Section 5: Administration

Policy Number	Policy Name
05-001-00	Nursing Policy Manual Maintenance
05-001-01	Nursing Policy Manual Maintenance guidelines
05-001-02	Nursing Policy Change Request Form
05-001-03	Nursing Policy Development
05-001-04	Archiving Nursing Policies and Guidelines
05-005-00	Critical Incident Stress Management
05-005-01	Critical Incident Stress Management Guidelines
05-006-00	Nursing Practice – Employer Responsibilities
05-007-00	Nursing Practice – Employee Responsibilities
05-008-00	Nursing Practice – Additional Nursing Function
05-008-01	Developing Policy for Additional Nursing Functions
05-008-02	Performing Additional Nursing Functions
05-008-03	Decision-Making Model for Performing Additional Nursing Functions
05-009-00	Transferred Functions
05-010-00	Competency for Transferred Functions
05-011-00	Reduction of Core Community Health Nursing Services
05-013-00	Orientation
05-014-00	Reference Materials
05-014-01	Approved Reference List
05-014-02	Pharmacy Resources-in the formulary
05-015-00	Statutes and Legislation
05-015-01	Statutes and Legislation Reference Sheet
05-016-00	Provision of Care in Emergency Situations
05-017-00	Equipment Management System
05-018-00	Standard Emergency Equipment
05-019-00	Equipment – Basic Nursing
05-019-01	Basic Nursing Equipment
05-020-00	Equipment – Advanced Nursing
05-020-01	Advanced Nursing Equipment
05-021-00	Occupational Health and Safety
05-021-01	Occupational Health and Safety Program
05-022-00	Smoke Free Workplace
05-023-00	Treating Immediate Family Members
05-024-00	Clients in Police Custody
05-024-01	Provision of Care to Clients in Police Custody
05-025-00	Gifts
05-025-01	Guidelines for Accepting Gifts
05-026-00	Loss or Theft of Property
05-027-00	Contacting Clients through Local Radio
05-028-00	Scent-Free Workplace
05-029-00	Violence in the Workplace
05-030-00	Motor Vehicles
05-031-00	Fire Response and Evacuation
05-032-00	Compressed Gas
05-033-00	Managing Nursing Practice and Professional Conduct
05-034-00	Client Safety Events – Reporting and Management
05-035-00	Client Safety Disclosure Policy

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS Community Health Nursing		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Nursing Policy Manual Maintenance		Administration	05-001-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		8
APPLIES TO:			
Community Health Nurses			

POLICY:

The Department of Health and Social Services (HSS) shall establish and maintain a process of developing, reviewing and revising the policies and guidelines for the *Community Health Nursing Standards Policies and Guidelines* manual.

HSS shall establish and maintain a process of developing policies and guidelines for the community health nursing standards.

PRINCIPLES:

Provisions for reviewing and revising nursing policies and guidelines are fundamental to a continuous quality improvement program. These provisions will ensure care delivery is based on best practices and current knowledge.

Standardizing policies and guidelines will:

1) Improve awareness of information and resources available to nurses.
2) Reduce the incidence of developing duplicate guidelines.
3) Promote equitable and consistent nursing service delivery throughout the territory.
4) Reduce clinical errors/incidents

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Guideline 05-001-01	Nursing Policy Maintenance Guidelines
Template 05-001-02	Nursing Administrative Policy Change Request Form
Guideline 05-001-03	Nursing Policy Development
Guideline 05-001-04	Archiving Nursing Policies and Guidelines

GUIDELINE 05-001-01

GUIDELINES:

1) The *Community Health Nursing Standards Policies and Guidelines* Manual is intended for use by the Department of Health and Social Services and its primary healthcare team.

2) A committee shall be established to review the *Community Health Nursing Standards Policies and Guidelines* Manual and any submissions requesting a policy change. This review committee shall be established under the direction of the Chief Nursing Officer and be representative of the nursing force across the territory.

3) Every effort has been made to ensure the information contained within the manual is reflective of current evidence-based practice. Best practices, however, continue to evolve as new nursing knowledge is developed.

4) All users of the *Community Health Nursing Standards Policies and Guidelines* Manual have the opportunity to suggest changes to the policies and guidelines and to participate in the review process. See *Nursing Policy Change Request Form* (Template 05-001-02).

TEMPLATE 05-001-02

All users of the *Community Health Nursing Standards Policies and Guidelines Manual* have the opportunity to request a change to the policies and guidelines.

The *Nursing Policy Change Request Form* shall be completed and submitted electronically to the office of the Chief Nursing Officer.

Chief Nursing Officer
Department of Health and Social Services
Box 1000, Station 1000
Iqaluit, Nunavut
X0A 0H0

NURSING POLICY CHANGE REQUEST FORM

REQUESTED CHANGE (check one):	□ New	□ Deletion	□ Revision
EXISTING POLICY TITLE & NUMBER:			
SUGGESTED POLICY REVISIONS (Attach Policy Revision)			
RATIONALE AND REFERENCES (Attach Supporting Documentation)			
Requested By		Date	

FOR USE BY REVIEW COMMITTEE

GUIDELINES 05-001-03

1. POLICY AND/OR GUIDELINE DEVELOPMENT, REVISION OR DELETION (ORIGINATOR)

When a policy or guideline has been identified for development, revision, or deletion, the following steps must be completed by the person requesting the change:

1.1 Identify the need for the development, revision or deletion of a policy.

1.2 Notify the Policy Revision Coordinator (identified through the Nursing Leadership Advisory Committee) of the intent to develop, revise or delete the policy or procedure

1.3 Obtain electronic versions of the following:
- a) Policy Template
- b) Nursing Policy Change Request Form

1.4 Research Applicable Legislation and Best Practice
- a) Review and reference all relevant legislation, standards of practice etc. to ensure policy or procedure reflects any legal obligations and current practice

1.5 Develop or revise the policy or procedure and obtain stakeholder feedback
- a) Use the Policy template
- b) Save each version of the working copy with the word “draft” and the current date in the document name (i.e. name of doc – draft Jan 01 2001)
- c) On the approval form, include a list of all the relevant stakeholders who were consulted on the new policy or guideline.

1.6 Review draft policy with the Policy Revision Coordinator
- a) Review is for written structure, format and inclusion of all essential information.
- b) Edit as required
- c) Complete Nursing Policy Change Request Form and attach to the new/revised/deleted policy. New and Revised policies and guidelines should also have the out-dated version attached in order for the Policy Revision Coordinator to be able to archive these documents.

2. POLICY AND/OR GUIDELINE DEVELOPMENT, REVISION OR DELETION (POLICY REVISION COORDINATOR)

When a policy or guideline has been identified for development, revision, or deletion, the following steps must be completed by the Policy Revision Coordinator:

2.1 Create a draft file to track progress and changes

2.2 Review draft policy with the Originator
- a) Review is for written structure, format and inclusion of all essential information
- b) Edit as required
- c) Assign Policy number (if applicable)

2.3 Identify all existing policies and procedures that are similar to, or will be impacted or replaced by the new, revised, or deleted policy or procedure

2.4 Submit the draft policy and the Nursing Policy Change Request Form to the Policy Review Committee and obtain endorsement from the Policy Review Committee.

2.5 Submit endorsed new policy to the Chief Nursing Officer for final approval and signatures.

2.6 Prepare the final document and distribute
- a) Final formatting
- b) File the master copy and the signed Nursing Policy Change Request Form
- c) Archive deleted, revised or replaced policy or guideline and Nursing Policy Change Request Form

2.7 Submit the electronic version of the new policy or guideline to the designated Informatics technician to update the public folder

2.8 Update the hard copy of the *Standards Policies and Guidelines* Manual

2.9 Insert policy or guideline in the master copy of the *Standards Policies and Guidelines* Manual

2.10 Send e-mail to all HSS Regional Directors, Director of Health Programs, and NLAC members with notification of reviewed, new, revised and/or deleted policies and guidelines for the previous month.

2.11 The Director of Health Programs will be responsible for informing the staff affected by any new or revised policies or guidelines.

2.12 It is the responsibility of the Chief Nursing Officer to inform management of education requirements related to the content of a new or revised policy or procedure.

3. POLICY AND/OR GUIDELINE REVIEW ONLY – NO CHANGES REQUIRED

When a policy or guideline has been reviewed and no changes are required, the following steps must be completed by the Originator and the Policy Review Coordinator:

3.1 The Nursing Policy Change Request Form is completed and submitted as outlined in (1).

3.2 Review draft policy with the Originator

a) Review written structure, format and inclusion of all essential information
b) Edit as required

3.3 Submit the draft policy and the Nursing Policy Change Request Form to the Policy Review Committee for review and feedback.

3.4 The Policy Review Coordinator will notify the Chief Nursing Officer of the submission and the Policy Review Committee's decision to not implement the proposed changes.

3.5 The Policy Review Coordinator will notify the originator of the Policy Review Committee's decision not to implement the proposed changes.

3.6 The completed Nursing Policy Change Request Form shall be filed.

4. SIGNATURE

Policies will take effect upon final signature from the Chief Nursing Officer and the Deputy Minister of Health and Social Services and implemented upon dissemination to the regions.

GUIDELINES 05-001-04

1. ARCHIVING

1.1 Archiving will be done electronically as well as by hard copy based on the Government of Nunavut Administrative or Operational Records Classification System (ARCS or ORCS) and must be easily retrievable.
1.2 Policies and Guidelines that have been deleted, revised or replaced will be retained by the Policy Revision Coordinator until transferred to the Regional Records Management at year end.
1.3 All Policies and guidelines that have been transferred to Records Management are to be retained in the warehouse for a period of 7 years from date of revision or deletion.
1.4 After the allotted period of 7 years, the records will be transferred to the Archivist who will decide whether to retain or destroy the documents.
1.5 Records Management will forward a list of documents set to be destroyed to the appropriate department to ensure that files are not required for audits, etc.

2. INVENTORY

The Policy Review Coordinator will maintain a master inventory list of current and archived policies and procedures.

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

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS Community Health Nursing		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Critical Incident Stress Management		Administration	05-005-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		4
APPLIES TO:			
Community Health Nurses			

POLICY:

The Regional Health and Social Services departments shall develop a Critical Incident Stress Management (CISM) Plan that includes:

- **Education and prevention**
- **Organized intervention for those suffering critical incident stress**
- **A resource and referral network**

Health care workers shall have access to Critical Incident Stress Management in the workforce.

DEFINITIONS:

Critical Incidents (CI): Events that may cause personnel to experience unusually strong emotional reactions that have the potential to interfere with their ability to function at the time of the incident or later. Critical incidents include the death of a fellow employee, serious injury to a coworker or acquaintances, severe threatening situations faced by personnel, unexpected deaths in the community (Davis, Herbert & Hoffman, 2003).

Critical incident stress (CIS) is the reaction of normal people experiencing normal responses to abnormal situations. The stress response can be immediate or delayed and can be triggered by one or a series of events. (Davies et al., 2003)

Critical incident stress management (CISM) is a process to deliver a range of interventions, guided by protocols based on an approved model and resources, in order to prevent burnout. (Davies et al., 2003)

PRINCIPLES:

The Regional HSS offices shall make available immediate defusing, critical incident stress debriefing, and/or post traumatic counseling to employees who have suffered as a result of critical incident stress.

Critical Incident Stress (CIS) is cumulative and contributes to burnout. CISM contributes to greater staff satisfaction, retention and well-being; while promotes healthy stress management.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Guideline 05-005-01 Critical Incident Stress Management Guidelines

Guideline 05-004-04 Disclosure of Critical Incident

REFERENCES:

Canadian Council on Health Services Accreditation (2006). *Leadership and Partnerships: Standard 13.* Ottawa, ON.

Canadian Council on Health Services Accreditation (2007). *Patient/Client Safety Goals and Required Organizational Practices: Patient Safety Area 1: Culture of Safely.* Ottawa, ON.

Davies, J. M., Hebert, P., & Hoffman, C. (2003). *The Canadian Patient Safety Dictionary.* Calgary, AB: Royal College of Physicians and Surgeons of Canada.

Government of Nunavut. *Employee and Family Assistance Program.*

1. Prompt support of a critical incident by a manager/supervisor sets the tone for workplace trauma and grief.

2. The continuum of responses includes:

   Consultation: offers problem solving, planning, and support to managers, supervisors, and human resource personnel.

   Education: provides educational in-services and literature on pre-trauma awareness regarding traumatic stress reactions, self-care and utilizing an Employee and Family Assistance Program (EFAP) as a resource (information about the program is available through HR).

   Crisis management briefing: a large group meeting held at any time during or after an event with the goal of informing allowing psychological decompression and promoting stress management. Meetings generally last 30-45 minutes and are repeated as the situation changes. Information, stress survival skills, and instruction are provided.

   Defusing: a small group process held on-site within the first 12 hours post-crises that acknowledges the discomfort and complexity of stress reactions, explains and normalizes the traumatic stress reaction, identifies red flag and healthy coping mechanisms, and encourages use of EFAP (or other resource) throughout the recovery process.

   Individual crisis intervention: telephone, e-mail, or face-to-face counseling with an EFAP counselor (or other resource) to discuss the impact of the incident on the individual, provide stabilization, discuss self-care/resources, and plan for the immediate future.

   Debriefing: Critical Incident Stress Debriefing (CISD) is a therapeutic intervention by facilitated mental health professionals for a group of individuals who have been exposed to a traumatic event. A CISD is usually conducted 1-14 days post-crises and can last two to three hours. The goal is to promote psychological closure after an event and to triage for future support such as referral of individuals for health intervention.

   Post-debriefing*:* allows the response team an opportunity to review the impact of the incident, attend to outstanding action items, plan and monitor the recovery plan, and plan for future critical incidents

3. Provide access to a resource team. This may be region-specific or a territorial-based partnership or initiative.

4. Each Region should establish protocols which address:
   - Reporting a Critical Incident (CI)
   - Prompt response
   - Accessing the CISD management team

REFERENCES:

Canadian Council on Health Services Accreditation (2006). *Leadership and Partnerships: Standard 13.* Ottawa, ON.

Canadian Council on Health Services Accreditation (2007). *Patient/Client Safety Goals and Required Organizational Practices: Patient Safely Area 1: Culture of Safety.* Ottawa, ON.

Government of Nunavut Human Resources. *Employee and Family Assistance Program.*

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

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Government of Nunavut Human Resources. *Employee and Family Assistance Program.*

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

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS **Community Health Nursing**	
TITLE:	**SECTION:**	**POLICY NUMBER:**
Nursing Practice – Employer Responsibilities	Administration	05-006-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
July 10, 2022 / July 10, 2025	Update	2
APPLIES TO:		
Community Health Nurses, Public Health Nurses, Registered Nurses, Supervisors of Home and Community Care, Home Care Nurses, Nurse Practitioners, Licensed Practical Nurses and Registered Psychiatric Nurses		

1. BACKGROUND:

The Department of Health (Health) is responsible for hiring nurses in every category employed in Nunavut.

2. POLICY:

2.1 Health will ensure nurses are aware of:

- 2.1.1 Employer policies, procedures, guidelines, and protocols through orientation and ongoing education
- 2.1.2 Nursing competencies through the *Nunavut Nursing Competency Framework (2017)*
- 2.1.3 Performance expectations as outlined in job descriptions provided
- 2.1.4 Nunavut legislation and regulations related to nursing practice

2.2 Health will determine the minimum educational requirements and educational equivalencies for nursing positions and liaise with Health Human Resources in developing job descriptions accordingly.

2.3 Health will ensure that a systematic method of keeping policies current is established through the Office of the Chief Nurse.

2.4 Health will establish and monitor policies that outline the parameters for nurses to perform basic nursing functions within the scope of practice of their designation.

2.5 Health will establish and monitor policies that outline the parameters for nurses to perform additional nursing functions and transferred functions.

3. PRINCIPLES:

3.1 The Registered Nurses Association of Northwest Territories and Nunavut (RNANT/NU) sets the minimum standards of practice for registered nurses and nurse practitioners. Registration is a legal requirement to practice in Nunavut

3.2 The Government of Nunavut is currently the registering body for Licensed Practical Nurses employed in Nunavut. Registration through the Division of Professional Practice is a legal requirement to practice in Nunavut.

3.3 Registered Psychiatric Nurses practicing in Nunavut must maintain registration in a jurisdiction that regulates psychiatric nurses – currently Manitoba and Alberta.

4. RELATED POLICIES, PROTOCOLS AND LEGISLATION:

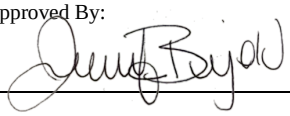
05-001-00 Nursing Policy Manual Maintenance

05-008-00 Nursing Practice – Additional Nursing Function

05-009-00 Transferred Functions
05-015-00 Statues and Legislation
Nursing Profession Act, SNWT 2003, c 15
Licensed Practical Nurses Act (S.Nu.2010, c.25)

5. REFERENCES:

Nunavut Nursing Competency Framework (2017)
Human Resources Manual, Government of Nunavut
Community Health Nursing Administration Manual
The College of Registered Psychiatric Nurses of Manitoba
College of Registered Psychiatric Nurses of Alberta

Approved By: 	Date: July 21, 2022
Jennifer Berry, Assistant Deputy Minister, Operations, Department of Health	
Approved By: 	Date: July 10, 2022
Jenifer Bujold, A/Chief Nursing Officer	

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS **Community Health Nursing**	
TITLE:	**SECTION:**	**POLICY NUMBER:**
Nursing Practice – Employee Responsibilities	Administration	05-007-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
July 10, 2022 / July 10, 2025	Update	2
APPLIES TO:		
Community Health Nurses, Public Health Nurses, Registered Nurses, Licensed Practical Nurses, Nurse Practitioners and Registered Psychiatric Nurses		

1. BACKGROUND:

Nursing is a self-regulating profession. Their responsibilities as professionals are outlined in the scope of practice and standards of practice of their regulating body. The Department of Health (Health) supports these responsibilities and outlines additional responsibilities as the employer of nurses hired to work in any capacity in Nunavut.

2. POLICY:

2.1 All Registered Nurses and Nurse Practitioners must be registered with the Registered Nurses Association of Northwest Territories and Nunavut (RNANT/NU) as prescribed by the Nunavut Nursing Act (s.Nu.2003, c.17)

2.2 All Registered Psychiatric Nurses must be registered with either The College of Registered Psychiatric Nurses of Manitoba (CRPNM)or the College of Registered Psychiatric Nurses of Alberta (CRPNA).

2.3 Currently, all Licensed Practical Nurses must be registered by the Division of Professional Practice, Department of Health, Government of Nunavut.

2.4 Nurses are responsible to maintain a safe level of practice; no statement or policy by a professional association or employer relieves the responsibility for the nurse's own actions.

2.5 All nurses must practice within the Government of Nunavut policies and within the professional standards of practice and code of ethics of their profession.

2.6 All nurses are responsible to clarify employer performance expectations and to familiarise themselves with policies, procedures and protocols used in their workplace.

3. PRINCIPLES:

3.1 RNANT/NU has the legislated authority through the Nunavut *Nursing Profession Act* (1999) to establish, maintain and promote standards of practice for registered nurses and nurse practitioners. Registration is a legal requirement.

3.2 Nurses are legally liable for all actions in their personal and professional capacity.

3.3 Nurses need to be familiar with employer policies and program standards, as these documents inform and support practice in Nunavut.

4. RELATED POLICIES, PROTOCOLS AND LEGISLATION:

Nursing Profession Act, SNWT 2003, c 15

Licensed Practical Nurses Act (S.Nu.2010, c.25)

5. REFERENCES:

Registered Nurses Association of Northwest Territories and Nunavut. (2019). *Standards of Practice for Registered Nurses and Nurse Practitioners.*

Registered Nurses Association of Northwest Territories and Nunavut. (2019). *Scope of Practice for Registered Nurses and Nurse Practitioners.*

Canadian Nurses Association. (2017). *Code of Ethics for Registered Nurses.*

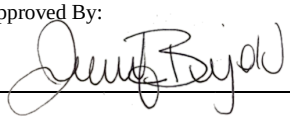
College of Licensed Practical Nurses of Alberta. (2013). *Standards of Practice for Licensed Practical Nurses in Canada.*

College of Licensed Practical Nurses of Alberta. (2013). *Code of Ethics for Licensed Practical Nurses in Canada.*

College of Registered Psychiatric Nurses of Alberta. (2013). *Code of Ethics and Standards of Psychiatric Nursing Practice.*

The College of Registered Psychiatric Nurses of Manitoba. (2017). *Code of Ethics 2017.*

The College of Registered Psychiatric Nurses of Manitoba. (2014). *Registered Psychiatric Nurse Entry-Level Competencies.*

Approved By: 	Date: July 21, 2022
Jennifer Berry, Assistant Deputy Minister, Operations – Department of Health	
Approved By: 	Date: July 10, 2022
Jenifer Bujold, A/Chief Nursing Officer	

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS		
	Community Health Nursing		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Nursing Practice – Additional Nursing Function		Administration	05-008-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		4
APPLIES TO:			
Community Health Nurses			

POLICY:

Where the Department of Health and Social Services requires nurses to perform additional nursing functions they must make provisions to assess and/or develop specialized competence. A nurse must successfully complete a program of instruction and supervised practice in the function/activity, ensuring that the formalized program of instruction includes:

- **Competency standards (exact competency standard should be identified).**
- **Knowledge of underlying principles including conditions under which it may be performed (a written teaching guide should be available).**
- **Demonstrated competence.**

PRINCIPLES:

Basic nursing programs provide sufficient theoretical background in subjects such as physiology and pharmacology to enable the registered nurse to understand the theory behind a specific additional nursing or transferred function and to develop the required specialized competence. Basic nursing programs do not provide specific theory or clinical practice for additional nursing functions.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Guideline 05-008-01 Developing a Policy for Additional Nursing Functions
Guideline 05-008-02 Performing Additional Nursing Functions
Guideline 05-008-03 Decision-making model for performing additional nursing functions

REFERENCES:

Nunavut *Nursing Act* (S.Nu. 2003, c.17).
Registered Nurses Association of Northwest Territories and Nunavut (2004). *Guidelines for Nursing Practice Decisions*. Yellowknife: RNANTNU

GUIDELINE 05-008-01

The following points should be included when drafting policy for additional nursing functions:

1) The need for additional nursing function is documented and substantiated.

2) Possible complications and/or consequences of the additional nursing function are reviewed and a protocol for safe implementation is established.

3) Evidence that the additional nursing function will be practiced often enough to maintain competence must be supplied.

4) There must be provision for review, and if certification is required, recertification to assure competency is maintained.

5) Verification of competence should be recorded so that both the registered nurse and the agency possess an up-to-date record of authorization.

RNANTNU (2004) provides criteria for deciding whether a nurse should perform an additional function. The function should be performed only if:

1) The nurse's experience and competence levels are high enough that she feels comfortable performing the function.

2) The function does not conflict with the RNANTNU Nursing Standards.

3) The agency states that the function is reasonable and appropriate and is consistent with current professional nursing practice. A written departmental policy must identify the function specifically and outline how to implement it.

4) There is a certification process based upon a program of theory and practice which leads to a certification to perform the special nursing function.
If the employer does not provide an education program consisting of both theory and practice, an equivalent alternative to get the necessary training for certification should be given.

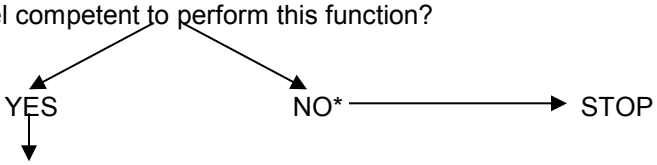
5) A monitoring system has been set up by the department to make sure that the function is performed only by those nurses who are certified. And, there must be a process for ongoing instruction and re-certification.

RNANTNU (2004). *Guidelines for Nursing Practice Decisions*. Yellowknife: RNANTNU

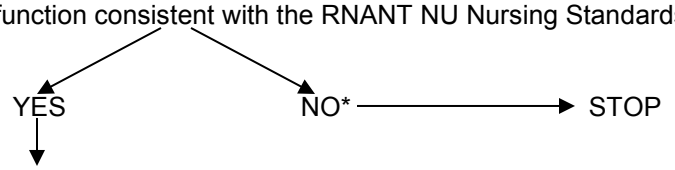
Approved by:	Effective Date:
11 FEB 2011 **Chief Nursing Officer** **Date**	April 1, 2011
February 11, 2011 **Deputy Minister of Health and Social Services** **Date**	

REFERENCE SHEET 05-008-03

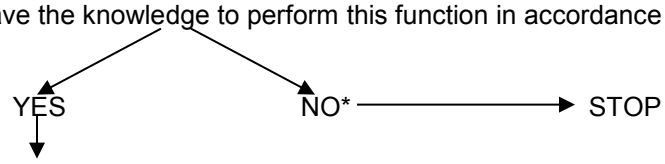
1. Do I feel competent to perform this function?



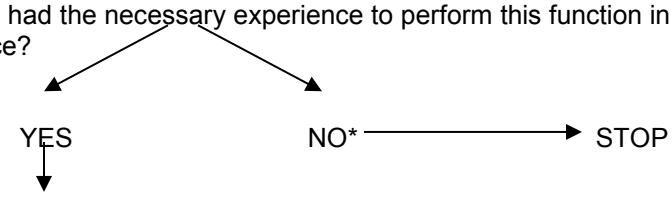
2. Is this function consistent with the RNANT NU Nursing Standards?



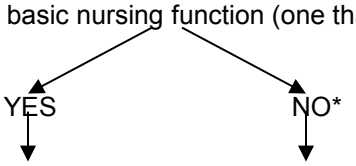
3. Do I have the knowledge to perform this function in accordance with current practice?



4. Have I had the necessary experience to perform this function in accordance with current practice?



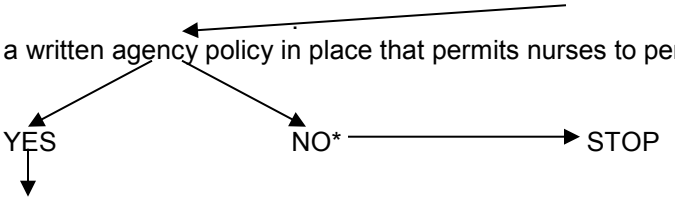
5. Is this a basic nursing function (one that was taught in the basic nursing program)?



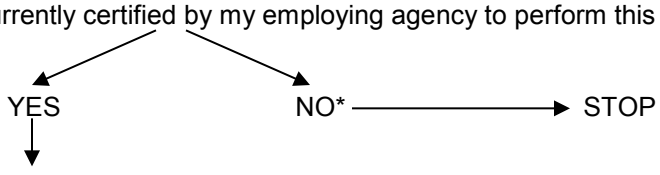
Perform the function

Then it is either a special nursing function or transferred function. Proceed with the next question.

6. Is there a written agency policy in place that permits nurses to perform this function?



7. Am I currently certified by my employing agency to perform this function?



Perform the function

* In a life-threatening situation regardless of location, a nurse in the absence of a more qualified practitioner should perform whatever functions she thinks are reasonable given the dire situation. In such a situation, a nurse should not feel constrained by lack of policy or educational preparation.
Nunavut Nursing Act

RNANTNU (2004). *Guidelines for Nursing Practice Decisions*.

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS **Community Health Nursing**	
TITLE:	**SECTION:**	**POLICY NUMBER:**
Transferred Functions	Administration	05-009-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
December 13, 2021 / December 2024	05-009-00, 05-009-01, 05-009-02	3
APPLIES TO:		
Healthcare Providers employed in Health Centres		

1. **BACKGROUND:**
   1.1. In Nunavut, health care provision in health centres is provided primarily by Registered Nurses (RNs) who are employed as Community Health Nurses (CHNs) practising under an expanded role as sanctioned by the Department of Health (Health).

   1.2. While the Canadian Nurses Association and the Registered Nurses Association of Northwest Territories and Nunavut (RNANTNU) set the standards and scope of practice for Registered Nurses, the Legislative Assembly provides the legislative acts that regulate the profession within Nunavut.

   1.3. The CHNs are supported by Licensed Practical Nurses (LPNs), Public Health Nurses (PHNs), Mental Health Nurses (MHNs) Supervisors of Home and Community Care (SHCCs), Acute Care Paramedics (ACPs) and Primary Care Paramedics (PCPs) who may also practise in an expanded role as authorised by Health.

   1.4. Health develops policy statements and medical directives in collaboration with Physicians Services as well as other professions from which the functions involved in the expanded role are being transferred.

2. **POLICY:**
   2.1. Any function that is outside of the basic scope of practice for Registered Nurses, LPNs, ACPs and PCPs will be authorised by Health in a written policy statement developed in partnership with the profession from which the function is being transferred.

   2.2. Any policy developed must be reviewed at minimum every three years to ensure alignment with changing legislation and best practices.

   2.3. Health will explicitly outline the parameters for which sanctioned functions may be transferred to healthcare providers in health centres.

3. **PRINCIPLES:**

3.1. The development of policies for transferred functions is the shared responsibility of nursing administration and the profession from which the function is being transferred. The authorisation and maintenance of transferred functions to CHNs, LPNs, PHNs, SHCCs, MHNs, ACPs and PCPs are the responsibility of the Department of Health.

3.2. The primary concern in the transfer of functions is that client safety is maintained.

3.3. Transferring of functions does not change the legal responsibility of the employer, the profession transferring the function or the healthcare provider.

4. **DEFINITIONS**:

4.1. **Transferred function**: any function transferred from one profession to another through policy or directive, e.g., CHNs are able to diagnose and initiate laboratory investigations without an order from a physician or nurse practitioner. This function was transferred to CHNs from physicians through policy and medical directive.

4.2. **Healthcare Provider:** In the context of this policy, refers to Registered Nurses employed as Community Health Nurses, Supervisors of Home and Community Care, Mental Health Nurses or Public Health Nurses; Licensed Practical Nurses, Acute Care Paramedics and Primary Care Paramedics.

4.3. **Certification:** an educational program resulting in a certificate – e.g., Basic Radiography Training and Immunisation Certification are both programs that result in a certificate.

4.4. **Verification of competence:** confirmation that a healthcare provider who has successfully completed a course of education designed to teach a specific skill can demonstrate that skill effectively. Verification of competence may done by a clinical nurse educator, mentor, or supervisor.

5. **GUIDELINE FOR TRANSFERRED FUNCTIONS**

5.1 When drafting a policy to transfer functions to a registered nurse, licensed practical nurse or acute and primary care paramedic, the following points are considered:

- Ensure a profession has sanctioned functions to be transferred and develop the policy in collaboration with the profession transferring the function.
- The need to transfer a function is documented and substantiated.
- Possible complications and/or consequences of the delegation are reviewed and a protocol for safe transfer of function is established.
- Evidence that the transferred function will be practised often enough to maintain competence must be provided.
- There must be a provision for review and, where indicated, recertification to ensure competency is maintained.
- Verification of competence should be recorded so that both the healthcare

provider and Health possess and up-to-date record of authorisation to perform the function.

5.2 Registered Nurses Association of Northwest Territories and Nunavut (2004) developed *Guidelines for Nursing Practice* which outlines a decision-making model for performing additional nursing functions and transferred functions (Reference Sheet 05-008-03). This model should be used as a reference in the development of all policies related to additional functions and transferred functions for any health centre healthcare provider.

6. GUIDELINE FOR PERFORMING TRANSFERRED FUNCTIONS

6.1 Healthcare Providers (HCP) may perform transferred functions providing that:

- HCP successfully completes a program of instruction leading to competence in the function.
- HCP is appropriately certified if required and maintains such certification.
- HCP meets the necessary competence level to perform the function and demonstrates confidence in performing the function.
- HCP is authorised by Health to perform the function and maintains an up-to-date record of such authorisation.

6.2 The instruction program for transferred functions must:

- Be reviewed at the same time the supporting policy is reviewed.
- Have identified competency standards.
- Include knowledge of underlying principles, and conditions under which it may be performed (a written teaching outline should be available).
- Have a method for demonstrating competence.

7. RELATED POLICIES, PROTOCOLS AND LEGISLATION:

- Guideline 05-009-01 Policy Guidelines for Transferred Functions
- Guideline 05-008-03 Decision-Making Model for Additional Functions and Transferred Functions

Approved By:	Date: December 12, 2021
Jennifer Berry, Assistant Deputy Minister for Operations – Department of Health	
Approved By:	Date: December 13, 2021
Jennifer Bujold, Chief Nursing Officer	

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS **Community Health Nursing**		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Competency for Transferred Functions		Administration	05-010-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
December 13, 2021	December 2024		2
APPLIES TO:			
Community Health Nurses, Supervisors of Home and Community Care, Public Health Nurses, Mental Health Nurses, Licensed Practical Nurses, Primary Care and Acute Care Paramedics			

1. BACKGROUND:

1.1. The Department of Health (Health) recognises that most health care provided in community health centres in Nunavut is delivered by healthcare providers (HCP) who are practicing under an expanded role as sanctioned by Health. Health supports these healthcare providers by ensuring that they have access to the training necessary to demonstrate competency in advanced skills.

2. POLICY:

2.1. The HCP must successfully complete a program of instruction and supervised practice in the transferred function.

2.2. HCPs are responsible for maintaining a safe level of practice and should be aware that no statement of policy by a professional association or employer relieves responsibility for the HCP's own acts.

2.3. No HCP is compelled to perform any transferred function in which the HCP does not have confidence in having achieved the necessary level of competence.

3. PRINCIPLES:

3.1. The development of policies for transferred functions is the shared responsibility of nursing, Health administration and the profession from which the function is being transferred.

3.2. The authorisation and maintenance of transferred functions to healthcare providers are the responsibility of the Department of Health.

4. **DEFINITIONS**:

4.1. **Healthcare Provider:** refers to Registered Nurses employed as Community Health Nurses, Supervisors of Home and Community Care, Public Health Nurses, Mental Health Nurses; Licensed Practical Nurses and Primary Care and Acute Care Paramedics.

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

TITLE:		SECTION:	POLICY NUMBER:
Reduction and Suspension of Core Community Health Nursing Services		Administration	05-011-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
April 30, 2022	April 30, 2023	UPDATE 05-011-00	26
APPLIES TO:			
Community Health Centres			

1. BACKGROUND:

The Department of Health (Health) acknowledges that there are unique challenges and constraints to healthcare service delivery in Nunavut. Uncontrollable events such as public health crises, mass casualty events, staffing shortages, inclement weather, and air travel interruption can all adversely impact healthcare service delivery in a community.

The complement of community health nurses present in every community health centre is required for delivery of core community health nursing programs (CCHNP). A deficit of appropriately trained and available nurses and allied health care providers may result in a decreased capacity to deliver CCHNP. In order to support reductions and suspensions to CCHP in community health centres (CHC) a standardized approach is necessary to ensure Health maintains patient safety and access to care for Nunavummiut.

In honouring Qanuqtuurniq and Piliriqatigiinniq Health may delegate roles and responsibilities of Health Care Providers in the community health centres. Supplemental resources to support health centres will be considered at each stage reduction of CCHNP.

2. POLICY:

2.1 The decision to reduce community health services requires consultation between the Supervisor of Community Health Services (SCHP), Community Health Nurses (CHNs), allied health care providers and the Director of Health Programs (Director).

2.2 The decision to suspend community health services requires consultation with the SCHP, Director, Health Programs, Executive Director (ED), the Assistant Deputy Minister, Operations (ADM, Ops) and, if appropriate, the Chief of Staff and Manager of Risk Management.

2.3 Other Health staff who provide services or clinics to the community in the same facility will respect and comply with the notice of Reduction or Suspension of Core Community Health Services and will be expected to continue to provide their services within the limitations (if any) created by the reduced or suspended nursing services.

2.4 In preparation to reduce or suspend community health services, the health centre will ensure the following program master lists are updated: Prenatal program flagging high risk pregnancies; pediatric chronic disease program flagging high risk pediatrics; adult chronic disease program flagging high risk patients; mental health program flagging long-acting antipsychotic injection patients, clozapine patients and high-risk patients.

3 PRINCIPLES:

3.1 Health must establish collaborative relationships with other programs and/or departments when creating policies, guidelines, and business contingency plans. These plans shall be

consistent with risk management strategies and ensure the continued safety of the community and Health employees.

3.2 Health will maintain a standardised process with reasonable expectations for what core services can be safely delivered or deferred.

3.3 Any reduction or suspension of services will be done in such a way as to minimise the impact on patient care as much as is reasonably possible given the circumstances of the reduction or suspension.

3.4 A deficit in Community Health Nurses and allied Health Care Provider results in decreased capacity to deliver standardised programs.

3.5 Health will take a collaborative and territorial approach through the Health Centre Closure Task Force to make decisions regarding the allocation of Human Resources to mitigate risk in relation to the reduction or suspension of community health services in communities across Nunavut.

4 **DEFINITIONS**:

Core Community Health Nursing Programs – Each community will offer comprehensive nursing services through the seven (7) core community health nursing programs:

i. Maternal health
ii. Infant and child health
iii. School-age health
iv. Adult health
v. Chronic care
vi. Communicable disease control
vii. Treatment and emergency services

Reduction of Community Health Nursing Services – Any reduction in the service capacity of a health centre, regardless, if it is a reduction in the number of core community health nursing programs, number of appointments per day, or other.

Suspension of Core Community Health Nursing Services (CCHNPs) – Temporary discontinuation of ALL core community health nursing services.

Personal Safety - The prevention and mitigation of unsafe acts including risk of personal injury or danger to the individual (Canadian Council on Health Services Accreditation (CCHSA, 2006)

Adverse Community Event - A present or imminent event that is affecting or could affect the health, safety, or welfare of people, or is damaging or could damage property (CCHSA, 2006) Examples include: fire, floods, influenza outbreak, or support staff are assisting in a community event (i.e.: search and rescue).

Adverse Event – Adverse event can be defined in one of three ways:

i. An unexpected and undesirable incident directly associated with the care and services provided to the client.
ii. An incident that occurs during the process of providing health care and results in client injury or death.
iii. An unfavorable outcome for a client, including an injury or complication. (CCHSA, 2006)

5 **GUIDELINE REDUCTION OF CORE COMMUNITY HEALTH NURSING PROGRAMS**:

5.1 **<u>The Decision to Reduce CCHNPs</u>**

5.1.1 The reduction of CCHNPs for any reason other than inclement weather is a joint consultation between the SCHP or designate and the Director of Health.

5.1.2 The SCHP and Director will refer to ***Appendix A: Criteria for Decision-Making Tree to Minimize Disruption to Services*** to determine the operational stage

for the CHC.

5.1.3 ***Appendix A*** will serve as a guide where both Primary Criteria and Secondary Criteria must be taken into consideration when making this decision.

5.2 **Procedure for Reduction of Core Community Health Nursing Programs**

5.2.1 In consultation with the Director, the SCHP and/or Community Health Nurse (CHN) will organise daily, and weekly clinics based on a safe and manageable workload. Refer to ***Appendix B Core Community Health Programs – Minimum Standards During Reduced Nursing Services*** for guidance on the reduction of services.

5.2.1.1 **Appendix C** ***"Respond" – Decision Making Tree for Minimizing Disruption to Service*** provides guidance on the frequency of follow-up with the Director and CHC on delivered services and workload.

5.2.2 The SCHP is responsible for determining which appointments should be delayed, postponed, or retained using ***Appendix B Core Community Health Programs-Minimum Standards During Reduced Nursing Services*** as a guideline.

5.2.2.1 Deferred appointments for high-risk clients need to be logged and prioritized when reduction of core community health nursing programs re-open.

5.2.3 Core services to be maintained by health centres during emergency situations are, in order of priority: Refer to ***Appendix B Core Community Health Programs – Minimum Standards During Reduced Nursing Services*** for list of core community services and order of priority.

5.2.4 At any point in time if the SCHP is uncertain of how to proceed they will contact the Director for support.

5.2.5 The SCHP, Director, ED and ADM ops will follow ***Appendix B: "Respond" – Decision Making Tree for Minimizing Disruption to Service*** to determine what additional supplemental resources can support the health centre.

5.2.6 The SCHP will additionally delegate responsibilities for HCP that are present in the community by using ***Appendix D: Community Health Centre Role Delegation*** **Table** as a guideline. If further direction on this is needed the SCHP may consult the Director.

5.3 **Communication for Reduction of Core Community Health Nursing Programs**

5.3.1 The Director must communicate all health centre reductions of service for any reason other than inclement weather to the ED, either directly or through email.

5.3.2 The Director must maintain a log of all reductions of service in the region including the reason and amount of time that the reduction is in place. Refer to ***Appendix E: Health Centre Calendar Reductions Log***.

5.3.3 The ED or Director must report updates to the task force for any health centre reductions of service for any reason other than weather and lasting longer than 48 hours, along with the reason for reduction and the plan for resolution. These updates and the mitigation plans are documented on the closure tracker.

5.3.4 It may also be necessary to advise the Manager of Risk Management depending on the nature and potential risk involved in the reduction of service.

5.3.5 Notice of service reduction for any reason beyond 48 hours, must be communicated to the community leadership (Mayor and Senior Administrative Officer (SAO)) by the SCHP prior to notifying the community.

5.3.6 All Radio, social media, and other notices will be made using a pre-approved script

or template from Communications found in the Complete Closure in Microsoft Teams in the general channel.

i. Announcement to be made on local community radio and local CHC telephone answering services.
ii. Written notices/posters must also be displayed in the CHC and at prominent sites in the community.
iii. All notices and announcements must include an alternate phone number for emergency services.
iv. All written notices will also be printed in all official languages and to include an alternate phone number for emergencies if applicable.

6 GUIDELINE SUSPENSION OF CORE COMMUNITY HEALTH NURSING SERVICES:

6.1 The Decision to Suspend Core Community Health Nursing Programs

6.1.1 The SCHP, Director of Health Programs, ED and ADM of Operations will refer to ***Appendix A: Criteria for Decision Making-Tree to Minimize Disruption to Services*** to determine the operational stage for the CHC. This table will serve as a guide where both Primary Criteria and Secondary Criteria must be considered when making this decision.

6.1.2 The decision to suspend core community health nursing services is a joint consultation between the SCHP in the community, the Director, Health Programs, the ED, and the ADM, Operations.

6.1.3 Consultation with the Chief of Staff is necessary as part of the decision-making process, although they are not directly involved in making the decision to suspend services.

6.1.4 Consultation with the Manager of Risk Management is to be considered.

6.1.5 Refer to the Standard Operating Procedure found on the Complete Closure Microsoft Team in the general channel for guidance, communication tools and operational tools.

6.2 Procedure for Suspension of Core Community Health Nursing Programs

6.2.1 The SCHP, Director, ED and ADM ops may temporarily relocate remaining RNs or HCPs from the community following a complete suspension of CCHNPs. However, it may not be reasonable to relocate the nurse from the community due to personal obligations. In this situation, the ED and Director, in consultation with the ADM, Operations will put mechanisms in place to ensure the staff and clients adhere to the decision to suspend CCHNPs.

6.2.2 The SCHP, Director, ED, and ADM Ops will follow ***Appendix C: "Respond" – Decision Making Tree for Minimizing Disruption to Service*** to determine what additional supplemental resources can support the health centre.

6.2.3 The CHC will solely be operated within the boundaries of paramedic services and will only operate for time sensitive, urgent presentation, and emergency presentations.

6.2.4 Support staff within the health centre shall continue their regular duties. The doors to the health centre will not be open for service except in emergency situations and/or if a client does not have access to a phone and needs to call for help.

6.2.5 Other Health Care providers: HCN, PHN, or LPN that remain in the community

may be expected to continue to provide nursing services as per Stage 3: Emergency Services Only as outlined in ***Appendix B: Core Community Health Programs – Minimum Standards During Reduced Nursing Services*** under the direction of the Director of Health, ED, and ADM ops if suspension of services extends beyond two weeks.

6.2.6 All clinics held by visiting health professionals such as specialty clinics, paraprofessional teams, dental or eye clinics will be deferred unless they provide their own support staff and can function without the support of community health nursing services.

6.2.7 The Director will hold teleconferences at least once daily during suspension of CCHNPs to review concerns with the support staff and allied health professionals working in the affected health centre.

6.2.8 A designated health centre employee shall keep the Director, fully apprised of any urgent matters or potential medevacs on a continuous basis.

6.2.9 The most responsible health centre delegate is as follows: SCHP>CHN> HCN/LPN/PHN > Paramedic > Support staff

6.2.10 The most responsible health centre delegate in collaboration with the regional Director will be responsible to develop a plan to monitor the generic SCHP email, correspondence received via fax or Meditech printer, and oversee administrative functions for the health centre.

6.2.11 The Director will make arrangements with the RCMP to patrol the health centre on a regular basis.

6.2.12 If there is not a Health employee working in the facility during the Suspension of CCHNPs, a process for securing the keys to the health centre shall be determined. Community Government Services must be notified. Doors and windows to the facility shall be kept locked.

6.3 **Guideline on Pharmaceuticals During the Suspension of Core Community Health Nursing Programs**

6.3.1 Suspension of CCHNP with paramedics only and no registered nurses:

6.3.1.1 CHC stocked controlled substances are allowed to remain, paramedics will follow the controlled substances guidelines outlined in the formulary

6.3.2 Suspension of CCHNP with no registered nurses and no paramedics:

6.3.2.1 CHC stocked controlled substances are to be counted, packaged, documented and sent to the regional pharmacist/pharmacy technician for safekeeping by the SCHP or CHN prior to community departure. The narcotic keys are be sent to the local CGS department for safekeeping.

6.3.2.2 The SCHP or designate will review clients who are due for upcoming injection medications (I.e. Depo-Provera, Methotrexate, etc.) and book appointments for administration prior to departure if medication scheduling permits.

6.3.2.3 The Director will contract territorial pharmacy in advance in order to facilitate increased stocked over the counter medications at Northmart by the retail pharmacy division of The North West Company.

6.4 **Communication of Suspension of CCHNP**

6.4.1 The ED will submit a Briefing Note to the ADM, Operations as soon as possible outlining the details of the service suspension.

6.4.2 The ADM, Operations will be responsible for briefing the Deputy Minister

6.4.3 The ED and Director will consult with the ADM, Operations to determine how health services delivery will be affected and then:

i. Advise Health Centre staff of the situation.

ii. Prepare a formal notice to advise the Community leadership of the pending suspension.

6.4.4 The Director will advise in writing the decision to Suspend CCHNOs at minimum to:

i. Hamlet Health Committee Chairperson in communities with a health committee

ii. RCMP

iii. Regional Manager of Human Resources

iv. Community and Government Services

v. Regional Manager, Family Services

vi. Chief of Emergency at the regional referral hospital

vii. Boarding Home Manager

6.4.5 The Director must maintain a log of all reductions of service in the region including the reason and amount of time that the reduction is in place. Refer to ***Appendix E: Health Centre Calendar Reductions Log***.

6.4.6 All Radio, social media, and other notices will be made using a pre-approved script or template found in the Complete Closure in Microsoft Teams in the general channel.

i. Announcement to be made on local community radio and local CHC telephone answering services.

ii. Written notices/posters must also be displayed in the CHC and at prominent sites in the community.

iii. All notices and announcements must include an alternate phone number for emergency services.

iv. All written notices will also be printed in all official languages and to include an alternate phone number for emergencies.

7 RELATED POLICIES, PROTOCOLS AND LEGISLATION:

Policy 04-040-00 Primary Care and Advanced Care Paramedic Medical Directive
Policy 05-003-00 Risk management
Policy 05-008-00 Nursing Practice – Additional Nursing Functions
Policy 07-009-00 Unregulated Health Care Workers – Employer's Responsibilities
Policy 07-010-00 Unregulated Health Care Workers – Nurse Responsibilities
Policy 07-044-00 Virtual Triaging for Community Health Centres Experiencing emergency services or Suspension of Core Community Nursing Services.
Policy 08-017-00 Unregulated Healthcare Workers Performing Laboratory Routines

8 **APPENDICES**:

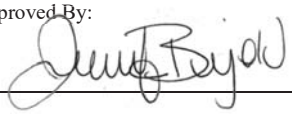
Appendix A: Criteria for Decision Making-Tree for Minimizing Disruption to Services

Appendix B: Core Community Health Programs – Minimum Standards During Reduced Nursing Services

Appendix C: "Respond" - Decision Making Tree for Minimizing Disruption to Service

Appendix D: Community Health Centre Role Delegation Table

Appendix E: Health Centre Calendar Reductions Log

Approved By: 	Date: 05-May-2022
Jenifer Berry, Assistant Deputy Minister – Department of Health	
Approved By: 	Date: April 30, 2022
Jenifer Bujold, a/Chief Nursing Officer	
Approved By:	Date:
Francois De Wet, Medical Chief of Staff	

Appendix A: Criteria for Decision Making-Tree to Minimize Disruption to Services

Note: The following criteria, along with contextual information, should be used to determine which stage is most appropriate. Consider criteria in the order which they appear in the table.

Exception to the Criteria

- If the staffing complement is reduced to one nurse, **full closure is required** (i.e., consideration of secondary criteria is not necessary).

	Primary Criteria	Community*	STAGE 0: Full Services	STAGE 1: At Risk of Reduced Services	STAGE 2: Reduced Services	STAGE 3: Emergency Services Only	STAGE 4: Complete Closure
1	**Nursing Staff Complement** *Numbers reflect realistic complement, as opposed to actual complement, and include the SHP See *Minimum Standards During Reduced Nursing Services*	6-Nurse Centre (Pangnirtung, Igloolik, Pond Inlet, Baker Lake, Arviat, Rankin Inlet, Cambridge Bay)	6 Nurses	5 Nurses	3-4 Nurses	2-3 Nurses	1 Nurse
		5-Nurse Centre (Kinngait, Gjoa Haven, Kugluktuk)	5 Nurses	4 Nurses	3-4 Nurses	2-3 Nurses	1 Nurse
		4-Nurse Centre (Sanirajak, Clyde River, Arctic Bay, Taloyoak, Kugaaruk, Coral Harbour, Naujaat, Sanikiluaq)	4 Nurses	3 Nurses	3 Nurses	2 Nurses	1 Nurse
		3-Nurse Centre (Kimmirut, Qikiqtarjuaq, Chesterfield Inlet, Whale Cove)	3 Nurses	N/A	2 Nurses	2 Nurses	1 Nurse
		2-Nurse Centre (Grise Fiord, Resolute Bay)	2 Nurses	N/A	N/A	N/A	1 Nurse

	Secondary Criteria	Key Considerations Use the following criteria to determine which stage is most appropriate; move stage up or down based on the selected levels (i.e., High, Moderate, Low)					
2	**Nursing Staff Experience** (Community Health Nursing only)	– **Experience** level of staff members – Number of staff members that are **new to CHC** – **Length of time** staff members have been in current roles	**HIGH Level of Experience** (e.g., majority of staff have experience in CHC or relevant PHC experience)	**MODERATE-HIGH Level of Experience** (e.g., majority of staff have experience in CHC or relevant PHC experience)	**MODERATE Level of Experience** (e.g., some staff have experience in CHC or relevant PHC experience)	**LOW Level of Experience** (e.g., majority of staff have limited to no experience in CHC or relevant PHC experience)	**N/A**
3	**Supervisor of Health (SHP) Program Experience**	– **Experience** level of SHP – Ability of SHP to take **first on-call** – **Length of time** staff has been in SHP role	**HIGH Level of Experience** (e.g., highly experienced SHP; able to function as CHN)	**MODERATE-HIGH Level of Experience** (e.g., highly experienced SHP; able to function as CHN)	**MODERATE Level of Experience** (e.g., moderately experienced SHP; able to function as CHN)	**LOW Level of Experience** (e.g., new or minimally experienced SHP; unable to function as CHN)	**N/A**
4	**Surge Capacity**	– **Volume and acuity** of visits to CHC – **Recent outbreak** (e.g., RSV)	**LOW Volume/Acuity** (e.g., low volume and acuity of visits; no recent outbreaks)	**MODERATE-HIGH Volume/Acuity** (e.g., normal volume and acuity of visits; no recent outbreaks)	**MODERATE Volume/Acuity** (e.g., above normal volume and acuity of visits; one recent outbreaks)	**HIGH Volume/Acuity** (e.g., high volume and acuity of visits; one or more recent outbreaks)	**N/A**
5	**Nurse Practitioner (NP) Experience** (Only consider if NP is available in community)	– **Experience level** of NP – **Ability** to perform CHN duties (including covering call) – **Comfort level** with performing CHN duties – **Length of time** staff has been NP in the GN	**HIGH Level of Experience** (e.g., highly experienced NP; able to perform CHN duties if required)	**MODERATE-HIGH Level of Experience** (e.g., highly experienced NP; able to perform CHN duties if required)	**MODERATE Level of Experience** (e.g., moderately experienced NP; able to perform CHN duties if required)	**LOW Level of Experience** (e.g., new or minimally experienced NP; unable to perform CHN duties)	**N/A**
6	**Additional Clinical Staff Availability and Experience** (e.g., Licensed Practical Nurse, Public Health Nurse, Home Care Nurse, Mental Health Nurse, Midwife, Paramedic)	– **Number and type** of staff members available – **Experience** level of staff members – **Ability** to perform CHN duties (including covering call); ability to independently manage programs – **Comfort level** with performing CHN duties – **Length of time** staff members have been in current roles	**HIGH Availability/Experience** (e.g., additional clinical staff available and able to support clinical functions in CHC)	**MODERATE-HIGH Availability/Experience** (e.g., additional clinical staff available and able to support clinical functions in CHC)	**MODERATE Availability/ Experience** (e.g., additional clinical staff available and able to support clinical functions in CHC)	**LOW Availability/Experience** (e.g., additional clinical staff unavailable or unable to support clinical functions in CHC)	**N/A**
7	**Support Staff Availability and Experience** (e.g., Clerk Interpreters, Housekeeping, Unit Clerk)	– **Number and type** of staff members available – **Experience** level of staff members – **Ability** to perform additional responsibilities – **Length of time** staff members have been in current roles	**HIGH Availability/ Experience** (e.g., stable and reliable support staff; support staff able to perform additional responsibilities)	**MODERATE-HIGH Availability/Experience** (e.g., stable and reliable support staff; support staff able to perform additional responsibilities)	**MODERATE Availability/ Experience** (e.g., some support staff have experience; support staff able to perform additional responsibilities)	**LOW Availability/Experience** (e.g., limited support staff available; new or minimally experienced support staff)	**N/A**
8	**Physician Availability and Experience** (Only consider if physician is available in community)	– Ability to **independently perform clinical functions** (i.e., without CHN support) – **Experience** level and **specialty** of physician – **Length of time** staff has been physician in the GN	**HIGH Availability/Experience** (e.g., highly experienced physician; able to independently perform clinical functions in CHC)	**MODERATE-HIGH Availability/Experience** (e.g., highly experienced physician; able to independently perform clinical functions in CHC)	**MODERATE Availability/ Experience** (e.g., moderately experienced physician; requires support to perform clinical functions in CHC)	**LOW Availability/Experience** (e.g., new or minimally experienced physician; unable to perform clinical functions in CHC or requires significant support)	**N/A**
9	**Security Concerns**	– **Security concerns** that make it unsafe for staff to work alone – Availability of Security Services	**LOW Security Concerns**	**MODERATE Security Concerns**	**MODE-HIGH Security Concerns**	**HIGH Security Concerns**	**N/A**

Appendix B: Core Community Health Programs-Minimum Standards During Reduced Nursing Services

The following charts should be used guides to assist the Supervisor of Health Programs (SHP) with organizing priority programs/services; they also indicate which programs/services can be safely deferred. For each stage, a minimum standard of care that the Community Health Centre (CHC) should strive to maintain is defined, including relevant tasks and the respective care providers responsible for task completion. If this standard is not achievable, additional supports should be considered – Refer to the **Decision-Making Tree for Minimizing Disruption to Health Services** (Appendix B).

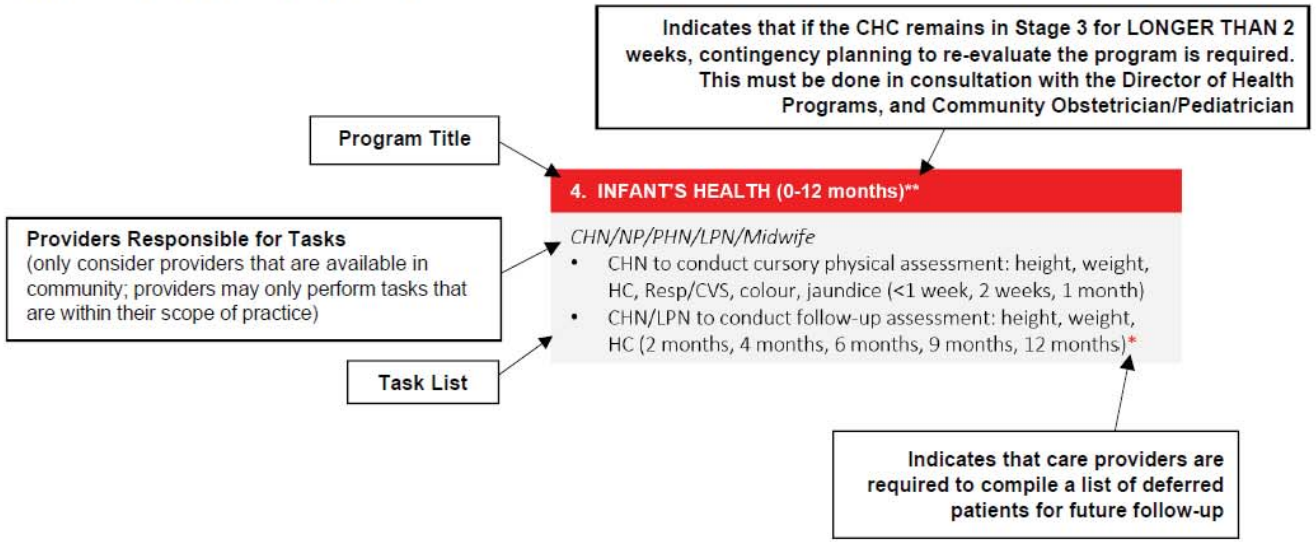
Priority healthcare delivery should always be based on resuscitation, emergent, then urgent presentations:

1) **CTAS Level 1 (RESUSCITATION):** Conditions that are threats to life or limb (or imminent risk of deterioration) requiring aggressive intervention.
   Examples – Cardio/Respiratory Arrest; Major Trauma; Shock States; Unconscious Patients; Severe Respiratory Distress

2) **CTAS Level 2 (EMERGENT):** Conditions that are a potential threat to life, limb for function, requiring rapid medical intervention or delegated acts.
   Examples – Altered Mental States; Head Injury; Severe Trauma; Neonates; MI; Overdose; CVA

3) **CTAS Level 3 (URGENT):** Conditions that may deteriorate to Level 2 within three hours without intervention.
   Examples – Moderate Trauma; Asthma; GI Bleed; Vaginal Bleeding in Pregnancy; Acute Psychosis and/or Suicidal Thoughts; Acute Pain

UNDERSTANDING THE CHARTS



CHN	Community Health Nurse
NP	Nurse Practitioner
LPN	Licensed Practical Nurse
CHR	Community Health Representative
DOT	Direct Observation Worker
PHN	Public Health Nurse
HCN	Home Care Nurse
MHN	Mental Health Nurse
MHC	Mental Health Counsellor
ACP	Advanced Care Paramedic
PCP	Primary Care Paramedic

Appendix B: Core Community Health Programs – Minimum Standards During Reduced Nursing Services

STAGE 0: FULL SERVICES (FULLY STAFFED)

1. PRENATAL HEALTH

CHN/NP/Midwife
- Initial prenatal appointments at 10-12 weeks during dedicated timeslot
- Routine prenatal appointments based on gestational age and risk factors during dedicated timeslot
- Initial- and trimester-specific screening labs & US

ACP/PCP/LPN
- Assist with pre-appointment vital signs, height, weight, urinalysis, Hgb POCT. Assist with post-appointment labs.

2. POSTPARTUM HEALTH

CHN/NP/Midwife/PHN
- Home visit/ clinic visit within 1 week of returning postpartum (only PHN/CHN/NP)
- Phone call check-up 6 weeks postpartum, including inquiry regarding contraception

ACP/PCP/LPN
- Assist with pre-appointment vital signs, height, weight. Assist with post-appointment labs.

3. WOMEN'S HEALTH

CHN/NP/Midwife
- Routine well women program during dedicated timeslots
- Follow routine cervical cancer screening
- Follow-up on abnormal PAP results; refer to MD/NP, if required
- Family planning appointments re: contraception (e.g., birth control (Plan B), pregnancy test)

ACP/PCP/LPN
- Assist with pre-appointment vital signs, height, weight. Assist with post-appointment labs

4. INFANT'S HEALTH (0-12 months)

CHN/NP/PHN

Routine well infant appointments during dedicated timeslots (booked at <1 week, 2 weeks, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months)
- Immunize as per NU Immunization Schedule
- Follow pediatric patients enrolled in the CDC program (CHN/NP only)
- Complete routine labs based on the pediatric chronic disease recommendations
- Conduct risk assessments and flag pediatric CDCs (follow-up and monitor as per risk assessments)
- Follow-up on child welfare concerns with Family Services
- Home visit/ clinic visit within 48 hours of returning home (height, weight, head circumference, wellness check)

Midwife
- Routine well infant appointments < 2 months old
- Home visit/ clinic visit within 48 hours of returning home (height, weight, head circumference, wellness check)

PCP/ACP/LPN
- Assist with pre-appointment vital signs, height, weight, head circumference. Hgb POCT if needed.
- Immunize as per NU Immunization Schedule
    - MD/NP order required for PCPs and ACPS, LPNs may follow NU immunization schedule

5. CHILD HEALTH (1-5 years)

CHN/NP/PHN
- Routine well child appointments during dedicated timeslots (booked at 15 months, 18 months, 2-3 years, preschool screening) – CHN/NP/PHN only
- Immunize as per NU Immunization Schedule
- Follow pediatric patients enrolled in the CDC program (CHN/NP only)
- Complete routine labs based on the pediatric chronic disease recommendations
- Conduct risk assessments and flag pediatric CDCs (follow-up and monitor as per risk assessments)
- Follow-up on child welfare concerns with Family Services

ACP/PCP/LPN
- Assist with pre-appointment vital signs, height, weight, head circumference, vision screening, Hgb POCT if needed.
- Immunize as per NU Immunization Schedule
    - MD/NP order required for PCPs, LPNs may follow NU immunization schedule
- Complete ordered labs for chronic disease patients

CHR
- Health education

6. SCHOOL HEALTH (5-15+ years)

CHN/NP
- Follow pediatric patients enrolled in CDC program
- Complete routine labs based on the pediatric chronic disease recommendations
- Conduct risk assessments and flag pediatric CDCs (follow-up and monitor as per risk assessments)
- Routine physical assessment

PHN/LPN/ACP/PCP
- Health education
- Vision screening
- Fluoride supplementation
- Routine physical assessment (PHN only)
- Immunize as per NU Immunization Schedule (Gardasil).
    - MD/NP order required for ACP/PCP (May autonomously administer Influenza and COVID-19 vaccines without an order for eligible populations aged five years and older) LPN may follow NU Immunization Schedule

CHR
- Health education

7. ADULT HEALTH

CHN/NP
- Immunizations – PEP
- Immunizations – Prophylaxis based on recommendations and risk (e.g., pneumovax-23, pneumococcal-13, COVID, Influenza)
- Maintain screening guidelines

ACP/PCP/LPN
- Assist with pre-appointment vital signs, height, weight. Post appointment labs.
- May autonomously administer COVID-19 vaccines without MD/NP order for eligible populations

8. COMMUNICABLE DISEASE

CHN/NP/PHN/LPN/ACP/PCP
- COVID case management
- STI case management (CHN/PHN/NP only)
- TB case management (PHN only, CHN if no PHN)
- Report case findings
- Contact tracing and follow-up
- Disease prevention education

(Stage 0 continued on page 2)

DOT worker
- DOT TB meds

Appendix B: Core Community Health Programs – Minimum Standards During Reduced Nursing Services

STAGE 0: FULL SERVICES (FULLY STAFFED)

9. HEALTH PROMOTION

CHR/PHN
- Communication strategies
- Public education strategies
- Meetings with community leadership
- Interagency meetings

10. CHRONIC CARE

CHN/NP
- Follow routine adult CDC patients on dedicated weekly timeslot
- Complete routine labs based on chronic disease recommendations
- Conduct risk assessments and flag adult CDCs (follow-up and monitor as per risk assessments)
- INR/Coumadin monitoring

LPN/ACP/PCP
- Assist with pre-appointment vital signs, height, weight, medication reconciliation, POCT
- Assist with post-appointment tasks: phlebotomy and process labs, perform INR POCT for patients on Coumadin

11. HOME CARE

HCN
- Provide routine care for home care patients
- Support referral process of home care patients
- Follow palliative patients in community

12. MENTAL HEALTH AND ADDICTIONS SERVICES

MHN/MHC
- Provide routine care for mental health patients being followed, including metabolic monitoring
- Provide counselling support and psychoeducation for addictions, trauma, grief, loss, stress, poor coping, *etc.*
- Administer long-acting antipsychotic injections (if no MHN available, CHN/NP is responsible for administering long-acting antipsychotics injections)
- Track and dispense medications to patients on a weekly/bi-weekly/monthly plan; review medication profile and arrange for renewals
- Support with patients presenting in acute mental health crisis during and after-hours as per the on-call schedule
- Assess patients detained in cells requiring clearance
- Support public education strategies and community outreach

13. TREATMENT SERVICES

CHN/NP
- Sick clinic and walk-ins
- Initiate diagnostic and monitoring bloodwork
- All follow-ups
- Prescription renewals (updated assessment and labs required for the prescription are completed)
- Driver's medicals
- Marine medicals
- Baffinland and work screening medicals
- Pre-op appointments (e.g., general anesthetic dental)
- WSCC workplace injuries appointments
- Sick notes

ACP
- Sick clinic and walk-ins
- All follow-ups
- Prescription renewals (updated assessment)
- Pre-op appointments (e.g., general anesthetic dental)
- In-clinic triage
- Task-oriented assistance with CHN/NP (e.g., labs, PIV start)
- Requires consult with NP/MD to close loop on new assessments

LPN/PCP
- Pre-op appointments (e.g., general anesthetic dental)
- Pre appointment vital signs, height, weight
- Task-oriented assistance with CHN/NP (e.g., labs, PIV start)

14. EMERGENCY CARE BY CHN/NP/ACP/PCP

Fully operational

PCP/ACP
- Assist 1st nurse on call with emergencies (CTAS 1-2s) during regular operational hours
- Support ad hoc tasks if a 3rd clinician is required after hours due to health centre volume and acuity
- Take the role as MRP for emergencies (ACP only)
- Cover 2nd nurse on call position (ACP only)

Appendix B: Core Community Health Programs – Minimum Standards During Reduced Nursing Services

STAGE 1: AT RISK OF REDUCED SERVICES

In *Stage 1*, it is expected that full program and healthcare services will be offered. However, depending on the CHN complement and impact of the secondary criteria (See Table 1), there may be fewer appointments booked per day.

1. PRENATAL HEALTH	6. SCHOOL HEALTH (5-15+ years)	11. HOME CARE
Fully operational	*Fully operational*	*Fully operational*
2. POSTPARTUM HEALTH	**7. ADULT HEALTH**	**12. MENTAL HEALTH AND ADDICTIONS SERVICES**
Fully operational	*Fully operational*	*Fully operational*
3. WOMEN'S HEALTH	**8. COMMUNICABLE DISEASE**	**13. TREATMENT SERVICES**
Fully operational	*Fully operational*	*Fully operational*
4. INFANT'S HEALTH (0-12 months)	**9. HEALTH PROMOTION**	**14. EMERGENCY CARE BY CHN/NP/ACP/PCP**
Fully operational	*Fully operational*	*Fully operational*
5. CHILD HEALTH (1-5 years)	**10. CHRONIC CARE**	
Fully operational	*Fully operational*	

Appendix B: Core Community Health Programs – Minimum Standards During Reduced Nursing Services

STAGE 2: REDUCED SERVICES

1. PRENATAL HEALTH
If Midwife in community, program fully operational

CHN/NP/Midwife
- Initial prenatal appointments at 10-12 weeks during dedicated timeslot (spread throughout the week)
    - Prenatal appointments to be prioritized
- Routine prenatal appointments based on gestational age and risk factors during dedicated timeslot
- Initial- and trimester-specific screening, bloodwork, labs, US

ACP/PCP/LPN
- Assist with pre-appointment vital signs, height, weight, urinalysis, Hgb POCT. Assist with post-appointment labs.

2. POSTPARTUM HEALTH
If Midwife and/or PHN in community, program MAY be fully operational

CHN/NP/Midwife/PHN
- Home visit/ clinic visit within 1 week of returning postpartum
- Phone call check-up 6 weeks postpartum, including inquiry regarding contraception; defer in-person appointment if no concerns during call*

ACP/PCP/LPN
- Assist with pre-appointment vital signs, height, weight. Assist with post-appointment labs

3. WOMEN'S HEALTH

CHN/NP/Midwife
- Follow-up on abnormal PAPs (i.e., LSIL - delegation email to community MD/NP referral)*
- Family planning appointments regarding contraception (e.g., birth control (Depo/Plan B), pregnancy test)
- Defer routine PAPs for cervical cancer screening*

ACP/PCP/LPN
- Assist with pre-appointment vital signs, height, weight. Assist with post-appointment labs
- Assist with urine pregnancy test; MD/NP consultation required

4. INFANT'S HEALTH (0-12 months)

CHN/NP/PHN
- Conduct cursory physical assessment: height, weight, head circumference, Resp/CVS, colour, jaundice (<1 week, 2 weeks, 1 month)
- Conduct follow-up assessment: height, weight, head circumference (2 months, 4 months, 6 months, 9 months, 12 months)*
- Immunize as per NU Immunization Schedule
- Continue to follow medium-high risk CDC patients (CHN/NP only)
- Conduct risk assessments; flag pediatric CDCs (follow-up and monitor if medium-high risk)
- Follow-up on child welfare concerns with Family Services
- Defer routine CDC patient follow-ups*

4. INFANT'S HEALTH (0-12 months) (continued)

Midwife
- Conduct cursory physical assessment: height, weight, head circumference, Resp/CVS, colour, jaundice (< 2 months)
- Home visit/ clinic visit within 48 hours of returning home (height, weight, head circumference, wellness check)

PCP/ACP/LPN
- Assist with pre-appointment vital signs, height, weight, head circumference. Hgb POCT if needed.
- Immunize as per NU Immunization Schedule
    - MD/NP order required for ACP, PCP. LPN may follow the NU Immunization Schedule

5. CHILD HEALTH (1-5 years)

CHN/NP/PHN
- Immunize as per NU Immunization Schedule
- Conduct follow-up assessment: height, weight (12 months, 15 months, 18 months, 2-3 years)
- Conduct physical assessments/G&D for high-risk patients; conduct preschool screening
- Follow medium-high risk CDC patients (CHN/NP only)
- Conduct risk assessments; flag pediatric CDCs (follow-up and monitor if medium-high risk)
- Follow-up on child welfare concerns with Family Services
- Defer routine physical assessments*
- Defer routine CDC patient follow ups*

PCP/ACP/LPN
- Assist with pre-appointment vital signs, height, weight, head circumference. Hgb POCT if needed.
- Immunize as per NU Immunization Schedule
    - MD/NP order required for ACP, PCP. LPN may follow the NU Immunization Schedule

6. SCHOOL HEALTH (5-15+ years)

CHN/NP
- Continue to follow medium-high risk CDC patients
- Conduct risk assessments; flag pediatric CDCs (follow-up and monitor if medium-high risk)
- Defer routine CDC patient follow-ups*

PHN/LPN/ACP/PCP *(may defer the following (except Gardasil) if insufficient staff)**
- Health education
- Vision screening
- Fluoride supplementation
- Cursory physical assessment (PHN only)
- Immunize as per NU Immunization Schedule (Gardasil).
    - MD/NP order required for ACP/PCP (may autonomously administer COVID-19 vaccines without an order for eligible populations aged five years and older)
- LPN may follow the NU Immunization Schedule

CHR
- Health education

7. ADULT HEALTH

CHN/NP/LPN/ACP/PCP
- Immunize as per NU Immunization Schedule (Gardasil)
    - MD/NP order required for ACP/PCP (May autonomously administer COVID-19 vaccines without an order for eligible populations aged five years and older)
- LPN may follow the NU Immunization Schedule

8. COMMUNICABLE DISEASE

CHN/NP/PHN/LPN/ACP/PCP
- COVID case management
- STI case management (CHN/PHN/NP only)
- TB case management (PHN only, CHN if no PHN)
- Report case findings
- Contact tracing and follow-up
- Disease prevention education

DOT worker
- DOT TB meds

9. HEALTH PROMOTION

Program on hold

(Stage 2 continued on page 5)

* Care providers are required to compile a list of deferred patients for future follow-up

Appendix B: Core Community Health Programs – Minimum Standards During Reduced Nursing Services

STAGE 2: REDUCED SERVICES

10. CHRONIC CARE

CHN/NP/HCN

- Provide care for and follow medium-high risk and fragile CDC patients
- Conduct risk assessments and flag adult CDCs (only monitor medium-high risk)
- INR/Coumadin monitoring
- Defer routine low-risk CDC appointments*

LPN/ACP/PCP

- Assist with pre-appointment vital signs, height, weight, medication reconciliation, POCT
- Assist with post-appointment tasks: phlebotomy & process labs, perform INR POCT for patients on Coumadin

11. HOME CARE

HCN (if no HCN, CHN/NP to follow high-risk and palliative patients)

- Provide routine care for home care patients
- Support referral process of home care patients
- Follow palliative patients in community

If no HCN in community, CHN/NP to:

- Follow high-risk and palliative patients

12. MENTAL HEALTH AND ADDICTIONS SERVICES

MHN/MHC (If no MHN in community, CHN/NP to consult on-call MHN for guidance on following high risk patients)

- Provide routine care for mental health patients being followed
- Provide addiction counselling support; refer to treatment centre, if required
- Provide Depo medications for all patients on injectable antipsychotics (CHN/NP/LPN/RN to administer if no MHN)
- Track and dispense medications to patients on a weekly/bi-weekly/monthly dispensing plan (CHN/NP/LPN/RN if no MHN)
- Support with patients presenting in acute mental health crisis
- Assess patients detained in cells requiring clearance

13. TREATMENT SERVICES

CHN/NP

- Non-deferrable/urgent walk-ins/sick clinic patients only
- Initiate diagnostic and essential monitoring bloodwork
- Triage essential follow-ups (e.g., post-surgical)
- Ensure medication renewals are communicated to community physician (short renewals only where thorough follow ups can be deferred at a later date; obtain longer renewal at that time)
- Pre-op appointments (e.g., general anesthetic dental)
- Continue WSCC workplace injury appointments
- Defer all medicals EXCEPT Driver's Medicals for essential community jobs (e.g., water truck delivery)*
- Defer non-urgent appointments and follow-ups*

ACP

- Sick clinic and walk-ins
- All follow-ups
- Prescription renewals (updated assessment)
- Pre-op appointments (e.g., general anesthetic dental)
- In clinic triage
- Task orientated assistance with CHN/NP (e.g., labs, PIV start)

*Requires consult with NP/MD to close loop on new assessments

LPN/PCP

- Pre-op appointments (e.g., general anesthetic dental)
- Pre appointment vital signs, height, weight
- Task-oriented assistance with CHN/NP (e.g., labs, preparing medications, PIV start)

14. EMERGENCY CARE BY CHN/NP/ACP/PCP

Fully operational

PCP/ACP

- Assist 1st nurse on call with emergencies (CTAS 1-2s) during regular operational hours
- Support ad hoc tasks if a 3rd clinician is required after hours due to health centre volume and acuity
- Take the role as MRP for emergencies (ACP only)
- Cover 2nd nurse on call position (ACP only)
- Cover 1st nurse on call position (ACP only)
    - If supported by virtual triage program

* Care providers are required to compile a list of deferred patients for future follow-up

Appendix B: Core Community Health Programs – Minimum Standards During Reduced Nursing Services

STAGE 3: EMERGENCY SERVICES ONLY (1)

The following guidelines should be used if operating in *Stage 3* for LESS THAN than 2 weeks. Care for non-urgent patients can be deferred for up to 2 weeks until contingencies can be made. If the health centre remains in Stage 3 for longer than 2 weeks, previously deferred patients must be re-prioritized.

1. PRENATAL HEALTH**
If Midwife in community, program fully operational

CHN/NP/Midwife
- Follow high-risk prenatal patients only (communicate with community obstetrician/midwife to determine which patients must be followed)
- Initial- and trimester-specific screening, bloodwork, labs, US for high-risk patients only

LPN/PCP/ACP
- Assist with pre-appointment vital signs, urine analysis POCT
- Assist with post-appointment phlebotomy, lab processing
- Obtain history and physical assessment; review findings with MD/NP on any concerns/issues along with POC (ACP only)

2. POSTPARTUM HEALTH
If Midwife in community, program MAY be fully operational

CHN/NP/Midwife/PHN
- Phone call check-up within 1 week of returning postpartum (PHN/CHN/NP/LPN)
- Phone call check-up 6 weeks postpartum, including inquiry regarding contraception; defer in-person appointment if no concerns during call*

ACP
- Assist with follow-up prenatal phone check-ups; address concerns or issues with MD/NP/Midwife and determine need to assess patient in the health centre
- Forward birth control inquiries to CHN/MD/NP/Midwife

3. WOMEN'S HEALTH

CHN/NP/Midwife
- Follow-up on abnormal PAPs (i.e., LSIL - delegation email to community MD/NP referral)
- Family planning appointments regarding contraception (e.g., birth control (Depo/Plan B), pregnancy test)
- Defer routine PAPs for cervical cancer screening*

LPN/PCP/ACP
- Assist with urine pregnancy test; MD/NP consultation required

4. INFANT'S HEALTH (0-12 months)**

CHN/NP/PHN
- Conduct cursory physical assessment: height, weight, head circumference, Resp/CVS, colour, jaundice (<1 week, 2 weeks, 1 month)
- Conduct follow-up assessment: height, weight, head circumference (2 months, 4 months, 6 months, 9 months, 12 months)*
- Immunize as per NU Immunization Schedule
- Continue to follow high risk CDC patients (CHN/NP only)
- Conduct risk assessments; flag pediatric CDCs (follow-up and monitor if high risk)
- Follow-up on child welfare concerns with Family Services
- Defer routine CDC patient follow-ups*

Midwife
- Routine well infant appointments <2 months old
- Home visit/ clinic visit within 48 hours of returning home (height, weight, head circumference, wellness check)

PCP/ACP/LPN
- Assist with pre-appointment vital signs, height, weight, head circumference. Hgb POCT if needed.
- Immunize as per NU Immunization Schedule
  - MD/NP order required for ACP/PCP
- LPNs may follow the NU Immunization Schedule
- Complete cursory physical assessments (respiratory/CVS, colour, jaundice); review abnormal findings with MD/NP/Midwife (ACP only)

5. CHILD HEALTH (1-5 years)**

CHN/NP/PHN
- Conduct physical assessments/G&D for high-risk patients; conduct preschool screening
- Immunize as per NU Immunization Schedule
- CHN/LPN to conduct follow-up assessment: height, weight (12 months, 15 month, 18 month, 2-3 years)
- Continue to follow high-risk CDC patients (CHN/NP only)
- Conduct risk assessments; flag pediatric CDCs (follow-up and monitor if medium-high risk)
- Follow-up on child welfare concerns with Family Services
- Defer routine physical assessments*
- Defer routine CDC patient follow ups*

PCP/ACP/LPN
- Assist with pre-appointment vital signs, height, weight, head circumference. Hgb POCT if needed.
- Immunize as per NU Immunization Schedule
  - MD/NP order required
- LPNs may follow the NU Immunization Schedule
- Complete cursory physical assessments (respiratory/CVS, colour, jaundice); review abnormal findings with MD/NP/Midwife (ACP only)

6. SCHOOL HEALTH (5-15+)

PHN/LPN/ACP/PCP
- Immunize per NU Immunization Schedule (Gardasil)
  - MD/NP order required for ACP/PCP

7. ADULT HEALTH

CHN/NP/LPN/ACP/PCP
- Immunizations – Influenza, PEP
  - MD/NP order required for ACP/PCP for PEP
- Immunizations – COVID

8. COMMUNICABLE DISEASE

CHN/NP/PHN/LPN/ACP/PCP
- COVID case management
- STI case management (CHN/PHN/NP only)
- TB case management (PHN only, CHN if no PHN)
- Report case findings
- Contact tracing and follow-up
- Disease prevention education

DOT Worker
- DOT TB meds

Unregulated Health Care Worker
- Abbott ID Now POCT (with training)

9. HEALTH PROMOTION

(Stage 3 continued on page 7)

Program on hold

* Care providers are required to compile a list of deferred patients for future follow-up

** If the CHC remains in Stage 3 for LONGER THAN 2 weeks, contingency planning to re-evaluate the program is required. This must be done in consultation with the Director of Health Programs, and Community Obstetrician/Pediatrician

Appendix B: Core Community Health Programs – Minimum Standards During Reduced Nursing Services

STAGE 3: EMERGENCY SERVICES ONLY (2)

The following guidelines should be used if operating in *Stage 3* for LESS THAN than 2 weeks. Care for non-urgent patients can be deferred for up to 2 weeks until contingencies can be made. If the health centre remains in Stage 3 for longer than 2 weeks, previously deferred patients must be re-prioritized.

10. CHRONIC CARE

CHN/NP
- Provide care and follow only high-risk and fragile CDC patients
- Conduct risk assessments and flag adult CDCs (only monitor high-risk)
- Continue INR/Coumadin monitoring
- Defer routine low-medium risk CDC appointments*

LPN/ACP/PCP
- Assist with pre-appointment vital signs, height, weight, medication reconciliation, POCT
- Assist with post-appointment tasks: phlebotomy & process labs, perform INR POCT for patients on Coumadin
- Assist with CDC history, physical exam; review findings with MD/NP on assessment sequela/complications) along with plan of care (ACP only)

11. HOME CARE

HCN
- Provide care to high-risk home care patients
- Continue to follow palliative patients in community

If no HCN in community, CHN/NP to:
- Follow high-risk and palliative patients

LPN/ACP/PCP
- Assist with pre-appointment vital signs
- Assist with post-appointment tasks: phlebotomy & process labs
- Assist with routine home care needs/medical needs (e.g., dressing changes)

12. MENTAL HEALTH AND ADDICTIONS SERVICES
If MHN/MHC in community, no changes to program delivery

If no MHN/MHC in community, CHN/NP/RN/LPN to:
- Administer long-acting antipsychotic injections
- Dispense PO medications to patients on a weekly/bi-weekly/monthly dispensing plan
- Continue with clozapine lab monitoring

If no MHN in community, CHN/NP to:
- Consult on-call MHN for guidance on following high risk patients; refer to client list

13. TREATMENT SERVICES

CHN/NP/LPN
- Non-deferrable/urgent walk-ins/sick clinic patients only
- Initiate diagnostic and essential monitoring bloodwork
- Triage essential follow ups (e.g., post-surgical)
- Ensure medication renewals are communicated to community physician (short renewals only where thorough follow ups can be deferred at a later date; obtain longer renewal at that time)
- Pre-op appointments (e.g., general anesthetic dental)
- Continue WSCC workplace injury appointments
- Defer all medicals EXCEPT Driver's Medicals for essential community jobs (e.g., water truck delivery)*
- Defer non-urgent appointments and follow-ups*

ACP
- Sick clinic and walk-ins
- All follow-ups
- Prescription renewals (updated assessment)
- Pre-op appointments (e.g., general anesthetic dental)
- In-clinic triage
- Task-oriented assistance with CHN/NP (e.g,. labs, PIV start)
- Requires consult with NP/MD to close loop on new assessments

LPN/PCP
- Pre-op appointments (e.g., general anesthetic dental)
- Pre appointment vital signs, height, weight
- Task orientated assistance with CHN/NP (e.g., labs, preparing medications, PIV start)
- Communicate prescription renewals to the community NP/MD

14. EMERGENCY CARE BY CHN/NP/ACP/PCP

Fully operational

ACP/PCP
- Assist 1st nurse on call with emergencies (CTAS 1-2s) during regular operational hours
- Support ad hoc tasks if a 3rd clinician is required after hours due to health centre volume and acuity
- Take the role as MRP for emergencies (ACP only)
- Cover 2nd nurse on call position (ACP only)
- Cover 1st nurse on call position (ACP only)
    - If supported by virtual triage program

* Care providers are required to compile a list of deferred patients for future follow-up

Appendix B: Core Community Health Programs – Minimum Standards During Reduced Nursing Services

STAGE 4: Suspension of Core Community Nursing Services

In *Stage 4*, the CHC will solely be operated within the boundaries of the paramedics . The clinic will only operate for time sensitive and urgent presentations, along with emergencies.
The following guidelines should be used if operating in *Stage 4* for LESS THAN than 2 weeks. Care for non-urgent patients can be deferred for up to 2 weeks until contingencies can be made. If the health centre remains in Stage 4 for longer than 2 weeks, previously deferred patients must be re-prioritized.
All routine programs and follow-ups for high-risk patients will be put on hold. In circumstances where there are forecasted suspension of core nursing services for an extended period of time and there are other health care providers such as LPN, MHN, PHN, and HCN in the community, services will be provided within the limitations outlined in Stage 3: Emergency Services only within their respective scope.

1. PRENATAL HEALTH

Program on hold

EXCEPTION: Routine prenatal appointments for clients >32 weeks identified as high risk

2. POSTPARTUM HEALTH

Program on hold

3. WOMEN'S HEALTH

Program on hold

4. INFANT'S HEALTH (0-12 months)

Program on hold

EXCEPTION: <2 months - Complete cursory physical assessments (respiratory/CVS, colour, jaundice) with height, weight, HC; review abnormal findings with MD (ACP/PCP only)

5. CHILD HEALTH (1-5 years)

Program on hold

6. SCHOOL HEALTH (5-15+ years)

Program on hold

7. ADULT HEALTH

Program on hold

EXCEPTION: Immunization – PEP only

8. COMMUNICABLE DISEASE

Program on hold

9. HEALTH PROMOTION

Program on hold

10. CHRONIC CARE

Program on hold

EXCEPTION: INR/Coumadin monitoring

11. HOME CARE

Program on hold

EXCEPTION: Palliative Care

12. MENTAL HEALTH AND ADDICTIONS SERVICES

If MHN/MHC in community, no changes to program delivery

If no MHN/MHC in community, ACP to:

- Administer long-acting antipsychotic injections if an active prescription is present
- Dispense oral prescription medications to patients on a weekly/bi-weekly/monthly dispensing plan
- Continue with clozapine lab monitoring

(Stage 4 continued on page 9)

13. TREATMENT SERVICES

Program on hold

Appendix B: Core Community Health Programs – Minimum Standards During Reduced Nursing Services

STAGE 4: Suspension of Core Community Nursing Services

In *Stage 4*, the CHC will solely be operated within the boundaries of the paramedics . The clinic will only operate for time sensitive and urgent presentations, along with emergencies.
The following guidelines should be used if operating in *Stage 4* for LESS THAN than 2 weeks. Care for non-urgent patients can be deferred for up to 2 weeks until contingencies can be made. If the health centre remains in Stage 4 for longer than 2 weeks, previously deferred patients must be re-prioritized.
All routine programs and follow-ups for high-risk patients will be put on hold. In circumstances where there are forecasted suspension of core nursing services for an extended period of time and there are other health care providers such as LPN, MHN, PHN, and HCN in the community, services will be provided within the limitations outlined in Stage 4: Emergency Services only within their respective scope.

14. EMERGENCY CARE BY ACP/PCP

Fully operational

Inclusive of, but not limited to:

- CV/Resp arrest
- Trauma
- Altered level of consciousness
- Acute confusion/delirium
- Extreme/unilateral weakness/CVA symptoms
- Sudden severe headache
- Seizure
- Chest pain
- Syncope
- Symptomatic Arrythmia
- SOB moderate-severe or WOB
- Apnea in infants
- Hemoptysis either gross or accompany
- CP/SOB
- Infant <3 months with fever
- Vaginal bleeding in pregnancy
- SEPSIS (or SIRS criteria >3)
- Angioedema or Anaphylaxis
- Suicidal ideation/attempt
- Hallucinations/psychosis
- Overdose (intentional/accidental)
- DKA/HHS

15. URGENT CARE

Only operational for time sensitive and urgent presentations

Inclusive of, but not limited to:

- Ocular foreign body
- Ocular pain
- Acute vision changes
- Peri-orbital swelling
- Dysphagia
- Uncontrolled epistaxis
- Mild SOB – no WOB
- Abdo pain moderate-severe
- Moderate-severe lower GI bleed
- Laceration requiring sutures
- Animal/human bites
- Cellulitis
- Fishhook
- LUTS or discharge with either LBP or pelvic pain
- Emergency contraception
- Sexual assault

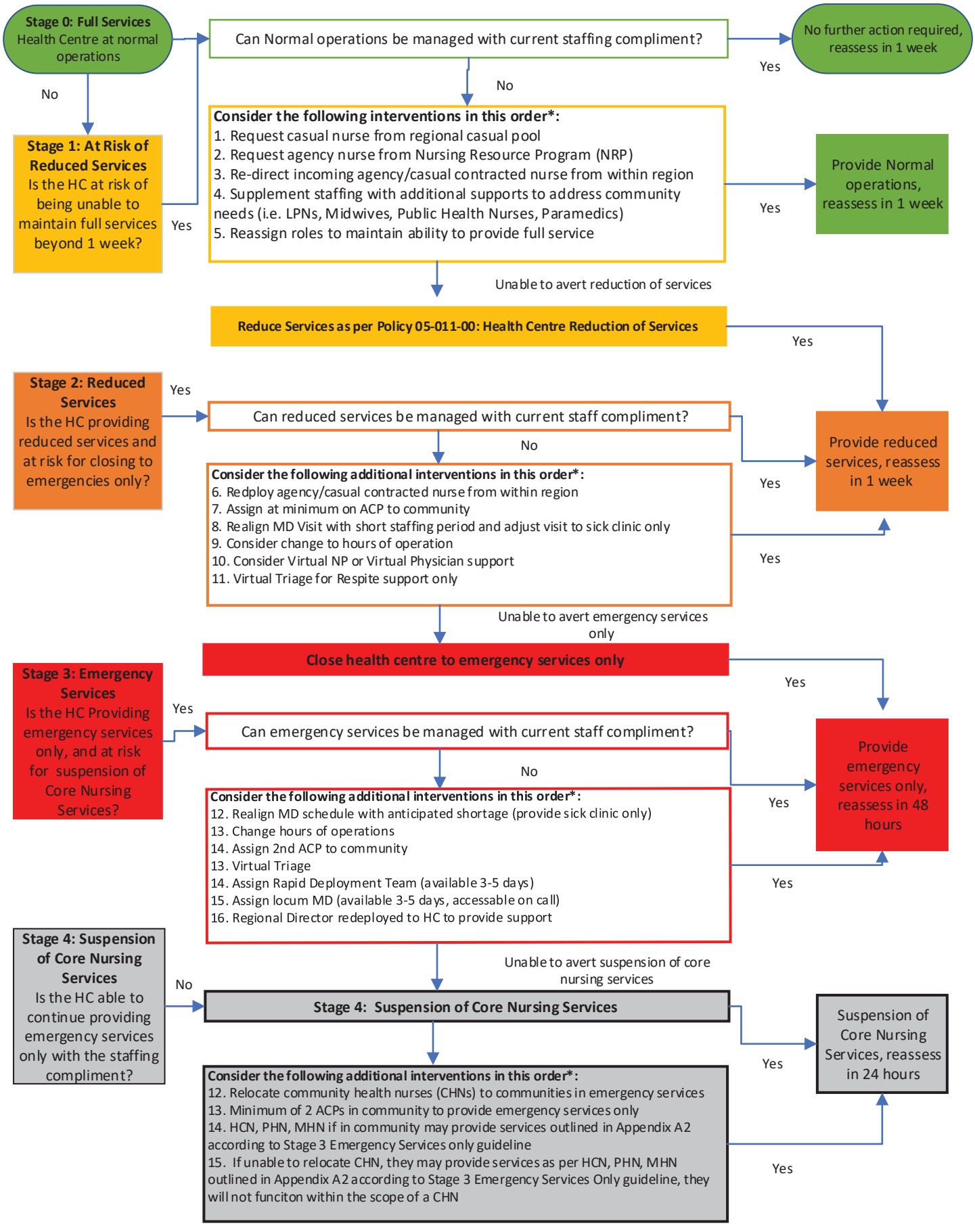
16. MANDATORY PATIENT POPULATIONS THAT MUST BE SEEN AS PER TELEPHONE TRIAGE POLICY

After review of this list, refer to CTAS Table below for guidance on triaging*

- All patients whose condition is determined to: require resuscitation; be emergent; be urgent
- Infants under 1 years of age
- All patients aged 65 years and older
- All pregnant patients
- All patients who are up to 2 weeks postpartum
- All patients who have been discharged from a hospital or care facility within the last 48 hours
- All patients who have had a surgical procedure that required the use of general anesthetic in the previous 10 days
- All patients that have had an endoscopic procedure within the previous 3 days
- All patients with complex medical conditions
- All patients who have had multiple calls or visits to the health centre in the previous 72 hours with the same presenting complaint(s)
- All patients in the custody of the RCMP when an officer contacts the health centre regarding a health concern of a detainee

*CTAS Level	Priority	Action
1	Resuscitation	To Be Seen Immediately
2	Emergent	To Be Seen Immediately
May vary	'Must See' Criteria as per Telephone Triage Policy	To Be Seen Immediately or Within 4 Hours Depending on Priority/ Urgency of Presenting Complaint
3	Urgent	To Be Seen Within 4 Hours
4	Less Urgent	Advice Given; Appointment To Be Booked Within 24-48 Hours
5	Non-Urgent	Advice Given; Appointment To Be Booked Within 7 Days
5	Non-Urgent	Advice Given; No Follow-Up Required

Appendix C: "Respond" - Decision Tree for Minimizing Disruption to Health Centre Nursing Services



* Order subject to change based on territorial and community needs, staffing skill mix, available resources, and lenght of expected staffing shortage

Appendix D: Community Health Centre Role Delegation Table

Table 1: Regulated Health Care Worker

During times of emergencies and when surges in Community Health Centre (CHC) services exceed capacity, additional health care professionals (HCP) may be mobilized to support patient care. Upon arrival to the CHC, the HCP will report directly to the Supervisor of Community Health Programs (SCHP) for their specific assignment of duties. All requests for assistance from the HCP while in the CHC must be triaged through the SCHP.

Inpatient Care Nurses, Public Health Nurses, Home Care Nurses, Licensed Practical Nurses, Registered Psychiatric Nurses DO NOT work within an expanded scope. To perform any task outside of the HCP's scope of practice (as determined by their licensing body), **a direct order from a qualified practitioner or a medical directive is required**.

Program	Services & Duties	Virtual Nurse Practitioner with LPN Assist	Licensed Practical Nurse	Public Health Nurse	Home Care Nurse	Inpatient Nurse	Midwife Limited to providing care to women of reproductive age and infants up to one year of age	Mental Health Nurse (RN/RPN)	Advanced Care Paramedic	Primary Care Paramedic
All programs/ services in CHC and community										
Treatment & Urgent Services (e.g. Sick Clinic, After-Hours Care)	Comprehensive Patient Assessment in Sick Clinic	Restrictions around certain presentations and patient populations	Vitals, medication reconciliation, height, weight, visual acuity, ECG with order		No delegation to diagnosis, initiate drug therapy	No delegation to dx, initiate drug therapy	(Pre / Postnatal Women / Newborn & Women of childbearing years (i.e. Family planning)	Limited to mental health presentations (e.g., SI, anxiety, depression, psychosis); assist with vitals, medication reconciliation, height, weight)	May do preliminary assessment, including POCT testing as per directive	*During suspension only May do preliminary assessment, including POCT testing as per directive
	Telephone Triage/ On-Call Support	Virtual Triage	Support for emergencies; medivacs; monitor stable short-term admissions		2nd on call support for emergencies; medivacs	2nd on call support for emergencies; medivacs	Pre- and postnatal, women, women of childbearing age (i.e. family planning)	Limited to psychiatric support		
	Advanced Skills (e.g., Suture, Back Slab)				With training; long-term cross-training goal	With training; long-term cross-training goal	Limited to maternal & perineum		With training	
	IV Therapy (Including Initiation, Infusions, Medication Administration)			With training					With order from NP or MD	With order from NP or MD
	Wound Care		Within scope; no suturing	Within scope; no suturing	Within scope; no suturing	Within scope; no suturing			Within scope; suturing if trained by AMS	Within scope; no suturing
	Collect & Package Lab Specimens (Including Blood Work & POCT)			With training				Case-by-case basis; would need to posses knowledge, judgement, skills and competency		

Last Updated: April 30, 2022

Permitted to fully perform service/duty

Limitations on performing service/duty; described in table

Not permitted to perform service/duty

Program	Services & Duties	Virtual Nurse Practitioner with LPN Assist	Licensed Practical Nurse	Public Health Nurse	Home Care Nurse	Inpatient Nurse	Midwife Limited to providing care to women of reproductive age and infants up to one year of age	Mental Health Nurse (RN/RPN)	Advanced Care Paramedic	Primary Care Paramedic
	Monitor Patients (e.g., IV/ Inhalation Therapy, Awaiting Medivac, Monitoring Drug Effects)			Assess individual competencies			Prenatal	Limited to patient on continuous observation		
Public Health	General Patient Assessment		With training		With training	With training	Women of childbearing years STI only			
	Immunization (With Certification)		May immunize according to schedule, no well child assessment				Women of childbearing years and infants under 2 months	COVID Only	COVID Only Requires order from NP or MD for other immunizations	COVID Only Requires order from NP or MD for other immunizations
	Communicable Disease Screening/ Testing (STI & TB)	TB testing with training	Administration of program, treat only lab confirmed positive with consult to MD or NP		With training	With training	Women of childbearing years STI only		Treat only if lab confirmed positive and order from MD or NP	
	Contact Tracing		With training		With training	With training	STI only	COVID-19 - with training	With training	With training
	Community & Individual Health Promotion Activities							Assess on individual basis		
	Program Admin-Recall, Spreadsheet									
Maternal Health Program	Pre- & Postnatal History, Physical Assessments		Vitals, weight, medication reconciliation	Post partum home visits (with training)	Post partum home visits (with training)	Low risk with training			Low risk with training	
	Routine Lab Tests & Immunization (As Per SCHP, CHN, Midwife)		May immunize according to schedule, Lab Tests require order from NP or MD						With order from MD or NP	With order from MD or NP
	Telephone Triage/ Urgent & Emergent Care		Emergency support		Emergency support	Emergency support				
	Program Admin-Recall, Spreadsheet									
	Health Promotion/ Patient Education		Training with specialty education delivery	Training with specialty education	Training with specialty education	Training with specialty education				

Last Updated: April 30, 2022

Permitted to fully perform service/duty

Limitations on performing service/duty; described in table

Not permitted to perform service/duty

Program	Services & Duties	Virtual Nurse Practitioner with LPN Assist	Licensed Practical Nurse	Public Health Nurse	Home Care Nurse	Inpatient Nurse	Midwife Limited to providing care to women of reproductive age and infants up to one year of age	Mental Health Nurse (RN/RPN)	Advanced Care Paramedic	Primary Care Paramedic
Adult Health (Drivers, Pre-Operative, Well Man, Well Woman)	General Patient Assessments		Vitals, Med reconciliation, height, weight, visual acuity, ECG with order	Vitals, medication reconciliation height, weight, visual acuity, ECG with order	No delegation to dx & initiate drug therapy	No delegation to dx & initiate drug therapy	Well woman within childbearing years only	Vitals, medication reconciliation, height, weight	Must follow the parameters of medical directive	*During suspension only Must follow the parameters of medical directive
	Routine Lab Tests & Immunization (As Per SCHP, CHN, Midwife)						Well woman within childbearing years only		Order from physician or NP	Order from physician or NP
	Health Promotion/ Patient Education/ Lifestyle Counselling									
	Program Admin-Recall, Spreadsheet									
Well Child/ School Health	General Patient Assessment		Vitals, height, weight, visual acuity	Low risk with training	Low risk with training	Low risk with training	Newborn to 8 weeks			
	Immunization		This could be green				Newborn to 8 weeks old		With order from NP or physician	With order from NP or physician
	Health Promotion/ Patient Education				Training with specialty education	Training with specialty education	Newborn to 8 weeks old		Training with specialty education	Training with specialty education
	Program Admin-Recall, Spreadsheet									
Chronic Disease	General Patient Assessment		Vitals, medication reconciliation, height, weight, visual acuity, ECG with order		No delegation to dx & initiate drug therapy	No delegation to dx & initiate drug therapy		Limited to mental health conditions; vitals, medication reconciliation, height, weight	Vitals, medication reconciliation, height, weight, visual acuity, ECG with order	Vitals, medication reconciliation, height, weight, visual acuity, ECG with order
	Home Visits		Wellness Check	Assess on individual basis				MHA patients	Wellness checks	Wellness checks
	Collect & Package Lab Specimens (Including Blood Work & POCT)			With training				With training?		
	Health Promotion/ Patient Education/ Lifestyle Counselling							Limited to mental health conditions		
	Program Admin-Recall, Spreadsheet									
Admin	Monitor & Order Pharmacy Stock									

Last Updated: April 30, 2022

Permitted to fully perform service/duty

Limitations on performing service/duty; described in table

Not permitted to perform service/duty

Program	Services & Duties	Virtual Nurse Practitioner with LPN Assist	Licensed Practical Nurse	Public Health Nurse	Home Care Nurse	Inpatient Nurse	Midwife Limited to providing care to women of reproductive age and infants up to one year of age	Mental Health Nurse (RN/RPN)	Advanced Care Paramedic	Primary Care Paramedic
	Monitor Supplies; Order Stock									
	QC Check for POC Equipment							With training		
	Set-Up & Support Physician and Specialist Clinics						Obstetrics and Gynecology	Psychiatry		
	Register Patients in MEDITECH									
	Enter Lab Orders into MEDITECH		If ordered by NP or physician				Limited to own patients	If ordered by physician only, may do labs if trained	If ordered by NP or MD	If ordered by NP or physician
	Follow-Up on Labs & Diagnostic Test Results (As Directed by the SCHP)		Would require consultation with physician or NP.				Limited to maternal/newborn 8 weeks old	If ordered by mental health-physician/NP	Would require consultation with NP or physician	

Last Updated: April 30, 2022

Permitted to fully perform service/duty

Limitations on performing service/duty; described in table

Not permitted to perform service/duty

Table 2: Unregulated Health Care Workers

During times of emergencies and when surges in Community Health Centre (CHC) services exceed capacity, additional non-regulated health care workers (HCW) may be mobilized to support patient care and CHC operations. Upon arrival to the CHC, the HCW will report directly to the Supervisor of Community Health Programs (SCHP) for their specific assignment of duties. All requests for assistance from the HCW while in the CHC must be triaged through the SCHP.

- Considering that non-regulated HCWs have limited training, tasks must be assigned on an individual basis, based on the HCW's knowledge, skill, and ability to safely perform the duty. When tasks are assigned or delegated to the HCW, the Registered Nurse or Nurse Practitioner, who delegated the task maintains responsibility for patient care, refer to Policy 07-010-00 Unregulated Health Care Workers – Nurse Responsibilities.

- Training will be arranged for the unregulated HCW to ensure competency for the following tasks prior to performing them: pediatric height, weight and head circumference; visual acuity; vital signs; glucometer POCT, hemocue POCT; urinalysis (using clinitek) POCT; urine pregnancy test POCT; COVID-19 nasal swab POCT.

Service	Services & Duties	Clerk Interpreters	CHC Administrative Assistant	Custodial Staff	Community Health Representative	Home Care Workers (Level I)	Home Care Workers (Level II) & HCC Representative	DOT/ TB Workers	Mental Health Workers
Direct Patient Care	1:1 Supervision of Patients Formed Under the Mental Health Act *Ensure support staff are comfortable with this task prior to assisting & no relation to the patient								
	Heights & Weights (All Adults)								
	Weigh & Measure Children (Well Child Visits, MD Clinics & Pre-Op Only)	With training	With training	With training	With training	With training	With training	Also include TB program	
	Measure & Document Blood Pressure, Heart Rate, O_2 Sats – Adolescent & Adult (Using Automatic Machine Only)	With training	With training	With training	With training	With training	With training	With training	
	Measure & Document Heart Rate & O_2 Saturation – Pediatrics (Using Automatic Machine Only) *Age 6 Years & Older Limitation	With training	With training	With training	With training	With training	With training	With training	
	Home Visits (Includes Patients Not Registered With HCC Program)							Limit to TB	Limit to MHA
	Deliver Medication Blister Packs to Patients *Requires a phone call for approval before								

Last Updated: April 30, 2022

Permitted to fully perform service/duty

Limitations on performing service/duty; described in table

Not permitted to perform service/duty

Service	Services & Duties	Clerk Interpreters	CHC Administrative Assistant	Custodial Staff	Community Health Representative	Home Care Workers (Level I)	Home Care Workers (Level II) & HCC Representative	DOT/ TB Workers	Mental Health Workers
Emergency Care	Take & Make Phone Calls								
	Replace O_2 Tanks	With training	With training	With training	With training	With training	With training		
	Provide Support for Families *Ensure support staff are comfortable with this task prior to assisting								
	Assist With/ Arrange Debriefings & Ongoing MH Support Of Staff And Community								
Lab & Diagnostic Imaging	Perform QC & Patient POCT for Glucometer, Urine Analysis (Clinitek Only), Urine Pregnancy, Hemocue, COVID-19 Nasal Swab POCT – Age Limit To 12 Years of Age & Older *Based on volunteering only & must outline that there is no extra financial incentive to assist with poct	With training	With training	With training	With training	With training	With training	With training	
	Packing Lab Specimens	With training	With training	Also ship TDG: certification required	With training		With training	With training	
	Performing X-Rays	Based on BRT training	Based on BRT training	Based on BRT training	Based on BRT training			Based on BRT training	

Last Updated: April 30, 2022

Permitted to fully perform service/duty

Limitations on performing service/duty; described in table

Not permitted to perform service/duty

Service	Services & Duties	Clerk Interpreters	CHC Administrative Assistant	Custodial Staff	Community Health Representative	Home Care Workers (Level I)	Home Care Workers (Level II) & HCC Representative	DOT/ TB Workers	Mental Health Workers
Program Support	Program Admin- Update Program Spreadsheets *Excel training if needed								
	Recall – Contact Patients to Notify of Appointment Times								
	Make & Deliver Appointment Cards			Delivery only		Delivery only			
	Set Up & Support for Physician & Specialist Clinics								Limit to MHA clinics
	Register Patients in MEDITECH								
Population Health/ Community Liaison	Health Promotion Activities/ Patient Education in Waiting Room (As Directed)					Could they not do this?			
	Communicate Updates to Community & Other Community Agencies, Organizations (e.g., Hamlet)							Limit to TB	Limit to MHA
	Deliver Health Promotion Information on The Radio							Limit to TB	Limit to MHA
	Retrieve List from Schools of Immunizations								
Administrative Support	Monitor Supplies & Order Stock								
	Collect Clinic Statistics (e.g., Number of Patient Encounters) (As Directed By SHCP)							TB program	MHA program

Last Updated: April 30, 2022

Permitted to fully perform service/duty

Limitations on performing service/duty; described in table

Not permitted to perform service/duty

4.2. **Transferred function:** any function transferred from one profession to another through policy or directive, e.g. CHNs are able to diagnose and initiate laboratory investigations without an order from a physician or nurse practitioner. This function was transferred to CHNs from physicians through policy and medical directive.

5. RELATED POLICIES, PROTOCOLS AND LEGISLATION:

- Policy 05-008-00 Nursing Practice- Additional Nursing Functions
- Guideline 05-008-01 Developing a Policy for Additional Nursing Function
- Reference Sheet 05-008-03 Decision-Making Model for Performing Additional Functions and Transferred Functions
- Policy 05-009-00 Transferred Functions

Approved By:	Date: December 12, 2021
Jennifer Berry, Assistant Deputy Minister for Operations – Department of Health	
Approved By:	Date: Dec 13, 2021
Jennifer Bujold, Chief Nursing Officer	

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS **Community Health Nursing**		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Orientation		Administration	05-013-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		2
APPLIES TO:			
Community Health Nurses			

POLICY:

The Department of Health and Social Services (HSS) shall provide each nurse with a coordinated orientation program in collaboration with the Department of Human Resources (HR). The orientation program shall be initiated at the time of hire and continue throughout the probation period.

Upon completion of the orientation program, an evaluation of the program shall be completed by the employee to ensure the learning needs of the new employees are being met.

DEFINITION:

Orientation is the process by which staff becomes familiar with all aspects of the work environment and their responsibilities. (Canadian Council on Health Services Accreditation, 2006)

PRINCIPLES:

A standardized, structured and organized orientation program:

1) Is a vital component of the overall risk management program;
2) Assists the new employee understand the social, technical and cultural aspects of the workplace and community;
3) Improves employee performance and retention;
4) Monitors orientation activities and employees progress.

The employer and employee both share the responsibility in identifying the learning needs and activities throughout the orientation period.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Government of Nunavut *Human Resource Manual: Employee Orientation*

Government of Nunavut *Human Resource Manual: Trainer's Allowance*

Nunavut Employee's Union *Collective Agreement*

REFERENCES:

Canadian Council on Health Services Accreditation (2006). *Glossary 6th Edition.* Retrieved December 18, 2007, from http://www.cchsa-ccass.ca/upload/files/pdf/International/GlossaryEng2007-e.pdf

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

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS		
	Community Health Nursing		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Reference Materials		Administration	05-014-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		9
APPLIES TO:			
Community Health Nurses			

POLICY:

The Department of Health and Social Services shall establish and maintain an approved list of reference materials for the nursing personnel. The reference list will include national publications which are regularly reviewed.

The Reference Materials List shall be endorsed by the Nursing Leadership Advisory Committee.

PRINCIPLES:

Reference materials which are easily accessible enhance the delivery of nursing care within the territory.

The approved references will be consistent with territorial and federal standards, policies, guidelines, and legislation. The list will also standardize the reference materials used throughout the territory and thus help standardize nursing practice throughout the territory.

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

REFERENCE SHEET 05-014-01

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	GENERAL			
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	Stedman's Medical Dictionary for the Health Professions and Nursing	6	2007	Lippincott Williams and Wilkins
	OPERATIONAL			
	Anti-infective Guidelines for Community-Acquired Infections		2009	Mums Guidelines Clearinghouse
Gray, J.	Therapeutic Choices	5	2008	Canadian Pharmacists Association
Ottawa Hospital	Parenternal Drug Therapy Manual	30	2009	Ottawa Hospital
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	CLINICAL			
Health Canada	FNIHB Clinical Practice Guidelines			
Tortora, G.	Principles of Human Anatomy	11	2008	Wiley
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Author	Title	Ed.	Copyright	Publisher
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Wilson, W	Clinical Handbook of Ear, Nose and Throat Disorders		2002	Parthenon Pub. Group
Lucente, F	Essentials of Otolaryngology	5	2004	Lippincott
Wolff, K	Fitzpatrick's Color Atlas and Synopsis of Clinical Dermatology	6	2009	McGraw-Hill
Canadian Diabetes Association	**2008** Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada		2008	Canadian Diabetes Association
Chan, Paul D	Treatment Guidelines for Medicine and Primary Care		2008	Current Clinical Strategies
EMERGENCY CARE				
Tintinalli, J	Emergency Medicine	6	2003	McGraw Hill
Buttaravoli, P	Minor Emergencies: Splinters to Fractures	2	2007	Saunders
Emergency Nurses Association	Emergency Nursing Core Curriculum	6	2007	Elsevier Health Science
Proehl,J.A.	Emergency Nursing Procedures	4	2008	Elsevier Health Science
PAEDIATRICS				
Health Canada	FNHIB Pediatric Clinical Practice Guidelines			FNIHB
Hay, W	Current Pediatric Diagnosis and Management	19	2008	McGraw Hill

Author	Title	Ed.	Copyright	Publisher
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Zitelli, B	Atlas of Pediatric Physical Diagnosis	5	2007	Mosby
Fleisher, G	Textbook of Pediatric Emergency Medicine	5	2005	Lippincott, Williams and Wilkins
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Fraser, D	Myles Textbook of Midwives	15	2009	Churchill Livingston
Fortner, K	Johns Hopkins Manual of Gynecology and Obstetrics	3	2006	Lippincott
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Chan, Paul D	Current Clinical Strategies: Gynecology and Obstetrics		2008	Current Clinical Strategies
MENTAL HEALTH				
American Psychiatric Association	Diagnostic and Statistical Manual of Mental Disorders IV	4	2000	American Psychiatric Publishing
Petit, J. R.	Handbook of Emergency Psychiatry		2003	Lippincott, Williams & Wilkins
Oootoova, I.	Perspectives on Traditional Health		2004	Nunavut Arctic College
Burns, D. D.	The Feeling Good Handbook	Rev	1999	Plume

Author	Title	Ed.	Copyright	Publisher
MENTAL HEALTH				
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Robinson, David J.	Mental Status Exam Explained	2	2002	RAPID PSYCHLER PRESS
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Council on Remote Area Nurses Australia	Avoiding Burn-out in remote areas: surviving the day to day hassles, a guide for remote health practitioners		2000	
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Council on Remote Area Nurses Australia	Surviving Traumatic Stress: A Guide for Multi-disciplinary remote and rural health practitioners and their families		2001	

Author	Title	Ed.	Copyright	Publisher
MENTAL HEALTH				
Pauktuutit	There is a Need, So We Help: Services for Survivors of Child Sexual Abuse		2003	
Franklin, Cynthia	The School Practitioner's Concise Companion to Mental Health		2008	Oxford University Press
Thompson, G	Verbal Judo: The Gentle Art of Persuasion		2004	Harper Collins
PUBLIC HEALTH				
Last, J	A Dictionary of Epidemiology	5	2008	Oxford University Press
Diem, E	Community Health Nursing Projects: Making a Difference		2004	Lippincott, Williams & Wilkins
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Wong, D	Maternal Child Nursing Care	4	2009	Mosby
Stone, J	The Pregnancy Bible: Your Complete Guide to pregnancy and Early Parenthood	2	2008	Firefly Book
COMMUNICABLE DISEASE				
	Canadian Immunization Guide	7	2006	Public Health Agency of Canada
	Canadian Guidelines on Sexually Transmitted Infections		2006	Public Health Agency of Canada
Toman	Toman's Tuberculosis: Case Detection, Treatment and Monitoring	2	2004	World Health Organization
Heymann, David	Control of Communicable Diseases Manual	19	2008	American Public Health Association

Author	Title	Ed.	Copyright	Publisher
COMMUNICABLE DISEASE				
	Epidemiology and Prevention of Vaccine Preventable Disease	11	2009	Public Health Foundation
	Canadian Tuberculosis Standards	6	2008	Canadian Lung Association
NUTRITION				
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Macmillan, K	A Caregiver's Guide: A Handbook About End of Life Care		2004	Military and Hospitaller Order of St. Lazarus of Jerusalem
	99 Common Questions (and More) About Palliative Care: A Nurse's Handbook	3	2006	Edmonton, Regional Palliative Care Program
Bickley, L S	Bates Pocket Guide to Physical Examination and History Taking	6	2008	Lippincott, Williams & Wilkins
Edelman, Carole	Health Promotion Throughout the Lifespan	6	2005	Mosby
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LABORATORY				
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Author	Title	Ed.	Copyright	Publisher
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Ouellette, H.	Clinical Radiology Made Ridiculously Simple	2	2007	McGraw-Hill
MANAGEMENT				
Nunavut Employees Union	Collective Agreement		2008	
Government of Nunavut	Human Resources Manual			
Government of Nunavut	GN Administrator's Manual			
Liebler, J	Management Principles for Health Professionals	5	2008	Jones and Bartlett
Jones, R.	Managing and Leading in the Allied Health Profession		2006	Radcliffe Publishing
Hewison, A	Management for Nurses and Health Professionals: Theory into Practice		2004	Blackwell Science
Daft, R.	The Leadership Experience	4	2007	Thompson Southwestern
OCCUPATIONAL HEALTH AND SAFETY				
	Emergency Response Guidebook		2008	Transport Canada
Canadian Standards Association	Occupational Health and Safety Management		2006	Canadian Standards Association

REFERENCE SHEET 05-014-02

1. Drug Info Services are available from Iqaluit Monday to Friday 0830 to 1700 EST. All health care professionals in Nunavut can take advantage of this service. If you have a drug-related question, you can contact the Qikiqtani General Hospital Pharmacy or email druginfo@gov.nu.ca

2. Anti-infective Review Panel. (2009) .Anti-infective Guidelines for Community-Acquired Infections Toronto; ON: Mums Guideline Clearinghouse ISBN

3. CPS - Compendium of Pharmaceutical and Specialties (2011) (Call QGH pharmacy)

4. Gray, J., (ed.), (2007). Therapeutic Choices. (5th ed.). Ottawa, ON: Canadian Pharmacists Association ISBN 1894402324

5. Bedard, M. & al. (2009) Parenteral Drug Therapy Manual (30th edition) The Ottawa Hospital, General Campus

6. Hale, T., (2008). Medications and Mother's Milk. (13th ed.) Drug Reference book for Breastfeeding and Lactating mothers TX: Pharmasoft Publishing (order www.iBreastfeeding.com)

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

TITLE:		SECTION:	POLICY NUMBER:
Statutes and Legislation		Administration	05-015-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		2
APPLIES TO:			
Community Health Nurses			

POLICY:

The Department of Health and Social Services shall establish a process which ensures nursing staff are aware of and have access to Nunavut and Canadian Statutes and Legislation.

PRINCIPLES:

Territorial and Federal statutes and legislation guide professional practice and professional conduct; while promoting professional development and awareness.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Reference Sheet 05-015-01 Statutes and Legislation

REFERENCES:

Canada Health Act R.S.C. 1985, c.6.

Controlled Drugs and Substances Act R.S.C. 1996, c.19.

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

REFERENCE SHEET 05-015-01

Applicable Statutes and Regulations include the following but are not limited to:

Boards of Management Dissolution Act
Work Site Hazardous Materials Information System Regulations
Vital Statistics Fees Regulations
Territorial Hospital Insurance Services Regulations
Safety Forms Regulations
Safety Act
Reportable Disease Order
Pharmacy Forms Regulation
Pharmacy Fees Regulations
Pharmacy Act
Nursing Profession Regulations
Nursing Act (Nunavut)
Medical Profession Regulations
Medical Profession Act
Medical Care Regulations
Medical Care Act
Human Tissue Act
Hospital Standards Regulations
Hospital Insurance and Health and Social Services Administration Act
Guardianship and Trusteeship Act – Health Care Regulations
Guardianship and Trusteeship Act
General Safety Regulations
Forms (Vital Statistics Act)
Access to Information and Protection of Privacy Act
Coroners Act
Dental Profession Act
Evidence Act
Human Rights Act
Nunavut Mental Health Act
Nunavut Midwifery Professions Act
Inuit Language Protection Act

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS		
	Community Health Nursing		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Provision of Care in Emergency Situations		Administration	05-016-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		2
APPLIES TO:			
Community Health Nurses			

POLICY 1:

In the event that a client's needs exceed the services and equipment available to the community health centre, the client shall be transferred via a medical evacuation to the nearest referral centre for further treatment.

Regional Health and Social Services shall establish a process for initiating and completing a medical evacuation, in accordance with the Government of Nunavut *Client Travel Policy*.

POLICY 2:

In an emergency situation, the registered nurse is permitted to perform those acts contained within the Dental Profession Act, the Medical Profession Act, the Pharmacy Act, or the Veterinary Profession Act. The nurse should be knowledgeable about those sanctioned acts as he/she may be held liable if injuries or death were caused by gross negligence.

PRINCIPLES:

"Nothing in the Dental Profession Act, the Medical Profession Act, the Pharmacy Act, or the Veterinary Profession Act prohibits a person who holds an existing certificate of registration from doing, in the course of administering emergency medical aid or treatment, anything for which a license is required under any of those acts or from doing anything in an emergency in an attempt to relieve pain and suffering of a person or animal, nor shall she be held liable for civil damages such as a result of acts of commission or omission performed in good faith in the course of administering emergency medical aid unless it is established that injuries or death were caused by gross negligence on his/her part."
Nunavut *Nursing Act* (S.Nu. 2003, c.17).

RELATED POLICIES, GUIDELINES OR LEGISLATION:

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

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

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS	
	Community Health Nursing	
TITLE:	**SECTION:**	**POLICY NUMBER:**
Equipment Management System	Administration	05-017-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
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APPLIES TO:		
Community Health Nurses		

POLICY:

The Regional offices of the Department of Health and Social Services (HSS) shall ensure equipment is adequate to allow for the assessment, planning, implementation, and evaluation of comprehensive nursing care.

The HSS shall establish and monitor protocols which support monitoring, ordering, replacing, repairing and disposing of equipment and supplies; as well as equipment preventive maintenance.

PRINCIPLES:

The equipment available in each health centre will vary according to the size and location of the facility; access to physician and essential services; access to instructional programs to allow safe care and usage; and budgetary restrictions.

A standardized list for crash cart items / layout is available through the pharmacy and therapeutics committee.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 05-018-00 Standard Emergency Equipment

REFERENCES:

Government of Nunavut Pharmacy and Therapeutics Committee (DATE). *Standard Emergency List for Nunavut Health Centres.* Iqaluit, NU.

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

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS Community Health Nursing		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Standard Emergency Equipment		Administration	05-018-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
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APPLIES TO:			
Community Health Nurses			

POLICY 1:

The Supervisor of health programs or delegate shall maintain the crash cart and its contents according to the Nunavut Formulary.

Policy 2:

The Supervisor of health programs shall ensure standard emergency equipment is checked daily.

PRINCIPLES:

Standardizing emergency equipment promotes familiarity among float nurses and potentially improving outcomes in emergency situations.

RELATED POLICIES, GUIDELINES OR LEGISLATION:

Nunavut Pharmacy & Therapeutics Committee (2007). Nunavut Formulary

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

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS		
	Community Health Nursing		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Equipment – Basic Nursing		Administration	05-019-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		2
APPLIES TO:			
Community Health Nurses			

POLICY:

Where equipment is deemed to be basic to nursing practice no special instruction for its care and usage should be required. If a nurse requires instruction for the care and use of such a piece of equipment he/she should advise his/her supervisor. A list of equipment and supplies that should be considered basic to nursing practice is located in Guideline 05-019-01.

PRINCIPLES:

Equipment and supplies in this category are central to nursing care and nurses should be generally knowledgeable about their care and use. Where a nurse is not familiar with such equipment or supplies the information should be easily obtained from a colleague or supervisor.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Guideline 05-019-01 Basic Nursing Equipment

GUIDELINE 05-019-01

Airways: Oropharyngeal; Nasopharyngeal
Ambu Bag
Audio-Visual Equipment
Bath tub lifts
Cast cutters
Catheters: Nasal; Urethral
Century Tub
Croupette
Cord Clamps
Doptone
Eye Charts (including color vision)
Fetoscope
Glucose Monitoring Unit
Incubator
Instruments (assorted)
Intravenous Equipment/Apparatus
Laerderal Resuscitator and Mask (Adult)
Mechanical Lifting Devices
Monkey Bars
Nasogastric Tubes
Nebulizer
Needles
Ohio Transport Incubators
Otoscope
Ophthalmoscope
Oxygen valves / cylinders
Parallel Frames
Paediatric Resuscitator with mask
Philadelphia collar
Projectors
Restraints
Ring cutter
Sand bags
Scales
Specimen collectors
Sphygmanomometer
Stethoscope
Stretchers
Suction
Syringes
Tensors
Thermometers
Tourniquet
Tongue forceps
Triangular bandages
Urinary drainage bags
Vaporizer

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

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS	
	Community Health Nursing	
TITLE:	**SECTION:**	**POLICY NUMBER:**
Equipment – Advanced Nursing	Administration	05-020-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
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APPLIES TO:		
Community Health Nurses		

POLICY:

Where specialized competence is required for the safe care and use of equipment an instructional program should exist that contains:

a) **Knowledge of underlying principles for its care and use,**
b) **Provision for supervised practice,**
c) **Method to demonstrate specialized competence,**
d) **Provision for maintenance of competency where the equipment is used infrequently.**

PRINCIPLES:

The safe care and use of equipment is central to quality client care.

Note: a list of equipment and supplies that should be considered to require the development of specialized competence is located in Guideline 05-020-01. It is intended as a reference for the development of specific equipment policies and protocols.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Guideline 05-020-01 Advanced Nursing Equipment

GUIDELINE 05-020-01

Audiometer and Impedance equipment
Autoclave
Cardiac monitor
Centrifuge
Circoelectric bed
Defibrillator
Endotracheal tubes
Electrocardiograph machines
Entonox cylinders
Hare splint
Heart monitor
Heimlich flutter valve
Intravenous pressure infuser
Laboratory equipment
Laryngoscope
Mechanical ventilators
Medevac bags
Microscope
Obstetrical monitors
Obstetrical emergency bags
Oxygen concentrators
Pulmonary lung function machine
Sealed chest units
Spencer Hemoglobinometer
Stryker frames
Survival packs
Thomas splints
Tonometer
Traction apparatus
Transcutaneous electrical nerve stimulation unit (TENS)
Vaginal speculums
X-ray and developing equipment

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

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS	
	Community Health Nursing	
TITLE:	**SECTION:**	**POLICY NUMBER:**
Occupational Health and Safety	Administration	05-021-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
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APPLIES TO:		
Community Health Nurses		

POLICY:

The Department of Health and Social Services (HSS) shall ensure a safe and healthy workplace in accordance with the provisions of the Nunavut Safety Act and Regulations.

PRINCIPLES:

The Worker's Safety and Compensation Commission recognizes that all parties in the workplace share in the responsibilities of controlling hazards and preventing injuries. In recognition of its ultimate responsibility for health and safety in the workplace, HSS seeks to provide its employees with the safest and healthiest environment possible.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Nunavut Safety Act and Regulations

GUIDELINES 05-021-01

DEPARTMENT OF HEALTH AND SOCIAL SERVICES RESPONSIBILITIES

1. The Department of Health and Social Services (HSS) shall establish, maintain and evaluate an Occupational Health and Safety Program to ensure provision of:

    - A safe workplace;
    - Safe processes, procedures, techniques, machinery and equipment;
    - Necessary training and instruction for workers;
    - Adequate supervision to workers to ensure the safe performance of assigned work;
    - Education to promote worker awareness of health and safety hazards at the workplace and the right to refuse hazardous work;
    - Necessary safety equipment in good repair;
    - Systems for identification and control of hazards;
    - Systems to report all serious injuries and accidents.

2. Each health centre shall establish a worksite Health and Safety Committee in accordance with the Nunavut Safety Act and Regulations.

3. The Committee should meet a minimum of six times per year and is responsible for:

    - Identifying unhealthy or hazardous situations at the work site, and recommending corrective actions;
    - Investigating and resolving worker complaints;
    - Developing and promoting prevention measures;
    - Recommending health and safety improvements;
    - Participating in investigations of serious accidents;
    - Reviewing accident investigation reports, Incident Reports and Injury on Duty Reports, and recommending further follow-up action as necessary;
    - Securing expert advice where required;
    - Obtaining necessary information on hazards;
    - Keeping minutes of all minutes and records of all matters dealt with;

SUPERVISOR RESPONSIBILITIES

1. Supervisors of Health Programs (SHP) shall be responsible for ensuring workers do not undertake work which involves uncontrolled hazards, and that all work is carried out in accordance with safe work procedures and practices.

SUPERVISOR RESPONSIBILITIES (CONT'D)

2. SHP shall ensure that work is assigned with consideration for the workers ability to safely perform the work, and shall:

    - Ensure proper instruction is provided to workers under his/her supervision;
    - Ensure that workers use protective equipment and devices;
    - Advise workers of any potential or actual danger to health and safety.

WORKERS RESPONSIBILITIES

1. Workers shall be responsible for taking all necessary precautions to ensure their own health and safety, and the health of any other person in the workplace.

2. Workers shall have final responsibility for ensuring that work is carried out in a safe and healthy manner, and shall:

    - Use all necessary safety equipment, clothing, and devices;
    - Carry out work in accordance with all established safe work procedures;
    - Follow safety instructions from the supervisor;
    - Correct or report immediately any hazard that requires corrective action;
    - Report in the prescribed format all work related incidents, accidents and injuries;
    - Post a copy of the complete minutes after each meeting on a prominent notice board in the health centre. Copies of two consecutive meetings should remain posted.

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

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

TITLE:		SECTION:	POLICY NUMBER:
Smoke Free Workplace		Administration	05-022-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		1
APPLIES TO:			
Community Health Nurses			

POLICY:

The Department of Health and Social Services (HSS) supports and adopts the smoke-free workplace policy as issued by the Government of Nunavut.

Visitors, staff and clients are not permitted to smoke inside the health centre, government vehicle or within a three metre radius surrounding any entrance or exit of the health centre.

DEFINITIONS:

Designated Workplace means the enclosed areas of buildings and facilities, including vehicles or equipment, leased, rented, owned or operated by the Government of Nunavut, its Corporations or Agencies.

PRINCIPLES:

The Government of the Nunavut recognizes the health hazards associated with tobacco smoke in the workplace. Accordingly, the Government of Nunavut does not permit smoking, in any form, in designated workplaces.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Government of Nunavut. *Human Resource Manual*

Nunavut Tobacco Control Act

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

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS **Community Health Nursing**		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Treating Immediate Family Members		Administration	05-023-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		1
APPLIES TO:			
Community Health Nurses			

POLICY:

Every effort must be made to ensure regulated health professionals and other health care practitioners are not the primary health care giver for immediate family member. They may participate in the health care in a supportive role if they so request.

DEFINITIONS:

Immediate Family includes spouse, children, parents and siblings.

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

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS		
	Community Health Nursing		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Clients in Police Custody		Administration	05-024-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		3
APPLIES TO:			
Community Health Nurses			

Policy 1:

When a client is in police custody and requires medical attention, the police shall transport the client to the health centre for further assessment. The practitioner will not assess and treat the client in the police station. If extenuating circumstances arise, the practitioner shall discuss the case with the Supervisor of health programs to determine an appropriate plan of care.

Policy 2:

Police officers are responsible for ensuring the safety and security of the public and the supervised client at the community health centre. Clients who are in police custody require constant supervision while at the community health centre.

The health centre staff is not responsible for the supervision or guarding of clients who are in police custody. It is the responsibility of the police to provide continuous 24-hour guard for such clients and will ensure at least one police officer remains with the client at all times.

Policy 3:

Clients in police custody will not have access to any object/material that could be used as a weapon, i.e. steel utensil, instruments from procedure trays, glass, razors, needles, and mirrors.

Definitions:

Clients who are in police custody are individuals who are under arrest and supervision of the police agency and require constant supervision.

Principles:

The Department of Health and Social Services is committed to ensure the safest possible environment for clients who are in police custody.

The police will assess the level of risk associated with each client before attending the health centre.

Related Policies, Guidelines And Legislation:

Guidelines 05-024-01 Provisions of Care to Clients in Police Custody

GUIDELINE 05-011-01

Ambulatory Services

1. Clients will be assigned appointments at the beginning or the end of the clinic schedule where possible.
2. The Supervisor of health programs (SHP) should be notified ahead of time. The SHP or delegate will meet the client and police Officer upon arrival.
3. Upon arrival to the clinic, the client and the police officer shall be taken immediately to an empty examination room.
4. Where possible such clients should be seen in one location.
5. If the client requires suturing, all sharp objects must be removed from the room after the procedure.
6. The RCMP officer must accompany the client for all tests/procedures and the areas should be notified in advance (if applicable). These areas should take precautions with sharp objects.

Restraints

1. Clients in police custody will always be shackled and/or handcuffed as appropriate.
2. Restraints are the responsibility of the Police officer. Restraints may include handcuffs, shackles and/or security belts.
3. Under no circumstances should a member of the health care team remove the restraints (shackles, handcuffs etc.) from the client.
4. The health care professional may request that the police officer remove the restraints if they interfere with treatment or compromise client safety.
    - The police officer must be consulted.
    - If the police officers agree to the removal of the restraint, they are responsible to remove the restraint and must remain with the client.
    - In the event that the restraints cannot be safely removed, then the inability to treat is to be charted, and further medical advice is required.

Visitors

1. Should a visitor arrive at the community health centre, the staff should consult directly with the police officer and obtain approval.

2. If the visitor is not permitted access to the client, as directed by the police officer, the visitor will be asked to leave the health centre.

Release of Information

1. During assessments and treatments, police shall position themselves away from the bedside so that visual contact is maintained while personal health information cannot be overheard unless:
    - The client consents to bedside attendance or;
    - The police officer determines that bedside attendance is required to reduce or eliminate a significant risk of bodily harm.

2. Personal health information about a client from correctional facilities may be disclosed to the Correctional Facility in which the client is being detained, in order to assist the institution in making a decision concerning arrangements for the provision of health care to the client or the placement of the individual into custody, detention, release, conditional release discharge or conditional discharge.

3. Questions about disclosure of client information to correctional facilities are directed to the ATIPP Coordinator for the Department of Health and Social Services.

4. No information regarding the client shall be released to the public including the location of the client in the hospital. All public inquiries are to be directed to the Supervisor of health programs.

References

Adapted from the University Health Network manual

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

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS		
	Community Health Nursing		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Provisions of Care to Clients in Police Custody		Administration	05-024-01
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		2
APPLIES TO:			
Community Health Nurses			

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   - The police officer determines that bedside attendance is required to reduce or eliminate a significant risk of bodily harm.

2. Personal health information about a client from correctional facilities may be disclosed to the Correctional Facility in which the client is being detained, in order to assist the institution in making a decision concerning arrangements for the provision of health care to the client or the placement of the individual into custody, detention, release, conditional release discharge or conditional discharge.

3. Questions about disclosure of client information to correctional facilities are directed to the ATIPP Coordinator for the Department of Health and Social Services.

4. No information regarding the client shall be released to the public including the location of the client in the hospital. All public inquiries are to be directed to the Supervisor of health programs.

References

Adapted from the University Health Network manual

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

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS		
	Community Health Nursing		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Gifts		Administration	05-025-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
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APPLIES TO:			
Community Health Nurses			

POLICY:

Employees, volunteers and physicians working with the Department of Health and Social Services (HSS) are to refrain from accepting gifts (except those gifts of nominal value and those listed in Guidelines 05-025-01) from clients, vendors/suppliers or others doing business with or seeking to do business with HSS.

Employees, volunteers and physicians must also avoid giving gifts to clients, vendors/suppliers or others doing business with or seeking to do business with HSS.

DEFINITIONS:

Employees are permanent, temporary, full-time, part-time, casual or contract employees and for the purposes of this policy, also includes residents, students, affiliated organizations and other personnel conducting business for or at the community health centre.

Volunteers are individuals giving their time to the health centre without remuneration

Clients are individuals who have or will receive medical attention, care and/or treatment at the community health centre. For the purposes of this policy this definition includes family, friends and the client's support group.

Vendor/Suppliers (including Drug Companies) are any person, company or contractor that sells and/or provides goods or services to HSS. This definition includes both current and prospective vendors/suppliers.

Gift is defined as a voluntary transfer of property from one person or entity to another made without charge or consideration. Gifts include but are not limited to articles of value such as money, donations or property and/or offers of travel, accommodation, meals, entertainment, equipment or other special considerations.

Nominal Value is defined as being less than twenty-five ($25.00) dollars**.**

Cumulative Value of Gifts is the increasing value of the gifts as one party successively gives gifts to another party.

PRINCIPLES:

The codes of ethics, standards of practice and guidelines of the respective regulated health professional groups shall supplement the information contained within this policy.

PRINCIPLES:

No employee shall accept a gift which could influence their decision on any health centre business including procurement

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Guideline 05-025-01 Guidelines for Accepting Gifts

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

Government of Nunavut (n.d.) *Human Resource Manual.*

1. All gifts accepted are to be reported to the employee's immediate supervisor, who will determine whether the gift is of nominal value and/or falls within the exceptions listed below. The immediate supervisor must also take into consideration the cumulative value of multiple gifts.

2. The acceptance of gifts is expected to be transparent and may be audited.

Gifts from Clients

1. The Department of Health and Social Services recognizes that clients may wish to express their appreciation to employees. In these instances, employees may suggest that the client write letters of appreciation or contact the MLA.

2. Employees are prohibited from soliciting tips, personal gratuities or gifts from clients. Unsolicited gratuities and gifts may be accepted from clients only if such gifts are of the nominal value. Gifts should not be accepted if such acceptance would compromise the client/clinician therapeutic relationship. To the extent possible, any acceptable gift should be shared with the employee's colleagues.

3. If a client or another individual wish to present a monetary gift, they should be referred to the Director of Health Programs.

Gifts from Existing or Potential Vendors/Suppliers

1. Employees may retain gifts and/or promotional items from vendors/suppliers and agents working on behalf of vendors/suppliers, only if such gifts and/or promotional items are of the nominal value. HSS expects and trusts that employees will exercise good judgment and discretion in accepting gifts.

2. To the extent possible, any acceptable gift should be shared with the employee's colleagues.

Exceptions

1. In making a decision to accept the gift under these exceptions, an employee should consider the following: reason for the gift; whether it is appropriate; his or her role at the health centre and how the acceptance of the gift might be perceived by others.

2. He or she should also consider whether an obligation or reciprocity is implied for either party in the transaction. As a standard of reasonableness, the employee should ask whether he or she would be comfortable telling his or her supervisor, peer or family about the gift.

Vendor/Supplier Sponsored Entertainment and Events

1. At a vendor/supplier's invitation, an employee may accept meals and refreshments, as well as attendance at a workshop, conference or an information session at the vendor/supplier's expense, subject to the criteria above.

2. Any concerns regarding whether a donation may or may not be accepted should be referred to the immediate program supervisor.

Where an employee has received a gift under these exceptions, he or she will notify the Director of Health Programs so that a record of the gift can be kept.

Reporting

All employees are obligated to report to their immediate supervisor, any instances where they believe they or another employee have failed to comply with this policy.

Related Policies, Guidelines and Legislation

Government of Nunavut (n.d.). Financial Administration Manual
Canadian Nurses Association Standards of Practice
Canadian Medical Association – Practice Guidelines
Canadian Research-Based Pharmaceutical Companies Code of Marketing Practices

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

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS **Community Health Nursing**	
TITLE:	**SECTION:**	**POLICY NUMBER:**
Loss or Theft of Property	Administration	05-026-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
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APPLIES TO:		
Community Health Nurses		

POLICY:

Theft of property or money on facility premises shall be reported to administration. The facility shall not be responsible for the loss, disappearance or damage of employee's personal property or valuables.

Persons found to have participated in such theft, if discovered, are subject to legal prosecution. If such persons are also employees, appropriate disciplinary actions may be instituted, as specified in the Human Resources policies and procedures.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Government of Nunavut. *Human Resources Manual.*

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

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

TITLE:		SECTION:	POLICY NUMBER:
Contacting Clients Through Local Radio		Administration	05-027-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
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APPLIES TO:			
Community Health Nurses			

POLICY:

The Department of Health and Social Services' staff shall not use the local radio as a means of communicating with individual clients. The announcement of individual client names on the radio is a breach of confidentiality.

Principles:

Telephone contact is the most efficient method for reaching clients in the community. However, for those clients who do not have telephone service in their home, alternative methods which preserves the client's privacy must be sought. For example, appointment cards can be delivered to the client's home.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Government of Nunavut. *Human Resources Manual.*

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

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

TITLE:		SECTION:	POLICY NUMBER:
Scent-Free Workplace		Administration	05-028-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
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APPLIES TO:			
Community Health Nurses			

POLICY:

The Department of Health and Social Services will provide a scent-free work environment, in accordance with the Human Resources policy.

Wherever possible, HSS will eliminate the use of products whose scents or other properties are known to cause health problems for clients and staff or provide an appropriate substitute.

Principles:

The Department of Health and Social Services is committed to providing a safe and healthy work environment.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Government of Nunavut. *Human Resources Manual.*

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

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS	
	Community Health Nursing	
TITLE:	**SECTION:**	**POLICY NUMBER:**
Violence in the Workplace	Administration	05-029-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
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APPLIES TO:		
Community Health Nurses		

POLICY:

The Department of Health and Social Services (HSS) is committed to providing a safe and healthy work environment for all staff. Therefore, HSS will not tolerate violent acts or threats by members of the public (clients /visitors) directed at staff or affiliated personnel including volunteers. This policy outlines actions to be taken in the workplace to prevent incidents of violence and to ensure the appropriate management of such incidents should they occur.

Note: Acts of violence directed by one staff member against another are managed through the Code of Conduct and the Discipline Policy contained within the Human Resources Manual.

DEFINITIONS:

Critical Incident: a traumatic event which does or is likely to cause extreme physical and/or emotional distress to staff and may be regarded as outside the normal range of experience of the people affected.

Staff: include all permanent full time, part time and casual workers, physicians, volunteers, students & contractors.

Workplace violence: any act of force or aggression which may threaten, assault or abuse any staff member in the course of their association with HSS. It also includes psychological violence such as bullying, mobbing, teasing, ridicule or any other act or words that could psychologically hurt or isolate a person in the workplace.

POLICIES, GUIDELINES AND LEGISLATION:

Human Resource Manual

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

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS		
	Community Health Nursing		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Motor Vehicles		Administration	05-030-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
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APPLIES TO:			
Community Health Nurses			

POLICY:

All vehicles, which belong to the Government of Nunavut (GN), shall be used for the purpose of delivering community health programs and services. The provisions for motor vehicle use must be in accordance with the Community and Government Services *Motor Vehicle Policy*.

DEFINITIONS:

Government Vehicle- Any vehicle or mobile equipment which has been purchased or leased with GN funds.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Community and Government Services *Motor Vehicle Policy*
Community and Government Services *Vehicle Use Guidelines*
Motor Vehicles Act
All Terrain Vehicle Act

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

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS Community Health Nursing		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Fire Response and Evacuation		Administration	05-031-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
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APPLIES TO:			
Community Health Nurses			

POLICY:

Written fire response and evacuation plans shall be developed, maintained, and be readily accessible to staff in each community health centre. All employees shall be oriented to the plan and participate in the testing of the plan as requested (e.g. Fire Response Drills).

For all fire-related emergencies, the Supervisor of health programs is responsible for commanding and directing fire response operations until the local Fire Chief arrives on scene.

PRINCIPLES:

A fire response and evacuation plan aims to preserve and safeguard the lives of the clients, public and health centre staff.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 05-021-00 Occupational Health and Safety
Guideline 05-021-01 Occupational Health and Safety Program

Community and Government Services *Vehicle Use Guidelines*
Motor Vehicles Act
All Terrain Vehicle Act

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

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

TITLE:		SECTION:	POLICY NUMBER:
Compressed Gas		Administration	05-032-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
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APPLIES TO:
Community Health Nurses

POLICY:

All compressed gas cylinders shall be safely handled by all Health and Social Services staff. The cylinders will be securely stored in accordance with Guideline 05-032-01.

PRINCIPLES:

Safe handling and storage of compressed gas cylinders preserves and safeguards the lives of the clients, public and health centre staff.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 05-021-00	Occupational Health and Safety
Guideline 05-021-01	Occupational Health and Safety Program
Guideline 05-032-01	Handling and Storage of Gas Cylinders

GUIDELINE 05-032-01

1. No Medical Gas is to be within or outside the hospital without the protective cap, where appropriate, securely in place. This excludes cylinders actually in use.

2. Medical Gas Cylinders are to be kept only in designated areas:

    - Radiology department
    - Emergency treatment room
    - Clinic rooms

    Medical Gas tanks are **NOT** to be kept in the main lobby, or corridors.

3. Large cylinders are to be moved on an approved carrier only, with the safety chain in place.

4. All stored cylinders are to be secured in position by chain, or in appropriate stand or cart. Never lie the cylinder down.

5. Empty cylinders should be removed as soon as possible and transported to the oxygen storage room.

6. Full cylinders must be ordered immediately to ensure ample oxygen is available in the community should any emergency arise.

7. All cylinders are to have level of contents displayed by use of an appropriate tag. Perforated sections are to be torn off as appropriate.

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

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS	
	Community Health Nursing	
TITLE:	**SECTION:**	**POLICY NUMBER:**
Managing Nursing Practice and Professional Conduct	Administration	05-033-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
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APPLIES TO:		
All Health Staff		

1. BACKGROUND:

Health is committed to providing excellent health care services by safe, ethical and competent health care providers. The purpose of this policy is to provide a standardized process to managing practice concerns to ensure timely action can be taken to protect the public and address the learning needs of its health care staff. The GN *Human Resources Manual* provides policies and procedures on how to monitor and evaluate staff performance, and how to identify and handle performance concerns. This policy is intended to be used as an adjunct to the performance management policies set out in the *HR Manual* and not to replace them. An adjunct policy is required, as nurses are also accountable to a nursing regulatory body, whereby mandatory reporting regulations are stated in the by-laws of the Registered Nurses Association of Northwest Territories and Nunavut (RNANTNU).

2. POLICY:

All nursing practice and professional conduct concerns shall be addressed in a timely manner and in accordance with Government of Nunavut Human Resources (HR) policies and procedures. When an employee's performance or behaviour is unsatisfactory, corrective action must be promptly taken.

3. PRINCIPLES:

3.1 Nurses are responsible and accountable for demonstrating they are able to meet job expectations and the nursing regulatory body's standards of practice.
3.2 Upholding client safety and quality of care are key priorities for the Department of Health.
3.3 All Health staff are responsible for acting upon nursing practice or professional conduct concerns which come to their attention and the Department of Health provides a supportive environment for reporting of such concerns.
3.4 Regulated nursing professionals have the professional obligation to report to the regulatory body, any situation in which they have reason to believe there is a risk to the public resulting from unprofessional conduct of a nurse.
3.5 Performance evaluations must be frequent and ongoing to prevent or minimize performance concerns and allow for early intervention to safeguard client care. Performance evaluations are not about blame or shame, but rather provide an opportunity for continuous quality improvement and professional development.

4. DEFINITIONS:

Competence: The integration of knowledge, skills, attitudes and judgment, abilities, experience and the underlying ethical intent of professional nursing practice, in a given context, and in accordance with standards of practice.

Competencies: The integrated knowledge, skills, attitudes and judgment required for performance in a designated role and setting.
Director: For the purposes of this policy, Director refers to all program and facility Directors within the Department of Health.
Nurse: For the purpose of this policy, nurse refers to all regulated nursing professions – Registered Nurses, Licensed Practical Nurses, Nurse Practitioners, Registered Psychiatric Nurses.
Unprofessional Conduct: An act or omission of a nurse constitutes unprofessional conduct if a Board of Inquiry finds that the nurse:

a) Engaged in conduct that:
   - Demonstrates a lack of knowledge, skill or judgment in the practice of nursing,
   - Is detrimental to the best interests of the public,
   - Harms the standing of the nursing profession,
   - Contravenes the nursing act or the regulations, or
   - Is prescribed by the bylaws as unprofessional conduct; or

b) Provided nursing services when his or her capacity to provide those services, in accordance with accepted standards, was impaired by a disability or a condition, including an addiction or an illness.

5. GUIDELINE:

Professional practice and professional conduct concerns may be reported from a variety of sources such as a colleague, a client, a client's family, chart review, performance evaluation, or clinical audit; and therefore, the process for managing the matter may vary slightly under those circumstances. The following guideline focuses on the scenario whereby the concern is reported by a department of health staff.

Preventing Professional Practice Concerns
An effective strategy for managing professional practice concerns is preventing or reducing its occurrence. Strategies for preventing nursing practice and professional conduct concerns include: ▪ Effective recruitment practices (e.g. verification of employment history, reference checks, pre-employment checks, CRC, certification checks), matching skills and experience with the intended position; ▪ Offering orientation to new employees and ongoing professional development training; ▪ Clear expectations communicated at time of hire and with subsequent ongoing performance reviews about required competencies (knowledge, skills and judgment) and behaviours required to demonstrate safe, competent and ethical nursing practice in their current clinical role. ▪ Providing resources early on to support areas of improvement; ▪ Training for direct supervisors in effective staff management; ▪ Provide information about how staff can access the support and advice they need
Professional Practice Concern Identified
When a professional practice concern has been identified by a staff member, he/she is required to report it to their supervisor (Be specific and factual; avoid assumptions). If there is an immediate risk to the client or public, that staff member may need to intervene immediately to protect client safety and prevent harm. If the practice concern has been raised through the office of Patient Relations or the Continuous Quality Improvement unit, the staff member will notify the Director of that region for further review. The supervisor shall provide feedback to the staff member who reported the concern, to advise that a review of the concern will be conducted. It is important not to divulge specific details of the action which breeches the nurse's right to privacy and confidentiality. Note: At any time, the staff member who reported the concern is not satisfied that action has taken place, he/she shall notify the Director, CNO, or Director of Professional Practice Unit.

Validating the Concern

The supervisor/ manager is required to gather the facts about the practice concern and report the findings to the Director. Consult the Chief Nursing Officer (CNO) and/or Director of Professional Practice as needed.

Determine if it is a professional practice concern by asking the following questions:

- ☐ Does the concern present a risk to clients?
  - What are the actual or potential effects on client care?
  - Are the clients / public at risk if the situation is not corrected?
- ☐ Does the practice concern conflict with standards, policies and/or guidelines?
  - Are there written GN standards/policies/procedures and practice guidelines?
  - Are there written statements from the nursing organization or regulatory body (i.e. By-laws, Standards of Practice, CNA Code of Ethics)?
- ☐ Does the concern demonstrate a significant lack of knowledge, skill or ability in a specific area?
- ☐ Does it contribute to a toxic work environment?

If you answered 'yes' to any of these questions, you may have a professional practice concern – Further analysis and reporting is required. Refer to the subsequent sections in this policy for guidance.
If you answered 'no', your concern is not likely a professional practice concern and it should be discussed with your supervisor for next steps.

Other questions that may help you better understand the circumstances of the concern:

- ☐ Does the absence of policy, procedure and guidelines contribute to this concern?
- ☐ Are there common factors associated with this concern? If so, what are they?
- ☐ Is the concern recurring?
  - How often and under what circumstances did the situation occur?
  - Do others have similar concerns? Is there any documentation in the nurse's HR file?
  - Has this concern recurred in a collective group of nurses versus an individual nurse?

If you answered 'yes' to any of these questions, you may have identified a gap in the organizational system that may be interfering with the nurses' ability to act in accordance to nursing standards, policies and procedures. Further analysis and action is required, which is beyond the scope of this policy; discuss with your supervisor.

Resources: The following resources outline the specific competencies required of the nursing role and can guide the validation and analysis phases: Nursing standards of practice, FNIHB clinical guidelines, GN policies and procedures, CNA code of ethics, job description, and nursing competency documents (GN and RNANTNU).

Analyzing the Professional Practice Concern

When a professional practice concern has been identified, all evidence and the circumstances around the practice concern need to be examined; consider if the concern relates to:

- ***Competence and gaps in Knowledge***
  For example: pathophysiology, current treatments, medication administration, resources, policies
- ***Competence and gaps in Skills***
  For example: psychomotor skills, use of client monitoring equipment, teaching clients, communication skills, calculating pediatric medication doses
- ***Competence and gaps in Judgment***
  For example: recognizing when to refer, advocating for changes in physician orders, altering the plan of care, prioritizing work
- ***Competence and Ethical Practice***:
  Attitude (For example: respect for colleagues and clients, awareness of own beliefs, sensitivity to feelings, personal values, body language, tone of voice, teamwork, flexibility)
  Behaviours (For example: ineffective/disruptive communication patterns, absenteeism, other concerns)
- ***Competence and Cultural Safety:***

For example: incorporates Inuit Societal Values and cultural practices and beliefs into all dimensions of health care practice, and reflects these in individualized client care plans; recognizes the impact of historical trauma and events on clients' utilization of health care services and the therapeutic nurse/client relationship)

Review any previously implemented performance management plans and note any improvements the nurse made in his/her practice. Consider:

- ☐ What assistance, educational activities or supports were offered in the past?
- ☐ Did the nurse receive this assistance, complete the activities or use the supports? If not, why not?
- ☐ Did these activities and supports make a difference in his/her practice? If so, how is this demonstrated?
- ☐ Has the environment changed? If so, how?

Document all relevant information relating to the concern, while protecting client confidentiality. At minimum, the following Information is to be documented:

- ☐ Date(s), time(s) and location(s) of events.
- ☐ Who was involved, including staff and clients? Avoid using client names or other specific identifiers.
- ☐ Describe what happened, including any near misses.
- ☐ Indicate which standards were not met and how this affected or could have affected client care.
- ☐ The actions taken to address the situation and additional recommendations to resolve the concern.
- ☐ Keep a copy for the supervisor's records and send a copy to the Director.

Acting upon Professional Practice Concerns

Arrange a meeting with the nurse to discuss the concern(s) and the practice expectations in a clear, fair, respectful and supportive manner. The discussions need to be framed around learning from the incident and improving practice. HR policies and procedures are to be strictly adhered to.

Practical Tips: Arrange the time and location of the meeting such that it minimizes potential disruptions

Listen to the nurse's perspective, as he/she may not agree there is a concern. Recognize the nurse's perception is his/her reality and allow time for the nurse to discuss that perspective. Build on the nurse's strengths and be clear about which behaviours need to change.

1. *If the practice concern was determined to be an isolated incident involving a gap in knowledge or training **AND** does not pose ongoing risk to public safety, the supervisor will:*

- Instruct the nurse to complete a Professional Development plan (PD) based on his/her self-assessment - Set a date to review the PD plan (Refer to *Follow-up Plan* section).
  (Use the RNANT/NU Continuing Competence Program template found at https://www.rnantnu.ca/registration/continuing-competence
- If necessary, discuss how colleagues will be informed of any changes (i.e. buddy system, or call schedule).
- Document the meeting details in the nurse's HR file.
- Engage the nurse educator and Director if additional resources are needed to support the development of and/or fulfillment of the learning plan activities.

2. *If the Director and Supervisor deem the concern(s) to be serious in nature, suggest that a recurrence may be likely and pose ongoing client safety risks, the supervisor and director will:*

- Notify CNO, HR and submit a formal complaint to the nursing regulatory body (see *External Reporting of the Practice Concern* section)
- Initiate progressive discipline measures as advised by HR or Employee Relations. Roles and responsibilities in the progressive disciplinary process are outlined in the *Employee Discipline Policy* (found in the GN *HR Manual*). HR policies and procedures are to be strictly followed.

AND Implement one or more of the following based on the nature of the concern:

- Provide supervision of practice until the concern is resolved and the nurse is meeting nursing

standards;
- Restrict specific duties until remediation plan objectives have been met;
- Suspend all duties pending further investigation – Consult HR, Employee Relations and CNO first

Example of when a one's practice requires restriction until further investigation: The nurse shows significant and repeated deficiencies in knowledge, skill or judgment which has significant potential of resulting in public harm.

3. *If the concern involves an allegation of criminal activity, the Executive Director, Assistant Deputy Minister – Operations, HR, and the nursing regulatory body must be notified immediately. The Legal division for the GN is also to be contacted for advice on how to proceed with reporting to RCMP.*

External Reporting of the Practice Concern

Not every error or practice concern means that a nurse poses ongoing risk to client / public safety and therefore does not automatically require reporting to the nurse's regulatory body.
Examples of appropriate reporting to the nursing regulatory body:

- ☐ The nurse demonstrates significant and/or repeated deficiencies in knowledge, skill or judgment;
- ☐ The nurse demonstrates poor insight, or gaps in understanding or application of basic nursing principles;
- ☐ The nurse demonstrates a lack of appreciation for the seriousness of potential outcomes for clients who receive substandard care;
- ☐ The nurse was involved in an alleged criminal activity.

Nursing Regulatory Body: The Executive Director will promptly notify the Director of HR staff and CNO of the intent to report a practice concern to the regulatory body. The CNO will notify the ADM-operations.

- Whenever possible, the CNO should be notified prior to submitting the complaint to the nursing regulatory body in order to verify that (1) any ongoing client safety risks have been addressed; (2) additional resources/supports have been put in place to support the nurse, team and/or client; (3) appropriate practice restrictions (as warranted) have been instituted; and (4) that all related documentation has been secured in a single repository.
  (Note: When the CNO is not available, the Director of Professional Practice is to be consulted.)
- If a nurse's employment has been terminated due to reasons of professional misconduct, incompetence or incapacity, the GN still has an obligation to report the nurse to their regulatory body.

Documentation for Formal Reporting: When a professional practice concern is being reported to the regulatory body, all documentation must be gathered before the complaint is submitted and secured in a single electronic repository that is accessible to the regional administrative team (directors and ED), Director of HR and the CNO. This is extremely important in our transient environment where staff originally involved in submitting the complaint is no longer working in the region when the nursing regulatory body requests supporting documents. The ED will have oversight of the creation and maintenance of such electronic files.
The types of supporting documents to include in the electronic repository include (but not limited to):

- ☐ A copy of the letter submitted to the nursing regulatory body;
- ☐ A copy of all meeting records, letters, and emails;
- ☐ A copy of all related performance evaluations and performance management forms;
- ☐ A copy of any incident report forms associated with the practice concern; and
- ☐ A copy of relevant documentation from client's health record.
- ☐ Copy of staffing schedule and call log (if relevant).
- ☐ Protect confidentiality of whistle blower and patient – this will determine where this will be stored.

Reference Check: When a practice concern has been identified and the nurse resigns or employment is terminated before resolution of the practice concern, Health staff are encouraged to disclose the unresolved concerns to future employers who seek a reference check for that nurse. When Health staff are unsure what details can be disclosed to maintain confidentiality of the HR file, contact HR.

Follow-up Plan

Once nurses are advised of practice concerns, they are responsible and accountable for demonstrating they are able to meet job expectations and the nursing regulatory body's standards of practice. In most incidences, once a nurse becomes aware of practice concerns, the nurse will self-initiate steps necessary to improve their practice. Nurses with significant and ongoing concerns may require more attention, direction and skilled assistance from the supervisor, nurse educator or other resource person.

The department has a responsibility to provide a support system (e.g. training, human resources, equipment, etc.) that enables nurses to meet the professional standards of practice set by the nursing regulatory body. Always ask - have we done our due diligence in educating, training, mentoring, monitoring and evaluating?

*** **Follow procedures outlined in the *HR Manual* for managing performance concerns*****

- At the follow up meeting, review the PD plan and develop a learning plan to support the nurse's needs (See Appendix: *Learning Plan* for guidance). Be clear about how you will assist the nurse and what the nurse must do to meet his/her learning needs. Consult professional practice resources as necessary (e.g. Director Professional Practice, nursing regulatory body, CNO, PHN-C).
- At set intervals, monitor the PD plan objectives with the nurse, program supervisor and/or clinical educator
- After practice concerns have been addressed through the learning plan, it is important to evaluate the outcome and determine if the practice concern has been resolved.
    - For most situations, the nurse's practice will improve. In such cases, continued support shall be offered through the standard performance review process.
    - If, after a reasonable time and effort, the nurse is not meeting the learning plan objectives, consult the Director and HR to determine next steps. Brief the CNO of any ongoing concerns.
- Document the details of all follow up meetings, as per the *HR Manual*.

Practice Restrictions Imposed by the Nursing Regulatory Body

If the regulatory body imposes practice restrictions on the nurse's license following an inquiry, a letter will be issued. The nurse must disclose the conditions of their settlement agreement to the employer in these circumstances.

- When the Director receives a copy of the settlement agreement from the nurse, it is to be forwarded to the Executive Director, Director of HR, and CNO.
- The CNO is responsible for responding to the settle agreement letter, as the nursing regulatory body requires written confirmation and agreement from the employer when practice restrictions are instituted.
- A plan to address any practice restrictions will be developed between the Director, Supervisor and Nurse Educator and reviewed with the CNO.

6. Related Policies, Protocols and Legislation:

Canadian Nurses Association. *Code of Ethics for Registered Nurses*
GN HR Manual: Policy 801 Employee Discipline
GN HR Manual: Policy 802 Discipline – Casual Employees
GN HR Manual: Policy 803 Suspension Pending Investigation
Nunavut Nursing Act
RNANTNU Bylaws: #5 Professional Conduct
RNANTNU Bylaws: #24 Release of Information
RNANTNU *Standards of Nursing Practice for Registered Nurses and Nurse Practitioners*

7. References:

College of Registered Nurses of British Columbia (2014). *Assisting Nurses with Practice Problems*.
GN *Human Resources Manual*
Nunavut Nursing Act
RNANTNU Bylaws
RNANTNU *Standards of Nursing Practice for Registered Nurses and Nurse Practitioners*

Approved By: Colleen Stockley	Date: Feb 9/18
Colleen Stockley, Deputy Minister – Department of Health	
Approved By:	Date:
Jennifer Berry, Chief Nursing Officer – Department of Health	

Appendix: Professional Development Learning Plan

Learning plans include the following statements:

- The Practice standard / objective that governs the specific practice concern(s). For example, a nurse initiates an abdominal x-ray without a written order, protocol or medical directive. The practice standard that is breached would be:
    - "Demonstrates professional responsibility and accountability by practicing in accordance with relevant legislation, standards and GN policies"
- Learning Activities
    - The activities and resources should also reflect self-learning activities for the nurse, as there is an expectation that each nurse demonstrate ownership of their learning goals and activities, as part of their membership in a self-regulated profession.
- Resources needed to carry-out the learning activities (e.g. articles, policies, nurse educator, online course, etc.)
- Expected Results (criteria for measuring changes / outcomes)
- Timeline
- Evaluation / outcome of the learning activities.

The professional development learning plan is to be reviewed with the nurse at set intervals.

<u>SAMPLE</u> Nursing Professional Development Learning Plan

Employee's Name:		**Position**:	
Practice Standard / Objective	**Learning Activities and Resources Needed**	**Expected Results and Timeline**	**Evaluation / Outcome**
1. Demonstrates professional responsibility and accountability by practicing in accordance with relevant legislation, standards and GN policies	- Review RNANTNU *Standards of Practice for Registered Nurses and Nurse Practitioners* - Review the following GN policies and protocols: …	Is accountable and accepts responsibility for all nursing actions and for achieving practice standards. Refers to and adheres to GN policies and protocols and FNIHB Clinical Practice Guidelines Consults supervisor and physician appropriately Date: #####	
2. Demonstrates professional responsibility and accountability by practicing in accordance with Code of Ethics for Registered Nurses	- Review CNA *Code Of Ethics For Registered Nurses by (enter date ###)*	Incorporates nursing values and ethical responsibilities into every aspect of client care and team interactions Uses effective conflict management strategies	
3. Maintains timely, comprehensive and accurate documentation utilizing SOAP format	Review the following: - CRNBC *Documentation in Nursing Practice Learning Module* - GN *Documentation policies* - RNANTNU *Documentation Guidelines* - *Guidelines for Writing SOAP notes and History and Physicals* - *A Practical Guide to Clinical Medicine* To be completed by *(enter date ###)*	Documents accurate and comprehensive health history, including history of presenting illness, past medical history, allergy status and medication history Documents each client encounter according to GN policy and RNANT/NU standards Vital signs and weights will be documented in the body of the nursing note and not in the margin	

SAMPLE Nursing Professional Development Learning Plan

Employee's Name:		**Position**:	
	- Random chart audits will be conducted by SCHP weekly	Completes Prenatal records as per GN guidelines	
Comments:			

Employee's Signature:	**Date of Initial Receipt:**
Supervisor's Name and Signature:	**Date of Issue:**
Employee's Signature:	**Date of Final Review:**
Supervisor's Name and Signature:	**Date of Final Review:**

RESOURCES:
List all resources that were included as part of the learning activities, for example:

- RNANTNU documentation guidelines
- CRNBC documentation module https://www.crnbc.ca/Lists/Flash%20Modules/Documentation/player.html
- GN Documentation Policies (attached separately)
- A Practical Guide to Clinical Medicine – Sections History of Presenting Illness; The Rest of the History; and Review of Systems https://meded.ucsd.edu/clinicalmed/history.htm
- RNANTNU Standards of Practice for Registered Nurses and Nurse Practitioners http://rnantnu.lamp.yk.com/wp-uploads/2013/05/Standards-of-Practice-for-RNs-and-NPs-2014.pdf

	Department of Health Government of Nunavut	**NURSING POLICY, PROCEDURE AND PROTOCOLS** Community Health Nursing	
TITLE:		**SECTION:**	**POLICY NUMBER:**
Client Safety Event - Incident Reporting and Immediate Management		Administration	05-034-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
July 12, 2022	July 12, 2025	Update	13
APPLIES TO:			
All Department of Health Staff (Community Health Centre and Iqaluit Health Service Providers)			

1. BACKGROUND:

The Department of Health (Health) is committed to delivering safe and quality care for Nunavummiut. In addition to supporting client and family needs, timely notification, review, and management of harmful incidents are key activities to reducing preventable harm and improving quality of care for Nunavummiut.

Harm and errors in healthcare almost always occur due to complex system interactions involved in delivering care. Incident reporting is a **non-punitive** learning process which provides frontline staff with the ability to identify system and organizational constructs that may lead to undesirable outcomes. All staff play a critical role in identifying and reporting incidents and contributing to a learning culture to understand what happened, how and why it happened, and how it can be prevented from happening again.

2. POLICY:

2.1 It is the responsibility of all staff to report client safety incidents, including near misses, through the MEDITECH Quality and Risk Management (QRM) Module or downtime incident reporting process as soon as safely possible.

2.2 Immediate action will be taken to respond to client, visitor, and staff needs, and to prevent imminent recurrence.

2.3 All incident reports will be reviewed by the appropriate immediate supervisor within one (1) business day. The supervisor, and/or other relevant members of leadership, will:

- 2.3.1 Respond to any actionable items within a maximum of thirty (30) calendar days; and
- 2.3.1 Proactively address any ongoing concerns in collaboration with involved parties until all concerns have been addressed.

2.4 All client safety incidents categorized as severity level 5 and 6, or identified as never events, will receive additional notifications and actions as outlined in *Policy 05-036-00 Client Safety Event – Screening for and Conducting Incident Analysis.*

2.5 Following review of an incident, learnings will be shared as appropriate with involved staff, other practice areas, and the organization.

3. PRINCIPLES:

3.1 This policy aligns with the following Inuit Qaujimajatuqarigit Principles:

i. *Tunnaganarniq*, fostering good spirits by being open, welcoming and inclusive;
ii. *Inuuqatigiitsiarniq*, respecting others, relationships and caring for people;
iii. *Piliriqatigiinniq*, working together for a common cause, and more specifically, for the health and safety of clients of the Department of Health;
iv. *Pilimmakasarniq/Pijariuqsarniq,* development of skills through practices, effort, and action.

3.2 Clients, visitors, and staff have the right to a safe environment in which to receive care, visit, and work.

3.3 Health actively supports a workplace environment rooted in just culture. A just culture ensures that staff feel comfortable, safe, and encouraged to report quality and safety concerns because there is trust that a fair and consistent approach will be applied when reviewing and responding to unexpected events. This includes:

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

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

3.5 The Government of Nunavut (GN) has mandated responsibilities under the *Workers Safety and Compensation Commission Act* (WSCC) and the *Safety Act* for Nunavut to protect the health and safety of its clients, visitors, and staff.

4. DEFINITIONS:

Client: A person who receives health services.

Clinician: A person who provides health services for Health either as an employee or a contractor, including physicians. The term 'staff' is inclusive of clinicians in this policy.

Critical Incident: An unintended event or circumstance that occurs when a client's interaction with the health system results in severe harm or death and does not result primarily from the client's underlying medical condition, or from a known risk of treatment.

Harm: An unexpected or normally avoidable outcome that:

i. Negatively affects a client's health or quality of life;
ii. Occurs or occurred during the course of health care treatment; and
iii. Is not directly due to the client's underlying illness.

Harm implies impairment of structure or function of the body and/or any deleterious effect arising there from, including disease, suffering, disability, and death. Harm may be physical, social, or psychological.

Immediate Supervisor: The staff member to whom you report (e.g., Supervisor of Health Centre (SHP), Regional Manager, or Director of Health Programs (Director)).

Incident: An unintended event or circumstance which could have resulted, or did result, in unnecessary and/or unintended harm to the client. This includes near miss, no harm, and harmful events.

Incident Report: A written report describing the factual elements of an incident. Incident reports 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. These reports are confidential and are not a part of the client's medical record nor the clinician's file.

Just Culture: An organizational approach which balances the need for staff to act safely with the responsibility of a responsive, safe system. A just culture ensures that staff feel comfortable, safe, and encouraged to report quality and safety concerns because there is trust that a fair and consistent approach will be applied when reviewing and responding to unexpected events.

Levels of Harm: See ***Appendix A: Patient Safety Incident Levels of Harm***.

Never Event: A subset of serious adverse clinical events. These incidents are considered critical regardless of the client outcome. Never Events have known mitigation strategies that, when appropriately implemented, would prevent the occurrence of the event.

Systems Thinking: An approach which focuses on the conditions under which people work (i.e., the system), rather than on the individual. Systems thinking in healthcare emphasizes that client safety incidents typically occur due to system failures.

5. PROCEDURE:

The following procedure applies to all incidents involving client care (severity level 1-6). See section 5.10 for other incident types. The order of procedural activities is recommended; however, the actual order may reflect the needs of each situation and activities may be done concurrently.

See ***Appendix B: Policy Guides*** for quick reference guides separated by stakeholder group.

5.1 Immediate Response and Risk Management

5.1.1 Staff shall take immediate action to protect the health and safety of clients, visitors, and staff. This may involve:

i. Ensuring that the physical environment and situation are safe for clients and staff;

ii. Responding to the immediate needs of the client and family.

5.1.2 If imminent harm may reoccur, or if the incident imminently impacts the safety of others, staff shall take measures to reduce the risk of recurrence and other potential threats;

5.1.3 The immediate supervisor shall provide support to staff involved in the incident. Consider:

5.1.4 Providing a quiet, private place for communication and documentation to occur;

5.1.5 Arranging coverage of duties to provide involved staff with respite;

5.1.6 Arranging a debrief with mental health staff, or using Homewood services, for all facility staff directly or indirectly involved in the incident no later than 72 hours after the event:

i. Employee and Family Assistance Program 24/7 Hotline: 1-800-663-1142

5.1.7 Facilitating debriefing use ***Appendix C: Guiding Questions for Debriefing After Critical Incidents.***

5.2 Preservation of Evidence

5.2.1 Staff or the immediate supervisor shall remove, label, and secure any items involved in the incident or that may have contributed to the incident (e.g., biomedical equipment, packaging, medication, supplies) in a restricted location (e.g., supervisor's office), if possible. Items shall be secured until further instruction is provided.

5.2.2 If death has occurred, do not remove any items touching the client (e.g., dressings, lines) until instructed by the coroner to do so.

5.3 **Notification of Immediate Supervisor**

5.3.1 The most responsible health practitioner and supervisor shall be notified as soon as safely possible.

5.3.2 Depending on the level of harm, verbal notification is required in addition to automatic notifications. Submission of an incident report via the MEDITECH QRM Module will prompt automatic email notifications to the required stakeholders (see Table 1).

5.3.3 The date and time of all verbal notifications must be entered in the MEDITECH QRM Module.

Practice Point: Verbal or email notification is not a replacement for submitting an incident report in a timely manner. The incident report is what initiates the screening process for further incident analysis and is essential to maintaining the integrity of the process.

Table 1: Verbal and Automatic Notification Requirements

	Near Miss, No Harm, Mild Harm, Moderate Harm	**Severe Harm, Death, Never Events**
Verbal Stakeholder Notification Requirements	• Most responsible health practitioner • Immediate supervisor (to be notified by the staff member who witnessed or discovered the incident or their delegate)	• Most responsible health practitioner • Immediate supervisor (to be notified by the staff member who witnessed or discovered the incident or their delegate) • Director of Health Programs (to be notified by the immediate supervisor or their delegate) • Executive Director (to be notified by the Director or their delegate) • Assistant Deputy Minister, Operations (to be notified by the Executive Director or their delegate) • Others, as required (e.g., RCMP, Coroner, Mental Health Services, Department of Family Services (to be notified by the staff member who witnessed or discovered the incident, the immediate supervisor, or their delegate)
Automatic Stakeholder Notifications (sent upon submission of MEDITECH QRM Module Incident Report)	• Supervisor • Director of Health Programs	• Supervisor • Director of Health Programs • Executive Director of Health Programs • Assistant Deputy Ministry – Operations • Chief of Staff • Chief Nursing Officer • Manager, Continuous Quality Improvement Unit and/or Iqaluit Health Services (IHS) Quality Assurance and Risk Management Coordinator

The immediate supervisor is responsible for notifying Health IT (HealthIT@gov.nu.ca) when supervisory coverage changes to ensure appropriate access levels with the MEDITECH QRM Module and inclusion in the Manager's dictionary for referrals.

5.4 **Disclosure**

5.4.1 Staff and the immediate supervisor shall review the *Policy 05-035-00 Client Safety Event Disclosure Policy* prior to initiating disclosure.

5.4.2 The immediate supervisor shall ensure that disclosure is provided as soon as possible. Immediate disclosure to the client/family must include:

i. Information about the event (e.g., objective facts, known consequences to the client of the incident),

i. Information regarding next steps (e.g., urgent teleconference, incident analysis),

ii. The contact information of the immediate supervisor.

5.4.3 Disclosure may be ongoing if further information is discovered through the analysis of the safety incident.

5.5 **Documentation in Client Medical Record**

5.5.1 Staff shall document the facts and times of what occurred, including follow-up clinical actions, in the client's medical record as soon as safely possible and no later than the end of the shift. Documentation shall be objective, factual, concise, specific, and accurate.

5.5.2 Documentation may include: details of the event, clinical assessments, statements made by the client and/or caregiver(s), notification details, disclosure details, details of treatment provided, details of the client's response to treatment.

i. All discussions with the client and/or caregivers related to the incident shall be documented in the client's medical record.

5.5.3 Documentation may **not** include: subjective insights, opinions, assumptions, blame, accusatory language. Documentation in the client's medical record shall not reference the incident report.

5.5.4 If required, staff may augment the client's medical record with a retrospective summary. These must be entered as soon as possible and marked as a late entry.

5.5.5 Complete additional reports and forms as required (see Section 5.10 *Other Incidents)*.

5.6 **Reporting a Client Safety Incident**

5.6.1 All staff have a responsibility to report incidents and near misses for the purposes of learning and improving safety. Incident reports shall be factual and objective (see Table 2).

5.6.2 The staff member who witnessed or discovered the incident shall complete an incident report using the MEDITECH Quality and Risk Management (QRM) Module;

i. Contact healthcqi@gov.nu.ca or IHSquality@gov.nu.ca to learn how to submit an incident report;

ii. For incidents resulting in no harm, mild harm, or moderate harm, and for near misses, documentation shall be completed within 24 hours of occurrence.

iii. For incidents resulting in unexpected and/or unintended severe harm or death, and/or classified as a never event, documentation shall be completed within 12 hours of occurrence.

5.6.3 For staff who do not have access to the MEDITECH QRM Module, reporting responsibilities are assigned to the most responsible health practitioner or to the immediate supervisor of the individual who witnessed or discovered the incident.

5.6.4 If the MEDITECH QRM Module is not available before the end of the shift, the staff member who witnessed or discovered the incident shall complete a *Downtime Form* and provide to the immediate supervisor before the end of the shift.

i. The *Downtime Form* shall only be used when the *MEDITECH QRM Module* is not available or as a communication tool between the staff identifying the incident and the staff entering the report.

5.6.5 The *Downtime Form* must be transcribed into MEDITECH by the immediate supervisor or their delegate as soon as MEDITECH becomes available.

5.6.6 There are multiple ways to access the *Downtime Form*:

i. Microsoft Teams: GN-HEA-CNO-Nunavut Nurses Education > Health Continuous Quality Improvement Channel

ii. By email request: HealthCQI@gov.nu.ca or IHSQuality@gov.nu.ca

iii. Printed copies may be available in areas where staff are known to not have MEDITECH accounts

5.6.7 If more than one client is involved in or impacted by an incident, a report shall be completed for each client.

5.6.8 If non-patient factors (e.g., employee injury, damage to property) are involved, additional incident report(s) must be completed (see Section 5.10).

Table 2: Guide for Writing Incident Report 'Description of Event'

	Required	DO NOT Include:
Description of Event	• Relevant dates/times • Brief, factual description of event or circumstance • Outcome of event/circumstance • Assessment of client • Client's response	• Subjective insights or opinions • Assumptions • Speculation • Vague language • Accusatory language or blame

5.7 Immediate Management (For Immediate Supervisors and/or Directors)

5.7.1 Once notified of a safety incident, the immediate supervisor and Director are responsible for ensuring that appropriate incident management has occurred. This includes ensuring completion of procedural activities listed from 5.1 through 5.6.

5.7.2 If more than one area of care is involved, incident management shall be a collaborative effort between supervisors.

5.7.3 Additional responsibilities of the immediate supervisor and/or Director include:

i. Reviewing the facts of the incident and gathering relevant information to obtain a preliminary understanding of what occurred, including speaking with staff involved;

ii. Entering a referral to the appropriate supervisor(s) (e.g., SHP);

iii. Taking local action to prevent recurrence of a similar event;

iv. Documenting additional actions taken on the incident report;

v. Ensuring the level of harm entered in the MEDITECH QRM Module is accurate and adjusting if necessary;
    a. Contact HealthCQI or the Iqaluit Health Service (IHS) Quality Assurance and Risk Management Coordinator if assistance is required to determine and/or adjust the correct level of harm.

5.7.4 If an incident has resulted in unexpected and/or unintended severe harm or death, and/or is classified as a never event, further review is required.

5.7.5 See *Policy 05-036-00 Client Safety Event – Screening for and Conducting Incident Analysis* for information, including preparation for an Urgent Teleconference.

5.8 **Sharing Learnings**

5.8.1 The immediate supervisor and/or Director is responsible for:

i. Sharing learnings with the client/family. Refer to the *Policy 05-033-00 Client Safety Event Disclosure*

ii. Providing feedback to staff whom reported the incident, including actions taken to prevent reoccurrence;

iii. Sharing learnings and actions taken with other areas/staff where a similar event could occur or with those whom are impacted by actions taken.

5.9 **Closing Incidents**

5.9.1 Depending on the level of harm, various stakeholders are responsible for closing incident reports through the MEDITECH QRM Module (see Table 3).

5.9.2 An incident report cannot be closed by the staff member who enters it; it must be referred to their immediate supervisor to be closed (e.g., if a SHP enters a report, it must be closed by their Director, even when it is a no harm incident).

5.9.3 Documentation by the immediate supervisor and/or Director must include: additional steps taken to provide support to client/family/staff, findings related to what happened and how it happened, actions taken to prevent recurrence;

5.9.4 Documentation must not include: speculation, blame, assumptions or opinions of the quality of care provided by healthcare practitioners.

Table 3: Documentation Requirements

	Near Miss, No Harm, Mild Harm, Moderate Harm	Severe Harm, Death, Never Events
Timeframe to Close (from the time incident report is submitted)	30 days	90 days
Closed By	Immediate supervisor of reporting staff	Director, Executive Director, HealthCQI or IHS Quality Assurance and Risk Management Coordinator

5.10 **Other Incidents**

Incident Type	Requirements
Employee Injury/ Workplace Violence	Complete Non-Patient Incident Report in the MEDITECH QRM Module; contact OH&S for more information
Incident Involving a Visitor	Complete Non-Patient Incident Report in the MEDITECH QRM Module

Breach of Client Privacy	Complete ATIPP Privacy Breach Report (available from the ATIPP Coordinator or HealthCQI@gov.nu.ca) and submit to the ATIPP Coordinator
Theft or Loss of Personal or Facility Property	Complete Non-Patient Incident Report in the MEDITECH QRM Module
Other	Complete additional forms, as required. Examples include: - Workers' Safety and Compensation Commission (WSCC) form - Report of Adverse Events Following Immunization Form - Maintenance Work Order - Biomedical Work Order

6. APPENDICES

APPENDIX A: PATIENT SAFETY INCIDENT LEVELS OF HARM
APPENDIX B: POLICY GUIDES
APPENDIX C: GUIDING QUESTIONS FOR DEBRIEFING AFTER CRITICAL INCIDENTS

7. RELATED POLICIES, PROTOCOLS AND LEGISLATION:

Policy 05-033-00 Managing Nursing Practice and Professional Conduct
Policy 05-035-00 Client Safety Event Disclosure Policy
Policy 05-036-00 Client Safety Event – Screening for and Conducting Incident Analysis
Workers Safety and Compensation Commission Act (WSCC) and the Safety Act for Nunavut

8. REFERENCES:

Alberta Health Services (n.d.) Immediate management checklist. Retrieved from https://www.patientsafetyinstitute.ca
Alberta Health Services (n.d.) Ongoing management checklist. Retrieved from https://www.patientsafetyinstitute.ca
St. Joseph's Healthcare Hamilton (2020, January). Safety Incident Reporting and Management – Patient and Visitor

Approved By:	Date: July 21, 2022
Jennifer Berry, Assistant Deputy Minister, Department of Health	
Approved By:	Date: July 12, 2022
Jenifer Bujold, a/Chief Nursing Officer	
Approved By:	Date:
Dr. Francois De Wet, Territorial Chief of Staff	

Appendix A: Patient Safety Incident Levels of Harm

Level of Harm	Patient Safety Incidents
1 – Near Miss	An incident that has potential for harm and is intercepted or corrected prior to reaching the patient.
2 – No Harm	Patient outcome is not symptomatic or no symptoms are detected and no treatment is required.
3 – Mild Harm	Patient outcome is symptomatic, symptoms are mild, loss of function or harm is minimal or intermediate but short term, and no or minimal intervention (e.g., extra observation, investigation, review, or minor treatment) is required.
4 – Moderate Harm	Patient outcome is symptomatic, requiring intervention (e.g., additional operative procedure, additional therapeutic treatment, short term hospitalization for assessment and/or minor treatment in either ED or hospital unit), an increased length of stay, or causing minor permanent or long-term harm or loss of function.
5 – Severe Harm	Patient outcome is symptomatic, requiring life-saving intervention or major surgical/medical intervention (e.g., prolonged hospitalization or admission to a high acuity setting such as an ICU), or shortening life expectancy or causing major permanent or long-term harm or loss of function.
6 – Death	On balance of probabilities, death was caused or brought forward in the short term by the incident.

SUPPORT TOOL ONLY – NOT PART OF CLIENT MEDICAL RECORD

The order below is recommended; however, the actual order may reflect the needs of each situation and activities may be done concurrently.

Client Safety Event – Incident Reporting and Immediate Management

POLICY GUIDE A: FOR CARE PROVIDERS

Purpose: to provide an overview of actions to take in the immediate response to a safety incident

Intended Audience: the individual(s) who discover and/or respond to the incident (typically, the care provider)

IMMEDIATE RESPONSE

- **Ensure the physical environment and situation is safe** for clients and care providers
- **Provide support** to client(s)/ family involved (i.e., respond to physical and emotional needs)
- **Reduce the risk** of incident recurrence; remove potential threats to client, family, and staff
  - ASK YOURSELF - Is anyone else at risk of harm? Does this incident impact care or safety? What can we do to decrease the risk/harm and prevent recurrence?

PRESERVE EVIDENCE

- **Remove, label, and secure** equipment, packaging, medication and other hazards that may have contributed to the incident; store items in a restricted location
  - If death has occurred, do not remove any items touching the client until instructed by the Coroner to do so

NOTIFY

If unexpected and/or unintended SEVERE HARM or DEATH has occurred, verbally notify Immediate Supervisor ASAP

- Notify the most responsible health practitioner
- Notify immediate Supervisor
- Notify Coroner (if required)
- Notify RCMP (if required)

DISCLOSE

- In collaboration with the immediate supervisor, **initiate the disclosure process** as per the *Client Safety Event Disclosure Policy* (if required), and document details in the client's medical record:
  - Meeting date, time, place
  - With whom, by whom (roles and functions of all present)
  - Agreed upon treatment options

DOCUMENT

- **Document the FACTS and TIMES** of what occurred, including follow-up actions, in the client's medical record:
  - Details of what occurred
  - Notifications
  - Clinical assessments
  - Treatment provided and response

REPORT!

- **Complete an Incident Report** using the MEDITECH Quality and Risk Management (QRM) Module or Downtime Form as soon as safely possible. Include factual, objective information that is concise and specific.

POLICY GUIDE B: FOR IMMEDIATE SUPERVISORS

Purpose: to provide an overview of actions to take in the immediate and ongoing response to a safety incident

Intended Audience: the immediate Supervisor of the individual(s) who discovered and/or responded to the incident

ASSESS RESPONSE

- **Review and ensure** that all steps in Policy Guide A have been completed
  - Ensure that the immediate needs of clients/family/staff have been addressed
    - E.g., arrange a team debrief, facilitate peer support, arrange coverage duties
  - Ensure that items involved in the incident are removed and secured
  - Complete disclosure with the most responsible health practitioner, if required
  - Verify that documentation, including incident reporting, is complete and accurate
- ASK YOURSELF – Are there any further immediate actions required to decrease or mitigate risk/harm to the client and to others? Have we done everything that we can do to manage/mitigate the risk or harm and prevent recurrence?

NOTIFY

If unexpected and/or unintended SEVERE HARM or DEATH has occurred, verbally notify Director of Health Programs ASAP

- Notify the most responsible health practitioner
- Notify Director of Health Program (if required)
- Notify Coroner (if required)
- Notify RCMP (if required)

GATHER INFORMATION

- **Review the facts** of the incident and gather relevant information to obtain a preliminary understanding of what occurred
  - Client medical record
  - Incident report
  - Policies, procedures
  - Review environment
  - Examine objects/hazards
  - Speak with involved staff to understand what happened and how it happened

REVIEW

- If the incident requires an Urgent Teleconference, as determined by the CNO/COS, use the information gathered in the previous step to **develop a timeline of events**
- If the incident requires further review, participate as required

CLOSE THE LOOP

- **Close the loop** with staff who reported the incident
  - Thank staff for reporting and provide information regarding next steps
  - Ask if staff have any recommendations for improvement

DOCUMENT

- Review the level of harm entered in the MEDITECH QRM Module and adjust, if necessary
- Supplement documentation with additional actions, including ongoing disclosure discussions
- Close incident reports (severity level 0-4) through the MEDITECH QRM Module **within 30 days**

DISCLOSE

- Continue the disclosure process as per the **Client Safety Event Disclosure Policy**; ensure that the client/family is provided with information regarding next steps

The order below is recommended; however, the actual order may reflect the needs of each situation and activities may be done concurrently.

Client Safety Event – Incident Reporting and Immediate Management; Client Safety Event – Screening for and Conducting Incident Analysis

POLICY GUIDE C: FOR DIRECTORS

Purpose: to provide an overview of actions to take in the ongoing response to a safety incident

Intended Audience: the Director of the individual(s) who discovered and/or responded to the incident

ASSESS RESPONSE

- **Review and ensure** that all steps in Policy Guides A and B have been completed
  - Ensure that the immediate needs of clients/family/staff have been addressed
    - E.g., arrange a team debrief, facilitate peer support, arrange coverage duties
  - Ensure that items involved in the incident are removed and secured
  - Complete disclosure with the most responsible health practitioner, if required
  - Verify that documentation, including incident reporting, is complete and accurate
- ASK YOURSELF – Are there any further immediate actions required to decrease or mitigate risk/harm to the client and to others? Have we done everything that we can do to manage/mitigate the risk or harm and prevent recurrence?

NOTIFY

If unexpected and/or unintended SEVERE HARM or DEATH has occurred, verbally notify Executive Director ASAP

- Notify Executive Director (if required)
- Notify internal (e.g., Pharmacy, Occupational Health and Safety)
- Notify external stakeholders, as required (e.g., mandated legislated reporting)

REVIEW

- If the incident requires an Urgent Teleconference, as determined by the CNO/COS, prepare by **reviewing the timeline and relevant documentation** (e.g., incident report)
- If the incident requires further review, participate as required

FOLLOW-UP

- **Follow-up** with owners of actions/ recommendations to monitor progress

SHARE

- In collaboration with the Quality Team, **share learnings** with involved staff members, and others, as appropriate

DOCUMENT

- Review the level of harm entered in the MEDITECH QRM module and adjust, if necessary
- Supplement documentation with any additional actions, including ongoing disclosure discussions
- Close incident reports (severity level 5-6, Never Event) through the MEDITECH QRM Module **within 90 days**

DISCLOSE

- Continue the disclosure process as per the **Client Safety Event Disclosure Policy**; ensure that the client/family is provided with information regarding next steps
- Share learnings with the client/family, as appropriate

APPENDIX C: Guiding Questions for Debriefing After Critical Incidents

When used after an unexpected death, resuscitation or other traumatic event, debriefing provides a safe forum for staff to **discuss and process** a recent traumatic event. Debriefing can be a formal or informal process to provide emotional and psychological support immediately following a traumatic event. This allows the team to identify opportunities for improvement in a non-threatening environment focused on **learning and improvement**.

Gather staff in a quiet space and consider the following guiding questions:

- **What went well?**
- **What did we learn?**
- **What would we do differently next time?**
- **What changes could be recommended to improve processes or performances?**

Upon completion of debriefing, identify additional supports for staff, including how to access them:
- Employee and Family Assistance Program 24/7 Hotline: 1-800-663-1142

Department of Health Government of Nunavut	Department of Health POLICY, PROCEDURE AND PROTOCOLS **Operations**	
TITLE:	**SECTION:**	**POLICY NUMBER:**
Client Safety Disclosure Policy	Administration	05-035-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
November 20, 2016 / November 2019	05-004-04	8
APPLIES TO:		
Health Care Professionals		

PREAMBLE

Clients are entitled to information about themselves and about their medical condition including the risk inherent in healthcare delivery. Independently, the client has the right to control what happens to his or her body. This requires that information be provided about possible unexpected client safety incidents.

The obligation to disclose is a key part of the client safety management system and a requirement by Accreditation Canada. Current Healthcare literature commonly recognizes that having a clear framework in place is necessary for health care professionals to feel comfortable carrying out disclosure; furthermore, an effective acknowledgement and apology can have a profound healing effect, restore relationship and even strengthen them.

The Legal Treatment of the *Apologies Act* in Nunavut establishes that apologizing does not constitute an admission of guilt or civil liability, and cannot be used against the person giving the apology in legal proceedings. Bearing in mind this statement along with best practices and those principles highlighted in section 2 of this policy, the department of health reinstates the need and its determination to train health care professionals on disclosure and its requirements through development and adoption of the following policy:

1. POLICY

1.1 Disclosure of incidents shall take place, as soon as it is practical. The following are incidents:

1. Harmful incidents;
2. No harm incidents when the immediate supervisor decides, according to section 5.1 of this Policy, that disclosure is to take place; and
3. Near miss incidents when the immediate supervisor decides, according to section 5.1 of this Policy, that disclosure is to take place.

2. PRINCIPLES

2.1 This Policy is based on the following principles:

1. *Tunnganarniq,* fostering good spirits by being open, welcoming and inclusive;
2. *Inuuqatigiitsiarniq,* respecting others, relationships and caring for people;
3. *Piliriqatigiinniq,* working together for a common cause, and more specifically, for the health and safety of client s of the Department of Health;
4. Client s deserve a high standard of care and transparency from the Department of Health;
5. Disclosure is a non-punitive activity that does not seek to blame individuals; and

6. The Department of Health is a learning organization that continuously seeks to improve its processes.

3. DEFINITIONS

Apology: means an expression of sympathy or regret, a statement that a person is sorry or any other words indicating contrition or commiseration;

Client: means the client of the Department associated with the disclosable incident;

Client safety incident: means an event or circumstance which could have resulted or did result in harm to the client and it includes a near miss, a no harm incident and a harmful incident;

Department: means the Government of Nunavut's Department of Health;

Disclosee(s): means the person(s) entitled to information about a disclosable incident under section 8 of this Policy;

Disclosure: means the communication of information about a disclosable incident to the disclosee(s);

Disclosure meeting: includes the initial disclosure meeting and any subsequent disclosure meeting about the same disclosable incident;

Harm: means an unexpected or normally avoidable outcome that

1. negatively affects a client 's health or quality of life;
2. occurs or occurred in the course of health care treatment; and
3. is not due directly to the client 's underlying illness;

Harmful incident: means an event or circumstance that resulted in permanent harm/damage or death to the client;

Health care professional: means a person who provides health services in Nunavut for the Department, either as an employee or a contractor and, for greater certainty, includes physicians;

Immediate supervisor: means

1. the Supervisor of Community Health Programs for the community or equivalent if the disclosable incident is reported by a member of the public; and
2. the supervisor of the health care professional who reported the client safety incident if the report was made by a health care professional.

Initial disclosure meeting: means the first meeting through which a disclosable incident is communicated to the disclosee(s);

Most responsible professional: means the health care professional based at the facility where the client is receiving health services who has the final responsibility and accountability for the care of the client at the facility;

Near miss: means an event or circumstance which could have resulted in harm to the client but did not reach the client;

No harm incident: means an event or circumstance which could have resulted in harm to the client, reached the client, but did not cause discernable harm to the client;

Subsequent disclosure meeting: means a meeting that takes place after the initial disclosure meeting to provide the disclosee(s) with further information about a disclosable incident;

Substitute decision maker: means a person other than the client who is legally authorized to consent to medical treatment or receive personal health information on behalf of the client;

Risk: means the chance that someone could be harmed by a client safety incident.

4. SCOPE OF APPLICATION

This Policy applies to all health care professionals.

5. PROCEDURE

5.1 Which Incidents Must be Disclosed

Table 1: When to Disclose an Incident

Type of Incident	Is Disclosure Required?
Harmful Incidents	Disclosure is mandatory
Near Miss Incidents or No Harm Incidents	Disclosure may be required. The immediate supervisor shall consider the following when deciding whether disclosure is required: i. whether an ongoing risk to the client exists; and ii. whether being informed of the incident would be beneficial for the client.

Note: Resources have been provided in the Appendices to assist health care professionals determine whether a client safety incident qualifies as a disclosable incident.

- Appendix A: Assists with classifying the type of client safety incident
- Appendix B: Assists with determining whether the incident is a disclosable incident based on the degree of harm.

If there is uncertainty as to whether a particular client safety incident is a disclosable incident, consultation with the appropriate supervisor must take place

5.2 Recipients of Disclosure

5.2.1 Disclosee: The following person(s) are entitled to information about a disclosable incident:

a. The client; or

b. The client's parent, legal guardian, next of kin or substitute decision maker, as appropriate, if the client is unable to consent to medical treatment.

5.2.2 When the person(s) entitled to information under section 5.2.1 of this Policy change(s) between disclosure meetings, the disclosure team must provide the person(s) newly entitled to information with the information previously disclosed.

5.2.3 When the client requests that a friend, relative or elder participate in a disclosure meeting, the disclosure team will make accommodations for the client's request.

5.3 **Refusal of disclosee(s) to participate in disclosure**

5.3.1 If there is no risk to third parties, a disclosee may, on his or her own initiative, refuse to participate in the disclosure process.

5.3.2 When a disclosee declines to participate, the disclosure team shall

a. Inform the disclosee that the disclosure process will remain available to discuss the matter at a later time;
b. Document the refusal to participate in the client 's health record; and
c. Document the refusal in a secure file at the Regional Office.

5.4 **The Disclosure Team**

5.4.1 The supervisor is to assemble the disclosure team as soon as possible after the incident occurred. The supervisor is to consider the following when selecting the team:

a. The health care professionals' qualifications, training and knowledge of the incident;
b. The team should be comprised of at least two health care professionals;
c. It is preferable to have the most responsible provider on the team;
d. It is preferable to have at least one physician and one nurse on the team;

5.4.2 Health care professionals can refuse to be a member of a disclosure team in certain circumstances such as:

a. Emotional or physical stress preventing them from carrying out disclosure professionally; or
b. Concerns or fears that participating in disclosure may threaten their own safety.

5.4.3 Every attempt is to be made to keep the disclosure team membership the same between disclosure meeting(s) to provide continuity for the disclosee. The immediate supervisor may be required to change the team composition under certain circumstances such as:

a. One of its members is no longer a department employee or contractor; or
b. One of its members is refusing to remain part of the disclosure team as per section 5.4.2 of this Policy.

5.4.4 When the disclosure team membership is changed, the immediate supervisor must ensure that all relevant information about the disclosable incident is given to the new disclosure team member(s) before the next disclosure meeting takes place.

5.4.5 *Postponing Disclosure*

The disclosure meeting may be postponed if there are reasonable grounds to believe that holding the meeting at the time envisioned by this Policy could result in immediate and grave danger to the mental or physical health or safety of the disclosee(s) or another person.

a. The disclosure team shall collaborate with the Regional Executive Director, the Territorial Chief of Staff and the Chief Nursing Officer before making the decision to postpone the disclosure meeting.
b. The disclosure team shall document, in a secure file at the Regional Office, the following information:

i. Names and functions of all persons who participated in making the decision;
ii. Date of the decision; and
iii. Detailed reason(s) for postponing the meeting.

c. The disclosure team shall re-evaluate the status at frequent intervals to determine when the disclosure meeting can be held without immediate and grave danger to the disclosee or other person.

5.5 **The Initial Disclosure Meeting**

5.5.1 *Preparing for the initial disclosure meeting*

As soon as possible after forming a disclosure team, the immediate supervisor shall arrange a disclosure team meeting during which the team will

a. review all relevant records and facts about the disclosable incident, as available at that point in time;
b. assess the client 's health care needs and prepare treatment options and recommendations, as appropriate;
c. determine which disclosure team member will be the main communicator. It is preferable for the most responsible provider to play that role;
d. assess the potential need(s) of the client and disclosure team members for the supports listed in section 5.10 of this Policy and develop plans to meet those needs;
e. set a time and location for the initial disclosure meeting that meets accessibility and privacy needs;
f. arrange for the services of an interpreter, as required.

5.5.2 *Informing disclosee(s) of initial disclosure meeting*

The main communicator for the team will inform the disclosee(s) of the time and location for the initial disclosure meeting.

5.5.3 *Key items to cover at initial disclosure meeting*

a. acknowledge that the most responsible provider is not present, should that be the case;
b. share the objective facts about the incident, as known at that point;
c. explain the consequences of the incident for the client , as known at that point;
d. offer an apology for what happened;
e. explain the actions taken to address the consequences of the incident;
f. explain treatment options and recommendations, as appropriate;
g. explain the investigative process that is to follow and how the resulting findings will be communicated;
h. explain that the disclosure team remains accessible for ongoing communication and provide appropriate contact information;
i. offer, based on needs, the supports listed under section 5.10 of this Policy;
j. leave ample time for the disclosee(s) to ask questions and the team to respond;
k. offer to research any questions that the disclosure team cannot answer immediately and arrange for a timely follow-up.

5.6 **Subsequent Disclosure Meeting(s)**

5.6.1 The immediate supervisor shall organise subsequent disclosure meetings under the following circumstances:

a. each time new significant facts regarding the incident become known following the initial disclosure meeting; and
b. upon completion of the investigative process for the incident where an investigation took place.

5.6.2 *Preparing subsequent disclosure meeting(s)*

The disclosure team will meet prior to the subsequent meeting to:

a. review the findings of the investigative process or the new significant facts about the incident that have emerged but have yet to be disclosed;
b. develop an action plan to reduce the risk of a similar incident reoccurring by considering the findings of the investigative process if it has been completed;
c. reassess the client 's health care needs and prepares treatment options and recommendations, as appropriate;
d. reassess the potential needs for the and develop plans to fulfill them ;
e. sets a time and location for the subsequent disclosure meeting; and
f. arrange for the services of an interpreter, if required.

5.6.3 The main communicator informs the disclosee(s) of the time and location for the subsequent disclosure meeting(s).

5.6.4 *Key items to cover at subsequent disclosure meeting(s)*

At a subsequent disclosure meeting(s), the disclosure team must

a. acknowledge that the most responsible provider is not present, when applicable;
b. explain the new significant facts about the incident that have emerged or what has been learned from the investigative process;
c. explain the steps taken to reduce the risk of a similar incident reoccurring;
d. provide an overview of the action plan developed;
e. offer further apology for what happened;
f. explain that the disclosure team remains accessible for ongoing communication and provide appropriate contact information;
g. offer, based on needs identified, the supports to the client ;
h. leave ample time for the disclosee(s) to ask questions and the disclosure team to respond; and
i. offer to research any questions that the disclosure team cannot answer immediately and arrange a timely follow-up.

5.7 **Strategies for disclosure meeting**

Table 2: Best Practices for Disclosure Meetings
▪ Hold the conversation face to face unless there are extenuating circumstances; ▪ Adopt a transparent, ethical, and sincere approach; ▪ Use active listening skills, such as empathy; ▪ Use terminology and words likely to be understood by the disclosee(s); ▪ Confirm that the information is understood by the disclosee(s) and allow time for questions; ▪ Demonstrate sensitivity to the culture and language of the disclosee(s); ▪ Encourage disclosee(s) to speak from their own perspective and in their own words about their experience; ▪ Foster good spirits by being open, welcoming and inclusive; and ▪ Respect others as well as relationships and care for people

5.8 **Follow-up**

5.8.1 The disclosure team, involving other staff members as appropriate, must implement the action plan created under sections 5.6.2 and 5.6.3.e of this Policy in order to reduce the risk of a similar incident reoccurring.

5.8.2 The disclosure team, in collaboration with the continuous quality improvement division staff, monitor and evaluate the effectiveness of the action plan.

5.9 **Documentation**

5.9.1 The disclosure team shall document the following about the disclosure meeting(s) in a secure file at the Regional Office:

a. Time, place, and date of disclosure meeting(s);
b. Names and functions of all persons in attendance;
c. The material facts presented;
d. The actions taken to address the consequences of the incident to the client;
e. Treatment options and recommendations presented as well as those agreed upon;
f. Questions asked by the disclosee(s) and the responses; and
g. Expected follow-up, if any.

5.9.2 The disclosure team must document the following about every disclosure meeting in the client 's health record:

a. Time, place, and date of the meeting;
b. Names and functions of all persons in attendance; and
c. Treatment options agreed upon.

5.10 **Support**

5.10.1 The disclosure team may offer the client(s) a referral to mental health or social work services, as required.

5.10.2 The immediate supervisor will offer support to the disclosure team members by

a. providing each member with the contact information for the employee assistance program;
b. offering to arrange for mental health or social work services if needed; and
c. referring them to professional legal assistance services if required.

6. Continuous Quality Improvement

6.1 To evaluate the disclosure policy, designated Department of Health staff (for example, client relations manager or quality improvement lead) may randomly select participants of a disclosure meeting to seek their feedback on the disclosure process.

6.2 The Department will deliver training on this Policy at the time this Policy comes into force and on an ongoing basis.

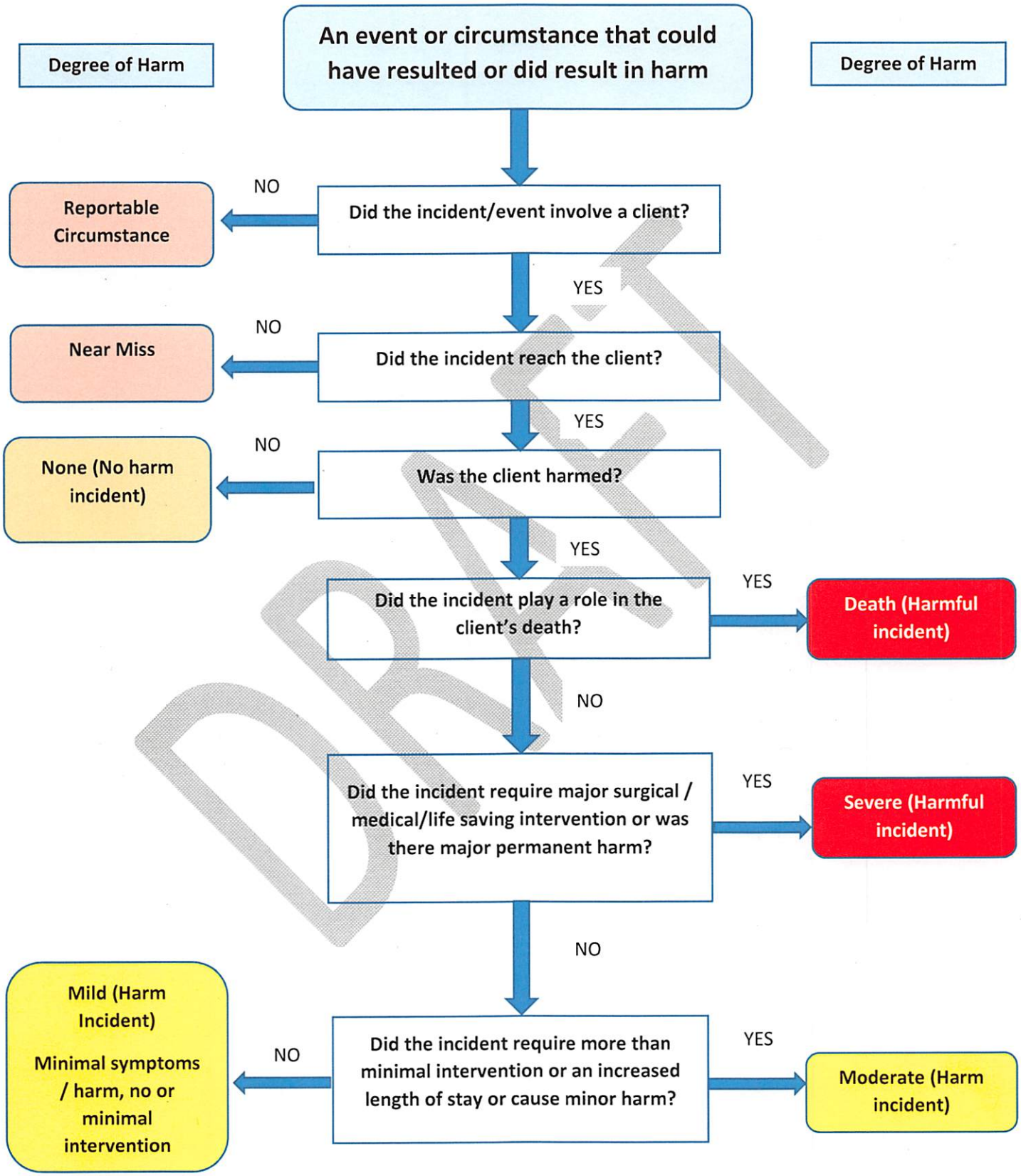
7. Related Policies, Protocols and Legislation

Consolidation of Legal Treatment of Apologies Act (S.Nu. 2010, c.12)

Policy 05-002-00	Continuous Quality Improvement Program
Policy 05-003-00	Risk Management
Policy 05-004-00	Risk Management Incident Reporting
Policy 05-005-00	Critical Incident Stress Management
Policy 06-001-00	Confidentiality
Policy 06-003-01	Release of Information

Approved By: Colleen Stockley	Date: Nov 15/16
Colleen Stockley, Deputy Minister – Department of Health	
Approved By: W D Macdonald	Date: 30/11/2016
Dr. William Macdonald, Medical Chief of Staff	
Approved By:	Date: Nov 15/16
Jennifer Berry, Chief Nursing Officer	

Appendix A: Understanding harm and no harm incidents

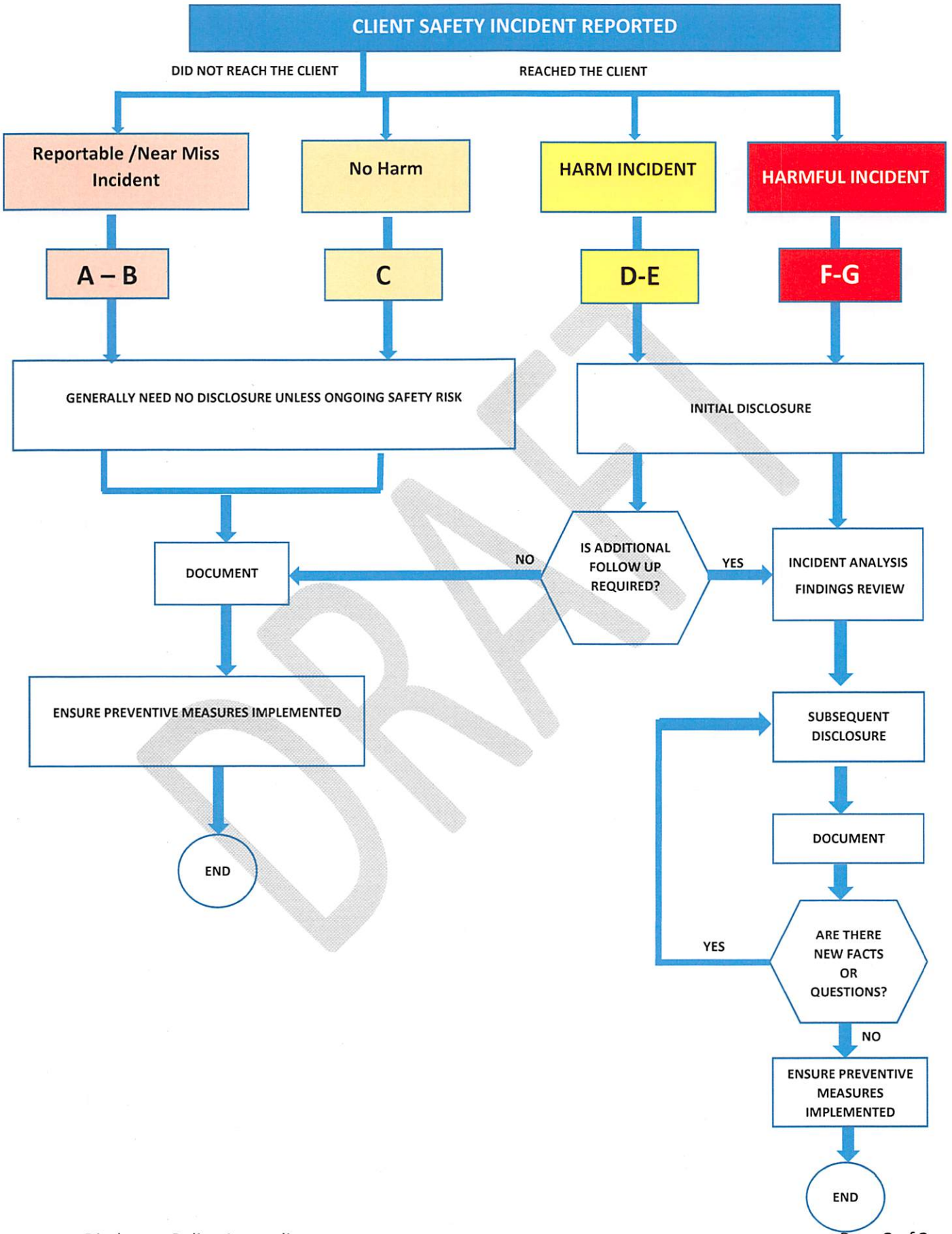


Appendix A: Understanding harm and no harm incidents

Severity's Scale Categorizing Degree of Harm

CATEGORY	DESCRIPTION	Degree of Harm	Type of incident
A	A situation that has potential for harm and does not involve a client.	Reportable circumstance	Reportable incident
B	An incident that has potential for harm is intercepted or corrected prior to reaching the client.	Near Miss	Near Miss
C	Outcome is not symptomatic or no symptoms are detected and no treatment is required.	None	No Harm
D	Outcome is symptomatic, symptoms are mild, harm is minimal and no or minimal intervention (for example extra observation, investigation, review or minor treatment) is required.	Mild	Harm Incident
E	Outcome is symptomatic, requiring intervention (for example, additional operative procedure, additional therapeutic treatment) or an increased length of stay, or causing minor harm.	Moderate	
F	Outcome is symptomatic, requiring life – saving intervention or major surgical / medical intervention, or shortening life expectancy or causing major permanent, long – term harm or loss of function.	Severe	Harmful incident
G	Incident contributed or resulted in the dealth of the client.	Death	

Appendix B: Disclosure Flowchart – When to disclose?



	Department of Health Government of Nunavut	**NURSING POLICY, PROCEDURE AND PROTOCOLS** Community Health Nursing	
TITLE:		**SECTION:**	**POLICY NUMBER:**
Client Safety Event – Screening for and Conducting Incident Analysis		Administration	05-036-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
July 12, 2022	July 12, 2025	NEW	11
APPLIES TO:			
All Department of Health Staff (Community Health Centre and Iqaluit Health Services Providers)			

1. BACKGROUND:

The Department of Health (Health) is committed to delivering safe and quality care for Nunavummiut. In addition to supporting client and family needs, timely notification, review, and management of harmful incidents are key activities to reducing preventable harm and improving quality of care for Nunavummiut.

Harm and errors in healthcare almost always occur due to complex system interactions involved in delivering care. Incident reporting is a **non-punitive** learning process which provides frontline staff with the ability to identify system and organizational constructs that may lead to undesirable outcomes. All staff play a critical role in identifying and reporting incidents and contributing to a learning culture to understand what happened, how and why it happened, and how it can be prevented from happening again.

2. POLICY:

2.1 All client safety incidents categorized as severity level 5 and 6, or identified as never events will receive a Critical Incident Urgent Teleconference (CIUT) to determine the need for further action and review.

2.1.1 All client safety incidents categorized as severity level 4 will be screened for the necessity of a CIUT.

2.2 The incident analysis process shall be initiated within 48 hours of the incident report being received. Final reports will receive approval by the Quality Improvement Committee and additional parties, as required.

2.3 The immediate supervisor and staff shall provide support to clients and families throughout the critical incident analysis process. The immediate supervisor will offer the opportunity for clients and families to participate in the review process, including follow-up on the analysis findings.

2.4 The immediate supervisor and/or Director shall provide support to staff throughout the critical incident analysis process. Additional resources may be offered (e.g., Employee and Family Assistance Program 24/7 Hotline: 1-800-663-1142).

2.5 Following incident analysis, the immediate supervisor and/or Director shall share learnings with involved staff, client/family, other practice areas, and the organization, as appropriate.

3. PRINCIPLES:

3.1 This policy aligns with the following Inuit Qaujimajatuqarigit Principles:

i. *Tunnaganarniq*, fostering good spirits by being open, welcoming and inclusive;
ii. *Inuuqatigiitsiarniq*, respecting others, relationships and caring for people;
iii. *Piliriqatigiinniq*, working together for a common cause, and more specifically, for the health and safety of clients of the Department of Health;
iv. *Pilimmakasarniq/Pijariuqsarniq,* development of skills through practices, effort, and action.

3.2 Clients, visitors, and staff have the right to a safe environment in which to receive care, visit, and work.

3.3 Health actively supports a workplace environment rooted in just culture. A just culture ensures that staff feel comfortable, safe, and encouraged to report quality and safety concerns because there is trust that a fair and consistent approach will be applied when reviewing and responding to unexpected events. This includes:

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

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

3.5 The Government of Nunavut (GN) has mandated responsibilities under the *Workers Safety and Compensation Commission Act* (WSCC) and the *Safety Act* for Nunavut to protect the health and safety of its clients, visitors, and staff.

4. DEFINITIONS:

Client: a person who receives health services.

Clinician: a person who provides health services for Health either as an employee or a contractor, including physicians. The term 'staff' is inclusive of clinicians in this policy.

Critical Incident: An unintended event or circumstance that occurs when a client's interaction with the health system results in severe harm or death and does not result primarily from the client's underlying medical condition, or from a known risk of treatment.

Harm: An unexpected or normally avoidable outcome that:

i. Negatively affects a client's health or quality of life;
ii. Occurs or occurred during the course of health care treatment; and
iii. Is not directly due to the client's underlying illness.

Harm implies impairment of structure or function of the body and/or any deleterious effect arising there from, including disease, suffering, disability, and death. Harm may be physical, social, or psychological.

Immediate Supervisor: The staff member to whom you report (e.g., Supervisor of Health Centre (SHP), Regional Manager, or Director of Health Programs (Director).

Incident: An unintended event or circumstance which could have resulted, or did result, in unnecessary and/or unintended harm to the client. This includes near miss, no harm, and harmful events.

Incident Report: A written report describing the factual elements of an incident. Incident reports 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. These reports are confidential and are not a part of the client's medical record nor the clinician's file.

Just Culture: An organizational approach which balances the need for staff to act safely with the responsibility of a responsive, safe system. A just culture ensures that staff feel comfortable, safe, and encouraged to report quality and safety concerns because there is trust that a fair and consistent approach will be applied when reviewing and responding to unexpected events.

Never Event: A subset of serious adverse clinical events. These incidents are considered critical regardless of the client outcome. Never Events have known mitigation strategies that, when appropriately implemented, would prevent the occurrence of the event. See Appendix A: Never Events and Urgent Teleconference Criteria.

Systems Thinking: An approach which focuses on the conditions under which people work (i.e., the system), rather than on the individual. Systems thinking in healthcare emphasizes that client safety incidents typically occur due to system failures.

5. PROCEDURE

Refer to *Policy 05-034-00 Client Safety Event – Incident Reporting and Immediate Management* for information regarding the immediate response to client safety incidents.

5.1 Screening Client Safety Incident for Analysis

5.1.1 After a client safety event occurs, the Chief Nursing Officer and Chief of Staff are responsible for determining if a CIUT is required.

i. See **Appendix A: Never Events and Urgent Teleconference Criteria;**

ii. See **Appendix B: Urgent Teleconference Template**

iii. If an incident has resulted in unexpected and/or unintended moderate harm (severity level 4), the event will be screened for the necessity of an CIUT.

iv. If an incident has resulted in unexpected and/or unintended severe harm or death (severity level 5 or 6), or is classified as a never event, a CIUT is required to determine the need for further action and review.

5.1.2 CIUT's are to be held within 48 hours of an incident occurring. When an incident occurs on a non-business day, the CIUT shall occur as soon as reasonably possible.

5.1.3 To prepare for the CIUT, the immediate supervisor and/or the Director shall:

i. Gather information (e.g., relevant policies, incident report, client medical record) to obtain a preliminary understanding of what occurred;

ii. Speak with involved staff to understand what happened;

iii. Refer to the appropriate manager, if input is required;

iv. Develop a written timeline using the information gathered.

5.1.4 The Quality Team is responsible for coordinating and facilitating CIUTs.

5.1.5 The decision to conduct further review of an incident shall be made collectively during the CIUT.

5.1.6 Upon the decision to conduct further review, the following information is required:

i. Type of analysis: **Appendix C: Criteria for Selecting a Method of Incident Analysis** shall be used, along with contextual information, to determine which method of analysis is most appropriate

ii. Analysis Chair (individual accountable for the completion of the review)

iii. Analysis Lead (individual responsible for the completion of all activities)

iv. Analysis Team

v. Additional action items

5.1.7 If a CIUT is deemed not necessary, the immediate supervisor is responsible for ensuring

the completion of local actions to manage the incident.

5.2 **Conducting Incident Analysis of a Client Safety Incident**

5.2.1 Analyses must be completed as soon as reasonably possible;

5.2.2 The Analysis Chair is accountable for the completion of all analysis activities;

5.2.3 The Analysis Lead is responsible for the completion of all analysis activities;

5.2.4 The Analysis Team is responsible for contributing to the development of findings and recommendations;

5.2.5 The Quality Team is responsible for supporting all analysis activities.

5.3 **Presenting Findings and Recommendations**

5.3.1 Final reports should be presented to the Quality Improvement Committee (QIC) within 30 days of CIUT decision for concise analyses, and within 90 days of CIUT decision for comprehensive analyses (dependent on timing of QIC meetings);

5.3.2 The Analysis Lead and/or Quality Team is responsible for presenting a summary of the incident, the key findings, and the recommendations to the QIC;

5.3.3 QIC is responsible for providing feedback and approval on recommendations;

5.4 **Managing Recommendations**

5.4.1 The Analysis Lead and/or Quality Team is responsible for ensuring completion of all recommendations. This includes following up with the designated recommendation owners.

5.4.2 The Quality Team is responsible for managing the Client Safety Event Tracker.

5.5 **Sharing Learnings**

5.5.1 The Quality Team and Analysis Lead are responsible for:

i. Sharing learnings with the client/family (see *Policy 05-035-00 Client Safety Event Disclosure*);

ii. Ensuring that feedback is provided to staff who reported the incident;

iii. Sharing learnings with those impacted by the change(s);

iv. Sharing learnings and actions taken with those impacted by the change(s) and with other areas/staff where a similar event could occur.

5.5.2 Examples of platforms for sharing learnings: Morning Report, SHP meetings, Quality and Patient Safety Rounds.

6. APPENDICES:

APPENDIX A NEVER EVENTS AND URGENT TELECONFERENCE CRITERIA

APPENDIX B URGENT TELECONFERENCE TEMPLATE

APPENDIX C CRITERIA FOR SELECTING A METHOD OF ANALYSIS

7. RELATED POLICIES, PROTOCOLS AND LEGISLATION:

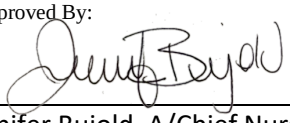
Policy 05-034-00 Client Safety Event – Incident Reporting and Immediate Management

Policy 05-035-00 Client Safety Event Disclosure Policy **REFERENCES**:

Alberta Health Services (n.d.) Immediate management checklist. Retrieved from https://www.patientsafetyinstitute.ca

Alberta Health Services (n.d.) Ongoing management checklist. Retrieved from https://www.patientsafetyinstitute.ca

St. Joseph's Healthcare Hamilton (2020, January). Safety Incident Reporting and Management – Patient and Visitor

Approved By: 	Date: July 21, 2022
Jennifer Berry, Assistant Deputy Minister – Department of Health	
Approved By: 	Date: July 12, 2022
Jenifer Bujold, A/Chief Nursing Officer	
Approved By:	Date:
Dr Francois De Wet, Territorial Chief of Staff	

Appendix A Never Events and Urgent Teleconference Criteria

Never Events for Hospital and Community Care in Nunavut

Never Event: A subset of serious adverse clinical events. These incidents are considered critical regardless of the client outcome. Never Events have known mitigation strategies that, when appropriately implemented, would prevent the occurrence of the event.

Surgical or Procedural Events
1. Surgery or other invasive procedure performed on the wrong client or wrong body part, or conducting the wrong procedure[1]
2. Unintended foreign object left in a client following surgery or other procedure[2]
3. Client death or severe harm due to the administration of the wrong inhalation or insufflation[1]
Product or Device Events
4. Client death or severe harm associated with the use or function of a device in client care in which the device is used for functions other than as intended[2]
5. Client death or severe harm arising from the use of improperly sterilized instruments of equipment provided by the healthcare facility[1]
Client Protection Events
6. Client under continuous observation leaves a health facility without the knowledge of staff[1]
7. Client death by suicide, attempted suicide, or self-harm resulting in severe harm, while being cared for in a health care facility[2] at which time the client was prescribed continuous observation[1]
Care Management Events
8. Client death or severe harm associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong client, wrong time, wrong rate, wrong preparation, or wrong route of administration)[2]
9. Client death or severe harm due to a failure to inquire whether a patient has a known allergy to medication, or due to administration of a medication where a client's allergy had been identified[1]
10. Wrong tissue, biological implant, or blood product given to a client[1]
11. Any stage 3, stage 4, or unstageable pressure ulcers acquired after admission/presentation to a healthcare facility[2]
12. Client death or severe harm of a frail client, or client with altered level of consciousness within a healthcare facility[1]
Environmental Events
13. Client death or severe harm associated with a burn incurred from any source during a client care process in a healthcare facility[2]

1. Agency for Healthcare Research and Quality (2019, September). *Never events.* https://psnet.ahrq.gov/primers/primer/3/Never-Events
2. Government of Nunavut (2017). *Pediatric and Adult – Telephone Triage Policy (07-006-00)*
3. Canadian Patient Safety Institute (2015, September). *Never events for hospital care in Canada.* http://www.patientsafetyinstitute.ca/en/toolsresources/neverevents/Pages/default.aspx

Urgent Teleconference Criteria

- All client safety incidents categorized as severity level 4 will be screened for the necessity of an urgent teleconference.
- All client safety incidents categorized as severity level 5 and 6, or identified as Never Events, will be screened for the necessity of an Urgent Teleconference; if severity level is confirmed with the information available at the time, the event will receive an urgent teleconference and further review.
- If regional staff, leadership, or the quality team deems a near miss or mild harm event to have a high risk of recurrence or high potential for harm, the event may be reviewed through the Urgent Teleconference process.

EXCLUSION CRITERION
1. Death of a palliative client where no care issues have been identified by family or staff.
Care Delivery
1. Client death or moderate to severe harm is suspected to have been associated with healthcare delivery or omission of services. Examples include: a. Issues in care raised by staff or family deemed related to the outcome; b. Breach in applicable policies/processes and accepted practices; c. Client seen within 7 days at a healthcare facility for an issue related to the outcome, or seen 3 or more time for the same complaint(s) with no clear diagnosis or improvement (refer to policy 07-035-00); d. Access to care concerns (e.g., after-hour triage, clinic closure, decreased services, unavailable staff etc.).
Surgical or Procedural Events
2. Client death intraoperatively or within 10 days of discharge from operation or procedure[1,2]
Product or Device Events
3. Client death or moderate to severe harm associated with intravascular air embolism that occurs while being cared for in a health care setting[1]
Client Protection Events
4. Minor or client of any age who is unable to make decisions, discharged to anyone other than their authorized medical travel escort [1,3]
5. Client death occurs within 10 days of receiving care or treatment for a mental health condition from a healthcare facility within the organization and partner organizations
Care Management Events
6. Client death or moderate to severe harm of maternal or neonatal client associated with labour or delivery in a low-risk pregnancy while being cared for in a healthcare facility[1]
7. Client death or moderate to severe harm resulting from the irretrievable loss of an irreplaceable biological specimen[1]
8. Client death or moderate to severe harm resulting from failure to follow-up or communicate laboratory, pathology, or radiology test results[1]
9. Client death or moderate to severe harm resulting from failure to identify and treat metabolic disturbances[3]
10. Client death or severe harm resulting from significant medical travel delay.
Environmental Events
11. Client death or moderate to severe harm resulting from the use of restraints or bedrails while being cared for in a healthcare facility[1]
Criminal Events
12. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider[1]
13. Abduction of a client of any age from a healthcare facility[1]
14. Sexual abuse/assault of a client within or on the grounds of a healthcare facility[1]
15. Client death or moderate to severe harm to a client or staff member resulting from a physical assault (e.g., battery) that occurs within or on the grounds of a healthcare facility[1]

1. Agency for Healthcare Research and Quality (2019, September). *Never events.* https://psnet.ahrq.gov/primers/primer/3/Never-Events
2. Government of Nunavut (2017). *Pediatric and Adult – Telephone Triage Policy (07-006-00)*
3. Canadian Patient Safety Institute (2015, September). *Never events for hospital care in Canada.* http://www.patientsafetyinstitute.ca/en/toolsresources/neverevents/Pages/default.aspx

Appendix B Urgent Teleconference Template

*This template is subject to minor changes; content will remain comparable to below.

Urgent Teleconference - CONFIDENTIAL

Instructions for an Urgent Teleconference

1. **Purpose**:

- Gather necessary local and senior stakeholders to understand the safety event, review steps already taken, and identify other actions that need to take place;
- Identify any additional risk and establish a mitigation plan to prevent further harm from occurring;
- Determine if staff members or health centre need any additional support *(e.g. additional staffing, critical stress management counseling)* and to identify persons responsible for action;
- Determine if additional evidence or information may need to be collected *(e.g. reports from referral sites, biomed QC information, photographs of infrastructural damage);*
- Review current disclosure provided to patient/family and identify if further disclosure is needed;
- Decide whether a further review is required, the type of review, and identify who will lead and participate in the process *(i.e. CQI/ IHS Quality, Director, etc.);*
- Identify any other action items necessary, establish who is responsible for action items identified and determine follow-up on action items identified.

The Urgent Teleconference DOES NOT:

- Replace immediate notifications;
- Replace immediate mitigation or management of an incident;
- Act as a clinical debrief;
- Act as an incident analysis process.

2. **Responsibilities**:

- Once the **Director** has been notified of a safety event, the Director must confirm the harm level reported and shall contact the Quality Team to arrange an Urgent Teleconference for:
  - Incidents resulting in severe harm or death;
  - Incidents which pose a high risk to safety (patients, staff or community).
- **The Quality Team (i.e. CQI/ IHS Quality)** is required to coordinate the teleconference. Identification of necessary participants shall be done in collaboration with the Director, Chief Nursing Officer and/or Territorial Chief of Staff.
- A brief overview of what happened with details of the event, relevant history and what has already been done in response will be provided by the **Director.** This task may be delegated to the **Immediate Manager** *(e.g. SCHP)* **or most responsible provider** *(on a case by case basis).*

3. **Timelines**:

- Calls are to be held within 24-48 hours of incident occurring *(if incident occurs on a non-business day, established notification procedures are to be followed as directed by the Client Safety - Incident Reporting and Management Policy. An Urgent Teleconference is to occur as soon as reasonably possible on the following business day.)*
- Following the decision to undertake further review, the goal is to complete the review within 90 days.

Questions or Comments?

Territorial Office: HealthCQI@gov.nu.ca **or IHS Office:** IHSQuality@gov.nu.ca

Urgent Teleconference - CONFIDENTIAL

"The information in this document has been collected for the purpose of improving the quality of health care and directly related programs and services. It is thereby conducted as a Quality Assurance Activity under the auspice of sections 13, 14, and 15 of the Nunavut Evidence Act ("the Act") as a Quality Assurance Activity."

The focus, in keeping with a just culture, is to coordinate a fair, consistent, and supportive response, and to learn from the safety event.

Date of Teleconference	Click to enter date.	**Time of Teleconference**	Click to enter.
Event Identifier (e.g., QRM)	Click to enter.	**Client Identifier (e.g., DOB)**	
Date of Safety Event	Click to enter date.		
ATTENDANCE			
☐ Facilitator (i.e., Quality)	Click to enter name.	☐ Manager/ Supervisor	Click to enter name.
☐ Chief of Staff	Click to enter name.	☐ Director	Click to enter name.
☐ Chief Nursing Officer	Click to enter name.	☐ Executive Director	Click to enter name.
☐ Most Responsible Physician	Click to enter name.	☐ Patient Relations	Click to enter name.
☐ Chief of Service	Click to enter name.	☐ Other	Click to enter name.

CASE REVIEW

1. Provide a brief overview of the events *(i.e., what happened, where and when it happened, timeline and details of the event, other relevant information)*
E.g., relevant past medical history, significant timeline leading to event, the event, resulting actions, event outcomes, contributing factors, any actions taken to prevent recurrence, other relevant safety/risk information

2. Is there any outstanding information required to understand what happened?
Choose an item.

3. With the information currently known, was the generally accepted standard of care provided?
Choose an item.

4. With the information reviewed, is anyone else immediately at risk? *(consider: are there actions required to reduce the risk of this event imminently happening again?)*
Choose an item.

5. Are there any other staff/physician(s) to be notified or referrals to be cancelled? *(e.g., sending physician/staff, pharmacy, specialists)*
Choose an item.

6. Is there evidence that needs to be preserved? *(e.g., equipment, supplies, medication, biomedical)*
Choose an item.

7. Will staff (e.g., nurses, physicians, support staff) require additional support? *(e.g., Employee Family Assistance Program (EFAP), debriefing)*
Choose an item.

8. What is ONE thing that went well during the incident?
E.g., staff communication

ASSESSMENT

9. Does this meet the definition of an incident? *(an event or circumstance which could have resulted, or did result, in unnecessary and/or unintended harm to the client. This includes near miss, no harm, and harmful events)*
Choose an item.

Urgent Teleconference - CONFIDENTIAL

ASSESSMENT CONTINUED…

10. The reported level of harm was Choose an item.. With the information provided, Choose an item., and the actual level of harm is determined to be Choose an item.

Near Miss (1): An incident that has potential for harm and is intercepted or corrected prior to reaching the patient.	Severe Harm (5): Patient outcome is symptomatic, requiring life-saving intervention or major surgical/medical intervention (e.g., prolonged hospitalization or admission to a high acuity setting such as an ICU), or shortening life expectancy or causing major permanent or long-term harm or loss of function.
No Harm (2): Patient outcome is not symptomatic or no symptoms are detected and no treatment is required.	Death (6): On balance of probabilities; death was caused or brought forward in the short term by the incident.
Mild Harm (3): Patient outcome is symptomatic, symptoms are mild, loss of function or harm is minimal or intermediate but short term, and no or minimal intervention (e.g., extra observation, investigation, review, or minor treatment) is required.	Not an Incident
Moderate Harm (4): Patient outcome is symptomatic, requiring intervention (e.g., additional operative procedure, additional therapeutic treatment, short term hospitalization for assessment and/or minor treatment in either ED or hospital unit), an increased length of stay, or causing minor permanent or long-term harm or loss of function.	Insufficient Detail: An incident for which the report carries insufficient information to evaluate the severity of harm. (Note that this is not an option within the MEDITECH QRM Module, but may be selected during the Urgent Teleconference).

11. Is this a critical incident (i.e., level 5 or 6)? ☐

12. Is this a Never Event? ☐ *If yes, immediate notification to _____ is required*

FAMILY AND DISCLOSURE

13. **Has patient/family support been offered?** Choose an item. **Comments:** Describe.

14. **Did disclosure occur?** Choose an item.

a. **If YES, by whom?** Click or tap here to enter text.; **To whom?** Choose an item.
Date of disclosure: Click here to enter a date. ; **Was it documented?** Choose an item.

15. **With the information discussed, is there anything new to disclose?** Choose an item.

a. **If YES, by whom?** Name and role.

FURTHER REVIEW AND LEARNING

16. **Is further review required?** Choose an item.

☐ *Comprehensive Incident Analysis*	☐ *Concise Incident Analysis*	☐ *Aggregate Analysis*	☐ *Educational Case Study*	☐ *Quality Improvement Project*	☐ *Professional Proficiency Review*	☐ *External Review*
Analysis facilitated by Quality Team and reviewed by QIC Typically for severe harm/ death, high context incidents, complicated/ complex incidents, incidents impacting multiple practice areas, and multi-incidents	Succinct analysis conducted by Regional Director or Unit Manager with Quality Team support Typically for no, low or moderate harm, low context incidents, simple/complicated incidents, incidents localized to one practice area	Analysis facilitated by Quality Team and reviewed by QIC For multiple incidents that are identified by a particular trend; also referred to as aggregate analysis	Group learning from an incident (e.g., M&M rounds)	Quality of care or process improvement project done at local unit or program level	Education, training, and support to staff involved *See Managing Nursing Practice and Professional Conduct Policy*	Determined by ADM-Operations, CNO, and COS after conducting a chart review or upon findings of a systems analysis

If YES, determine potential analysis team members:

Analysis Chair	Analysis Lead	Clinical Lead	Quality Resource	Frontline Staff	Other Stakeholders
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.

17. **Who will be the main patient/family contact and will let them know a review is occurring?** Click or tap here to enter text.

18. **Who will conduct the patient/family interview?** Click or tap here to enter text.

19. **Who will loop back with the individual who reported the safety event? Crystal Culp**

ACTION ITEMS

20. **Action Items** *(to be sent out post-call):*

Action Item (e.g., actions to: respond to immediate incident, prevent recurrence, support staff)	MRP	Expected Completion Date

**MRPs are responsible for providing updates to the Quality Team to close the loop.
Action Items are logged in a database for tracking and data analysis purposes. Significant items will be brought to QIC.**

Appendix C Criteria for Selecting a Method of Incident Analysis

(ADAPTED FROM THE CANADIAN INCIDENT ANALYSIS FRAMEWORK)

Exceptions to the Criteria

- If the incident resulted in severe harm or death, a comprehensive analysis is required;
- If the incident meets two or more of the secondary criteria for a comprehensive analysis, a comprehensive analysis is required.

Primary Criteria	**Comprehensive**	**Concise**	**Aggregate**
Severity Level (See Appendix A: Severity Level Definitions)	Severe Harm or Death (5-6); Never Event	Reportable Circumstance to Moderate Harm (1-4)	Variable
Secondary Criteria	**Comprehensive**	**Concise**	**Aggregate**
Complexity Level (technical/social complexity, degree of predictability; simple – obtaining a blood sample via venipuncture; complicated – admitting a patient to an organization; complex – transferring a patient between organizations)	Complicated, Complex (typically, an unpredictable process and outcome with multiple interacting components)	Simple, Complicated (typically, a predictable process and outcome with few interacting components)	Simple, Complicated or Complex
Area of Impact	Team, Unit/Program, Organization, System (typically impacts or has the potential to impact multiple areas)	Team, Unit/Program, Possible Organization (typically localized to one program or department)	Team, Unit/Program, Organization, System, Sector, Industry
Context (internal pressures – historical incident data, alignment with strategic priorities, resources available; external pressures – regulatory mandates, alignment with literature/evidence)	High (e.g., significant risk identified in initial findings, evidence of recurrence, poses organizational risk)	Low (e.g., localized incident, unlikely that incident occurred previously, limited alignment with strategic priorities)	Low, Medium or High
Additional Considerations	**Comprehensive**	**Concise**	**Aggregate**
Resources Required/ Available (time, financial, human)	Moderate to Extensive (typically led by an interdisciplinary team with additional consultation; significant resources required)	Limited (typically led by one to two individuals; limited resources required)	Moderate to Extensive
Expected Timeline of Analysis	Weeks to Months (<90 days)	Hours to Days (<30 days)	Variable