintainer. Each community has one.

### 4.3.3 Morning Report

In every health center, the day begins with Morning Report. Policy 06-017-00 *Morning Report* is included in the appendices for this section and can also be found at <https://www.gov.nu.ca/health/information/manuals-guidelines>. This policy should be thoroughly and carefully reviewed.

It is important to ensure that Morning Report is efficient. It cannot last longer than 30 minutes except in very exceptional cases. The SHP sets the tone and ensures that all information is disseminated appropriately, being mindful that Personal Health Information is extremely confidential. This is not a time for story-telling or personal commentary. Comments about lifestyle or gossip about community members is strongly discouraged.

Morning Report is also the time that the SHP may assign daily tasks to staff. Examples of these tasks are Point of Care Testing (POCT) quality checks, emergency room and birthing cart checks, ordering stock supplies, etc.

### 4.3.4 Point of Care Testing (POCT) Quality Control:

Quality Control is required on all point of care testing devices and kits in the health centre. This is done on a scheduled basis – daily, weekly, or monthly depending on the device. Kits have quality control performed on new shipments and/or new lot numbers when received at the health centre as per POCT procedures and protocols.

Each health centre has a hard copy POCT Binder, however, the most up to date information is located in Microsoft Teams → Nunavut Nursing Education → Point of Care Testing → Files. If you do not have access to this Team, please contact your Educator. The list of approved *POCT and QC expectations* and the *POCT QC checklist* are included in the appendices. Quality Control must be done routinely according to schedule and the assignment of this task should be rotated so that all nurses are comfortable with the procedure. The POCT program is one of the foci for the Licensed Practical Nurse (LPN), however, it is still important to ensure that the nurses are all proficient in the process as all staff have responsibility to perform QC checks after hours, as required.

One of the primary reasons for non-compliance is lack of testing supplies. It is important to ensure that those supplies are inventoried and re-ordered in a timely manner with close attention to expiry dates.

Another reason for non-compliance is “no time/workload”. This is not an appropriate reason for not ensuring quality control. It is the responsibility of the SHP to ensure that the QC testing is done and is

considered a priority. This supports the need to assign the POCT program to a specific team member and to set up a routine schedule for when these functions will be done each day.

Many SHPs assign a nurse to complete the glucometer testing during morning report since it is done on a daily basis.

If QC is not performed, the POC equipment may have a lockout function which will then delay care.

Quality Control results must be submitted to the POCT Coordinator on a monthly basis.

#### 4.3.5 Following Morning Report

Once Morning Report is complete, the SHP turns their attention to the other daily tasks.

Many SHPs may have already started their day by reviewing booked appointments and ensuring that there are sufficient nurses to attend to them.

When there are insufficient nurses, it is important to direct the front desk staff to contact clients to rebook their appointments, while ensuring that clients with more urgent needs are given priority.

### 4.4 Daily Duties

#### 4.4.1 Front Desk Management

The clerical staff working at the front desk of the health centre can provide the SHP with significant support if they are provided with clear direction. By building a relationship based on trust and mutual respect, the SHP will have access to community information that might otherwise be missing. The clerical staff are valued members of the health care team as they are usually the first point of contact for community members and can provide a welcoming environment for the public.

Depending on the size of the community, there may be clerk-interpreters, registration clerks, receptionists, medical travel clerks and file clerks working at the front desk.

The clerical staff need to be aware of the SHP's priorities in scheduling appointments and how and when to communicate with the SHP in case of emergency. It is also important to provide a system by which the clerical staff notify the On-Call nurse when there is a phone call that cannot wait.

**The clerical staff should be asking for and checking health cards, checking expiry dates, and updating contact information with every encounter.** This is important to ensure that everyone receives the services to which they are entitled.

The SHP should review Policy 06-015-00 *Missed or Cancelled Appointments* with all administrative staff who are booking appointments. Booking appointments in a way that accommodates client needs and

advising clients regarding appointments, including telehealth appointments in a timely way will improve rates of appointments attended.

It is important to remember that the SHPs are leaders to the entire team that reports to them, not just the nurses. Building positive relationships with all team members and fostering a work environment where everyone feels valued and supported is essential to a SHP's success.

#### 4.4.2 Health Cards

Current Nunavut Health Cards are necessary for medical travel and medevacs. Without a health card, out of territory healthcare providers cannot receive payment for services.

Health cards are sent out automatically prior to expiry to the address on file by the Health Insurance office in Rankin Inlet.

Moving to another community without advising Health Insurance Programs is the biggest reason for expired health cards.

Children who have reached one year of age need their own health card. One simple strategy is to have the application for enrollment submitted when the infant has their first visit to the health centre. The health centre clerical staff can then submit the application on the parent's behalf. **Application forms and further information are available at <https://www.gov.nu.ca/health/information/health-care-card>.**

Children under one year of age may use their mother's health card.

People moving to Nunavut should apply for a health card immediately. They will be able to access service through their previous health card for three months after arrival.

The clerical staff must complete an Outpatient Services Report for these clients as well as for visitors who may require care.

RCMP should have a current Nunavut Health card. Additionally, they have access to Blue Cross for some services not covered by the territorial health insurance plan.

Health care for members of the Canadian Armed Forces and all Federal employees is paid through a federal health plan.

#### 4.4.3 Housekeeping and Caretaking Staff

Housekeepers and caretakers are key members of the health centre team. It is important for both housekeepers and caretakers to have a clear schedule of tasks to be completed. While there is a Housekeeping Manual, it has not been translated into Inuktitut; the housekeeper may speak English as a second language, therefore, the SHP should have a working knowledge of this resource in order to provide support.

The move to single use instruments within the Department of Health is relatively new and ongoing. While sterilization remains a safe and effective Infection Prevention and Control (IPAC) practice, it is

challenging in the health centre environment. Since the policies are still in place (listed at the beginning of [this section](#)), the SHP should be aware of them.

While neither clerical staff nor the housekeeping/caretaking staff are commonly considered as healthcare workers, they are members of the healthcare team. The SHP should follow the principles of the policies concerning unregulated healthcare workers when assigning new tasks to any of the nonprofessional and paraprofessional staff.

#### 4.4.4 Reviewing Diagnostic Test Results, Consult Notes Etc.

The SHP is responsible for the initial review of diagnostic test results, consult notes etc. There are times when the SHP must delegate this duty to a CHN because of the necessity of attending to other priorities. If a CHN is completing this duty on behalf of the SHP, the CHN must report any abnormalities so that the SHP is aware of any potential risks. The SHP should delegate the follow up. In some regions, lab results are received via fax and are completely paper based. The SHP should note on the result to whom the follow up is delegated and the date that this is done. If the SHP considers that the follow-up is urgent, it is also necessary to check and make sure that this task is completed. The SHP may do this by asking the delegated CHN to report back at a specific time.

#### 4.4.5 Tracking Referrals

CHNs may refer clients to the Community Physician. Community Physicians and Nurse Practitioners refer to specialists. There may be some regional variations based on agreements with the out of territory service providers. For example, in the **Kivalliq region**, CHNs can refer clients to the Ear, Nose and Throat (ENT) specialists who come to their communities and to the Eye Clinic.

The SHP **must** review referrals to ensure that they contain all of the necessary information, which follows a standard format: Chief Complaint, History of Present Illness, Past Medical History etc. Incomplete referrals can result in delayed appointments, inaccurate triage, and delayed diagnosis and treatment.

These referrals are often kept in a binder in health centres; however, this is not always the best way to manage. The binder must be kept up to date. Paper is easily lost and cannot be easily mined for data, such as wait times; therefore, an electronic system is more efficient.

The health centre should have a referral tracking system; if not, one should be set up. This system allows the SHP to ensure no client is lost to follow up. This tracking system should contain:

- Client identifiers
- To whom the client is referred.
- The reason for the referral.
- The date the referral was sent.
- The date of appointment once received.
- The date of completion, i.e., the client attended the appointment.

Once an appointment or further direction is sent to the health centre (usually by fax), that information can be entered into the tracker. If there is no response to the referral in a week or so, the SHP may then follow up with the provider to obtain a progress report.



The SHP may assign this task to a clerk, ensuring that sufficient training has been provided so that the clerk understands not only the steps to be followed but also the reason for them. It is also important to reiterate the necessity of keeping all client information confidential.

In both the **Kivalliq** and **Qikiqtaaluk** regions, referrals are entered into Meditech, and the SHP can request a report of pending and completed referrals from eHealth by completing the eHealth Projects Service Request form and emailing it to [healthprojects@gov.nu.ca](mailto:healthprojects@gov.nu.ca). The form is included in the appendices.

If this is the system on which the SHP is relying, the SHP must be mindful to request the reports routinely and systematically in order to avoid problems. Being proactive provides for more effective administration.

The SHP is free to devise their own system being mindful that they are accountable for the care these clients receive. A proactive stance in ensuring that no client is lost to follow-up is protective of both the clients and the health centre staff.

#### 4.4.6 Client Complaints and Communication with Community Members

Office of Patient Relations (OPR) provides an opportunity for clients, and/or their advocates to provide feedback on the quality and delivery of healthcare services. There are several possible ways to file a concern:

- Clients may send a complaint by completing a standardised form available at <https://www.gov.nu.ca/health/information/patient-relations>.
- By submitting a letter, by fax 1-867-975-5388
- Email directly to [patientrelations@gov.nu.ca](mailto:patientrelations@gov.nu.ca) or
- Call toll free 1-855-438-3003

A Patient Relations staff member will then send the client concern to either the Regional ED or the Director of Health Programs for investigation. The Director may then contact the SHP for assistance in the review.

It is the SHP's responsibility to review and compile the necessary notes. This is best done by constructing a timeline of events and submitting the supporting documentation.

Complaints from community members can be stressful for health centre staff. The SHP needs to be mindful that a defensive attitude could contribute to a negative environment and should, instead, see the opportunity to improve service or communication or both. Complaints are often easily resolved because they are miscommunications but, at times, they reveal service or policy gaps which can be successfully addressed.

It is important for the SHP to:

- Encourage complainants to send their concern directly to Patient Relations for appropriate resolution and tracking purposes.
- Acknowledge the client's distress – this is not an admission of guilt, but an honest expression of empathy.

- Maintain an attitude of respect and compassion throughout
- Not engage in arguing and to be conscious that the client may perceive efforts to console as dismissive.
- Remain consciously objective and self-reflective.

Complaints are important to the department in providing an environment of continuous quality improvement. It is necessary, therefore, that the SHP respond to complaints and requests for information from senior managers as expeditiously as possible.

If the client prefers to keep the complaint at the health centre level (i.e., does not want to submit the complaint to Patient Relations), the SHP must communicate the complaint to the Director in order to ensure transparency and to advise the Director regarding both the specifics of the complaint and the plan for resolution.

Clients may exhibit varying degrees of frustration or anger when submitting a complaint. There may be other external factors contributing to the client's response, unknown to health centre staff. The SHP must respond to this state as calmly and sensitively as possible. Allowing the client to vent their emotions without interruption will often alleviate the situation. The SHP can then reiterate the concern, asking if this interpretation is correct, and giving the client time to respond. Once the issue is defined, the SHP may want to discuss it with the Director and should provide the client with a date and time when they will once again discuss the complaint.

The SHP must document all communications with the client, either in the client record if the concern is clinical or in an email to the director. This will prevent any misunderstanding which might occur at a later date. The Director should forward the complaint and resolution to Patient Relations for tracking purposes.

#### 4.4.7 Medical Travel

Medical Travel is frequently the subject of client concern and so follows the complaints section.

Medical travel in Nunavut is governed by Medical Travel Policy. This policy is developed by the Medical Travel team and approved by Cabinet. The policy is found at <https://gov.nu.ca/health/information/legislation-and-policy-0>

Each health centre has at least one Medical Travel Clerk who is tasked with processing medical travel.

The Territorial Travel Program has developed a training guide for Medical Travel Clerks. Once the training is available, SHPs are expected to have all Medical Travel Clerks and Clerk-Interpreters attend the training.

The Medical Travel Clerk receives medical appointments, either from the SHP or directly from the fax machine or email. The clerk should keep a log for tracking purposes which includes the date that the appointment was received. The clerk is the first reviewer of appointments and should be encouraged to bring questions about appropriateness or validity of appointments to the SHP before completing the referral paperwork.

Once the clerk has a client appointment, the referral paperwork is completed, and the clerk contacts the client. **The clerk must notify the client about the appointment date as soon as it is received.** Clients

may need to make arrangements of their own for absence from work or for childcare. **It is important that the clerk ask the client whether they require an escort.** This prevents late requests which are more difficult to arrange. The client, with or without the escort, must come to the health centre to sign the referral papers. These are then given to the SHP for final signature.

***See SHP Medical Travel Flowchart located in the Appendices for a full flowchart of the below.***

The SHP must:

- Ensure that the referral is necessary and appropriate.
- Workers Safety and Compensation Commission (WSCC) travel is not arranged by Health other than a medevac.
- **GN employees have specific guidelines included in the appendices.**
- **Clients leaving the territory for medical appointments or confinement are only provided travel to the nearest site where the service can be provided.** For these clients, the referral sites are Yellowknife, Edmonton, Winnipeg, and Ottawa. The client must provide for their own and their escort's travel beyond these points. If the client is going to remain out of territory post discharge, they are responsible for their own expenses. This clause refers to non-indigenous clients who may wish to see a specialist in their community of origin and to those who prefer to deliver their babies in a site closer to extended family.
- Ensure that all dental appointments funded through NIHB have been approved by Health Canada. There must be an approval number on the referral. If there is not, contact the Dental Coordinator. The appointment will need to be cancelled.
- Verify that the referral site is not a private clinic. If there is doubt, the SHP may contact Health Insurance Programs in Rankin Inlet at [nhip@gov.nu.ca](mailto:nhip@gov.nu.ca) or call 1-800-661-0833 to verify.
- Verify that photo ID is current.
- Verify that the client health card is current.
  - If the card is expired or if recently moved to NU and the client is indigenous, prior approval may be obtained (for scheduled travel) from Health Insurance Programs/Non-insured Health Benefits (NIHB) for attendance at the appointment. **In the event of a medevac, post approval is required through Health Insurance/NIHB.**
  - If the client is non-indigenous and does not hold a valid NU healthcare card, they will be responsible for their own travel and should be advised of this. In the case of a medevac, Health will arrange, however the client must be advised they will be invoiced. No return travel will be booked. The exception would be, when it is a GN employee with a term over 4 months or dependent of employee.
- Every client is eligible for one escort if they meet the criteria. Verify that the escort request meets the medical travel policy and is appropriate. Escorts who have had previous violations of the escort agreement should not be considered except in very extenuating circumstances. Every effort should be made to engage a different escort in these cases.
  - Be mindful that Medical Travel Policy does not support the provision of escorts for reason of emotional support.
- **Second escorts requests** are approved by the regional EDs and reviewed by NIHB (if client is indigenous and being supported for travel by NIHB). The referral and the second escort request form are submitted to the regional medical travel specialists who submit them to the ED for approval. Non-Indigenous client requests or GN employees do not need NIHB approval prior to

being submitted to the Director. The reason for a second escort should be clearly substantiated and legible. **The exception to this is the Qikiqtaaluk region.** Their travel referrals are processed by the medical travel specialists in Iqaluit, however, second escort request and NIHB approvals are processed by the regional office who then submit them to the ED for approval.

- **Review requests to bring infants** – must be under the age of two by the date of appointment. Infants must have a caregiver available in the referral city. Escorts are not provided for the purpose of childcare. The Director will approve or deny this request. For further information, please review the Medical Travel Policy
- **Regional EDs have delegated authority to approve second escort requests.**

***See SHP Medical Travel Flowchart located in the Appendices for a full flowchart of the above.***

Once all the paperwork has been signed by the SHP, the medical travel clerk will submit it to the Regional Medical Travel Specialists. The specialists book accommodations and travel for the client (both NIHB and GN employees) and return these details to the medical travel clerk. It is important for the travel clerks to submit all necessary paperwork to the regional office as quickly as possible giving the travel specialists sufficient time to arrange logistics.

#### 4.4.7.1 Right to Appeal

Clients who disagree with an escort denial have the right to appeal. All appeals (both primary and second escort) are sent to the ADM Programs and Standards for review and final decision. The appeals form is emailed to [medicaltravelappeals@gov.nu.ca](mailto:medicaltravelappeals@gov.nu.ca).

#### 4.4.8 Jordan's Principle and the Inuit Child First Initiative

There are times when parents, attending an appointment with their child, would like to bring other children with them. This is especially true when the child (the client) will be out of territory for a few weeks or months. Health does not provide financial support for these requests. The SHP can contact Jordan's Principle/Child First for assistance or provide this information to the parents. The Child First initiative ensures that Inuit children have access to the essential government funded health, social and education products, services, and supports they need, when they need them. Jordan's Principle is more focused on First Nations children; however, both services have been used interchangeably.

The children must be recognised by an Inuit land claim organisation (i.e., have an N number) and be under the age of majority. To request funding, either the Medical Travel Clerk or Clerk-Interpreter (with consent) or the parent can contact the initiative at 1-855-572-4453 or [sac.principedejordanrn-nrjordanprinciple.isc@canada.ca](mailto:sac.principedejordanrn-nrjordanprinciple.isc@canada.ca).

For further and more specific information regarding coverage and submission of requests, please access the following website: <https://www.sac-isc.gc.ca/eng/1536348095773/1536348148664>.

#### 4.4.6 Extended Health Benefits (EHB)

Extended Health Benefits are available to non-indigenous residents with one of specified conditions, seniors aged 65 or older, and all residents who have exhausted their third-party insurance or have no medical travel benefits.

A list of specified conditions is available at <https://gov.nu.ca/health/information/extended-health-benefits-ehb-eligible-specified-conditions>.

EHB are of particular importance when a non-indigenous client is out of territory on approved medical travel for an extended period. For those clients that have no travel benefits or have exhausted employer benefits or are registered with the EHB program, the program will provide some support for accommodation, meal per diems and ground transportation. The SHP should bring the EHB program to the client's attention when a client has been diagnosed with a chronic condition.

Questions can be addressed by email to [ehb@gov.nu.ca](mailto:ehb@gov.nu.ca), or by phone 1-800-661-0833.

#### 4.4.6.1 Extended Stays – NIHB

NIHB will provide travel benefits up to 90 days when a client is required to access health services outside their home community. If a client is going to be out long-term (chemo, transplant list etc.), it is critical that an extension is requested to continue the client past the 90 days. As long as the client is in active treatment (under the care of NU and OOT physician) these approvals will continue until the client is able to return to their home community.

Further questions regarding prior approval/extended stay can be addressed by emailing [nihbpriorapproval@gov.nu.ca](mailto:nihbpriorapproval@gov.nu.ca).

#### 4.4.7 Medical Evacuations (Medevacs)

Medevacs are charter flights with medical staff and the necessary equipment to transport critically ill clients to a referral site. The company is under contract to the Government of Nunavut. The government submits a request for proposals (RFP) through the Community and Government Services (CGS) tendering website. Interested parties apply and submit their proposals. The proposals are reviewed by an evaluation committee who evaluate the proposals using a systematic, mandated approach. This is a highly confidential process. Once the decision has been made, the contract is awarded to the winner. Currently, each region has a separate contract, but this may change over time and the contract may become territorial with one provider and one contract for all three regions.

Medevacs are provided for:

- Clients whose illness is too critical to be cared for in the community.
- Clients who require more than 4-hours of 'in patient' care.
- Clients who may require investigation not available in the community and are too ill to travel on a scheduled flight.
- Clients whose condition cannot wait for the next scheduled flight.

The decision to medevac is made by the physician on call in collaboration with the consulting CHN. The physician is responsible to contact the referral emergency room for acceptance of the client. Once the client has an accepting physician, a medevac can be initiated. This is done in different ways across the territory.

#### 4.4.7.1 Kitikmeot Medivac

In the **Kitikmeot**, the physician contacts MedResponse who then facilitate linkage with an emergency doctor or specialist in either Yellowknife or Edmonton. Once the decision to medevac has been made, MedResponse initiates the medevac.

#### 4.4.7.2 Kivalliq Medivac

In the **Kivalliq** region, the On-Call physician is responsible for obtaining a receiving physician at the referral site. Once the receiving physician has agreed, the CHN contacts the medevac provider to initiate the evacuation.

#### 4.4.7.3 Qikiqtaaluk Medivac

In the **Qikiqtaaluk** region, On-Call services are provided by the emergency room physicians at QGH in Iqaluit. Once the decision to medevac is made, the staff at the hospital make the arrangements. The CHNs in the health centre provide the transfer documents for the medevac provider and the referral paperwork for medical travel.

**In all regions**, it is the CHN's responsibility to ensure that all paperwork is completed and faxed or emailed to the appropriate destinations and that the client and escort health card and/or identification are valid.

The SHP **must** be notified of:

- All impending medevacs
- Escalating issues if the physician refuses to medevac but the CHN thinks that the medevac is necessary and requires the SHP to advocate on behalf of the client.
- Requests for more than one escort
- Unusual escort requests or requests to bring an infant.
- Requests for CHNs/physician to accompany medevac to referral site
- Serious deterioration of the client
- Unaccountable delays in medevac arrival

The SHP must contact the Director if there is a request for a CHN/physician to accompany the medevac. This request has serious implications for staffing and should only be approved when absolutely necessary for the safety of the client. The Director may also be best placed to intervene if there are unaccountable delays in medevac arrival times that put the client at risk of serious harm.

#### 4.4.8 Case Management and Discharge Planning

During and following hospitalisation, discharge planning for clients is provided by out of territory services in all three regions.

##### 4.4.8.1 Kitikmeot Region

There is no case management currently for the **Kitikmeot Region**. Discharge planning is provided by Stanton Territorial Hospital in Yellowknife and Northern Health Services Network in Edmonton. Both of

these services are contracted by Health and provide support for hospitalised clients in those two cities. While they do not provide service for outpatient clients, both services will offer support if necessary.

#### 4.4.8.2 Kivalliq Region

Case management for the **Kivalliq Region** is provided by Kivalliq Inuit Services (KIS), based in Winnipeg. KIS is a GN service staffed by GN employees. All referrals for out of territory care are sent to KIS which then coordinates appointments, provides transportation and interpreter services. The services are provided for both inpatient and outpatient clients.

#### 4.4.8.1 Qikiqtaaluk Region

Case management for the **Qikiqtaaluk Region** is provided by Ottawa Health Services Network, Inc. (OHSNI) based in Ottawa and by case management at Qikiqtani General Hospital (QGH). OHSNI is a non-profit contractor for the GN. All referrals for out of territory care are sent to OHSNI which then coordinates appointments, provides transportation for clients as well as interpreter services. These services are provided to both inpatient and outpatient clients. Case management is staffed with GN employees and provides service for hospitalized community members as well as referrals to Iqaluit.

## SECTION 5 WEEKLY DUTIES

### *Key Takeaways for this section:*

- The *GN Formulary 2021* contains all the information necessary to manage the health centre pharmacy.
- Routine ordering of medication, supplies and equipment is critical to efficient health centre operation.
- Keep close track of ordering and ensure that LCAs are used appropriately and according to policy.

This section will cover ordering processes for pharmacy, equipment, and supplies. Please also review *A Quick Guide to Facility Management Services Provided By CGS* in the appendices for more information regarding managing the health center facility, both financially and operationally.

Policies that apply:

- 05-017-00 Equipment Management System
- 05-019-00 Equipment – Basic Nursing
- 05-020-00 Equipment – Advanced Nursing
- 05-032-00 Compressed Gas
- 05-030-00 Motor Vehicles
- 07-028-00 LPN Directive: TB Program
- 07-032-00 Testing, Diagnosing and Treating Syphilis infections for Public Health Nurses and Community Health Nurses
- 07-041-00 Primary Care and Acute Care Paramedic Medical Directive
- 09-003-00 Stock Medications
- 09-004-00 Medication Administration – Nursing Practice
- 09-005-00 Dispensing Medication
- 09-006-00 Administering or Dispensing Pharmaceuticals – Documentation
- 09-010-00 Repackaging and Labeling Pharmaceuticals

References:

Section 9 of the Community Health Nurse Policy Manual is available online at:

<https://www.gov.nu.ca/health/information/manuals-guidelines>.

The formulary also contains policies. These are contained in Sections 7, 8, 9 and 10 of the formularies. It is important that the SHPs familiarise themselves with all of these policies.

The **Immunization Manual** is available at <https://www.gov.nu.ca/health/information/manuals-guidelines>.

Government of Nunavut Motor Vehicle Policy found at

[https://www.gov.nu.ca/sites/default/files/renewal\\_of\\_motor\\_vehicle\\_policy\\_-\\_may\\_31\\_2020.pdf](https://www.gov.nu.ca/sites/default/files/renewal_of_motor_vehicle_policy_-_may_31_2020.pdf).

### 5.1 Appendix

- A Quick Guide to Facility Management



- Palliative Care Kits Policy Procedure Order Form
- GN Motor Vehicle Policy
- Vehicle Maintenance Log
- Manual for Archiving Hard Copy Patient Records for the Department of Health

## 5.2 Pharmacy

Pharmacy is included in tasks that are completed weekly as inventory and ordering should be done on that basis. Narcotic counts must be completed on a weekly basis, at minimum, though more frequently is strongly encouraged when and where possible.

### 5.2.1 General Information

Most medications for **Inuit** clients are covered by the Non-Insured Health Benefits (NIHB) program. Clients must have a valid Nunavut Health number. Some medications are only covered on an exception or limited use basis. In these cases, the retail pharmacist will contact NIHB for the appropriate form. NIHB will fax the form directly to the prescriber. The SHP should ensure that the form is completed and submitted to the pharmacy in a timely manner.

NIHB also provides funding for medical equipment and supplies. The form for prior approval of these items is available at [http://nswoc.ca/wp-content/uploads/2019/04/NIHB\\_General\\_MSE\\_Prior\\_Approval\\_Form.pdf](http://nswoc.ca/wp-content/uploads/2019/04/NIHB_General_MSE_Prior_Approval_Form.pdf).

For more information about Non-insured Health Benefits, please access <https://www.sac-isc.gc.ca/eng/1576790320164/1576790364553>.

**Non-Inuit** clients are responsible to pay the retail pharmacy directly for their medications.

The **Nunavut Formulary 2021**, comprised of two binders, governs what medications can be held in the health centres and provides direction in all aspects of pharmacy. It is available on Teams: **GN-HEA-CNO-Nunavut Nurses Education > Pharmacy Channel in Files**. Binder #1 of the Formulary is also available at: <https://www.gov.nu.ca/health/information/manuals-guidelines>. A hard copy is kept in the health centre pharmacy.

The Pharmacy and Therapeutics (P&T) Committee approves new medications and pharmacy policies.

### 5.2.2 Pharmacy Security

The pharmacy must be locked at all times. It has been common practice in many health centres to leave the pharmacy door open during the day for ease of access for the nurses. **This is absolutely forbidden.**

The formulary includes a list of the staff authorized to access the pharmacy in Section 5 of Binder #1.

The pharmacy rooms in health centres tend to overheat due to the size of the vaccine fridges and the inadequate air flow. This is a chronic problem but has not resulted in the compromise of any

Pharmacy doors have combination locks – either digital or mechanical. The passcode for the locks should be changed routinely and never be given out other than to nurses or physicians in the health centre.

medications, however, it can be uncomfortable for the nurses. One option is to put pharmacy room renovation on the Ongoing Lifecycle Project list for improved air exchange. The overheating is not a reason to leave the pharmacy door open. The door can be kept open only so long as there is a nurse in the room.

If the process for changing the code is unknown, the SHP must contact the CGS facility manager for assistance. Once the product information is known, the code changing process will be available through the manufacturer and can often be found online.

### 5.2.3 Ordering Medications (Stock and Prescription)

Controlled substances must be kept in a locked cupboard in the pharmacy and the key must be kept in the lockbox unless being carried by a nurse. If there is no lockbox in the health centre, the regional pharmacy team can provide information on ordering one.

Whether or not an order is placed, the pharmacy stock should be monitored on a weekly basis with special attention being paid to expiry dates and high use medications.

Stock medications are ordered for the health centre in order for CHNs to be able to provide immediate treatment to clients. They are also necessary for emergency situations.

Stock medications are not intended to replace prescriptions.

It is important for the SHP to discuss prescription filling timelines with the retail pharmacy in order to provide information to CHNs about the quantity of stock medication that should be dispensed. There should only be as much medication dispensed as is necessary until the arrival of the shipment from the retail pharmacy.

The assessment and ordering of pharmacy stock medications can only be done by a nurse who has authority to be in the pharmacy (Binder #1, Section 5).

If the task is assigned to an unregulated healthcare worker, the worker must be supervised in the pharmacy by one of the authorised persons.

Orders for stock medication are submitted to the regional pharmacy technicians in Cambridge Bay and Rankin Inlet for the **Kitikmeot and Kivalliq** regions. The **Qikiqtaaluk** region submits orders to the Qiqiktani General Hospital pharmacy in Iqaluit.

Stocking requirements for Antidotes, Crash Carts, and Emergency Rooms are discussed in the formulary.

Automatic substitutions are outlined in Section 7.2.

Prescribing Restrictions on drugs are noted in Section 7.3.

High Alert/High Risk Medication Policy and medication list are found in Section 8.3.

The pharmacy technicians in the regional centres attempt to maintain minimum/maximum amounts in health centre pharmacies. They distribute medications to health centres based on these numbers regardless of the size of the order. The technicians may also amend the order based on the stock that they have.

There are times of the year when medications, particularly antibiotics are in higher use. The winter months generally see an uptick in respiratory, ear and throat infections. During these times, it is important to be proactive in both ordering medication and communicating with the regional pharmacy technician to explain the greater need.

The minimum/maximum numbers assist in reducing wastage in the health centres.

One relatively easy way to maintain inventory control in pharmacy is to have a list of the medications with boxes for counting. For example:

Medication	Date	Date	Date	Date	Date
Allopurinol	3	2	3	3	3
Amoxil 250/mg/5 mls	20	17	10	20	10

A table, similar to the table above, will enable the SHP to monitor medication usage, to be proactive in ordering, to reduce wastage created by over ordering and to prevent medication shortages.

Stock medication should be dispensed in small amounts and prescriptions provided as often as possible.

Prescription medications are ordered from retail pharmacies and returned to them if the prescribed medication is not picked up or expires.

The SHP should contact the retail pharmacy to familiarise themselves with the policies and protocols in place with them since they are not GN facilities and are not on contract to the GN. The retail pharmacy staff will advise on how they prefer to receive physician/NP prescriptions, how they deliver, what to do in the event of loss and how to return expired medication.

#### 5.2.4 Receiving Medications

Stock medications are dispensed to health centres by the regional pharmacy technicians.

When parcels are taken to the airline for shipping, a waybill is produced. A copy of the waybill accompanies the products being shipped. The number of boxes received must match the number of boxes on the waybill. The airline requests a signature on the waybill when boxes are received. The waybill **MUST NOT** be signed unless the numbers match. It is important to ensure that any staff receiving boxes from the airlines are only signing the waybill if the number of boxes received matches the number shipped on the waybill. The signed and dated waybill is faxed to the regional Stores Warehouse.

The **Kitikmeot and Kivalliq regions** each have a pharmacy technician in the regional health centres located in Cambridge Bay and Rankin Inlet.

The **Qikiqtaaluk region** utilises the pharmacy services at QGH. The SHPs in the region keep a record of the waybill. They do not send it to the Stores Warehouse in Iqaluit.

**If unregulated staff are tasked with receiving medication in the pharmacy, they may only do so with a nurse authorised to be in the pharmacy.**

When stock medications are received from the regional Pharmacy Technician, the medications should be checked off against the packing slips and the original order. If medications are missing, it is necessary to contact the regional Pharmacy Technician who will track or explain missing medications. Both the signed and dated waybill and packing slip must be faxed to the regional Warehouse staff who will submit them to the Purchasing Officer for completion. The Purchasing Officer submits the signed packing slips and waybills along with the invoice to the Department of Finance for payment. This is the process followed in the **Kivalliq and Kitikmeot regions**.

The exception is the **Qikiqtaaluk region** where the SHP keeps a copy of the waybill and does not fax it to the Stores Warehouse.

The same process applies to receiving prescription medications. The retail pharmacy will submit a 'shipping/receiving report' of medications being shipped. Once the medications are received, each should be verified against this report which is then faxed back to the retail pharmacy. The individual bags should remain sealed.

It is the SHP's responsibility to ensure that prescribed medication is received and stored appropriately. In this way, problems can be averted before the client receives the medication.

This is a duty that can be assigned to an unregulated worker supervised by a nurse authorised to be in the pharmacy or to a CHN or LPN.

#### 5.2.5 Storing Medications

Stock medication is kept in the locked pharmacy. Prescription medications can be kept in the pharmacy or in a locked cupboard and must be stored securely when the health centre closes.

All stock medication should have the expiry date written clearly on the bottle. Stock must be rotated so that older unexpired stock is at the front. In practice this is a "First In – First Out" approach where the older stock is moved to the front and newer stock is placed behind it, making the stock that was first put in will also be first taken out.

An **expiry binder** is kept in many health centres and is very useful in saving labour. If your health centre does not already have an expiry binder the SHP should work with their team to create one and implement it.

The binder is broken down by years, and then months. The expiry date of received medication is entered into the expiry binder. At the end of each month, when the nurse assigned to the task is doing expiry checks, the binder is pulled, and the correct month is checked. Only those medications need to be removed. For example, if Amoxicillin 250 mg/5 ml suspension, is expiring in March 2024, the information is written on that page in the binder. When March 2024 arrives, the nurse flips to that page and removes the drugs expiring that month from the pharmacy. This is a huge timesaver for staff.

All cooler boxes must be opened immediately, unpacked and the contents refrigerated. The Temperature Markers must be checked to verify that the cold chain has been maintained. If there is a break in the cold chain, a cold chain break incident report must be filed, and the pharmacy technician or retail pharmacist must be notified.

Delivery of boxes late in the day can be problematic. If the cooler boxes are not opened and stored immediately, the cold chain may be broken, resulting in loss of the medications. It is the SHP's responsibility to ensure that pharmacy deliveries arriving late in the day are opened. **It is not acceptable to leave this to the next morning.** This task **MUST BE COMPLETED IMMEDIATELY.** The SHP can assign this task to a CHN. This would be an appropriate use of administrative overtime.

Prescription medications should remain in the original pharmacy packaging and be stored in alphabetical order by client surname. A copy of the shipping/receiving report can be given to the clerical staff for notification of clients. The clerical staff is responsible to notify clients that their prescriptions have been received in the health centre. The client or person picking up the medication must sign for it. They can do so by initialling the retail pharmacy slip on the package.

Once the pharmacy receipt is initialed, it should be kept in a file folder in the pharmacy. The receipts can be shredded at the end of the fiscal year, March 31st.

If a client does not pick up the medication within three weeks, the SHP can consider placing the medication on hold and confirming with the client that they no longer want this medication. The SHP can also offer an appointment with the community physician or NP to review medications. If the client is not agreeable to any suggestions and does not want to take the medication, it should be returned to the pharmacy and a note must be written in the client's health record indicating that the medication has been returned.

### 5.2.6 Return of Expired or Unused Medication

Expired stock medication should be returned to the regional pharmacy at least monthly.

Expired prescription medication or medication which has not been picked up must be returned to the retail pharmacy.

Disposal of medications is discussed in Section 8.5, Binder #1.

The return of expired controlled substances is found in Section 23 of Binder#1.

Client specific controlled substances supplied by the retail pharmacies are returned to these pharmacies in the **Kivalliq** and **Kitikmeot** regions when the medications expire or are not used. The exception is the **Qikiqtaaluk** region where these medications are returned to the pharmacy at Qiqiktani General Hospital. The retail pharmacies in that region will not accept returned controlled substances. **Every SHP, however, should be mindful to check with their retail pharmacy to ensure that the health centre is compliant with their particular procedures.**

It is important that a nurse reviews the content of both boxes prior to shipping to ensure that there is no mix-up in the returns. Sending expired stock medication to the retail pharmacist or expired prescription medication to the regional pharmacy will lead to an administrative burden for both pharmacies.

The regional pharmacy may be able to return the expired medications to the manufacturer for credit. Similarly, the retail pharmacist may receive credit from NIHB.

**Expired medication must be kept in the pharmacy until they are ready to be returned. They may not be stored in any other area of the health centre.**

**Prescription medication is the property of the client for whom it was ordered. Prescription medication ordered for one person cannot be used for another person, regardless of shortages of that medication in the health centre.**

### 5.2.7 Ordering and Storage of Vaccines

Vaccines are ordered from the regional Pharmacy. The Regional Communicable Disease Coordinator (RCDC) may work with the regional Pharmacy Technician for estimation of amounts of seasonal vaccine such as flu vaccine for each health centre or the Pharmacy Technician may contact each SHP individually for an estimation of their need.

Vaccines arrive in cold pack boxes. It is critical to ensure these boxes are received and stored immediately and to check the Temperature Markers to verify that the cold chain has not been broken.

**Some COVID-19 vaccines require storage in the freezer.** The SHP must confirm storage requirements with the regional pharmacy technician in order to prevent unnecessary loss.

If the cold chain has been broken, an incident report must be submitted through the Meditech QRM module.

The regional Pharmacy Technician must be notified immediately if there are any discrepancies or cold chain breaks.

**Vaccine is stored in the vaccine refrigerator kept in the pharmacy. The temperature must be kept between 2 and 8 degrees Celsius and must be checked and logged twice daily, once in the morning, and once before the end of day.**

Further information on ordering and storage of vaccines is available in the Immunization Manual at: [https://www.gov.nu.ca/sites/default/files/3.0\\_practice\\_guidelines\\_complete\\_may2020.pdf](https://www.gov.nu.ca/sites/default/files/3.0_practice_guidelines_complete_may2020.pdf)

Section 3 of the guidelines deal with ordering vaccines and maintenance of the vaccine refrigerator.

It is the responsibility of the SHPs to familiarise themselves with the Immunisation Manual, particularly the sections on ordering, storage, management of cold chain breaks and reporting of vaccine incidents.

### 5.2.8 Controlled Drugs and Substances

‘Pharmacy, nursing and medical staff are responsible for ensuring that the acquisition, storage, prescribing, administration, record keeping, and disposal of narcotics and controlled drugs complies with the Federal Controlled Drugs and Substances Act.’ *Nunavut Formulary 2021.*

**Section 11 of the Formulary (Binder #1) provides information on every aspect of Nunavut Narcotic and Controlled Drugs Policy. Of particular importance, the Narcotic and Controlled Drug Listing lists the drugs permitted in health centres as well as by whom they may be dispensed.**

Narcotics are ordered from the regional Pharmacy Technician in each region. Once the order is received in the health centre, the packing slip (which is usually a copy of the original order) must be signed by the receiving nurse and faxed back to the Technician. The signed record must be kept on file in the health centre for seven (7) years. The Narcotic and Controlled Drug Pharmaceutical Order Form is available in Binder #1 of the Formulary, Appendix 1.

As discussed earlier, controlled drugs and substances must be kept in a locked cupboard in the locked pharmacy. The key must be in the possession of a nurse or in a lockbox in the pharmacy. If the key is lost or misplaced, the Director must be informed immediately, and an incident report submitted through Meditech.

The narcotic count must be done at least weekly by two (2) nurses and whenever a nurse begins working at the health centre, is leaving the health centre for vacation, or is ending their employment at the health centre. This information is found in Section 11.6 of Nunavut Formulary 2021, Binder #1. While the count must be done weekly at minimum, it is within the SHP's authority to require it more often if deemed appropriate. Some health centres do a daily count following morning report. Narcotic counts are not required on weekends or holidays.

All controlled substance counts must be recorded on the Controlled Substances Register in **RED** ink. When a page is finished the 'Brought Forward Balance' should be signed by two (2) nurses.

Whenever a new stock of controlled substances is received and entered into the register, a count must be performed for that medication. Examples of narcotic signing, receiving controlled substances, etc. can be found in Section 11 of Binder #1.

**Count discrepancies** are discussed in Section 11, #7 of the *Formulary 2021*, Binder 1.

All controlled substance discrepancies must be investigated immediately and reported to the SHP.

Any loss must be reported to the Director and the Territorial Director of Pharmacy, immediately and a *Loss or Theft Report Form for Controlled Substances* must be submitted to the Territorial Director of Pharmacy in Iqaluit within 72 hours. This form is available in Section 11, Appendix 2 of the 2021 Formulary.

The Territorial Director of Pharmacy then forwards a copy of this report to the Compliance Monitoring and Liaison Division, Office of Controlled Substances within 10 days of the discovery of loss.

A review of the incident will be undertaken by the Territorial Director of Pharmacy to identify measures that can be implemented to prevent similar count discrepancies in future.

The count can only be adjusted by the SHP and co-signed by a second nurse.

### *Wastage*

If any controlled substance is wasted for any reason, this fact must be recorded on the Controlled Substances Register and co-signed by a second nurse. In health centres, after hours, the second nurse signature is not required unless the second nurse is already in the health centre. For greater clarity, after hours a second nurse should not be called in to co-sign, but if the second nurse is already present, they should co-sign.

Bulk oral liquid narcotics are allowed 10% wastage. The count must be corrected by two (2) registered nurses if the discrepancy is noted either immediately after the dispensing of the medication or on completion of each bottle. The total allowed wastage is not to exceed 10%, even with multiple corrections.

Used fentanyl patches must be folded in half toward the adhesive side and pressed firmly before placing it in a sharps container. Gloves must be worn by the nurse during the patch removal.

**Further information regarding quantities of medication that can be dispensed and labelling, and documentation required can be found in Section 11 of the Formulary.**

**Controlled Substances Audits** are conducted by the Territorial Director of Pharmacy or designate every two years to ensure that controlled substances are being dispensed appropriately and to deter their misuse and abuse. The audit report is submitted to the ADM Operations for review. Verbal and written feedback is provided to the health centre nursing staff.

While this is termed a controlled substances audit, the SHP should be mindful that the Territorial Director of Pharmacy will audit the entire pharmacy to ensure compliance with policy and that medications are appropriately ordered and stored.

**Receiving controlled substances from the regional pharmacy and returning expired controlled substances to Qikiqtani Hospital Pharmacy is discussed in Section 11.23 of the Formulary.**

**The exception to this is the Qikiqtaaluk region. The health centres in this region must send their expired or unused retail narcotics to Qikiqtani General Hospital pharmacy for destruction as well.**

**The SHPs in the Kitikmeot and Kivalliq regions should verify the return of expired medication and controlled substances with their retail pharmacies as these processes may change over time.**

### 5.2.9 Ordering Palliative Care Medications

Medications used in palliative care and the corresponding policy are included in the Palliative Care Kit found in Binder #2 of the *Nunavut Formulary 2021*, Tab 14.

In most cases, these medications would be ordered specifically for a client by the physician or Nurse Practitioner and sent to the retail pharmacy.

In the case where these medications **cannot be delivered by the retail pharmacy in a timely way**, the kit can be ordered from the Qikiqtani Hospital Pharmacy using the order form and following the protocol found in Binder #2 of the *Nunavut Formulary 2021*. Please also see the *Palliative Care Kits for the Communities Policy and Procedure* located in the appendices.

## 5.3 Purchasing

This section will discuss the ordering of equipment and supplies and the processes available to obtain them.

Health Centres require supplies and equipment to function properly. The SHP is responsible to maintain inventory so that shortfalls do not occur.



Every health centre has a budget. This budget is static, meaning that it does not essentially change year over year, although some changes may be made by the Department of Finance in consultation with the ED in moving funds from one coding line to another. This means that, whether all the money is spent or not, the budget will remain the same during the following fiscal year.

Financial coding “strings” or lines refer to the numbers that identify which part of the health centre budget (or alternative funding source) is being accessed to pay for the product or service being requested.

The coding string looks like this:

Section	Fund	Region	Community	Detail Costing	Vote	Detail Object	Amount
XXXXX	01	1 or 2 or 3 or 4	XXXX	XXX	01 or 04	XXXX	

Iqaluit is Region 1, Qikiqtaaluk/Baffin is Region 2, Kivalliq is Region 3, and the Kitikmeot is Region 4. The region number is from East to West.

The vote is either Vote 1 which refers to permanent funding such as salaries or Vote 4 which refers to contributions made by external parties – usually the federal government. Vote 4 funding is year to year and not permanent however, Health Canada has provided 10-year funding blocks for Population Health community initiatives as well as the Home Care Program. Nurses hired for the home care program are funded through Vote 4 and so, technically, are on a 10-year term.

More information about what coding strings mean can be obtained from the Regional Manager of Finance or the Director, Health Programs.

There are several types of funding sources to be aware of. For most supplies and minor equipment purchases (less than \$5000 in value), health centres will use O&M funding (Operations and Maintenance). This funding source is typically referred to as the “health centre budget”.

Other funding sources:

1. Small capital funding – This funding source is intended mainly for planned new or replacement equipment/vehicles that are valued over \$5000.
2. Ongoing Lifecycle funding - This fund can be used to fund improvements to the health centres – new flooring, windows, paint etc.

The SHPs have limited authority over the budget; however, it is important to be aware of it when making purchases or requesting more staff. In particular, upstaffing of community staff requires consultation with the Director; substantiation is required.

Some things to consider:

- Keeping an inventory of supplies will assist in ensuring that shortfalls do not occur.
- Ordering routinely helps to maintain adequate supplies and reduces waste.
- Ordering only as much as can be stored in the health centre is important because storing excess materials in sea cans/shipping containers can lead to wastage. While many health centres have

and use sea cans/shipping containers, they are difficult to open in winter and the supplies are often forgotten, become wet and potentially mouldy, or expire.

- Keep all supplies together. There should not be multiple areas where the same supplies are stored. This is both inefficient and makes it difficult to know how many supplies exist.

Here are four ways to purchase supplies and equipment:

1. Local Contract Authority (LCA)
2. Request for Supplies and Services (RSN)
3. Internal Requisition
4. Revolving Stock Requisition which is obtained from the regional Purchasing Officer.

**Health centres never contact suppliers directly, nor do they request quotes for items they wish to purchase.** Purchasing officers are the only employees authorised to request quotes. To do otherwise, puts the GN at risk of complaints of unfair practice.

Products purchased by the purchasing officers in each region and in Iqaluit are done through HealthPro contracts. HealthPro is a group purchasing organisation (GPO) that provides medical equipment, medical consumables, support services, and pharmaceutical procurement services for its members. HealthPro enters into supply contracts with vendors for these products and HealthPro member organisations (i.e., GN Dept. of Health) have the option to sign onto, or “commit” to those contracts. The products are still purchased directly from suppliers, not HealthPro, but the GN gets the benefit of having the same pricing as all other HealthPro members. Products that are within the scope of committed HealthPro contracts do not require sole-source approval over \$5000. The products available through this contract have been extensively researched and are offered at more competitive rates than if the GN were to do its own procurement for the same products.

**Sole source approvals** refer to purchases of at least \$5,000 that are either urgent or can only be supplied by one company. The GN is committed to fair trading practices. All purchases of \$5,000 or greater are put out for tender and companies can bid to fill them. If the item needs to be submitted to only one company or must be filled quickly, the Deputy Minister must approve the sole source before it can proceed.

### 5.3.1 Local Contract Authority (LCA)

Every indeterminate SHP has signing authority for Local Contract Authority (LCAs). This request to the Department of Finance is made shortly after the SHP is hired.

Signing authority for casual or agency SHPs can be requested– *“Public officers, including casual, temporary, or seconded employees and individuals doing business as service contractors attached to Government departments may be designated as accounting officers and expenditure officers (FAA S.40(1)).*

Financial signing authority permits approval of government expenditures, commitments, disbursements, billings, General Ledger entries, and similar transactions. This authority is delegated to expenditure officers, accounting officers, and other signing authorities according to the provisions of the *Financial Administration Act*, Regulation 9918.

Either the Regional Manager of Finance or the Director will request signing authority for new SHPs. A Finance Officer in Iqaluit will then contact the SHP for signature of the Specimen Signature Record (SSR) which will indicate the delegation being given to the SHP – this is always \$5,000 for goods and services, making the SHP the expenditure authority for LCAs.

The Local Contract Authority Form (LCA) is the written contract form for locally available goods and locally available, simply described services. LCAs are often used to purchase items available in the community rather than waiting for an order, such as for food items used for programs etc.

The LCA form may not be used for contracts costing more than \$5,000. Goods costing more than \$5,000 are requisitioned using the Requisition for Supplies and Services Form, whether the goods are available locally or not.

For further clarity, LCAs may not be split into separate contracts to circumvent the \$5,000 limit.

**LCAs cannot be used outside of Nunavut.** They can not be used to purchase items in another territory or province.

LCA forms are individually numbered and are bound into a book format for convenience.

Complete the information on the LCA and itemise the quantity and name of the items being approved for purchase – e.g., 2 bags of oranges. The SHP with signing authority, signs the LCA.

The LCA remains in the book and the entire book is taken to the store; do not detach any sheets before the purchase is made. At the time of purchase, the staff taking the book to the store will sign the form as proof of receipt of the product. The store clerk will also sign the form.

Each LCA has 3 copies. The top white copy is given to the retailer and is signed by the SHP as the contract or expenditure authority. The green copy is submitted along with the receipt to Finance. This can be done electronically as in the **Qikiqtaaluk** region where the green copy and receipt are emailed to [accountspayable-healthbaffin@gov.nu.ca](mailto:accountspayable-healthbaffin@gov.nu.ca), faxed, or mailed in First Pak. The yellow copy remains in the book. Once the book is complete, it is returned to the Regional Manager of Finance.

A new book should be requested before the old book is completed. New books can be obtained from the Regional Manager of Finance who will advise if that duty has been assigned to another Finance staff member.

### 5.3.2 Request for Supplies and Services (RSN) and Internal Requisitions

The acronym **RSN** actually stands for **Requisition for Supplies and Services Number**. This is a numbered form available from regional office whose distribution and usage are tracked by the Department of Finance.

In communities, the RSN forms are only used for emergency local purchases. All routine orders should go through the routine ordering procedures outlined below. The form must be fully completed by itemising the products and/or services that are required, including an estimate of the price and details of the preferred store or business.

The exception to this is the **Kivalliq Region**. RSNs are used for any purchase of supplies not listed in the Kivalliq warehouse catalogue. These requisitions are sent to the regional Stores Warehouse and furthered to the Director for approval.

The completed form is faxed to the Director for approval and signature except for the **Qikiqtaaluk region**. Completed forms in that region are emailed to [accountspayable-healthbaffin@gov.nu.ca](mailto:accountspayable-healthbaffin@gov.nu.ca).

The completed and signed form can then be issued to the store or business that is providing the goods and/or services.

The original receipt must be attached to the RSN copy and sent to the purchasing officer. Once received, the copy and the attached receipt are matched with the original signed copy and submitted to Finance for payment.

**Internal Requisitions** are available in the Meditech system and are currently only in use in the **Kivalliq region** for ordering supplies. The Internal Requisition (IR) is created from the Kivalliq Stores catalogue and submitted to the Regional Stores Warehouse. If unsure of the process, the SHP should contact the Director for clarification.

### 5.3.3 Small Capital Funding

The small capital fund supports the purchase of needed items costing \$250,000 or less – items such as large furniture, medical equipment, and vehicles. The request is sent to the ED in September of each year with a submission deadline in October. The regions must prioritise their needs. It is important to ensure that the SHP in each health centre submits their needs to their Director in a timely way. Once the requests are prioritised on a spreadsheet for the region, the submission is sent to the Capital Planner. Eventually, all of the requests are sent to the ADM, Operations for approval.

With awareness of this fund, the SHP can plan for the purchase of much needed but expensive medical equipment or vehicles.

### 5.3.4 Ongoing Lifecycle Projects

At the same time that the small capital submissions are requested, the Capital Planner sends requests for ongoing lifecycle submissions. This fund can be used to fund improvements to the health centres – new flooring, windows, paint etc. If the project is valued at \$10,000 or less, a work order can be submitted to Community and Government Services (CGS) and the work is completed by CGS – Asset Management Division. If the cost is greater than \$10,000, the project can be submitted to Ongoing Lifecycle Projects. Once approved, the renovations and improvements are paid for through the Capital Planner and not out of the Health Centre budget.

### 5.3.5 Barge Order

Early in the new calendar year, a notice will be sent out regarding the barge arrival times in communities. This is the time to prepare the barge order for the health centre. The deadline for barge orders is usually some time in April but delivery does not occur until late August/September.

There was a time in Nunavut's history, where the barge was the way that most supplies came to communities. While this is no longer the case, the barge remains the most cost-effective way of bringing large or heavy items to the communities and should be reserved for this purpose in order to reduce waste through overstocking.

It is important to ensure that hazardous goods such as oxygen or other gases required in the health centre are ordered through the barge order. The SHP is responsible to forecast oxygen requirement for the following year. The exception is the **Qikiqtaaluk** region. Health centres in that region order oxygen directly from QGH stores and the cylinders are sent by air.

Other products that should be brought in on the barge:

- Furniture
- Copy paper
- Filing cabinets
- Cleaning supplies
- IV fluids

Care must be taken when requesting IV fluids in the barge order. It is wisest to limit this request to 0.9% Normal Saline in 1 litre or 500 ml bags. Saline is the most commonly used IV fluid. The expiry date is usually long, but the SHP should request that the expiry date exceed the following New Year. For the sake of clarity, the barge order will not arrive until August or September. If the fluids are expected to expire in October or November, they will be wasted.

Once the order is complete, it is submitted to the Director for review and then on to the regional Purchasing Officer for furtherance to Procurement in Iqaluit.

The barge is also used to remove empty oxygen tanks in the **Kitikmeot and Kivalliq** regions. The tanks must be correctly packaged, and the necessary dangerous goods paperwork must be completed. This is done with assistance from the Regional Warehouse.

In the **Qikiqtaaluk**, the used cylinders are sent to Qiqiktani General Hospital where they are filled and returned on a regular basis every 3 to 4 months.

### 5.3.6 Purchasing Medical Equipment

Medical equipment is standardised across the territory. Only items listed in the Catalogue of Standardised Medical Equipment can be ordered. The item name, product number and cost, must be included on the requisition.

The Territorial Procurement Committee (TPC) is responsible for the catalogue in both initiating new products and removing old ones. The catalogue includes a form to be completed and submitted to the TPC for equipment that staff would like to have considered for inclusion.

The Catalogue is available online on Teams. The path is:

**GN-CNO-Territorial SHP Meetings>General>Files>Operational Manuals and Guides.**

### 5.3.7 Purchasing Health Centre Supplies

It is important to maintain an inventory of health centre supplies in order to ensure the availability of products. While the process of compiling an inventory will be labour intensive, once the list is complete, it can be delegated to a team member to maintain. Caretakers and clerical staff are often given this duty.

By reviewing this inventory weekly, the SHP can be proactive in ordering supplies.

Generally speaking, the order for supplies is sent via email to the Regional Warehouse or, via internal requisition through Meditech (in the **Kivalliq** region). In the **Kivalliq region**, an RS is used for items not in the catalogue.

If the Warehouse cannot complete the order, it is submitted to the Purchasing Officer for completion.

The Purchasing Officer submits the order to the contracted company and inputs the information into Meditech so that the order can be tracked.

It is important for the SHP to keep a file, either paper or electronic, of all of the submitted orders to avoid duplication.

If an order is not received in a timely way, the SHP should contact the regional Warehouse for information regarding the delay rather than reordering. The SHP should never contact the supplier directly. It is the responsibility of the regional warehouse staff or purchasing officer to contact suppliers regarding delays.

#### 5.3.7.1 Laboratory Supplies

Each region currently has a separate contract for out of territory laboratory specimen processing. Some lab supplies are available directly through this contract while others must be ordered separately. The out of territory laboratory will provide the list of supplies as well as an order form. Other supplies can be ordered through the Regional Stores Warehouse who may forward the request to the Regional Purchasing Officer if the supplies are not regularly kept in stock. The regional pharmacies provide Point of Care Testing supplies. If uncertain, the SHP should clarify the process with the Director.

It is advisable to maintain an inventory log similar to the **expiry binder** mentioned in the [Pharmacy section](#). In fact, the Expiry Binder can also be used for lab specimen stock to ensure expired stock is removed. Keeping the Expiry Binder current is another duty that can be delegated to an LPN.

Laboratory supplies should only be kept in the laboratory room in order to prevent overordering and wastage. If items are kept in too many places, they will be overlooked and will expire without being used.

#### 5.3.7.2 Stamp Order

Stamps are ordered from the regional purchasing officer. The purchasing officer sends the order to the Finance Department who will issue a cheque to Canada Post. Once the cheque is received, the order is prepared. The purchasing officer will send the order to the health centre once it has been received from

Canada Post. The SHP in each health centre should check with their Regional Purchasing Officer regarding their process. In some regions, an email is sufficient; in others an RSN is requested.

### 5.3.8 Receiving Ordered Products

Products are delivered to communities in Nunavut via the airlines. The airlines produce a waybill when products are delivered to them for furtherance.

Whether delivered by the airport staff or picked up by a health centre employee, the waybill must be checked to ensure that the number of boxes listed have actually been delivered. If there are items missing, a trace should be initiated through the airline by quoting the waybill number.

Once ordered supplies or medical equipment are received, the shipment should be unpacked as soon as possible, and the items marked off on the packing slip. The packing slip and waybill are signed and dated and sent to the Regional Purchasing Officer who will then prepare an invoice for payment. The signed packing slip and waybill are necessary for submission along with the invoice, to Finance in order for suppliers to receive payment.

If an order is only partially complete, the packing slip is retained until the rest of the order arrives.

Alternatively, the packing slip can be submitted with a note that the checked products have been received but not the complete order. A note should also be included in the file of orders being kept by the SHP for follow-up at a later date.

Delays at the community level can have significant impact for all communities if suppliers are not paid.

### 5.3.9 Disposing of Equipment

When equipment or furniture is broken, is obsolete or reached end of life, it becomes necessary to dispose of it.

Disposal of these items is done through the surplus process. Items cannot just be taken to the dump or given away.

The items to be disposed must be listed on a 'Report of Surplus' Form.

The approximate age of the item and the reason for disposal request must be clearly outlined (e.g., not functioning and cannot be repaired, obsolete, etc.). The form can be obtained from the regional Maintenance Coordinator in the Department of Community and Government Services. Once the form is completed, it must be submitted to the DM for approval; it is then sent to the Maintenance Coordinator who will send instructions regarding disposal.

In the **Qikiqtaaluk** region, the completed form is submitted to the Director who will then further it to CGS.

While CGS provides approval for surplusage and may provide direction about where the item must be taken, it is the health centre's responsibility to transport the items to their destination. This can be done by contracting a local firm to remove the items if they are large and heavy. The Director can be consulted if there are questions regarding this process.

It is important to routinely surplus outdated or broken equipment which otherwise, clutters the health centre or takes up valuable storage space.

## 5.4 Disposing of Paper Charts

Client records (charts) are kept for 20 years following the date of decease or, in the case of inactive files, the date of the last entry.

These charts do not need to remain in the health centres; they can be sent to the CGS Records Division in Iqaluit for the **Kivalliq** and **Qikiqtaaluk** regions or Cambridge Bay for the **Kitikmeot** region.

Requests can be made to Records for old charts should they be needed during the time before the date of destruction which will occur in 20 years.

### 5.4.1 Process for Disposing of Charts

Please see the ***Manual for Archiving Hard Copy Patient Records for the Department of Health*** in the Appendix.

All boxes of records, properly packed, are sent to the regional centres for review by the front desk staff at the regional facilities. If they are not packed and labelled correctly, they are returned to the health centre. If everything is correct, the regional staff send the boxes to CGS. All of the detailed information is included in the manual.

The **Qikiqtaaluk** region health centres send their boxes to Qikiqtani General Hospital.

The **Kivalliq** region health centres send their boxes to the Kivalliq Regional Health Facility.

The **Kitikmeot** region health centres send their boxes to the Kitikmeot Regional Health Facility.

## 5.5 Deceased Client Records in Meditech

The Health Records department in each regional hub is responsible for processing information in Meditech for all deceased clients in their communities. Once the clients are identified as deceased, eHealth will archive the records within the system.

The information required is:

- Name of deceased and date of birth
- Proof of expiry – a copy of the death certificate, report of death or record of death
- Date of expiry

If the client expires out of territory and the death certificate or record of death is not available, a copy of the documentation in the health record advising that the client has passed or a copy of the documentation from the case managers or discharge planners in the referral centre providing this information, can be used.

In the **Qikiqtaaluk**, the required information can be password protected and emailed to [deceased@gov.nu.ca](mailto:deceased@gov.nu.ca) or faxed to 867-975-8640.



In the **Kivalliq**, the required information can be password protected and emailed to [deceasedkiv@gov.nu.ca](mailto:deceasedkiv@gov.nu.ca).

In the **Kitikmeot**, the required information can be password protected and emailed to [deceasedkit@gov.nu.ca](mailto:deceasedkit@gov.nu.ca) or faxed to 867-983-4509.

## 5.6 Vehicle Purchasing and Maintenance

Health centres usually have a minimum of two motor vehicles. These vehicles are provided to use for necessary work during the day while the health centre is open. After hours they are used by the nurse on call and second nurse on call.

The health centre vehicles are not for use by the SHP after hours unless the SHP is on call.

The driver of the vehicle must have a valid Canadian driver's license at minimum; a Nunavut driver's license is preferred. Indeterminate employees must obtain a Nunavut license within 30 days of taking up residence in Nunavut. Employees under contract can have a valid driver's license from another jurisdiction if they are in Nunavut less than 90 days. After that time, they are required to obtain a Nunavut driver's license.

Only GN employees may drive a health centre vehicle. For greater clarity, agency nurses on contract to the health centre are considered GN employees for this purpose. Community physicians are also considered to be GN employees as are visiting contracted medical and paraprofessional staff. All of these staff members must provide a valid driver's license. Contracted specialist and paraprofessional staff should only use GN vehicles when a driver is not available to drive them to their destination.

The health centre may also have a motor vehicle for use by the Supervisor of Home and Community Care for the purpose of home visits which is also used by the Home and Community Care Workers. The vehicle can be used to transport home care clients to the health centre. If the home care nurse provides care for clients after hours – palliative clients, dressing changes etc., they will need their vehicle for transportation, even though they are not technically on call but providing a specific service to a specific client.

The nurse providing mental health services may also have a vehicle. The nurse providing mental health services may be on call after hours and would use the vehicle for this purpose.

The nurse providing the service for which the vehicle was purchased does not 'own' the vehicle and may not have access to the vehicle afterhours unless on call. Vehicles do not usually remain at the health centre after hours due to the risk of vandalism. The SHP may decide who might take an extra vehicle home but should give it to the person with the greatest need.

The nurse on call may pick up other staff members in the morning or give them rides home if it is convenient. The SHP must be mindful that this is a courtesy and not an obligation. Staff should have no expectation that this is a regular occurrence.

### 5.6.1 Vehicle Purchase

As discussed previously, vehicles are purchased through the small capital budget and the need must be justified. The SHP must forecast the need for a new vehicle in the year leading up to the new Small

Capital submission. It is important to monitor the number of times that the vehicle is sent for repairs. It is also important to ensure that the vehicles have routine maintenance.

### 5.6.2 Vehicle Maintenance

Health centre vehicles require routine maintenance and oil changes. It is also necessary to ensure that the vehicles are ready for the winter season and that the extension cords for plug ins are in good repair. During the winter months, it is essential that the vehicles be warmed for a minimum of 15 minutes prior to driving and, only in critical emergencies, should the vehicle be driven without this. If at all possible, the vehicles should be kept in a garage.

Ensuring that each vehicle has sufficient gas (at least half-tank) each day is an important task for delegation to the caretaker, particularly in winter.

Vehicle maintenance is usually accomplished through a work order to a local garage – either privately run or run by the hamlet. The work order is a necessary accompaniment to the invoice sent by the garage for payment. If an LCA is used to pay for the maintenance service, the work order and receipt must accompany the LCA when it is submitted to Finance.

An estimate should be obtained for anything other than routine maintenance and forwarded to the Director and the regional Manager of Finance for review and approval. There are times when an estimate is higher than the vehicle is worth. If it is at end of life, or the cost of repair is high enough to warrant a new vehicle, the Director may choose to surplus the vehicle, or the part might be ordered from an out of territory supplier at a lower cost so that labour is the only item being charged by the mechanic in the community.

A *Vehicle Maintenance log* can be found in the appendices of this manual.

### 5.6.3 Vehicle Registration and Insurance

Health will register all GN vehicles. New registrations, license plate stickers and proof of insurance are usually forwarded to each health centre in March/April for existing vehicles. It is the SHP's responsibility to ensure the Registration is updated in the vehicle and that the sticker is applied to the license plate.

New vehicles received on the Barge cannot be used until the registration and license plates are received and placed on the vehicle. These vehicles must be taken from the Barge and immediately driven to a secure location where they must remain until the registration and licensing is completed and Risk Management confirms that the vehicle is insured.

Every GN vehicle must be registered with Asset Management and Risk Management. The vehicle can not be used (except to transfer from sealift to parking area) until an asset number is assigned and risk management confirms that insurance is in place for the vehicle.

An updated vehicle list should be kept by each health centre.

At the beginning of each calendar year, risk management will send out the current listing for vehicles that Health owns. The list should be carefully reviewed and amended to reflect current GN Health vehicles.

#### 5.6.4 Report of Motor Vehicle Accidents

All motor vehicle accidents must be reported to the SHP. The SHP is responsible to ensure completion of the “Report of Motor Vehicle Accidents” form by the employee who was driving at the time of the accident. Injuries, vandalism, single party accidents etc. must be reported to Risk Management immediately. The Report is submitted both to the Director and to [riskmanagement@gov.nu.ca](mailto:riskmanagement@gov.nu.ca). Workers Safety and Compensation Commission (WSCC) forms must also be completed; injuries may not be immediately apparent.

The report and process are available at:

[https://www.gov.nu.ca/sites/default/files/files/Finance/Forms/Motor\\_Vehicle\\_Liability\\_Insurance.pdf](https://www.gov.nu.ca/sites/default/files/files/Finance/Forms/Motor_Vehicle_Liability_Insurance.pdf).

An incident report describing the event should also be submitted through Meditech QRM Module. This can be done by the person driving the vehicle or by the SHP.

The SHP must also ensure that the accident is reported to the RCMP by the employee who was driving the vehicle. The RCMP will complete their own report and send it to the regional Department of Economic Development and Tourism (ED&T).

The SHP should obtain the file number from the RCMP and note this on the Vehicle Accident Report. A copy of the Report is scanned and sent to [riskmanagement@gov.nu.ca](mailto:riskmanagement@gov.nu.ca).

#### 5.6.5 Renting a Motor Vehicle

There are times when health centre vehicles are in the garage for repairs and the health centre requires to rent a vehicle.

The SHP must first determine that all of the vehicles are being utilised appropriately. The only staff requiring a vehicle afterhours are the nurses who are on call. They do not require a vehicle during the day. For example, if the vehicle used for home care is not available, another health centre vehicle can be used by the Supervisor of Home and Community Care during the day. If one of the health centre vehicles used by the Nurse On-Call is not available, the vehicle used for home care can be used for this purpose after hours.

Rented vehicles are extremely expensive and every effort must be made to ensure that the rental is necessary.

**Renting a vehicle requires approval by the Deputy Minister. This is obtained through the Director who will consult with the ADM, Operations.**

The vehicle must be rented for the shortest time possible, and the need reassessed regularly.

## SECTION 6 BIWEEKLY DUTIES:

### *Key Takeaways for this section:*

- Ensuring that leave and attendance is strictly monitored and recorded will ensure that leave credits are correct.
- Verifying overtime is necessary and important to ensure transparency. It should be done as frequently as possible to avoid an unnecessarily challenging task on submission day.
- The Overtime Log must never leave the health centre under any circumstances.

This section will cover tasks that occur every two weeks: Payroll and Overtime and will incorporate the Leave and Attendance Register which is submitted monthly. Leave forms have an impact on Payroll and Overtime.

### 6.1 Leave and Attendance

Resources: Human Resources Manual available at <https://gov.nu.ca/human-resources/information/human-resources-manual>.

Nunavut Employees Union Contract available at [https://gov.nu.ca/sites/default/files/gn\\_neu\\_ca\\_2018-2024\\_en.pdf](https://gov.nu.ca/sites/default/files/gn_neu_ca_2018-2024_en.pdf).

One employee in each Health Centre should be assigned the duties of Leave and Attendance. These duties include:

- Daily monitoring of attendance of all employees.
- Ensuring that leave forms are submitted each pay week for all absences and following up with those staff members who have not submitted their leave forms.
- Ensuring that each employee signs the Leave and Attendance Register at the end of each month. This signature signifies that the employee agrees with their attendance record for that month.

The employee who is designated as the monitor should report any issues or concerns about the Attendance Register to the SHP.

The Attendance Register is sent to the designated regional Human Resource (HR) Assistant in each regional office. The HR Assistant then processes the approved leave forms and enters this information into the Leave and Attendance System to verify and update each employee's Leave Credit status.

As required under the Nunavut Employee Union (NEU) Contract, the HR Assistant provides each employee with an annual printout of their Leave Credits. Each employee verifies this against their own records, signs the printout and returns it to the HR Assistant.

### 6.2 Leave

The Human Resources Manual defines all of the leave allowances.

Staff employed in health centres are expected to be present and ready to start work by 08:30. The workday ends at 17:00. There may be some communities that have different opening and closing times, but regardless of this, the workday is 7.5 hours long.

There are two paid 15-minute breaks, one mid-morning and the other mid-afternoon.

Generally, over the one-hour unpaid lunch break (12:00-13:00), the health center is closed. A nurse on call is available during this time for emergencies. The SHP has the authority to schedule one nurse to cover the health centre at noon and to take an earlier or later lunch to compensate, rather than incurring additional overtime costs if the nurse is called in. This will be discussed further in the overtime section.

An employee is expected to report to work unless on authorised leave.

An employee is entitled to be paid for authorised leave in the following circumstances:

- Annual leave.
- Sick and injury on duty leave.
- Court leave.
- Special leave.
- Time off in lieu of overtime payment.
- Medical travel time.
- Training and education leave.
- Domestic violence leave.
- Special Leave 08 (quarantine) for employees who are sick with COVID-19. This leave will be reassessed quarterly by the Department of Human Resources.

An employee is required to complete an *Application for Leave* form for all leave or time off other than:

- Casual leave of less than two hours to attend an appointment with a doctor, dentist, or lawyer during working hours.
- Time off for special occasions approved by the Minister of Human Resources.
- Time off for voting.

Employees should discuss leave with the SHP as far in advance as possible and complete the leave form which is available on the GN Intranet.

The SHP does not have authority to approve leave but should initial leave forms to indicate agreement with the request, particularly in the case of annual leave. The exception is the **Kivalliq region** where SHPs have been delegated the authority to approve leave forms based on coverage and vacation leave accumulated by staff members.

Once completed, the form is submitted to the HR Assistant in the regional office. The HR Assistant will verify that the leave credits are available and will submit the form to the Director, Health Programs for approval.

**ALL** leave taken without permission is recorded on a leave form as AWOL (Absent without Leave).

### 6.3 Payroll

Submission of payroll documents occurs every two weeks, corresponding with a pay period. Each region has a specific email address and dates for submission of payroll documents.

**Qikiqtaaluk Region:** [payroll-healthbaffin@gov.nu.ca](mailto:payroll-healthbaffin@gov.nu.ca).

**Kivalliq Region:** [rihealthfinance@gov.nu.ca](mailto:rihealthfinance@gov.nu.ca).

**Kitikmeot Region:** [payrollkithealth@gov.nu.ca](mailto:payrollkithealth@gov.nu.ca).

### 6.3.1 Time Sheets

Indeterminate employees are paid automatically and are not required to complete time sheets.

All casual and relief employees must complete a time sheet in order to be paid.

Nurses contracted through an agency complete time sheets supplied by their employer and submitted to them. The SHP must validate and sign them before the agency nurse sends them to their company.

Employees are responsible for completing their own timesheets. The fields at the top of the sheet should be completed including the employee's name, community, and position.

Each regular workday in the community should be recorded as 08:30 – 17:00 (or whatever hours the health centre is open) with 1 hour off for lunch. There are 7.5 hours of paid work in each workday. A separate time sheet is presented for every pay period.

The completed timesheet must be signed by the employee prior to being forwarded to the SHP for verification and signature.

If the timesheets are either not completed correctly or are not received by the Pay Cut-Off Day, the employee will not be paid on the next Pay Day.

All time worked between 08:30 and 17:00 Monday to Friday is paid at straight time unless one of the days worked was a designated holiday.

Casual employees are only paid for statutory holidays if they have worked the previous 15 days.

Agency staff are paid for stat holidays even when they are not on call. However, they are only paid for those holidays if they have worked a total of thirty (30) days in the preceding 12 months. They are also not paid if they do not report to work on the last scheduled day before the stat or on the day after the stat.

Every effort should be made to ensure that employees take the full one-hour lunch break to which they are entitled. This can be done by flexing lunch hours when staff must stay in the health centre over the lunch hour. The NEU contract states that lunch must be taken as close to noon as possible. At times, it is not possible, and some staff may take lunch at 11:00, 11:30, or 13:00 to ensure that overtime is not being incurred unnecessarily.

All timesheets and overtime claims, verified and signed by the SHP, must be submitted to regional office on the required day and in the required way. This is usually at some point early in the designated pay week. An email is usually sent to all SHPs to remind them that payroll is due. Timesheets are either faxed or scanned and emailed. Scanning and emailing is the preferred route.

## 6.4 Overtime

### Reference documents:

Nunavut Employee Union (NEU) Contract is available at

<https://www.gov.nu.ca/human-resources/information/collective-agreements>

Human Resources Manual is available at

<https://gov.nu.ca/human-resources/information/human-resources-manual>

### 6.4.1 General Information

**Please note that Administrative Overtime is discussed in [Section 4.3.1](#).**

Every attempt should be made to post the call schedule for CHNs a month in advance.

Nurses are usually placed on-call in rotation. This ensures that all the nurses have an equal number of shifts.

During times of health centre closure or virtual respite, LPNs or Advanced Care Paramedics (ACPs) can be placed on second call. This may assist in providing more work/life balance for CHNs. LPNs and ACPs may not be placed on first call because they cannot triage clients. If an ACP is covering first call for a meal break, a CHN must be available to take calls and triage for the ACP.

**Per the NEU contract:** *“Subject to the operational requirements of the service the Employer shall make every reasonable effort: (i) to allocate overtime work on an equitable basis among readily available qualified employees who are normally required in their regular duties to perform that work; and (ii) to give employees who are required to work overtime reasonable advance notice of this requirement.”*

It is particularly important that the SHP is objective in scheduling staff and does not play favourites. This can lead to a grievance on the part of the nurses and loss of confidence in the SHP.

**Changes to the schedule must be approved by the SHP.** There are many nurses who do not like to be on call and will give up or trade their shifts. Being on call provides nurses with experiential learning and is vital to ongoing skill development. The SHP needs to be aware of the skill level of the nurse giving up call before approving and should be cautious in allowing this for a nurse who is relatively new to the health centre. In these situations, it is also important that the SHP provide support by pairing new nurses on first call with a more experienced nurse on second call. The second on call nurse should not be another novice nurse if possible.

There are CHNs who will call in their second on call for every client interaction. This is a practice that should be strongly discouraged by the SHP. Experienced nurses should be calling in their second on call if they are overwhelmed with clients, have a serious emergency, or have a client whose illness is unfamiliar. Experienced CHNs should not be calling their second for routine matters. If they have questions regarding clients or medications etc., a phone call to their second will suffice.

Discretion must be used when dealing with novice CHNs. These CHNs should be encouraged to call their more experienced second whenever they have a question or need a second opinion.

If both nurses on call are overwhelmed with the volume of work after hours, the first nurse on call (NOC) must contact the SHP for approval to call in an LPN or paramedic to assist. This can also occur if a client

remains in the health centre awaiting a medevac and requires constant monitoring. The second NOC could then return home if appropriate. The SHP must, again, ensure that LPNs or paramedics are called in on a rotational basis to ensure fairness. The SHP must also be mindful that the third staff being called in is not on standby and will be paid for either 4 hours of straight time or time worked at time and a half – whichever is greater. The SHP should also justify this call-in to the Director via email, either when the call-in occurs or when the overtime claims are submitted. A third staff should only be called in to assist with clinical work. It is not appropriate to have a third staff doing administrative duties that can be completed during the day.

**Standby:** Standby is the term used to reference mandatory overtime. Staff on standby are required to be available by phone during the period that they are on standby and to attend as soon as possible if they are called in.

<b>Standby standard rate (could vary with new collective agreements)</b>	\$25/8 hour
<b>Standby rate, rest days and designated holidays (could vary with new collective agreements)</b>	\$30/8 hour
<b>Standard hours, workweek</b>	17:00 – 01:00 and 01:00 – 08:30
<b>Standard hours, weekend</b>	17:00 to midnight, then every 8 hours afterwards 00:00 – 08:00, 08:00 – 16:00 etc.

**Call-backs:** If an employee is called back to work and agrees to come in, they are entitled to 4-hours of straight time OR the appropriate overtime rate, whichever is greatest. This is a call back. **Employees on standby (mandatory overtime) are not entitled to call backs.** This can be a source of confusion when speaking with Human Resources or Finance staff.

The first time the CHN is called back to the health centre, the client interaction is paid at 1.5X the standard rate (2.0X on Sundays or statutory holidays) OR 4-hours straight time – whichever is greater. Although this benefit is only meant to apply to the first time, many nurses will attempt to claim it later in the first 8-hour period if it is to their advantage. Neither Finance nor Employee Relations support this practice. The SHP must not approve it.

This benefit applies to each 8-hour block of standby. For greater clarity, the CHN ends work at 17:00 on weekdays when call starts. The CHN is called back to the clinic at 18:00 and can claim 4-hours of straight time. The CHN is eligible to claim another 4-hour block at 01:00 (during the week) when the next 8-hour block begins. **These are known by most nurses as ‘call-backs’.** They are not call-backs as understood by staff from other departments.

In order to claim 4-hours of straight time for the first client interaction while on call, the interaction must be a face-to-face interaction lasting at least 15 minutes.

Four hours of straight time cannot be claimed for courtesies such as picking up staff at the airport or going to the health centre because a security guard is locked out. In situations such as these, the nurse can only claim the amount of time actually worked.



<b>Call Backs</b>	
<b>Technical Definition</b>	An employee asked and agreed to come back to work. This definition does not include employees already on Standby.
<b>Pay Entitlement</b>	4-hours of straight time OR the appropriate overtime rate, whichever is greatest

Claims for **telephone advice** are in 15-minute increments. They are paid at 1.5X between 07:00 and 23:00. After 23:00, 30 minutes are claimed at 1.5X until 07:00. Overtime is not paid for hang up phone calls, wrong numbers, or general questions such as ‘when is the dentist coming?’.

<b>Telephone Advice</b>	
<b>Between 07:00 and 23:00</b>	1.5 X rate in 15-minute increments
<b>Between 23:00 and 07:00</b>	1.5 X rate in 30-minute increments

**As per the NEU contract**, “employees who are required to provide professional services over the telephone, or through electronic communication while on standby” are entitled to be paid for the phone call or email. For greater clarity, professional services mean providing advice, assessment, education etc. The call must be documented on telephone triage forms or directly in the client’s record. It is the SHP’s responsibility to ensure that each claim is supported by appropriate documentation.

Extended clinics occur when clients remain in the clinic after 17:00. The nurses generally stay, depending on volume remaining, until those clients have been seen. The nurse on call is expected to take a break during this time and have dinner while the second nurse on call covers for emergency calls.

As stated earlier, ACPs can be used to cover for dinner breaks but the SHP must provide coverage by themselves or a CHN to ensure appropriate triage.

Here is an example of scheduling utilised in Rankin Inlet:

The first Nurse on Call starts work at 08:00 and takes lunch at 11:30 to 12:30. Dinner break occurs from 16:30 to 18:30 and the first Nurse on Call takes call again from that time. The second Nurse on Call (the previous day’s First on Call) starts work at 10:00, covers lunch for the first NOC and takes lunch from 12:30 – 13:30. The second NOC works until 18:30.

For greater clarity, the First NOC works from 08:00 – 16:30 (7.5 hours) and resumes call, working overtime starting at 18:30.

The second NOC who was on first the previous day, ends the previous day’s call at 08:00 and has respite until 10:00. The second NOC day starts at 10:00 and ends at 18:30 (7.5 hours).

While nurses can request administrative overtime to catch up on charting, they may not use extended clinic for this purpose. The SHP should be aware of this need to encourage nurses to complete their documentation immediately following the client interaction.

If the extended clinic continues 3 hours past the end of the day, the CHN can claim Duty Travel rates for a missed meal. The SHP should discourage this practice by ensuring that the nurse is taking a dinner break prior to this time. This can be done by having the second on call nurse cover while the first on call takes a break. Another option is to keep frozen meals in the health centre freezer labelled for the nurse on call.

The claim for Duty Travel rates for missed meals applies to any staff whose workday extends 3 hours past the end of the workday – LPNs, support staff, etc.

**Rate of Pay:**

Overtime is paid at 1.5X the standard rate for the first 4-hours and double time for any time worked past 4-hours.

Overtime on the second day of rest and on designated holidays is paid at 2.0 X the standard rate.

<b>Overtime, first 4 hours</b>	1.5 X rate
<b>Overtime, after first 4 hours</b>	2 X rate
<b>Overtime, rest days and designated holidays</b>	2 X rate

6.4.1.1 On-Call Log

Every health centre maintains an on-call log for the nurses on call. Each nurse on call is expected to complete the log immediately following a client interaction, or in the case of telephone advice, immediately prior to or following morning report.

Every entry on the *Overtime and Supplementary Pay Authorisation Form*, completed by CHNs, must be corroborated in the log. The entry in the log includes the time the visit started and ended, the name of the client and the reason for the visit.

The entries in the log are divided by call shift and include the names of the first and second nurses on call.

**The on-call log is a confidential document and must not leave the health centre.** There have been cases where the log was removed from the health centre and lost, creating a confidentiality breach.

If an on-call log is lost or misplaced for any reason, the Director must be advised immediately. This notification cannot be delayed. Searching for the log can be ongoing during and after the notification.

6.4.2 Procedure

Overtime claims are submitted with payroll every two weeks.

The overtime claim is recorded on the *Overtime and Supplementary Pay Authorisation Form* which is available in electronic form on the GN Intranet. The form should be completed electronically whenever possible for the sake of legibility.

All health centre employees use the same form regardless of designation.

All employees submitting overtime claims must do so by the day of payroll submission. Every SHP has the authority to decide how soon the forms must be submitted to themselves for verification.

CHNs, whether indeterminate, casual, or agency must record all overtime in the overtime log legibly. The overtime log is used by the SHP to verify each entry on the overtime claim. The SHP must initial each entry on the overtime claim as it is verified and sign the form as supervisor, once verification is complete. This is the process for all staff claiming overtime, not just nurses.

Because this is often a time-sensitive and labour-intensive exercise, it might be wise for the SHP to request overtime claims every day or earlier in the week than the payroll submission date so as to reduce the amount of work required on submission day.

Overtime is considered eligible for payment only when the time recorded on the Overtime Form is matched by an entry in the overtime log and in the Client Record. This includes any telephone advice given. If the second Nurse on Call or the SHP is consulted or called in, this must also be recorded by the first Nurse on call in the Overtime Log.

There is a minimum of 15 minutes between claims for overtime. Less than 15 minutes is considered an extension of the preceding claim.

Call starts at 17:00 and ends at 08:30 the following morning.

Healthcare providers and healthcare workers who must remain in the health centre during lunch to provide care to an emergent client and cannot take a later lunch, may attempt to claim Duty Travel rates for the missed lunch. This claim should not be approved. The only time an employee can claim Duty Travel rates for a missed meal is: "Where an employee is required to work three (3) or more hours of overtime immediately following his/her regularly scheduled hours of duty, and, because of the operational requirements of the service, the employee is not permitted to leave his/her place of work, the Employer will either provide the employee with a meal or meal allowance equal to the amount of the dinner in accordance with the Duty Travel Article (Article 41)." NEU Contract

The nurse on call is also responsible to answer the phone and may need to see clients emergently during the hour that the health centre is closed for lunch. If this occurs, the SHP needs to ensure that the nurse on call takes a lunch break when the other CHNs return to the health centre. Another option for the SHP is to flex lunch hours for the nurses on call so that one takes lunch at 12 and the other, either at 11:00 or 13:00. An overtime claim for the lunch hour should be rare and only in the case where an extreme emergency does not allow the nurse to take a later break.

The best solution, however, is to ensure that all staff working through lunch, take lunch as soon as possible when staff return to the health centre. If this is done, staff cannot claim overtime for the lunch period nor attempt to claim for a missed meal.

SHPs are expected to audit overtime intermittently by checking the client record to substantiate claimed overtime.

Audits include review of chart entries and must assess the reason for Overtime and the advice or care provided against established practice standards.

All concerns identified regarding claimed overtime must be brought to the attention of the Director or Facility Director.

## SECTION 7 STAFFING

### *Key Takeaways for this section:*

- All casual staff whether regular or relief, must have a completed and approved CSA before they start work.
- A CSA extension must be submitted at least two weeks before the end date of the CSA to avoid any delays.
- Transient furnishing and cleanliness are the responsibility of the health centre. Keeping the units fresh and orderly will help attract casual nursing staff.

Staffing the health centre with nursing staff is an ongoing job that is shared between the SHP and the Director. There is no strict timeline to this, but at minimum, the SHP needs to review the staffing schedule monthly.

The nurse staffing schedule is provided by the Regional Office.

In the **Kivalliq region**, a monthly meeting is held with all of the SHPs, the Director, and a Human Resources Officer to review all health centre staffing, both nursing and support staff.

This section will cover the hiring of full-time, casual and agency nurses, full-time support staff, casual and relief staff.

Transient housing will also be reviewed in this section.

Policies that apply.

- 05-013-00 Orientation
- 05-014-00 Reference Materials

### 7.1 Indeterminate Staff

The Government of Nunavut refers to full-time, permanent staff as 'indeterminate' staff.

Indeterminate nurses are hired regionally, meaning that the Director, Health Programs, and regional Manager of Human Resources review and interview all applicants whose resumes they receive.

The process begins with sending a Job Action Request (JAR) to Human Resources. This is done by the Regional HR staff. The next step is to secure housing approval. A vacant position cannot be posted until housing is approved. This is done centrally by the Deputy Ministers. Once housing is approved, the position can be posted. Resumes are reviewed when received, and interviews are arranged.

Every effort is made to ensure that the newly hired nurse can attend the territorial orientation as soon as possible after arrival in the territory.

#### 7.1.1 Resignation

When indeterminate staff resign their position, they must submit a letter of resignation to their immediate supervisor. The immediate supervisor accepts the resignation after 72 hours (3 business days). The 72-hour wait is mandatory according to Human Resources policy and allows for a 'cooling off' period. During this time, the employee can rescind their resignation.

The letter of resignation and the acceptance are then submitted immediately to both the Director and the Regional Manager of Human Resources (Health) so that the process of final payout and the rehiring process can begin.

All leave forms for the employee should also be submitted so that all documents are up to date.

It is important to let the employee know that the final paycheque will only be available once all of the documents have been submitted and processed by the Payroll department.

### 7.1.2 Territorial Orientation

**The Territorial Community Health Nurse Orientation** takes place on a quarterly basis. Newly hired indeterminate nurses are the priority. Regions submit requests to the Chief Nursing Office where the final decision regarding who will attend, is made. There is a pre-orientation module that must be completed prior to starting the process. The nurses participate in a two week in class session followed by a minimum four-week mentorship in their home community. Successful completion is necessary for continued employment.

The nurses attending orientation are provided with accommodation and are paid their salary. Following orientation, they may also submit expense claims for meals as well as any accrued overtime.

When there is space, indeterminate nurses who were hired prior to the inception of the territorial orientation may submit a request to participate in the orientation process. Casual nurses with longstanding commitment to working in the territory are also eligible.

It is important for the SHP to assess the skill level of the CHNs in the community to decide who might be a suitable mentor for the CHNs returning from the in-class portion of the orientation. Emotional intelligence is also important – the ability to engage, to be patient, kind, and firm are important aspects of mentorship.

Nurses new to Nunavut need to know the resources that can be accessed for guidance in making diagnostic and treatment decisions. The SHP should ensure that the mentors are utilising the First Nations Inuit Health Branch Clinical Guidelines as their primary resource. Other resources are noted in the policy and guidelines listed at the beginning of this section.

It is also important for the SHP to engage with inexperienced staff in providing both encouragement and support. Nurses on contract are far more likely to return to a community when they feel welcomed.

The nurses returning from the in-class portion of the orientation must complete a number of modules as well as participating in the work of the clinic. It is very difficult to complete these modules after a full day of work; the SHP should make every effort to give the nurse blocked out time during the workday to complete the modules – either a full day or a half day at least once a week, preferably twice. The new hires are not counted as part of the health centre nursing complement.

## 7.2 Casual Nursing Staff

Casual nursing in Nunavut is quite different from nursing in the southern provinces. Nurses are hired on contract. The length of the contract is dependent on the need; however, a six to eight-week contract is preferred. Contracts can be longer; shorter contracts are discouraged.

Casual nurses are interviewed by phone centrally by the Nursing Resource Program (NRP) in Iqaluit. The NRP has access to all of the community staffing schedules and can direct the resumes to the region most in need. The regional Director, Health Programs and the regional Manager of Human Resources complete the process for onboarding of casual nurses.

Once a casual nurse agrees to fill a need, a casual staffing action (CSA) is completed. In both the **Kitikmeot and Qikiqtaaluk** regions, this is done by Human Resources (HR) staff in the regional office. The CSA is approved by the Regional HR Manager. A travel request is then completed by HR in these two regions and submitted to Regional ED for approval. The casual nurse's Registered Nurses Association of the Northwest Territories and Nunavut (RNANTNU) license must be included with the paperwork. Normally, out of territory (OOT) travel requests require ADM approval. In the case of casual nurses, however, this authority has been delegated to EDs, unless the contract is shorter than two weeks. Travel and accommodation are then booked by the Duty Travel team in Iqaluit and the tickets and information are emailed to the casual nurse.

In the **Kivalliq region**, this paperwork is prepared by the SHP and submitted to **Kivalliq Health Operations** where it is reviewed by the Director. Human Resources staff finalise the CSA and submit the OOT request to the Duty Travel team in Iqaluit.

### 7.2.1 Casual Nurse Orientation

Casual nurses may attend the territorial orientation program if there is room – indeterminate nurses are the priority. The orientation is very expensive and should be reserved for those casual staff who have demonstrated a commitment to the region.

Each region has a nurse educator who reports to the Chief Nursing Officer. The educators have developed a casual nurse orientation which covers most of the areas necessary for safe practice in the North. It is important for the SHP to collaborate with the educator to ensure that the new casual nurse has sufficient support to practise safely. The educators have developed a number of education modules that are available on Microsoft Teams. At minimum, the new nurse should be buddied with a skilled nurse for a minimum of two weeks, but preferably for six weeks. A nurse who is supported is more likely to return.

### 7.2.2 Agency Nurse Orientation

Technically, the agency providing the nurse is responsible to ensure that the nurse is sufficiently oriented. This is not always the case, and the SHP should keep a close eye on new agency nurses. It is more expedient, if possible, to support these nurses rather than returning them, unless the issue is one of insufficient experience to be able to orient successfully. Buddying a new agency nurse with someone who is more skilled for a couple of weeks is usually all that is required.

## 7.3 Agency Nursing Staff

Health contracts agency nursing services through the CGS Request for Proposals (RFP) process. This process invites proponents to submit proposals for the requested service or product. Once the competition closes, the proposals are reviewed and scored by a committee and the contract is awarded.

Currently, the contract for agency services is held by one agency, Bayshore, which is contracted to provide Registered Nurses in every category working in Nunavut, as well as Registered Midwives.

In all regions, the Agency Task Authorization (ATA) form is submitted to the Nursing Resource Program (NRP). Regional staff complete Part A and obtain the necessary approvals prior to submission to the NRP.

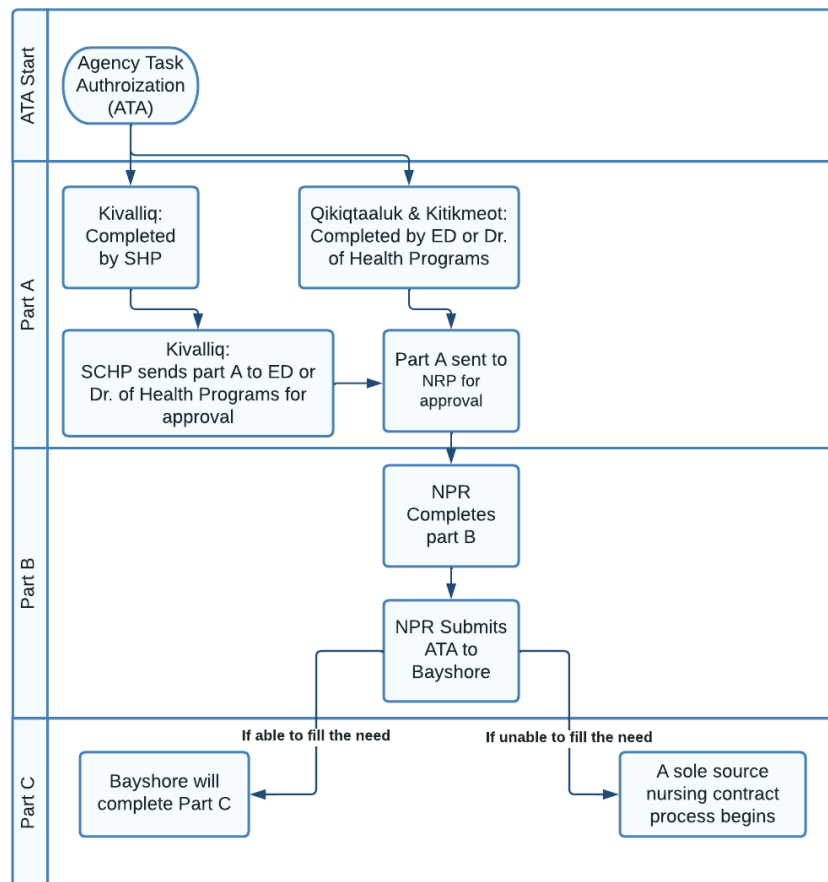
The NRP completes Part B of the ATA and submits it to Bayshore. If Bayshore is able to fill the need, they will propose a candidate on Part C of the ATA.

The NRP approves the proposed nurse/travel itinerary on Part D and returns the now completed ATA to Bayshore and the regional team who initiated the ATA.

If Bayshore is unable to fill the need, the NRP is working on a process of sole source contracts with other agencies. Sole sources are GN contracts that are not put out for tender (the usual process) but contract with a single provider. This is only done when there is no one else who can fulfill the requested need or when the need is urgent.

For all intents and purposes, the SHP only needs to understand the process. All agency nurse requests, whether filled by Bayshore or a different agency, must go through the NRP.

**AGENCY TASK AUTHORIZATION PROCESS FLOW**



## 7.4 Casual Non-professional Staff

Every health centre has a complement of non-professional staff – housekeeper, caretaker, clerk-interpreters, etc. Casual staff are hired to fill gaps when support staff are on annual leave or absent for other reasons as well as when a position is vacant, and hiring has not yet been finalised.

There are two categories of casual support staff – regular and relief.

**Regular** casual staff are hired to fill longer term vacancies. They are expected to report to work 5 days/week and (depending on the length of the CSA), can collect sick benefits and annual leave. If they have earned sufficient leave, they must complete the same leave form discussed in [Section 6.2](#).

**Relief** staff are also known as “as and when” staff and are most commonly referred to as RESAs (Relief Employee Staffing Action). They do not report to work automatically, but are called in to fill a short vacancy – to cover for sick leave etc. Relief staff do not have sick and annual leave benefits. They can collect overtime in the same way as casual and indeterminate staff. For greater clarity, if they are called in to work from 08:30 to 17:00, and stay at work until 18:00, relief staff would be entitled to one hour of OT. If, however, they work until 17:00 and then go home but are called in at 18:00 until 20:00, this would be two hours of straight time.

If relief staff do not work any hours for three consecutive months, they are deemed to be terminated.

The process for hiring is the same whether the staff is casual or relief.

It is important to be aware of the end date of regular CSAs; if the CSA needs to be extended or renewed, the process can be lengthy from the HR end, and two weeks notice is the minimum amount of time needed for completion and obtaining all of the necessary signatures. In practice the sooner the request can be submitted, within reason, the better.

Once the SHP has decided that casual staff are required, the following items need to be supplied to the HR Officer responsible for hiring of support staff in the Regional Office:

- Name
- Resume
- Current Criminal Records Check (CRC) and Vulnerable Sector Check (VSC)
- Date of birth
- Social insurance number
- Marital status and
- Contact information

All casual employees must sign an Oath of Confidentiality and possess a cleared RCMP Criminal Records Check.

If the SHP does not have a candidate, posters can be posted in local stores and the post office outlining the position and necessary qualifications.

**CSAs and RESAs are completed by the SHP in the Kivalliq region and by HR staff in the other two regions.** The HR Officer forwards the completed form to Human Resources in Iqaluit to be signed by the Deputy Minister. Most delays in processing occur at this point.



Once approved, the completed and approved CSA is forwarded to the Department of Finance, Pay and Benefits for processing. The CSA is also sent to the employee for their signature.

All casual employees MUST have a completed and approved CSA PRIOR to the start of their employment. If they do not, they are not covered by Workmen's Compensation and their pay will be significantly delayed while the paperwork is sorted out.

## 7.5 Summer Students

The Summer Student Employment Equity Program (SSEEP) is designed to provide opportunities for students to gain meaningful work experience and training. They are funded through the Department of Human Resources.

Health centres are encouraged to hire summer students for a variety of duties – assistance for both the professional and non-professional staff or for special projects.

The goals of the program are to provide employment or training opportunities for students that will develop their skills, enrich their academic programs, and help them evaluate their career options within the territorial public service.

Questions can be directed to:

- Iqaluit: [IqaluitSummerStudents@gov.nu.ca](mailto:IqaluitSummerStudents@gov.nu.ca)
- Kitikmeot: [KitikmeotSummerStudents@gov.nu.ca](mailto:KitikmeotSummerStudents@gov.nu.ca)
- Qikiqtaaluk: [QikiqtaalukSummerStudents@gov.nu.ca](mailto:QikiqtaalukSummerStudents@gov.nu.ca)
- Kivalliq: [KivalliqSummerStudents@gov.nu.ca](mailto:KivalliqSummerStudents@gov.nu.ca)

## 7.6 Transient Housing

There are two types of transient housing in communities – allocated units and units obtained through a Memorandum of Agreement (MOA).

Each health centre usually has one or more units allocated from housing. Housing is responsible to maintain these units – Health does not pay rent for them. Health is responsible for furnishing the units.

Sometimes, the allocated units are insufficient for the needs of the health centre, and it is necessary to acquire another unit. The SHP can speak with the local housing authority to see whether there is an available unit. If a unit is available, the SHP can discuss the possibility of renting the unit with the Director. The unit is rented through the Regional Manager of Finance (Health).

Once the unit is rented, Housing is responsible for large furniture, while Health supplies kitchen equipment, linens, towels, bedding etc.

A very few health centres have accommodation attached – usually on the second floor, but not always. Some of these units are designated as transient units and Health is responsible for furnishing those units. If repairs are required, a Community and Government Services (CGS) work order must be submitted.

### 7.6.1 Allocation of Transient Housing

The SHP allocates the transient units in the community. The first priority is to ensure that there is sufficient room for healthcare providers. The second priority is Health employees travelling to the community. There are times when other departments may request a transient unit for a night or two for their employees. This request will come through the Director and every effort is made to accommodate departments.

**Visiting health professionals** may also request transient housing. For most regions, the visiting specialists are under contract and their accommodations are covered. They should stay in the local hotel unless they are working after hours and staying in the transient units is safer.

The SHP should maintain a visual schedule of transient housing allocations. It is important not to overbook. Nurses generally do not like to stay in hotels because they are unable to cook, and this is a significant additional cost to the health centre. Hotel accommodations are expensive, and the nurses are also paid a per diem when they stay in one. The Treasury Department, Government of Canada, decides the fee amount for per diems. The fee scale is updated on April 1 and October 1, each year.

### 7.6.2 Transient Unit Rules and Expectations

Transient units are shared accommodation. Persons occupying the transient units are expected to behave accordingly – to be thoughtful and considerate of their roommates.

Generally speaking, females are housed with females and males with males. This is not always possible and there are times when males and females may need to cohabit. The SHP should advise the incoming staff to ensure that there are no objections to this. Every effort should be made to ensure that the roommates are comfortable.

Every occupant of a Transient Unit is required to comply with the list of rules and expectations prominently posted in each Unit. The SHP should verify that the rules remain posted and are up to date. The unit should be tidy, and the bedding should be washed prior to leaving the unit.

Staff utilizing transient units are expected to clean the unit when leaving, however, this has been a source of problems. The CHN might be on call prior to leaving and not have time to clean. The nurse might be needed on the morning prior to leaving and ensuring adequate staffing is the priority.

The SHP can bring a relief housekeeper in to clean the unit more thoroughly on a routine basis. Regular cleaning will help to keep the units comfortable for incoming staff.

Keys to the transient units are given to the occupants. The keys must be returned to the SHP prior to the staff's departure. If the staff member leaves with the keys, the SHP must contact the Housing office in the community to have a new key cut. Since the staff member will also likely have keys to the health centre, it is important that the SHP has a system for ensuring that all keys are returned prior to departure. If a nurse leaves the community with the keys, the SHP should request that the nurse return the keys by registered mail.

### 7.6.3 Pets

Pets are generally not permitted in the transient units because they are shared accommodations.

Pets are absolutely forbidden in transient units in the **Kivalliq**.

The SHP cannot approve a casual/agency nurse to bring a pet in the **Qikiqtaaluk** or the **Kitikmeot** regions. The Director, may at their discretion, provide written approval. **Written approval from the Director in advance of travel is necessary.**

### 7.6.4 NO Smoking

All Government of Nunavut Units and Workplaces are designated as Non-Smoking. This rule is inviolable. Smoking is not permitted within three (3) meters of public entrances, including entrances to transient units. Legislation stipulates that anyone in violation of this policy may incur a fine ranging from \$5,000 to \$50,000, which is levied against both the offending staff member and the Department for failing to enforce the policy.

Persons who wish to smoke must go outside. Smoking through an open window or door or with the fan on are not acceptable alternatives.

A NO-SMOKING Poster must be displayed in every Transient Unit.

### 7.6.5 Supplies Provided in Transient Units

The Nunavut Housing Corporation provides the basic requirements in allocated Transient Units. These items are – beds, dressers, end tables, lamps, couches, refrigerator, stove, washer, and dryer.

Units obtained through a Memorandum of Agreement (MOA) may or may not have all of these items. The SHP must purchase the necessary furnishings if they are not provided. This should be done locally with an LCA.

Health supplies additional necessities for each transient unit:

- TV with cable
- Microwave
- Coffee pot and kettle
- Dishes, utensils, and cookware
- Bed and bath linens and pillows
- Window coverings
- Bathroom tissue (only supplied initially in small amounts. Casual staff are expected to supply their own ongoing.)
- Cleaning supplies
- Landline.

It is advisable to keep an inventory of furnishing and supplies for each transient unit that can be updated by the person delegated to monitor.

### 7.6.6 Supplies Not Provided in Transient Units

Computers and internet are not provided in any Transient Unit. Bandwidth is limited and expensive and would be unsustainable. Transient and agency nurses may contact local service providers for the purchase of modems which can be used in any community in Nunavut, and they may purchase internet access for the time they are in the community.

When nurses are on call, they can use their on-call phone to 'hotspot' the internet as required.

### 7.6.7 Reporting Housing Issues

The SHP must be advised of any issue or problems with the Transient Units. The SHP contacts the local housing authority via email (for tracking purposes) to report the issue and request resolution. If Housing does not respond in a timely way, the SHP (or delegate, e.g., Administrative Assistant) should follow up by phone. If there is still no action, the SHP should advise the Director who can then contact the Regional Manager of Staff Housing. In some smaller communities, the SHPs or their delegate may need to connect with landlords for houses rented under a MOA.

The exception to this is in-health centre transient units. CGS is responsible for repairs to these units. The SHP will need to submit a CGS work order.

### 7.6.8 Water and Sewage

Water is delivered by truck to a storage tank in every building in all communities that do not have a Utilidor system. This is the majority of communities in Nunavut.

Sewage removal is managed in the same manner. The sewage trucks have a scheduled service to each building to pump out sewage holding tanks. This service is automatic.

If there are problems, the SHP can contact the hamlet during office hours or the after-hours number as appropriate.

The Transient Unit residents should be cautioned about water usage on arrival, particularly during blizzards when water/sewage trucks may be off the road. Water and sewage trucks may not deliver on the weekends, so laundry should then be avoided. It is useful to know the delivery schedule for the transient units to ensure that there is sufficient water available.

## SECTION 8 CHART AUDITS AND NURSING PRACTICE CONCERNS:

### *Key Takeaways for this section:*

- Addressing practice concerns is key to maintaining excellence in healthcare delivery.
- The SHP must complete three (3) documentation audits/month.
- Just Culture focuses on the choices made by staff and the environmental conditions in which those decisions are made.

Any practice concern is potentially a client safety event. Early identification and intervention are key to keeping both community and staff safe. One way that a SHP can remain proactive and alert to potential practice issues is to complete chart audits as required and to develop plans to address any issues that are highlighted through them.

This section will discuss:

- Just Culture
- Chart audits
- Identification of practice concerns
- Incident reporting

Policies that apply:

- 04-004-00 Health Centre Documentation Audit including Chart Audit Tool
- 05-016-00 Provision of Care in Emergency Situations
- 05-033-00 Managing Nursing Practice and Professional Conduct
- 05-034-00 Client Safety Event – Incident Reporting and Immediate Management
- 05-035-00 Client Safety Disclosure Policy
- 05-036-00 Client Safety Event – Screening for and Conducting Incident Analysis
- 06-008-00 Documentation Standard
- 06-009-00 Documentation Format

### 8.1 Appendix

- Just Culture: It's more than policy

### 8.2 Just Culture

Health is committed to promoting a Just Culture whereby all staff feel comfortable to report safety incidents, near misses, and concerns.

This includes:

- Fostering an environment of support and safety for staff.
- Ensuring that reports are reviewed in a non-judgmental, consistent, fair, and supportive manner, using the systems thinking approach.
- Supporting individual and organisational learning by providing the opportunity to discuss safety incidents, review contributing factors, and determine how to reduce the risk of recurrence.

The Just Culture focus is on evaluating the behaviour and choices made by an individual and not on the outcome of the event. It distinguishes among normal human error, unintentional risk-taking behaviour,

intentional risk-taking behaviour, and reckless behaviour. Just Culture recognises that, even with human error, numerous factors impact the choices made by individuals. It lends itself to continuous improvement of work processes and systems to ensure the highest level of client and staff safety. It encourages the use of non-disciplinary actions whenever it is appropriate. These actions include strategies such as coaching, training, and education. Just Culture does not tolerate reckless behaviour. It holds individuals accountable for their own performance and behavioural choices in accordance with their job responsibilities but does not expect them to be accountable for systemic flaws. Just Culture recognises that perfection is not sustainable and that errors will occur.

Just Culture provides a way for SHPs to view practice concerns by seeing them as decisions impacted by several factors, some personal and some systemic. If an error occurs, why did it occur? Was the staffing inadequate to the point that the nurse was exhausted? Was the nurse up all night? Was there a gap in policy or procedure that resulted in the error, etc.? Were there personal stressors at play? Did the nurse understand the risk involved in making the decision? Did the nurse understand the policy?

It is important for SHPs to ensure that their health centre adheres to the concept of Just Culture by discouraging unnecessary commentary from staff. To effectively address practice concerns, the SHP needs to be seen as fair, objective, compassionate and supportive by staff. The SHP's ability to self-reflect is a valuable tool in this process.

*Just Culture: It's more than a policy* is included in the appendices for further reading.

More information is also available at <https://justculture.hqca.ca/>.

### 8.3 Chart Audits

Completing chart audits assists the SHP to ensure that nursing staff is compliant with policy and procedure as well as meeting an excellent standard of care.

SHPs must complete 3 chart audits/month. The month's audits will focus on one nurse whether indeterminate, casual or agency – CHN, NP or Public Health Nurse and the review will include one complex case, one focused visit, and one pediatric visit.

Chart audits may also be done for paramedics who are agency personnel but are held to the same documentation standards as nursing staff.

Once each nurse has had an initial set of 3 charts reviewed, the SHP will begin a second set for each nurse, e.g. if there are 5 CHNs and 1 NP and 1 PHN, the initial reviews will be completed in 7 months. In the 8<sup>th</sup> month, the SHP will circle back to the first CHN reviewed, unless a new staff member has come on board.

The charts are audited for documentation adherence to the standards required by Health.

Documentation reflects the care given. There are several options – the care given may be adequate, but the documentation may not reflect it. The care given may be inadequate and the documentation provides evidence of the gaps.

The third option is that the care given is excellent and the documentation reflects it. This is the ideal.

Once the chart audits are completed, the SHP meets with the nurse to discuss the audit. The feedback provided might be that the documentation is excellent or there may be minor or more significant gaps.

The nurse whose documentation meets an excellent standard should be congratulated and might be considered to assist others.

If there are gaps, the SHP must present the evidence, and together with the nurse, produce a learning plan. The regional Educator can assist with this process if the SHP has any uncertainty.

Once the learning plan is in place, the SHP must continue to monitor the documentation. The secondary review will hopefully demonstrate improvement. The SHP should consult the regional Educator if the documentation continues to be substandard.

## 8.4 Incident Reports

Incident reporting is included in this section because it is the vehicle often used to submit a practice concern to the SHP. While there are other ways to bring forward a concern, this is one of the most common. In keeping with the way that this manual has been organised, information about all types of incident reports is included.

Incident reporting is a non-punitive learning process that increases safety for clients, visitors, and staff and informs quality improvement initiatives.

Incident reports are factual descriptions of an incident. They provide valuable data that are used to identify local, regional, and territorial trends. Incident reports inform policy and health system changes to improve client and staff safety. They are confidential and are not a part of the client's medical record or the employee's file.

Policy 05-034-00 *Client Safety Event – Incident Reporting and Initial Management* provides explicit information regarding how, why, and when incident reports must be submitted. It is the SHP's responsibility to understand and comply with the policy.

Incident reports are completed in the Quality and Risk Management (QRM) Module of Meditech.

If Meditech is down, a Downtime form must be completed.

### 8.4.1 Types of Incident Reports

Not every incident report is a client safety event.

Client safety incidents include medication errors, treatment errors, and inadequate care.

Other types of events are:

- Employee injury
- Incidents involving visitors – this can include injury to a visitor which would be submitted on a Non-Patient Incident Report although the visitor would subsequently be a client
- Breach of Confidentiality
- Theft or loss of Personal or Facility Property

## 8.4.2 Levels of Harm

- **Near Miss (1)** – an incident that has potential for harm and is intercepted or corrected prior to reaching the client. Example – a medication order questioned because it didn't seem appropriate to the client's condition and found to be on the wrong client chart.
- **No Harm (2)** – Client is not symptomatic, or no symptoms are detected. No treatment is required. Example – client is given wrong dosage of medication, but dosage is non-toxic, and no harm is done.
- **Mild Harm (3)** - Client is symptomatic but symptoms are mild. Loss of function is short term and there is minimal, or no treatment required. Example – client is given wrong medication but remains asymptomatic and remains under observation for two hours prior to being discharged.
- **Moderate Harm (4)**- Client is symptomatic, requiring intervention such as short-term hospitalisation or causing minor permanent or long-term harm or loss of function.
- **Severe Harm (5)** – Client is symptomatic, requiring life-saving intervention or major med/surg intervention or shortening life expectancy or causing major permanent or long-term loss of function.
- **Death (6)** – death was caused or brought forward in the short term by the incident.

## 8.4.3 Never Events

Never events are incidents that should never have happened because there are known strategies already in place to ensure that they never occur.

Never events are always critical regardless of the client outcome.

Examples of Never Events:

- Client under continuous observation leaves a healthcare facility without the knowledge of the staff.
- Client death by suicide, attempted suicide or self harm resulting in severe harm while being cared for in a healthcare facility while the client was prescribed continuous observation.
- Client death or severe harm associated with a medication error.
- Client death or severe harm due to a failure to inquire whether a client has a known allergy or due to administration of a medication where a client's allergy has been identified.
- Client death or severe harm of a frail client or client with altered level of consciousness within a healthcare facility.

## 8.4.4 The Incident Reporting Process

- 1) An incident is witnessed or discovered.
- 2) The involved staff member notifies the SHP within 24 hours.
- 3) The involved staff member submits an incident report in the Quality Risk Management (QRM) Module in Meditech with the following information:
  - Dates and times of the incident.
  - Description of the unexpected event, problem, or circumstance.
  - The outcome.
  - The severity.



- The immediate response by staff.
- An assessment of the client.
- The parties notified.
- The client response.

DO NOT INCLUDE: subjective insights/opinions, assumptions, speculation, vague language, accusatory language, or blame.

The incident report must be submitted by the end of the workday. If the report is submitted 24 hours later than the incident, it must be entered as a LATE ENTRY.

If more than one client is involved, a separate report for each client must be submitted.

If other non-patient factors are involved (e.g., employee injury or damage to property), separate reports must be submitted. If more than one employee is injured, separate reports must be submitted for each employee.

- 4) If Meditech is not available, a Downtime form must be completed and submitted to the immediate supervisor (usually the SHP). **How to access the Downtime Form:**

**By email request:** [HealthCQI@gov.nu.ca](mailto:HealthCQI@gov.nu.ca). Email can also be sent to [IHSQuality@gov.nu.ca](mailto:IHSQuality@gov.nu.ca).

Printed copies should be made available in areas where staff are known to not have MEDITECH accounts.

Once Meditech is back online, the SHP or delegate is responsible to transcribe the Downtime Incident Report into the QRM Module.

If a staff member reporting the incident does not have access to Meditech, the Most Responsible Person (MRP) or the SHP must submit the incident.

- 5) Notifications: Submission of incident reports in the QRM Module results in automatic notifications HOWEVER, if an incident resulted in an unexpected death, severe harm, is a NEVER event, or has a high likelihood of recurrence, the Director must be notified verbally. In some of these cases it may also be necessary to notify the RCMP and the coroner.
- 6) While the incident report, itself, is not included in the client record, all interactions with clients must be recorded. Documentation of the event in the client's medical record must be objective, factual, concise, specific, and accurate. It includes details of what was witnessed or discovered, any statements made by the client or caregiver, the name of MRP notified and the time, details of disclosure to the client and family, details of treatment provided and the response, all discussions with clients or caregivers including any subsequent information shared following disclosure. It must not contain subjective insights or opinions, assumptions, blame or accusatory language. **The incident report is not included in or referenced in the medical record.**
- 7) Immediate Action:  
The SHP must:
- Ensure that the physical environment and situation are safe for the client, visitors, and staff. Remove, label, and secure any items involved in or that may have contributed to the incident in a secure location. If death has occurred, the coroner must be consulted prior to removing any items.
  - Respond to the immediate needs of the client and family.
  - Take measures to reduce the likelihood of recurrence or other potential threats.
  - Provide support to clients, visitors, and staff.

- Provide a quiet, private place for communication and documentation to occur.
  - Arrange coverage of duties to provide respite for affected staff if necessary.
  - Arrange and facilitate debrief using Homewood services or mental health staff for all staff directly or indirectly involved no later than 72 hours after the event.
- 8) The SHP must review all incident reports within 1 business day. To gain a preliminary understanding of the incident, the SHP reviews the facts of the incident and gathers relevant information, speaks with involved staff to understand what happened and how it happened. The SHP reviews the Level of Harm to ensure that it is accurate and adjusts it, if necessary, by contacting Health Continuous Quality Improvement (CQI).
  - 9) The SHP and/or the Director are responsible for sharing learning with the client and family (if there are additional learnings after the immediate investigation). They also provide feedback to the involved staff including actions taken to prevent recurrence.
  - 10) An incident cannot be closed by the submitting staff member. If the SHP submits the incident, the Director, Health Programs is responsible to close it. Closure must include any additional steps taken to provide support and any key findings. Near miss, no harm, mild harm, and moderate harm events must be closed within 30 days. Severe harm, death and NEVER events must be closed within 90 days. While closure of incidents is mandated in policy, it should also be viewed as best practice. If there is difficulty in closing an incident, the SHP is advised to contact the Director for advice.
  - 11) Urgent teleconferences with the SHP, involved staff, Director, Chief Nursing Officer, Chief of Staff, and Health CQI staff are held for client safety incidents with severe harm, death, NEVER events or events with a high likelihood of recurrence.

## 8.5 Addressing Nursing Practice Concerns

Addressing nursing practice concerns is one of the greatest responsibilities for SHPs and Directors.

- RNs and NPs are licensed through the Registered Nurses Association of the Northwest Territories and Nunavut (RNANT/NU). LPNs are licensed by the Registrar for Nunavut – the Director of Professional Practice but will eventually be incorporated into RNANT/NU. Midwives are also registered by the Director of Professional Practice. While all nurses have a mandatory duty to report nursing practice and professional conduct concerns to their regulatory body, RNANT/NU also states that “in many cases it is best to raise concerns you may have with the actions or conduct of a nurse directly with the nurse or the nurse’s employer. Depending on the nature of the concern, you may find the matter can be resolved in a fair and timely manner without our involvement.” (rnanntnu.ca, 2019)

Addressing practice concerns is **also** the responsibility of the employer and any practice concern should be communicated to the Director.

Concerns about CHNs and PHNs are shared with the Director. The exception is Rankin Inlet, where concerns about PHNs are shared with the Manager of Public Health and the Director.

Practice concerns regarding agency personnel, including paramedics, are directed to their agency and to the Director.

Practice concerns regarding Supervisors of Home and Community Care should be first addressed with their supervisors – the regional Managers of Home and Community Care and the Director of Health Programs.

Concerns about midwives are directed to the Regional Manager of Midwifery and the Director of Professional Practice.

Concerns regarding mental health nurses, registered psychiatric nurses, and mental health consultants are addressed initially by the regional Manager of Mental Health.

There are two exceptions to this rule: (1) if the concern being communicated is one of workplace harassment or abuse by the supervisor and (2) if there are workplace or client safety concerns that have not been dealt with by the SHP.

In the first case, the process outlined in the Human Resources Manual should be followed. This is available at:

[https://gov.nu.ca/sites/default/files/hrm1010\\_respectful\\_and\\_harassment\\_free\\_workplace\\_en.pdf](https://gov.nu.ca/sites/default/files/hrm1010_respectful_and_harassment_free_workplace_en.pdf).

In the second case, the staff member can contact the Director.

As Health moves toward incorporating a Just Culture approach, the policy regarding the Management of Nursing Practice and Professional Conduct has been updated accordingly. This policy is specific to nurses only, regardless of category.

While the policy has been approved by the ADM Operations, training remains in the process of development.

In the meantime, there are some important points to remember:

- Maintain absolute confidentiality and discourage any discussion about the concern among staff.
- Gather the facts.
- Communicate the concern to the Director via phone or email.
- Use the available resources. Discuss the issue with the Director and involve the regional educator if the problem appears to be a gap in knowledge or a misunderstanding of policy.

## 8.6 Disruptive Behaviour

Resources:

- Code of Values and Ethics available at: [https://gov.nu.ca/sites/default/files/code\\_of\\_values\\_and\\_ethics\\_final\\_english\\_1.pdf](https://gov.nu.ca/sites/default/files/code_of_values_and_ethics_final_english_1.pdf).
- Workplace Violence Prevention Human Resource Manual Section 1009 available at [https://gov.nu.ca/sites/default/files/hrm1009\\_workplace\\_violence\\_prevention\\_0.pdf](https://gov.nu.ca/sites/default/files/hrm1009_workplace_violence_prevention_0.pdf).
- Respectful and Harassment Free Workplace Human Resource Manual Directive 1010 available at [https://gov.nu.ca/sites/default/files/hrm1010\\_respectful\\_and\\_harassment\\_free\\_workplace\\_en.pdf](https://gov.nu.ca/sites/default/files/hrm1010_respectful_and_harassment_free_workplace_en.pdf).
- Workplace Conflict Management Human Resource Manual Directive 1018 available at [https://gov.nu.ca/sites/default/files/hrm1018\\_workplace\\_conflict\\_management\\_-\\_may\\_6\\_2016\\_2.pdf](https://gov.nu.ca/sites/default/files/hrm1018_workplace_conflict_management_-_may_6_2016_2.pdf).
- The Human Resource Manual is available online at: <https://gov.nu.ca/human-resources/information/human-resources-manual>.

- Code of Ethics for Registered Nurses (2017 edition) available at: [https://hl-prod-ca-oc-download.s3-ca-central-1.amazonaws.com/CNA/2f975e7e-4a40-45ca-863c-5ebf0a138d5e/UploadedImages/documents/Code\\_of\\_Ethics\\_2017\\_Edition\\_Secure\\_Interactive.pdf](https://hl-prod-ca-oc-download.s3-ca-central-1.amazonaws.com/CNA/2f975e7e-4a40-45ca-863c-5ebf0a138d5e/UploadedImages/documents/Code_of_Ethics_2017_Edition_Secure_Interactive.pdf)

No matter how large the building, health centres in Nunavut are small, intimate work environments. During the day, there may be anywhere from two to seven nurses working with one or two LPNs. There might be a Public Health Nurse, a Nurse Practitioner and/or a Paramedic. The home care nurse, if there is one, is often off-site. Support staff might include administrative staff, housekeeping, and caretaking.

Tensions between staff, whether professional or support staff, can negatively impact the health centre environment to the point of causing harm to clients.

“What constitutes unacceptable behaviour is somewhat subjective and exists on a continuum, from behaviours that may be distracting to some individuals but not others, to those that are more aggressive, deliberate, intentionally demeaning, psychologically harmful, or physically threatening. Left unaddressed, disruptive behaviour can have a significant and escalating negative impact on the workplace and patient care.” (Managing Disruptive Behaviour in the Healthcare Workplace - Provincial Framework, 2013).

**Disruptive behaviour** can be overt – yelling, uncontrolled anger, condescending language, using intimidation tactics, eye rolling, exaggerated sighing, glaring, etc. It can also be subtle – persistent lateness; repeated refusal to comply with accepted policies; chronic refusal to work collaboratively with colleagues, other staff, or clients; and failure to respond to call for assistance.

**Harassment** is a pattern of deliberate, persistent disrespectful behaviour targeting an individual that results in the recipient feeling intimidated, demeaned, humiliated, or embarrassed.

**Bullying** is usually psychological in nature and intended to undermine or humiliate a particular person or group, often in a situation where there is a power imbalance. (Managing Disruptive Behaviour in the Healthcare Workplace - Provincial Framework, 2013)

The Department of Human Resources (HR) has two ways of dealing with inappropriate behaviour.

The SHP should carefully review both to be aware of the differences between them and to be able to advise staff.

#### **Directive 1010:**

This directive emphasizes the need for respectful behaviour at all times to all people and under all circumstances.

The behaviour in question must meet certain criteria.

In brief:

- Abuse of power which endangers an employee’s job, undermines performance, threatens livelihood, or interferes with career or education opportunities.
- Harassment – unwanted conduct including through email or social media that is based on a violation of the Nunavut Human Rights Act.

- Personal harassment that has the purpose or effect of violating a person’s dignity and results in an intimidating, hostile, degrading, humiliating or offensive environment for the employee but is not a violation of the Human Rights Act.
- Sexual harassment.

The complaints process involves submitting the complaint with specific details, dates, times, witnesses etc., to the Deputy Minister. The complaint is reviewed by Employee Relations staff to ensure that the complaint meets the necessary criteria, and if validated, results in a third-party investigation and the respondent (person about whom the complaint is made) is notified. If the complaint is not substantiated, the respondent is not advised. The entire process is confidential.

There are two remedial processes outlined in the Directive – informal and formal.

**Directive 1018:**

The purpose of this directive is the minimization of workplace conflict.

The directive differs from 1010 in that the respondent does not intend harm and may not even be aware that there is conflict. An example would be a staff member who has difficulty managing their emotions in difficult situations or someone who complains constantly, bringing down staff morale.

The complaint should be reported to the SHP and can also be made to the Regional Manager of HR, an Employee Relations Consultant and/or a Nunavut Employee Union (NEU) representative. The complainant should make notes of the incidents with dates, times, locations and the name of the person about whom the complaint is being made.

The SHP assesses the situation and, in consultation with the complainant, takes immediate action to try to provide resolution. The SHP can request assistance from HR or ER. If both parties (complainant and respondent) agree, mediation may occur.

**SHP Responsibilities:**

The SHP responsibilities are similar for both directives:

- To promote and provide a work environment free of workplace harassment and/or conflict.
- To understand the directives and to be able to explain them to all staff.
- To take appropriate action as soon as possible to resolve complaints brought to their attention.
- To inform their Director when there is workplace conflict causing distress.
- To monitor situations where complaints have been substantiated to ensure that corrective measures have been successful.
- To ensure that there is no retaliation against persons involved in complaints.

It is important for the SHP to remember that a single act of inappropriate behaviour does not necessarily constitute disruptive behaviour. The context is important. Was the environment itself, stressful? Were there mitigating circumstances that might explain the behaviour? While it is very important that the SHP respond to the behaviour, it is equally important not to react emotionally.

What is not Disruptive Behaviour:

- Performance management when giving a staff member objective, constructive feedback in a respectful, fair, consistent, and accountable manner.
- Expressing an opinion about client safety or quality of care concerns or giving a colleague constructive feedback in a respectful manner.
- Advocating to influence decisions regarding clinical care, resource allocation, etc.

The key point to remember is that communication must be respectful at all times.

Strategies for coping with disruptive behaviour:

- Establish clear expectations for behaviour in the health centre – the same expectations for all staff. Role model the expected behaviour.
- Frame interpersonal behaviour as a performance expectation. This allows for continual reinforcement and becomes a performance improvement strategy rather than a disciplinary strategy.
- Confront disruptive behaviour when it is observed.
- Document disruptive behaviour when it occurs.
- Evaluate complaints when they are brought to the SHP's attention: Would a reasonable person find the behaviour objectionable or inappropriate? Was anyone harmed in the incident?

The regional Managers of Human Resources or the Manager of Human Resources in Iqaluit as well as the Employee Relations officer responsible for Health are available to answer questions and offer support.

## SECTION 9 CHN COMPETENCIES AND PERFORMANCE EVALUATIONS

### *Key Takeaways for this section:*

- All employees are required to have an annual performance evaluation (PE).
- Nothing in the PE should be a surprise to the employee.
- Spreading the completion of PEs over several months eases the burden on the SHP's time.
- PEs are confidential and their completion cannot be delegated.
- The disciplinary system is progressive.

### Policies that apply:

- 05-009-00 Transferred Functions
- 05-023-00 Treating Immediate Family Members
- 07-001-00 Community Health Nursing
- 07-002-00 Basic Nursing Procedures
- 07-003-00 Nursing Skills Certification
- 07-005-00 Immunisations
- 07-027-00 Certificate of Illness
- 07-029-00 Infant Telephone Triage and Infant Assessment
- 07-030-00 Pediatric and Adult Telephone Triage
- 07-031-00 CHN Expanded Role – Diagnosing, initiating lab and x-ray tests, and initiating treatment.
- 07-035-00 Escalation of Medical Care
- 07-039-00 Informed Refusal of Treatment

### 9.1 Appendix

- Nursing Competency Framework
- Performance Management Guidelines

### 9.2 CHN Competencies

CHNs in Nunavut practise in an expanded scope through medical directive. Policy 07-031-00 *CHN Expanded Role – Diagnosing, Initiating Lab and X-ray tests and Initiating Treatment* is explicit in regard to what a CHN can do. 05-009-00 *Transferred Functions* explains how the delegation of functions occurs.

It is important for the SHP to review and be knowledgeable about all of the policies in Section 7 of *The Community Health Nursing Standards, Policies, and Guidelines* manual. The manual is available in hard copy in all health centres but is often not kept up to date. An up-to-date copy is also available online at <https://www.gov.nu.ca/health/information/manuals-guidelines>.

The *Nunavut Nursing Competency Framework* provides indicators for the competencies necessary for nurses to practise safely and ethically in Nunavut. The framework is included in the appendices of this manual.

There are seven domains in the Framework:

- Professional Role, Responsibility and Accountability
- Cultural Safety
- Specialised Knowledge-based Practice
- Health Assessment and Analysis of Findings
- Therapeutic Management Evaluation
- Health Promotion and Protection and Illness and Injury Prevention
- Continuous Quality Improvement

Referring to this framework will assist the SHP in completing performance evaluations.

### 9.3 Performance Evaluations

GN employees are required to have a yearly performance evaluation (PE). While this traditionally occurs at the end of the fiscal year in March, PE can occur at any time. All PEs should be completed and submitted by the end of the fiscal year. When there are numerous employees to review, it might be wise for the SHP to plan on doing a number of evaluations per month rather than having to complete them all at once.

Prior to beginning PEs, it is recommended that the SHP read the *Performance Management Guidelines for Supervisors*. It is available in the Human Resources Manual at <https://gov.nu.ca/human-resources/information/human-resources-manual>. A copy is also available in the appendices. Particular attention should be paid to the scoring system.

Every new employee should have standards and objectives completed so that they know what they need to accomplish. The standard and objective setting process is described in the *Performance Management Guidelines*. Ensuring that new employees are evaluated relatively frequently during their first year of employment may help in resolving any performance issues that might arise.

If the SHP has concerns about the performance of any staff member (including casual and agency staff), the concern must first be discussed with the employee. The employee must be clearly informed of:

- Their inappropriate action or conduct.
- The expected standard of performance.
- Any corrective action they can take.
- A specific date on which their subsequent performance will be reviewed.

If correction does not occur, this can be brought forward in the PE.

The SHP should provide brief, concrete examples of performance in the comments. If the employee is scoring below or above 3, in particular, it is important to be able to justify the score.

PEs are completed for all staff as above.

Nurses have additional professional/regulatory standards that they are required to maintain. If the practice or conduct concern for any nurse, indeterminate, casual or agency is received as a complaint or has compromised client safety, the SHP must follow Policy 05-033-00 *Managing Nursing Professional Practice and Professional Conduct*. If the SHP is unsure of which route to follow, the Director or the Regional Manager HR can be consulted.



It may be impractical to complete performance evaluations for all casual nurses; however, when there are practice or conduct concerns and these have been addressed by the SHP, a PE should be completed, particularly if the concerns have not been resolved. The PE should be submitted to both regional Health HR and the Nursing Resource Program. The same applies for agency nurses.

Employees are often anxious about performance evaluations. Nothing on their evaluation, however, should be a surprise. If an individual's performance is being rated at less than 3 (average), the supervisor should have been communicating that the performance needed improvement prior to the evaluation.

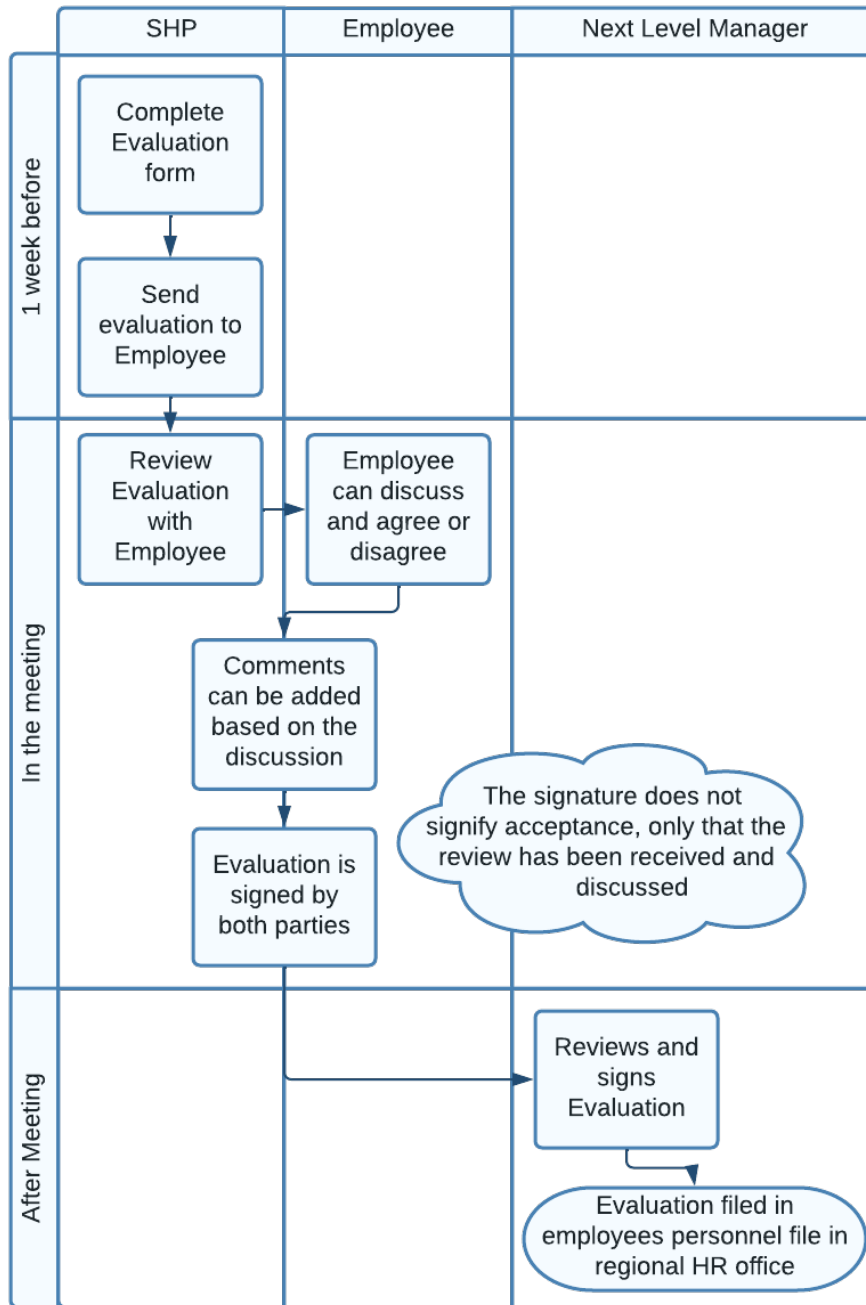
If there have been issues during the review period that have been satisfactorily resolved, these can be mentioned in the evaluation along with the resolution, but do not have to be included. These issues should not affect the score.

The SHP provides the evaluation to the employee one week prior to meeting with them. During the meeting, the evaluation is reviewed, and the employee is encouraged to comment or ask questions.

There are times when an employee disagrees with the evaluation. If that is the case, the employee has a space to make that comment and then signs the evaluation. The signature does not signify acceptance, only that the review has been received and discussed. The SHP should explain that signing the evaluation doesn't mean they've accepted it, only that they have discussed it. It can also help to encourage the employee to record their disagreement on the PE; this can help to diffuse tension. If the employee continues to refuse to sign the document, the supervisor indicates this on the form and advises the employee that the PE will be placed in their personnel file.

The PE is then sent to the next level manager for sign off and is eventually filed in the employee's personnel file in the regional HR office.

PERFORMANCE EVALUATION FLOWCHART



9.4 Disciplinary Process

The disciplinary process in the GN is progressive unless the misconduct is extremely serious (e.g., theft, physical assault, or serious insubordination).

Full review of the disciplinary process is available in the Human Resources Manual Section 8 [https://gov.nu.ca/sites/default/files/hrm801\\_employee\\_discipline\\_0.pdf](https://gov.nu.ca/sites/default/files/hrm801_employee_discipline_0.pdf).

Discipline or correction of any kind is only done in private, never in front of other staff, clients, or visitors to the health centre.

Discipline is a method of correcting a problem – it is not punishment. Discipline should only occur after the employee has an opportunity to present their version of events. This is done in a fact-finding meeting. The fact-finding meeting is conducted by Human Resources staff and the supervisor. Twenty-four (24) hours notice must be given, and the employee has the right to union representation. The employee may request postponement for a maximum of three (3) days while they arrange for a union representative.

The process of discipline/correction can be stressful for all parties involved. This should be seen as an opportunity to identify areas for improvement rather than a punitive system. The goal is to support every employee to be successful in their role.

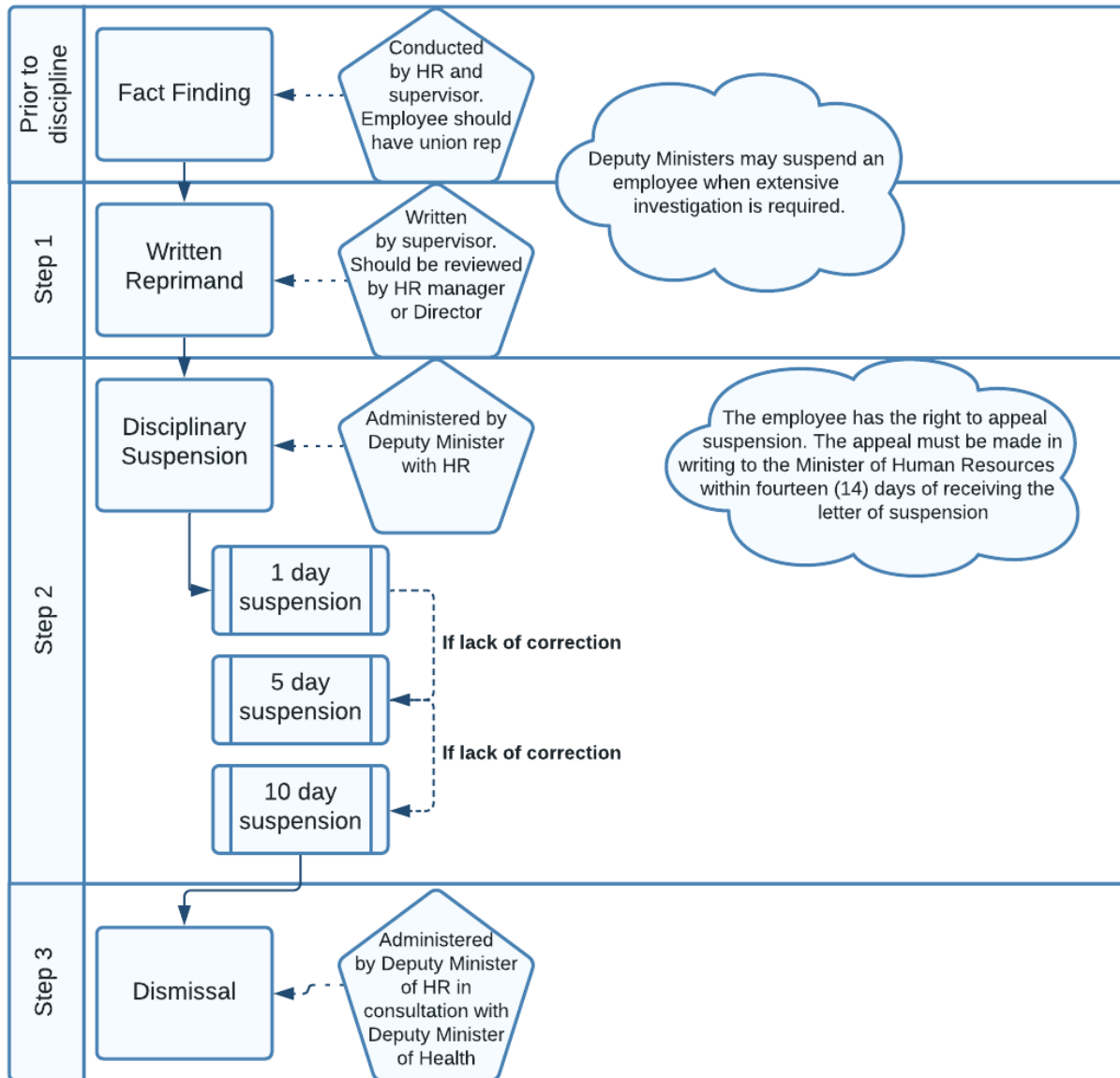
Deputy Ministers may suspend an employee when extensive investigation is required. The employee may not enter the work site and may not leave the community without permission during this time. The employee has the right to appeal this decision. The appeal must be made in writing to the Minister of Human Resources within fourteen (14) days of receiving the letter of suspension.

The steps involved in progressive discipline:

- **Step 1** – Written Reprimand by the immediate supervisor. This should be reviewed with the HR Manager, or Director.
- **Step 2** – Disciplinary Suspension – administered by the Deputy Minister in consultation with Employee Relations. Suspensions are applied progressively – 1 day, 5 days and 10 days. Each suspension is done for lack of correction. After a 10-day suspension, dismissal is considered.
- **Step 3** – Dismissal – Only the Deputy Minister of Human Resources in consultation with the Deputy Minister of Health has the authority to dismiss an employee. Employee Relations assists with this process, working with the Director and Human Resources to compose the letter to the Deputy Minister requesting dismissal.

For further details, please refer to Section 8 of the Human Resources Manual.

**DISCIPLINARY PROCESS FLOWCHART**



## SECTION 10 LONG TERM AND CONTINUING CARE CENTRES

There are three continuing care/long term care centres (CCC/LTC) in Nunavut – Cambridge Bay, Gjoa Haven and Igloolik. A fourth continuing care centre has been built in Rankin Inlet and will soon be accepting residents.

The Coordinator of Home and Continuing Care in Iqaluit is responsible for approvals for placement in CCC/LTC centres both in and outside of Nunavut.

Applications are usually made through the Supervisor of Home and Continuing Care in communities or the SHP.

CCC/LTC centres are managed by a nurse administrator who is usually a registered nurse but may also be a licensed practical nurse. It is staffed by LPNs and Continuing Care Workers (CCWs) who function as personal support workers.

CCC/LTC centres are homes, not hospitals. The elders are referred to as residents, not patients or clients. Staff support the independence and dignity of the residents, assist with personal care and meals, medication supervision, and provide leisure activities and outings.

The nurse manager and the LPNs monitor the health of residents in keeping with their scope of practice.

Some centres have access to a nurse practitioner who provides routine health maintenance and may be available during the day for acute presentations of illness.

### 10.1 SHP Role in CCC/LTC Centres

It is important for the SHP to maintain a collegial relationship with the Nurse Manager and staff at the CCC/LTC.

The residents are community members and have the same right to quality health care as all Nunavummiut.

If the health centre does not have a nurse practitioner, it is important for the SHP to arrange physician visits to the centre when the community physician is on site.

When a resident has an acute illness, the nurse manager and LPNs will contact the nurse on call for assistance. Neither the nurse manager nor the LPNs have authority to diagnose and treat. The SHP must ensure that the nurse on call presents to the CCC/LTC to examine the resident and facilitate treatment or referrals. The nurse on call should not provide telephone advice without examination.

The staff at the centre will make every effort to bring the resident to the health centre but it is important for the SHP to understand that this is not always possible, particularly in winter, when conditions might prove difficult for the resident to be outside. The safety and dignity of the residents are paramount.

Having a collegial relationship with the staff at the centre has many benefits. In times of emergency or short staffing, CCC/LTC staff will often help. Health centre staff are invited to special events and can develop relationships with residents.

## SECTION 11 SPECIALTY AND PHYSICIAN CLINICS AND DENTISTRY

### *Key Takeaways for this section:*

- Referrals must be reviewed prior to specialist visits to ensure all details are complete.

Policies that apply:

- 07-043-00 Nurse Practitioner Consultation Process

### 11.1 Appendix

- Dentist Prescribing in Nunavut
- Guidelines for assessment and treatment of dental emergencies
- NU Dental Emergency Form

### 11.2 Locum Physicians and Nurse Practitioners

Locum physicians provide services in all communities in Nunavut. Physician Services decides the number of days per year for each community. Generally speaking, the same physicians provide services to specific communities, although there may be some variation depending on availability. If there are situations where extra physician coverage might be needed, the SHP should advise the Director and contact Physician Services directly to resolve the issue. This usually happens if a physician has not been to the community for an extended period and there is a backlog of clients waiting to be seen.

It is the usual practice that community members see a CHN before being referred to the physician. This saves time for the physician in that the problem is known, and some diagnostic testing may be initiated prior to the physician visit. Sometimes the issue can be resolved by the CHN.

If a community member, however, insists on seeing the physician, there is no reason not to allow this.

Nurse Practitioners may also be contracted to come to communities that do not have this position filled indeterminately. The Director or SHP may initiate a casual contract for NP services. The NPs generally focus on clients with complex, chronic conditions.

CHNs must write a referral to the physician or NP as noted in Section 4.3.5. The SHP should review the referrals prior to the arrival of the physician to ensure that the referral is complete, and any diagnostic testing ordered is available.

In all three regions, referrals for the community physician are entered into Meditech and printed. The SHP usually keeps a binder for these referrals, or the SHP may use assigned wall slots. The most important thing to remember is that the SHP needs to have a system that keeps the referrals orderly and up to date so that no referral is lost. The advantage of using Meditech is that the physician may also view the referral before coming to the community and may request additional diagnostic testing for the

appointment. Whether the physician uses it or not is beside the point; the opportunity is there and can facilitate data collection on service demands.

Hallway consults are frequently used by CHNs when a physician and/or NP is on site. The SHP should actively discourage this except in urgent/emergent situations where a delay could result in harm to the client. Both client and physician/NP safety are risked when they are asked to make a diagnostic or treatment decision without the time needed to do a thorough chart review. Additionally, this is a potential locus for a breach of confidentiality.

The Front Desk staff are usually responsible for arranging appointments and notifying clients. In some communities, a specific clerk-interpreter may be assigned to the locum physician. Most physician appointments are 30 minutes; however, it is best for the SHP to contact the physician for their preference. Some physicians prefer an hour visit. Some physicians like variation depending on whether the visit is an initial one or a follow-up. During periods of surge (i.e., during bronchiolitis season) or short staffing, the locum physician should be scheduled to cover sick clinic walk-ins for a minimum of two hours each morning.

NPs may have a clerk-interpreter assigned or may arrange to book their own appointments. They usually require one-hour appointments.

The SHP should also work in collaboration with the physician/NP to arrange home visits for those Home and Community Care clients who cannot attend the clinic and for the residents of Continuing Care or Long-Term Care facilities.

### 11.3 Specialty Clinics

Health contracts visiting specialty services for each region.

**Qikiqtaaluk Region** – visiting specialists are arranged by Ottawa Health Services Network, Inc. (OHSNI) except for psychiatry which is organised through the Centre for Addictions and Mental Health (CAMH) in Toronto. The region receives a calendar of scheduled visits for the entire year. Most visits are in Iqaluit and community members travel there. Some clinics, e.g., Orthopedics and Cardiology may make occasional community specific visits.

Psychiatry visits are arranged twice yearly.

One to two months prior to the visiting specialist clinic, each health centre is advised which clients will be seen and travel is arranged.

Specialist referrals must be made by a physician or nurse practitioner. The provider may select either Ottawa or Iqaluit for the visit. The referrals are triaged by the staff at Qikiqtani General Hospital Specialist Clinic. If the referral is deemed urgent, OHSNI is contacted to book the appointment in Ottawa. Less urgent appointments are referred to the specialist travel clinics if they are arriving reasonably soon.

**Kitikmeot Region** – The specialists at Stanton Territorial Hospital provide specialist services to the Kitikmeot. The calendar is sent by mail and fax on a quarterly basis. Referrals in this region are not entered into Meditech but go directly to the specialists in Yellowknife. The referral is returned with an appointment in Yellowknife or a note to add to the travelling clinic.

The SHP keeps a binder or spreadsheet of referrals which need updating after each visit.

**Kivalliq Region** – Ongomiizwin Health Services, Indigenous Institute of Health and Healing, University of Manitoba, supplies specialists for the Kivalliq region. A calendar is faxed to health centres each month with the specialist clinics for communities and the dates of visits.

Referrals are entered in Meditech by physicians and nurse practitioners and are submitted to [kivalliqmedicalreferrals@gov.nu.ca](mailto:kivalliqmedicalreferrals@gov.nu.ca).

If the specialists are in Rankin Inlet, the Medical Secretary in Rankin Inlet coordinates appointments for clients coming from the communities depending on the urgency advised by the referring physician. If the referral is non-urgent, the referral may be deferred to the next visit.

### 11.4 Virtual Care

Telehealth has long been used to provide family visits for clients hospitalized in the southern provinces or in long-term care homes both in and outside of Nunavut as well as for specialist consultations with clients.

Due to the world-wide nursing shortage, exacerbated by the challenges created by COVID-19, the Department of Health has developed processes to provide remote solutions to continue to provide timely, quality healthcare to Nunavummiut.



Virtual care is delivered through the NU Virtual Care Network (telehealth). Each health facility in Nunavut has a Virtual Care Cart (telehealth unit).

Attendance to all appointments for virtual care is critical to the ongoing health and safety of Nunavummiut.



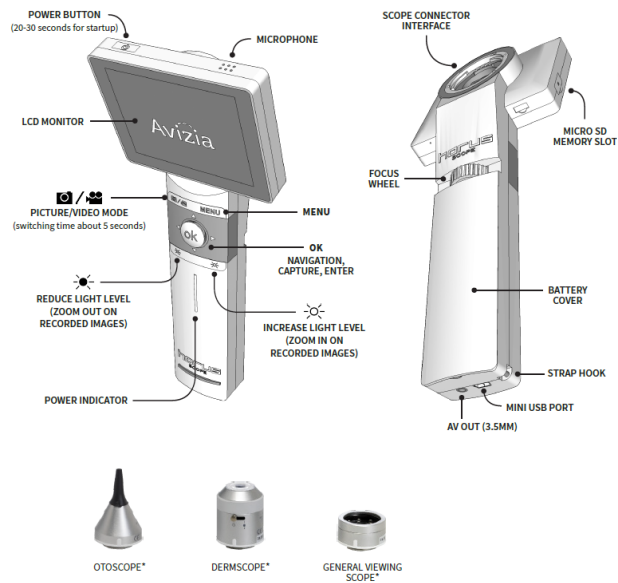


*Desktop Videoconferencing Unit*

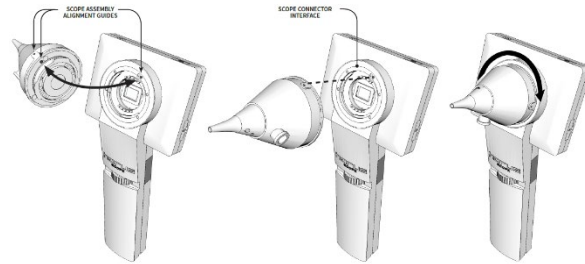
### 11.5 Horus Scopes

Besides the telehealth screen, Virtual Care Carts are equipped with Horus Scopes. These are precision photoelectronic instruments with otoscope, dermoscope and general viewing scopes. This allows the virtual provider to examine ears, nares, throat, skin or view any requested anatomy closely.

[JedMed Horus Scope User Guide HD](#) is a video link for operation of the JedMed Horus Scope.



*JedMed Horus scope interface*



### 11.5.1 Cleaning and Disinfection

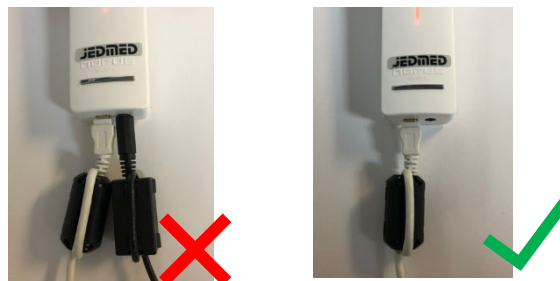
The Horus Scope is a precision photoelectronic instrument that should be handled with specific care. Please note the following cleaning instructions:

- Power off the Horus Scope before cleaning it.
- Disinfect the control unit and charger station with a soft cloth with alcohol. Wait for cleaning liquid to dissolve before powering on and connecting the charger station and USB cable to the control unit.
- It is recommended to clean the optical lens with cleaning cloth or lens cleaning tissue such as THORLAB Inc., ([www.thorlabs.com](http://www.thorlabs.com)) Lens Cleaning Tissue.
- Clean the contact plate before each use for a new patient:
- Disinfect the contact plate with soft cloth moistened with alcohol (70% ethyl alcohol).




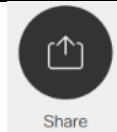
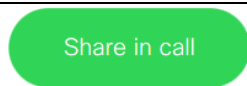
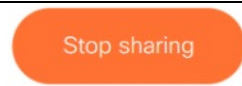
NOTE: The Horus Scope is not intended to be sterilized.

### 11.5.2 Charge device

Make sure device is charged before appointment by connecting USB cable to the connector on the bottom of the device. You can not use device for Telehealth and charge it at the same time.



### 11.5.3 Using JedMed during Virtual Care appointment

1.		Power on JedMed.
2.		Connect black end of cable to bottom of the device.
3.		Connect yellow end of the cable to Telehealth cart.
4.		While you are connected to appointment, press Share button.
5.		Press Share in call.  Use focus wheel to focus the image.  Optionally press OK button to freeze the image.
6.		When no longer needed, press Stop sharing button. Power down device when done.

### 11.6 Virtual Care Programs

There are two virtual Nurse Practitioner programs used by the Department of Health to deliver services remotely to health centres as well as specialist and interdisciplinary clinics provided through telehealth.

### 11.7 vNP Chronic Disease Management

The Virtual Nurse Practitioner (vNP) Chronic Disease Management (CDM) program began as a pilot with three participating communities. It is now comprised of approximately nine communities but Health hopes to expand this program across the territory in the coming years and will be adding four (4) communities at the beginning of 2023.

As the program develops, this section will be updated.

A nurse practitioner is engaged by the program manager for the participating community. The SHP and CHNs work with the vNP to roster the clients who will participate and coordinate the schedules. The vNP provides availability and books appointments through the Virtual Care Team via an email to [gn.telehealth@gov.nu.ca](mailto:gn.telehealth@gov.nu.ca).

The Virtual Care Team enters the appointments into the iScheduler at least one week in advance of the appointments. Each health centre has at least one staff member who has access to the iScheduler. The iScheduler should be reviewed, at minimum, on a weekly basis. Daily review is best practice.

The administrative staff in the health centre contact the clients in a timely manner to advise them of their appointment. The admin staff should ask the client if they are free to attend and advise the Virtual Care Team and vNP if they are not free. The appointment can then be rebooked.

vNP appointments are booked over one morning or afternoon during the week and 4 to 6 clients are seen. An LPN attends the appointment with the client to perform any needed examination and actions any in-community orders. The LPN is trained to complete examinations by successfully completing modules developed by the Office of the Chief Nursing Officer.

The telehealth machine comes on automatically at the time of the appointment and disconnects when it is done.

### 11.8 Virtual Specialist and Interdisciplinary Clinics

When referrals are sent to specialists, dietitians, physiotherapists, etc., the individuals to whom the referrals are sent, have the option of providing care through telehealth. These appointments are all made through the GN telehealth. This is a helpful service in that it requires no travel on the part of clients.

The telehealth appointments are entered into the iScheduler. The Virtual Care Team sends notifications of these appointments to the health centre. The iScheduler is checked daily to ensure that clients are notified in a timely manner and that all information or diagnostic tests required are obtained prior to the appointment.

Appointments may be for pre-operative assessments, follow-up surgical or obstetric appointments, cardiology and neurology consultations, rehabilitation assessments and consultations, dietitian clinics, Mental Health clinics, etc.

### 11.9 Emergency and Closure Supports

Due to an ongoing challenge in acquiring the necessary staff to keep health centres open, there are times, particularly during holiday seasons, when health centres need to suspend services for periods of time.

During these times, the health centres are predominantly operated by Advanced Care Paramedics (ACP). vNPs and vMDs help provide client care and support the providers present during the suspension period.

This program is managed by the Closure Logistics Team.

Every health centre in Nunavut now has a Virtual Room available on their Virtual Care Cart.

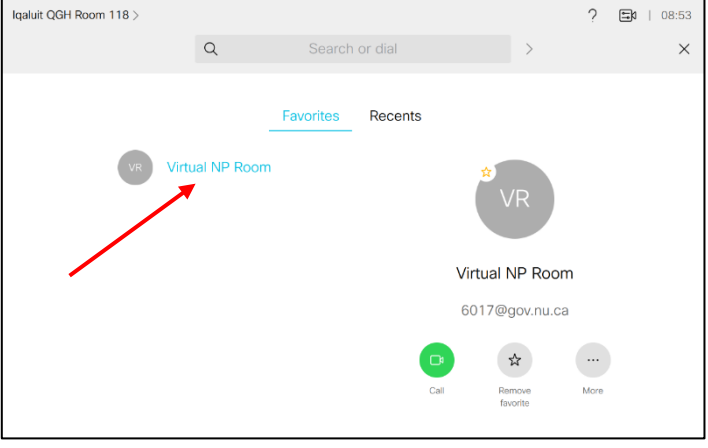
This is the room used for access to vNPs and vMDs during suspension of services and can be used for ad hoc situations when a SHP has questions, and the Virtual Care Team has an available vNP or vMD.

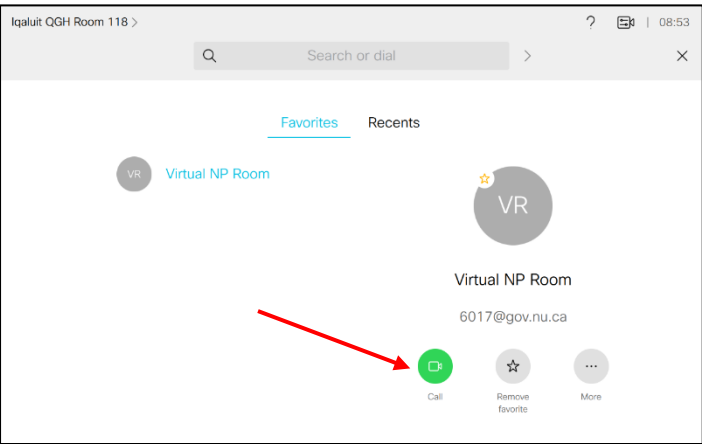
The Virtual Room can also be used when an on-call physician or specialist would like to see or virtually examine a client in the ER.

Ad hoc sessions may not interfere with scheduled telehealth sessions. For greater clarity, scheduled appointments for clients with chronic disease and the vNP or scheduled appointments with a vMD or vNP during closures take priority.

The health centre HCP must coordinate with the vNP or vMD prior to entering the virtual room to notify them that the HCP will be joining. After the consultation is completed, the HCP will manually disconnect.

### How To Connect:

1.	 A screenshot of a mobile application interface titled "Iqaluit QGH Room 118". The screen displays five circular icons: a green "Call" icon with a white telephone handset, a blue "Share" icon with a white document and arrows, an orange "Meetings" icon with a white calendar, a grey "System Controls" icon with a white power button, and a purple "Camera Control" icon with a white camera lens. A red arrow points from the left edge of the screen to the "Call" icon. The top right corner shows a question mark, a signal strength icon, and the time "08:49". The bottom right corner features the "elehealth" logo.	On the touch screen, click the green "Call" button
2.	 A screenshot of a mobile application interface titled "Iqaluit QGH Room 118". At the top is a search bar labeled "Search or dial". Below it are two tabs: "Favorites" (selected) and "Recents". Under "Favorites", there is a contact entry for "Virtual NP Room" with a grey circular icon containing "VR". A red arrow points from the left edge of the screen to this contact. To the right, a larger view of the "Virtual NP Room" contact is shown, including a grey circular icon with "VR", the name "Virtual NP Room", and the email address "6017@gov.nu.ca". At the bottom, there are three icons: a green "Call" icon, a grey "Remove favorite" icon with a star, and a grey "More" icon with three dots.	

3.		Click the green “Call” button
<p>Finished! That’s it! You should connect into the room. You will see the virtual nurse practitioner when they also enter the virtual room.</p> <p>Remember to end the call when you are done meeting with the virtual nurse practitioner.</p>		

### 11.10 Planning the Clinic

Once confirmed, the dates for upcoming community visits by the dentist and the Eye Clinic should be advertised in the community. Each community will have their own way of doing this – posters, radio or Facebook Community page notices are all acceptable. Specialist clinics are not advertised because the appointment list is completed before their arrival.

#### 11.10.1 Before the Clinic

The SHP or delegate compiles and reviews all the referral forms for the visiting specialist, verifying that the information on the consult is complete, that any diagnostic testing ordered has been completed and that the results are available in the health record.

The SHP assigns a team member to the clinic.

The staff member assigned to the clinic will vary from health centre to health centre depending on capacity. A clerk may be assigned for scheduling and notifying clients, or it may be an LPN. The LPN may also assist the specialist with the clinic. It might also be a CHN.

A master list is given to the staff member who then schedules the appointments and notifies the clients in advance of their appointment time. The master list is compiled by the SHP, and advice should be given to the team member in terms of making cohorts of clients and planning for possible no-shows etc. Once the appointment schedule is finalised, a copy is faxed to the specialist. This allows the specialist to review the clinic prior to arrival in the community.

Identify the clinic room that will be used by the visiting specialist. If the specialist is bringing a resident, two rooms will be required so that they may see clients simultaneously. Bringing a resident requires prior approval and may be contingent on available clinic space and accommodation.

### 11.10.2 Special Consideration

Male specialists seeing female clients for pelvic exams require a female chaperone. Similarly, female physicians performing rectal or genital exams on male clients should have a chaperone. A staff member should also be assigned to the specialist to assist with vital signs, heights, and weights, and point of care testing if necessary. The staff member may be a CHN, an LPN or an unregulated healthcare worker who has been successfully trained in performing these functions.

Each specialty clinic may have different requirements. These requirements may change over time. Rather than listing what each specialty may require in the manual, it is best for the SHP to review with each specialist what they may require prior to arrival. For example, there is a Gynie Box in the Kitikmeot region that holds all the supplies the gynecology team requires. The SHP should review the contents with the team to ensure that all items are still required, and no added items are needed.

### 11.11 Post Clinic Responsibilities

The SHP or delegate reviews all health records for clients seen by either the community physician or a visiting specialist once the appointment is completed.

In the **Qikiqtaaluk region**, documentation and orders are generally entered into Meditech. The SHPs in those regions review the Meditech notes and process any orders that might be there – prescriptions, orders for future labs, diagnostic imaging etc. If the physicians want the lab work or diagnostic imaging done on the same day, they can enter those orders into Meditech themselves. Consults for specialists are also entered into Meditech.

Specialist visits in the **Qikiqtaaluk** region usually take place in either Iqaluit or in Ottawa.

If the appointment is in Iqaluit, orders may be entered into Meditech during the visit if any testing is required on the same day. If the orders are for future work to be completed, the order is written on the specialist report. The SHP has access to both electronic and paper copies for review.

If the appointment is in Ottawa, orders for testing are completed on the day of the appointment or are coordinated with OHSNI. OHSNI would provide the details in the discharge report that is sent to the community.

In the **Kivalliq** region, all referrals, including urgent referrals are sent to [kivalliqmedicalreferrals@gov.nu.ca](mailto:kivalliqmedicalreferrals@gov.nu.ca).

Specialists in the **Kivalliq** dictate their notes and a printed copy is faxed to the health centre. The SHP or delegate is responsible to ensure that notes are reviewed, and orders are completed.

In the **Kitikmeot region**, this process remains primarily paper based. The SHP reviews all charts and processes any orders. Consults are faxed to the specialty clinic in Yellowknife.

If referrals are kept in a paper binder, these referrals must also be updated or removed once the appointment is complete. The original referral is kept in the client chart.



## 11.12 Dentistry

Each region contracts dental services through the Request for Proposals (RFP) process. The contracts are usually awarded for a period of five years with options to renew.

Dentistry in Canada is a non-insured service. This means that it is not paid for through government health plans. Non-Insured Health Benefits (NIHB) funds dental services for all indigenous clients in the territory unless they have employee benefits. Services supplied are general care such as cleaning, fillings, and extractions. Simple endodontist services may be supplied in the community if the dentist has been trained. More complex endodontist services require prior approval from Health Canada.

The dentistry contractor provides a schedule of visits to the dental coordinator in each region. The number of visits is mandated by the contract. If the SHP has concerns about the frequency of visits, complaints or the quality of treatment provided, they can be brought to the Regional Dental Coordinator who will then refer them to the Territorial Dental Officer if necessary.

The dentists provide treatment to clients and submit referrals to the Dental Coordinator for treatment that cannot be done in the community. The Dental Coordinator submits the referrals to Health Canada for approval. If the request is approved, the client is funded to travel to the referred dentist. If the request is not approved, the referring dentist may have to resubmit the referral. When the referral is approved, the Dental Coordinator advises the local Medical Travel Clerk who then follows the same process as for any other appointment.

In the **Kivalliq region**, all dental referrals are submitted to [kivalliqmedicalreferrals@gov.nu.ca](mailto:kivalliqmedicalreferrals@gov.nu.ca).

There are times when SHPs hope to add an appointment when the client is going out of territory for a dental appointment. This cannot be done without the approval of Health Canada. The SHP must submit the request to the Dental Coordinator who will then contact Health Canada. Approval is not guaranteed.

The dental contractor is mandated to provide oral surgery services once or twice a year. These services are for difficult extractions that cannot be done without sedation. The only sedation permitted is conscious sedation. If the oral surgery trip cannot be scheduled in a timely way, those clients are sent OOT.

Children between the ages of three and twelve who do not have any underlying health issues are sent to Churchill from both the **Kivalliq** and **Kitikmeot** regions and to Iqaluit from the **Qikiqtaaluk**. The **Kitikmeot** and sometimes, the **Kivalliq** trips are charters and the child and accompanying parent must remain in Churchill for about a week.

**Children under the age of three** require sedation and are sent for individual appointments to Iqaluit, Winnipeg, or Edmonton.

All children and adults considered high risk due to medical history are sent for individual appointments to Iqaluit, Winnipeg, or Edmonton.

CHNs may submit emergency referrals to the Dental Coordinator if there is no dentist in the community and the need is acute and significant. The Dental Coordinator follows the same process as with other referrals but may receive the approval sooner than usual. Sometimes, travel may be approved to

another community in the region if the dentist is on site. Sometimes, a request may be made to treat the client with antibiotics and to resubmit once the treatment is completed. Please see Guidelines For Assessment And Treatment of Dental Emergencies and the NU Dental Emergency Form in the appendices for more information.

Clients who arrange their own dental appointments without approval from Health Canada are responsible for the associated costs.

Please see *Prescribing and Dispensing Drugs for Dentists in Nunavut* in the appendices for more information.

### **GN Employees**

Indeterminate GN employees and casual employees with continuous service of greater than six months are provided with dental benefits. These are described in both the HR manual Section 1606 and the NEU Collective Agreement Section 37.04. GN employees are responsible for costs if the dentist requires payment up front before submitting a claim to the third-party insurance company. It is advisable for the employee to be aware of this when booking appointments.

Travel for dental care is not provided for GN employees. They may access the community dentist and may arrange dental care if they are out of territory on approved medical travel. If they extend their visit to accommodate a dental appointment, they must pay any extra costs themselves. This may include paying for an extra night in accommodation or using annual leave to accommodate a dental appointment. For further information please see the Medical Travel Guidelines for GN Employees included in the appendices.

Emergency dental care for GN employees is covered when approved by the Territorial Dental Coordinator in Iqaluit. The request for emergency care is sent to the Regional Dental Coordinator who forwards it to Iqaluit. The Territorial Coordinator returns the approval (or non-approval) to the Regional Coordinator who forwards it to the local health centre Medical Travel Clerk. The employee is expected to make their own dental appointment. As per Medical Travel policy, (see <https://gov.nu.ca/health/information/legislation-and-policy-0> ), the travel is only to the nearest point where service can be provided.

Children of Inuit GN employees have the same access to dental care through NIHB as children of non-GN employees, however, their parents cannot claim GN benefits when they escort them, apart from the benefits provided for everyone.

## SECTION 12 COMMUNICABLE DISEASE, IMMUNISATION AND SCHOOL IMMUNISATION PROGRAMS

### *Key Takeaways for this section:*

- All providers administering vaccines must have current Nunavut certification.
- The Regional Communicable Disease Coordinator is a valuable Public Health Resource.
- Planning an effective preschool clinic is a team effort.
- Vaccines must be unpacked and stored in the vaccine fridge immediately on receipt.

### Policies that apply:

- 07-004-00 Chief Medical Officer of Health
- 07-005-00 Nunavut Immunisation Certification
- 07-028-00 LPN Medical Directive: TB Program
- 07-032-00 Testing, diagnosing, and treating syphilis infections for public health nurses and community health nurses
- 07-033-00 COVID-19 Nursing Assessment and Advice Protocol
- 07-034-00 COVID-19 Laboratory Testing Authority
- 07-040-00 COVID-19 Allied Health Provider Notification of Results
- 07-042-00 Establishing the Plan of Care for High-Risk COVID-19 Patients
- Medical Directive: Testing, Diagnosing and Treating *Chlamydia Trachomatis* and *Neisseria Gonorrhoea* Infections for Public Health Nurses

All manuals listed below, and the Community Health Nursing Standards and Policy Manual are available online at: <https://www.gov.nu.ca/health/information/manuals-guidelines>.

- Communicable Disease Manual
- Nunavut TB Manual 2018
- Immunisation Protocol for Pfizer-BioNTech COVID-19 Vaccine
- Moderna SPIKEVAX Protocol
- IMVAMUNE Protocol
- Immunisation Manual
- Nunavut Influenza Immunisation Protocol
- Nunavut Synagis Protocol (distributed every fall)

### 12.1 Appendix

- Reporting Diseases Poster Nunavut 2020

### 12.2 General Information

Nunavut's new Public Health Act became law on January 7, 2020.

The Act is available at <https://www.nunavutlegislation.ca/en/consolidated-law/public-health-act-consolidation>.

The Chief Medical Officer of Health (CMOH) is the former title given to the Chief Public Health Officer (CPHO) which is the new title.

The Public Health Act provides the authority for many of the mandates followed by the Environmental Health Officers in the territory.

**art 2** of the Act gives the CPHO the authority to establish programs for health and wellness promotion and for an immunisation program.

**Part 3** provides authority for programs for public health surveillance and the ongoing measurement of the health of Nunavummiut and of determinants of health. Part 3 also lists the duty to report for health care professionals.

**Part 5** discusses Public Health Emergencies.

Reportable Diseases are outlined in Schedules 1 and 2 are included in the appendix. Also see *Reporting Diseases, Events, and Conditions* and *Reportable Diseases January 2020* located in the appendices for more information.

### 12.3 Regional Communicable Disease Coordinator

Each region has a Regional Communicable Disease Coordinator (RCDC) who is the person who serves as a facilitator between the Communicable Disease Subject Matter Experts in Iqaluit and the health centres in the region. The **Qikiqtaaluk** region has two RCDCs based in Iqaluit. The **Kivalliq** RCDC is based in Rankin Inlet. The **Kitikmeot** RCDC is based in Cambridge Bay.

RCDCs are not frontline workers and do not provide direct client care under any circumstances.

All diseases and conditions requiring mandatory reporting must be reported to the RCDCs in the time required.

RCDCs are valuable resources. They work with SHPs regarding immunisations and vaccines, the school immunisation programs as well as the specialised programs such as Synagis and the yearly Influenza vaccine program, reportable communicable diseases, particularly Tuberculosis, and, currently, COVID-19. RCDCs also advise on the diagnosis and treatment of invasive reportable diseases and Syphilis. They collect information and track compliance for treatment of sexually transmitted infections. They are available to answer any questions regarding immunisations and catch-up schedules, any concerns or confusion about lab results related to communicable disease, questions about sexual health programming, vaccine fridge excursions, cold chain breaks, and advice regarding pre and post exposure prophylaxis for diseases such as rabies, meningitis etc. They also help with the extensive contact tracing, diagnosis, and treatment of tuberculosis.

### 12.4 Immunisation Certification for Healthcare Provider Staff

All immunisation providers must be certified to give publicly funded vaccinations in Nunavut. Immunisation certification consists of the successful completion of an online exam and an immunisation skills checklist. The online exam includes a review of 6 education modules and a 75- question multiple choice exam. The passing grade for the exam is 80% and exam writers will have 3 chances to

successfully achieve a passing grade. A certificate is then emailed to the immunisation provider. Recertification occurs every 3 years.

It is the responsibility of the SHP to maintain a file of copies of the immunisation certificates for staff providing immunisations and to ensure that recertification occurs in a timely way.

Policy 07-005-00 *Nunavut Immunisation Certification* provides the list of specific immunisations that each category of healthcare provider is authorised to give.

The Nunavut Immunisation Certification Course and Examination are available at <https://governmentofnunavut.thinkific.com/courses/immunization-certification>.

## 12.5 School Programs

### 12.5.1 Pre-school Screening Program

The pre-school screening program is traditionally held in May of each year, prior to the end of the school year, however, it can be held at any time before kindergarten starts.

Prior to the inception of the *Access to Information and Protection of Privacy Act*, elementary school principals requested information from the health centre regarding the children attending this screening program. This is no longer permissible. It would be considered a breach of confidentiality. The principals can post notices in the community for children of the required ages to present to the school for registration, as they do in more southern jurisdictions.

The names of children eligible for the pre-school clinic are drawn from the immunisation lists.

Once the list is compiled, organising the clinic may be tasked to the Public Health Nurse if there is one in the community. Otherwise, the SHP may enlist the aid of the CHNs and Community Health Representatives (CHRs).

Consents for immunisation and examination must be signed by parents or guardians prior to or while attending the clinic. Consent forms for TB screening are available in Section 3.2 of the Immunisation Manual.

The SHP may purchase items for 'goody bags' and treats for the children. These are usually handed out at the end of the clinic. Historically, the SHP or CHRs might canvas local stores for donations, however, this is no longer acceptable. An LCA can be used instead. The clinic is usually decorated, and stations are assigned for all of the activities.

The stations involved are height and weight measurement, vision, and hearing screening (if applicable), developmental screening, physical exam and, finally, the vaccination and TB screening. CHRs can be tasked with height and weight measurement and vision screening, but unless they have been trained to use an audiometer, the hearing screen should be assigned to a CHN who has the training. If no staff in the health centre have been trained to use an audiometer or if there is no audiometer, hearing screening may be deferred. Similarly, developmental screening using the **Nipissing** Developmental Tool should only be done by a trained healthcare provider.

The Infant and Child Health Program Standards and Protocol are found in the *Community Health Nursing Program Standards and Protocols Manual*. These outline the minimum standards of practice for the preschool examination. The necessary documentation can be found in this section as well.

### 12.5.2 Fall School Programs

The SHP and/or Public Health Nurse should meet with the principal of the local schools as early as possible in the school year to start planning for the school-based immunisation programs.

**School Screening for TB:** School screening for Tuberculosis infection is used to gauge the rate of infection in the communities. Screening is conducted as per the Nunavut Tuberculosis Manual 2018, Section 12, which also outlines the preschool screening.

The Manual is available in hard copy in each health centre and online at <https://www.gov.nu.ca/sites/default/files/nunavut-tuberculosis-manual-2018.pdf>.

School screening for TB occurs in September of each year.

**HPV, Varicella, and Tdap Administration:** Review Section 8 of the *Immunisation Manual* in hard copy in the health centre or at [https://www.gov.nu.ca/sites/default/files/8.0\\_setting\\_up\\_clinics\\_-\\_april\\_20\\_2018.pdf](https://www.gov.nu.ca/sites/default/files/8.0_setting_up_clinics_-_april_20_2018.pdf).

These immunisations are given to Grade 6 students. **Human Papilloma Virus vaccine** is given in two doses, six months apart and should be started in September to ensure that both doses are given prior to the end of the school year. **Tetanus, Diphtheria, Acellular Pertussis (Tdap)** is given in one dose. If the child has not received the 4-6-year-old polio booster, the polio vaccine should also be given. One dose of **Varicella** vaccine is indicated for all children in Grade 6 who have only had one dose of varicella containing vaccine previously.

**Men-C-ACYW Vaccine:** Meningococcal vaccine is administered to all Grade 9 students.

### 12.6 Synagis Program

The Synagis (Palivizumab) Program is indicated for infants at high risk for serious morbidity and mortality secondary to Respiratory Syncytial Virus (RSV). Eligibility is outlined in the *Synagis Protocol Manual 2021-2022*. This manual is available at <https://www.gov.nu.ca/health/information/manuals-guidelines>.

Candidates for the Synagis program must be registered and approved prior to receiving the vaccine.

If there are any questions, the SHP should contact the RCDC.

### 12.7 Influenza Immunisation Campaign

Every fall, the Influenza (Flu) Campaign start date is announced by the CPHO. Prior to this time, the RCDC works with the SHPs and the regional pharmacy technician or in the case of the **Qikiqtaaluk**, the pharmacy at the Qikiqtani General Hospital to estimate the amounts of vaccine necessary for each community. The vaccine is shipped by air and must be tracked and unpacked as soon as it is received. Any break in the cold chain must be reported immediately to both the RCDC and the regional pharmacy technician. SHPs in the **Qikiqtaaluk** would report directly to the pharmacy at the hospital.

Once flu vaccine is available, it should be offered to every community member at every visit. As well, if possible, operationally, the SHP may want to offer vaccine clinics at work sites or at the schools.

Section 8 of the *Immunisation Manual* offers guidelines for the necessary logistics and equipment for setting up an off-site clinic.

Consent forms need to be signed and documentation needs to be completed for each immunisation given.

## 12.8 Pandemic Response

At the time of writing of this manual, the world is in the process of recovering from a pandemic. Like every other province and territory in the country, Nunavut was under Public Health orders. Policies and protocols to govern nursing activities regarding COVID-19 were developed. The CPHO was the lead for the response and the RCDCs and educators were key in ensuring that the community health centres continued to operate safely.

While Public Health Orders are no longer in place, health centres have a greater awareness of being vigilant for the threats posed by communicable disease outbreaks.

This is not the first time that Nunavut has been involved in preparation for a possible pandemic. Previously, health centres prepared for Ebola when there was a large outbreak in Africa with transmission occurring in a few cities in the US and Canada. H1N1 is another example of pandemic preparation. During that time, Health provided mass vaccination clinics throughout the territory.

## 12.9 Vaccine Associated Adverse Event

Section 3.5 in the *Immunisation Manual* discusses vaccine-associated adverse events including definition, criteria for diagnosis and reporting criteria. It also contains the necessary form for report – *Report of Adverse Events following Immunisation (AEFI)*. **All incidence of adverse events must be reported to the RCDC.**

**Reporting Adverse Events** is discussed in the *Immunisation Manual* in Section 3.5.1 available at [https://www.gov.nu.ca/sites/default/files/3.0\\_practice\\_guidelines\\_complete\\_may2020.pdf](https://www.gov.nu.ca/sites/default/files/3.0_practice_guidelines_complete_may2020.pdf).

**Report of Adverse Events Following Immunisation (AEFI) is found subsequent to this section following Page 6.**

**Any errors in vaccine administration, regardless of adverse events, must be reported in an incident report submitted in the MEDITECH QRM Module.**

## SECTION 13 PERSONAL HEALTH INFORMATION, RELEASE OF INFORMATION AND ATIPP

### *Key Takeaways for this section:*

- Confidentiality is fundamental to open and trusting client-healthcare provider relationships.
- Staff members may only access client health records for those clients in their care.
- The ATIPP Coordinator must be consulted prior to releasing personal health information to a third party.

### Policies that apply:

- 05-027-00 Contacting Clients Through Local Radio
- 06-001-00 Confidentiality
- 06-002-00 Transmission of Health Information by Facsimile
- 06-003-00 Release of Information
- 06-004-00 Intra-Departmental Release of Information
- 06-005-00 RCMP Investigations
- 06-008-00 Documentation Standards

### 13.1 Confidentiality

Confidentiality is a fundamental aspect of healthcare delivery. Clients share the most personal and private information with health professionals. Unless there is complete trust in the absolute confidentiality of the information that is divulged, the client may withhold vital details that affect their health.

The protection of personal health information is legislated in the Access to Information and Protection of Privacy Act. The act and regulations are available at <https://www.gov.nu.ca/eia/access-information-and-protection-privacy-atipp-act>.

Personal information is defined as:

- Name, home or business address, phone number.
- Race, colour, national or ethnic origin, religious or political beliefs or associations.
- Age, sex, sexual orientation, marital status, or family status.
- Any identifying number, symbol or other particular assigned to an individual.
- An individual's fingerprints, blood type or inheritable characteristics.
- Information about an individual's health and health care history including physical and mental disability.
- Information about educational, financial, criminal or employment history.
- Anyone else's opinion about an individual.
- An individual's personal opinions except where they are about someone else.



All members of the healthcare team play a part in maintaining confidentiality of personal health information.

Conversations in which the care of a client is discussed should not take place in areas where they can be overheard by other clients or staff members. Any documents containing any of the above-listed information must be maintained securely so that confidentiality is not breached.

Computer monitors must not be left open when the healthcare provider is out of the room and must never be in full view of clients.

No staff member, including CHNs, are permitted to look at paper or electronic charts for clients for whom they are not responsible.

The overtime log should be secured when not in use and must not leave the health centre under any circumstances.

Morning report is another scenario at substantial risk for breaching confidentiality. It is important that the SHP is aware of and compliant with the Morning Report policy which is included in the appendices.

The SHP must ensure that all new employees and any students have signed the *Oath of Confidentiality* and are aware of its importance.

***Any suspected breach of confidentiality must be reported to both the Director, Health Programs and the ATIPP (Access To Information and Protection of Privacy Act) Coordinator in Iqaluit.***

The ATIPP Coordinator will then decide whether further information or action is required and whether the matter must be submitted to the Information and Privacy Commissioner.

## 13.2 Release of Information

A release of information signed by the client must be on file before information about the client can be given to anyone outside of the healthcare team. This does not apply to referrals to other healthcare professionals.

There will be times when clients want a copy of their own records. This is their right; however, they must sign a Release of Information. Although the information is theirs, the record itself is not.

If a client requests a copy of their records, the SHP or delegate must contact the regional Manager of Health Records for release of records from Meditech. The SHP should also strongly encourage the client to review the record with a healthcare provider to explain unfamiliar processes and answer questions.

It might also be prudent for the SHP to intermittently remind all healthcare providers, including physicians, of the requirements outlined in Policy 06-008-00 *Documentation Standards*. HCPs should not document anything in the client record that they would not want to be read in a court of law.

Information may not be provided to family members except with express consent from the client, even during emergencies. Written consent or documented verbal consent to share information with family

members can be obtained from clients at any time and is particularly important when a client's health may be deteriorating.

If a request for information is provided by a third party, such as a lawyer or insurance company, the request must first be submitted to the ATIPP Coordinator in Iqaluit, who will then advise what may be released.

If a request for information is presented by the RCMP, client consent must be obtained unless the RCMP also submit a search warrant, subpoena, or order for production requesting specific client information. The ATIPP Coordinator must still be consulted prior to releasing any information.

### 13.3 ATIPP

The Access to Information and Protection of Privacy Act (ATIPP) exists to make public bodies, including Health, more accountable to the public and to protect personal privacy by:

- Giving the public a right of access to records held by public bodies.
- Giving individuals a right of access to, and a right to request correction of personal information about themselves held by public bodies.
- Specifying limited exceptions to the rights of access.
- Preventing the unauthorised collection, use or disclosure of personal information by public bodies.
- Providing for an independent review of decisions made under this act.

Under ATIPP legislation, anyone may request government documents including emails. The request must be written and specific in terms of the information requested. It is submitted to the ATIPP office in Iqaluit.

If the SHP has any concerns regarding releasing information to clients or third parties, they must contact the ATIPP Coordinator in Iqaluit.

'Atipping' emails is a frequent practice for those seeking information. It is incumbent on SHPs to ensure that both they and their staff are aware and maintain a neutral and respectful tone in emails. Emails should not be a vehicle for expressing frustration or anger and should never include personal and unvalidated opinions about others. It is also important to be mindful that using upper script (CAPITALS) is considered to be an expression of anger and should never be used in emails.

## SECTION 14 POPULATION HEALTH PROGRAMS

### *Key Takeaways for this section:*

- Director approval is necessary for after hours population health clinics.
- Monitoring the status of population health programming is a key SHP responsibility.
- LPNs can be utilised in booking appointments, arranging follow-up, and updating public health program spreadsheets.
- Written handover of public health program updates is required when the nurse leaves the community.

Policies that apply:

- 02-002-00 Core Community Health Nursing Programs

The population health programs are: Prenatal, Well Child, Well Woman, Well Man, Communicable Disease/TB, and Chronic Disease. The SHP assigns each of these programs to a nurse. If there is a Public Health Nurse in the community, they are usually assigned the Well Child/ School Immunisation Programs. If the programs are small enough, they may also be responsible for Communicable Disease/TB. In smaller communities, each nurse may have more than one program. Every CHN is also given a number of Chronic Disease clients to follow. The SHP may also have a program. In some health centres, the programs are assigned to rooms or given colours and the colour or room assigned to the nurse. Any system can be used as long as the SHP understands who is responsible for the program and ensures that the program work is being done. The SHP must also ensure fair distribution of programs so that no one is overburdened.

Programs are administered by the CHNS or Public Health Nurse but the clients in each program are seen by all of the healthcare providers.

LPNs can assist in monitoring and updating public health program tracking spreadsheets.

The standards for each program are available in the *Community Health Nurse Standards and Protocols Manual* which is only available in hard copy. The most up to date guidelines for Prenatal, Well Child and Cervical Screening Guidelines are available online at <https://www.gov.nu.ca/health/information/manuals-guidelines>.

The SHP assigns a nurse to each program and monitors the nurse's progress on a weekly or monthly basis. If possible, each nurse should be booked out of the clinics for 2 hours/week to keep the programs up to date. Keeping a program up to date means ensuring that clients are seen appropriately, appointments are booked, and appropriate testing is completed.

Historically, most program clients have been seen on specific afternoons every week. This is an outmoded and not client-centred practice, and as such does not need to be followed. To increase compliance, the SHP and CHNs can work out a better system where appointments are booked throughout the week. As long as sufficient time is given for each appointment, there is no reason to have all of the well women exams done on a Tuesday afternoon, as an example.

## 14.1 Monitoring Population Health Programs

### 14.1.1 The Prenatal Program

The prenatal program is the only program where documentation is not available in Meditech. All of the documentation remains paper-based, and the prenatal documentation is filed in a separate chart during the gestation period. This documentation is filed into the client's full chart once the pregnancy has been completed. If a midwife is present in the community, the charts may be kept separately through the postpartum period.

The SHP can monitor the prenatal program by reviewing the spreadsheet and doing random chart audits to ensure that blood work is being ordered appropriately, referrals are completed and that all of the necessary screening has been offered. Risk assessments should also be done with each prenatal visit. The SHP should be aware of high-risk obstetrical clients and ensure close oversight of their care.

### 14.1.2 The Well Child and School Immunisation Program

Immunisation cards for children are kept in diverse ways across the territory. In some health centres, all of the cards are maintained in file boxes by year of birth. In other centres, only the 0 – 2 age group is kept this way and the other cards are kept in the client charts. Another way of keeping them is to file cards in binders by year of birth.

Vaccination histories are also available in MEDITECH. If the histories are not up to date, the immunisations can be entered into this section of MEDITECH.

These programs are often given to the Public Health Nurse if this position is on the health centre organisational chart.

A spreadsheet is maintained for the 0-2 age group which receives most of the childhood immunisations. The older children may receive their vaccinations at school or be called in individually, although this is not as efficient a practice.

The SHP can review the spreadsheet with the nurse to ensure that the children are being booked appropriately. Most spreadsheets have a way of flagging children who are behind on their immunisations. If there are many children behind, the SHP may request admin overtime to book afterhours immunisation clinics. This would require Director approval.

### 14.1.3 Well Woman and Well Man Programs

These programs offer preventative, age-related screening for adults. Breast, cervical, prostate, and colorectal cancers are some examples. Rates for cancers of several types are higher in Nunavut than the rest of the country, making screening important to this high-risk population.

Well Man and Well Woman appointments are often not well attended. The SHP should make every effort to ensure that appointments are made at the client's convenience and strongly encourage attendance. Screening can also be done when clients are attending appointments for other reasons.

Spreadsheets are usually maintained for these programs.

#### 14.1.4 Communicable Disease and TB

The nurse managing communicable disease is primarily responsible for ensuring that sexual infection is tested, contact traced, and treated appropriately. Contact tracing and treatment forms are completed and submitted to the RCDC once treatment is complete. This documentation does not remain in the chart because the names of the contacts are confidential. The treatment is documented in the chart but not the form.

TB screening is discussed in the Section 12.4.2.

Tuberculosis is endemic in Nunavut. Its occurrence is not spread evenly across the territory, however. It is particularly prevalent in certain communities in the **Kivalliq** and the **Qikiqtaaluk**. New SHPs and SHPs entering a community on a contract basis should contact the RCDC for information regarding the status of TB in the community. SHPs should review the TB manual found at <https://www.gov.nu.ca/health/information/manuals-guidelines> if there are cases in the community.

#### 14.1.5 Chronic Disease

This is the most difficult program to monitor because each CHN has a number of chronic disease clients.

Encouraging Supervisors of Home and Community Care and CHNs to partner regarding their mutual clients can provide much needed assistance in ensuring that clients with chronic disease receive optimal treatment.

Some health centres have access to the Virtual NP Chronic Disease Program to assist in bringing care for clients with chronic disease up to date. This program is reviewed in Section 11.2.1.

Most health centres maintain a master spreadsheet of all chronic disease clients, colour coded in some way to identify which nurse is responsible. The individual nurses are responsible to enter information as testing etc. is completed. The spreadsheet identifies the underlying condition, the frequency of visits, and necessary testing, etc.

The SHP can monitor the spreadsheet and follow up with individual nurses if there are issues of noncompliance by either client or nurse.

#### 14.1.6 Handover of Population Health Programs

Policies that apply:

- 07-019-00 Transfer of Care Between Colleagues

When a nurse leaves a community for annual leave or the completion of a contract, the nurse must provide a written handover of the program for which they are responsible. This handover should be completed using the SBAR (Situation, Background, Assessment, Recommendation) format required in the policy. The policy contains the procedure necessary to complete this documentation effectively.

The SBAR should be given to the SHP to ensure that the SHP is aware of the program status.

If the nurse must leave the community emergently, (and, due to the airline travel schedule, it is rare for a nurse to leave on the same day), handover should be prioritised.

## SECTION 15 DEATH IN THE COMMUNITY

### *Key Takeaways for this section:*

- The coroner should be advised of all deaths in a community to avoid missing a reportable death.
- Unexpected deaths are reported to the Director by phone.
- Preparing a body for burial is not a health centre responsibility.

### Policies that apply:

- 05-005-00 Critical Incident Stress Management
- 05-034-00 Client Safety Events – Reporting and Management
- 05-035-00 Client Safety Disclosure Policy
- 07-012-00 Certification of Death
- 07-013-00 Pronouncing Death
- 07-014-00 Reporting Death to the Coroner
- 07-015-00 Stillbirth
- 08-004-00 Post Mortem Samples

Death that occurs outside of the health centre, unexpectedly, is often reported to the SHP by the RCMP. While the RCMP may request assistance from the health centre staff, health centre staff should only attend the scene in the company of an RCMP officer.

If a community member calls the health centre to advise of an **unexpected** death, the SHP must contact the RCMP and should only attend the scene in the company of the RCMP.

The coroner should be notified for all deaths in a community. This saves confusion in deciding whether a death is reportable or not. There have been cases where a reportable death was missed, and the body removed before the coroner could investigate.

The SHP must also notify the Director or the Facility Director of any death in the community and submit an incident report through the MEDITECH QRM Module.

If the death is **expected**, the SHP will often send an email notifying the other health centres in the region of the death and offering condolences to relatives in the other communities.

If the death is **unexpected**, the Director must be notified by phone, with an email providing the same essential details sent as soon as reasonably possible.

In most communities, health centres as well as other places of business will close for an hour or two during the funeral of a community member. This is an expectation of the community. The nurse on call must remain available but most of the community staff and some nurses will attend the funeral.

Part of the SHPs role is to help build and foster a positive relationship with a community. Showing respect for community members who have been lost is one important way this can be achieved.

## 15.1 Pronouncing Death

Physicians, NPs, CHNs and LPNs can pronounce **expected** deaths, i.e., palliative, or elder death.

Only physicians and NPs can pronounce **unexpected** death unless there are none in the community. In those cases, CHNs may pronounce.

Paramedics can pronounce death if there is no one else in the community to do so.

## 15.2 Certification of Death

The *Vital Statistics Act* states that only physicians, or coroners who are investigating, may sign the certificate of death. Because there are times when there is no physician or coroner in the community, CHNs or NPs, may sign the certificate, but the original must then be sent to the Registrar General of Vital Statistics who will co-sign. In the case of expected deaths when there is no physician, coroner, or NP in the community, and a CHN is unavailable or not present, an LPN may sign the certificate of death. The original must then be sent to the Registrar General of Vital Statistics who will co-sign.

If family members request the Certificate of Death, a copy may be issued to them. A copy of the certificate should also be filed in the client's health centre chart.

## 15.3 Stillbirth

Refer to Policy 07-015-00 *Stillbirth* and the accompanying Guideline which describe the necessary steps in detail.

## 15.4 Post-Mortem Samples

While ensuring that post-mortem samples are obtained is the responsibility of the coroner, the community coroners are not healthcare providers and will not likely have the training necessary to obtain samples.

The coroner must provide authorisation for a nurse to collect the samples. This is detailed in Policy 08-004-00 *Post-Mortem Samples*. There are accompanying guidelines as well as the *Coroners Protocol for Body Fluid Collection*.

If a nurse is uncomfortable or doesn't think that they are competent to collect the samples, it is the SHP's responsibility to support by finding an alternative resource or by demonstrating the procedure for the nurse.

## 15.5 Post-Mortem Responsibilities

In most communities, there are members who will attend to the body and prepare it for burial. Often these are church members or community elders. The family also may choose to do this themselves and the health centre staff may assist as necessary.

Preparing the body is not the health centre's responsibility. If the body has had particularly traumatic injuries, some nurses may choose to prepare the body so that the family is not exposed to the image of those injuries. This is not expected nor is it the nurse's job. It is an individual choice.

## 15.6 Placement of the Body Pending Funeral

If the RCMP and/or Coroner have no concerns regarding the death of an individual, the body is placed in the Hamlet morgue pending funeral arrangements. If the health centre has a morgue, it may also be used. Hamlet morgues are often rudimentary or non-existent. It is the Hamlet's responsibility to handle the remains of all except Coroner or RCMP cases.

If a community member died while out of territory, the hamlet usually arranges transportation from the airport. The hamlet may request to use the health centre morgue if the community does not have a suitable place to hold the coffin.

If a client passes away while on medical travel, Health will pay the funeral home and transportation costs for the client's return. The funeral home will usually contact the Regional Manager of Finance with the invoice.

## 15.7 Burial Permit

The Burial Permit is issued and completed by the Hamlet. If the client died outside of the community and a funeral home service has prepared the body to ship back to the community, the permit will accompany the body. It will be sent along with all the documentation accompanying the body and will be provided by the airline, together with the transport paperwork and attached to the casket wrapping or inserted in the casket.

If the health centre receives the Burial Permit, it must immediately be forwarded to the Hamlet so that burial arrangements can be made. It is the responsibility of the Hamlet to mail the original burial permit to the Registrar General of Vital Statistics.

## 15.8 Letter for Compassionate Travel

The regional Inuit Organisations will often assist in funding for relatives who wish to attend the funeral of the deceased. This funding is for air travel only and does not include the cost of food and accommodation. This is the responsibility of the families. Health does not provide any funding for these purposes.

The organisations require a letter of support from the SHP. If requested, the SHP may write a letter which contains the date of death, the name of the deceased and the date of birth as well as a brief description of why the letter is requested. The letter should not include any information about the illness, injury, or cause of death. The letter is faxed to the requesting agency and a copy is placed in the deceased's chart.

## 15.9 Suicide and Accident Scenes

The Hamlet is responsible for the clean-up of accident and suicide scenes. This is not the responsibility of Health or the staff in the health centres.



## SECTION 16 MEDITECH AND HELP DESK

### *Key Takeaways for this section:*

- The SHP must complete the Meditech User Request form and submit it to eHealth prior to a staff member's arrival in community.
- The SHP must request email and internet access for incoming staff members through the Help Desk Service Portal.

### 16.1 eHealth

eHealth is responsible for MEDITECH, the GN's interoperable electronic health record or iEHR. eHealth is also responsible for telehealth services for Health only, for digital radiology and the Picture Archiving Communications System (PACS) which allows x-ray and ultrasound images to be uploaded for viewing in various jurisdictions. Currently, the Ottawa Group, a group of radiologists in Ottawa, have the contract to report on Nunavut images.

The **Kivalliq** and **Kitikmeot** regions have one eHealth Systems Officer on site in the Regional Health Facility. The **Qikiqtaaluk** has multiple Systems Coordinators on site in Iqaluit. The Systems Officers and Systems Coordinators can assist with training new staff and troubleshooting any MEDITECH issues that may arise.

All healthcare providers must document in MEDITECH. It is the SHP's responsibility to ensure that staff are utilising the system and not documenting in paper charts except for prenatal care. Clients must be registered in MEDITECH by front desk staff during the day and by nurses on call after hours. If the client is not registered, the nurse cannot document and this can cause miscommunication between health care providers, leaving the client at risk.

Referrals to the community physician as well as to out of territory physicians and allied health services should be entered into MEDITECH.

Incident reports are entered into MEDITECH.

Laboratory requisitions are entered in MEDITECH in both the **Kivalliq** and **Qikiqtaaluk** regions. The **Kitikmeot** region remains paper-based because their lab contract does not include an interface with the system.

Ultrasound and x-ray requests must be entered and completed in MEDITECH.

The SHP is responsible to ensure that incoming staff are provided access and training to MEDITECH by completing the MEDITECH user request form and submitting it to [eHealth@gov.nu.ca](mailto:eHealth@gov.nu.ca) prior to the staff member's arrival. The staff member must have access to GN email prior to this request.

### 16.2 Meditech Downtime

There are times when Meditech is unavailable for periods of time. This may be due to maintenance or other issues.

It is important to keep a Downtime box with all necessary forms for use during these times. When the box begins to deplete, the SHP or delegate must ensure that the forms are copied and replenished.

If the last form is used prior to being replenished, the SHP or delegate can contact Health Records in Iqaluit for new copies.

### 16.3 Help Desk

Help Desk is a division of Community and Government Services (CGS). They are a centralised service although there are Help Desk staff members in each region. Help Desk is responsible for all GN email access and issues, software, servers, printers, telehealth requests for departments other than health and the phone system.

The SHP must request access to email and internet for incoming employees by using the [Help Desk Service Portal](#). This must be done at minimum 10 days prior to their arrival. If not requested in a timely way, the incoming staff member will have no computer access.

The Help Desk Service Portal provides a Catalog of functions from requesting access for new employees or extending accounts, to ordering computers or wall jacks etc.

Every health centre in Nunavut has a generic email for the SHP. This email address is used by regional offices and other departments to communicate with the SHP. The SHP must contact Help Desk through the Help Desk Service Portal prior to leaving the community to add the name of the incoming SHP to ensure access. If possible, this should be done a minimum of seven working days prior to departure. This is the only method that should be used. Any other method, such as emailing HelpDesk will only cause delays.

Help Desk also provides support for Microsoft Teams which is in wide use within Health and across the territory. Microsoft Teams FAQs and best practices are available at:

<https://govnuca.sharepoint.com/sites/GN-CGS-IM-IT-Forms/IMIT%20Training%20and%20Reference%20Material/Forms/AllItems.aspx>.

The GN uses Mitel phones which can be ordered from Revolving Stock on the GN Intranet.

If the phone system is faulty, Help Desk must be notified immediately. Help Desk will notify Northwestel if there appears to be a systemic issue, however, there are times when the GN system is simply outdated and needs to be replaced.

#### 16.3.1 Yubikeys

The Government of Nunavut was attacked by ransomware on November 1, 2019. Since that time, security around email and internet usage has been significantly increased.

The Yubikey is a hardware security key that helps prevent GN accounts from being hacked.

The Yubikey must be actively used for day-to-day primary GN environment access.

Yubikey information and user guides are available at <https://govnuca.sharepoint.com/CyberSecurity/YubiKey>

Each nurse will have a Yubikey and is obliged to keep it secure.

## SECTION 17 WORKERS' SAFETY & COMPENSATION COMMISSION (WSCC)

Reference: Workers' Compensation Act s.NU. 2007

Workers' compensation and workplace health and safety in Nunavut is governed by the Workers' Compensation Act and the Safety Act.

WSCC impacts health centre operations in several ways:

### 17.1 Safety Inspections

Safety inspections of the health centres generally occur on a yearly basis. Inspections can result in directions or orders that detail the corrective actions that need to be completed by an agreed upon date. Inspections can also provide positive observations and feedback.

The inspection generates a Workplace Inspection Report. The report will detail observations and, if a hazard is identified, will provide directions with a deadline for compliance. This deadline is set by the Inspector and an employer representative. The SHP can request a revised deadline if more time is required.

The SHP must share the Workplace Inspection Report with the Director who may be able to assist if the SHP has any difficulty resolving the identified issues in a timely way.

More information about workplace inspections can be found at <https://www.wsc.nu.ca/health-safety/ohs-information/inspection-process>.

### Occupational Health and Safety Committees (OHS Committee)

An OHS committee must be established in every workplace where 20 or more workers are likely to work for more than 90 days. This refers to all staff other than relief workers. If casual workers are present for 3 or more months, they are counted. The committee is composed equally of workers who are representative of the workers on site and individuals selected by the employer to represent the employer. The minimum number of committee members is four (4) – two worker representatives and two employer representatives.

If there are fewer than 20 workers (and that is the case for most smaller health centres), the SHP shall designate one worker as the OHS representative for the workers.

Another option is to develop a joint OHS committee if there is more than one Health division in the community e.g., health centre and long-term care facility, etc.

More information about OHS committees is available at <https://www.wsc.nu.ca/sites/default/files/documents/Joint%20OHS%20Committee%20Code%20of%20Practice%20NT%20and%20NU%20English.pdf>.

## 17.2 Workplace Injuries

Healthcare Providers (HCPs) who attend an injured worker, must report the work-related injury to the WSCC by submitting a **First Medical Report** within three days of the initial visit.

The **First Medical Report** is a PDF fillable form available at <https://www.wsccl.nu.ca/claim-services/claim-health-care-providers/report-injury>.

The form is sent to Iqaluit by fax or email. The address and fax number are listed at the bottom of the form.

If the injured worker is an employee of the health centre, the SHP or delegate must also submit an **Employer's Report of Incident**. The form must be completed within three business days or penalties are incurred.

For more information about the Employer's Report, access <https://www.wsccl.nu.ca/claim-services/claim-employers/report-injury>.

Workers who suffer a workplace injury that requires medical aid must complete the **Worker's Report of Injury**. This form is available at <https://www.wsccl.nu.ca/sites/default/files/documents/Worker%27s%20Report%20of%20Injury%20form.pdf>.

Failure to submit all necessary forms in a timely way can result in penalties.

The Manager of Occupational Health and Safety can also be contacted if the SHP has any questions or concerns about any aspect of WSCC.

## SECTION 18 COMMUNITY INVOLVEMENT

### *Key Takeaways for this section:*

- Volunteering time in community programs is a wonderful way to meet community members and to bring more work/life balance to health centre staff members.

SHPs and other health centre staff members are encouraged to involve themselves in community activities in which they are interested. These activities may be health related such as community walks or craft activities such as sewing or knitting circles. These activities will improve work/life balance for fulltime staff and are not considered work-related. They are not eligible for overtime compensation.

There are committees, however, that are work-related and are eligible for compensation.

### 18.1 Interagency Committee

The interagency committee may be run by the hamlet or the RCMP. The SHP or delegate is encouraged to attend. Other attendees include departments such as Family Services. The committee works as a team to improve services in the community and may work together to solve concerns that arise.

If the SHP is new to the community, contacting the Senior Administrative Officer (SAO) or the RCMP should provide information regarding this committee.

If there is no committee and the SHP desires to initiate one, training is available through CGS.

### 18.2 Health Committee

The health committee is a hamlet committee. The SHP may request inclusion. CHRs often attend the health committee meetings. This committee receives Health Canada funding to decide health promotion priorities in the community.

### 18.3 Canadian Prenatal Nutrition Program (CPNP)

Each community has a CPNP program funded through Health Canada. The CPNP Coordinator can be contacted for information regarding involvement of the SHP, or any healthcare provider interested in providing education sessions.

## SECTION 19 EMERGENCY SITUATIONS

### *Key Takeaways for this section:*

- Always maintain client and staff safety.
- Establish a fire plan if one does not exist.
- Be aware of the Community Disaster Plan.
- Fan out lists are important to keep all staff abreast of events and expectations.
- Ensure that all emergency equipment and satellite phones are maintained and functional.

### Policies that apply:

- 05-005-00 Critical Incident Stress Management
- 05-011-00 Reduction and Suspension of Core Community Health Nursing Services and accompanying appendices
- 05-031-00 Fire Response and Evacuation
- Human Resources Manual Section 1011 Bad Weather available at [https://gov.nu.ca/sites/default/files/hrm\\_1011\\_-\\_bad\\_weather.pdf](https://gov.nu.ca/sites/default/files/hrm_1011_-_bad_weather.pdf).

### 19.1 Satellite Phones

Every health centre in Nunavut has a number of satellite (sat) phones. It is critical for the SHP to ensure that sat phones are working and that all staff know how to use them. The sat phone must be tested monthly and the test is logged.

While many health centres have portable antennas that can be set up so that the sat phone can be used inside, these are not always operational. **The sat phone should be tested using the antenna if it exists. If the antenna does not allow the sat phone to be used inside, the user will need to go outside to test or use the phone.**

If the sat phone is not working, the SHP or delegate can contact the Senior Health Emergency Planner at 867-975-5729.

### 19.2 Fan-Outs

A fan-out or phone tree is a messaging pattern where messages are broadcast in a one-to-many pattern. If the health centre is being closed for any reason, the SHP would contact one or two people who would then call two or three other people to pass the message along.

As an example, the SHP might call one of the CHNs and one of the administrative staff. These two people would then call two or three other people. Those two or three other people would call another two or three, until all staff have been reached.

Fan-outs are also helpful if staff are needed to return to the health centre during a critical emergency.

### 19.3 Health Centre Closure

In all the scenarios below, or due to short staffing, it may be necessary to either reduce services or to close the health centre entirely.

It is important for the SHP to review and understand Policy 05-011-00 *Reduction and Suspension of Core Community Health Nursing Services* with the attached addenda. By doing this, the SHP will be prepared to assign necessary tasks in the event that the health centre needs to close.

In all circumstances except for weather, the SHP must communicate reductions of service to the Director who is responsible to keep statistics for use by the Department.

The Director is aware of weather closures because Help Desk sends out an email advisory in those cases.

## 19.4 Blizzards

Blizzards are common in Nunavut and do not often cause alarm, however, they do create situations which are sometimes difficult to contend with. When planes are grounded, medical travel is disrupted, and medevacs may be delayed for prolonged periods of time.

A combination of factors is used when making the decision to close GN offices. This includes:

- Visibility of less than 200 metres.
- Constant wind speed exceeding 60 kilometres per hour.
- Wind chill index of –50 degrees Celsius or greater.
- Status of road clearing and any municipal decisions to remove road clearing machinery from roadways; and/or
- Availability of taxi or other public transportation services in the community.

GN offices are automatically closed in a community where the municipality has closed the roads.

There is usually one person in the community (most often the Community Liaison Officer [CLO] or Government Liaison Officer [GLO]) who notifies CGS regarding the weather conditions. CGS then puts out an advisory via email.

The health centre may or may not be advised that blizzard conditions have prompted closure.

The SHP may be pressured to close by staff when the weather is bad. The SHP does not have the authority to close the health centre and must contact the Director if there has not been a notification from CGS.

If the blizzard starts during the night, community staff will not likely come to work in the morning. The nurses generally come to work unless there has been a fan-out from the SHP. If the health centre closes, the nurses on call are expected to be available and may work from home or come to the health centre.

In the absence of a formally announced GN office closure, employees must assume that they are expected to be at work. If an employee fears for his/her safety when required to travel to their place of work in bad weather, they may request use of their banked leave (annual or lieu). A leave form must be completed.

If the blizzard is declared mid-morning or mid-afternoon, support staff will be expected to go home. The SHP must assess the situation in the clinic. If the clinic remains busy, it is not practical to have all the nurses leave except for the on-call nurses. In this case, it might be best to call a quick meeting to

troubleshoot the situation. It is best not to leave on-call nurses to deal with the situation without support.

## 19.5 Fire

Every health centre should have an evacuation plan in case of fire. The most important aspect of the plan is to secure the immediate safety of staff, clients, and visitors. If there is no plan in place, the SHP can work with the Director and the Fire Marshall to establish one. There should also be an alternate site for provision of service. The SHP can consult with the SAO, Mayor, and CGS staff to find a suitable place to provide emergency services and an alternate site if this is required for a longer period.

A spontaneous fire drill should be held, at minimum, once yearly, to ensure that all staff and visitors can be evacuated quickly and efficiently.

If fire breaks out, once the fire department has been alerted, the SHP must notify the Director, the Hamlet office, and any other stakeholders that might be impacted. An incident report must be submitted to the MEDITECH QRM Module.

## 19.6 Lockdown

Occasionally, threats will occur in the community or in the health centre. At that time, it may be necessary to lock down. The doors to the clinic must be locked and all accesses secured. Staff should not leave the health centre. Community members may leave if it is deemed safe to do so.

The SHP must notify the Director if the health centre is locked down. The Director will notify the ADM, Operations.

The RCMP will advise the SHP when it is safe to reopen.

Once the situation is resolved, the SHP must submit an incident report to the MEDITECH QRM Module.

## 19.7 Loss of Phone or Internet Service

Help Desk must be notified immediately regarding loss of phone or internet.

If the phone lines in the health centre are not operational, another method of communication with the community must be established. This may be the use of cell phones or satellite phones or, if possible, the use of a line in another Health building in the community. The RCMP may also be able to assist.

The community and relevant stakeholders (mental health, family services, etc.) must be advised of the situation and alternate means of emergency communication must be established. In some communities, the SAO is considered a relevant stakeholder in order to respond to any community concerns that may be relayed to the Hamlet Office.

If the internet is down, the SHP must ensure that downtime procedures and forms are utilised.

The Director must be notified, and an incident report submitted to the MEDITECH QRM Module once computer access is re-established. Downtime forms may be used if the disruption continues for longer than a few hours.



## 19.8 Failure of Power Grid

The failure of the power grid is a community wide emergency. The health centre is somewhat protected by the generator, and it is advisable for the SHP to ensure that the generator is checked by the Facility Maintainer on an annual basis, at minimum. This will allow for some lights and emergency room power, but this must be conserved. The phones and computers will not work. The satellite phone can be used in this instance to immediately notify the Director. CGS will almost certainly be aware.

Downtime forms and procedures must be utilised. Alternate means of emergency communication must be established.

## 19.9 Workplace Violence

Resource: Human Resource Manual Section 1009 Workplace Violence Prevention available online at:

[https://gov.nu.ca/sites/default/files/hrm1009\\_workplace\\_violence\\_prevention\\_0.pdf](https://gov.nu.ca/sites/default/files/hrm1009_workplace_violence_prevention_0.pdf).

Workplace violence in this context refers to community members to health centre staff.

If the SHP is aware of staff/staff concerns of harassment or threat, refer to Section 8.5 Disruptive Behaviour. If the SHP is uncertain how to proceed, they should contact the Director.

### 19.9.1 Verbal Harassment

Verbal harassment may include yelling, insults, swearing, etc., directed by a client or visitor to a staff member. The SHP should respond to any loud commotion in the health centre. The aim of any actions is de-escalation and maximising the safety of the clients, staff, and any visitors at the time of the incident.

The SHP or delegate must complete an incident report for submission to the MEDITECH QRM module.

### 19.9.2 Threats

All threats made against staff members and health property should be taken seriously. Staff actions should be aimed at maximising safety for all of those present by immediately calling another staff member as well as security personnel if present. The RCMP should also be notified.

Threats should be reported by submitting an incident report to the MEDITECH QRM module.

### 19.9.3 Physical Assault and Risk Behaviour

Physical assault and risk behaviour may include punching, hitting, and throwing objects. The SHP should focus on maximising safety for all of those present by immediately attending or calling other staff members to attend as well as security personnel if they are present in the building. The SHP must also call the RCMP or assign someone to call on their behalf using closed loop communication.

Closed loop communication is a three-step process, where 1) the transmitter communicates a message to the intended receiver, using their name, when possible, 2) the receiver accepts the message with acknowledgment of receipt via verbal confirmation, seeking clarification if required and 3) the original transmitter verifies that the message has been received and correctly interpreted, thereby closing the loop.

The SHP should be sensitive to the fact that community support staff members may be uncomfortable making this call. If the community staff seem uncomfortable or resists the request, the SHP can call the RCMP or delegate the call to one of the nursing staff.

If a staff member has been physically assaulted, they should undergo a physical examination and counselling should be offered. Critical incident debriefing can be initiated by the SHP by contacting Health Human Resources and/or the Regional Executive Director.

The staff member who has been assaulted can and should press charges. The assaulted staff, and not the GN, is making the complaint against the assaulter. Notwithstanding, the GN does not tolerate violence against employees.

For further information, the SHP should review Section 1009 of the Human Resources Manual. This is available at [https://gov.nu.ca/sites/default/files/hrm1009\\_workplace\\_violence\\_prevention\\_0.pdf](https://gov.nu.ca/sites/default/files/hrm1009_workplace_violence_prevention_0.pdf).

The SHP or delegate must submit an incident report regarding the event to the MEDITECH QRM module. A report of worker injury must also be submitted to the Workers Safety and Compensation Commission (WSCC).

### 19.10 Loss of Water/Sewage

In most communities in Nunavut, water is brought to homes by truck and sewage is pumped out by truck once or twice a week. Health centres have the same system, but service is usually provided daily because of the size of the centre, the number of people using it and the services provided. If the health centre does not have any water or the toilets cannot be flushed, the hamlet must be notified immediately. If the sewage tank is too full, the water will not run. Advise the Hamlet that the health centre will close if the situation is not addressed ASAP. This is a public health issue. If the health centre closes, the Director must be immediately contacted by phone with an email to follow as soon as it is reasonably possible.

### 19.11 Community Disaster

Every community in Nunavut has or should have a community disaster plan. The Community Disaster Plan is usually kept in the SHP office. If it is not in the office, the SHP can contact the SAO of the community for a copy. The SHP should review this to understand the community expectations for the health centre. The health centre is often called on to participate in disaster planning events or in mock disasters. The SHP must make every effort to attend.

## 19.12 Severe Maintenance Issue

This refers to serious issues – the roof falls in, a door is torn off its hinges, the health centre is flooded, failure of the sewage system (as opposed to the system needing to be emptied), etc.

The first thing the SHP must do is to contact the facility maintainer. The facility maintainer may also be known as the settlement maintainer. The maintainer will assess the damage and make immediate necessary repairs. If the problem is larger than the maintainer can handle, the maintainer will advise the Facility Management Coordinator or the Regional Facilities Manager in the regional centre.

The Director must also be advised.

The health and safety of the staff and visitors to the health centre are the priority. If the damage affects the health centre's ability to function, e.g., overpowering smell of sewage, the health centre must close. Nurses on call must remain available. The community and the Director must be notified.

If the health centre must remain closed for a period, Policy 05-011-00 *Reduction and Suspension of Core Community Health Nurses Services* must be followed.

The Director and the SHP will troubleshoot viable options to maintain service until the health centre repairs have reached a stage where staff may return to work.

## 19.13 Essential Medication Shortage

If the SHP discovers that there is a shortage of essential medication, the priority is to access the medication. This can be done by calling the regional pharmacy technician who can hopefully, ship the medication quickly. Other options are to call the SHPs in neighbouring communities to see if they can send a few bottles. The Director should also be advised. An email will usually suffice unless the SHP is having difficulty resolving the problem. If so, the SHP should call the Director for assistance.

Once this is done, the SHP needs to review their system for monitoring medication ordering. If the duty has been assigned to a staff member, has the ordering been done appropriately? Is there a gap in the system that allowed a shortage to occur? Have the shipments been delayed due to weather? Is the medication on back order or in short supply? Has there been an unanticipated increase in the dispensing of a medication that warrants further investigation?

## 19.14 Missing Paycheques

The GN has now moved to a complete Direct Deposit system.

If a staff member complains that the pay was not deposited, the SHP should contact the Finance Officer and Human Resources Officer in the regional office to advise them of the situation. The Finance Clerk will follow up with the Department of Finance to find out what has happened. The HR Officer can check to ensure that CSAs have been submitted and approved if the staff member is casual.

Usually, another deposit can be made during the off cycle. Off cycle refers to specific days that the Department of Finance issues cheques that were not issued during payroll.

The best way to avoid missing pay is to ensure that all time sheets are correctly completed and submitted on the required day and that CSAs are up to date. Even if this process is followed perfectly errors can occur resulting in missing paycheques.

If the missing pay is overtime pay for a CHN, the SHP should direct them to their payroll officer. The GN is required to pay overtime hours within four weeks from the day that the overtime claim is submitted.

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## APPENDICES

Appendices are located in a separate file folder and consist of:

SHP Manual Section	Appendix Item	File name
<b>Section 1</b>	Job Description	Supervisor Health Programs - Generic JD
		20201029_How to do Shared Decision M [7522]
	5000 Years Inuit Heritage	5000 Years Inuit Heritage – ITK
	A Brief Introduction to Inuit Organisations History	A Brief Introduction to Inuit Organisations History - March 2020
	Department of Health Orientation Handbook	Orientation Handbook - March 2020
	Manager of outpatient services job description Nurse Manager Outpatient Services	Manager of outpatient services job description Nurse Manager Outpatient Services - Generic JD - Dec 17, 2020, CNO
<b>Section 2</b>	GN Leadership Framework and Competency Model	GN Leadership Competency Model Final 201520131
<b>Section 3</b>	Morning Report policy	06-017-00 Morning Report Policy
	POCT and QC expectations	Approved POCT and QC expectations
	POCT QC checklist	QC Monthly Checklist
	SCHP Medical Travel Flowchart	SCHP Medical Travel Flowchart
<b>Section 4</b>	Vehicle Maintenance Log	Vehicle Maintenance Log
	CGS & GN Motor Vehicle Policy	renewal_of_motor_vehicle_policy_-_may_31_2020
	Palliative Care Kits for the Communities Policy and Procedure	Palliative Care Kits Policy Procedure Order Form Revised and Approved by MAC February 2021
	A Quick Guide To Facility Management Services Provided By CGS	CGS-2018-A-Quick-Guide-to-Facility-Management-Services-2018_EN
<b>Section 7</b>	Just Culture: It's more than a policy	Just_culture__It_s_more_than_policy.9
<b>Section 8</b>	Nunavut Nursing Competency Framework	Nursing Competency Framework-Eng.
	Performance Management Guidelines for Supervisors	Performance_Management_Guidelines_Handbook_0
<b>Section 9</b>	Prescribing and Dispensing Drugs for Dentists in Nunavut	Dentist Prescribing in Nunavut - Protocol CW edits Aug
	Guidelines For Assessment And Treatment of Dental Emergencies	Guidelines for assessment and treatment of Dental emergencies
	Guidelines for Assessment and Treatment of Dental Emergencies	NU Covid Dental Emergency Form - Template 2020
<b>Section 10</b>	Reporting Diseases, Events, and Conditions	3._reporting_diseases_poster_nunavut_jan2020
	Reportable Diseases January 2020	REPORTABLE DISEASES JANUARY 2020