Section 6: Communication

Policy Number	Policy Name
06-001-00 06-001-01	Confidentiality Confidentiality Guidelines
06-002-00 06-002-01	Transmission of Health Information by Facsimile Guidelines for Transmitting Information by Facsimile
06-003-00 06-003-01	Release of Information Guidelines for the Release of Information
06-004-00 06-004-01	Intra-Departmental Release of Information Intra-Department Guidelines for the Release of Information
06-005-00 06-005-01 06-005-02 06-005-03	RCMP Investigations Guidelines for RCMP investigations Law Enforcement Disclosure Form Letter to RCMP to Disclose Client Information
06-006-00	Health Records Management
06-007-00	Health Record Control
06-008-00 06-008-01	Documentation Standards Documentation Standard Guidelines
06-009-00 06-009-01	Documentation Format SOAP Documentation Guidelines
06-010-00	Date and Time Sequence
06-018-00	Call Record and On-Call Physician Consultation
06-011-00	Email Consultation
06-012-00	Forms Management
06-013-00 06-013-01 06-013-02	Interpreter Services Interpreter Services Strategies for working with Interpreters
06-014-00 06-014-01 06-014-02	Telephone Communication Telephone Communication for Receptionists and Clerk Interpreters Front Desk Triage
06-015-00 06-015-01	Missed or cancelled appointments Guidelines for handling missed or cancelled appointments
06-016-00 06-016-01	Child Welfare Reporting Child Welfare Concerns
06-017-00	Morning Report

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

POLICY:

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

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

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

PRINCIPLES:

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

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

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

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

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

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

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Guideline 06-001-01 Confidentiality Guidelines

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

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

REFERENCES:

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

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

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

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

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

GUIDELINES 06-001-01

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

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

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

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

Verbal Communications

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

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

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

Written Information

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

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

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

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

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

Computerized Information

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

Employee Conduct

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

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

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

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

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

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

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

POLICY:

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

DEFINITIONS:

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

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

PRINCIPLES:

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

RELATED POLICIES, GUIDELINES AND LEGISLATION:

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

GUIDELINES 06-002-01

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

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

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

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

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

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

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

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

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

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

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

POLICY

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

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

DEFINITIONS:

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

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

PRINCIPLES:

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

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

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

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

RELATED POLICIES, GUIDELINES AND LEGISLATION:

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

GUIDELINES 06-003-01

INTERNAL RELEASE OF HEALTH INFORMATION

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

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

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

EXTERNAL RELEASE OF CLIENT INFORMATION

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

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

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

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

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

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

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

RELEASE OF INFORMATION TO THE RCMP

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

RELEASE OF INFORMATION FOR EXTERNAL DATABASE REPORTING

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

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

Approved by: 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:**
Intra-Departmental Release of Information		Communications	06-004-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		2
APPLIES TO:			
Community Health Nurses			

POLICY:

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

PRINCIPLES:

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

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

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

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

RELATED POLICIES, GUIDELINES AND LEGISLATION:

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

GUIDELINES 06-004-01

The following guidelines will apply:

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

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

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

POLICY:

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

POLICY:

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

PRINCIPLES:

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

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

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

DEFINITIONS:

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

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

RELATED POLICIES, GUIDELINES AND LEGISLATION:

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

GUIDELINE 06-005-01

RCMP INVESTIGATIONS

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

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

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

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

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

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

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

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

Approved by:	Effective Date:
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:**
Health Records Management		Communications	06-006-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		2
APPLIES TO:			
Community Health Nurses			

POLICY:

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

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

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

DEFINITIONS:

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

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

PRINCIPLES:

Health records are confidential and legal.

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

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

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

RELATED POLICIES, GUIDELINES AND LEGISLATION:

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

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

REFERENCES:

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

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

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

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

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

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS	
	Community Health Nursing	
TITLE:	**SECTION:**	**POLICY NUMBER:**
Health Record Control	Communications	06-007-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018 / February 2021		1
APPLIES TO:		
Community Health Nurses		

POLICY:

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

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

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

PRINCIPLES:

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

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

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

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS Community Health Nursing	
TITLE:	**SECTION:**	**POLICY NUMBER:**
Documentation Standard	Communications	06-008-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
Jan 18, 2023 / Jan 18, 2026	06-008-00/01	5
APPLIES TO:		
All Regulated and Unregulated Health Care Providers		

1. BACKGROUND:

1.1. The health record is a legal document, establishes professional accountability and may be used as evidence in a court of law or professional conduct proceeding. Health records are also used for quality improvement, risk management, funding and resource management.

1.2. This policy will review the process and procedures for recording personal health information to ensure the highest standard of documentation is met.

2. POLICY:

2.1. All health care providers are responsible for comprehensive, concise and accurate documentation of client interactions which they have provided, in the client's health record.

2.2. All health care providers must abide by the professional standards of their regulatory bodies, federal and territorial legislation, Government of Nunavut policies and procedures and accreditation standards regarding the manner in which documentation is done.

2.3. All health care providers shall document in the Government of Nunavut (GN) interactive electronic health record (iEHR) – Meditech, utilizing downtime procedures as required when the iEHR is unavailable.

2.4. Paper based documentation is only permitted to those records approved by the Dept. of Health (i.e. prenatal records). These paper records are typically limited to those not yet available in Meditech.

2.4.1 Documentation is completed in blue or black ink only. No spaces are left blank between entries.

3. PRINCIPLES:

3.1. HCPs are accountable for ensuring their documentation of client care is accurate, timely and complete.

3.2. HCPs safeguard client health information by maintaining confidentiality and acting in accordance with information retention and destruction policies and procedures that are consistent with standards and legislation.

3.3. Documentation communicates to all HCPs the plan of care, the assessment, the interventions necessary based on the client's history and the effectiveness of those interventions.

3.4. Documentation demonstrates the health care provider's commitment to providing safe, effective and ethical care by showing accountability for professional practice and the care the client receives, and transferring knowledge about the client's health history.

4. DEFINITIONS:

4.1. **Documentation**: refers to any written and/or electronic recording that describes the status of a client or the client care provided.

4.2. **Downtime Procedures:** paper-based procedures utilized when Meditech is unavailable. This includes documentation in the client's paper chart.
4.3. **Healthcare Provider:** refers to any regulated or unregulated healthcare provider authorized to document in the client's electronic or paper health record.
4.4. **Interactive electronic health record (iEHR):** a digital version of a client's paper chart. EHRs are real-time, client-centred records that make information available instantly and securely to authorized users. Meditech is the GN's iEHR.
4.5. **Authorized users:** refers to all healthcare professional who may access the iEHR client records. Authorized users document using their own signature and designation. Authorized users may vary regionally.

5. GUIDELINE:

5.1. Firsthand Knowledge

5.1.1 The HCP who provides the service or witnesses the event is the person responsible for documentation.

5.1.2 In the event of an emergency situation, a designated recorder will document the actions and care provided by other HCPs.

5.1.2.1 The Designated Recorder should document the presence of all other staff during the emergency and provide the name and designation of any staff when recording the care they provided.

5.1.2.2 HCPs providing care should verify the entries made by the Designated Recorder about care that they have provided by adding an addendum to the iEHR or by initialing the entry in the paper record, whichever is appropriate.

5.1.3 The HCP will continue to be responsible for documenting on their clients in the event of a delayed medivac where medevac staff are on site. Documentation is required until the client departs from the community.

5.2 Contemporaneous and Chronological Document

5.2.1 Documentation shall occur in a timely manner, either during, or immediately after the care has been provided.

5.2.2 Any documentation not completed by the end of the shift must be clearly documented as a **LATE ENTRY.**

5.2.3 The actual time and date of the interaction or service provided must be recorded clearly.

5.2.4 The time of the documentation is automatically recorded in Meditech.

5.2.4.1 The actual time of documentation must be recorded if the client's paper chart is being utilized.

5.2.5 Failure to record events in chronological order may cast suspicion on the accuracy of the record during legal proceedings and thus question the credibility of the HCP and the health record.

5.2.6 In emergency or critical situations documentation should be ongoing and completed immediately following the event.

5.3 Detail and Frequency of Documentation

5.3.1 The frequency of documentation reflects the acuity and complexity of the client's care needs. Documentation is more frequent when the client's status is acute, emergent or complex. Documentation occurs:

i. When there is a response to care provided

ii. When there are changes in client status
iii. When education, recommendations and instructions are provided
iv. After evaluation of interventions
v. When transfer or discharge plans are made or occur

5.4 Document Concisely

5.4.1 Documentation should be concise, factual, objective, and accurate.

5.4.2 Concise documentation contains essential information about the client status or care as succinctly as possible.

5.4.3 Pertinent negative findings that assist in refining the differential diagnosis should be included.

5.4.4 Factual documentation contains accurately perceived data obtained from a variety of sources, e.g., observation, inspection, palpation and auscultation. When recording client statements, utilize quotations with exactly what was said.

5.4.5 Objective documentation is the recording of facts or conditions without distortion of personal bias. Objective data is observed or measured and includes interventions, actions or procedures as well as the client's response. Avoid generalizations and vague expressions such as 'status unchanged'. Document only conclusions that can be supported by data and avoid value judgments or unfounded conclusions.

5.5 Consultations

5.5.1 Document all nurse-initiated consultations, showing timely reporting of any abnormal findings, medical direction given, and action taken.

5.5.2 All verbal physician/Nurse Practitioner (NP) orders to prescribe, modify, or discontinue treatment should be clearly recorded.

5.5.3 Whenever physician/NP orders are verbally verified for accuracy, this discussion should also be clearly documented in the record.

5.5.4 When an NP is consulted, it is the responsibility of both the nurse and the NP to document the interaction as per Policy 07-043-00 *Nurse Practitioner Consultation Process.*

5.6 Document refusal of treatment/discharge against medical advice

5.6.1 Include in documentation:

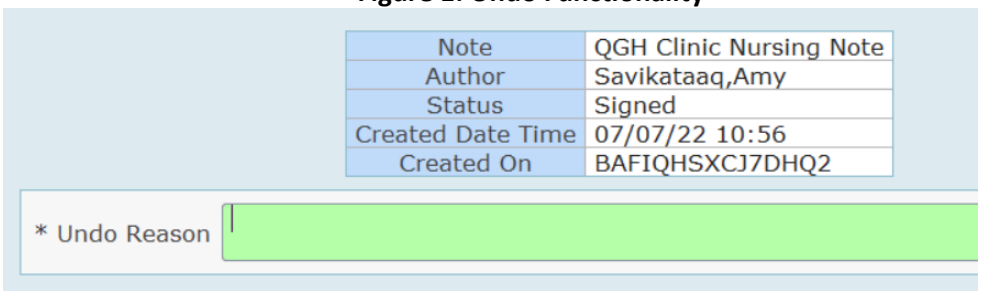
i. The circumstances of the refusal
ii. The information provided to the client/family regarding potential consequences of refusal
iii. Any additional client teaching provided
iv. Any treatment or medication provided and reasons to seek medical attention.
v. Complete the form included with Policy 07-039-00 *Informed Refusal of Treatment.*

5.7 Correction of Errors

5.7.1 There are two options to correct an error on the EMR or Meditech

5.7.1.1 If a note is completed on the wrong patient in the EMR on Meditech, the HCP who completed the note can delete the note using the Undo functionality. A reason for deleting the note is a mandatory free text section. Refer to Figure 1.

Figure 1: Undo Functionality



5.7.1.2 This note will no longer be visible in the EMR for clinicians to view but will remain in the electronic chart which is accessible to health records staff and is the legal chart from which all documentation requests are taken.

5.7.1.3 The other option is to do an addendum. This would be used to correct an error that was made in a note or to add something that may have been forgotten initially.

5.7.1.4 Anyone can place an addendum on any note as the original note has not been altered. The HCP is only adding to the note.

5.7.1.5 The original note will be titled Original Note and the addendum will state Addendum entered and is electronically signed by the person doing the addendum with a date and time stamp of the addendum. Refer to Figure 2.

Figure 2: Creating an Addendum

5.7.2 In the paper record, errors are corrected by drawing a single line through the erroneous entry only by the HCP who made the original entry.

5.7.3 Entries may not be obliterated with correction fluid or pen.

5.7.4 The correction is initialed by the HCP.

6 RELATED POLICIES, PROTOCOLS AND LEGISLATION:

Reference Sheet 03-002-00 Common Government of Nunavut Acronyms

Reference Sheet 03-003-00 Common Abbreviations
Policy 06-009-00 Documentation Format
Policy 07-039-00 Informed Refusal of Treatment
Policy 07-043-00 Nurse Practitioner Consultation Process

7 REFERENCES:

Accreditation Canada. (2020). *Required Organizational Practices 2020 Handbook.* Retrieved from https://src.healthpei.ca/sites/src.healthpei.ca/files/Accreditation/Accreditation_Canada_Required_Organizational_Practices_Handbook.pdf

British Columbia College of Nurses & Midwives. (2019, July 22). *Practice Standard for BCCNM Nurses Documentation.* Retrieved from https://www.bccnm.ca/NP/PracticeStandards/General%20Resources/NP_PS_Documentation.pdf

Canadian Nurses Protective Society. (2007, January). *Quality Documentation: Your Best Defense.* Retrieved from https://cnps.ca/article/infolaw-qualitydocumentation/

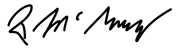
IWK Health Centre. (2019, 02 05). *Minimum Documentation Standards for Health Care Providers.* Retrieved from http://policy.nshealth.ca/Site_Published/IWK/document_render.aspx?documentRender.IdType=6&documentRender.GenericField=&documentRender.Id=75983

Nova Scotia College of Nursing. (2022, January). *Documentation for Nurses.* Retrieved from https://cdn3.nscn.ca/sites/default/files/documents/resources/DocumentationGuidelines.pdf

Nurses Association of New Brunswick . (2020, May). *Standards for Documentation.* Retrieved from http://www.nanb.nb.ca/media/resource/NANB-Standards-Documentation-May20-E.pdf

Ontario, C. o. (2019). *Documentation, Revised 2008.* Retrieved from https://www.cno.org/globalassets/docs/prac/41001_documentation.pdf

Registered Nurses Association of the Northwest Territories and Nunavut. (2015, January 19). *Documentation Guidelines.* Retrieved from Registered Nurses Association fo the Northwest Territories and Nunavut.

Approved By:	Date:
	2023-03-09
Jennifer Berry, Assistant Deputy Minister – Operations, Department of Health	
Approved By:	Date:
	2023-03-09
Robert McMurdy, A/Chief Nursing Officer	

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

TITLE:		SECTION:	POLICY NUMBER:
Documentation Format		Communications	06-009-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
Jan 18, 2023	Jan 18, 2026		2

APPLIES TO:
All regulated and unregulated Healthcare Providers

1. **BACKGROUND:**
   - **1.1.** Healthcare providers (HCP) are legally required to document the care they have provided to a client in the client's health record. The documentation is utilized to communicate between health professionals and to ensure quality and continuity of care. Standard formatting of documentation ensures a complete, accurate, comprehensive, timely and consistent method of recording client information. The Department of Health endorses SOAP charting as the format to be used in health centres in Nunavut.

2. **POLICY:**
   - **2.1.** HCPs working in community health centres will employ the principles of SOAP charting with each clinical encounter unless a Government of Nunavut approved form is available or the clinical situation is not conducive to this format (e.g., charting during an emergency).

3. **PRINCIPLES:**
   - **3.1.** HCP documentation reflects the client's perspective, identifies the HCP and promotes continuity of care by allowing other partners in care to access the information. It ensures HCPs are providing safe, effective, ethical care by showing accountability for professional practice.
   - **3.2.** Quality documentation is a nurse's best defense in a legal proceeding.

4. **DEFINITIONS:**
   - **4.1.** **Regulated and unregulated healthcare providers** refer to: Community Health Nurses (CHNs), Nurse Practitioners (NPs), Licensed Practical Nurses (LPNs), Supervisors of Community Health Programs (SHPs), Public Health Nurses (PHNs), Home Care Nurses (HCNs), Mental Health Nurses (MHNs), Mental Health Consultant (MHC), Registered Midwife (RMs), Acute Care Paramedics (ACPs) and Primary Care Paramedics (PCPs) who are authorized to document in the client's electronic or paper health record
   - 4.2 **SOAP charting**: Problem focused documentation using the headings Subjective, Objective, Assessment and Plan. Provides a framework for clinical reasoning and evaluation.

5. **GUIDELINE: SOAP CHARTING**

   SOAP charting is the standard format to be used by all HCPs working in a Community Health Centre.

   - **5.1. S – Subjective**

     This includes information provided by the client, what they stated or information obtained

from the health record. The section details the presenting concern (preferably in the client's own words); history of the presenting concern (events leading up to the appointment); review of systems; any allergies; current medications; past medical history; surgical history; family history; social history; and immunizations.

5.2. O – Objective

These are the observations made by the HCP during the examination or interaction with the client/family. Information may include vital signs, general appearance, physical assessment, any current and relevant laboratory test results, imaging results and consults.

5.3. A – Assessment

This is an appraisal statement of the client's current condition and includes any medical/nursing diagnoses as well as differential diagnoses. Differential diagnoses should be supported by evidence in either the subjective or objective areas.

5.4. P – Plan

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

- Care and treatment provided during the clinic visit along with the response to treatment if relevant
- Medications prescribed and/or dispensed
- Education and counselling provided to client/family
- Follow-up plans and referrals.

Evaluation of the plan should occur during subsequent visits, even if the client does not immediately return. Did the plan work? Were any changes required?

6. RELATED POLICIES, PROTOCOLS AND LEGISLATION:

Policy 06-006-00	Health Records Management
Policy 06-008-00	Documentation Standards

7. REFERENCES:

Canadian Nurses Protective Society. (2020, October). *InfoLAW: Quality Documentation: Your Best Defense.* Retrieved from https://cnps.ca/article/infolaw-qualitydocumentation/

College of Nurses of Ontario. (2019, April). *Practice Standard: Documentation, Revised 2008.* Retrieved from https://www.cno.org/globalassets/docs/prac/41001_documentation.pdf

IWK Health Centre. (2019, February 5). *Minimum Documentation Standards for Health Care Providers.* Retrieved from http://policy.nshealth.ca/Site_Published/IWK/document_render.aspx?documentRender.IdType=6&documentRender.GenericField=&documentRender.Id=75983

Nova Scotia College of Nursing. (2022, January). *Documentation for Nurses.* Retrieved from https://cdn3.nscn.ca/sites/default/files/documents/resources/DocumentationGuidelines.pdf

Approved By:	Date:
	2023-03-08
Jennifer Berry, Assistant Deputy Minister, Operations – Department of Health	
Approved By:	Date:
	2023-03-11
Rob McMurdy, A/Chief Nursing Officer	

GUIDELINES 06-009-01

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

S = SUBJECTIVE DATA

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

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

O = OBJECTIVE DATA

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

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

A = ASSESSMENT

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

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

P = PLAN

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

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

Evaluation of the care plan is documented as:

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

REFERENCES:

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

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

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

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS		
	Community Health Nursing		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Date and Time Sequence		Communications	06-010-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		1
APPLIES TO:			
Community Health Nurses			

POLICY 1:

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

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

POLICY 2:

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

PRINCIPLES:

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

RELATED POLICIES, GUIDELINES AND LEGISLATION:

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

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

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

POLICY:

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

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

PRINCIPLES:

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

RELATED POLICIES, GUIDELINES AND LEGISLATION:

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

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

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

POLICY:

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

DEFINITIONS:

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

PRINCIPLES:

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

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

Approved by:	Effective Date:
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:
Interpreter Services		Communications	06-013-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
Oct 24, 2022	Oct 24, 2025	06-013-00, 06-013-01, 06-013-02	8
APPLIES TO:			
All Healthcare Providers			

1. BACKGROUND:
   1.1. The Department of Health is committed to treating all people in a way that allows them to maintain their dignity and independence by providing safe, high-quality patient and family centred care to Nunavummiut. Integral to this is the ability to communication effectively in a person's preferred language to promote service accessibility, quality and equality (Office of the Languages Commissioner, October 2015). This policy defines the safe and effective use of interpreters during healthcare interactions.

2. POLICY:
   2.1. The Department of Health (Health) will strive to provide all health services (see 5.5) in the client's or subsequent decision maker's (SDM) preferred language.
   2.2. Maintenance of confidentiality is required of any person providing interpretation.
   2.3. Use of clerk interpreters for translating is the standard for providing interpreter services during AND after clinic hours.
      2.3.1 If required, an ad hoc interpreter (e.g., family, friend) may provide interpretation.
      2.3.2 The Health Care Professional (HCP) must advise the ad hoc interpreter to interpret exactly what the patient says and not to edit or summarize any information.
   2.4. Health shall establish a process for ongoing training, monitoring, and evaluating of the interpreter's competencies.

3. PRINCIPLES:
   3.1. Health ensures that all clients (regardless of whether they are unilingual or not) will have the option to effectively communicate their medical history and condition, understand the assessment of their medical condition and treatment options in their preferred language.
   3.2. Interpreter services are essential to the provision of safe, quality care in Nunavut.
   3.3. Supports the principles of Inuit Qaujimajatuqangit and guiding principles of Katujjiluta.
   3.4. Using a trained medical interpreter is the best practice for ensuring health information is accurately exchanged and confidentiality maintained.

4. DEFINITIONS

   Vital Documents: Includes but not limited to intake forms, consent forms, education/information material (pertaining to a healthcare service, medical condition, or directives to follow), advance care plans, healthcare directives.

Practice Point: Advanced Care Plans are a vital document however, as per guidelines for completing those forms, a qualified interpreter is required; an ad hoc interpreter may not be used for the completion of an Advanced Care Plan

Ad Hoc Interpreter: Any person other than clerk interpreter (e.g., family, friend, bystander, community member), or telephone interpreter service endorsed by Health.

Healthcare Provider (HCP): Community Health Nurse; Supervisors of Community Health Programs, Nurse Practitioner, Physician, Registered Midwife, Registered Nurse, Licensed Practical Nurse, Public Health Nurse, Mental Health Nurse, Primary Care Paramedic, Advanced Care Paramedic.

5. PROCEDURE
   - 5.1. The HCP is responsible for identifying the client's or SDM's preferred language at the time of arrival to the health facility.
   - 5.2. The HCP shall do their utmost to offer services in the client's or SDM's preferred language.
   - 5.3. The HCP shall document the client's preferred language in the client's health record.
   - 5.4. The Supervisor of Community Health Programs is responsible for ensuring accessibility and maintenance of Clerk Interpreter contact information. This includes posting after-hours contact numbers for Clerk Interpreters in the staff area and ensuring that the nurse-on-call is aware of the location of the after-hours contact numbers.
   - 5.5. The HCP shall utilize interpreter services during the provision of health services including but not limited to:
     - i. Providing emergency medical services,
     - ii. Obtaining medical histories or informed consent,
     - iii. Explaining any diagnosis and plan for medical treatment,
     - iv. Discussing any mental health issues or concerns,
     - v. Explaining any change in regimen or condition,
     - vi. Explaining any medical procedures, tests, or surgical interventions,
     - vii. Explaining client rights and responsibilities,
     - viii. Explaining the use of restraints or seclusion/isolation,
     - ix. Providing medication instructions and explanation of potential side effects,
     - x. Explaining discharge plans,
     - xi. Involving client's during client and family care conferences,
     - xii. Discussing advanced care directives and/or end of life decisions,
     - xiii. Obtaining financial and/or insurance information.
   - 5.6. Interpreter services may be in-person or telephone-based, see *Appendix A: Accessing Phone Based Interpreter Services Via CanTalk*.
   - 5.7. The delivery method of services should be determined by considering: the critical nature of the clinical intervention and the availability of qualified interpreters.
   - 5.8. Every effort should be made to utilize clerk interpreters prior to an ad hoc interpreter.

5.9. The HCP shall obtain informed consent from the client or SDM prior to use of interpreter services. This may be obtained through the Informed Consent Card (see Appendix B), or a conversation through an interpreter. If a client declines interpreter services, the HCP shall document this in the client's health record.

> Practice Point: Interpreters shall decline to provide services when there is a real or perceived conflict of interest, or where they feel inadequately prepared, trained, or qualified. In this case access see *Appendix A: Accessing Phone Based Interpreter Services Via CanTalk*.

5.10. If no qualified interpreter is available and the client and ad hoc interpreter agree to proceed, interpretation may proceed. This interaction should be followed up with an appropriate interpreter as soon as reasonably possible.

5.11. When vital documents are not available in all languages, the interpreter shall assist the HCP and client review the document line by line.

5.12. The HCP shall document the interpreted interaction, including:

i. Method of obtaining informed consent and from whom,
ii. Name, affiliation, and contact information of the person who interprets (for non-health centre staff)
iii. Relationship of the interpreter to the client if an ad hoc interpreter is used
iv. Disclosed limitations of encounter
v. Provision of oral translation of all vital documents to clients
vi. Synopsis of the information provided to the client, and any decisions/ outcomes related to the interpreted discussion

5.13. Breaches of confidentiality must be reported via the electronic incident reporting system (MEDITECH QRM), AND to the ATIPP office via the *Privacy Breach Policy and Report*.

6. TIPS FOR WORKING WITH INTERPRETERS:

6.1. If working with an ad hoc interpreter, assess their English language proficiency by:

i. Asking if they are comfortable with the situation in which they will interpret
ii. Testing their proficiency with basic conversation (e.g., Where are you from?)
iii. Asking if they can describe specific body functions that relate to the interaction

6.2. Explain that confidentiality must be maintained, particularly if an ad hoc interpreter is being utilized (e.g., relative, friend).

6.3. Face the client and speak to them (not the interpreter).

6.4. Speak clearly, enunciate, and use simple terms. Avoid using jargon or slang.

6.5. Use short sentences and ask the interpreter to relay information after each sentence. Remember: interpreters must translate <u>everything</u> that they hear.

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

6.7. Ask the client to repeat, in their own words, the information provided by the HCP.

6.8. Interpreted communication typically takes twice as long as communication in the same language; schedule enough time for the interaction.

7. APPENDICES:

APPENDIX A: ACCESSING PHONE BASED INTERPRETER SERVICES VIA CANTALK

APPENDIX B: INFORMED CONSENT CARD

8. RELATED POLICIES, PROTOCOLS AND LEGISLATION:

06-008-00 Documentation Standards

Executive and Intergovernmental Affairs - Privacy Breach Policy and Report found at: http://intranet/policies/2018/EIA/Privacy%20Breach%20Policy%2011,%2019.pdf

9. REFERENCES:

The Registered Nurses Association of the Northwest Territories and Nunavut (RNANT/NU). (N.D.). Cultural Safety Position Statement Position.

First Nations Health Authority (2019). Health and Wellness Planning: A Toolkit for BC First Nations.

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

Inuit Language Protection Act, SNu 2008, c 17

Office of the Languages Commissioner of Nunavut (2015). Final Report of the Office of the Languages Commissioner – Qikiqtani General Hospital

Katujjiluta 2022, Government of Nunavut

Approved By:	Date: 2022-11-03
Jennifer Berry, Assistant Deputy Minister Operations, Department of Health	
Approved By:	Date: 2022-11-03
Robert McMurdy, a/Chief Nursing Officer	

APPENDIX A: ACCESSING PHONE BASED INTERPRETER SERVICES VIA CANTALK

Immediate Interpretation Customer Flowchart

Government of Nunavut

Call CanTalk at: 1-877-209-7356

↓

Give the CanTalk Representative the following Information:

CIN Number = **1190**

Your FIRST and LAST NAME

↓

State the Language you are requesting.

(The CanTalk Rep. can identify the language for you if required)

CanTalk Representative connects the interpreter within 30 seconds.

↓

Introduce yourself and you may brief the Interpreter on the nature of the call, then conference in the caller.

↓

After the call is completed, you may request for the interpreter to stay on the line for a further debriefing (this will require the customer to hang up first), or simply hang up to complete the interpretation.

APPENDIX B: INFORMED CONSENT CARD

The role of the interpreter is to be your voice.
The interpreter will gain knowledge of the personal health information that is discussed today.
All information exchanged during interpretation is confidential and the Health Centre interpreter is not authorized to use or disclose this information to anyone outside of the health care team for any reason.

I consent to have an interpreter

If I consent to use a family member, friend or community member to interpret, they will be informed that information discussed today is personal information and is not to be discussed outside of the health centre. I understand that the health centre is not responsible if my family or friend interpreter discloses my information.

I consent to have my family, friend, or community member be my interpreter

Le rôle de l’interprète est d’être votre voix.
L’interprète acquerra des connaissances au sujet des renseignements personnels sur votre santé dont il est question aujourd’hui.
Tous les renseignements échangés au cours de l’interprétation sont confidentiels et l’interprète du centre de santé n’a l’autorisation sous aucun prétexte de les utiliser ni de les divulguer à quiconque à l’extérieur de l’équipe de soins de santé.

J’accepte de recourir au service d’interprétation.

Si j’accepte de faire appel à une ou à un membre de ma famille, de mon cercle d’amis ou de mon entourage pour me servir d’interprète, cette personne sera informée que l’information dont il est question aujourd’hui est personnelle et qu’elle ne doit pas être discutée à l’extérieur du centre de santé. Je comprends que le centre de santé n’est pas responsable si la ou le membre de ma famille ou de mon cercle d’amis qui me sert d’interprète divulgue de l’information me concernant.

J’accepte de faire appel à une ou un membre de ma famille, de mon cercle d’amis ou de mon entourage pour me servir d’interprète.

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

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

APPLIES TO:
Community Health Nurses

POLICY 1:

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

POLICY 2:

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

POLICY 3:

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

PRINCIPLES:

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

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

GUIDELINES 06-014-01

INITIAL TELEPHONE CONTACT WITH FRONT DESK / RECEPTIONIST STAFF

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

ON HOLD

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

TAKING A MESSAGE

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

DISCLOSURE OF TEST RESULTS/ TREATMENT ADVICE

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

DISTRESSED OR ABUSIVE CALLERS

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

CONFIDENTIALITY

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

AFTER HOURS

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

GUIDELINES 06-014-02

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

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

URGENT: REFER PROMPTLY TO THE NURSE ON CALL.

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

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

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

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

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

APPOINTMENT NEXT DAY:

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

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

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS Community Health Nursing	
TITLE:	**SECTION:**	**POLICY NUMBER:**
Missed or Cancelled Appointments	Communications	06-015-00

EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
Oct 24, 2022	Oct 24, 2025	06-015-00, 06-015-01	2

APPLIES TO:
Community Health Centre Staff

1. BACKGROUND:
   1.1. The Department of Health (Health) strives to ensure that all Nunavummiut have access to equitable health care. The purpose of this policy is to provide a standardised process to ensure that clients who miss their appointment, cancel their appointment or if their appointment is cancelled by the community health centre because of changes in operation will have the opportunity to have their appointment rebooked.

2. POLICY:
   2.1. The clerk/interpreters or delegate shall notify the Supervisor of Community Health Programs (SCHP) or delegate of all missed or cancelled appointments by the end of the following business day.
   2.2. The SCHP or delegate shall ensure that all missed or cancelled appointments are documented as per guideline.
   2.3. The SCHP or delegate shall ensure that clients are offered the opportunity to rebook missed or cancelled appointments in consultation with the client, with a minimum of three (3) attempts to rebook appointment.

3. PRINCIPLES:
   3.1. Continuity of care is maintained when missed or cancelled appointments are followed up appropriately.

4. GUIDELINE
   4.1. Client appointments should be booked at the next available appointment or as close to the time that the client calls.
   4.2. Clerk/Interpreter or delegate are to follow Policy 06-014-00 Telephone Communication.
   4.3. Clerk/Interpreter or delegate shall advise clients when making an appointment to call the health centre to cancel or rebook if they cannot attend.
   4.4. Clerk/Interpreter or delegate shall make every effort to rebook an appointment at the time that the client calls to cancel.

5. AMBULATORY MODULE PROCEDURE:
   5.1 The clerk/interpreter or delegate shall enter the reason for cancellation using the 'change appointment status' option. This includes telehealth appointments regardless of the presence of a health care provider.
   5.2 Clients who do not cancel and do not attend will be automatically designated as 'Missed Appointment' in the registration fields at midnight on the business day for which the

appointment is booked.

5.3 A report of 'Missed Appointment' can be requested through the regional Executive Director (ED) who will liaise with Health IT staff to establish report parameters.

5.4 'Missed Appointment' clients should be contacted for rebooking on the next business day. No further documentation is required.

5.5 'Missed Appointment' Telehealth rebooking will require consultation with the physician or nurse practitioner providing the service and should be undertaken by the SCHP or delegate.

6. NON-AMBULATORY MODULE PROCEDURE

6.1. The clerk/interpreter or delegate will submit a list of all cancelled and missed appointments to the SCHP or delegate at the end of the business day. This includes Telehealth appointments.

6.2. The clerk/interpreter or delegate will register all the listed clients in Meditech.

6.2.1. 'No Show' clients will be registered as cancelled or missed appointment

6.2.2. Telehealth clients will be registered as Telehealth.

6.3. The SCHP or delegate will complete documentation in the clients' health records regarding the missed or cancelled or appointment.

6.4. The clerk/interpreter or delegate will contact all clients to rebook appointments at the client's convenience.

7. DOWNTIME PROCEDURE

7.1 When Meditech is unavailable, the clerk/interpreter or delegate will maintain a list of missed or cancelled but not rebooked appointments on a daily basis.

7.2 The clerk/interpreter or delegate will contact all listed clients to rebook their appointments at the client's convenience.

7.3 Once Meditech is again available, the clerical staff will register all clients on the list and follow procedures as outlined in 4.4 or 4.5.

8 RELATED POLICIES, PROTOCOLS AND LEGISLATION:

06-008-00 Documentation Standards

06-014-02 Telephone Communication

Approved By: 	Date: 2022-11-03
Jennifer Berry, Assistant Deputy Minister, Operations, Department of Health	
Approved By: 	Date: 2022-11-03
Robert McMurdy a/Chief Nursing Officer	

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS		
	Community Health Nursing		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Child Welfare		Communications	06-016-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		5
APPLIES TO:			
Community Health Nurses			

POLICY:

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

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

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

DEFINITIONS:

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

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

PRINCIPLES:

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

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

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

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

RELATED POLICIES, GUIDELINES AND LEGISLATION:

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

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

Access to Information and Protection of Privacy Act

REFERENCES:

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

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

GUIDELINE 06-016-01

Procedure for Reporting to the Child Protection Worker

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix 1 – Morning Report Flow Chart

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

1. **BACKGROUND:**

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

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

2. **POLICY:**

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

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

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

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

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

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

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

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

3 PRINCIPLES:

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

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

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

4 DEFINITIONS:

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

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

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

4.2 Clinicians: Regulated Health Professionals

Appendix 1 – Morning Report Flow Chart

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

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

5.2 The SCHP will take attendance and record any absentees.

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

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

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

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

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

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

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

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

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

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

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

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

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

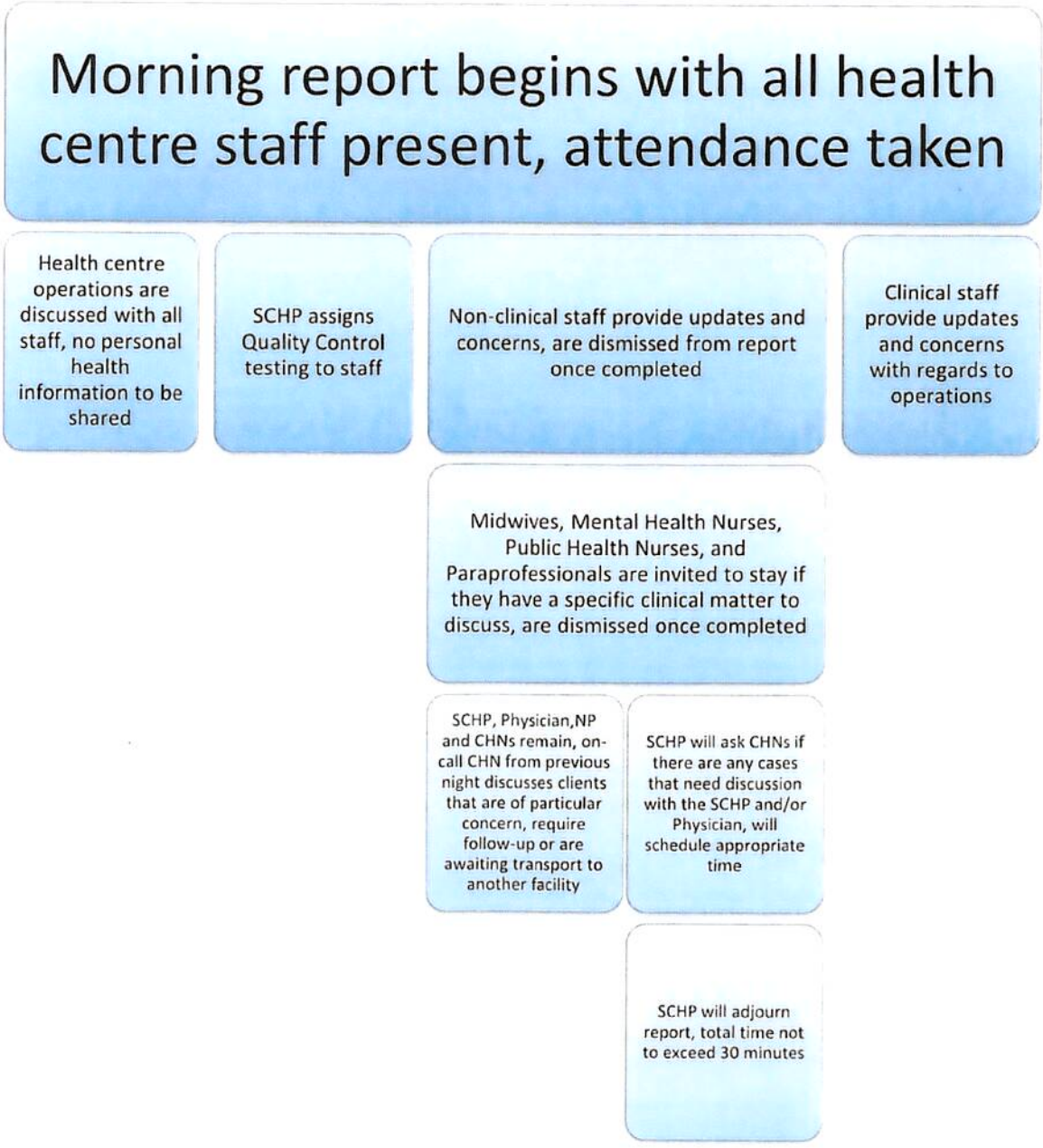
5.15 The SCHP will adjourn the meeting, the total meeting time should not exceed 30 minutes

6. REFERENCES:

Public Health Act of Nunavut

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

Appendix 1 – Morning Report Flow Chart



Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS Community Health Nursing		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Call Record and On-Call Physician Consultation Procedure		Communications	06-018-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
March 31, 2021	March 31, 2023		7
APPLIES TO:			
Nurses and Regional On-Call Physicians			

1. BACKGROUND:

Quality communication is essential in providing safe health care. The nurse serves as the link between the client and other members of the health care team through verbal and written consultation. The call record serves to a) standardize the documentation of telephone consultations between the nurse and on-call physician; and b) provide quality assurance of the telephone interaction.

2. POLICY:

2.1. Nurses are required to complete the *Community Call Record* found in Appendix A when consulting the on-call physician.

2.2. Nurses will consult the on-call physician and transmit the *Community Call Record* according to the procedure in 5.0.

2.3. Nurses must additionally document the physician consult according to the Documentation Standard Policy 06-008-00 and SOAP Documentation Guidelines 06-009-01.

2.4. The Community Call Record is a communication tool and does not replace the necessary documentation of the patient encounter as a SOAP note.

2.5. Community Call Records cannot be scanned into an EHR without authorization from Health IT.

3. PRINCIPLES:

3.1. Quality documentation is necessary for communication between clinicians, assists in quality improvements, is legal proof of the care provided, and serves to meet legislative requirements.

3.2. The nurse will document the interaction in the client's chart following Documentation Standard Policy 06-008-00 and Soap Documentation Guidelines 06-009-01.

3.3. Access to Information and Protection of Privacy (ATIPP) policies regarding the emailing of Personal Health Information (PHI) must be strictly followed when the *Community Call Record* is transmitted between Nurse and Physician.

3.4. The Department of Health promotes a professional and respectful workplace which supports collegial working relationships between nurses and physicians.

4. Definitions

4.1. Nurse: Nurse refers to Registered Nurse (RN), Licensed Practical Nurse (LPN), Registered Psychiatric Nurses (RPN), Mental Health Nurses (MHN), Mental Health Consultant (MSW), Home Care Nurse (HCN), Public Health Nurse (PHN) or Nurse Practitioner (NP).

4.2. Physician On-Call: Physician On-Call refers to the Physician assigned to on-call duties in the specific region during the time of consultation.

4.3. Non-Urgent: Non-Urgent refers to conditions that may be acute but non-urgent as well as conditions which may be part of a chronic problem with or without evidence of deterioration.

4.4. Urgent: Urgent refers to conditions that could potentially progress to a serious problem requiring emergency interventions.

4.5. Emergent: Emergent refers to conditions that are a potential threat to life, limb or function requiring rapid medical interventions and the use of condition specific controlled medical acts.

4.6. Resuscitation: Resuscitation refers to conditions that are considered threats to life or limb and have imminent risk of deterioration requiring immediate aggressive interventions.

5. **PROCEDURE**

Kitikmeot & Kivalliq Regions

5.1. Pertinent medical information is entered into the fillable *Community Call Record* by the nurse.

5.2. The *Community Call Record* is emailed to the regional physician on-call, maintaining ATIPP protocols for PHI transmission as follows:

- 5.2.1. Non-urgent/Urgent – Email prior to contacting on-call physician by phone.
- 5.2.2. Emergent/Resuscitation – Phone on-call physician followed by email of *Call Record* as soon as clinical data had been collected, when reasonably possible, considering client needs and safety.

5.3. After the *Community Call Record* is received by Physician:

- 5.3.1. Non-urgent/Urgent - the *Community Call Record* will be triaged by the on-call physician who will contact the nurse for a telephone consult within 30 minutes of receipt.
- 5.3.2. Emergent/Resuscitation – the Physician should be contacted directly by phone to provide immediate consultation.

5.4. In emergent/resuscitation situations, the nurse is to call the regional physician on-call or community physician. If unable to reach the regional physician on-call or community physician, the nurse is to call Qikiqtani General Hospital (QGH) Emergency Department (ED) directly.

5.5. The on-call physician will give verbal orders to the nurse over the phone, the nurse will read back verbal order to confirm accuracy.

5.6. The *Community Call Record* is emailed back to the consulting nurse with clearly written orders and plan of care as soon as possible. This acts as a co-signature for verbal orders received.

5.7. If further consultation is required during the client interaction, the physician will update orders on the original *Community Call Record.*

5.8. For emergent/resuscitation situations, the on-call physician will connect regularly with the nurse via telephone at intervals which will vary based on the client's condition. The nurse will ensure any changes in condition are communicated to the on-call physician as soon as reasonably possible, this includes telephoning the physician to provide an update if the time since the last contact warrants it. For the sake of clarity, responsibility for communication lies with the nurse and the physician. If either considers that communication needs to be intensified, it is incumbent on the nurse or physician to initiate.

5.9. The nurse will document in the client's chart, at minimum:

i. The date and time of consult
ii. The date and time of response from physician
iii. Orders received, and action taken

5.10. The call record will be placed in the consult section of the client's chart to become part of the clinical record.

NOTE: On-call physicians are arranged by Medical Affairs. Schedules and contact information are released monthly.

Qikiqtaaluk Region

5.11. Pertinent medical information is entered into the *Community Call Record* by the nurse.

5.12. For obstetrics clients ≥ 22 weeks, do not use the community call pager system. Refer to the *Obstetrics On-call System: Guidelines for CHNs* for guidance on how to access Obstetrics.

5.13. The nurse will consult the covering community physician or refer the client to the next community physician clinic for:

5.13.1. Non-urgent clients who do not require an intervention in the next 48 hours

5.14. The *Community Call Record* is e-mailed to the community pager e-mail address (communitypager@gov.nu.ca) maintaining ATIPP protocols, and then page #174 to review the case with the physician on-call for:

5.14.1. Emergent and Urgent clients

5.14.2. Non-urgent clients when medical advice or intervention is required within 48 hours

The form can be faxed under special circumstances when e-mail is not available.

5.15. In resuscitation situations, the nurse is to call the QGH ED emergency line directly. The nurse will identify themselves as a CHN, indicate that they need immediate physician assistance. This is only to be done for:

5.15.1. Resuscitation clients

5.15.2. Emergent clients requiring immediate intervention outside the nurse's scope of practice

If there is difficulty getting through to the emergency line, call the ED through the hospital switchboard.

5.16. Call backs should be expected within 30 minutes of receipt of the *Community Call Record.* If the nurse does not hear back within 30 minutes:

i. The nurse will page a second time

ii. If no call back after the second page, the nurse will call the ED directly to speak with an ED nurse who will verify the physician received the page, and whether the physician is tied up with another emergent case

5.17. The physician will give verbal orders to the nurse over the phone, the nurse will read back verbal order to confirm accuracy.

5.18. The *Community Call Record* will be e-mailed back to the nurse as soon as possible with clearly written orders and plan of care. This acts as a co-signature for verbal orders received.

5.19. If further consultation is required during the client interaction, the physician will update the original orders on the *Community Call Record.*

5.20. For emergent/resuscitation situations, the on-call physician will connect regularly with the nurse via telephone at intervals which will vary based on the client's condition. The nurse will ensure any changes in condition are communicated to the on-call physician as soon as reasonably

possible, this includes telephoning the physician to provide an update if the time since the last contact warrants it. For the sake of clarity, responsibility for communication lies with the nurse and the physician. If either considers that communication needs to be intensified, it is incumbent on the nurse or physician to initiate. The nurse will document in the client's chart, at a minimum:

i. The date and time of consult
ii. The date and time of physician consult
iii. Orders received, and action taken

5.21. The call record will be placed in the consult section of the client's chart to become part of the clinical record.

Kitikmeot, Kivalliq & Qikiqtaaluk Regions

5.22. If the consulting nurse has concerns with the physician's assessment and plan, it must be discussed with the physician at the time of the call. This will allow the nurse to advocate for the client, clarify any misunderstandings, and highlight client assessment findings that may have been overlooked or misunderstood. If, after the discussion, the nurse and physician cannot come to an agreement on a treatment plan, the nurse will contact the Supervisor of Community Health Programs (SCHP) or Director of Health Programs to discuss the concerns.

5.22.1. If the SHP or Director shares the concerns after discussing the case, they will contact the physician to discuss the case.

5.22.2. The Director may contact the Territorial Chief of Staff for cases which require further escalation.

6. Related Policies, Protocols and Legislation:

Policy 06-008-00	Documentation Standard
Guidelines 06-009-01	SOAP Documentation
ATIPP Policy	Emailing, Sending & Capturing Personal Health Information
Policy 05-035-00	Qikiqtaaluk Obstetrics On-Call Pager System Guidelines for CHNs
Appendix A:	Community Call Record

7. **REFERENCES:**

Implementation Guideline for the Canadian Emergency Department Triage & Acuity Scale found at http://ctas-phctas.ca/wp-content/uploads/2018/05/ctased16_98.pdf

Canadian Nurses Protective Society (2006). *Communication* found at https://cnps.ca/index.php?page=87

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Francois de Wet, Chief of Staff, on behalf of the Medical Advisory Committee	