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Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Publicly Funded Programs		Administration	H3C 01-001-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
16/11/23	16/11/2025	1.3	2
APPLIES TO:			
Managers			

1. BACKGROUND:

1.1. The purpose of this policy is to ensure Home, Community, and Continuing Care (HCCC) is a publicly funded program, addresses the basic health needs of Nunavummiut when they cannot be met by individuals or families, upholding the Inuit Societal Value Pijittirniq.

1.2. HCCC is accountable to the Department of Health (Health) for safe, efficient, and effective delivery of all publicly funded HCCC programs and services.

2. POLICY:

2.1. HCCC will provide Nunavummiut with client centred, evidence-based, trauma informed, and culturally responsive services and supports.

2.2. The delivery of services and supports will be done in a safe, efficient, and effective manner which supports transparency and fiscal responsibility.

3. BACKGROUND:

3.1. HCCC provides services and supports to Nunavummiut whose needs exceed the capacity of their family to support them. These services uphold the Inuit Social Value Pijittirniq .

REFERENCES:

Tools and Resources:

Nunavut Economic Forum. (n.d.) Pinasuaqtavut 2004-2009 [PDF]. Retrieved from http://www.nunavuteconomicforum.ca/public/files/library/POLITICA/PINASUAQ.PDF

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Approved By: CNolan	Date: 16 Nov 2023
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date: 16 November 2023
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

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Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Single Point of Entry-Continuing Care		Administration	H3C 01-002-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
14/04/2023	14/04/2025	1.5	2
APPLIES TO:			
Managers			

1. BACKGROUND:

1.1.The Territorial Home, Community and Continuing Care (THCCC) Division, acts as the point of entry into continuing care services. Continuing Care uses a single referral form unique to Nunavut. This is completed by a clinician in the community, and is then sent to the Territorial Home, Community and Continuing Care (THCCC) division.

2. POLICY:

2.1. The Territorial Home, Community and Continuing Care Division is responsible for ensuring objective evaluation of clients seeking long term care services.
2.2. The THCCC will work with the community-based referring clinician to ensure that service provisions match client needs.
2.3. The THCCC will maintain a wait list for long-term care.
2.4. Home Care Services are managed by the Supervisor of Home and Community Care (SHCC), in each community, and access is covered under Admissions and Application to Home, Community and Continuing Care policy.

3. PRINCIPLES:

3.1. HCCC Recognises that current services are limited and it is necessary to prioritise those clients with the greatest need.
3.2. HCCC operates a single point of entry into HCCC residential care programs to ensure equitable distribution of services and supports and to ensure consistency of care across all regions in Nunavut.

REFERENCES:

Accreditation Canada. (2016a). Qmentum program 2016. Standards long-term care services. Ottawa, ON: Accreditation Canada Publisher.

Accreditation Canada. (2016). Qmentum program 2016. Standards home care services. Ottawa, ON: Accreditation Canada Publisher.

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Government of Nunavut. (2015). Continuing care in Nunavut – 2015 to 2035 [PDF]. Department of Health. Retrieved from http://assembly.nu.ca/sites/default/files/TD%2078-4(3)%20EN%20Continuing%20Care%20in%20Nunavvut,%202015%20to%202035_0.pdf

Approved By:	Date: 14/04/2023
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date: 14/04/2023
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

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Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Development of Goals and Objectives for Service Design and Delivery		Administration	H3C 01-003-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
14/04/2023	14/04/2026	1.9	3
APPLIES TO:			
Managers			

1. Background:

1.1. In developing goals and objectives of service design and delivery, Home, Community, and Continuing Care (HCCC) identifies what information is collected from clients and families, partners, and the community to inform the goals and objectives for service design and delivery. Information can come from internal and external sources such as the Canadian Institute of Health Information (CIHI), census data, end-of-service planning reports, waitlist data, and community needs assessments.

1.2. Health service needs are informed by health status, capacities, risks, and determinants of health (e.g., income, social support networks, education and literacy, employment/working conditions, access to health services, gender, and culture) (Accreditation Canada, 2016a).

2. Policy:

2.1. HCCC ensures that the development of program goals and objectives support the Program Vision, Mission, and Values (Philosophy) Statements and provide the foundation for delivering services (Accreditation Canada, 2016b).

2.2. HCCC goals and objectives for service design and delivery are co-designed with clients and families, partners, and the community.

2.3. Goals and objectives are aligned with the organisation's strategic directions and are the foundation for delivering services. Objectives are clear, have measurable outcomes and success factors, and are realistic and time specific.

2.4. Goals and objectives are aligned with the health service needs of the community.

2.5. Goals and objectives are meaningful to the team. They are reviewed annually or as needed, and their achievement is evaluated. Goals and objectives align with federal and provincial/territorial objectives as required (Accreditation Canada, 2016c).

3. Principles:

3.1. In developing goals and designs through a collaborative and constative process, HCCC upholds

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the values of *Inuuqatigiitsiarniq, Tunnganarniq, Pijitsirniq, Aajiiqatigiinniq*, and *Piliriqatigiinniq*.

4. DEFINITIONS:

Inuuqatigiitsiarniq: Respecting others, relationships and caring for people.

Tunnganarniq: Fostering good spirits by being open, welcoming and inclusive.

Pijitsirniq: Serving and providing for family and/or community.

Piliriqatigiinniq: Working together for a common cause.

Aajiiqatigiinniq: Decision making through discussion and consensus.

5. GUIDELINE:

5.1. In developing any goal or design, HCCC team members identify key stakeholders including, but not limited to, end users, clients, client families, community members, and other departments or divisions which may be directly impacted by the goal or program design and delivery.

5.2. HCCC team members organise stakeholder meetings to gather information to inform the goal or program design.

5.2.1. Once the goal or design is completed, HCCC team members are to re-engage with stakeholder groups to gain feedback and disseminate information.

6. REFERENCES:

Accreditation Canada. (2016a). Qmentum program 2016. Standards aboriginal integrated primary care. Ottawa, ON: Accreditation Canada Publisher.

Accreditation Canada. (2016b). Qmentum program 2016. Standards aboriginal community health and wellness. Ottawa, ON: Accreditation Canada Publisher.

Accreditation Canada. (2016c). Qmentum program 2016. Standards home care services. Ottawa, ON: Accreditation Canada Publisher.

Canadian Patient Safety Institute. (2015). Improvement frameworks: Getting started kit. Retrieved from https://www.patientsafetyinstitute.ca/en/toolsResources/ImprovementFramework/Documents/Improvement%20Frameworks%20GSK%20EN.PDF#search=Improvement%20frameworks%20getting%20started%20kit%2E

Centres for Disease Control and Prevention. (2015). Develop SMART objectives. Retrieved from https://www.cdc.gov/phcommunities/resourcekit/evaluate/smart_objectives.html

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Health Quality Ontario. (2018). Patient partnering framework. Patient Partnering. Retrieved from http://www.hqontario.ca/Engaging-Patients/Patient-Engagement-Framework

Approved By:	Date: 14/04/2023
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date: 14/04/2023
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

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Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Collaborative Service Design		Administration	H3C 01-004-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
14/04/2023	14/04/2025	1.8	2
APPLIES TO:			
Managers			

1. BACKGROUND:

1.1. Home, Community, and Continuing Care (HCCC) recognises that programs and service design processes provide optimal outcomes when end-users are included in the design process.

1.2. HCCC actively engages clients, families, community members, and partners within the Department of Health (Health), and the Government of Nunavut (GN), to ensure service and program design meet the needs of the clients.

2. POLICY:

2.1. During the development, design, or review of any new or existing programs, HCCC actively consults with the following stakeholder groups:

- Clients using the service/resource
- Clients waiting for the service/resource
- Client families
- Community members where services/resources are delivered or located
- Health divisions which operate adjacent to the service/resource
- GN divisions and departments which may contact the service/resource

3. PRINCIPLES:

3.1. HCCC upholds the values of *Qanuqtuurniq, Pijitsirniq, Piliriqatigiinniq*, and *Aajiiqatigiinniq* in the development, design, and review of new and existing programs and services.

3.2. HCCC is committed to ensures clients, their families, and other stakeholders are actively engaged in the development, design, and review of any new or existing programs and services to ensure a truly client-centred process.

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5. REFERENCES:

Accreditation Canada. (2016a). Qmentum program 2016. Standards aboriginal integrated primary care. Ottawa, ON: Accreditation Canada Publisher.

Accreditation Canada. (2016b). Qmentum program 2016. Standards remote/isolated health services. Ottawa, ON: Accreditation Canada Publisher.

Canadian Institute for Health Information. (CIHI). 2018. Retrieved from https://www.cihi.ca/en

Carman, K., Dardess, P., Maurer, M., Workman, T., Ganachari, D., Pathak-Sen, E. (2014). A roadmap for patient and family engagement in healthcare practice and research. The American Institute for Research. Retrieved from http://trailhead.institute/wp-content/uploads/2017/04/patient_and_family_engagement_roadmap.pdf

Institute for Patient- and Family-Centred Care. (n.d.). Retrieved from http://www.ipfcc.org/

Statistics Canada. (2019). Census program. Retrieved from: https://www12.statcan.gc.ca/census-recensement/index-eng.cfm

Approved By: CNolan	Date: 14/04/2023
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date: 14/04/2023
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

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Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Seamless Integration of Programs and Services		Administration	H3C 01-005-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
14/04/2023	14/04/2025	1.4	2
APPLIES TO:			
All Home, Community, and Continuing Care Team Members			

1. Background:

1.1. Home, Community, and Continuing Care (HCCC) recognises that it is critically important to look at the full range of services accessible to clients, as it is often beyond the capacity of one department or one service provider to deliver all needed services. (Accreditation Canada, 2016a).

1.2. Integration is a collaborative and cooperative relationship between healthcare disciplines to achieve optimal client care. An inter-professional team is a group of people that may include regulated healthcare providers, unregulated healthcare providers, and other staff, working collaboratively to improve the health and meet the care needs of individuals, families, and communities.

2. Policy:

2.1. HCCC collaborates and coordinates with other Department of Health (Health) programs and services throughout the continuum of care to ensure HCCC clients receive all necessary supports and services to meet their assessed care needs.

3. Principles:

3.1. HCCC upholds and honours the values of *Piliriqatigiinniq* and *Pijitsirniq* and Inuit Qaujimajatuqangit (IQ) in its operations and takes a collaborative approach to the provision of healthcare services for clients.

4. Definitions:

Pijitsirniq: Serving and providing for family and/or community.

Piliriqatigiinniq: Working together for a common cause.

5. Protocol:

5.1. The governing body establish formal agreements with the external health services when it

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is not available in the Long Term Care (LTC) setting, the community, and/or Nunavut.

5.2. The HCCC staff are aware of the scope of services available and how to access them in the community, in Nunavut or out of the territory.

5.3. There is a mechanism to share the reports with the LTC leaders, client and/or their guardian.

REFERENCES:

Tools and Resources:

Accreditation Canada. (2016a). Qmentum program 2016. Standards Home Care. Ottawa, ON: Accreditation Canada Publisher.

Accreditation Canada. (2016b). Qmentum program 2016. Standards aboriginal community health and wellness services. Ottawa, ON: Accreditation Canada Publisher.

Community Health Nurses of Canada. (2011). Canadian community health nursing: Professional practice model & standards of practice [PDF]. Retrieved from https://www.chnc.ca/en/standards-of-practice

Nunavut Economic Forum. (n.d.) Pinasuaqtavut 2004-2009 [PDF]. Retrieved from http://www.nunavuteconomicforum.ca/public/files/library/POLITICA/PINASUAQ.PDF

Approved By: CNolan	Date: 14/04/2023
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date: 14/04/2023
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

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Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Evaluation of Services by Clients and Families		Administration	H3C 01-006-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
14/04/2023	14/04/2025	1.11	3
APPLIES TO:			
All Home, Community, and Continuing Care Team Members			

1. BACKGROUND:

1.1. Home, Community, and Continuing Care (HCCC) recognises that ongoing evaluation of programs and services by end-users and their families is essential to ensure services and supports are meeting the needs of the community.

1.2. Collecting information and feedback from clients and their families provides opportunities to identify areas of improvement, programs and services which have become redundant, and new needs which need to be addressed.

1.3. HCCC upholds Inuuqatigiitsiarniq, Tunnganarniq, Aajiiqatigiinniq, and Piliriqatigiinniq through active inclusion of clients and their families in the evaluation of HCCC programs and services.

2. POLICY:

2.1. HCCC will regularly review all programs and services to ensure that services and supports provided meet the needs of the community.

2.2. The evaluation of programs and services that support clients must include clients and their families as key stakeholders during the evaluation process. Evaluation data may be gathered by a variety of methods, including surveys, focus groups, interviews, meetings, or records of complaints.

2.2.1. The evaluation methodology will be determined by the Regional Manager and must be suitable to the community, region, and resources available.

2.2.2. The minimum frequency for evaluation is annually.

2.3. Data and information collected through the evaluation process will be shared with appropriate stakeholders, team members, and leadership.

3. PRINCIPLES:

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3.1. The ongoing evaluation of programs and services ensures that they are relevant and meeting the needs of the community.

3.2. Ongoing evaluation requires that community-based stakeholders including clients accessing the supports and services, as well as their families, are consulted as part of the evaluation process.

4. DEFINITIONS:

Inuuqatigiitsiarniq: Respecting others, relationships and caring for people.

Tunnganarniq: Fostering good spirits by being open, welcoming and inclusive.

Aajiiqatigiinniq: Decision making through discussion and consensus.

Piliriqatigiinniq: Working together for a common cause.

5. GUIDELINE:

5.1. When the evaluation of an HCCC service, support, or program is initiated a list of stakeholders will be developed. The list will include the following groups in addition to any other stakeholders identified:

- Current clients
- Families of current clients
- Past clients
- Families of past clients
- Potential future clients
- Families of potential future clients

5.2. The evaluation methodology will be determined by the Regional Manager and will be appropriate to the region, community, and capacity. It is recognised that different modalities of evaluation require different resources and produce different data sets and information.

5.3. The Regional Executive Director, Health and/or the Territorial Director, Home, Community, and Continuing Care may request additional evaluations be completed for specific communities and regions based on information, feedback, and data collected during the standard evaluation.

6. REFERENCES:

Accreditation Canada. (2016a). Qmentum program 2016. Standards aboriginal community health and wellness services. Ottawa, ON: Accreditation Canada Publisher.

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Accreditation Canada. (2016b). Qmentum program 2016. Standards home care. Ottawa, ON: Accreditation Canada Publisher.

Accreditation Canada. (2016c). Qmemtum program 2016. Standards effective organization. Ottawa, ON: Accreditation Canada Publisher.

Accreditation Canada. (2016d). Qmentum program 2016. Standards governance. Ottawa, ON: Accreditation Canada Publisher.

Government of Nunavut-Department of Health and Social Services Continuous Quality Improvement (CQI) Program. This program establishes priorities for monitoring and making quality improvements; develops an annual CQI work plan to address program priorities and coordinates with other performance monitoring activities such as risk management; monitors the progress in achieving the outcome indicators and communicates these results within the organization; and involves the appropriate people and assigns responsibilities. Can be accessed at: http://nuhealthintranet.com/

Smith, M. (2002). Patient's bill of rights: A comparative overview. Government of Canada. Law and Government Division. Retrieved from http://dsp-psd.pwgsc.gc.ca/Collection-R/LoPBdP/BP/prb0131-e.htm#CONCLUSIONtxt

Approved By:	Date:
CNolan	14/04/2023
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date:
	14/04/2023
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

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Department of Health Government of Nunavut	Home, Community, and Continuing Care Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Ethical Decision Making		Administration	H3C 01-007-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
04/01/2024	04/01/2026	NEW	1
APPLIES TO:			
All Home, Community, and Continuing Care Team Members			

1. Background:

The division of Home, Community, and Continuing Care (HCCC) recognizes the importance of ensuring that all HCCC team members engage in a decision-making process that is respectful, ethical, and reflects the values of HCCC, the Department of Health (Health) and the Government of Nunavut (GN).

2. Policy:

2.1. HCCC proactively adopts the Iqaluit Health Services Ethics Framework.

2.2. All HCCC team members will be held to the processes and guidelines laid out in the Iqaluit Health Services Ethics Framework, included as an appendix to this policy (Iqaluit Health Services Ethics Framework, 2023). See Appendix A.

2.3. All HCCC team members will, when required, consult with the Health Department's medical Ethicist.

3. Principles:

3.1. HCCC recognises and upholds it duty to ensure that all team members behave and act in a way which is respectful, ethical, and representative of the GN, Health, and HCCC itself.

4. References:

Iqaluit Health Services Ethics Framework. (2023, 03 15).

Approved By:	Date:
	4 January 2024
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date:
	4 January 2024
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

Return to TOC

Department of Health Government of Nunavut		Home, Community, and Continuing Care Programs and Standards	
TITLE:		**SECTION:**	**POLICY NUMBER:**
Ethical Decision Making Framework		Administration	H3C 01-007-01
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
04/01/2024	04/01/2026	NEW	1
APPLIES TO:			
All Home, Community, and Continuing Care Team Members			

See below

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1. Mission and Vision of the Ethics Framework

Through collaboration, innovation, and integration of Inuit Qaujimajatuqangititaq, Iqaluit Health Services (IHS) is committed to providing quality ethical health care services that empower Nunavummiut to thrive.

Ethics in healthcare refers to making the best possible call, while being able to justify the decision. This becomes difficult when the best possible call is not clear or obvious. Because of this, the IDEA Framework was developed and has been adopted and adapted by many healthcare organizations across Canada, including Iqaluit Health Services.

2. Values

This ethics framework is grounded in Inuit Societal Values as outlined below:

- ***Inuuqatigiitsiarniq*** or respecting others, loyalty and caring for people.
  Inuit care about family, community and make decision through collaboration.
- ***Tunnganarniq*** or fostering good spirit by being open, welcoming and inclusive.
  Inuit welcome strangers, friends, and family as part of their culture.
- ***Pijitsirniq*** or serving and providing for others.
  An Inuit world view is considered **WE** more than **ME**.
- ***Aajiiqatigiinniq*** or decision making through consensus.
  Inuit make decision through consensus rather than majority rule.
- ***Pilimmaksarniq / pijariuqsarniq*** or development of skills through practice, effort and action.
  Inuit believe in life long, learning and continued assessment through the promotion and the acquisition of new skills.
- ***Piliriqatigiinniq / Ikajuqtigiinniq*** or working together for a common cause.
  The nature of life in the North mandates working together and supporting others.
- ***Qanuqtuurniq*** or being innovative and resourceful.
  Inuit believe in the accomplishment of goals and the effective use of resources. The lack of resources has mandated people to use what they have and make resources last.
- ***Avatittinnik Kamatsiarniq*** or respect and care for the land, animals, and the environment.
  Inuit have a close relationship with the land and the animals that provide them with resources to survive. They respect the environment as they are depending on the word around them for survive.

By incorporating Inuit Societal Values, we strive to be thoughtful, kind, caring, considerate, and empathetic to our clients, families, caregivers, and to each other. We are client and family centered. We respect privacy and we encourage empathy by being non – judgemental, expressing gratitude, and being emotionally self - aware.

IHS has contracted The Ottawa Hospital's Department of Clinical and Organizational Ethics (TOH Ethics Department) to assist with case-specifical clinical ethical consultations to aide the organization with difficult decision making.

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Clinical Ethical Dilemmas:

When faced with an ethical dilemma, healthcare providers should adhere to the following:

IDEA Framework:

1. IDENTIFY the facts
2. DETERMINE ethical principles in conflict
3. EXPLORE the options
4. ACT and evaluate

Step 1: Identify the Facts	**Step 2: Determine Ethical Principles in Conflict**
Identify what is known versus what is not known. • Medical Indications • Client Preferences • Quality of Life, and • Contextual Features, Users of the framework should take into account all of the relevant considerations and stakeholders; this often includes facts that may not be known initially.	This step clarifies and articulates the ethical issues at hand. Common ethical principles to consider might include, but are not limited to: • Autonomy • Beneficence (or doing good) • Non-maleficence (or doing no harm) • Justice
Step 3: Explore Options	**Step 4: Act and Evaluate**
Brainstorm different options and consider the potential outcomes and impacts of each one (the potential positive and negative outcomes of each). Do the options satisfy the ethical principles from Step 2? Do the options comply with corporate policy, regulations, and the law?	Develop and document the action plan in the client's chart. Evaluate the plan. Were the intended results obtained, or is additional follow-up and/ or action required? Ongoing documentation and communication of the evaluation is necessary. Self-evaluate your decision. What have you learned?

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Administrative Ethical Dilemmas:

THE ACCOUNTABILITY FOR REASONABLENESS FRAMEWORK (A4R)

Adapted from The Champlain Centre for Healthcare Ethics

In recognizing that not all ethical issues that arise in health care are clinical in nature, an ethical decision-making framework has also been accepted for organizational decision-making. The Accountability for Reasonableness Framework (A4R) is based on the notion of public accountability which requires that reasons and rationales for limit-setting decisions be publicly available. In Organizational limit-setting decisions, it is very difficult to agree on fair outcomes or fair principles. This makes using a clinical decision-making tool for these issues challenging. The goal of this framework is to ensure that a fair process is available for stakeholders to follow, and expectations are set to consider relevant values in the justification of organizational decisions. Five of such values are considered below:

Value	Description
Relevance	Decisions should be based on reasons (i.e., evidence, principles, values) that stakeholders can agree are relevant to meeting diverse health needs under resource constraints.
Publicity/Transparency	Decisions and their rationales should be transparent and made publicly accessible.
Revision/Appeals	There should be opportunities to revisit and revise decisions if new information or evidence emerges and there should be a mechanism to challenge and dispute resolutions.
Enforcement	There should be either public or voluntary regulation of the process to ensure that the first three values are met.
Empowerment	There should be efforts to optimize the effective opportunities for participation in priority setting and to minimize power differences in the decision-making context.

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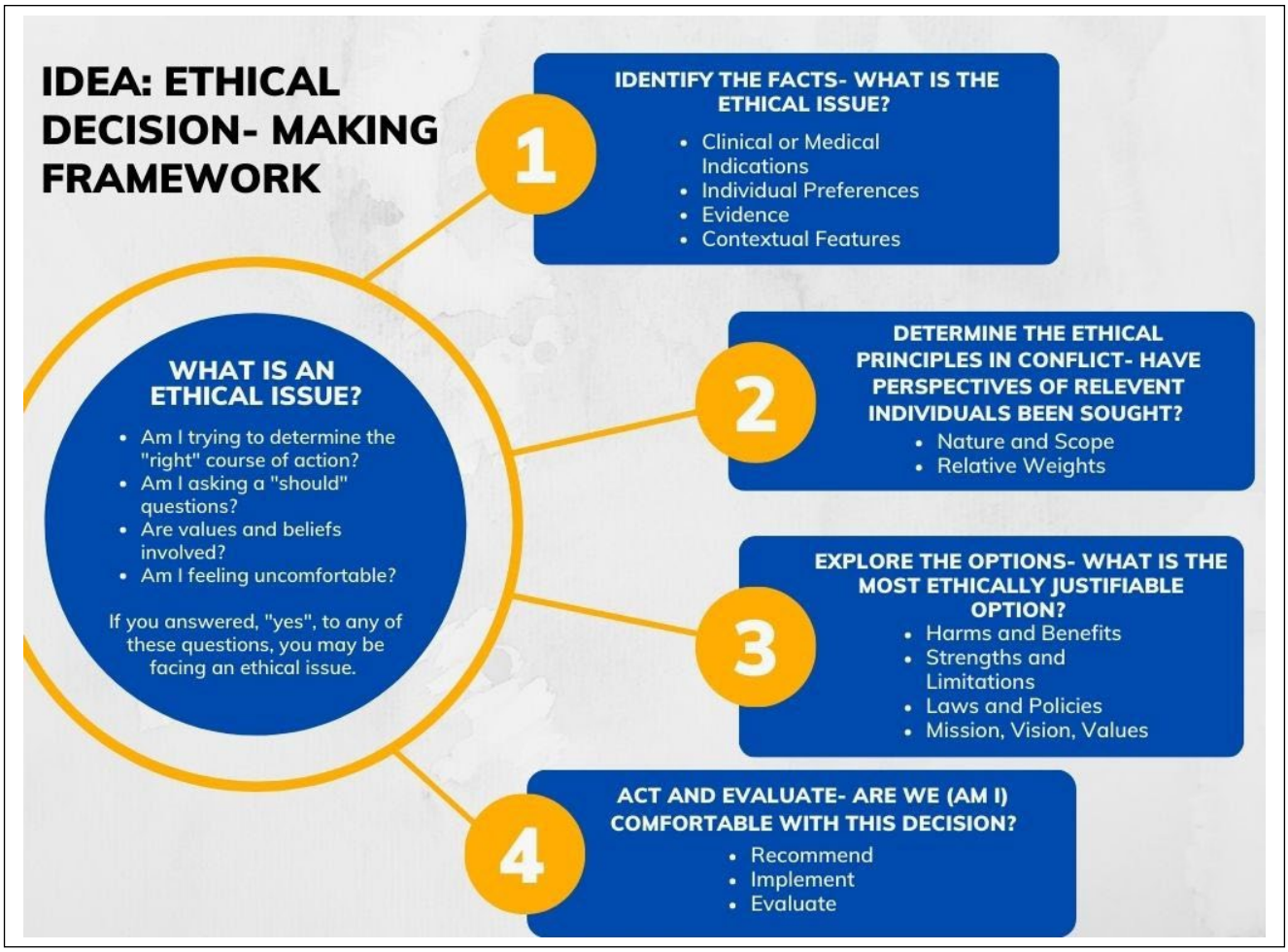
3. Quick Reference Guide- Clinical



In the event of a clinical ethical dilemma that cannot be addressed by the client's Primary Care Provider, the provider must bring forward the issue to their manager, who will consult with the Senior Leadership Team (SLT). SLT will work with TOH Ethics Department and will bring the suggestion from the Ethics group to the IHS Client and Family Advisory Committee, when appropriate, for final review. If the ethical dilemma requires urgent resolution and cannot be delayed, the provider will contact the Chief of Staff for further guidance.

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Department of Health Government of Nunavut	Home, Community, and Continuing Care Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Evidence Informed Decision Making		Administration	H3C 01-008-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
16/11/2023	16/11/2025	2.13	2
APPLIES TO:			
All Home, Community, and Continuing Care Team Members			

1. Background:

1.1. The Home, Community, and Continuing Care (HCCC) division of the Department of Health (Health) is dedicated to ensuring that Nunavummiut receive the best possible healthcare as close to home as possible.

1.2. Team-based care is evidence informed and enables equity, diversity, and inclusion and cultural safety approaches.

2. Policy:

2.1. HCCC team members will employ evidence informed decision making to ensure that the delivery of healthcare services for clients are based on current best practices.

2.2. HCCC team members will use approved reference materials and resources to supplement their own knowledge and experience.

2.3. HCCC team members will use approved, verified, and standardised assessments as part of information gathering activities.

2.4. The HCCC Division will collaborate with partners in Inuusivut Mental Health and Addictions, Public Health, Population Health, and Continuing Quality Improvement to facilitate the development of robust evidence-informed decision-making tools.

3. Definitions:

Evidence Informed Decision Making: A continuous interactive process involving the explicit, conscientious, and judicious consideration of the best available evidence to provide care within a client and location specific context (health-evidence.ca, 2010).

4. Principles:

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4.1. HCCC recognizes and upholds its duty to provide Nunavummiut access to healthcare services which ensure the best possible outcomes, are based on current best practices, and make use of evidence informed decision making.

5. GUIDELINE:

5.1. HCCC team members, supervisors, managers, and leadership will access approved and verified resource and reference materials when additional information is required.

5.2. HCCC leadership will ensure that all HCCC team members have access to information regarding current best practices.

5.3. The HCCC division in partnership with other Health divisions will develop and implement a data collection and analysis process to provide the necessary quality information to ensure that HCCC team members are able to make evidence informed decisions.

6. REFERENCES:

Accreditation Canada. (2016). *Qmentum program 2016. Standards leadership*. Ottawa, ON: Accreditation Canada Publisher.

Canadian Nurses Association. (2010). *Position statement: Evidence-informed decision-making and nursing practice.* Retrieved from https://www.cna-aiic.ca/-/media/nurseone/page-content/pdf-en/evidence-informed-decision-making-and-nursing-practice.pdf?la=en&hash=D774440B63837990633A0C087F0E12358024318A

Approved By:	Date: 16 Nov 2023
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date: 16 November 2023
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

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Department of Health Government of Nunavut		Home, Community, and Continuing Care Programs and Standards	
TITLE:		**SECTION:**	**POLICY NUMBER:**
Approved Resources and References		Administration	H3C 01-009-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
16/11/23	16/11/2025	NEW	3
APPLIES TO:			
All Home, Community, and Continuing Care Team Members			

1. BACKGROUND:

1.1. The Government of Nunavut (GN), Department of Health (Health), and the Home, Community, and Continuing Care Division (HCCC) are united in their commitment to ensuring that all Nunavummiut receive the best possible healthcare services as close to home as possible.

1.2. Materials listed in this policy have been reviewed and approved by the Territorial Division of Home, Community, and Continuing Care. These materials provide additional information which Home, Community, and Continuing Care Team members may need to access as part of their daily activities. These materials ensure that services provided are supported by current evidence-based best practices.

1.3. The delivery of healthcare services is reliant on the use of approved and verified reference material and resources.

2. POLICY:

2.1. HCCC team members will use approved reference materials and resources to supplement their own knowledge, skills, and understanding as required by a given situation.

2.2. HCCC team members will work within their scope of practice as defined by their Job Description, and will not perform those procedures, tasks, or activities which fall outside their scope even when sufficient reference materials and resources are available.

2.3. HCCC approves of the use of all materials listed in Community Health Nursing Policy 05-014-00. In addition to these materials HCCC approves the following for use:

- Pallium Palliative Pocketbook 2nd Edition or later
- Mosby's Canadian Textbook for the Support Worker
- Nutrition for Elders and Long-Term Care-A Guidebook for Facilities in Nunavut-Government of Nunavut
- Serving Country Food in Government-Funded Facilities and Community Programs-Government of Nunavut.

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- Registered Nurses' Association of Ontario (RNAO) Best Practice Guidelines (BPG)
- Nurses Specialised in Wound, Ostomy, and Continence Canada (NSWOCC) – Best Practice Recommendations (https://www.nswoc.ca/bpr)
- Government of Nunavut: Immunization Manual
- Government of Nunavut: Housekeeping Procedures Manual
- Government of Nunavut: Infection Prevention and Control Manual
- Government of Nunavut: Communicable Disease Manual
- Government of Nunavut: Nunavut TB Manual 2018 (or most recent updated version)

3. DEFINITIONS:

Inuuqatigiitsiarniq: Respecting others, relationships and caring for people.
Pijitsirniq: Serving and providing for family and/or community.
Pilimmaksarniq: Development of skills through observation, mentoring, practice, and effort.

4. PRINCIPLES:

4.1. The delivery of evidence-based, best practice healthcare requires access to current, relevant, and up-to-date reference materials and resources.

4.2. HCCC upholds Inuuqatigiitsiarniq, Pijitsirniq, and Pilimmaksarniq through the provision of approved reference materials and resources.

5. PROCEDURE:

5.1. HCCC team members in need of reference materials or resources for the purpose of completing a specific task, procedure, or activity will access those materials which have been approved through this policy or the Community Health Nursing Policy 05-014-000.

5.2. HCCC team members who need resources or references beyond what is included in this policy and the Community Health Nursing Policy 05-014-000 will contact the Territorial Home, Community, and Continuing Care Team for direction as to which resources and/or reference materials are appropriate.

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Approved By: CNolan	Date: 16 Nov 2023
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date: 16 November 2023
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

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Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Client Video and Photograph Guidelines / Client Recording Guidelines		Administration	H3C 01-010-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
14/04/2023	14/04/2025	1.15	4
APPLIES TO:			
All Home, Community, and Continuing Care Team Members			

1. BACKGROUND:

1.1. Home, Community, and Continuing Care (HCCC) recognises that the production of audio and video recordings, including photography using analog or digital technologies is an important part of documenting events.

1.2. HCCC recognises that each individual or their guardian/ decision maker has the autonomy to determine whether or not they will provide consent to have their image, likeness, voice, or other aspects of their person recorded.

2. POLICY:

2.1. HCCC team members will work to prevent inappropriate and unauthorised recording by providing visitors, guests, clients, volunteers, client family members, and others with information on the limitations on acceptable recording of clients and HCCC staff.

2.2. Family members of clients may record the client who is their family member within a social setting without completing a recording consent form as implied consent is presumed unless the client voices objection.

2.3. The creation of any recording for any purpose of any client who is not the immediate family member of the individual making the recording without obtaining a release through the Photograph Consent Form is strictly prohibited.

2.4. In the event of any unauthorised recording, HCC team members will:

- Request that the recording immediately stop;
- Document the unauthorised recording in the client's health record;
- Contact the privacy officer and risk management as well as their direct supervisor for further direction;
- Notify the client's guardian/ ; and
- Complete an incident report.

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2.5. In the event of any unauthorised recording, HCCC team members are not permitted to remove the recording device from the owner or to delete any recordings without written permission from the owner of the recording device. The owner of a device may delete the image and/or recording on their own.

2.6. HCCC team members can prohibit the making of recordings which they deem inappropriate, such as during a physical exam or clinical procedure.

2.7. HCCC team members have the right to refuse to be recorded by clients, guests, visitors, other staff members, or the family members of clients.

2.8. HCCC team members will not seek consent from clients for recordings by third parties on behalf of said parties. Any third-party individual or organisation wishing to record a client must obtain informed consent from the client or guardian/ . Additional written permission from the Facility Manager, Home, Community, and Continuing Care is required if the recording is to take place at a facility operated or contracted by Health. This does not apply to family members recording their loved ones who are clients.

3. PRINCIPLES:

3.1. HCCC recognises that family members may wish to make recordings of their loved ones who are HCCC clients, and that this process should be made as simple as possible for the benefit of the relationship between clients, their family members, and HCCC.

3.2. HCCC upholds the autonomy of all clients and their right to refuse consent to be recorded, and that recording without consent is a violation of privacy.

4. DEFINITIONS:

Implied Consent: Consent which is not explicitly given but can be seen as being implicitly granted by the circumstances of a situation or a person's actions – for example a client smiling for the camera when a family member is taking a photograph.

Informed Consent: Consent which is explicitly given by an individual after they have received all information about the activity they are giving consent for, including possible adverse outcomes and alternatives – for example a client giving consent to an interviewer who wishes to make a recording to document oral history after the interviewer has explained the scope of questions to be asked, the purpose of the recording, and how the recording will be stored, used, and distributed.

5. FORM:

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- Photo Consent form

6. PROTOCOL:

6.1. HCCC team members will not prohibit or interfere with the recording of clients by their family members unless:
- The client appears to not want to be recorded; and/or
- The situation is inappropriate for recording.

6.2. HCCC team members will ensure that all visitors, guests, family members of clients, and clients are aware of the limitations and necessary consents for making recordings.

6.3. HCCC team members can decline to be recorded and if recording continues will stop all activities and report the situation to their supervisor and complete an incident report.

6.4. HCCC team members will ensure that a completed consent form is placed in the client's health record prior to any recording of the client by non-family members.

6.5. In the event of unauthorised recordings, HCCC team members will firmly request that the individual making the recording stop. The team member will then document the unauthorised recording in the client's health record, contact risk management and the privacy officer for further instruction, complete an incident report, notify the ir immediate supervisor, and guardian/ if applicable.

6.6. HCC team members will not obtain consent for third parties to record clients for any reason.

6.7. HCC team members will not confiscate any recording device or delete any recordings without the written permission of the individual making the recording.

6.8. HCC team members may, at their discretion, prohibit any recording activity based on the context or nature of the situation.

REFERENCES:

Office of the Privacy Commissioner of Canada. (2015). A guide for individuals – Protecting your privacy: An overview of the office of the privacy commissioner of Canada and federal privacy legislation. Retrieved from https://www.priv.gc.ca/en/about-the-opc/publications/guide_ind/

Return to TOC

Approved By: CNolan	Date: 14/04/2023
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date: 14/04/2023
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

Return to TOC

Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Transition of Care Through Continuing Care Services		Operations	H3C 02-001-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
05/01/2024	05/01/2026	New Policy	3
APPLIES TO:			
All Home, Community, and Continuing Care Team Members			

1. **BACKGROUND:**
The Home, Community, and Continuing Care Program (HCCC) provides clients and residents with care in their home or residence. When client needs exceed program resources or scope of practice of the HCCC nursing staff, care must be transferred to a more appropriate program.

2. **POLICY:**
2.1. All clients admitted to HCCC programs require a nursing assessment per Policy H3C 03-02-00 *Client Assessment and Reassessment.*

2.2. Nursing staff shall monitor for and document all changes from baseline in the client record, including any consultations initiated as a result of the change.

2.3. The Supervisor of Home and Community Care (SHCC) or Nurse Manager of the Continuing Care facility is responsible for ensuring that appropriate consultation is initiated for transition of care as per the guidelines below.

3. **PRINCIPLES:**
3.1. Nurses are accountable for facilitating, advocating, and promoting the best possible care of clients.
3.2. Transfer of accountability is a crucial component of the care transition process.

4. **GUIDELINE:**
4.1. **Home Care:**

4.2. All clients admitted into the home care program require a nursing assessment. In the event that there is no Home Care Nurse in the community, the Home Care team will collaborate with the healthcare team at the Community Health Care Centre to have the client assessed.

If there are no CHNs, NPs, or Physicians in community, the home care team will connect with the Territorial Home and Continuing Care Team for further direction and support.

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4.2.1. Any change from baseline must be documented in the client's health record.

4.2.2. Changes in baseline must be reported to the CHN responsible for the client's chronic disease status and, following consultation, an appointment may be made with the nurse practitioner or physician. In the event that there is no CHN in the community the report will be made to the Advanced Care Paramedic (ACP) or other regulated healthcare provider in-community or by remote support such as the Virtual Nurse Practitioner Program.

4.2.3. In urgent or emergent situations, the Supervisor of Home and Community Care (SHCC), or Home Care Worker, shall report to the nurse-on-call at the health centre if the concern is urgent. In the event there is no CHN in community, the report will be made to the on-call ACP or other on-call advanced practice provider.

4.2.4. The SHCC/LPN shall document all consultations and referrals in the client's health record.

4.3. When needs of clients admitted to the home care program exceed the resources of the program, i.e., need more frequent care than may be provided, the SHCC shall contact the Manager of Home Care and initiate discussion with the client and family (with client consent) regarding transfer to a continuing care facility.

4.3.1. The SHCC or delegate is responsible for preparing a summary of client-specific information that is clear, concise and, comprehensive when transitioning a client to a continuing care facility.

5. GUIDELINE:

5.1. Continuing Care:

5.2. All residents admitted to a continuing care facility require a nursing assessment as detailed in policy H3C 03-002-00 *Client Assessment and Reassessment*.

5.2.1. Nursing staff shall monitor the health of residents according to the resident's care plan and document any changes from baseline assessment in the resident's health record.

5.2.2. Significant changes in baseline, i.e., sustained elevation or decrease in blood pressure or heart rate, difficulty breathing, choking, etc. shall be reported to the Nurse on-call at the Health Centre.

> In urgent or acute situations, the immediate needs of the resident must be addressed in the most appropriate manner depending on the circumstance and the scope and capacity of the HCCC team member(s) present.

5.2.2.1. Every effort shall be made to transport the resident to the health centre; however, resident safety is paramount, and the CHN may be requested to come to the facility if the resident is too frail.

5.2.3. If a resident demonstrates significant cognitive or physical deterioration and care exceeds the capacity of the facility to maintain resident safety and quality of life, the Nurse

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Manager shall contact the Territorial Coordinator of Home, Community, and Continuing Care to discuss transfer to a more appropriate facility.

5.2.4. The Nurse Manager or delegate is responsible for preparing a summary of client-specific information that is clear, concise and, comprehensive when transitioning a resident to a more appropriate continuing care facility, such as from an Elder's home to a Continuing Care Centre.

5.2.5. If there is no appropriate long term care facility in the community which can meet the client's needs, the Home, Community, and Continuing Care team will work with the CHC healthcare team to support the client pending transportation to a long-term care facility that can meet the client's needs either in another community or out of territory as required.

5.3. In acute situations or situations which require a transfer to health centre follows transfer of care policy, CHN 06-008-00, and CHN 07-019-00

6. Related Policies and Legislation:

H3C 03-002-00 Client Assessment and Reassessment
CHN Policy 06-008-00 Documentation Standards
CHN Policy 07-019-00 Transfer of Care Between Colleagues

7. References:

College of Nurses of Ontario. (2022, June 7). *Care Transitions: Transfer of Accountability.* Retrieved from https://www.cno.org/en/learn-about-standards-guidelines/educational-tools/ask-practice/care-transitions-transfer-of-accountability/

Approved By:	Date: 5 January 2024
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date: 5 January 2024
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

Return to TOC

Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Monthly Occupancy Services Reports - CCCs		Operations	H3C 02-002-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
14/04/2023	14/04/2026	Policy 1.12	2
APPLIES TO:			
Facility Managers			

1. BACKGROUND:

1.1. Home, Community, and Continuing Care (HCCC) acknowledges that clear and consistent communication is a necessary component of program, service, and support delivery.

1.2. HCCC communicates with other Government of Nunavut (GN) departments and divisions as well as external funders and other groups through reporting.

1.3. The reports generated by HCCC team members provides relevant data which contribute to collaborative efforts to support Nunavummiut.

1.4. HCCC uses reports internally as both part of a standard record keeping process and to ensure that HCCC team members are aware of current services, supports, and programs as well as any identified gaps or potential gaps.

2. POLICY:

2.1. Within the first five (5) calendar days of each month the Facility Manager, or their designate, will complete a Monthly Occupancy Report for the previous month and submit it to the Territorial, Home, Community, and Continuing Care division.

3. PRINCIPLES:

3.1. The collecting and maintaining of information including data and statistics related to service uptake and occupancy of facility spaces is essential to informing ongoing operational activities.

3.2. Relevant and vital statistics help HCCC to forecast expected services demands and ensure that Nunavummiut have access to supports, services, and programs which meet their needs.

4. PROCEDURE:

4.1. A monthly occupancy report for the resident count will be completed and submitted to the Territorial Home, Community, and Continuing Care division within the first five (5) calendar days of the start of the next month.

4.2. An electronic version of the template is available.

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5. REFERENCES:

Accreditation Canada. (2016a). Qmemtum program 2016. Standards home care. Ottawa, ON: Accreditation Canada Publisher.

Accreditation Canada. (2016b). Qmemtum program 2016. Standards effective organization. Ottawa, ON: Accreditation Canada Publisher.

Approved By: CNolan	Date: 14/04/2023
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date: 14/04/2023
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

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Building Nunavut Together

GOVERNMENT OF NUNAVUT

Monthly Occupancy Report
Facility:

Surname	Given Name	Gender	Room #	DOB dd/mm/yy	Home Community	Admission Date dd/mm/yy	Hospitalization/Leave
			1				
			2				
			3				
			4				
			5				
			6				
			7				
			8				
			9				
			10				

Date:
Completed by:

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Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Personal Health Information		Operations	H3C 02-003-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
05/01/2024	05/01/2026	New	5
APPLIES TO:			
Healthcare Providers and Healthcare Workers			

1. BACKGROUND:

The Home, Community, and Continuing Care Program (HCCC) recognizes that confidentiality is a fundamental aspect of healthcare delivery. Clients share the most personal and private information with health professionals. Unless there is complete trust in the absolute confidentiality of the information that is divulged, the client may withhold vital details that affect their health.

The protection of personal health information is legislated in the Access to Information and Protection of Privacy Act. The act and regulations are available at https://www.gov.nu.ca/eia/access-information-and-protection-privacy-atipp-act.

HCCC provides the following policy and guidelines for the access to, collection, release, and disposal of personal health information.

2. POLICY:

2.1. All staff have a role in maintaining confidentiality and shall comply with CHN Policy 06-001-00 *Confidentiality.*

2.1.1. Supervisors shall ensure that all employees and students under their supervision have signed the Government of Nunavut's (GN) *Oath of Office and Secrecy.*

2.2. Healthcare providers (HCPs) and healthcare workers (HCWs) shall only collect personal health information necessary for the care of the client.

2.3. No staff member is permitted to look at paper or electronic records for clients for whom they are not responsible.

2.4. Supervisors are responsible to ensure that there is a release of information signed by the client before information about the client can be given to anyone outside of the healthcare team.

2.4.1. Referrals to other healthcare professionals do not require a release of information.

> While there is implied consent for sharing of PHI within the circle of care client's do have the right to limit whom within the circle of care has access to their PHI and may limit the sharing of some or all information to specific members of the circle of care. It is advised that verbal consent for sharing within the circle of care be obtained and documented in the client's health record.

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2.5. Supervisors shall ensure that health records are disposed of in the manner required by Government of Nunavut policies and procedures.

3. PRINCIPLES:

3.1. 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.

3.2. 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.

3.3. 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).

4. DEFINITIONS:

Healthcare Provider refers to Supervisors, Licensed Practical Nurses, and any other regulated health professions employed in the Home, Community, and Continuing Care Program.

Healthcare Worker in this context refers to unregulated healthcare workers such as Continuing Care Workers and administrative staff.

Personal Health Information is defined as:

- Name, home or business address, phone number.
- Race, colour, national or ethnic origin, religious or political beliefs or associations.
- Age, sex, sexual orientation, marital status, or family status.
- Any identifying number, symbol or other particular assigned to an individual.
- An individual's fingerprints, blood type or inheritable characteristics.
- Information about educational, financial, criminal or employment history.
- Anyone else's opinion about an individual.
- An individual's personal opinions except where they are about someone else.

Supervisor refers to Nurse Managers of Continuing Care Facilities and Supervisors of Home and Community Care.

5. GUIDELINE: COLLECTION

5.1. HCPs and HCWs shall collect personal health information, and personal information only as it relates to the delivery of healthcare.

5.2. HCPs shall adhere to CHN Policy 06-008-00 *Documentation Standards* ensuring that documentation is concise, factual, objective, and accurate.

6. GUIDELINE: ACCESS

6.1. Conversations in which the care of the client is discussed shall not take place in areas where other clients or staff members can overhear them. Any documents containing any of the above-listed information must be maintained securely so that confidentiality is not breached.

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6.2. Computer monitors must not be left open when the HCP is out of the room and must never be in full view of clients.

6.3. All staff may only access health records for those clients in their care. For greater clarity, staff may not access their own health records, the health records of other staff members, family, or friends without express permission.

7. Guideline: Release of Information

7.1. A release of information signed by the client, or their guardian must be on file before information about the client can be given to anyone outside of the healthcare team. This does not apply to referrals to other healthcare providers.

7.2. Clients who request a copy of their health records must complete a Release of Information.

7.2.1. The Supervisor must contact the regional Manager of Health Records for the release of records from Meditech per CHN Policies 06-003-00 and 06-007-00.

7.2.1.1. In Iqaluit the request is placed with Health Records at Qikiqtani General Hospital (QGH).

7.2.2. The Supervisor should also strongly encourage the client to review the record with a healthcare provider to explain unfamiliar processes and answer questions.

7.3. Information about the client may not be provided to family members except with express consent from the client, even during emergencies. The only exception to this is when the client has a guardian who has power of attorney over medical decision making.

7.4. If a request for information is provided by a third party, such as a lawyer or insurance company, the request must first be submitted to the Access to Information and Protection of Privacy (ATIPP) Coordinator in Iqaluit, who will then advise what may be released.

7.5. If a request for information is presented by the RCMP, client consent must be obtained unless the RCMP also submits a search warrant, subpoena, or order for production requesting specific client information. The ATIPP Coordinator must still be consulted prior to releasing any information.

8. Guideline: Sending Personal Health Information by Email or Fax

8.1. Personal health information sent by email shall be password protected or encrypted.

8.1.1. If a staff member receives an email containing personal health information in error (incorrect recipient), the staff member shall immediately notify the sender and confidentially report the error.

8.1.2. The staff member shall not view or access the information and shall not forward it to the intended recipient.

8.1.3. The staff member shall delete the email unless otherwise directed by the sender.

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8.2. When sending personal health information via fax machine, the sender shall verify the appropriate printers and fax machines have been selected prior to sending. If unsure which printer to select, the sender shall request assistance from their supervisor.

8.3. If a transmission is sent in error, the staff shall request the recipients shred and not share the document.

8.3.1. The sender shall make corrections to the printers' names and fax numbers and send the document to the correct recipients.

8.4. If a fax transmission is received in error, the receiver shall contact the sender and confidentially report the error.

8.4.1. The receiver shall, unless otherwise directed by the sender, immediately shred the document and confirm with the sender when completed.

9. Guideline: Breach of Confidentiality

9.1. Staff members who suspect that confidentiality has been breached must immediately report the incident to their immediate supervisor.

9.2. The immediate supervisor must report the breach of confidentiality to their supervising Director, the Home, Community, and Continuing Care Coordinator, and the ATIPP Coordinator.

9.3. The ATIPP Coordinator shall decide whether further information or action is required and whether the matter must be submitted to the Information and Privacy Commissioner.

10. Guideline: Disposal of Personal Health Information

10.1. Supervisors shall utilize the process outlined in the Manual for Archiving Hard Copy Patient Records for the Department of Health to dispose of hard copy health records.

10.2. Boxes of files, properly packed as described in the Manual, are sent to the regional centres for review to ensure correctness. The regional staff will send the boxes to CGS.
The **Qikiqtaaluk** region send their boxes to Qikiqtani General Hospital.
The **Kivalliq** region send their boxes to the Kivalliq Regional Health Facility.
The **Kitikmeot** region send their boxes to the Kitikmeot Regional Health Facility.

10.3. The Health Records department in each regional hub is responsible for processing information in Meditech for all deceased clients in their communities. The Supervisor or delegate shall submit:

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

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

10.3.1. In the **Qikiqtaaluk**, the required information can be password protected and emailed to deceased@gov.nu.ca or faxed to 867-975-8640.

10.3.2. In the **Kivalliq**, the required information can be password protected and emailed to deceasedkiv@gov.nu.ca.

10.3.3. In the **Kitikmeot**, the required information can be password protected and emailed to deceasedkit@gov.nu.ca or faxed to 867-983-4509.

11. Associated Policies and Legislation:

CHN Policy 05-027-00 Contacting Clients Through Local Radio
CHN Policy 06-001-00 Confidentiality
CHN Policy 06-002-00 Transmission of Health Information by Facsimile
CHN Policy 06-003-00 Release of Information
CHN Policy 06-004-00 Intra-Departmental Release of Information
CHN Policy 06-005-00 RCMP Investigations
CHN Policy 06-007-00 Health Record Control
CHN Policy 06-008-00 Documentation Standards
Access to Information and Protection of Privacy Act

12. References:

SHP Manual Version 1, April 1, 2023

Approved By:	Date: 5 January 2024
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date: 5 January 2024
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

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Department of Health
Virtual Health and Digital Tool Privacy Guidelines

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Virtual Health and Digital Tool Privacy Guidelines

These Guidelines assists healthcare practitioners of Nunavut with their use of virtual care and digital health tools. It explains how healthcare practitioners can maintain privacy and security of personal information (PI) while providing care. Personal information, including personal health information (PHI), is protected by law under the Access to Information and Protection of Privacy Act (ATIPP). It is the responsibility of all Government of Nunavut employees, including healthcare workers, to safeguard PI/PHI when in use during healthcare operations.

Privacy and Security for Digital Health Solutions

Virtual care and digital health tools enable us to expand and improve healthcare services. Through virtual care tools patients can see the physician of their choice regardless of geographic restrictions. Digital tools an make it easier for patients to exercise their privacy rights to access information, sometimes directly accessing copies of records from home. They allow healthcare providers to collaborate and share information on community trends. With the right tool, healthcare providers can effectively provide services from their own homes

How These Guidelines Help You

These guidelines assist healthcare practitioners by providing:

- Best practices for each tool use.
- Technical requirements are needed to use the tool.
- Privacy and security practices that healthcare providers will need to follow.
- Risks and potential limitations against protecting patient information.
- Guides and additional resources that the provider can use themselves or provide to patients if there are questions.

Acceptable Use of Personal Health Information

The public entrusts significant amounts of PI and PHI with the Government of Nunavut. The Department of Health collects and processes PHI for a purpose: to provide health care and related services to patients. Employees of the Department of Health Data may only use PHI for authorized purposes directly related to the performance of their job responsibilities. PHI and other Department of Health Data cannot be used for any other purpose without the express approval of Department of Health management.

As employees of the Department of Health, Healthcare providers have access to sensitive information, including PHI, to fulfil their roles and responsibilities. As part of their professional duties, Healthcare providers must:

- Be limited in their access to PHI. Healthcare providers should only have access to information that is required for them to provide healthcare services.
- Complete all privacy related training provided by the Department of Health on privacy and the treatment of PHI.
- NEVER access this information without authorization and without a legitimate work purpose. This is known as “employee snooping”. Department of Health Healthcare providers and support who participate in employee snooping are subject to disciplinary actions.
- Remember that the Department of Health has a right to supervise their actions when using Department resources. As a safeguard for PHI, the Department may require logging, monitoring and auditing of all access and actions conducted on PHI.
- Report to the ATIPP coordinator if they suspect records are being accessed in an inappropriate manner.
- Cooperate in a timely manner with any initiated privacy investigations. Allegations of snooping within the Department of Health are taken very seriously and investigated.

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What Tool for What Task?

I want to….	You should use….
Have a virtual health video call between myself and my patient, or the patient's family	Nunavut Telehealth
Schedule a virtual health call with a patient	MyTeam, part of Nunavut Telehealth
Save my notes, including professional advisory on a patient's care	Always store in MEDITECH
Give my patients access to their health data	Requests should still go through the Department of Health Access and Correction Requests
Connect remotely to Meditech	Government of Nunavut (GN) Network
Set up a call between myself and another health practitioner over a specific patient	Microsoft Teams (MS Teams)
Collaborate with other healthcare providers on a community initiative or concern	Microsoft Teams (MS Teams)
Have a video call with another healthcare provider/ providers	Microsoft Teams (MS Teams)

I want to ….	You should use….
Have a video call with another healthcare provider/ providers	Microsoft Teams (MS Teams)
Set up a chat over a community health concern	Microsoft Teams (MS Teams)
Send another health care provider documents that contain PHI	Microsoft Teams (MS Teams) Documents must be encrypted and deleted after sharing is complete.
Give directions to clinical staff on the care of a specific patient	Microsoft Teams (MS Teams)
Give directions to clinical staff on best practices or new concerns	Microsoft Teams (MS Teams)
Email patients their personal health information	DON'T. Email is not a secure way of communication and has inherent risks when sending PHI.

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Virtual Health Visits

Thanks to growing technology, it is possible for patients in Nunavut to receive health care services without physically visiting provider clinics and hospitals. This is critical for improved health outcomes in the community. By enabling virtual health:

- Patients are not barred by geography, when travel to a healthcare provider is difficult or unfeasible.
- Clinical staff are protected if the patient has a contagious concern, such as COVID.
- Patients can seek expert advice quickly, from the comfort of home.
- Less time is needed for maintenance of regular care, such as booking appointments or follow-ups.

Telehealth: Virtual Video vs Telephone Health

Telehealth provides health care services and exchanges health information through electronic information and communication technology. Telehealth is the use of video conferencing equipment to connect health-care providers and their patients/clients in different physical locations. Telehealth enables patients/clients to see, hear and talk to their health-care provider on a television screen.

Video Calls

A video call allows interactive health services between healthcare providers and patients. Patients can book appointments for video calls and send messages to their clinicians.

Best Use for Video Calls:

- Scheduled or on-demand clinical appointments; virtual nature means ideal for servicing remote locations.
- Consultations where it is of value to see the patient for overall health, but not necessarily in-person.
- Remote diagnosis of medical conditions that do not require in-person testing.
- Screen-sharing results of tests.

Video Calls Are Not For:

- Collaborating with others in the Department of Health. Use Microsoft Teams (MS Teams).
- Sending information outside the Department of Health.
- Conditions where a physical exam is necessary to diagnose the condition.

Technical Requirements:

- Access to reliable internet and the ability to go online. Access may be data or Wi-Fi but may not be publicly accessible Wi-Fi.
- Device (PC, laptop, smartphone, or another mobile device) with the following:
- Audio capabilities and microphone.
- Video capabilities and camera.
- Operating system: still supported by vendor (Windows, OS X, iOS, Android).

Privacy and Security for Video Calls

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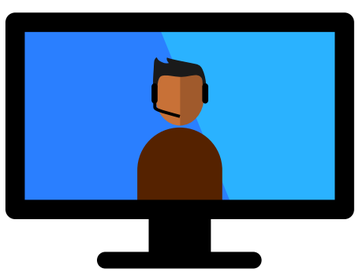
Best Practices for Video Calls

- Use a password for the call channel if permitted by the tool. Only the patient, healthcare provider, and persons authorized by the patient should be permitted on the call.
- Follow any tool-specific security guidelines provided by the Department of Health.
- Only use Virtual and Voice over Internet Protocol (VoIP) tools that have been authorized by the Department of Health.
- Never set up video calls with personal zoom accounts, google meet, or other video conferencing software.
- MS Teams is not approved for patient to healthcare provider calls.

At the start of each call:

- Verify the identity of the patient.
- Check your physical environment before taking a call. Is anyone in the office with you or who could come in unannounced?
- Remind patients the call follows the Department of Health's privacy practices. They can review the Department of Health Privacy Notice if they have questions.
- IF the call is going to be recorded, you must inform the patient and collect their consent. Calls that are recorded must be made accessible to the patient under ATIP.



During the call:

- Check before sharing your screen: is there sensitive information open?
- Ask before sharing patient information if more than one person is on the call.

After each call:

- Log out or lock your device when not in use.
- Collect and use the minimum amount of data needed for the purpose of providing care.

Video Call Practices to Avoid

- Don't record video calls, unless under the direction and following practices set out by the Department of Health. If we are unable to provide recordings to the patient upon request, and it risks non-compliance with ATIPP.
- Make sure to turn off any pre-installed and setup safeguards, including encryption of VoIP.
- Don't publicly post links to video chats or channels as this can turn into an invite for others to harass call participants. Calls can be intercepted or "bombed" by malicious attackers with harmful comments, imagery, and material.
- Don't share your video call username or password with anyone. Keep these confidential.
- Never provide virtual services or video calls in public areas where the call can be overheard. Third parties can listen in.
- Be careful not to leave webcams on after the call. This can expose unintended information.
- Software vulnerabilities identified or discovered within the tool must be corrected. Do not block software update or patching efforts by Computer Government Services (CGS).

Telephone Health Consultations

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Sometimes, a simple phone call is all the patient needs. Telephone consultations are particularly effective for fast consulting on routine matters where it isn't necessary to see the patient.

Best Use for Telephone Health:

- Scheduled appointments, ideal for servicing remote locations.
- Routine care, such as prescription renewals, where it is not necessary to see the patient's condition.
- Short consultations with clinical staff for quick care questions, or to determine if healthcare provider should be seen.
- Counselling and mental health services.
- Collaboration with other Department of Health staff.
- Collaboration outside the Department of Health.
- Simple information delivery and direction.

Telephone Health Calls Are Not For:

- Diagnosis of medical conditions.
- Walk-in appointments where the patient needs to be seen by a physician.
- Deeper analysis/review of care.
- Sending or receiving patient information. Never use smartphone functions (email, SMS) to send or receive patient PI/PHI without approval of the Privacy Officer.

Technical Requirements:

- Access to a phone provider (cellular or landline) with a reliable connection.
- Phone or smartphone.
- Phone number registered with the Department of Health.

Privacy and Security for Telephone Health

Best Practices for Telephone Calls

To reduce privacy and security concerns, we recommend the following:

- At the start of each call:
  - Verify the identity of the patient.
  - Check your physical environment before taking a call. Is anyone in the office with you or who could come in unannounced?
- Remind patients the call follows the Department of Health's privacy practices. They can review the Department of Health Privacy Notice if they have questions.
- Verify information, particularly the spelling of names and addresses.
  - If you are uncertain if you heard correctly from the other party, take the time to confirm what you've heard is accurate.
- Relaying potentially uncomfortable news? Ask first if you can speak freely. Remember it is difficult to assess emotional reactions over the phone.
- Collect and use the minimum amount of data needed. Only ask questions relevant to providing care.
- Consent for telephone calls are implied when the patient calls in or schedules the call.
- Upload any notes you take from the patient's call to their EMR record in MEDITECH.
- Only take calls in private locations, such as an office or closed room.

Practices to Avoid with Patient Telephone Calls

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- Never take telephone calls in public environments, such as coffee shops, restaurants, or busy areas. Third parties can listen in.
- If calling with test results or follow-up appointments, never leave PI/PHI with family members or on answering machines. Patients may not intend to share their health information with others in their household.
- Never give severe diagnosis, such as permanent damage or terminal illness over the phone, unless the patient consents.
- Never evaluate patient conditions or provide new diagnosis over the phone. There can be problems making accurate prescriptions without observing the patient.
- Do not record telephone calls, unless under the direction and following practices set out by the Department of Health. If we are unable to provide recordings to the patient upon request, and it risks non-compliance with ATIPP.

Collaboration Tools

Microsoft Teams (MS Teams)

Microsoft Teams (MS Teams) is a collaboration tool. It allows healthcare providers and other staff from the Nunavut Department of Health to virtually connect with other Department staff for discussion and document review, host chats, calls, meetings, and integrates with other Microsoft products. Staff may access or use MS Teams for authorized purposes directly related to the performance of their job responsibilities.

Staff must use appropriate privacy and security controls if communicating PI/PHI through Teams and is responsible for storing and managing data in compliance with Government of Nunavut record requirements.

Best Use for MS Teams:

- Collaborate with the Department of Health on providing optimum provincial care.
- Chat and discuss healthcare trends providers are encountering in their communities.
- Discuss care options for specific ailments with other knowledgeable providers.

MS Teams Is Not For:

- Chat, video calls between healthcare providers and patients, or patient family.
- Sharing records, documents, or information directly with patients.

Technical Requirements:

- Access to reliable internet and the ability to go online. Access may be data or Wi-Fi but may not be publicly accessible Wi-Fi.
- Device (PC, laptop, smartphone, or another mobile device).

General Best Practices for MS Teams

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- Unless given express approval by the Department of Health, only of MS Teams for purposes directly related to your job responsibilities.
- Staff may not communicate sensitive information through MS Teams without appropriate security measures in place.
- Teams is not a private chat: MS Teams use may be monitored for security and Department of Health compliance with applicable legislations.
- Sharing information or creation groups for collaboration? Always follow the principle of least privileged access. Information access should be on a need to know and need to use.
- MS Teams is not an official GN record repository or intended for long-term storage; ALWAYS save information in the appropriate location.
- Avoid creating channels. Each private channel creates a new SharePoint site with the default sharing settings.

General Best Practices for When Working with PHI and MS Teams

- Limit use or discussion of PHI in MS Teams. Avoid making requests for sensitive information, and if responding to questions, keep answers short and data need-to-know.
- Use aggregate, de-identified or anonymous information instead of PHI whenever possible.
- So long as your use of PHI is related to job responsibilities and providing care, patient consent is not needed to use PHI with MS Teams.
- Any changes to PHI MUST be updated/reflected in the patient's original EMR File.
- Sharing documents that include PHI in Teams? The document must be encrypted, and access code shared by a channel other than Teams itself.
- PHI in MS Teams must have a limited retention. Once the purpose is complete, PHI must be permanently deleted. Office accounts; MS Teams is not the approved solution for health calls.
- Access to patients PHI in a MS Teams should be regularly reviewed and audited to detect inappropriate access.
- Don't record calls (video or audio) if discussing a PHI or a patient's care.
- Never disclose patient PI/PHI with individuals, organizations or the Government of Nunavut departments outside the Department of Health using MS Teams.
- Do not use MS Teams for patient calls. Regardless, if patients have MS Office accounts; MS Teams is not the approved solution for health calls.

Best Practice for Specific MS Teams Tools

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Teams

As the name implies, Teams is a feature in MS Teams that places chat, files, and information together in a single group to allow collaboration. Teams can be useful for cooperation on healthcare initiatives. If setting up a 'Team' keep in mind the following:

- Teams should not be public. If public, anyone from the Government of Nunavut can view the Team.
- PHI cannot be discussed, included, or attached to documents within 'Public' Teams. Patient's PHI in Teams should not be shared with non-team members.
- Teams created by staff for collaboration on healthcare MUST be private.
- Avoid "general" Teams that have no specific focus; have a purpose in mind. Before creating a new Team, see if an existing Team meets your needs.
- All Teams sites must have an 'owner'; two owners is ideal. Owners actively manage members, making certain information is on a need-to-know. Owners remove members who no longer have clinical needs to access the Team.
- Not all apps available to MS Teams are secure. Apps must be requested and approved by CGS prior to download and installation. Third party Teams Apps should not be installed unless they are approved by CGS prior to download.
- Use sensitivity labels whenever a Teams may have PHI or sensitive information.
- A How-To document is available to assist with creating new Teams, adding members and assigning owners.

Chat

The chat feature in MS Teams can be used for quick conversation, without creating a full Team or formally inviting participants.

- If not everyone in a Team need access to the chat, use chat for smaller discussions.
- Use a Team if the chat will involve a larger group.
- If the chat is intended to help a particular patient, such as a one-on-one between a healthcare provider and a specialist, the discussion must be copied or amended as notes to the patient's original EMR file.
- Need help? A quick How-To document is available on how to use Chat.

Calls

MS Teams allows calling through the application itself, using Voice over Internet Protocol (VoIP) Calls are a simple way to facilitate discussions that include PHI, popular for instant communication.

If using the call feature of MS Teams:

- Do not record calls that discuss or include PHI.
- Keeping a transcript? If the transcript contains PHI, append a copy to the patient's original EMR record. This will make it easier to find, an confirm information is available to healthcare providers assisting the patient.
- Remember that if calls are recorded or transcripts taken, patients will have a right to access their recorded information in accordance with the Access to Information and Protection of Privacy Act.

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Meetings

Meetings in Teams can be conducted with audio, video, and screen sharing. Another useful feature of Teams is using Meetings to host webinars and live events.

If using Meetings:

- Be careful if screen sharing with MS Teams in meetings: participants can see anything on your screen that becomes visible to you. Close non-relevant documents, when possible, to avoid unintentionally sharing embarrassing, confidential or sensitive information, including PHI.
- Setting up a Meeting to discuss a particular patient? Limit information on the invitation to patient ID, or name and email/phone. Information in the invite should only identify the patient topic of call.
- Never use actual PHI in webinars: de-identified information or fake examples only.
- Do not record meetings if intending to discuss or share PHI.

Other Digital Communication Tools

Email

Email (electronic mail) is a simple, universal way to communicate across devices. All staff within the Department of Health have Government of Nunavut issued email addresses, and it is increasingly rare for parties outside the Department not to have their own. Email is a fast and convenient way to communicate; however, particular care must be taken when using email for healthcare services.

Best Use for Email

- Quick communications, including appointment reminders.
- Communications that do not include patient PI or PHI.
- Sending communications and documents to third parties who have no other means of communication.

Email Is Not For

- Sending PHI if other more secure channels are available and can be used by both parties.

Technical Requirements

- Access to reliable internet and the ability to go online. Access may be data or Wi-Fi but may not be publicly accessible Wi-Fi.
- Device (PC, laptop, smartphone, or another mobile device).
- Government of Nunavut issued email address.
- Email address for the recipient.

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Privacy And Security for Email

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Best Practices for Email

To reduce privacy and security concerns, we recommend the following:

- Only disclose PI/PHI if permitted under ATIPP.
- Encrypt the email if it must contain PI/PHI and limit the PI/PHI in email to only what is necessary for the other party.
- If you are unable to encrypt the email, get express consent from the patient before sending it.
- Confirm the email is addressed correctly before hitting send.
- Flag emails that contain PI/PHI as confidential.
- Include the Department of Health's disclaimer for emails with PI/PHI.
- Follow the requirements for emailing PI/PHI within the Government of Nunavut Network, found in the Department of Health's Emailing Digital Records Containing Personal Health Information (PHI) Directive.
- Follow the requirements for emailing PI/PHI outside the Government of Nunavut Network, found in the Department of Health's Emailing Digital Records Containing Personal Health Information (PHI) Directive.
- If sending to patients, provide a Notification for the use of Digital Communications before sending PHI.
- A Tip Sheet, *Guidelines on Emailing PHI,* is also available.

Practices to Avoid with Email

- Never use personal emails to send PI/PHI as a healthcare provider and part of the Department of Health.
- Don't encourage patients to send PI/PHI to the Department of Health using email, unless no other secure channel is available in a timely manner.
- Don't save emails with PI/PHI in Microsoft Outlook. Copy their contents into Meditech, then delete.
- Only use email for sending PI/PHI if no other option is available, and always follow the best practices listed above. Email is not considered a secure method of communication: emails can easily be sent to others, intercepted by third parties, and are difficult to securely destroy.

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Fax

A fax sends a document electronically to a machine owned by the recipient, who prints off the information. Fax is no longer the standard for transmitting information but is still in use by some locations.

There are several risks when using fax, which is included in these guidelines. As a rule, healthcare providers within the Department of Nunavut should never fax PI/PHI to a recipient unless a more secure channel, such as an encrypted email, is not feasible for the other party. However, for some situations, such as sending information to specialists/departments outside of Nunavut, fax may be needed to comply with the recipient's processes.

Best Use for Fax

- Communications that do not include patient PI or PHI.
- Sending communications and documents to third parties who have no other means of receiving PHI, or who require the Department of Health to use fax for sending copies of documents that include PHI.

Fax Is Not For

- Sending PHI if other, more secure channels are available and can be used by both parties.

Technical Requirements

- Access to an online or telephone connection.
- Access by both parties, sender, and recipient, to a machine or program on devices that can process fax.
- All fax machines must be located in a secure location only accessible to health care staff.
- Fax number for the recipient.
- Government of Nunavut issued fax number.

Privacy And Security for Fax

Best Practices for Fax

To reduce privacy and security concerns, we recommend the following:

- Only disclose PI/PHI if permitted under ATIPP. Use and disclosures of PI/PHI should always follow the Department of Health's Privacy Policy.
- Only fax PI/PHI when it cannot be accessed by the other party through MEDITECH, encrypted email, or another secure channel.
- Always use a cover letter and disclaimer to faxes that include PI/PHI. See the Department of Health's Faxing Digital Records Containing Personal Health Information (PHI) Directive for details.
- Limit the PI/PHI you submit in fax. If the information doesn't need to be there, don't include it.
- Only fax to health care facilities with which the Government of Nunavut has a contract.
- Before sending the fax, confirm the number you have is accurate. Check carefully when you dial the fax number.
- Immediately file records after they are faxed. If the record faxed is a copy of the original, shred it once transmission is confirmed.
- Check that the number of pages receives matches the cover sheet. Is there an error in the fax? Contact the sender and destroy the information if required.
- Is there a more secure method of sending the information? There are risks with sending PHI through fax, including lack of control over the other side's security, machines being vulnerable to attacks, and how easy it is to make errors that risk sending information to the wrong person.
- Follow additional guidelines and requirements as stated in the Department of Health's Faxing Digital Records Containing Personal Health Information (PHI) Directive.

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Practices to Avoid with Fax

- Never leave faxes with PI/PHI unattended.
- Don't use preprogrammed numbers without confirming the number is up to date and accurate.
- Don't fax to healthcare facilities the Government of Nunavut doesn't have a contract with. NEVER fax PI/PHI to personal fax machines, including those that belong to the patient.
- Never send faxes to unauthorized recipients. If this has occurred, contact the ATIPP Coordinator immediately.
- Machines may retain information even after a fax has been sent. It is the responsibility of the Department of Health to properly destroy fax machines when they are to be taken out of use.

Digital Photos

Photos can, if used with care, enhance the quality of patient care, such as a visual record of a changing condition. Sometimes patients will send clinics and healthcare providers photos of their ailments, a fast method to send visual information from remote locations, determining if there is a need for on-site visitation. However, in medical practice, the collection, use, disclosure, and retention of photos must be handled with care. Photographs can contain PI/PHI and require the same level of protection as other confidential.

Best Use for Digital Photos:

- Quick review of physical ailments and concerns remotely to determine if the condition require in-person care or can it be handled at home?
- May be part of testing or procedures for evaluating specific conditions.

Digital Photos Are Not For:

- Complete diagnosis of ailments.
- Copies of medical papers or needed documentation.
- Providing patients access to information. All access to information requests must go through the Department of Health's ATIPP Coordinator.

Technical Requirements:

- Equipment for taking the photo: digital camera or device with camera function.

Privacy And Security for Digital Photography

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Best Practices for Digital Photos

- Explicit, written consent is required before carrying out any photography that includes patients.
- Photos may only contain the patient in question. Staff and other individuals must not be present in the image unless express written consent from the other party has also been acquired.
- All photography that captures PI/PHI must comply with ATIPP. Establish and inform the patient of the purpose of the information's collection, who will have access, and that they may request access at any time.
- If a visual is needed from the patient, consider if there are better solutions that suit the patient's needs, such as scheduling a Virtual Video Call.
- If patients are going to send photos by email, SMS or another method, healthcare providers must remind them:
    - The Department of Health cannot secure photos sent through email, SMS or fax. Provide the patient with a Notification for the use of Digital Communications.
    - By submitting the photo, the patient expresses consent for the healthcare provider to use the photo in providing care and retaining it as part of the patient's medical record.
    - Photos may only contain the patient. Photos including other parties in the photo will not be maintained as part of the patient's record.
- Using a smart phone or tablet to take the photo? Confirm all settings, that photos are not automatically uploaded to cloud drives or external storage.
- Always place photography with patient PHI in their MEDITECH EMR file. For information on how to place photos in MEDITECH, see the Nunavut eHealth document "Adding Images to Notes" which provides step-by-step instructions.
- Once the photo has been transferred, immediately delete it from all other devices.

Practice to Avoid with Digital Photos:

- Photography of patients by clinical staff and healthcare providers must be for healthcare purposes only. Do not use photos for purposes other than providing care, unless expressly permitted as part of your work responsibilities.
- **NEVER** share photos or digital images of patients on social media, online sites, or forums. Such disclosures of PI/PHI are expressly prohibited by the Department of Health.
- Never take pictures of patients without their consent.
- Never store photos of patients on personal devices. There is risk of a data breach if the photo remains on a device that is compromised.
- Collect photos, such as a copy of the patient's driver's licence, for verification purposes. This is unnecessary collection of PI: a confirmation you've seen the image is enough.
- Avoid capturing more information than you intended. Many photos include metadata collection that was unintended by the photographer. For example, the photo may contain information on the patient's location, and when the photo was taken. Do you know if this data is captured?

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TEMPLATE: Notification for the use of Digital Communications

Notification of Digital Communications

While the Department of Health works diligently to protect your personal health information, use of common digital communication tools comes with risks. If you have discussed or requested using email, SMS, or other tools as a means to communicate with your healthcare provider, recognize the risks.

When using digital communications, the Department of Health cannot control the following:

- Information when stored on your device.
- Access applications on your device might have to messages, photos, or other information.
- Settings on your device, such as automatic cloud storage or social media sharing.
- Access to information in transit by telecom providers, software, or applications.

What are the risks of digital communications?

- Information can be viewed, changed, or deleted by third party if they have access to your device or accounts.
- Devices may be compromised due to malware or viruses, which can erase, scramble, or send information back to the attacker.
- Information may be intercept by third parties.
- Depending on your provider, information may be stored or accessed outside of Canada.

What can patients do to protect their information?

- Use strong passwords and protect them. Never share your password with others; if you suspect your password has been compromised change it.
- Set up device and software controls to protect information when possible. Use multifactor authentication, and encrypted communications.
- Keep devices current with security updates and install anti-malware software.
- Delete emails, texts, and other communications with sensitive information once the transaction is complete.
- Practice good security hygiene: be careful of strange messages, links and signs of online scams.

If a patient has consented to sending or receiving information by to their healthcare provider, clinic or another member of the Department of Health, it is the patient's responsibility to secure their own device, email, and other relevant accounts.

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TEMPLATE: Consent for the use of Digital Communications

Consent for the use of Digital Communications

I, _____ give my consent for the Department of Health for the sharing and communications of personal information using digital communications tools.

☐ I understand the risks of the transmission of personal information using digital communications tools including email, text, or the sharing photos.

☐ I understand I am responsible for all personal information stored on my own device, including access by third parties or settings.

Name: _____

Health Card #: _____

Phone or Email: _____

Signature: _____ Date: _____

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Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Conflict of Interest		Operations	H3C 02-004-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
14/04/2023	14/04/2026	Policy 1.17	3
APPLIES TO:			
All Home, Community, and Continuing Care Team Members			

1. BACKGROUND:

1.1. Home, Community, and Continuing Care (HCCC) is committed to providing Nunavummiut with evidence based, client centred care which upholds Inuit Qaujimajatuqangit.

1.2. HCCC acknowledges that to ensure the delivery of quality services and programs to Nunavummiut it is essential that team members completing these activities are free from bias and conflicts of interest to ensure equitable service delivery in accordance with the Nunavut Public Service Code of Values and Ethics.

2. POLICY:

2.1. HCCC team members advise clients at admission of their rights under the Program. These rights include the right to receive qualified healthcare that is free from conflict of interest, behaviours, and behaviours that take advantage of situations and/or clients.

2.2. All HCCC team members must obtain approval prior to engaging in an activity that may be a potential conflict of interest. To seek approval employees must:

- Verbally declare the activity to their manager or delegate
- Obtain approval of the activity, in writing, from their manager or delegate

2.3. HCCC team members must follow the Principles for Government Employees as laid out in the Government of Nunavut's Human Resource Manual (2016).

2.4. HCCC team members will not:

- Agree to provide qualified health services to any client where there is a personal/familial relationship, unless such a relationship has been disclosed to their supervisor and has been reviewed and authorised.
- Take advantage of the professional relationship with any client in any manner which results in personal gain for the employee or their family/friends.
- Make use of the Program's time, premises, equipment, or supplies, for business unrelated to the Program, unless such use is otherwise authorised.
- Take advantage of the professional relationship with any client in any manner which

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results in personal gain for the employee or their family/friends.

3. PRINCIPLES:

3.1. HCCC is committed to providing Nunavummiut with supports, services, and programs that are efficient, impartial, and operated with integrity.

3.2. HCCC ensures that all HCC team members are free of conflicts of interest in the delivery of services, programs, and supports.

4. DEFINITIONS:

4.1. **Conflict of Interest:** A conflict of interest exists when an employee has a private, personal, or financial interest that is inconsistent with his or her duties and the responsibility to act in the best interest of the public, because the employee could benefit personally from a decision or action. The private interest may influence or have the potential to influence how the employee carries out his or her duties (Nunavut Public Service Code of Values and Ethics, 2015).

5. GUIDELINE:

5.1. Any HCCC team member who suspects that there may be a potential conflict of interest in the execution of their duties will contact their immediate supervisor and/or Regional Manager, Home, Community, and Continuing Care and disclose the potential or actual conflict of interest and seek direction as to how to proceed.

REFERENCES:

Canadian Nurses Association. (2017). Code of ethics. Retrieved from https://cna-aiic.ca/en/nursing-practice/nursing-ethics

Government of Nunavut. (2006). Conflict of interest. Human Resource Manual. Retrieved from https://www.gov.nu.ca/sites/default/files/202_new_conflict_of_interest_final_dec_12_14.pdf

Government of Nunavut. (2010). Excluded employees' handbook. Retrieved from https://www.gov.nu.ca/sites/default/files/4-05_-_excluded_employees_handbook_non-union.pdf

Government of Nunavut. (2015). Summary of principles, reporting features, and prohibited

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activities. Human Resource Manual. Retrieved from https://www.gov.nu.ca/sites/default/files/6-01_-_info_-_disclosure_of_outside_activity_conflict_of_interest_outside_employment_203.pdf

Government of Nunavut. (2015). Code of values and ethics. Nunavut Public Service. Retrieved from https://www.gov.nu.ca/sites/default/files/3-10_-_codes_of_values_ethics_-_values_principles_for_the_public_servant_-_2015_english.pdf

Approved By: CNolan	Date: 14/04/2023
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date: 14/04/2023
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

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Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Workplace Safety		Operations	H3C 02-005-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
03/01/2024	03/01/2026	New	3
APPLIES TO:			
All Home, Community, and Continuing Care Team Members			

1. **BACKGROUND:**

The Home, Community, and Continuing Care Program (HCCC) places a high priority on ensuring the physical, mental, and emotional safety of their employees while they are at work.

HCCC complies with the following Human Resources Policies:

- Section 1002 Occupational Health and Safety
- Section 1009 Workplace Violence Prevention
- Section 1010 Harassment Free Workplace

HCCC recognizes the contractual right of employees to refuse dangerous work and provides the policy and guidelines below to ensure staff safety.

2. **POLICY:**

2.1. All HCCC team members shall treat their colleagues and clients with kindness and respect in keeping with the Government of Nunavut Code of Values and Ethics.

2.1.1. Supervisors shall ensure that all staff are aware of the GN Code of Values and Ethics, Section 1010 Harassment Free Workplace and Section 1009 Workplace Violence Prevention.

2.2. All HCCC staff who receive complaints from clients or residents regarding service provision or other healthcare related complaints will follow the guidelines laid out in the HCCC Complaints and Dispute Resolution Policy.

2.3. Home Care staff providing services in client homes alone, shall carry a means of communication and comply with the guidelines below.

3. **PRINCIPLES:**

3.1. The safety and security of HCCC employees is of paramount importance.

3.2. HCCC staff are considered to be in the workplace when providing services in the home.

4. **DEFINITIONS:**

HCCC Staff: refers to Supervisors of Home and Community Care, Nurse Managers of Continuing Care, Home and Community Care Workers, Continuing Care Workers, Cooks, Caretaker/Drivers,

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Housekeepers, Recreation Therapists, and any other staff employed in these programs or other programs operated, managed, or contracted by Home, Community, and Continuing Care Division.

Means of Communication: refers to cell phones or walkie/talkies.

Working Alone: Staff are considered to be working alone if they are travelling to a home or health centre alone and will be the only staff present in the home or health centre.

5. GUIDELINES – HOME CARE STAFF:

5.1. The healthcare provider (HCP) admitting a client to the home care program shall advise the client that smoking of tobacco or cannabis and the consumption of alcohol by any person in the house are prohibited during provision of service.

5.2. Home Care staff shall comply with CHN Policy 07-024-00 *Home Visits – Planned* and CHN Policy 07-025-00 *Home Visits – Unplanned and Urgent.*

5.2.1. Home Care staff providing service alone in a home shall take a means of communication with them and arrange check in times with their supervisor or co-worker.

5.2.2. At minimum, the Home Care staff shall check in with their supervisor or co-worker when they arrive in the home and when they are leaving.

5.3. Supervisors of Home and Community Care (SHCC) shall notify the on-call CHN or Advanced Care Paramedic (ACP) when they are providing service in a home after hours and arrange for appropriate check-in times.

5.3.1. In the event there no on-call CHNs or ACPs in the community the SHCC will collaborate with the territorial team to design the most appropriate and safe approach.

5.4. Home Care staff shall immediately leave any residence where an individual appears to be under the influence of alcohol or other substances.

5.5. Home Care staff shall report any concerns regarding their safety during home visits to their immediate supervisor.

5.6. In the event of an incident which threatens the safety of staff while providing services, the staff shall exit the house immediately, report to their supervisor, and complete an incident report in the Incident Reporting Module in Meditech.

6. RELATED POLICIES AND LEGISLATION

Safety Act, Occupational Health, and Safety Regulations R33. Working Alone, R34. Harassment, R35. Violence

CHN Policy 07-024-00 Home Visits – Planned

CHN Policy 07-025-00 Home Visits – Unplanned and Urgent

H3C 04-004-00 Client Rights and Responsibilities

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7. REFERENCES:

Workers' Safety and Compensation Commission. (2016, September). *Working Alone.* Retrieved from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.wscc.nt.ca/sites/default/files/documents/Working%20with%20Alone-%20English%20-%20NT%20and%20NU%20-%20September%2030%2C%202016.pdf

Approved By:	Date: 3 January 2024
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date: 3 January 2024
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

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Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Emergency Preparedness and Response		Operations	H3C 02-006-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
14/04/2023	14/04/2026	Policy 1.18	5
APPLIES TO:			
All Home, Community, and Continuing Care Team Members			

1. BACKGROUND:

1.1. Home, Community, and Continuing Care (HCCC) delivers services in communities throughout Nunavut. In any location where care is provided there is the potential for an emergency or disaster to occur. HCCC recognises that to mitigate and minimise injuries and loss of life stemming from an emergent or disaster situation it is necessary to have in place an Emergency and Disaster Plan.

2. POLICY:

2.1. Regional Managers, Home and Community Care and Managers of Residential Facilities collaborates with community-based HCCC team members, Risk Management, and community-based services to develop specific Emergency and Disaster Plans which are effective for the environment in which services are provided.

2.2. The HCCC Emergency and Disaster Plans will at a minimum:

- Identify key team members and their roles in initiating and coordinating a response to an emergent or disaster situation.
- Identify community-based partners, such as the Hamlet Offices, RCMP, and Fire Brigade and the roles and contact information for each partner.
- Identify education, training, and orientation that all team members will have in order to be able to respond effectively to an emergent or disaster situation.
- Outline how to access client lists in an emergency situation.
- Explain how to set priorities regarding the care needs of clients and families during an emergent or disaster situation.
- Identify ways of protecting and transporting client records during an emergent or disaster situation.
- Clearly describe a process to quickly access the appropriate and qualified staff in response

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to an emergent or disaster situation.

- Identify ways to communicate with clients, team members, community members, and community-based supports, and with others in the case of an emergent or disaster situation.

- Identify physical space requirements and a list of suitable locations in the event of an emergent or disaster situation.

2.3. The Emergency and Disaster Plans are reviewed and updated annually, after they are employed in an emergent or disaster situation, or anytime there is a significant change to the services provided by HCC in a community.

2.4. HCC team members review the Emergency and Disaster Plan every six months and conduct a minimum of one (1) drill every calendar year to ensure that all team members are familiar with the procedures.

3. PRINCIPLES:

3.1. HCCC upholds the values of *Inuuqatigiitsiarniq*, *Tunnganarniq*, *Pijitsirniq*, *Piliriqatigiinniq,* and *Qanuqtuurniq* in the development and implementation of Emergency and Disaster Plans.

3.2. HCCC ensures that all clients and team members are safe and provided with the necessary supports in the event of a disaster or emergent situation.

4. DEFINITIONS:

Inuuqatigiitsiarniq: Respecting others, relationships and caring for people.

Tunnganarniq: Fostering good spirits by being open, welcoming and inclusive.

Pijitsirniq: Serving and providing for family and/or community.

Piliriqatigiinniq: Working together for a common cause.

Qanuqtuurniq: Being innovative and resourceful.

5. GUIDELINE:

5.1. Regional Managers, Home and Community Care and Managers of Residential Facilities collaborate with Risk Management, community-based partners, and team members to develop community-specific Emergency and Disaster Plans.

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5.2. Emergency and Disaster Plans are reviewed semi-annually to ensure that they are:
- Reflective of services provided in the community;
- Functional;
- Up-To-Date; and
- Well understood by HCCC team members.

5.3. HCCC team members conduct at a minimum one (1) drill annually to test team members preparedness in the event of an emergency or disaster and identify any functional flaws within the Emergency and Disaster Plan.

6. References and Resources:

Government of Nunavut. (n.d.). Nunavut emergency management. Retrieved from https://www.gov.nu.ca/community-and-government-services/information/nunavut-emergency-management-0

Government of Canada. (2019). Emergency management. Indigenous Services Canada. Retrieved from http://www.aadnc-aandc.gc.ca/eng/1309369889599/1309369935837

Canadian Centre for Occupational Health and Safety. (2014). Emergency planning. Retrieved from https://www.ccohs.ca/oshanswers/hsprograms/planning.html

The Canadian Centre for Emergency Preparedness provides tools and templates including a risk assessment checklist, a risk assessment spreadsheet, and an exercise evaluation form. They can be accessed at:

- Canadian Centre for Emergency Preparedness. (2010). Retrieved from http://ccep.thrillworks.com

The Canadian Centre for Occupational Health and Safety provides information, tools and resources on various health and safety topics including risk assessments and emergency planning:

- Canadian Centre for Occupational Health and Safety. (2019). CCOHS. Retrieved from www.ccohs.ca

The Center for Disease Control and Prevention (CDC) has resources on Pandemic Influenza including Ethical Guidelines in Pandemic Influenza, and Pandemic Influenza Preparedness Tools for Professionals:

- Centers for Disease Control and Prevention. (n.d.). Influenza (flu): Pandemic Influenza. Retrieved from http://www.cdc.gov/flu/pandemic/

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Critical Incident Stress Management (CISM) Services are available for nurses working within First Nations communities. Services include pre-incident education, health and safety recommendations to prevent or reduce the impact of traumatic events, timely assessments, and coordination of interventions for nurses involved in critical incidents:

- Government of Canada. (2008). Critical incident stress management. Retrieved from https://www.csc-scc.gc.ca/005/006/253-2-gl-eng.shtml
  Or call: Employee Assistance Services (EAS), Health Canada at 1-800-268-7708

Federal Emergency Management Agency (FEMA – U.S) provides a comprehensive emergency management guide for business and industry:

- Federal Emergency Management Agency. (1993). Emergency management guide for business and industry. Retrieved from http://www.fema.gov/pdf/business/guide/bizindst.pdf

Flu.Gov (the official U.S. Government website for Pandemic Influenza) has several resources and tools to help businesses prepare for and manage flu outbreaks:

Centre for Disease Control and Prevention. (n.d.). Influenza (flu). Retrieved from http://www.cdc.gov/flu/pandemic/

Centre for Disease Control and Prevention. (2006). Home health care services pandemic influenza planning checklist. Retrieved from https://www.cdc.gov/flu/pandemic-resources/pdf/healthcarechecklist.pdf

The Government of Alberta has a Best Practice Guideline for Workplace Health and Safety During Pandemic Influenza:

- Government of Alberta. (2010). Best practice guideline for workplace health and safety during pandemic influenza including employment standards rights and obligations. Retrieved from https://open.alberta.ca/publications/9750778568193

The National Fire Prevention Association (NFPA), U.S., provides standards and information on emergency management including NFPA standard 1600: Standard on Disaster/Emergency Management and Business Continuity FNIHCC Programs which includes a self-assessment tool (Annex C) for measurement with the standard:

- National Fire Protection Association. (2019). NFPA: The leading information and knowledge resource on fire, electrical and related hazards. Retrieved from www.nfpa.org

Public Safety Canada provides a guide to business continuity planning:

- Government of Canada. (2018). A guide to business continuity planning. Public Safety Canada. Retrieved from https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/bsnss-cntnt-plnnng/index-en.aspx

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Public Services Health and Safety Association (PSHSA), formerly the Ontario Safety Association for Community and Health Care (OSACH), provides tools, information, and training in developing health and safety FNIHCC Programs for community and health care workers including their Small Business Health and Safety FNIHCC Programs Handbook, which provides information on developing an emergency plan:

- Public Services Health & Safety Association. (n.d.). PSHSA Safety group site. Retrieved from www.osach.ca

WorkSafe BC provides a variety of tools and resources in developing an emergency plan including a brief video on emergency planning and guides on preparing an emergency response plan:

- WorkSafeBC. (2019). WorkSafeBC. Retrieved from www.worksafebc.com

The World Health Organization (WHO) provides information and resources in planning for health outbreaks and pandemics:

- World Health Organization (WHO). (2019). Retrieved from http://www.who.int/en/

Approved By: CNolan	Date: 14/04/2023
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date: 14/04/2023
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

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Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Facility Maintenance		Operations	H3C 02-007-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
05/01/2024	05/01/2026	New	3
APPLIES TO:			
All Home, Community, and Continuing Care Team Members			

1. BACKGROUND:

Facility maintenance is the responsibility of the Department of Community and Government Services (CGS) as outlined in *A Quick Guide to Facility Management Services provided by CGS.*

CGS provides demand/routine maintenance, preventative maintenance, and discretionary maintenance services of facility systems.

The proper maintenance of healthcare facilities ensures that healthcare team members and residents have a safe and comfortable environment in which to deliver and receive services.

HCCC provides the following policy to ensure appropriate maintenance of their facilities.

2. POLICY:

2.1. All team members shall report any damage to doors, walls, floors, windows, etc., and malfunctioning of facility systems to their supervisor.

2.2. When appropriate, the supervisor will report the damage to the Facility and/or Nurse Manager or delegate who will then submit a service request to CGS via the Asset Planner website (or other means as dictated by CGS).

2.2.1. CGS will prioritize the request and assign it to the appropriate person.

2.2.2. In the event that the Facility Manager and/or Nurse Manager has questions about facility maintenance that are not addressed in the *Quick Guide to Facility Maintenance Services Provided by CGS,* they may contact CGS Facilities Management services directly.

2.2.3. In the event that the facility has a Facility Maintainer position, the Nurse Manager and/or Facility Manager may contact CGS Facilities Management if the required maintenance is out of scope for the Facility Maintainer.

2.3. The Nurse Manager shall consult with the Territorial Home and Continuing Care team, when larger projects for improvement of facility infrastructure are being considered. An email is to be sent to LTC@gov.nu.ca that outlines the need and/or requirements.

2.3.1. For further information regarding CGS responsibilities for facility maintenance, the Nurse Manager should consult *A Quick Guide to Facility Management Services Provided by CGS.*

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2.4. The Facility and/or Nurse Manager shall ensure that a team member immediately remove any snow or ice which may have accumulated outside of doors or on the steps and/or ramps attached to the facility.

3. PRINCIPLES:

3.1. Maintaining facility infrastructure keeps the facility operational and prevents larger expenditures required for large repairs.

3.2. Maintaining facility systems ensures the health and safety of team members and residents.

3.3. Team members tend to be more productive when they work in an environment that is safe and clean.

4. DEFINITIONS:

Infrastructure: the basic systems within the facility, e.g., physical infrastructure such as walls and floors, and the technical infrastructure of systems – heat, light, and power.

Ongoing Lifecycle Projects: a fund administered by the Capital Planner who requests submissions each fall. The funding supports improvements to health facilities costing greater than $10,000.

5. CONTACT INFORMATION:

Iqaluit:
Facilities Manager
Box1000–Station630
Iqaluit, NU
X0A0H0
Phone:(867)975-7126
24/7:(867)979-5650
Iqaluitworkorders@gov.nu.ca

Qikiqtaaluk Region:
Facilities Manager
Aqsarniit Building
Pond Inlet, NU
X0A0S0
Phone:(867)899-7321
Fax:(867)899-7329
Qikiqtaalukworkorders@gov.nu.ca

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Kivalliq Region:
Facilities Manager
P.O. Box 490
Rankin Inlet, NU
X0C0G0
Phone:(867)645-8154
Fax:(867)645-8197

Kitikmeot Region:

Facilities Manager
15Omingmak Street
Cambridge Bay, NU
X0B0C0
Phone:(867)983-4153
Fax:(867)983-4123

6. REFERENCES:

A Quick Guide to Facility Management Services Provided by CGS December 2022.

Approved By:	Date: 5 January 2024
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date: 5 January 2024
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

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Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
A Quick Guide to Facility Management Services Provided by CGS		Home, Community, and Continuing Care	H3C 02-007-01
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
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APPLIES TO:			
All Home, Community, and Continuing Care Team Members			

Building Nunavut Together
Nunavuliuqatigiingniq
Bâtir le Nunavut ensemble

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A QUICK GUIDE TO FACILITY MANAGEMENT SERVICES PROVIDED BY CGS

CGS is responsible for the provision of Facility Management services under its Facility Management Program to ensure corporate and regulatory compliance and proper, cost-effective operation of a facility contributing to an optimal, safe environment for occupants to function.

Community and Government Services
Facility Management Division
P.O. Box 1000 – Station 630
Iqaluit, NU X0A 0H0
Phone: (867) 975-7100

Update:
05 December 2022

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A Quick Guide to Facility Management Services provided by Community and Government Services (CGS)

Facility Management Division

The Facility Management Office of CGS operates and maintains facilities funded under the Facility Management Program on behalf of the Government of Nunavut (GN). Services provided include preventive maintenance, repairs services and the operation of building mechanical and electrical systems.

There are a number of different arrangements for providing Facility Management services. This can cause confusion for Clients about the responsibility for payment for maintenance and the degree of communication and consultation required for the work. The purpose of this document is to provide clarification and reduce potential misunderstandings with respect to the Facility Management Program

This document is intended to provide a better understanding of the operation and maintenance services available from CGS. It outlines the various financial arrangements for the maintenance of government assets and sets the parameters for service agreements and cost recovery.

WHAT ARE OPERATIONS & MAINTENANCE (O&M)?

O&M is a term that encompasses both the operations and maintenance of an asset. "Operations and Maintenance Expenditures are normally of a reoccurring or continuing nature, which are required for the delivery of Government programs or services, and which do not increase the number, value, original specifications, or life expectancy of assets owned or operated by the Government" (FAM 703-1 p.1, September 2009).

Operations - A day-to-day function of the program and the building. In addition to the program activity delivered from the facility, operations include facility expenses such as utilities and custodial services. The role of CGS in terms of facility operations differs from facility to facility but, in general includes payment for utilities in GN owned facilities and the provision of custodial services in GN general office space.

Maintenance - Maintenance is the ongoing process of keeping up the performance of facility systems, subsystems and components. The goal is increased efficiency, reliability, and safety and ensures the facility, its subsystems and components reach their full anticipated life. All maintenance services provided by CGS are based on the Maintenance Management System (MMS) and its standards.

WHAT IS CAPITAL?

Tangible Capital Assets – "Tangible Capital Assets (TCAs) are non-financial assets whose useful life exceed one fiscal year and are intended to be used on an ongoing basis for delivering government services. They may include such diverse items as buildings, vehicles, and equipment, aircraft and computer hardware and software systems. Tangible capital assets with a cost of less than $50,000 (fifty thousand dollars) are fully expensed in the year of acquisition" (Public Accounts p. 13, 2011). The total cost of a Capital Project includes the cost of planning, design, construction, reconstruction, acquisition, or installation of a Tangible Capital Asset. The $50,000 threshold is for accounting purposes only and does not imply that an item must have a value that exceeds $50,000 to be considered a capital acquisition.

Capital Expenditures – In general, capital expenditures include the "expenditure to acquire, construct, develop or prepare for use tangible capital assets [and] the cost of betterments made to existing capital assets" (FAM 703-1 p.2, September 2009).

Betterments – "A betterment is a cost incurred to enhance the service potential of a tangible capital asset. In general, [..] service potential may be enhanced when there is an increase in the previously assessed physical output or service capacity, where associated operating costs are lowered, the useful life of the property is extended or the quality of the output is improved" (PS 3150).

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TYPES OF MAINTENANCE SERVICES

Maintenance Services can be divided into three types of activities:

Preventive Maintenance (PM) Service: Preventive Maintenance accomplishes two separate functions: 1) The day-to-day checks, the legislative and code-required monitoring, testing, servicing and inspection of facility systems and components; and 2) the scheduled inspection, servicing and adjustment of systems and components to ensure they are performing as intended and reach their planned service life.

Repair Service: Repair Services include fixing or replacing broken, worn out or faulty facility components. Repairs may be required to address normal wear and tear, unanticipated breakdown, or to correct minor repairs resulting from isolated incidents of vandalism, willful damage or neglect. The intention is to replace components with the same or an equivalent component.

Discretionary Maintenance Service: This includes replacing wear-prone materials such as flooring and the periodic painting of walls. This also includes the replacement of system components at the end of their service life. ***The necessity for this is determined by the CGS Facility Manager or Maintenance Coordinator and is generally based on a predetermined schedule, priority and budget availability. Work can be accelerated with Client funding.***

WHAT IS A WORKPLAN?

A work plan is created annually for each facility. A work plan details the tasks required to maintain the assets to meet current applicable codes and regulations and to CGS standards. It identifies and estimates the costs for preventive maintenance, repair service and discretionary maintenance tasks. Estimates are based on historical costs. As part of the Preventive Maintenance process, CGS collects a variety of information related to facility life-cycle. Facilities, systems, subsystems and components that are inspected on a scheduled basis by CGS and that are identified as approaching the end of their economic or normal service life will be identified on the work plan so that the Client is aware of any items that may require budgets outside of the CGS Vote 01 Funding.

SERVICES COVERED UNDER CGS VOTE 01 FUNDING

Preventive Maintenance and Repair Service is covered under CGS Vote 01 Funding. In general, this funding is used to operate and maintain facilities and systems at a level of service and for a lifespan expected at the time the facility was originally designed and constructed. Typical examples include but are not limited to:

- Performing the daily checks and ongoing adjustments of a heating system as required by legislation and regulations.
- Changing air filters in a ventilation system.
- Performing monthly tests of a fire alarm system and performing or contracting the annual certification of the fire alarm system. This also includes the cost of "Central Monitoring" and associated telephone charges.
- Replacing a defective heat detector on a fire alarm system.
- Responding to mechanical alarms.
- Conducting scheduled maintenance and servicing of assemblies and components as outlined in the CGS Maintenance Management System.
- Painting walls and ceilings, replacing carpet or other flooring, on a limited basis, when associated with another repair service.
- Repairing a damaged door, window, or the hardware on this type of component.
- Supplying and installing light bulbs and tubes.
- Snow removal from defined access roads and parking lots

SERVICES NOT COVERED UNDER CGS VOTE 01 FUNDING

Life Cycle Renewal and Betterments are not covered under CGS Vote 01 Funding. This includes any work performed to upgrade, modernize, improve, renovate, regenerate, change the intended purpose or extend its original life of a facility or its sub-systems. Depending on the specific scope of work identified, this may be considered either Capital or Operations and Maintenance. An item categorized as O&M may not be funded under the CGS Vote 01 Operations and Maintenance Fund. Some items identified under Operations and Maintenance is not included in the CGS appropriation. Typical examples include but are not limited to:

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- Painting exterior walls, interior walls, and ceilings, replacing carpet or other flooring.
- Maintaining or repairing client-specific program equipment, such as furniture, medical equipment, basketball and volleyball nets, playground equipment etc.
- Installing new materials, equipment or furniture purchased by the Client.
- Repairing facilities, systems, subsystems and components that are beyond their economic or normal service life. This includes replacing entire systems where parts are no longer available due to obsolescence or changing technology.
- Replacing roofs, siding and foundation systems, or renovating these systems to change function, appearance or performance.
- Upgrades required to address changes in codes or interpretation of current codes.
- Changing all locks or re-keying an entire building locking system for security or key control.
- Boiler and furnace burner conversions to change the type of fuel used.
- Installing and maintaining surveillance cameras or intrusion alarm systems.
- Remediation or removal of asbestos, lead or other hazardous materials or cleaning up spilled hazardous or dangerous liquids in Client program buildings.
- Performing minor renovations, for example, moving a door to a different location, or tenant improvements such as adding partitions or constructing offices to meet changing program needs.
- Installing larger tanks (fuel, water, and sewer) to meet building use or program changes.
- Purchasing, repairing or installing blinds and other window coverings.
- Handling medical waste including loading and cleaning medical waste incinerators.
- Repairing damage caused by vandalism or occupants of the facilities.
- Removing or covering graffiti on a building.
- Repairing systems not properly installed or commissioned during construction.

Please note that these are examples and are in no way intended to be all encompassing. It should also be noted that these examples are a mixture of items that would be funded by the client either through the program's O&M funding or through capital funding (as described in the following Notes).

Notes:

Please note that these are examples and are in no way intended to be all encompassing. It should also be noted that these examples are a mixture of items that would be funded by the client either through the program's operation and maintenance funding or through capital funding (as described in the following Notes).

Notes:

1. For Betterments and Life Cycle Renewal Items, such as roof replacement, renovations or code-mandated replacement of major components, Client Capital funding should be identified through the normal capital planning process. The work should be implemented through the GN project management process.
2. Maintenance work that is not included in the CGS appropriation can be completed by the Facility Management Office of CGS with Delegated Authority for either O&M (Vote 1). Requests to clients for funding are submitted before the work is done, so that the client has the opportunity to approve the work and secure funding.

FINANCIAL ARRANGEMENTS

CGS uses a number of business or financial arrangements for carrying out maintenance work for its clients:

CGS Vote 1 Funding: The CGS appropriation includes base funding to carry out Preventive Maintenance, Repair Service and Discretionary Maintenance work, as outlined in the MMS Standards, on facilities belonging to Vote 1 Clients. Vote 1 Clients are not charged for normal CGS Vote 1 activities. An annual work-plan is created and reviewed with the client to outline preventive maintenance, repair service and planned discretionary maintenance items.

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Chargeback and Service Agreements: Some departments or Territorial Corporations/related Parties are funded to provide their own maintenance activities. When a client of this nature chooses to have CGS carry out the work for them, written agreements are required to define responsibilities. Typically, this is in the form of a Vote 4/5 Service Agreement or Memorandum of Understanding (MOU). A signed agreement must be in place for all clients who fund their own maintenance work. Typical Agreements include:

- **Full-Service Agreement:** CGS creates an annual work-plan based on MMS Standards, discusses the work plan with the client, makes any requested changes or adjustments to meet the clients identified budget and implements the plan. With full service, CGS assumes the responsibility to ensure the building systems and components are functioning. CGS automatically includes the client's assets in any contract for specialty services (such as fire alarm testing, generator load testing, elevator servicing, etc.). Cost recovery is outlined in the MOU or Service Agreement.

- **Specific Services/Limited-Service Agreement:** Clients request that CGS provide only specific services, such as boiler maintenance or testing of fire alarms, or specialized repair work. Clients provide for other maintenance services by other means.

In some instances, clients want a wide range of services but on a very limited basis. Although CGS tries to be flexible in meeting its client's needs, limited-service agreements are not recommended. In some cases, for example, where services are so limited that proper functioning of the building is at risk, or where administrative demands are excessive for the amount of work done, CGS may recommend not the use of this type of arrangement.

Cost recovery includes the following:

- Own-forces labor – actual number of hours worked at approved labor rates (approved by FMB).
- Materials – actual cost of purchased materials
- Contracted services – actual costs billed by third party

VANDALISM, WILLFUL DAMAGE AND NEGLECT

The Facility Management Program is funded to deal with minor repairs due to acts of vandalism, willful damage and neglect that may be required. The Facility Management Program is not funded for work that arises from incidents of a re-occurring nature or for major repair work resulting from this type of behavior. The Facility Management Office will inform the Client Designate of work arising from such behavior that is not funded by the Facility Management Program.
Work will be actioned by the Facility Management Office once authorization in the form of an approved budget is received from the Client. Due to the nature of the incident, if deemed necessary, the Facility Management Office will respond under its incident management procedures to complete the work and subsequently resolve budgeting issues as may be required.

MANAGEMENT OF HAZARDOUS WASTE

CGS staff and contracted maintenance service providers do not package, handle or transport program-generated material that could be classified as toxic, hazardous, explosive or biological waste. This includes medical waste, waste from school science labs and shops, and waste from college or other program laboratories. When ordered by WSCC or other regulatory agencies or requested by the client, the removal of building materials determined to be hazardous will be done using specialty contractors on a chargeback basis. CGS will be responsible for the removal of small amounts of material necessary to complete minor repairs. CGS will inspect buildings with identified hazardous materials on an annual basis to ensure the facility is safe to occupy.

MAINTAINING CLIENT PROGRAM SPECIALITY EQUIPMENT

Clients may have equipment and furnishings in their buildings and facilities that are specific to their program. As a rule, CGS will do very minor repairs to office furniture and repairs to permanently installed building systems such as school clock and bell systems or nurse call systems or intercom systems. Typically, the components of these systems become obsolete very quickly, as do the systems themselves, resulting in replacement of entire systems when repairs are needed. Maintenance, operation and repair of other specialty program equipment is not funded by CGS. This includes program items such as medical equipment. CGS is responsible to ensure that the program equipment has a suitable supply of utilities (water, electricity, heat) for the equipment to operate. Even under a chargeback arrangement, CGS staff and contracted maintenance service providers will not operate, repair, or service medical equipment that may have an impact on the health of people. Maintaining medical equipment is a specialty service. CGS staff is not trained to provide such service and the department is not funded for this work. CGS may, however, assist by establishing a service contract with a specialty firm on a chargeback basis.

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ALARM RESPONSE PROCEDURES

Alarm systems are installed in GN buildings for a variety of functions as outlined in the table below. Most of these alarms require someone to respond to the alarm situation. The decision as to who should respond to the alarms depends on the type of alarm, who is responsible for the facility, and the qualifications of the people in the community.

Listed below are the various types of alarms, and the agency that has the primary responsibility to respond to the alarms. It is up to the primary responder to determine who should provide the back-up services when the primary responder is not available. Although the Facility Management Office does not provide initial Intrusion Alarm response, if repairs are necessary to secure or repair the building, the Local Maintenance Service Provider should be contacted.

Type of Facility	Type of Alarm			
	Intrusion	Panic	Fire	Mechanical
Health Center	H&SS	H&SS	Fire Department	Local Maintenance Service Provider
GN General Office Space	CGS	N/A		
School	Education	N/A		
Wildlife Office	Environment	N/A		

GRAY AREAS – RESPONSIBILITIES OR FUNCTIONS

Obviously there will always be some gray areas, but it is important that CGS clients understand that their requirements are a priority, and that their requests will be given proper consideration. CGS strives to provide the same level of maintenance service to clients regardless of the Region. If there are questions about specific maintenance items, ask the CGS Facility Manager for clarification.

CONTACT INFORMATION AND REPORTING

Facility Management services are provided through the Community and Government Services regional offices. All GN facility related concerns should be reported to the respective regional office. Note that the process for accessing Facility Management Program services may vary from region to region based on the current organizational structure and the specific service arrangement for a particular community.

Facility Management services are now being requested through an online "Service Request Client" system known as Asset Planner **(see instructions below)**. This site is located at the following URL: https://www.assetplanner.com . If you do not have an account or have forgotten your account password, please email assetplanner@gov.nu.ca and we can help you with your concerns or comments.

With respect to all regions, the following contact information can only be used during regular business hours.

Iqaluit
Facilities Manager
Box 1000 – Station 630
Iqaluit, NU
X0A 0H0
Phone: (867) 975-7126
24/7: (867) 979-5650

Qikiqtaaluk Region
Facilities Manager
Aqsarniit Building
Pond Inlet, NU
X0A 0S0
Phone: (867) 899-7321
Fax: (867) 899-7329

Kivalliq Region
Facilities Manager
Box 490
Rankin Inlet, NU
X0C 0G0
Phone: (867) 645-8154
Fax: (867) 645-8197

Kitikmeot
Facilities Manager
15 Omingmak Street
Cambridge Bay, NU
X0B 0C0
Phone: (867) 983-4153
Fax: (867) 983-4123

iqaluitworkorders@gov.nu.ca qikiqtaalukworkorders@gov.nu.ca

Facility End Users should make a point of understanding the process for accessing Facility Management services and ensuring that normal, local, and emergency contact information for facility related concerns is made available to all building occupants. All work requests should be submitted using the online "Service Request Client" system as we are phasing out the old Work Order Request Form and email. Emergencies should be reported directly to the local Facility Maintainer and then the regional office.

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AssetPlanner™ Service Request Module

Client User Quick Start Guide

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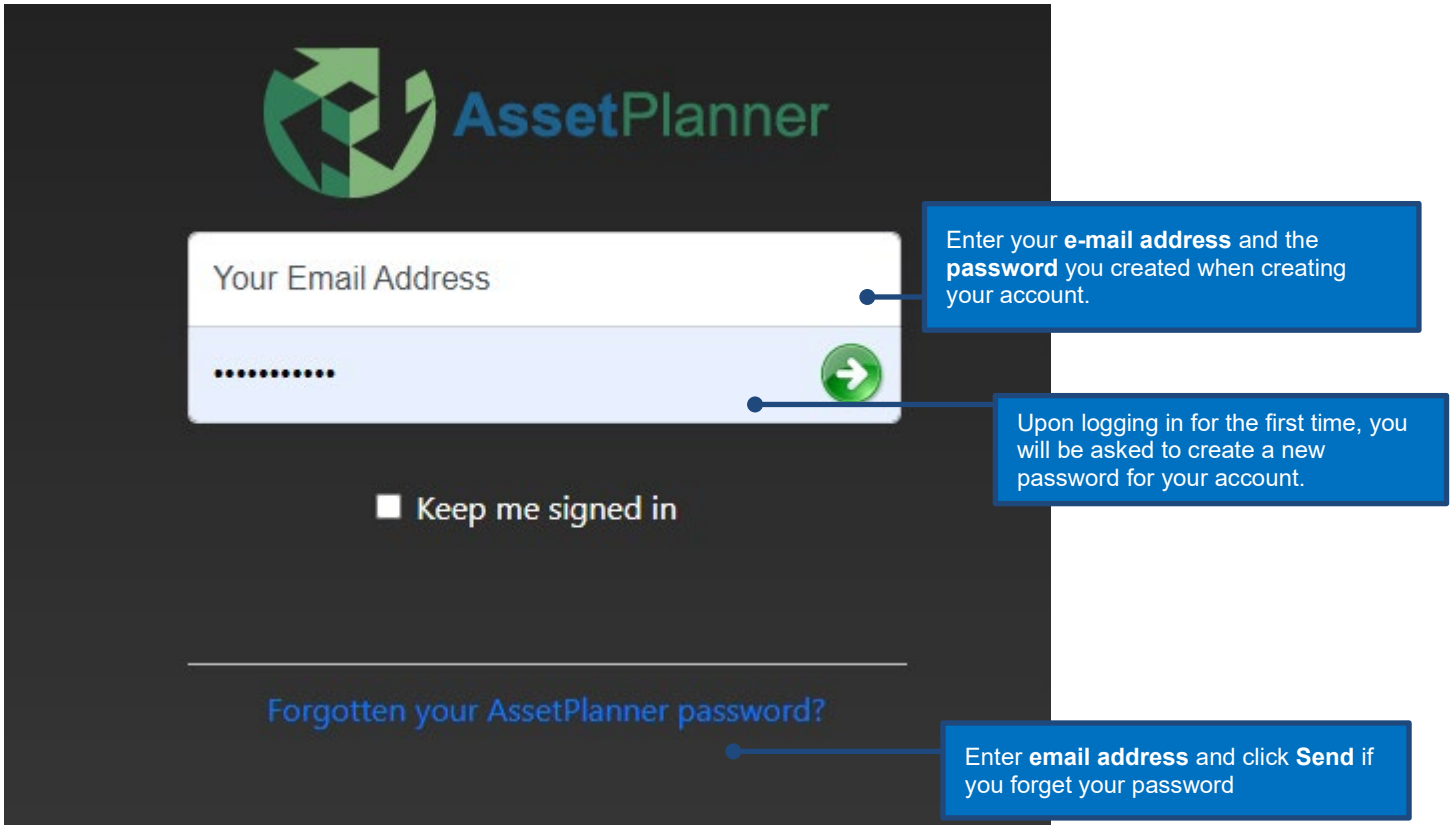
Web Link & Login

www.assetplanner.com



Note: To setup a new account please email assetplanner@gov.nu.ca and cc your immediate supervisor.

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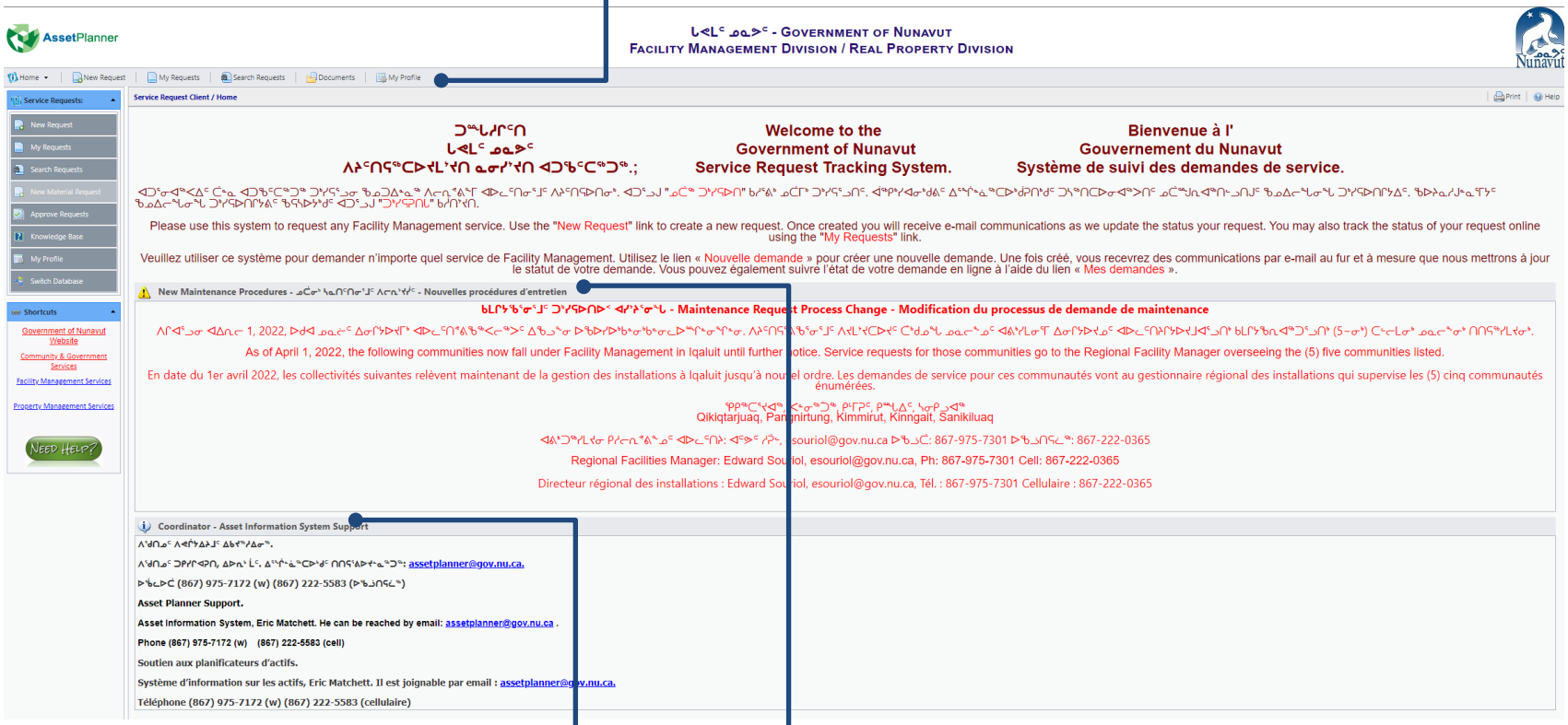
Home Screen Layout

The **Menu Bar** provides links find and create request as well as create triggers and review the SR templates.



These sections show alerts, updates, and announcements that may arise.

Create A New Service Request (page 1)

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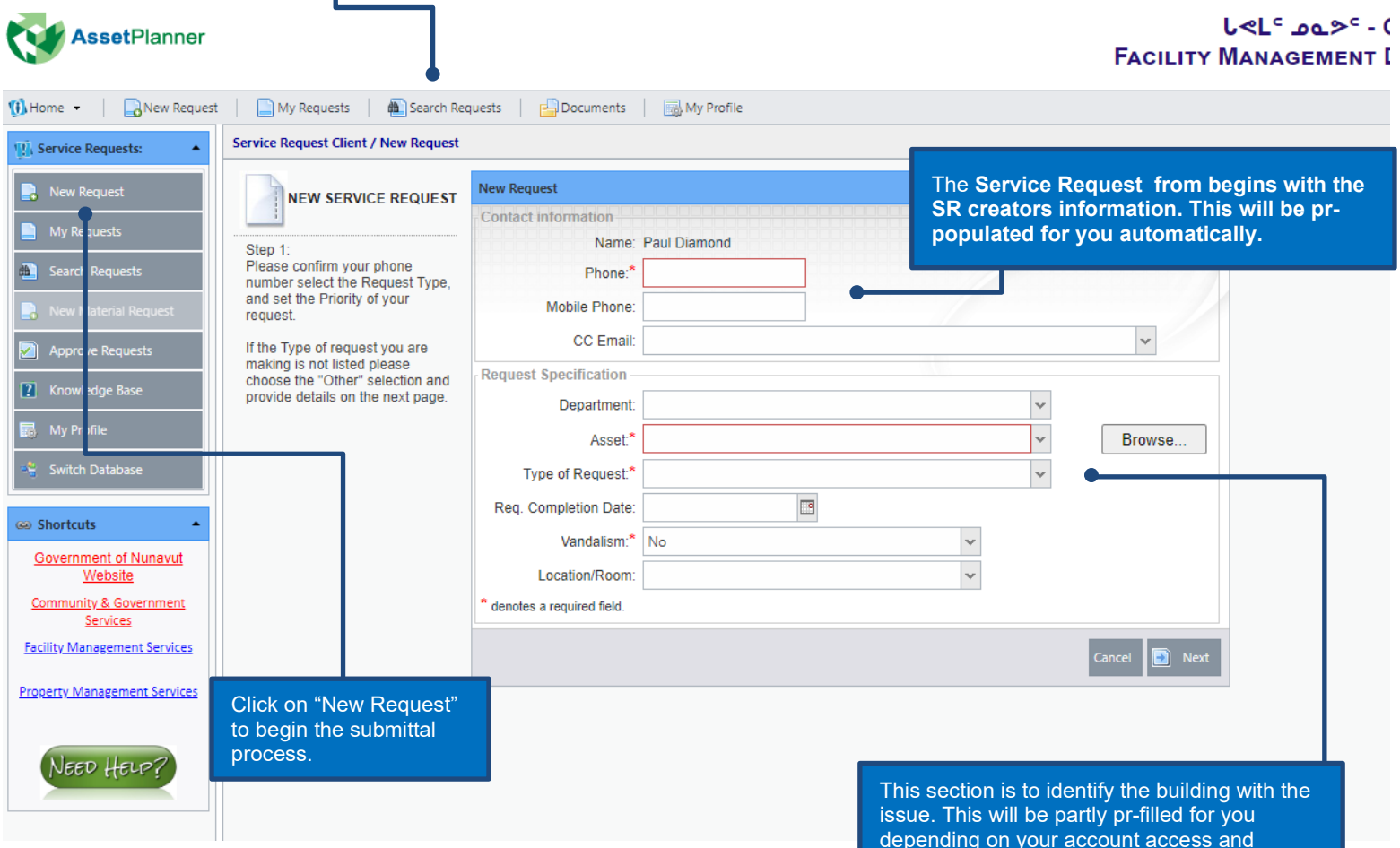
You can also use these tabs to create an SR or search for a pre-existing SR



The **Service Request from begins with the SR creators information. This will be pr-populated for you automatically.**

Click on "New Request" to begin the submittal process.

This section is to identify the building with the issue. This will be partly pr-filled for you depending on your account access and location. The other information must be completed by the user before proceeding.

Create A New Service Request (page 2)

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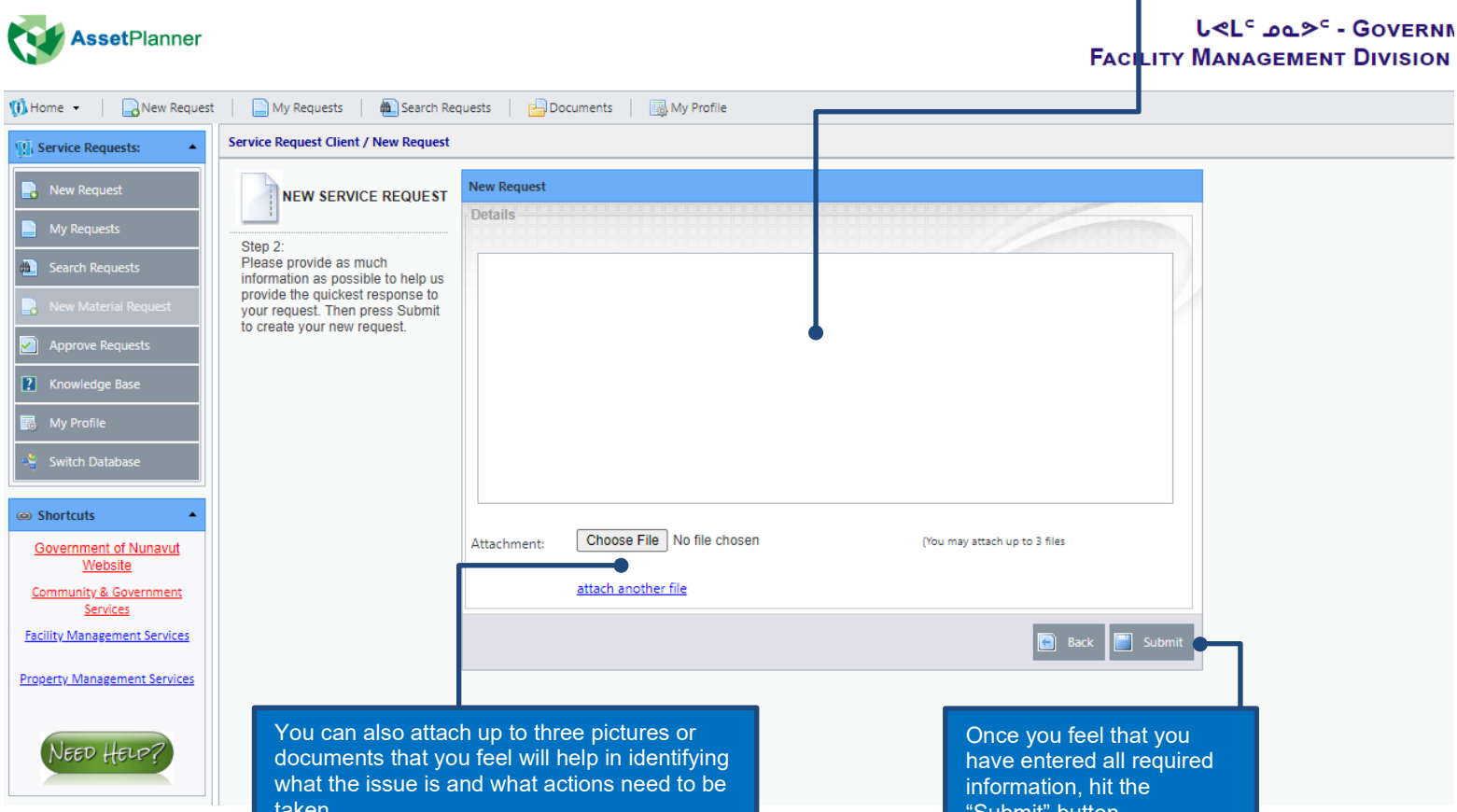
The section is where you will describe the reason for the service request in as much detail as possible.

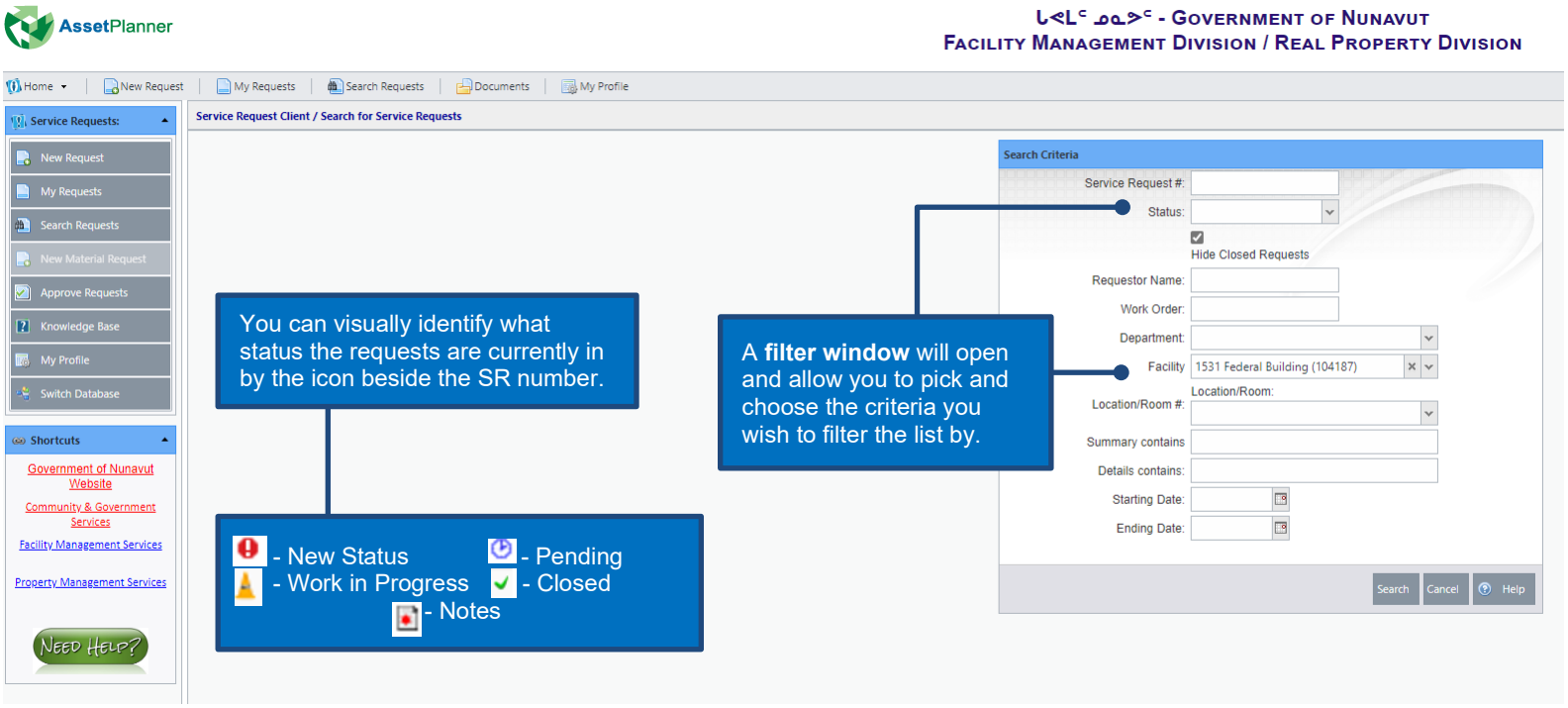


You can also attach up to three pictures or documents that you feel will help in identifying what the issue is and what actions need to be taken.

Once you feel that you have entered all required information, hit the “Submit” button.

Return to TOC

Search Service Requests



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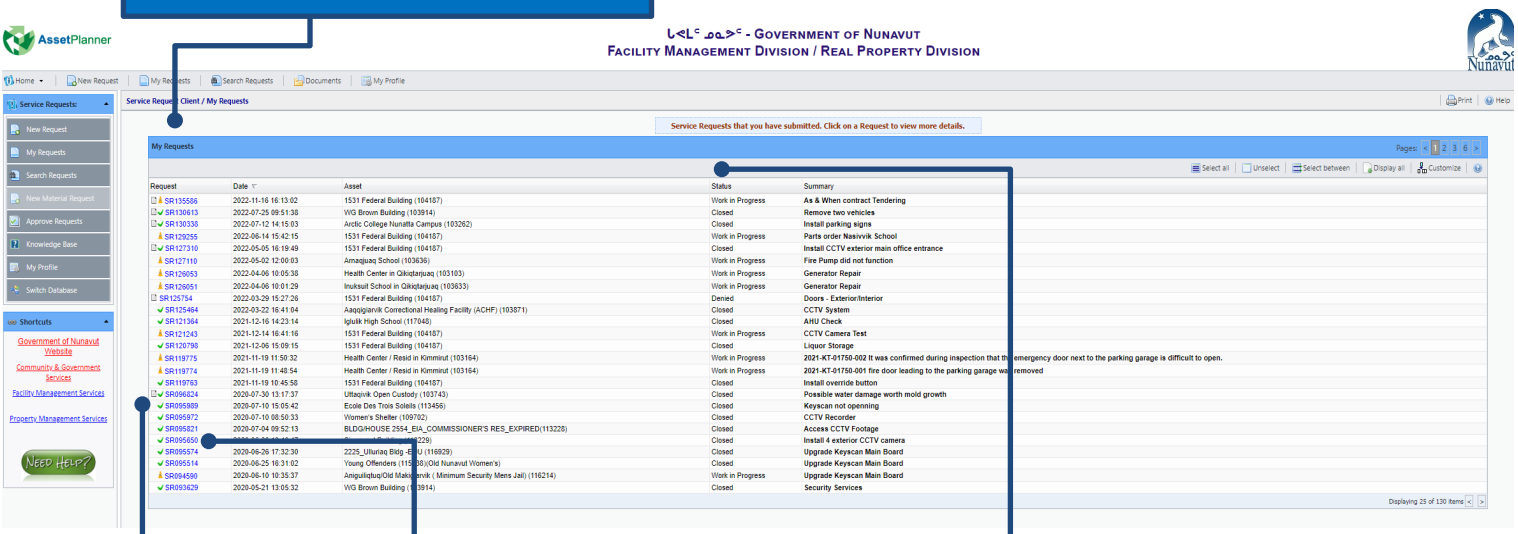
List Service Requests

The list of service requests is shown based on your account settings. You can see all requests you have submitted for a particular facility if you don't mind. This allows you to check on the request's status and send messages to ask for updates or to provide additional information.

This list shows all service requests you have



You can open and view any service request by clicking on the SR number in blue.

This column shows the status of each request.

You can visually identify what status the requests are currently in by the icon beside the SR number.

- New Status
- Pending
- Work in Progress
- Closed
- Notes

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Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Client Safety		Operations	H3C 02-008-00.
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
16/11/2023	16/11/2026	Policy 2.44	3
APPLIES TO:			
All Home, Community, and Continuing Care Team Members			

1. BACKGROUND:

The Home, Community, and Continuing Care Program (HCCC) is committed to providing an environment that promotes the safety, security, and quality of life of clients and families.

HCCC recognizes that timely notification, review, and management of harmful incidents are key activities to reducing preventable harm and improving quality of care for their clients.

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

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

In order to advance a client safety culture, all HCCC staff have an essential role and duty to engage clients and their families in all aspects of care. This requires understanding, respect for and sensitivity to diversity in culture, age, cognition, gender, sexual orientation, life experience, religion, or ethnicity.

2. POLICY:

2.1. All staff shall follow CHN Policy 05-034-00 *Client Safety Event – Incident Reporting and Immediate Management* and report all events affecting client safety as the policy requires.

2.1.1. All staff shall be mindful of potential risks to client safety and immediately report their concerns to their supervisor.

2.2. All staff with concerns about nursing professional practice or professional conduct shall report their concerns to their immediate supervisor as per CHN Policy 05-033-00 *Managing Nursing Professional Practice and Professional Conduct.*

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2.3. Healthcare Providers (HCPs) shall follow safe medication practices as per CHN Policy 09-004-00 *Medication Administration – Nursing Practice* and the Nunavut Formulary 2021 and medication reconciliation as per H3C 03-003-00 *Medication Reconciliation.*

2.4. All staff shall follow best practice when providing client care, including fall risk prevention.

2.4.1. When adjusting care due to staff shortages or other challenges, all staff must comply with the minimum requirements for safety.

3. Principles:

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

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

3.3. Client safety is the cornerstone of high-quality healthcare.

4. Definitions:

Client Safety Culture: an integrated pattern of individual and organizational actions and behaviour based on shared beliefs and values that enables individuals and organizations to continuously seek to minimize the potential for client harm which may result from the processes of care delivery.

Healthcare Providers: Supervisors of Home and Community Care, Nurse Managers of Continuing Care, and Licensed Practical Nurses.

5. Related Policies and Legislation:

CHN Policy 05-033-00 Managing Nursing Practice and Professional Conduct

CHN Policy 05-034-00 Client Safety Event - Incident Reporting and Immediate Management

CHN Policy 05-035-00 Client Safety Event Disclosure Policy

CHN Policy 05-036-00 Client Safety Event – Screening and Conducting Incident Analysis

H3C 03-003-00 Medication Reconciliation

H3C 03-002-00 Client Health Assessment and Reassessment

Workers Safety and Compensation Commission Act and the Safety Act for Nunavut

6. References:

Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services. (2008, April). *Patient Safety and Quality: An Evidence-Based Handbook for Nurses.* Retrieved from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://core.ac.uk/download/pdf/71353723.pdf

Canadian Patient Safety Institute. (2020, March). *The Safety Competencies: Enhancing Patient Safety Across the Health Professions. 2nd Edition.* Retrieved from https://www.healthcareexcellence.ca/en/resources/safety-competencies-framework/

Lang, A. M. (2009, May). *State of the Knowledge Regardifng Safety in Home Care in Canada: An Environmental Scan.* Retrieved from Canadian Patient Safety Institute: chrome-

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extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.patientsafetyinstitute.ca/en/toolsResources/Research/commissionedResearch/SafetyinHomeCare/Documents/Lang/Full%20report%20-%20State%20of%20the%20Knowledge%20Regarding%20Safety%20in%20Home%20C

Approved By: CNolan	Date: 16 Nov 2023
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date: 16 November 2023
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

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Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Reporting Suspected Abuse, Neglect, or Exploitation		Operations	H3C 02-009-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
16/11/2023	16/11/2026	Policy 2.49	4
APPLIES TO:			
Regulated and Unregulated Healthcare Providers and Healthcare Workers			

1. BACKGROUND:

Home, Community, and Continuing Care Program (HCCC) is committed to protecting clients in their care from any form of abuse or neglect by any individual(s) involved in their care. HCCC has zero tolerance for any abuse or neglect by staff members.

HCCC provides the following policy and guideline for reporting suspected abuse, neglect, or exploitation.

2. POLICY:

1. Suspected abuse of a minor is detailed in CHN policy 06-016-00 and all HCCC team members are required to follow the procedure laid out in that policy.
2. Suspected abuse by a staff member requires that an incident report be filed with the immediate supervisor as this is a Human Resources (HR) matter.
    a. Reporting the incident to the RCMP requires the consent of the client or their guardian.
    b. Reporting the incident to HR does **not** require consent of the client or their guardian.

2.1. All staff shall immediately report any incidence of suspected abuse, neglect, or exploitation to their immediate supervisor. In the event that it is the immediate supervisor who is the abuser, staff shall immediately report the incident to the supervisor's immediate supervisor.

2.1.1. The supervisor shall report the incident to their supervising Director and the Territorial Home and Continuing Care Coordinator.

2.1.1.1. If the incident involves a client under an order of guardianship, the Director shall contact the Office of the Public Guardian for advice and direction.

2.1.1.2. If the incident involves a minor under the age of 19, the supervisor shall contact the local Community Social Services Worker (CSSW) on call.

2.1.1.3. Incidents involving staff members must also be reported to the regional Manager of Human Resources (Health).

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2.1.1.4. The regional Manager of Human Resources will provide advice and direction for investigation of suspected abuse or neglect by a staff member.

2.2. Staff reporting the incident must complete an incident report if the incident involves a staff member. The incident report will be made using the incident reporting module of Meditech when possible, or in hard copy when Meditech is not available.

2.3. Consent must be obtained from the client before reporting suspected abuse of capable adults to anyone other than the staff member's supervisor.

2.4. Consent must be obtained from a capable client before reporting suspected abuse to the RCMP or other law enforcement agency, except in cases of mandatory reporting.

2.5. In the event that there is suspected abuse of a minor, staff must follow CHN policy 06-016-00 Child Welfare.

2.6. In the event that an adult client has a guardian, suspect abuse must be reported to that individual.

2.7. Consent is not necessary if reporting suspected abuse of a client by a staff member as this is a Human Resources/Job performance matter.

3. PRINCIPLES:

3.1. "Criminal activity by a public servant, whether within or outside the workplace, is a violation of (the Code of Ethics) … and may result in disciplinary action in accordance with the *Public Service Act* and any applicable collective agreement." (Government of Nunavut, 2015)

3.2. "Nurses refrain from judging, labelling, stigmatizing and humiliating behaviours toward persons receiving care or toward other health-care providers, students and each other." "Nurses do not engage in any form of lying, punishment, or torture or any form of unusual treatment or action that is inhumane or degrading. They refuse to be complicit in such behaviours. They intervene, and they report such behaviours if observed or if reasonable grounds exist to suspect their occurrence." (Canadian Nurses Association, 2017)

3.3. Licensed Practical Nurses "act promptly and appropriately in response to harmful conditions and situations, including disclosing safety issues to appropriate authorities." Licensed Practical Nurses "report to appropriate authorities and take other action in a timely manner to ensure a client's safety and quality of care when unethical or incompetent care is suspected." (College Of Licensed Practical Nurses of Alberta, 2013)

4. DEFINITIONS:

Assault: any contact without consent, or a physically threatening gesture towards a person such as lunging at them causing them to think they will be hit even if they are not. These actions can result in a sentence of up to 5 years in prison or up to 3 years of probation.

Emotional/Psychological Abuse: the infliction of anguish, pain, or distress through verbal or non-verbal acts:

- Verbal assaults including yelling, swearing, threats, derogatory comments, humiliation, and intimidation.
- Denial of rights.

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- Social isolation includes giving the 'silent treatment,' treating the client like a child/infant, and isolation from family/friends/regular activities.

Financial Abuse: misuse of client's funds, property or assets, fraud, forgery, and extortion.

Physical Abuse: use of physical force that may result in bodily injury, physical pain, or impairment.

- Slapping, punching, pushing, striking, shoving, shaking, choking, kicking, burning or other rough handling.
- Force-feeding.
- Inappropriate use of medication.
- Forced confinement.

Sexual Abuse: molestation, sexual assault, and sexual harassment.

Exploitation: the act of taking advantage of someone in order to profit from them or otherwise benefit oneself.

Neglect: abandonment of the client by a caregiver and failure or refusal to provide life necessities including withholding food/water, personal care, or healthcare services, etc.

5. GUIDELINE: SYMPTOMS OF ABUSE:

5.1. Physical Abuse, Neglect or Emotional Abuse may include:

- Depression, fear, withdrawal, anxiety, or passivity.
- Fear of family members, friends, or caregivers.
- Unexplained physical injuries – bruises, black eyes, welts, rope marks, cuts, punctures, burns, sprains, dislocations, internal injuries, etc.
- Dehydration or lack of food.
- Missing or broken eyeglasses, hearing aids or dentures.
- Malnourishment, being run-down.
- Poor hygiene, sores, or bed sores.
- Over-sedation.
- Sudden changes in behaviour.
- A caregiver that refuses to let visitors see the person alone.

5.2. Sexual Abuse may include:

- Bruises around the breasts or genitals.
- A sexually transmitted infection that cannot be explained.
- Bleeding from the vagina or anus that cannot be explained.
- Torn or stained underwear.

5.3. Financial Abuse may include:

- Money or valuable personal items missing without explanation.
- Unexplained lack of cash on hand.
- Going without food, clothing, or other necessities that the older person should be able to afford.
- Failure to pay rent or bills.
- Sale or transfer of the older person's property, with the older person confused about the reason.

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- A savings account drained without explanation.
- Sudden changes in a will.
- Unusual withdrawals from a bank account.
- Documents drawn-up and signed that the older person does not understand.

6. References:

Alberta College of Paramedics. (2019, December). *Code of Ethics.* Retrieved from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://abparamedics.com/wp-content/uploads/2020/01/Paramedics-Code-of-Ethics.pdf

Canadian Centre for Elder Law. (2011, July). *A Practical Guide to Elder Abuse and Neglect Law in Canada.* Retrieved from http://www.bcli.org/ccel: chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.bcli.org/sites/default/files/Practical_Guide_English_Rev_JULY_2011.pdf

Canadian Nurses Association. (2017). *Code of Ethics.* Retrieved from https://www.cna-aiic.ca/en/nursing/regulated-nursing-in-canada/nursing-ethics

College Of Licensed Practical Nurses of Alberta. (2013). *Code of Ethics for Licensed Practical Nurses in Canada.* Retrieved from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.clpna.com/wp-content/uploads/2013/02/doc_CCPNR_CLPNA_Code_of_Ethics.pdf

Government of Nunavut. (2013, February 5). *Family Abuse Intervention Act S.NU. 2006,c.18.* Retrieved from Nunavut Legislation: https://www.nunavutlegislation.ca/en/consolidated-law/family-abuse-intervention-act-consolidation

Government of Nunavut. (2015, January). *Nunavut Public Service Code of Values and Ethics.* Retrieved from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://gov.nu.ca/sites/default/files/code_of_values_and_ethics_final_english_1.pdf

Approved By:	Date: 16 Nov 2023
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date: 16 November 2023
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

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Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Complaints and Dispute Resolution		Operations	H3C 02-010-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
04/01/2024	04/01/2026	New	3
APPLIES TO:			
All Home, Community, and Continuing Care Team Members			

1. BACKGROUND:

Complaints are important to the Division of Home, Community, and Continuing Care (HCCC) in providing an environment of continuous quality improvement and, providing an opportunity to improve service and/or address policy or service gaps.

Tensions between staff, whether professional or paraprofessional staff, can negatively impact the work environment to the point of causing harm to residents/clients.

HCCC understands that 'long term care homes are both homes and workplaces, where the conditions of work are the conditions of care.' (Health Standards Organization, 2023)

In recognition of this principle, HCCC provides the following policy and guidelines for the management of complaints and dispute resolution. HCCC collaborates with the Division of Health Continuous Quality Improvement (CQI), Patient Relations, Employee Relations, and the Department of Human Resources in the provision of client-centered, culturally safe, and trauma informed care.

2. POLICY:

Complaints from clients, family members, and guardians must always be taken seriously.

HCCC team members should work collaboratively with the client, family members, and any guardians to address the concern. If this approach is unsuccessful the complainant should be encouraged to contact the Office of Patient Relations.

2.1. All complaints by residents, clients, guardians or family members shall be reported to the immediate supervisor.

2.1.1. All staff hearing a complaint shall acknowledge the complainant's distress, maintain an attitude of respect and compassion throughout, and refrain from arguing.

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2.1.2. The immediate supervisor shall, in the complainant's preferred language, work collaboratively with the complainant and HCCC team members to address the issue.

2.1.3. If unsuccessful the supervisor will encourage the complainant to send their concern directly to Patient Relations for appropriate resolution and tracking.

2.1.4. If the complainant declines to contact Patient Relations, the supervisor shall contact the Director in order to ensure transparency and to advise the Director regarding both the specifics of the complaint and the plan for resolution.

2.1.4.1. The Director shall advise the Territorial Coordinator of Home, Community, and Continuing Care and Patient Relations following communication with the supervisor noted in 2.1.3.

2.1.4.2. The Director will follow-up to ensure that the planned resolution has been successfully implemented in 30 calendar days.

2.1.5. The supervisor shall document all communications with the complainant, either in the client record if the complaint is clinical, or in an email to the Director.

2.2. Staff involved in disputes with other staff or with residents/clients, shall report the dispute to their immediate supervisor.

2.2.1. Supervisors who are aware of a dispute between staff – either reported or observed, shall follow the guideline below.

3. Principles:

3.1. Ajjigiktitsiniq – public service employees must carry out their responsibilities in a way that is fair, objective, and impartial.

3.2. Ujjiqsuittiarniq: - public service employees must perform their work in a courteous and conscientious manner and be respectful of the needs and values of co-workers.

3.3. The GN actively promotes a workplace atmosphere of mutual respect, fairness, and concern.

4. Definitions:

Cultural Safety: An outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health system.

Paraprofessional: refers to all unregulated workers, i.e., Continuing Care Workers (CCW), Home and Community Care Workers (HCCW), administrative staff, housekeepers, caretakers, etc.

Trauma-informed Care: An approach to care that recognizes that people may have experienced psychological or emotional trauma, the lasting effects of which may influence their physical and mental health, behaviour, and engagement with health service providers and services. Trauma-informed care makes people feel safe and comfortable and avoids retraumatizing them.

5. Guideline: Staff Disputes

5.1. The supervisor acts as a facilitator when staff disputes are reported or observed.

5.2. The supervisor responsibilities:

- To promote and provide a work environment free of workplace harassment and/or conflict.
- To take appropriate action as soon as possible to resolve complaints brought to their attention.

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- To inform their Director when there is workplace conflict causing distress.
- To monitor situations where complaints have been substantiated to ensure that corrective measures have been successful.
- To ensure that there is no retaliation against persons involved in complaints.

5.2.1. The supervisor meets with the complainants individually and confidentially, listening to their concerns and repeating the concern back to them to ensure accuracy.

5.2.2. Once this step is complete, the supervisor shall bring the complainants together to work out a resolution.

5.2.2.1. If a compromise cannot be reached, or there is clear wrongdoing by one of the complainants, the supervisor shall consult with the regional Manager of Human Resources.

5.3. At all times, the Supervisor shall adhere to GN Code of Values and Ethics, Respectful and Harassment Free Workplace Human Resource Manual Directive 1010, and Workplace Conflict Management Resource Manual Directive 1018.

6. Associated Policies and Legislation:

CHN Policy 05-029-00 Violence in the Workplace
CHN Policy 05-034-00 Client Safety Event – Incident Reporting and Immediate Management
CHN Policy 06-013-00 Interpreter Services

7. References:

SHP Manual Version 1 April 2023
Government of Nunavut Code of Values and Ethics
Human Resource Manual

Approved By: CNolan	Date: 4 Jan 2024
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date: 4 January 2024
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

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Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Individual Care Plan Development and Communication		Client Care	H3C 03-001-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
03/01/2024	03/01/2025	NEW	3
APPLIES TO:			
Nurse Managers, Supervisors of Home and Community Care, and Licensed Practical Nurses			

1. BACKGROUND:

The Home, Community, and Continuing Care Program (HCCC) understands the importance of individual care planning in delivery of quality healthcare services and in ensuring that the client's voice is always heard. The focus of care planning is the needs, concerns, beliefs, and goals of the client.

HCCC provides the following policy and guidance for the development and communication of individual care plans.

2. POLICY:

2.1. The Nurse Manager of a Continuing Care Centre or delegate and the Supervisor of Home and Community Care (SHCC) or delegate shall develop an individual care plan for each client in their care.

2.1.1. The care plan shall be developed with the client and/or their guardian as appropriate and other members of the care team, i.e., Licensed Practical Nurses (LPNs), Continuing Care Workers, Recreation Therapists, Home, and Community Care Workers, etc.

2.1.2. With the permission of the client or their guardian maker family members and other supports may be involved in the development of the individualised care plan.

2.2. The Nurse Manager and SHCC shall review the plan, at minimum, every six months, and when a change occurs, requiring a change in the plan.

2.3. The Nurse Manager or delegate shall communicate the finalized plan to the client in their preferred language, the client's family (with client permission) and the continuing care centre healthcare team.

2.4. The SHCC shall communicate the finalized plan to the client in their preferred language, the client's supporters (with client permission), the HCCWs, the CHN supervising the client's chronic disease program and the Supervisor of Health Programs.

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3. PRINCIPLES:

3.1. Individualized care planning is a continuous process resulting in an overarching care plan that is regularly reviewed.

3.2. An individualized care plan uses a holistic, systematic approach based on the person's strengths, values and aspirations and puts their goals, choices and lifestyle wishes in the centre of the process.

3.3. Care planning is a dynamic process of discussion, negotiation, decision-making and review that takes place between the person and the professional – who have an equal partnership.

3.4. Care planning is planned, proactive and anticipatory with regular follow-up and emergency planning for crisis episodes.

4. DEFINITIONS:

Care Plan: a written plan that sets out the planned care, the goals the care is to achieve, and clear directions for staff and others who provide direct care to the resident/client. The plan of care must cover all aspects of care, including medical, nursing, personal support, nutritional, dietary, recreational, social, restorative, religious and spiritual care.

5. GUIDELINE:

5.1. Nurse Manager, Supervisor of Home, and Community Care (SHCC), or Licensed Practical Nurse (LPN) populates the care plan template (Appendix A) using information from the client's health record, i.e., allergies, medications, chronic health conditions, etc.

5.2. Nurse Manager, SHCC, or LPN meets with the client/resident to complete the template and correct information, as necessary.

5.3. Nurse Manager, SHCC, or LPN meets with the client/resident and the healthcare team, including support workers to formulate the care plan.

5.3.1. Additional family/client supporters may be invited at client or guardian's request.

5.3.2. Client and program goals are discussed at this meeting.

5.3.3. Once the care plan is completed, the team reviews to ensure accuracy.

5.4. The Nurse Manager, SHCC, or delegate, enters the care plan into the client's health record in Meditech if available, or in the paper chart and communicates the plan as per 2.3 and 2.4.

5.4.1. A copy of the care plan is given to the client.

6. ASSOCIATED POLICIES AND LEGISLATION:

New Autonomy and the Right to Live at Risk

4-004-00 Client Rights and Responsibilities

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3-002-00 Client Care Assessment and Reassessment

7. REFERENCES:

Association of New Brunswick Licensed Practical Nurses. (2021, March). *The Nursing Care Plan.* Retrieved from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.anblpn.ca/wp-content/uploads/2021/04/The-Nursing-Care-Plan_2021.pdf

Astle, B. J. (2019). *Canadian Fundamentals of Nursing Sixth Edition.* Milton, Ontario: Elsevier Canada.

Healthify He Puna Waiora. (n.d.). *Care Planning for Healthcare Providers.* Retrieved from https://healthify.nz/healthcare-providers/c/care-planning/

Approved By:	Date: 3 January 2024
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date: 3 January 2024
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

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Department of Health
Munaqhiliqiyitkut
Ministère de la Santé

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CARE PLAN:

NURSING DIAGNOSIS:

DATE	ASSESSMENT (by system)	PLAN AND OUTCOME	NURSING INTERVENTION & RATIONALES	EVALUATION
				Met Unmet Met Unmet Met Unmet Met Unmet Met Unmet Met Unmet Met Unmet

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Department of Health, Continuing Care Centre
Munaqhiliqiyitkut
Ministère de la Santé

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PATIENT CARE PLAN:

NURSING DIAGNOSIS: Mild confusion, Bladder incontinent(dribbles)

DATE	ASSESSMENT	PLAN AND OUTCOME	NURSING INTERVENTION & RATIONALES	EVALUATION
March 08, 2024	**Mild confusion**	**Resident will experience lesser to no confusion**	**Nurse to orient resident of surrounding and staff – to ensure greater degree of safety**	Met Unmet
		Staff to give simple directions.	**To reduces anxiety experience in new environment.**	Met Unmet
				Met Unmet
March 08, 2024	**Occasional incontinence**	**Resident will have reduced episodes of incontinence.**	**Staff remind resident to use the bathroom frequently, nurse will assess side effect of medications.**	Met Unmet
				Met Unmet
		Resident will remain free of skin breakdown	**Staff to provide good peri care**	Met Unmet
				Met Unmet

SAMPLE

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Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Client Health Assessment and Reassessment		Client Care	H3C 03-002-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
05/01/2024	05/01/2025	2.17	4
APPLIES TO:			
Regulated Healthcare Providers			

1. BACKGROUND:

The Home, Community, and Continuing Care Program (HCCC) recognizes that the health status and needs of their clients change over time and require a comprehensive health assessment on admission and reassessments at timely intervals to ensure that excellence in service provision is maintained.

HCCC provides the following policy and guideline for the initial assessment and reassessment to obtain a holistic understanding of the client's needs.

2. POLICY:

2.1. Regulated Healthcare Providers shall complete a comprehensive assessment of the client within 72 hours of admission to any program or as soon as possible if there are resource constraints.

2.1.1. A comprehensive assessment must assess client's physical, social, spiritual, recreational, cognitive, and emotional status in addition to a medication reconciliation.

2.1.2. The assessment provides the team with the information required to develop and implement the resident's individualized care plan.

2.2. Regulated Healthcare Providers will complete on-going assessments of a client based on their individual care plan.

2.3. Regulated Healthcare Providers shall complete a comprehensive reassessment of the client at minimum quarterly.

2.3.1. The reassessment shall be completed more frequently if the client's status changes or there are changes from client's baseline physical or cognitive presentation.

2.3.2. Regulated Healthcare Providers shall also complete reassessments as requested by the family of the client, a physician, a Nurse Practitioner (NP) or a Community Health Nurse (CHN) involved in their care, for a stated purpose, e.g., upcoming specialist appointment.

2.3.3. Regulated Healthcare Providers shall compare the current reassessment with previous assessments and adjust the plan of care accordingly.

3. PRINCIPLES:

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3.1. The health and cognitive status of all individuals change over time, necessitating a comprehensive initial (baseline) assessment and ongoing reassessments to ensure that programs, supports, and services meet the client's stated and assessed needs.

3.2. Through the assessment/reassessment process, HCCC ensures that clients are provided with the correct supports for the correct amount of time to preserve and encourage independence and autonomy of clients.

3.3. Regulated Healthcare Providers must practise within their own level of competence and seek guidance from their supervisor, a physician, or nurse practitioner as required.

4. DEFINITIONS:

Regulated Healthcare Providers: refers to Supervisors of Home and Community Care, Nurse Managers of Long-term/Continuing Care, Licensed Practical Nurses, and Advanced Care Paramedics.

5. GUIDELINE: COMPLETING AN ASSESSMENT

5.1. The Provider responsible for admitting a client to the program or facility shall complete the assessment within 72 hours of admission. See Appendix A Long Form-Home Care. Appendix B Single Visit Home Care. Appendix C Assessment form Continuing Care.

5.1.1.The assessment consists of:

i. Past medical history – obtained from both the client and family or caregivers and the client's health record. This includes immunizations, current medications, allergies and timing and results of most recent screening tests such as mammograms, FIT testing, colonoscopies, etc.
ii. Family history – any familial conditions and cause and age of death for parents/ siblings, if known.
iii. Social history – the client's current living conditions – who they live with, employment or previous employment, significant relationships, spouse and children, alcohol use, tobacco and other substances use.
iv. Medication reconciliation as outlined in Policy 03-003-00 *Medication Reconciliation.*
v. Physical examination including vital signs, weights, nutritional status, pain as well as skin integrity. See Appendix D Head to Toe Assessment.
vi. Activities of daily living and assessment of mobility and transfers.
vii. Mental health needs, as well as cognitive assessment.
viii. Cultural as well as preferred spiritual practices.
ix. Documentation in accordance with CHN Policy 06-008-00 *Documentation Standards.*

5.2. The Regulated Healthcare Provider who has the specific training may perform the following assessments:

- Montreal Cognitive Assessment (MoCA)
- Mini Mental State Examination (MMSE)

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- Braden Scale for Predicting Pressure Sore Risk
- Fall Risk Assessment-FRAT, MORSE, SCOTT (SFRA)
- Clinical Frailty Scale

5.3. Regulated Healthcare Providers who do not have the required training for performance and scoring of the assessments listed in 5.2. may consider a referral to another clinician who is trained.

5.4. The Regulated Healthcare Provider completing the admission assessment shall discuss their findings with the client and family (with client consent) and formulate a plan for service provision, incorporating client/family goals along with health care needs.

5.5. If a client becomes unstable or develops needs that are beyond the scope of practice for the Regulated Healthcare Provider, the client will be referred to the Community Health Centre (CHC) for further evaluation and treatment. The CHC Team will address the condition until resolved.

5.5.1. In the event that the client is kept at the CHC for evaluation and/or treatment, the CHC Team is responsible for care until the client is discharged, either home, to the long-term care facility, or Out of Territory.

6. GUIDELINE: COMPLETING A REASSESSMENT:

6.1. Regulated Healthcare Providers shall reassess the client's physical/cognitive status and their service needs 90 calendar days after the initial assessment and every 90 calendar days ongoing, or on request by a physician, NP, or a CHN involved in the client's care (e.g., CHN responsible for Chronic Disease program), for a stated and specific purpose, when appropriate.

6.2. The reassessment will include reviewing the client chart and current medications to ensure that they are up to date and completing a physical examination, including vital signs and weight, and skin assessment.

6.3. The Regulated Healthcare Provider shall review the assessment, comparing it with the previous assessment and noting any changes.

6.4. The Regulated Healthcare Provider shall document the assessment as well as any changes noted compared to the previous assessment in the client's health record. For residents in continuing care, complete and share the Quarterly Report with the HCCC. See Appendix E.

6.5. The Regulated Healthcare Provider shall review the plan of care with the client and family (with client consent) and make changes accordingly.

6.6. The Regulated Healthcare Provider shall communicate the new plan of care to colleagues involved in the care of the client.

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7. Related Policies and Legislation:

CHN Policy 06-008-00 Documentation Standards
CHN Policy 06-019-00 Informed Consent
3-003-00 Medication Reconciliation
CHN Policy 07-019-00 Transfer of Care Between Colleagues
Policy 02-001-00 Transition of care through Continuing Care Services

8. References:

Astle, B. J. (2019). *Canadian Fundamentals of Nursing Sixth Edition.* Milton, Ontario: Elsevier Canada.

Approved By:	Date: 5 January 2024
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date: 5 January 2024
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

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Government of Nunavut
Department of Health and Social Services – Home Care

General Assessment **Community Code [ ]**

A. Referral Information

Referred By: ☐ Self ☐ Family ☐ Physician Other:

Diagnosis Code:	Reason For Referral:

☐ **Initial Assessment**	☐ **Re-Assessment**

Referral Date	**Assessment Date**	
/ / dd /mon/yy	/ / dd /mon/yy	☐ New Client ☐ Previous Home Care Client

Case Manager Name Please Print Name	Case Manager Signature

Assessment Team Member: Please Print Name	Assessment Team Member: Please Print Name	Assessment Team Member: Please Print Name
Signature	Signature	Signature

B. Client Profile

HCP #										**File #**

Last Name (please Print)	M	First	Date of Birth (dd/mon/yyyy) / /	Age	Gender

Community	Languages Spoken: ☐ English ☐ Inuktitut ☐ French ☐ Inuinnaqtun
Directions	Languages Understood: ☐ English ☐ Inuktitut ☐ French ☐ Inuinnaqtun
	Allergies ☐ **Yes** ☐ **No**
Phone:	**Medication**
Marital Status ☐ Single ☐ Married ☐ Commonlaw/Partner ☐ Widowed ☐ Divorced/Separated ☐ Recent Status Change	**Food** **Other** **Treatment**

C. Person (s) To Notify in Case of Emergency (ensure guardian or trustee noted if applicable)

Closest Family Member	**Emergency Response Number** ☐ **same**
Last Name (please Print) First	Last Name (please Print) First
Address	Address
Phone : Work : Phone : Home :	Phone : Work : Phone : Home :
Relation To Client:	Relation To Client:

D. Client Attending Physician

Last Name (please Print) First	Location: Phone:

Specialist

Specialist	Code
Last Name (please Print) First Location: Phone:	[ ]
Last Name (please Print) First Location: Phone:	[ ]

Legend: P - Problem # for Care Plan NP - No Problem FE - Further evaluation by whom e.g. N (Nurse) P (Physio) etc
U - In Use R - Required NR - Not Required

E. Client Statement 0f Problems and Needs

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F. Supportive Care In Home (Lives With Others)

Last Name (please Print)	First	Last Name (please Print)	First
Relationship	Age	Relationship	Age
☐ Supportive How?		☐ Supportive How?	
Last Name (please Print)	**First**	**Last Name (please Print)**	**First**
Relationship	Age	Relationship	Age
☐ Supportive How?		☐ Supportive How?	

G. Supportive Care Not In Home (assistance from others outside of Client Home)

Last Name (please Print)	First	Last Name (please Print)	First
Relationship	Phone#:	Relationship	Phone#:
Type and Amount of Support		Type and Amount of Support	

Last Name (please Print)	First	Last Name (please Print)	First
Relationship	Phone#:	Relationship	Phone#:
Type and Amount of Support		Type and Amount of Support	

Last Name (please Print)	First	Last Name (please Print)	First
Relationship	Phone#:	Relationship	Phone#:
Type and Amount of Support		Type and Amount of Support	

H. Physical Environment

Assessment Data	P#	NP	FE	Comments of Assessor and /or Client
Type of Residence ☐House ☐Elder's Lodge ☐ Apt Access issues (e.g. space, steps/stairs ☐ Stairs ☐ Doors ☐ Space				
Heating of Home: ☐ Oil ☐ Electricity☐ Propane ☐Other				
Cooking: ☐ Oil ☐ Electricity☐ Propane ☐Other				
Get Water ☐ Hauls Own Water ☐ Delivered ☐ Family Hauls Water				
Toilet Facilities: ☐ Flush ☐ Chemical☐ Outhouse ☐Other Bathing Facility _____				

Legend: P - Problem # for Care Plan NP - No Problem FE - Further evaluation by whom e.g. N (Nurse) P (Physio) etc
U - In Use R - Required NR - Not Required

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H. Physical Environment

Assessment Data	P#	NP	FE	Comments of Assessor and /or Client
Laundry ☐ By Hand ☐ Own Machine ☐ Other				
Food Storage ☐ Freezer ☐ Fridge ☐ Outside ☐ Other				
Safety Hazards Physical ☐ Physical Structures ☐ Escape Routes ☐ Smoke Detectors ☐ Security ☐ Other (specify)				
Safety Hazards Environmental ☐ Smokers ☐ Over crowded ☐ Abusive ☐ _____ ☐				

I. Physical Health

Do you have any other problems that limit your normal activity? (health)

- ☐ Diabetes
- ☐ Arthritis or Rheumatism
- ☐ Other Musculoskeletal problems'
- ☐ Cancer
- ☐ Heart/Circulation
- ☐ Diabetes
- ☐ Emot./Mental Disability
- ☐ Depression
- ☐ Other
- ☐ Sensory
- ☐ Respiratory
- ☐ Severe Arthritis
- ☐ VSD
- ☐ Substance Abuse
- ☐ Tuberculosis
- ☐ Wheelchair
- ☐ Home 0xygen
- ☐ Malnutrition
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Dialysis
- ☐ Physical/Mobility
- ☐ Angina
- ☐ Neurological
- ☐ Sick Babies
- ☐ Hep C
- ☐ Bronchitis

Other: please specify

Comments/Observations

J. Have You Been Hospitalized Recently?

☐ **Yes** ☐ **No** ☐ **Recovery Complete** ☐ **Recovery Incomplete, please explain:**

Hospital Stays In Last 12 Month	Reason	Length of Stay	Discharge Date

Legend: P - Problem # for Care Plan NP - No Problem FE - Further evaluation by whom e.g. N (Nurse) P (Physio) etc
U - In Use R - Required NR - Not Required

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K. Current or Recent Medication

Medication Prescribed or OTC	Dosage/Route	Prescribed by	Date Started dd/mon/yy
Other			

	P#	NP	FE	Comments
Understanding of medication/treatment				
Ability to administer medication				
Compliance with medication regime				
Other				

L. Treatments / Compliance

Radiation				
Physio/Ot				
Counselling				
Mental Health				
Other				

Legend: P - Problem # for Care Plan NP - No Problem FE - Further evaluation by whom e.g. N (Nurse) P (Physio) etc
U - In Use R - Required NR - Not Required

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M. General Health and Functional Status	P#	NP	FE	Comments
1. **Nutrition** Wt. Lbs/kg Any foods cause problem Diet prescribed by:				
Balanced diet ☐Yes ☐No Special diet? ☐Yes ☐No Compliance? ☐Yes ☐No Good fluid intake ☐Yes ☐No Adequate appetite ☐Yes ☐No				
2. Elimination **Incontinent** **Bowel** **Bladder** Frequent Problems ☐Yes ☐No ☐Yes ☐No Occasional ☐Yes ☐No ☐Yes ☐No				* Note bowel/bladder changes or problems
3. Respiration Breathing Difficulties ☐Yes ☐No Rate, rhythm,quality Activity tolerance Persistent Cough Oxygen Equip used ☐Yes ☐No Smoker ☐Yes ☐No If Yes -Quantity				
4. Skin/Circulation Pulse BP Skin problem/condition ☐Yes ☐No If Yes Describe Hand/foot care				(Check for hygiene, temperature, colour, ulcers, stomas, catheters, oedema etc)
5. Eyesight ☐Good ☐Fair ☐Poor ☐ Ptly orTotally Blind Glasses/contacts/surg corr ☐Yes ☐No Specialist /Supplier dd/mon//yy Date of last eye exam / /				*Note redness pain or excess swelling
6. Hearing ☐Good ☐Fair ☐Poor ☐Ptly or Totally Deaf Hearing Aid ☐Yes ☐No ☐R ☐L Any Problems Batterycondition/availability Supplier dd/mon//yy Date of last hearing test / /				* Note problems e.g. pain or discharge

Legend: P - Problem # for Care Plan NP - No Problem FE - Further evaluation by whom e.g. N (Nurse) P (Physio) etc
U - In Use R - Required NR - Not Required

Return to TOC

M. General Health and Functional Status			P#	NP	FE	Comments
7. Oral /Dental ☐ Own teeth ☐ Dentures ☐ Upper ☐Lower ☐ Partial ☐Orthodontic work Problems with teeth/chewing Swallowing or sore gums Practices good oral hygiene Date of last dental exam dd/mon//yy	 ☐Yes ☐Yes ☐Yes /	 ☐No ☐No ☐No /				
8. Mobility/Activity Difficulty Walking Fall Risk Motor function e.g. strength,tone,tremour. Joint stiffness/deformity (note pain, swelling or inflammation How do you get to places you can't walk? ☐Drive Self ☐ Friend ☐Taxi ☐ Family ☐ Other Other Restrictions?	☐Yes ☐High	☐No ☐Low				
9. Neurological Status Disorder Level of Responsiveness/consciousness Spatial awareness/balance Sense of touch/temp (note if good recognition of hazards or neglect) Paralysis(para/quad/hemi/complete/partial)	☐Yes	☐No				
10. Comfort Pain or Discomfort Type/Site/Severity Aggravated by: Relieved By:	☐Yes	☐No				
11. **Communication** Problem Speech Comprehension Literacy	☐Yes	☐No				
12. Reproduction Do You have concerns	☐Yes	☐No				
13. Social and Emotional Health Do you have social or emotional problems If yes Are you seeing anybody about this problem Involvement with family/friends/community Activities enjoyed (interests/hobbies). Interests/skills client would like to share. (e.g. teach Beading)	☐Yes ☐Yes	☐No ☐No				

Legend: P - Problem # for Care Plan NP - No Problem FE - Further evaluation by whom e.g. N (Nurse) P (Physio) etc
U - In Use R - Required NR - Not Required

Return to TOC

M. General Health and Functional Status	P#	NP	FE	Comments
14. **Psychological Health & Security**				
Orientation/Memory/Judgement/Dementia				
Mood/Affect (depression/euphoria/flat affect)				
Thought Process				
Behaviour (e.g. inappropriate/aggressive)				
Acceptance of Condition/Treatment				
Body Image				
Self Esteem/Morale				
Relationships in the home				
Coping Mech				
Impact of Bereavement/Recent Stress				
Impact of Recreation/Occupation (or lack of)				
Culture/Religion				
Financial Security				
15. Other Observations/Risk Factors				*Note: May affect HC service capability*
☐Evidence of drug/alcohol abuse				
☐Evidence of physical/mental/verbal abuse				
☐Other				
16. **Are you regularly seeing any of the following?**				
☐Community Health Representative				
☐Community Health Nurse				
☐Mental Health Worker				
☐Social Worker				
☐Other:				

Legend: P - Problem # for Care Plan NP - No Problem FE - Further evaluation by whom e.g. N (Nurse) P (Physio) etc
U - In Use R - Required NR - Not Required

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N. Activities of Daily Living	P#	NP	FE	Comments* Note "Who" helps wher
1. **Light Housework** ? (Dishes,dusting etc) ☐ Independent ☐ Needs help				
2. **Heavy housework?** (floors, kitchen etc.) ☐ Independent ☐ Needs help				
3. **Laundry?** ☐ Independent ☐ Needs help				
4. **Preparation of meals?** ☐ Independent ☐ Needs help				
5. **Shopping?** ☐ Independent ☐ Needs help				
6. **Personal financial affairs?** ☐ Independent ☐ Needs help				
7. **Bathing?** ☐ Independent ☐ Needs help				
8. **Care of hair?** ☐ Independent ☐ Needs help				
9. **Dressing and undressing?** ☐ Independent ☐ Needs help				
10. **Eating/Feeding ?** ☐ Independent ☐ Needs help				
11. **Rest/Sleep Patterns?** **Currently using medication for sleep?** ☐ yes ☐ no				
12. **If a telephone is available can a client use it** ? ☐ yes ☐ no				

O. Equipment and Supplies Note here if equipment needs repair, modification or replacement	P#	NP	FE	Comments
Mobility aids: ☐Walker ☐Canes ☐Crutches ☐ Wh/chair ☐ Prosthesis ☐Braces ☐Other				
Bathing aids ☐Grab bars ☐Bath seat ☐Hand shower ☐Other				
Toileting aids ☐ Raised toilet seat ☐ Rails/bars ☐ Commode ☐Bed Pan ☐ Urinal ☐Other				
Accessibility aids/adaptations ☐Lifters ☐ Poles/monkey bars ☐ Ramps ☐Hospital type adjustable beds/siderails ☐Home adaptations ☐Small personal aids e.g. eating aids reachers, long handled shoe ☐Other				
Respiratory aids ☐O_2 delivery systems e.g. concentrator ☐Nebulizers ☐ Aerosol compressors ☐CPAP machines ☐Other				

Legend: P - Problem # for Care Plan NP - No Problem FE - Further evaluation by whom e.g. N (Nurse) P (Physio) etc
U - In Use R - Required NR - Not Required

Return to TOC

O. Equipment and Supplies Note here if equipment needs repair, modification or replacement	P#	NP	FE	Comments
Medical/surgical supplies for: ☐ Ostomy/wound care ☐ Injections ☐ Incontinence ☐ Venous pressure/burnscar garments ☐ Other				

P. Analysis and Conclusions :	Assessors Observations, notes and other relevant information

Q. Level of Care Required:

Future ☐	Level 1 ☐	Level 4 ☐	Level 5 ☐
Level 2 ☐	Level 3 ☐	Respite ☐	Palliative ☐

R. In Home Services Required:

Service Postponed ☐
- ☐ Qualifies No Resources – Staff
- ☐ Qualifies No Resources – Equipment
- ☐ Environmental/Physical Safety Issues
- ☐ Other Reason

Service Declined ☐
- ☐ Does Not Qualify
- ☐ Client Refused
- ☐ No Service Req'd
- ☐ Other Reason

Services Required:
☐ RN ☐ SW ☐ PT ☐ OT ☐ RT ☐ SLP

☐ Other

☐ Support Personal Care ☐ Home Management
☐ Other

Service Start Date: (dd mon yy) / /

Note: Service Start Date should be established within 48 hrs of Assessment Date.

Legend: P - Problem # for Care Plan NP - No Problem FE - Further evaluation by whom e.g. N (Nurse) P (Physio) etc
U - In Use R - Required NR - Not Required

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Community Codes

Code	COMMUNITY
200	Arctic Bay
205	Broughton Island (Qikiqtarjuaq)
210	Cape Dorset
215	Clyde River
220	Grise Fiord
222	**Baffin Region**
225	Hall Beach
230	Igloolik
235	Iqaluit - Baffin Region
240	Kimmirut
245	Nanisivik
250	Pangnirtung
255	Pond Inlet
260	Resolute Bay
265	Sanikiliuaq
300	Arviat
305	Baker Lake
310	Chesterfield Inlet
315	Coral Harbour
320	Rankin Inlet
325	Repulse Bay
330	Whale Cove
333	**Kivalliq Region**

Code	COMMUNITY
400	Bathurst Inlet
405	Bay Chimo
410	Cambridge Bay
415	Gjoa Haven
420	Kugluktuk
425	Pelly Bay(Kugaaruk)
430	Taloyoak
444	**Kitikmeot Region**

Return to TOC

NUNAVUT HOME & COMMUNITY CARE PROGRAM

GENERAL ASSESSMENT_SINGLE VISIT

Referral/Assessment Date:	By:	
Diagnosis Code:	Client Type:	
HCP #:	File #:	
Last Name:	First Name:	Community:
Date of Birth:	Age:	Gender:

ALLERGIES:_____Yes _____No

Medication:

Food: **Other:**

Nursing Diagnosis (problem, plan of care, expected outcome)

I agree to the care plan as discussed with me. While on the Program I will let the Program Case Manager know if my condition, treatment, medications or home situation changes. I will let the Program staff know if I feel that the services are not meeting my needs. I will let the Program staff know if I cannot be at home at agreed on visit times and dates, or to reschedule a visit. I will permit the sharing of information about me with other Health & Social services staff that may be involved in my care or treatment.

Print Client or Responsible Representative Name:	Client or Responsible Representative Signature:	Date:
Print Case manager's Name:	Case manager Signature:	Date:
Print Interpreter Name:	Interpreter Signature:	Date:

Narrative Note:

Discharge Date:

Date: July 6, 2006

Return to TOC

Head-to-Toe Assessment:
Checklist and Documentation

Conducted by:_____
Date: _____ Time: _____

Vital Signs/Stats/Neurological:

- ☐ Oriented x 3
- ☐ Temp: _____
- ☐ BP: _____
- ☐ Heart rate: _____
- ☐ Respiratory rate: _____
- ☐ Height: _____
- ☐ Weight: _____

Notes: _____
_____

Head/Face:

- ☐ Distribution/condition of hair
- ☐ Scalp: no bumps, nits, lesions
- ☐ Palpate skill for tenderness
- ☐ Symmetrical facial movements
- ☐ Sharp and dull sensation on face intact

Notes: _____
_____

Eyes:

- ☐ Symmetrical
- ☐ Eyebrow & eyelash distribution
- ☐ Check conjunctiva, sclera, cornea
- ☐ PERRLA
- ☐ Six cardinal positions
- ☐ Snellen Chart: _____

Notes: _____
_____

Ears:

- ☐ Inspect/palpate auricle
- ☐ Inside ear/tympanic membrane
- ☐ Weber's test
- ☐ Rinne test
- ☐ Whisper test

Notes: _____
_____

Nose:

- ☐ Palpate nose/symmetry check
- ☐ Check septum and inside nostrils
- ☐ Patency of nares (breathe through each nostril)
- ☐ Intact smell
- ☐ Palpate sinuses

Notes: _____
_____

Mouth/Throat:

- ☐ Lips (moistness & color)
- ☐ Teeth & gums
- ☐ Buccal mucosa & palate
- ☐ Examine tongue
- ☐ Inspect uvula & tonsils
- ☐ Palpate jaw joint

Notes: _____
_____

Neck/Shoulders:

- ☐ Neck range of motion
- ☐ Shoulder shrug w/resistance
- ☐ Lymph nodes
- ☐ Palpate neck and trachea
- ☐ Check for JVD

Notes: _____

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Head to Toe Assessment-Page 2

Lungs/Thorax:

- ☐ Lung auscultation
- ☐ Resp. exclusion: _____
- ☐ Palpate thorax
- ☐ Spinal curvature
- ☐ Coughing? _____

Notes: _____
_____

Circulatory System:

- ☐ Carotid & temporal artery palpation
- ☐ Heart auscultation

Notes: _____
_____

Gastrointestinal:

- ☐ Abdominal inspection
- ☐ Auscultation for bowel sounds
- ☐ Abdomen palpation
- ☐ Problems with bowel/bladder?

Notes: _____
_____

Arms/Hands:

- ☐ ROM and strength
- ☐ Arm pulses (brachial and radial)
- ☐ Cap refill
- ☐ Skin turgor
- ☐ Sharp and dull sensation

Notes: _____
_____

Legs/Feet:

- ☐ ROM and strength
- ☐ Cap refill
- ☐ Leg pulses
- ☐ Sharp and dull sensation
- ☐ Assess gait

Notes: _____
_____

Genitourinary

- ☐ Pubic hair check
- ☐ Tenderness, lumps, lesions

Notes: _____
_____

Breast:

- ☐ Palpate breasts

Notes: _____
_____

Additional Notes:

_____
_____
_____
_____
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_____
_____
_____

Building Nunavut Together
Nunavuliuqatigiingniq
Bâtir le Nunavut ensemble

Return to TOC

QUARTERLY PROGRESS REPORT

CLIENT PROFILE:

Surname: First name: Date of Birth:

Community: Date of admission:

NU Health Card #: NTI Card #:

Next of Kin: Relationship:

Phone: Email:

Alternate Contact: Phone/Email:

Legal Guardian: Phone/Email:

Legal Trustee: Phone/Email:

Current placement: Date of last report:

DIAGNOSES/MEDICAL HISTORY:

ALLERGIES:

Is there a confirmed diagnosis of dementia? ☐ Yes ☐ No ☐ Query

Is there concern that the individual lacks capacity to make decisions ☐ Yes ☐ No

Does the client have an advanced care directive in place? ☐ Yes ☐ No

Code Status:

Type of Exam	Date of Last Exam DD/MMM/YY	Outcome / Recommended Treatment
Physical		
Dental		
Mental Health/Psychiatry		
OT/PT		

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Ultrasound		
ECG		
Audiology		
SLP		
X-Ray		
Influenza vaccine		
Covid 1st and 2nd vaccine – Booster		

CURRENT MEDICATIONS INCLUDING PRN (or attach med list)

Medication Name	Prescribed Dose	Purpose of Medication

MEDICATION CHANGES

Please provide information on any medication changes since the last Quarterly Progress Report was submitted (name of new and/or discontinued medications and the reason for the changes):

Medication Name	Prescribed Dose	Purpose of Medication

FUNCTIONAL STATUS:

Height:	**Weight:**
Hearing ☐ Good ☐ Fair ☐ Poor	Hearing aids ☐ Left ☐ Right

Return to TOC

Communication

☐ Communicates verbally ☐ Communicates in writing ☐ Unable to communicate

Languages spoken

☐ Inuktitut ☐ Inuinnaqtun ☐ English ☐ French ☐ Other:

Vision

☐ Good ☐ Fair ☐ Poor ☐ Uses glasses

Substances (indicate amounts and frequency)

☐ Nicotine ☐ Cannabis

☐ Alcohol ☐ Other

Dental

☐ No concerns ☐ Full dentures ☐ Partial dentures ☐ Missing teeth

Diet

☐ DAT ☐ Soft ☐ Minced ☐ Puree ☐ Swallowing concerns ☐ Fluids:

☐ Special Diet: ☐ Tube feeds

Skin

☐ Intact ☐ Wounds ☐ Comments:

Pain

☐ Verbalizes pain ☐ Evidence of pain ☐ Location:

☐ Type: ☐ Severity: ☐ Cause:

Sleep

☐ Regular sleep patterns ☐ Periodic waking at night ☐ Frequent waking ☐ Difficulty falling asleep ☐ Recent changes in sleep ☐ Excessive sleep Comment:

Dressing

☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent ☐ Uses aids

Bathing

☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent ☐ Uses aids

Feeding

☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent ☐ Uses aids

Hygiene (oral, grooming)

☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent ☐ Uses aids

Toileting

☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent ☐ Uses aids

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Continence – Bladder

☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent ☐ Catheter ☐ Brief

Incontinent: ☐ Occasionally ☐ Frequently

Continence - Bowel

☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent ☐ Ostomy ☐ Brief

Incontinent: ☐ Occasionally ☐ Frequently

Mobility

☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent ☐ Recent falls

Cause/Comments:

Transfers

☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent ☐ Mechanical lift

Stairs

☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent

Medication management

☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent

Managing Finances

☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent ☐ Frequent errors

Housekeeping

☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent

Grocery Shopping

☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent

Meal preparation

☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent

Using Telephone

☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent

Social

☐ Socializes regularly ☐ Socializes minimally ☐ Does not socialize ☐ Caregiver distress

Living Situation

☐ Lives alone ☐ Lives with family ☐ Other:

Equipment and special requirements

☐ Walker ☐ Manual Wheelchair ☐ Power Wheelchair ☐ Prosthesis ☐ PICC ☐ Central line

☐ IV ☐ Wound Care ☐ Oxygen ☐ Concentrator ☐ Portable Rate:

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☐ CPAP/BPAP ☐ Comments/Other:

Thought Processes

☐ Suspicious ☐ Delusional ☐ Confusion ☐ Hallucinations ☐ Obsessive

☐ Slow to respond ☐ Other:

Cognition and orientation

☐ Mild memory loss ☐ Moderate memory loss ☐ Significant memory loss

☐ Lack of judgement ☐ Lack of insight Disoriented to ☐ person ☐ place ☐ time

Emotional State

☐ Flat affect ☐ Labile ☐ Euphoric ☐ Depressed ☐ Anxious ☐ Other:

☐ Suicidal ideation ☐ History of suicide attempt – date/method:

Responsive Behaviours – document incidents below

☐ Physical aggression ☐ Verbal aggression ☐ Damages property ☐ Hurts self ☐ Vocal

☐ Sexually expressive ☐ Wanders, responds to redirection ☐ Elopes ☐ Resistant to care

☐ Agitated ☐ Suspicious ☐ Repetitive movements

INCIDENTS: (Since last report)

Specific Behaviour	# of events	Observed Indicators	Intervention	Outcome

RECREATION/ACTIVITIES: Please note recreational activities and frequency of participation:

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FAMILY CONTACT: Please indicate dates for any tele-health/video visit with family, or frequency of in-person visits with family since the previous Quarterly report.

PERMANANCY PLANNING

Level of Care ☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Has the resident's care level changed since last report? ☐ Yes ☐ No

CONCERNS OR ADDITIONAL NOTES:

Report Completed by:
Date Completed:
Report Covers period between:

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Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Medication Reconciliation		Client Care	H3C 03-003-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
16/11/2023	16/11/2024	2.22	5
APPLIES TO:			
Registered Nurses and Licensed Practical Nurses			

1. Background:

Medication Reconciliation is a formal process in which healthcare providers partner with clients, families, and other care providers to ensure accurate and complete medication information transfer at transitions of care. It is a systematic process for obtaining a best possible medication history and comparing the history to medications being taken to identify and resolve discrepancies.

The Department of Health (Health) provides the following policy for the process of medication reconciliation in home care and long-term care.

2. Policy:

2.1. Nurses completing admission assessments for the home care program or long-term care setting shall complete a medication reconciliation.

2.1.1. Medication reconciliation occurs during the initial intake assessment, following discharge from hospital, during any care transitions, with any client change in status, and at any time that new medications are ordered, or medication orders are rewritten.

2.1.2. Medication reconciliation must be completed annually if the above has not otherwise been completed as noted above or as part of a routine client reassessment.

2.1.3. Medication reconciliation must always include a review of prescriptions for anti-psychotics and other psychotropic medications to ensure clients are not overmedicated.

3. Principles:

3.1. Communicating effectively about medications is a critical component of delivering safe care.

3.2. Medication reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions.

4. Procedure:

4.1. Collect the Best Possible Medication History (BPMH) during, or within 24 hours of the admission process by interviewing the client and/or caregiver(s) to establish a complete list of medications that the client is taking.

4.1.1. Review the client's medication containers (in the home where possible), including prescription and non-prescription products.

4.1.2. If appropriate, ask the client how they take the medication – amounts and times.

4.1.2.1. If the client is unable to answer for themselves, information can be gathered from their caregiver and/or guardian.

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4.1.3. Contact the local retail pharmacy/pharmacies for a list of the client's medications.

4.1.4. Compare the information from the client with a list of medications generated by the local pharmacy/pharmacies and the client's health record.

4.1.5. Document the BPMH, including dosage and frequency, once the client interview and review of medications are complete.

4.1.6. Compare the BPMH with the most current information from the pharmacy and health record and identify any discrepancies:

- Medication taken that is not in the most current list of pharmacy medication lists or orders in the health record.
- Presence of medication in the health record or pharmacy generated list that the client is no longer taking.
- Medication that is being taken differently than prescribed – different dosage or frequency.

4.2. To resolve any discrepancies:

4.2.1. Discussion with family or physician/nurse practitioner as appropriate.

4.2.2. Document any identified discrepancies, the reason for each discrepancy.

4.2.3. If possible, contact the prescriber to clarify, or if needed book a new appointment with a prescriber for a new order.

4.3. Update the BMPH which becomes the reconciled medication list – the most up-to-date and accurate version of the client's medication list.

4.3.1. Include the date of completion.

4.3.2. Provide a copy of the list to the client/caregiver and to the pharmacy.

4.4. Enter the updated BPMH into the client's health record.

5. Related Policies:

CHN Policy 09-004-00 Medication Administration
CHN Policy 09-005-00 Dispensing Medication
CHN Policy 09-006-00 Administering or Dispensing Pharmaceuticals - Documentation

6. References:

Accreditation Canada, the Canadian Institute of Health Information, the Canadian Patient Safety Institute and the Institute of Safe Medication Practices Canada. (2012). *Medication Reconciliation in Canada: Raising the Bar - Progress to date and the course ahead.* Retrieved from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.ismp-canada.org/download/MedRec/20121101MedRecCanadaENG.pdf

Barnsteiner, J. (2008). Medication Reconciliation. In e. Hughes R.G., *Patient Safety and Quality: An Evidence-Based Handbook for Nurses* (pp. 459-468). Rockvile, Maryland: U.s.

Canadian Patient Safety Institute. (2017, March). Retrieved from Medication Reconciliation (Med Rec): Getting Started Kit: https://www.patientsafetyinstitute.ca/en/toolsResources/pages/med-rec-resources-getting-started-kit.aspx

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Approved By:	Date: 16 Nov 2023
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date: 16 November 2023
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

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BEST POSSIBLE MEDICATION HISTORY FORM

Client Name: Date:

Pharmacy Name and Phone:

Medications: Self-administered ☐ Caregiver Administered ☐

Blister Packs ☐ Personal Dosette ☐

Medication Allergies: ☐

Sources of Information Used to Complete Medication History:

Client Interview ☐ Caregiver Interview ☐ Medication Containers ☐ Blister Packs ☐

Pharmacy Profile ☐ Specialist Letter ☐ Hospital Discharge Summary ☐

Hospital Discharge Medication Reconciliation Form ☐

Medication	Dose	Route	Freq	Indication	Start Date	Prescriber	Comments

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MEDICATION RECONCILIATION FORM

Client Name: DOB: Completion Date:

Medication	Dose	Route	Freq	Indication	Start Date	Prescriber

Completed by: (PRINT NAME & DESIGNATION)

Signature:

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Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Client centred care conference		Client Cate	H3C 03-004-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
16/11/2023	16/11/2024	2.19	5
APPLIES TO:			
Home, Community and Continuing Care Team Members			

1. BACKGROUND:

Client Centred Care Conferences bring together the client, guardian, family, and other supports, as well as all healthcare team members involved in the client's care to ensure that the care plan reflects both the client's goals and the team's assessment of client needs. The Home Community and Continuing Care Program (HCCC) provides the following policy and guidelines for interdisciplinary care conferences to ensure a client-driven, culturally safe process for the provision of excellence in service delivery through effective and efficient use of resources.

2. POLICY:

2.1. Client Centred Care Conferences will be held for each client admitted to a long-term care facility within six weeks of admission and, at minimum, annually, or more frequently based on client disposition and health status.

2.2. A Client Centred Care Conference shall be held as required for clients with complex and/or urgent needs who receiving care and support through the Home Care Services Program.

3. PRINCIPLES:

3.1. There is an increasing complexity of skills and knowledge required to provide comprehensive care to clients.

3.2. The cooperation of a team allows for more effective fulfillment of the client's needs and contributes to better quality of their lives.

4. DEFINITIONS:

Client Centred Care Conference: coordination of client services by the Home and Continuing Care Team, and includes the client, the client's family/guardian or community supports, the community physician and/or nurse practitioner, and community health nurses involved in the client's care, allied health professionals such as physiotherapists or occupational therapists and family services workers as needed (Nursing Council of New Zealand, 2011).

5. GUIDELINE: LONG-TERM CARE:

5.1. A Client Centred Care Conference date will be assigned by the Nurse Manager when the client is admitted. The Client Centred Care Conference is scheduled within six weeks from the admission date.

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5.2. The Nurse Manager will work with all care partners, including the client's guardian, family (with client's permission), and other community partners to determine the best date and time of the Client Centred Care Conference.

5.3. Prior to the conference, the Nurse Manager shall send an invitation to the client's family (with client permission), guardian and any healthcare providers involved in the care of the client, in particular, the physician or nurse practitioner (NP). This may also include the Supervisor of Health Programs (SHP) of the local health centre or their delegate, physiotherapist, occupational therapist, or a specialist.

5.3.1. Out of community participants may conference through the approved audio-visual platform.

5.4. Prior to the conference, the Nurse Manager shall confirm the attendance of the physician, NP, guardian and any other out of community participants.

5.5. The Nurse Manager or delegate shall prepare a summary of the current plan of care, including medications, treatments, assessments completed or needed, and concerns, utilizing Appendix A: Facilitating a Client Centred Care Conference.

5.6. The Nurse Manager acts as facilitator and follows Appendix A: Facilitating a Client Centred Care Conference.

5.7. The Nurse Manager completes the summary when the Client Centred Care Conference is done, and files it in the client's health record.

5.7.1. Where Meditech is available the summary should be entered directly into the electronic health record.

5.7.2. Where Meditech is unavailable the summary, along with a narrative note should be added to the client's health record.

6. GUIDELINE: HOME CARE:

6.1. When required, the Supervisor of Home and Community Care (SHCC) assigns a date for a Client Centred Care Conference when the client is admitted to the home care program. The Client Centred Care Conferences is scheduled as required based on client disposition, case complexity, and available resources. Only clients with complex and/or urgent needs require a Client Centred Care Conference.

6.2. The SHCC invites the client, the client's family (with client consent), guardian, the SHP, Community Health Nurses (CHNs) involved in the client's care, the community physician and/or nurse practitioner and allied health professionals such as physiotherapists, occupational therapists, etc. who are currently involved in the client's care. 6.2.1. It is recognised not all parties may be able to attend and may send notes, questions, comments, or suggestions in place of attendance.

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6.3. The SHCC prepares a brief summary for presentation.

6.4. The SHCC acts as facilitator and follows Appendix A: Facilitating a Client Centred Care Conference.

6.5. The SHCC summarizes the proposed changes and requests orders as needed from the physician/NP.

6.6. The SHCC thanks all the participants and closes the meeting.

6.7. The SHCC documents a summary of the meeting along with any new orders in the client's health record in Meditech and files the completed summary in the client's hard copy health record.

7. Follow-Up Client Centred Care Conferences

7.1. Client Centred Care Conference shall occur annually for residents in long-term care. Client Centred Care Conferences will occur more frequently if the client's condition or needs change and there is a need to coordinate care with other service providers. This may include changes in the resident goal of care including wishes for palliative or end of life care.

7.2. The facilitator shall update the summary from the previous summary, highlighting any behavioural or treatment changes or concerns.

7.3. The follow-up Client Centred Care Conferences shall follow the same format as the initial Client Centred Care Conference.

References:

Bendowska, A., & Baum, E. (2023). The Significance of Cooperation in Interdisciplinary Health Care Teams as Perceived by Polish Medical Students. *International journal of environmental research and public health*, *20*(2), 954. https://doi.org/10.3390/ijerph20020954

Nancarrow, S. A., Booth, A., Ariss, S., Smith, T., Enderby, P., & Roots, A. (2013). Ten principles of good interdisciplinary team work. *Human resources for health*, *11*, 19. https://doi.org/10.1186/1478-4491-11-19

Interior Health. (2015, June). *Interdisciplinary Care Conference Planning Guidelines.* Retrieved from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://divisionsbc.ca/sites/default/files/Divisions/Provincial/Long-term%20Care%20Resources/IDCC%20DRAFT%20package%20November%201%2C%202015.pdf

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Nursing Council of New Zealand. (2011, July). *Guidelines for cultural safety, the Treaty of Waitangi, and Maori health in Nursing Education and Practice*. Retrieved from https://ngamanukura.nz/sites/default/files/basic_page_pdfs/Guidelines%20for%20cultural%20safety%2C%20the%20Treaty%20of%20Waitangi%2C%20and%20Maori%20health%20in%20nursing%20education%20and%20practice%282%29_0.pdf

Approved By:	Date: 16 Nov 2023
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date: 16 November 2023
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

Return to TOC

APPENDIX A: FACILITATING A CLIENT CENTRED CARE CONFERENCE:

The facilitator has prepared a brief summary of the client's care, using the following format:
Interdisciplinary Care Conference Summary:

- Name and age of the client/resident.
- Admission date.
- Relevant past medical history
- Current medications
- Relevant screening with most recent dates.
- Completed assessments and scores, e.g., MoCA, Fall Risk Assessment, etc.
- Current treatments and referrals.

1. State the purpose of the Client Centred Care Conference: initial, follow-up, or recent change.
2. Review any known advance directives or end of life wishes.
3. Explain the meeting process – introductions, review of summary and input from Client Centred Care Conference participants.
4. Introduce the participants – client or resident, family if present (or available remotely), all other participants.
5. Review the summary and advise of any recent changes or concerns, including any decline in mobility or greater assistance needed, any improvements resulting from current treatments, and any events that may be impacting changes, i.e., recent death of friends or family, recent episodic illness, etc.
6. Invite medical participants to add any relevant information, questions, or concerns.
   - Nurses
   - OT/PT if present
   - Recreation therapy
   - Family services
   - Physician/NP
7. Invite client/family to add any input and concerns.
8. Facilitator recaps all the previous information and concerns of the participants.
9. Physician/NP summarizes any changes in medical condition and options for treatment.
10. Discussion of the changes to be initiated to the plan of care.
11. The facilitator thanks everyone for their participation and closes the meeting.
12. The facilitator documents a summary of the meeting in the client's health record in Meditech, if available, and files the completed hard copy summary in the client's paper chart.

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Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Care of Clients – Responsive Behaviours		Client Care	H3C 03-005-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
16/11/2023	16/11/2024	2.25	4
APPLIES TO:			
Regulated and Unregulated Healthcare Providers and Healthcare Workers			

1. BACKGROUND:

Home, Community, and Continuing Care (HCCC) recognizes that all behaviour has meaning, and that responsive behaviours are often a form of communication of an unmet need.

Responsive behaviour is a term used to refer to actions, words, or gestures presented by a person with dementia or other conditions as a way of responding to something negative, frustrating, or confusing, or frightening in their social and physical environment.

Examples of responsive behaviours include but are not limited to one or more of:

- Pacing, undressing, handling objects;
- Physically hurting self or others;
- Verbally abusive comments or complaints;
- Resisting care;
- Socially inappropriate or disruptive actions;
- Wandering; and
- Withdrawal and social isolation

The goal of care is to prevent or minimize the situations in which the client exhibits the responsive behavior.

2. GUIDELINE:

2.1. Assess:

2.1.1. What responsive behaviours have been demonstrated? Description, frequency, timing, intensity, etc.

2.1.2. Are there underlying medical causes for the behaviour?

- Sleep deprivation
- Medication side-effects
- Caregiver approach
- Delirium

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- Dehydration
- Depression
- Cognitive decline
- Pain
- Constipation
- Pressure ulcers
- Overstimulation
- Boredom
- Social isolation/loneliness

The use of a screening tool and tracking tool will assist the care staff to understand the cause of these behaviours and track the patterns of these behaviours. Examples include:

- RAI/MDS Resident Assessment Instrument/Minimum Data Set
- Putting it all together P.I.E.C.E.S/RAI MDS Integration Job Aid
- Dementia Observation System
- Cornell Scale for depression
- Cohen Mansfield Agitation Inventory

2.2. Collaborate:

2.2.1. The staff observing the behaviour shall discuss it with the supervisor.

2.2.1.1. The behaviour may be known, and mitigating strategies may be in place.

2.2.1.2. The behaviour is new – the supervisor may call an all staff meeting to discuss the new behaviour, consider the factors influencing the behaviour, and troubleshoot solutions.

2.2.2. Staff shall avoid actions that may result in escalating behaviours such as arguing or insisting on care against resistance. Forcing care decreases trust and increases resistance and fear.

2.3. Engage Client, Family, and Alternate Decision Maker:

2.3.1. Request client and family input to problem-solve strategies to prevent or better manage responsive behaviours.

2.3.2. Invite family to share information about the client's routines, likes, dislikes, significant relationships, hobbies, food preferences, and strategies for communication and restlessness.

2.4. Consider the Environment:

- Consistent staffing assignments to build trust and a sense of safety.
- Flexible approaches for timing of meals and hygiene, work with the client and/or family to determine the best timing for service delivery.
- Ensuring that noise is minimized to the extent possible.
- Ensuring that the physical environment allows as much freedom of movement as possible.
- Murals or posters to brighten up rooms and hallways.

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2.5. Communicate the Care Plan:

Ensure that all staff and families are aware of the plan.

2.6. Evaluation and Modification of the Care Plan:

2.6.1.Every care plan will have a reassessment date – weekly, monthly, etc., as needed.

2.6.2.Evaluate the effectiveness of the plan incorporating feedback from family and staff.

2.6.3.Update the plan as required.

2.7. Document:

At minimum, documentation includes:

- Description of responsive behaviour.
- Time and place of occurrence.
- Observed precipitating factors.
- Strategies used to mitigate or redirect and their effectiveness.
- Discussion with supervisor or colleagues.
- Care plan.

Practice Point- Success Strategies:

- Consider weekly interprofessional meetings to problem-solve and strategize.
- Staff education on person-centred dementia care strategies.
- Regular rounds with HCPs and HCWs to discuss interventions and changes in behaviour or condition.
- Shift reports should include updates on behaviours and strategies.

REFERENCES:

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Approved By:	Date: 16 Nov 2023
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date: 16 November 2023
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

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Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Falls Prevention and Management		Client Care	H3C 03-006-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
03/01/2024	03/01/2025	NEW	5
APPLIES TO:			
All Home, Community, and Continuing Care Team Members			

1. BACKGROUND:

Home, Community, and Continuing Care (HCCC) recognizes that falls are the leading cause of injury among elders with 20 – 30 % of elders experiencing one or more falls per year. Falls are the cause of 85% of elders' injury-related hospitalizations and 95% of all hip fractures.

"In addition, many health issues among Indigenous people are deeply influenced by the early historical events of colonialism, residential schools and policies that disadvantage Indigenous people. Health outcomes are further impacted by issues such as racism, poverty, and lack of access to health services. Unsafe housing, hazardous pedestrian walkways and lack of safe transportation in many Indigenous communities also pose fall and injury risks" (Scott, 2018), resulting in a greater risk for falls and related injuries among Indigenous elders.

HCCC strives to ensure the safety of clients/residents in their care through provision of the following policy and guidelines regarding fall prevention and management.

2. POLICY:

2.1. The Nurse Manager and Supervisor of Home and Community Care (SHCC) or their delegates shall assess all residents/clients admitted to their programs for falls risk according to the guidelines below.

2.2. Nurse Managers and SHCCs or their delegates shall complete the assessment in the preferred language of the client/resident following CHN Policy 06-013-00 *Interpreter Services.*

2.3. Nurse Managers/SHCCs shall complete an individualized care plan outlining the factors and fall prevention strategies in consultation with the resident/client and the healthcare team utilizing a culturally safe, trauma-informed approach.

2.4. All falls shall be documented in the Meditech QRM Module – Desktop Incident Management and in the client record or in hard copy in their health record.

DEFINITIONS:

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Fall: Unintentionally coming to rest on the ground, floor, or other lower level with or without injury. This includes an unwitnessed fall - where the client is able/unable to explain the events and there is evidence to support that a fall has occurred.

Fall injury: Any injury from a fall that may or may not require medical attention.

3.0 **Guideline: Risk Assessment:**

2.5. Fall risk assessments are completed at admission, after significant change in health status, after a fall and annually as part of the standard client reassessment process detailed in HCCC Policy 03-002-00 Client Assessment and Reassessment.

2.5.1. Assessment tools can be classified into quick screening, or more comprehensive assessment tools. Based on ease of use and training, it may be appropriate for HCCC practitioners especially in the home care setting to start with screening in order to sort individuals into high or low risk categories (See Appendix A). If fall or mobility issues are identified it is appropriate to implement a more comprehensive tool to identify individual risk factors.

2.5.2. Fall risk assessments are completed using tools validated for use in various health care setting (See Appendix B)

Risk assessments include exploring both biologic, behavioural, social/economic and environmental causes of falls:

Biologic: Mobility impairment including balance, gait deficit and muscle weakness; advanced age, chronic disease, and acute illness.

Behavioural: History of falls, fear of falling, medications including antipsychotics and sedatives, risk taking behaviours, inappropriate footwear, poor nutrition and hydration.

Social/Economic: Living alone, lack of support network, low income, and poor living conditions.

Environmental: Obstacles and tripping hazards, slippery and uneven surfaces, poor lighting, and no handrails.

2.5.3. It is important that those who are administering the tools are trained, and acting within their professional scope of practice and it may be appropriate to refer to occupational or physical therapists.

2.5.4. Although there are no validated environmental hazard checklists, ensure the checklist used is designed for use with community or continuing care populations (See Appendix C).

2.6. Engage clients/residents, family (with client consent) or where appropriate their guardian regarding at risk for falls by exploring their knowledge and perceptions of risk and their level of motivation to address risk.

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2.7. Communicate the risk assessment findings to the client/residents, family and healthcare team.

2.8. Discuss options for interventions and support self-management for capable clients.

2.9. Develop an individualized plan of care in collaboration with the client/resident or where appropriate their guardian and the healthcare team.

3. GUIDELINE: POST FALL ASSESSMENT:

3.1. The SHCC, Nurse Manager, or regulated HCP delegate will conduct a physical examination including vital signs to assess for injury and determine the severity of any fall injury.

3.1.1. Moving of the client/resident must be done in accordance with the department's No Lift Policy.

3.1.2. If unwitnessed falls and witnessed falls with suspected head injury have occurred, a neurological assessment must be conducted. Neurological observations are documented every hour for four hours and then every 4 hours for 24 hours and then as required.

3.2. The client/resident will be monitored for injuries that may not be immediately apparent. Consider 24–48-hour monitoring.

3.3. The SHCC or Nurse Manager will complete a post-fall assessment form to determine factors that contributed to the fall, including an environmental assessment for factors such as icy walkways, tripping hazards, and etcetera (See Appendix D).

3.4. All falls shall be reported to the SHCC or Nurse Manager of Continuing Care.

3.5. The SHCC or Nurse Manager shall contact the Community Health Nurse (CHN) on call if the injury requires treatment out of scope for the SHCC or Nurse Manager.
In the absence of a CHN in the community, the on call Advanced Care Paramedic can be contacted or the community emergency support line/virtual Nurse Practitioner.

3.6. The Nurse Manager or SHCC will involve an Occupational Therapist and/or Physical therapist when the individual has multiple risk factors for falls such as mobility and cognitive limitations.

3.7. All assessments and interventions, including referrals, shall be documented in the client record.

4. GUIDELINE: INTERVENTION

4.1. Interventions can be put in place to create and maintain a safe environment for those individuals at risk for falls.

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4.1.1. Examples of interventions include environmental modification, exercise with balance training, appropriate use of assistive devices, as well as clothing and footwear, medication review and modification, and treatment visual problems, and cardiovascular disorders.

4.2. The post-fall assessment will include a review of the care plan and an update of the fall prevention strategies (See Appendix E).

5. Associated Policies and Legislation:

Policy 03-002-00 Client Health Assessment and Reassessment
Policy 04-008-00 Autonomy and the Right to Live at Risk
Policy 03-001-00 Individual Care Plan Development and Communication
CHN Policy 06-013-00 Interpreter Services

6. References:

Canada, P. H. (2014). *Seniors' Falls in Canada Second Report.* Retrieved from www.phac-aspc.gc.ca/seniors-aines/publications/public/injury-blessure/seniors_falls-chutes_aines/assets/pdf/seniors_falls-chutes_aines-eng.pdf

Public Health Agency of Canada. (2016, April 28). *You CAN Prevent Falls!* Retrieved from https://www.canada.ca/en/public-health/services/health-promotion/aging-seniors/publications/publications-general-public/you-prevent-falls.html

Registered Nurses' Association of Ontario. (2017, September). *Clinical Best Practice Guidelines Preventing Falls and Reducing Injury from Falls Fourth Edition.* Retrieved from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://rnao.ca/sites/rnao-ca/files/bpg/FALL_PREVENTION_WEB_1207-17.pdf?_ga=2.264557836.2032491448.1696416198-1780830871.1696416198&_gl=1*ia38*_ga*MTc4MDgzMDg3MS4xNjk2NDE2MTk4*_ga_4Y35X117T7*MTY5NjQxNjE5

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Approved By:	Date: 3 January 2024
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date: 3 January 2024
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

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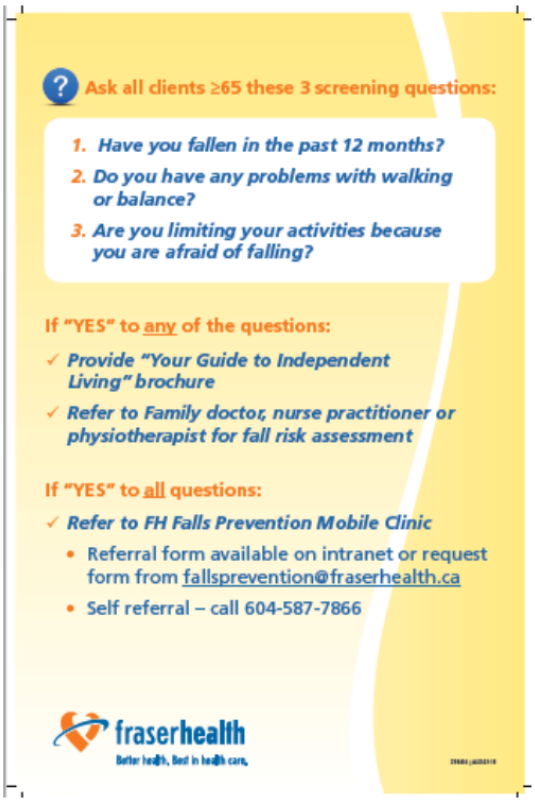
Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Falls Prevention and Management Appendix: Screening		Client Care	H3C 03-006-01
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
03/01/2024	03/01/2025	NEW	20
APPLIES TO:			
All Home, Community, and Continuing Care Team Members			

See Below

Appendix B: Ask Clients – 3 Screening Questions Poster (PS#258606) **or Pocket Card** (PS #258603)



Appendix C: Fall and Injury Prevention Pocket Card Home Health and Community Version (PS #258603)

- **Front of Pocket Card** - Universal Falls Precautions (SAFE) – HH & Community
- **Back of Pocket Card** - Ask Clients – 3 Screening Questions

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The following examples of tools have been either validated or are in use in various healthcare settings:

Long Term Care

• Area Ellipse of Postural Sway

• Mobility Fall Chart

• Scott Fall Risk Assessment (SFRA)

• Tinetti Balance Subscale

Home and Community Care:

• BERG Balance Scale (BBS)

• Falls Efficacy Scale International (FES-I)

• Staying Independent Checklist

• Timed-Up-and-Go Test (TUG)**

* FES-I is easily done by phone.

** TUG test is one of the easiest tests to carry out in a client's home to identify clients at risk for falls that require a more in-depth assessment and evaluation. A quick screen test of balance and gait where the person rises from a chair, walks at a normal pace for 3 meters and returns to a sitting position on a chair. A cut off score of 13.5 seconds or longer is predictive of falls. The test is best conducted as part of a multifactorial assessment among lower functioning individuals.

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Appendix F - CCS de la Vieille-Capitale Instructions and Tool

Reproduced with permission CSSS de la Vieille-Capitale; 2013.

Long Term Care

Centre de santé et de services sociaux de la Vieille-Capitale

Centre affilié universitaire

INSTRUCTIONS

Scott fall risk screening tool

Important: If a resident is restrained in the evaluation of fall risks, evaluate the resident according to his behavior without restraint.

Date : _____	**Reason for completing tool :**	Admission ☐ Change of status ☐ Review ☐ Post-fall ☐ Transfer ☐

- Admission = obligatory
- Post fall = if changes in risk factors
- Change of status = improvement or deterioration
- transfer = if significant change in the environment
- Review = evaluate the effectiveness of interventions or to review periodically the status of the user to the risks of falling.

RISK FACTORS	○	RAPID RESPONSE	☑
▶ Circle the risk factors present.		▶ Once a factor is present, a rapid response must be made.	
1. More than 2 falls in previous 6 months		▶ Falls described by the resident or his family or noted on the medical record	
2. Dizziness or vertigo ▪ In a standing position **or** ▪ Lying to sitting **or** ▪ Sit to stand		▶ Verbalized by the resident or observed during an intervention	

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3. Altered mental state Delirium, brain injury, dementia, depression **or** agitation **or** resident can't follow or remember the instructions		► Delirium or depression in the active phase
4. Attempts to unsafely get out of bed Due to lack of understanding, agitation or restlessness		► Observed only within transfers
5. Move to facility in past month		
6. Impaired mobility, balance or gait		► See also physiotherapy form.
7. Generalized weakness ▪ Resident verbalizes that they feel weak. **or** ▪ Unable to stand unassisted by side of bed for 2 minutes **or** ▪ Unable to do 2 or more of the following:: *get off and on toilet independently, sit to stand and back to sit without assistance, able to dress and groom independently, walk across room (20 feet), turn and walk back without assistance, transfer / move in bed*		► The inability to do the activities must be due to the weakness and not another problem such cognitive impairments. ► Incapacity with or without walking aid
8. Urinary and bowel elimination ▪ ≥ 7 voiding in 24 h **or** ▪ Nocturia (gets up at night ≥ 1 time) **or** ▪ Urgency **or** ▪ **Recent** incontinence (in the last month)		► Situations that make the resident tries to use the bathroom quickly, often or night.
9. Médication ▪ Take **≥ 5** medications (including PRN)		► Do not include drops, ointments, creams, vitamins and minerals (e.g. iron, calcium).
▪ Any prescribed benzodiazepine or psychotropic medications		
Sub-total		
10. Immobile (unable to walk or stand unaided) *Negative because the fall risk decrease*	**- 5**	► **ATTENTION, the factor 10 is negative, because it makes resident at a lower risk**

Safer Healthcare Now! Reducing Falls and Injuries from Falls Getting Started Kit

CONTRIBUTING FACTORS	☑	INTERVENTIONS RAPIDES	☑
► Circle the contributing factors present		► Once a factor is present, a rapid response must be made.	
Troubles of sensory perception ▪ Visual or hearing deficit ▪ Peripherical neuropathy ▪ Gnosis or hemineglect impairment		► Gnosis impairment: impaired recognition of objects or movements ► Difficulty perceiving elements of the environment or to understand how to mobilize members.	
Inadequate nutrition ▪ Malnutrition ▪ Consumption ≤ ¾ of meals including meal ▪ Consumption < 2 meals per day			
Physical restraint use			
Fear of falling. Possible behaviors are : ▪ Resident change his habits during his activities ▪ Resident restricts his displacements ▪ Resident walk with caution ▪ Resident becomes anxious when he's standing		► Two questions should be asked to the resident – Do you fear of falling? – Have you reduced your activities for fear of falling?	

Universal fall prevention plan (Check the interventions by screening score)

► **IMPORTANT : Use the identifier when the score is above 12 and that the resident should not transfer himself or walking alone**

Note that is possible, despite a higher score than 12, not to use the identifier if the risks are accepted by the user and his family or if the resident has a particular behavior. If this occurs, it's necessary:

- That the decision is made during a discussion with the interdisciplinary team and with agreement of the family;
- That the discussion and decision are the subject of a note in the medical record

Unsafe ambulation > 12

Implement interventions 1-9 and add

10. ☐ Hold an interdisciplinary meeting
11. ☐ Use identifier
12. ☐ Ensure a safe positionning in the chair

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Comments or other interventions	**N. B. : A note requires a signature at the end of it.**

► **Write in this section :**

- Other risk factors observed;
- Other prevention strategies used;
- If another professional gets a different score at screening, he indicates in this section and discuss with the nurse;
- Other

Complete by Nurse Date : _____

_____ Date : _____

Other professional

_____

Date for the next review :

_____ The next reassessment must be made minimally in 12 months.

► A reassessment date is obligatory and is determined based on professional judgment. This date must not exceed 12 months.

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Centre de santé et de services sociaux de la Vieille-Capitale
Centre affilié universitaire

Facility _____

Scott fall risk screening tool

Date : _____	Reason for completing tool : Admission ☐ Change of status ☐ Review ☐ Post-fall ☐ Transfer ☐		
RISK FACTORS	○	**RAPID RESPONSES**	☑
11. More than 2 falls in previous 6 months	6	▪ Maintenance of lifestyle-related ADL ▪ Orientation of the resident in time and space	☐ ☐
12. Dizziness or vertigo ▪ In a standing position **or** ▪ Lying to sitting **or** ▪ Sit to stand	1	▪ Information given to nursing staff telling resident to slow transfers ▪ Resident education to do his transfer slowly	☐ ☐
13. Altered mental state Delirium, brain injury, dementia, depression **or** agitation **or** resident can't follow or remember the instructions	2	▪ Introduction of routine care and activities	☐
14. Attempts to unsafely get out of bed Due to lack of understanding, agitation or restlessness	3	▪ Installing a mobility sensor (To be discussed with the occupational therapist)	☐
15. Move to facility in past month	1	▪ Increased surveillance	☐
16. Impaired mobility, balance or gait	2	▪ Increased surveillance ▪ Walking Aid left close (if applicable) ▪ Request the use of hip protectors	☐ ☐ ☐

17. Generalized weakness ▪ Resident verbalizes that they feel weak. **or** ▪ Unable to stand unassisted by side of bed for 2 minutes **or** ▪ Unable to do 2 or more of the following:: *get off and on toilet independently, sit to stand and back to sit without assistance, able to dress and groom independently, walk across room (20 feet), turn and walk back without assistance, transfer / move in bed*	1	▪ The level of assistance required for the performance of the activities is determined and recorded in the care plan	☐
18. Urinary and bowel elimination ▪ ≥ 7 voiding in 24 h **or** ▪ Nocturia (gets up at night ≥ 1 time) **or** ▪ Urgency **or** ▪ **Recent** incontinence (in the last month)	1	▪ Establishing a schedule of continence ▪ Using a commode near the bed ▪ Information provided to staff telling resident to offer voiding before administering a medication that causes drowsiness ▪ The night, changing the lighting leading to the toilet	☐ ☐ ☐ ☐
19. Médication ▪ Take **≥ 5** medications (including PRN)	1	▪ Monitoring of adverse reactions	☐
▪ Any prescribed benzodiazepine or psychotropic medications	1	▪ Monitoring the presence of daytime sleepiness	☐
Sub-total			
20. Immobile (unable to walk or stand unaided) *Negative because the fall risk decrease*	**- 5**	▪ Check the positioning in the chair ▪ Check the positioning in bed	☐ ☐
TOTAL		**Score < 7: universal precautions for falls.** **Score > 7: deemed to be at high risk for falls.** **Score >12: deemed to be at high risk for falls and unsafe ambulation.**	
SCOTT FALL RISK SCREENING TOOL			

CONTRIBUTING FACTORS	☑	RAPID RESPONSE	☑
Troubles of sensory perception ▪ Visual or hearing deficit ▪ Peripherical neuropathy ▪ Gnosis or hemineglect impairment	☐	▪ Surveillance of wearing glasses or hearing aids ▪ Initiation of action by care worker to assist the resident understanding ▪ Respect the visual field of the resident	☐ ☐ ☐
Inadequate nutrition ▪ Malnutrition ▪ Consumption ≤ ¾ of meals including meal ▪ Consumption < 2 meals per day	☐	▪ Stimulation of feeding ▪ Surveillance of wearing dentures ▪ Make water accessible and near the resident ▪ Surveillance of oral hygiene	☐ ☐ ☐ ☐
Physical restraint use	☐	▪ Ensure that surveillance is performed	☐
Fear of falling. Possible behaviors are : ▪ Resident change his habits during his activities ▪ Resident restricts his displacements ▪ Resident walk with caution ▪ Resident becomes anxious when he's standing	☐	▪ Walking stimulation with one or two care worker	☐

Universal fall prevention plan (Check the interventions by screening score)

Whatever score : (0 to 19)

1. ☐ Bed in low position
2. ☐ call bell in place
3. Good fitting footwear
   ☐ Yes ☐ No, call family
4. Good fitting clothes
   ☐ Yes ☐ No, call family
5. Cluttered room
   ☐ Yes ☐ No, call family
6. Maintain the resident autonomy
   ☐ Mobility ☐ ADL ☐ Continence

Score ≥ 7

Implement interventions 1-6 and add

7. ☐ Indicate the level of risk on care plan
8. ☐ Use customized strategies for fall prevention
9. ☐ If restraint use, to ensure its safe installation

Unsafe ambulation > 12

Implement interventions 1-9 and add

10. ☐ Hold an interdisciplinary meeting
11. ☐ Use identifier

12. ☐ Ensure a safe positioning in the chair

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Comments or other interventions	**N. B. : A note requires a signature at the end of it.**

Complete by Nurse _____ Date : _____

Other professional _____ Date : _____

Date for the next review : _____

The next reassessment must be made minimally in 12 months.

Adaption of the SCOTT, Vicky, et autres (2010). *Fall Screening Tool: Residential Care*

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HOME SAFETY QUESTIONNAIRE

Patient Name _____ **Date** _____

When you are prone to falling, your home can either support you or become a reason for your falls. The following is a list of common things that make a difference in a falling problem.

Look around you and answer the questions truthfully about how well your home is helping you avoid falling. Then think about how you can change things to make it less likely that you will fall. **Bring this form with you for your evaluation.**

Please choose the best response to each of the questions below.

1. As I move from room to room in my house, I slip or stumble from clutter of electrical cords, low furniture, or other things in my path. (Trips)

   Never **Rarely** **Once a week** **More than once a week**

2. As I move from room to room in my house there are sturdy things I can grab to steady myself if I feel unsteady. (Handholds)

   Everywhere **Most places** **Sometimes** **Few things to steady me**

3. I have good light when I walk in my house, (include nighttime trips to the toilet). (Light)

   Always **Almost always** **Sometimes** **Often dark**

4. While inside my home I walk in shoes, not barefoot or in slippers. (Footwear)

   Often **Usually** **Sometimes** **Mostly barefoot**

5. I slip or have difficulty getting on and off the toilet. (Toilet)

   Never **Rarely** **Sometimes** **Often**

6. I slip or have difficulty getting in and out of the bath or shower. (Bath)

   Never **Rarely** **Sometimes** **Often**

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7. I slip or have difficulty with steps or stairs in my house. (Stairs)

Never **Rarely** **Sometimes** **Often**

8. I stand on my toes to get things out of reach in my kitchen or closets. (Reach)

Never **Rarely** **Sometimes** **Often**

9. In the places I walk outside, there are uneven surfaces, cracked sidewalks, slippery steps, or other problems that make me trip or stumble. (Outside)

Never **Rarely** **Sometimes** **Often**

10. If I were to fall, hurt myself, and were unable to get up, I would be able to get help quickly. (Help)

Always **Usually** **Sometimes** **No – Usually Alone**

Home Safety Questionnaire: Scoring Instructions

Scoring Instructions

- Extreme left items score 0, with sequential left to right scores of 1, 2, 3.
- For example, Item 10:
- Always = 0, Usually = 1, Sometimes = 2, No – Usually Alone = 3.
- The higher the score, the more concern regarding the safety issue.
- Copy the score for each item into the same numbered and titled block on the Falls Evaluation: Initial Visit form.

Appendix J - Environmental Fall Risk Assessment Checklist

Adapted from: Boushon, B. et al. (2008). Transforming Care at the Bedside. How to Guide: Reducing Patient Injuries from Falls, Institute for Healthcare Improvement.

Reproduced with the permission of Institute for Healthcare Improvement; 2013.

Individual(s) Surveying:

Date:	
Organization:	
Unit:	
Rooms assessed (minimum 10 percent of rooms):	
Individual (s) Surveying:	

Environmental Consideration

Patient/Resident Room

- ☐ Is there adequate lighting in the patient's/resident's room? (Bright light - no burned out bulbs?)
- ☐ Is the nightlight on the patient's/resident's bed functional/operating?
- ☐ Does the patient/resident have an unobstructed path to the bathroom?
- ☐ Are patient/resident room furnishings safely arranged?
- ☐ Is bedside furniture free of sharp edges?
- ☐ Is the bedside furniture sturdy?
- ☐ Are beds/stretchers kept at lowest possible setting whenever possible?
- ☐ Are beds/stretchers kept in locked position?
- ☐ Were the upper siderails in the up position for patient/resident to reach controls?
- ☐ Was the bed check system on in the patient's/resident's room?
- ☐ Were the patient's /resident's personal belongings/telephone/call bell within reach?
- ☐ Are handrails provided in patient/resident bathroom properly secured?

- ☐ Emergency call button/cord in patient/resident care bathroom present and work properly?
- ☐ Are nonslip surfaces provided in patient/resident showers?
- ☐ Are the door openings into the patient/resident bathroom wide enough for an assistive device to fit through?
- ☐ Are door openings flush within the floor for ease of movement for patient/resident equipment?

Equipment

- ☐ Portable equipment pushed by patient /resident (i.e., IV pole) sturdy and in good repair?
- ☐ Are bedside commodes available on the unit and have proper rubber slip tips on the legs?
- ☐ Do walkers/canes/crutches have the appropriate tips?
- ☐ Are wheelchairs locked when stationary?
- ☐ Is broken equipment properly tagged for non-use?

Other Environmental Considerations

- ☐ Are floor surfaces/carpeting free of cracks and tripping hazards?
- ☐ Are hallways kept adequately clear/clutter free to allow patient/resident ambulation?
- ☐ Are floors properly marked when wet to avoid slipping or spill cleaned up immediately?
- ☐ Do parking lots have uneven pavement/tripping hazards?
- ☐ Do sidewalks have uneven pavement/tripping hazards?
- ☐ Entrance areas free and clear?
- ☐ Parking areas/entrances well-lit?
- ☐ Parking lots well marked?

Environmental Fall Risk Assessment Follow-Up

Item #	Corrective Action	Date Initiated	Responsible Individual(s)	Anticipated Date of Completion

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Appendix L - Post Fall Assessment Checklist

Reproduced with the permission of Windsor Regional Hospital, Windsor, Ontario; 2013.

This example of a post-fall assessment checklist used in a continuing care setting could be modified to sector specific requirements.

WINDSOR REGIONAL HOSPITAL | MALDEN PARK CONTINUING CARE CENTRE

Post Fall Investigation

Resident Name: _____ Date and Time of Fall: _____

1. **Was this fall observed?** ☐ **Yes** ☐ **No**

   If yes, by whom?

   1._____ **2.** _____

   (name & title of person) **(name & title of person)**

2. **Was the Resident identified as "High Risk" prior to the fall?** ☐ **Yes** ☐ **No**

3. **Resident's Vital Signs**

Temp.	Pulse	Resp.	B/P	O_2 Sat.	Blood Sugar(diabetics only)

4. **Does the Resident have a history of falls?** ☐ **Yes** ☐ **No**
5. **What was Resident's response to "Why do you think you fell?"**
6. **What footwear did the Resident have on?**

Barefoot / Socks		**Slippers**	
Shoes		**Other**	

7. Resident activity / needs at the time of the fall (Check all that apply):

	Yes	No		Yes	No
Getting in or out of bed?			Going to the dining room?		
Going to the bathroom?			Transferring?		
Getting up from chair?			In pain?		
Looking for something? Specify:			Other:		

8. Location of fall:

Resident's Room		Bathroom		Outside	
Dining Room		Shower		Hall	
Activity / Day Room		Toilet		Other:	

9. Was a restraint in place at the time of this fall?

Restraint	Yes	No	**Was the restraint in good repair?**	**Yes**	**No**
None					
Table Top					
Seat Belt					
Other					

10. What mechanical devices were in use?

Mechanical Device	Yes	No	**Was the mechanical device in good repair?**	**Yes**	**No**
None					
Personal Alarm					
Bed Alert					
Bed Rail(s) Circle number used: 0 1 2 3 4					
Hi-Lo bed, at lowest level					

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11. What assistive devices were in use?

Assistive Device	Yes	No	**Was the assistive device in good repair?**	**Yes**	**No**
Cane ☐ Straight ☐ Quad					
☐ Crutches					
Walker: ☐ Standard ☐ 2-wheeled ☐ 4 -wheeled					
Wheelchair					
Broda Chair					
Other:					

12. Mental Status of Resident: (check all that apply)

	Prior to the fall	**Following the fall**
Alert		
Able to follow directions		
Confused / Disoriented		
Change in behaviours		
Other:		

13. Physical Status of Resident at time of fall: (check all that apply)

Incontinence		Change in BP	
Weakness / fatigue		Recent weight loss / gain	
Unsteady gait		Decrease in fluid intake	
Recent acute illness Specify:		Recent change in lab values (Hgb, blood sugar)	
Pain		Recent cough / cold	
Visual impairment		Glasses on	
Hearing impairment		Hearing aid on & working	
Dizziness			

14. Environmental status at time of fall: (check all that apply)

Call bell within Resident's reach		Call bell on at time of fall	
Bed locked		Room light on	
Wheelchair locked		Night light on	
Throw rugs		Floor wet	
Uneven floor surface		Power / phone / TV cords	
Other:			

15. List all new medications or dosage / time changes or prn medications prescribed / administered to the resident within the past 48 hours:

Date	Medication

16. Did fall result in transfer to hospital? ☐Yes ☐ No

If yes, Ministry of Health Unusual Occurrence Form initiated? ☐ Yes

If yes, Complete WRH Risk Monitor Pro ☐ Yes

17. Executive Director notified only if the resident was transferred to hospital

Date & Time Executive Director notified: _____

18. Physician notified? ☐Yes ☐ No Date & Time: _____

19. Family notified ☐Yes ☐No Date & Time: _____

20. Is there a need to re-educate the resident, family and staff? ☐ Yes ☐ No

Return to TOC

Summary: Factors contributing to fall

_____

_____

_____

_____

Action Plan(s)

_____

_____

_____

_____

Post Fall Follow Up

Activity	Date
Fall documented in progress notes	
Fall entered in Incident Log	
Post Fall Investigation summary documented in progress notes	
Fall Risk Assessment Tool completed	
Fall Prevention Care Plan reviewed	

Unit Staff Safety Huddle:

Within 72 hours post fall Review incident, cause and action plan(s) Initial & Date when completed	Nights	Days	Evenings

Assessment completed by:

Name (print) Signature

_____ _____

Date/Time submitted to management:

_____

Date and Time

Return to TOC

Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Oral Hygiene		Client Care	H3C 03-007-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
16/11/23	16/11/2024	2.16	2
APPLIES TO:			
Supervisors of Home and Community Care, Home and Community Care Workers, Nurse Manager, Continuing Care Workers.			

1. BACKGROUND:

The Home and Continuing Care Program (HCCC) recognizes the importance of maintaining the oral health of its clients.

The Non-Insured Health Benefits (NIHB) branch of Health Canada provides funding for dental services for Inuit.

Dental services are provided by contracted dentists who visit every community in Nunavut a number of times yearly.

HCCC provides the following policy for the maintenance of optimal oral health of clients.

2. POLICY:

2.1. The HCCC Team will ensure that all client's have access to dental healthcare professionals for both preventative and acute care as required.

2.2. The Supervisor of Home and Community Care (SHCC) shall encourage each client in their care to access dental services at least once yearly.

2.2.1. The Home and Community Care Workers shall assist clients in their care with oral hygiene as necessary.

2.3. The Nurse Manager of Long-Term Care or delegate shall ensure that all residents shall visit the local dentist at least once yearly.

2.3.1. Residents without teeth will still require a visit with a dentist to screen for oral cancer and general oral health.

2.3.2. Residents with dentures shall visit the denturist if eligible for new dentures or if their dentures become damaged.

2.3.3. Long-term care staff shall assist those residents who require it, with oral hygiene twice daily.

2.4. The HCC staff assisting with oral care shall document the care provided in the client's health record.

2.5. Dental appointments shall be documented in the client's health record by the individual making or receiving the appointment.

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3. PRINCIPLES:

3.1. Good oral health is necessary for good physical health.

3.2. Oral infections can be implicated in cardiovascular disease, particularly endocarditis.

Approved By:	Date: 16 Nov 2023
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date: 16 November 2023
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

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Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Nutrition, Hydration, and Country Foods		Client Care	H3C 03-008-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
04/01/2024	04/01/2025	2.6	4
APPLIES TO:			
Nurse Managers of Continuing Care, Cooks, Supervisors of Home and Continuing Care			

1. BACKGROUND:

The Home, Community, and Continuing Care Program (HCCC) recognizes that good nutritional status is associated with successful aging, lower susceptibility to disease, prevention of pressure injuries, improved wound healing, better cognitive and physical performance, and improved quality of life (Alberta Health Services, 2019).

Country food has excellent nutritional value, plays a critical role in Inuit culture, and contributes to strong, sustainable, self-reliant communities (Nunavut Food Security Coalition).

HCCC also recognizes the importance of adequate hydration. Dehydration can result in constipation, fecal impaction, cognitive impairment, functional decline, delirium, and even death (Alberta Health Services, 2019).

HCCC provides the following policy and guideline for the management of nutrition and hydration and the integration of country foods in continuing care facilities, long term care facilities, and for home care programming funded to provide food.

2. POLICY:

2.1. Nurse Managers and Cooks in Continuing Care Centres shall ensure that their menus follow the Nunavut Food Guide and review menus with regional dieticians annually to ensure that menus contain a variety of tasty and nutritious food.

2.1.1. Nurse Managers shall provide country foods to residents as often as possible, but, at minimum, once monthly. Country food shall be stored as per the Serving Country Food in Government-Funded Facilities and Community Programs Guidebook.

2.2. Supervisors of Home and Community Care (SHCCs) shall provide country foods in any program for which they have received funding for food.

2.3. SHCCs shall assist their clients in obtaining country foods by providing information about sources of food and advocating with local Hunters and Trappers Associations for provision of country foods if possible.

3. PRINCIPLES:

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3.1. Nunavummiut have the right to adequate food, including the right to feed themselves and to participate in decisions about their food system.

3.2. Inuit traditional foods have outstanding nutritional value.

3.3. Food security is a priority for every community in Nunavut. Each one uses its Community Wellness Programs to address this issue.

3.4. Healthy eating is fundamental to fostering healthy people and communities.

4. DEFINITIONS:

Country foods: foods supplied by the land, including game meats such as caribou, muskox, and polar bear, fish such as Arctic char and maktaaq (whale meat), berries and bannock.

Dysphagia: difficulty swallowing caused by problems with neural control, or the structures involved in any part of the swallowing process.

Nutrients: substances or ingredients that promote growth, provide energy, and maintain life.

5. GUIDELINE:

5.1. Nurse Managers shall collaborate with facility cooks and regional dieticians in developing 3–4-week cycle menus. Menus shall be posted for easy access for the residents.

5.2. Teams to ensure that residents are engaged in menu planning and preferences for food and beverages.

5.3. Food service management includes providing three (3) meals and two to three (2-3) snacks daily, flexible mealtimes, clean, bright calm dining space, and opportunities to socialize with other residents and families.

5.3.1. The Nurse Manager shall ensure that staff are following the GN Serving Country Food guidelines for information on inspection, storing and preparing and serving country food.

5.3.2. Country foods may be purchased from local Hunters' and Trappers' Organizations, experienced hunters and Kivalliq Arctic Foods or Kitikmeot Foods or other retailers if available.

5.3.3. Facilities contracted by the GN are required to ensure that country foods are available to clients, and that an appropriate individual within the organization is specifically identified to ensure this occurs.

5.4. Continuing Care Workers shall record food and fluid intake by residents on a daily basis.

5.4.1. Adults older than 65 years of age require 30 ml/kg of fluid with a minimum of 1500 ml (6 cups daily).

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5.4.2. Nurses shall review food and fluid intake to ensure that adequate quantities have been consumed. Nursing staff including continuing care workers shall offer fluids at meals, snacks and on a 24-hour basis outside of mealtime to ensure adequate intake. If residents are consuming less than the minimum required amount (1500ml/day) for three consecutive days then the Nurse Manager shall be informed and use his/her clinical judgment to determine if the resident is at risk for dehydration. A referral shall be made to a physician, NP, or regional dietician (RD) for assessment and modification to the care plan.

5.5. Residents of Continuing Care Centres as well as Home Care Program Clients will be weighed on admission, and monthly to monitor for unintentional weight changes as a possible indicator of chronic disease or malnutrition.

5.5.1.Weights will be documented in the client's health record.

5.5.2 If a significant weight change occurs, the Nurse Manager shall be informed and use his/her clinical judgment to determine if a referral shall be made to the physician, NP, or RD for assessment and modification to the care plan. A significant weight change would be 5 percent or more in one month, 7.5% or more in over 3 months, and 10%+ over 6 months.

5.6. Residents of Continuing Care Centres shall receive a nutritional assessment by a dietician on admission, with change in condition and every 3 months. If a resident is identified at risk for dysphagia, malnutrition, low intake dehydration or the need for a modified diet, an individual nutrition care plan is completed by the dietician and review at least annually.

5.7. All staff shall be alert to signs of dysphagia – coughing and/or choking when eating or drinking, drooling or poor management of oral secretions, pocketing of food in cheeks, facial weakness, gurgles, hoarse voice or lots of throat clearing, multiple swallows for each bolus, decline in respiratory status, prolonged mealtimes, weight loss, recurring chest colds, pain with swallowing, increasing avoidance of multiple foods/liquids.

5.7.1. Residents presenting with the symptoms noted above shall be referred to a physician or nurse practitioner for consideration of swallowing studies.

5.8. SHCCs who have received funding for food provision in programming (e.g., elders' lunch programs) shall provide country foods if available in a timely way from the retailers noted in 5.1.1.

6. REFERENCES:

Alberta Health Services. (2019, July). *Nutrition Guideline Seniors Health Overview (65 years and older).* //efaidnbmnnnibpcajpcglclefindmkaj/https://www.albertahealthservices.ca/assets/in fo/nutrition/if-nfs-ng-seniors-health-overview.pdf

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Nunavut Food Security Coalition. (n.d.). *Nunavut Food Security Strategy and Action Plan 2014 - 16.*

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//efaidnbmnnnibpcajpcglclefindmkaj/https://www.nunavutfoodsecurity.ca/sites/defa ult/files/files/Resources/Strategy/NunavutFoodSecurityStrategy_ENGLISH.pdf

Approved By:	Date: 4 January 2024
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date: 4 January 2024
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

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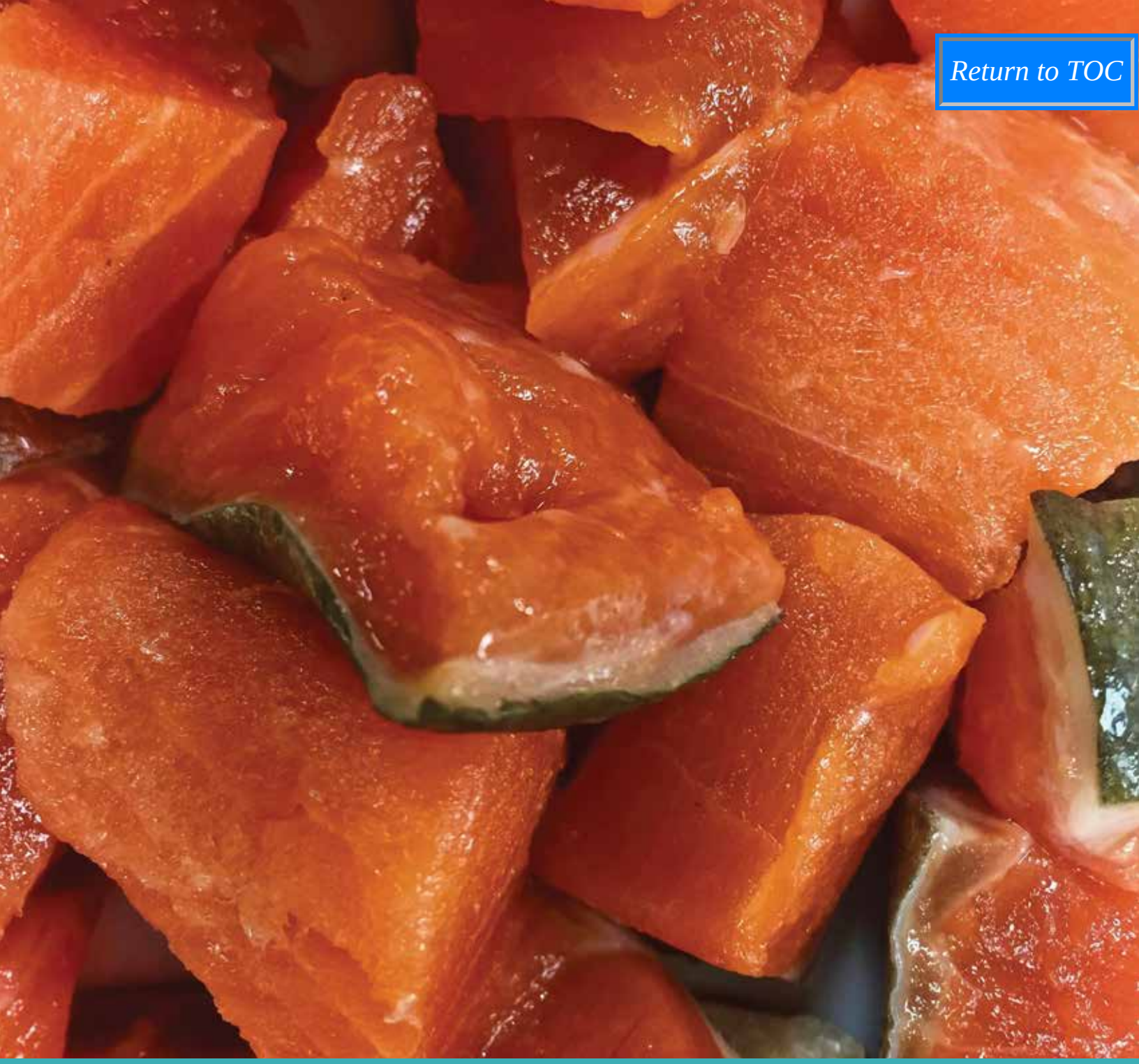

Nutrition for Elders & Long-Term Care

A Guidebook for Facilities in Nunavut

Nunavut

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Message from the Minister of Health

The Department of Health is committed to strengthening nutrition care and food services in Government of Nunavut funded facilities and community programs. I would like to take this opportunity to recognize the Department of Health staff who have created this guidebook and commend those individuals working with Nunavummiut living in care, who provided their valuable input.

Keeping true to the vision and priorities of Turaaqtavut, the Government of Nunavut will continue to work towards the well-being and self-reliance of our people and our communities through Inuusivut, by paying attention and valuing traditional knowledge while enhancing health care services throughout the territory.

Honourable George Hickes
MINISTER OF HEALTH

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Introduction

This guidebook will provide a resource for staff to support optimal health by meeting the nutrition and hydration needs of Nunavummiut in care. A critical component of this includes ensuring access to country food for clients. This guidebook can be used in conjunction with the booklet *Serving Country Foods in Government-Funded Facilities and Community Programs.* The facilities that may benefit from this guidebook include, but are not limited to:

- Regional long term care facilities
- Regional elders' homes
- Home care
- Residential care for mental health and addictions

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Food Service

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Best Practices

PART ONE: FOOD SERVICE

Providing the best care possible for Nunavummiut in government-funded facilities is a priority of the Department of Health. One important way to care for Nunavummiut is to ensure they are provided food that is tasty and healthy, and served in a way that suits their needs and wishes. A 3–4 week cycle menu is the way these goals are usually achieved in an institutional setting. A menu helps make sure that a variety of tasty and nutritious food is offered, and that managers and cooks know ahead of time what food to order and prepare. It is also very useful when there are new or replacement staff. A 3-week sample menu is provided in Appendix 1.

Staffing needs and the cycle menu

The sample menu included is based on cooking from scratch and therefore requires a full time cook 7 days a week for meal and snack preparation and associated duties. Support staff are needed to assist with meal and snack delivery, clean up and service of the evening meal. Support staff contribute to a pleasant and social eating environment by sitting with clients at meal time and assisting when needed. The manager, with input from the cook, orders and shops for food and ensures that kitchen appliances are working properly and required kitchen equipment is available.

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Tips for helping staff transition to using the 3-week cycle menu

Have a meeting to let all staff know that you will be using a new menu that has different meals every day for 3 weeks, and then starts over. Since support workers may also serve or prepare meals and snacks, it's important that they, too, know about the new 3-week cycle menu. Encourage staff to observe clients' acceptance of new menu items and share their observations with the cooks. Using a new menu can seem overwhelming at first because it means learning new recipes and creating a new work flow, and there may be some resistance, so it's important to provide support and encouragement. Typically, after 3-4 months, things will flow more smoothly.

To help clients know what will be served each day, purchase a whiteboard and marker (or chalkboard and chalk) and put it up where it can be seen by everyone. Ask a staff member to write down what will be served for lunch and supper every day.

To begin using the 3 week cycle menu, encourage cooks and staff to try out Week 1 as it is written. With staff, decide on a week to start Week 1. Use the *Food Order Sheet, Week 1* (Appendix 2) to help you make a food order at the store for Week 1. Check the fridges and freezers to make sure you don't order things that you have already. Check the dry storage area to make sure the non-perishables needed are in the facility.

Client and Staff Satisfaction with Menu

Ask the cook and other staff to write down the things that are working or not working with the new menu and recipes on the sheet called *Staff Notes on Menu Week 1* (Appendix 3). Encourage them to repeat Week 1, changing things that did not work well. Write any changes on the menu.

Once Week 1 is working smoothly, try out Week 2. Again, agree with staff on a week to try out Week 2 and use the *Food Order Sheet, Week 2* to make the local food order and check what is on hand in dry storage. Again, ask staff to write down the things that are working or not working with the Week 2 menu and recipes on the sheet called *Staff Notes on Menu Week 2* (Appendix 3). Encourage them to repeat Week 2 the following week, making changes as necessary. Do the same thing for Week 3.

Once a year, a meeting with staff and clients (and their families, if possible) should be held to get feedback about the menu and food service. The regional dietitian may be able to do this during his or her visit.

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Menu Substitutions

If a recipe is not enjoyed by clients and staff, it can be changed. There are several ways to do this. The recipe can be modified to make it more appealing. For example, if the Hamburger Soup recipe has too much tomato in it, cooks can reduce the amount of tomato and add another ingredient to make it tasty. Or, if a recipe is not enjoyed or does not turn out well, it can be replaced. In both cases, it is important to replace it with recipes or meals that have similar kinds of ingredients. For example, if the Fish Chowder recipe is not popular, it should be replaced with a recipe or meal that contains fish, milk and vegetables. For example, instead of Fish Chowder, you might serve fried fish, macaroni and cheese and glazed carrots or a tuna noodle casserole, with yogurt for dessert.

Tips for Ordering, Purchasing and Receiving Food Locally

Use the *Food Order Sheets, Week 1, 2 and 3* (Appendix 2) to help you place your order at the local store. The Iqaluit Week 1 order sheet has been completed. Use it as an example of how you can make your shopping list for Weeks 2 and 3.

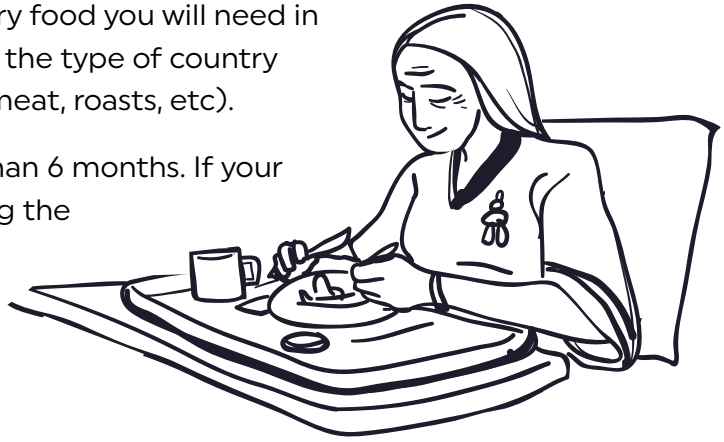
When fresh fruit and vegetables are on the menu, be sure they are inspected when you receive them to make sure they are good quality. If they are rotting or bruised, return them, and ask for a substitute.

Perishable foods such as meat and fish, eggs, fresh milk, yogurt, cheeses, fresh and frozen vegetables and fruit should be put in the fridge or freezer as soon as they are received.

When country food is donated, put it in a food storage bag and use a marker to write the name of the food and the date you received it. If possible, find out when the food was harvested and write down the date of harvest. See the GN Country Food Guidelines for more information and discuss safe handling of country food with the Environmental Health Officer or the Regional Dietitian during their visits.

If some country foods are not available locally, consider ordering them from commercial suppliers such as Kivalliq Arctic Foods or the Iqaluit Country Food Store. Use the menu to know much country food you will need in the next 6 months, and place an order for the type of country food and the desired cuts (ground, stew meat, roasts, etc).

Try not to store country food for longer than 6 months. If your country food freezer is full, consider asking the hunter to give the food to another community group such as the prenatal program, daycare or schools.



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Ordering by sealift

If you have storage space for non-perishable foods, a sealift order can help save money. Consult with the regional dietitian about your sealift order if you have question about amount and kinds of food to order. See Appendix 4 for suggestions on which foods to order by sealift, and which to buy locally.

Some advantages of ordering on sealift

- Saves money on non-perishable foods such as pasta, rice, flour, canned fish, canned fruits and vegetables, stuffing mix, vegetable oil, UHT milk, powdered milk, cereal, etc.
- Food is available in the facility, even during an unexpected storm or power outage.
- Provide a better choice of healthier foods that might be hard to find in the local store such as:
  - Lower sodium versions of soya sauce, soups, canned, flaked meats, etc.
  - Canned fruit packed in fruit juice or water instead of in heavy syrup
  - Whole grain products such as whole wheat flour, brown rice, whole wheat crackers
- Offer bigger sized packages of foods such as canned salmon, vegetable oil, flour, etc. which are usually cheaper.
- Offer wider choice of brands.

Here are some things to think about when making your sealift order:

1. **How much food to order.** Use the 3-week menu and the sealift order template to help figure out how much to order. For example, a menu may have hot cereal 5 mornings per week. You would need around 52 kilograms of oats to serve 8 people oatmeal this often for a year. If only 6 people eat oatmeal every morning, you would only need 39 kilograms of oats. If oats are used for other things such as muffins or cakes, you would need to add more.
2. **Brands.** Some brands are cheaper than others. For example, at Marché Daoust, a 10 kilogram bag of Selection all-purpose flour is around $14. The same amount of Five Roses flour is around $20. A case of Cloverleaf pink salmon (418 gram cans) is around $140. The same amount of Selection brand is around $103. These prices don't take into account shipping and crating costs.
3. **Type of packaging.** For example cello wrapped pasta is usually cheaper than boxed pasta. Plus it weighs a little less so shipping costs are less.
4. **Size of package.** Usually bigger package sizes are cheaper per serving. For example, the cost per serving is cheaper for bigger cans of salmon (418 grams vs 213 grams) and bigger bags of flour (10 vs 5 kilogram bags).

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What about ordering milk?

Fresh milk

Fresh milk is the cheapest way to get milk. Ordering the biggest container (4 litres) might be a better deal, but only if you are going to use it all during the week. For example, in the Week 2 Iqaluit menu, about 7 cups of fresh milk is called for in 4 recipes (mashed potatoes, creamy veggie rice, French toast and pudding). Other recipes call for evaporated milk because it gives a creamier result. If we estimate that the 8 clients and staff use ½ cup per day for their breakfast cereal, that would make a total of 28 cups of milk per week, plus the7 cups for recipes, for a total of 35 cups of milk per week. Each 4 litre container of milk is equal to 16 cups, so the facility would need two 4 litre containers and one 1 litre container for the Week 2 menu. Once milk is opened it needs to get used fairly quickly, so the big containers should be used first and the smaller container last.

Evaporated milk

Evaporated milk is more expensive than fresh milk, even when ordered on sealift, but it is called for in many of the recipes. It gives a creamier result than fresh milk because it is more concentrated. For example in the 3 weeks of the Iqaluit menu, 9 cans of evaporated milk are needed. For the whole year, this would be 156 cans or 6.5 cases of 24 cans.

When you add a can of water to a can of evaporated milk, it has the same nutrition and can be used the same way as fresh milk. Once opened it needs to be kept in the fridge.

UHT milk (Grand Pré)

UHT milk is even more expensive than evaporated milk, but it is probably a good idea to have
a case in dry storage for days when you cannot get out to purchase fresh milk. It does not need to have water added to it, so would also be good if ever there is a problem with the water.
When unopened, it can be kept in dry storage. Once opened, it must be kept in the fridge.

Powdered milk

Milk made from skim milk powder is usually less expensive than fresh milk, especially if it is ordered on sealift. It has the same nutrition as fresh skim milk. Some of the recipes in the menu, such as muffins and some desserts, call for skim milk powder, so it would be good to have some in dry storage. It is a great way to boost the nutrition value of baked goods.

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Tips for placing a sealift order based on the 3-week cycle menu

Use the *sealift Ordering Sheet* (Appendices 5) to help you estimate how much non-perishable food to order, for each week of the 3-week cycle menu. Since the new menu may be different from what was served last year, the kinds and amounts of food you need will probably be different. It is important to allow some time to make a new sealift order. It will help you save money and avoid unnecessary trips to the store.

A sample order sheet based on the facility's sample menu have been prepared as an example (Appendix 5). The amounts of each non-perishable food item needed for Weeks 1 and 2 were estimated and then multiplied by 17 since the Week 1 and 2 menus will each occur 17 times in the year. Managers will need to do the same thing for Week 3. This requires looking at each day and each recipe and writing in the ingredients and amounts. It requires some time and patience, but should help you have a good sealift order. The regional dietitian can help you with this task.

In Appendix 5, there are columns for the yearly amounts of sealifted foods needed for Weeks 1, 2 and 3. Weeks 1 and 2 have been filled in for you, but you will need to make the estimate for the Week 3 menu. By adding up the columns for Weeks 1, 2 and 3 you will get the total amounts needed for the year. Then, based on the sealift company you are working with, calculate how many bags or cases of each item you need to order. For example, if you use about 129 kilograms of flour for the year, you could order thirteen 10 kilogram bags of flour, if your provider has 10 kilogram bags available.

Tips for staff training

When the dietitian is visiting your facility, organize a staff meeting so that she can provide a training session on topics such as the importance of nutrition and hydration for the clients, special diets (low sodium, lactose intolerance, thickened fluids, etc), menu substitutions, allergy awareness, assisted feeding techniques, food safety, choking prevention, dysphagia, recording food and fluid intake, constipation, feeding clients with dementia, height and weight measures.

Look for opportunities for training of cooks and other staff members on food safety, nutrition and cooking. Food safety courses may be given by the Environmental Health Officer in your region.

Keep a record of the formal and informal training the staff receive (see Appendix 6).

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Look for opportunities for professional development for staff in early dementia care.

Examples are:

- The Alzheimer Society of Canada (http://alzheimer.ca/en/Home) has information on networks such as NICE (network for care of the elderly) and resources such as webinars by brainxchange, e-learning opportunities and education modules. http://alzheimer.ca/en/Home/We-can-help/Resources/For-health-care-professionals
- The Alzheimer Society of Montreal offers various in person educational modules for health care professional, ranging from 30 – 6 hours of training. http://alzheimer.ca/sites/default/files/%5Bzaboutme%3Adirectory%5D/alz_formations_spring2018_en.pdf
- Alzheimer Society of Alberta and the Northwest Territories maintains a help line and offers other support services. They have a regional office in Yellowknife. http://alzheimer.ca/en/ab/We-can-help/Education.
- Alzheimer Society of Manitoba offers Telehealth seminars (https://alzheimer.mb.ca/events/)
- Alzheimer Society of Ontario (http://alzheimer.ca/en/on/We-can-help/Education) offers *U-First* an online or in-person training program for caregivers and the First Link learning series for groups.

Emergency Menu

Canadian guidelines for long term care recommend that a 3-day emergency menu be developed. The Emergency Menu for your facility is included in the guidebook in Appendix 7. The food necessary to carry out the menu should always be available.

Kitchen equipment need for menu

- Immersion blender (for easily blending soups)
- Digital instant read thermometers (at least 2) Thermoworks Thermopop ($70) , Thermopro TP02S $11,
- Storage containers for 1-2 servings (1–2 cups, or 250–500millilitres)
- Storage containers for 8 servings (8 cups or 2 litres)
- Markers for the storage containers and sticky labels
- White board and markers or chalk board and chalk

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Recipes

Sixty recipes have been created to assist your facility in creating a menu that includes nutritious and appetizing food. The recipes can be found in Appendix 8.

- 30 main courses
- 6 sauce recipes
- 24 Soup, salad and sides recipes

Substitutions for common ingredients can be found in Appendix 9.

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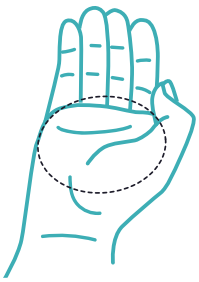
Examples of how much food to offer

Food	About how much to offer
Fruit juice	½ cup
Rice and pasta	1 cup
Bannock	About the size of half a slice of bread
Meat and Fish	About the size of the palm of your hand 

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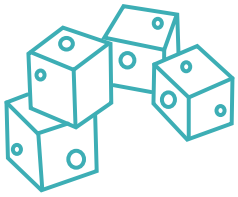
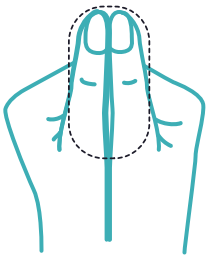
Food	About how much to offer	
Vegetables and Fruit	½ cup	
Yogurt	½ cup	
Cheese		

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Sodium

Sodium is part of salt. Another name for salt is sodium chloride. Our bodies need sodium, but only a little bit. Too much sodium isn't good for health. Sodium is in many store-bought foods.

For those with health problems such as COPD and high blood pressure, getting less sodium is important.

Country food is low in sodium and is always a good choice.

Here are some tips for getting less sodium.

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Tips When Cooking:

1. Measure carefully!

The ingredients below contain a lot of sodium. It's best to measure them with measuring spoons or cups.

- Salt
- Bouillon powder, cube or liquid
- Soya sauce (even the low sodium kind)
- Worcestershire sauce
- Ketchup
- Seasoning salts such as onion, garlic and celery salt (onion and garlic powders usually do not contain sodium)
- Baking powder
- Baking soda

2. Read the Nutrition Fact Table

Choose foods that have less than 15% Daily Value for Sodium

Which one of the instant mashed potato brands has less sodium?

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One serving of the No Name brand has only **4%** of the Daily Value for sodium.

One serving of the Betty Crocker brand has **18%**.

The no name brand has much less sodium.

3. Substitute for lower sodium options

Choose less often	Choose more often
Canned or dried soup mixes	Homemade soups with a small amount of salt or bouillon powder added. For a recipe that serves 8, aim for less than 1 teaspoon of salt or less than 3 teaspoons bouillon powder. Low sodium store-bought soups. If using canned or dried soup mixes, add more water or milk than is called for.
Dried noodles with seasoning mix (for example: Mr Noodles, Cup of Noodles, Ramen Noodles)	Noodles made without using seasoning mix. For one serving, use ½ teaspoon or less bouillon powder.
Frozen meats such as batter coated and seasoned chicken pieces or chicken wings	Homemade *Shake and Bake* style chicken Tender baked chicken wings (see recipe in Guidebook)

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Choose less often	Choose more often
Canned or dried gravy	Homemade gravy (see recipe in Guidebook) Low sodium store bought gravy
Store-bought pizza	Homemade pizza using ground meat instead of pepperoni and not too much cheese.
Some instant mixes for mashed potatoes and stuffing	Compare packages and choose one with less sodium. Homemade mashed potatoes or stuffing mix (see recipes)
Canned vegetables and vegetables in sauces	Plain frozen vegetables For canned foods, drain away the liquid, then rinse and drain again. This removes some sodium.
Soya sauce as a dip or other dips	See other recipes for lower sodium dips in Guidebook. Dilute soya sauce with water.

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Trouble Digesting Milk and Milk Products

(Lactose Intolerance)

Milk contains a kind of sugar called lactose. Some people don't digest this sugar well.

People who don't digest lactose can feel gassy and have diarrhea after having milk or foods made with milk.

Some people can have a small amount of milk and foods made with milk and still feel good. Others have to avoid milk and foods made with milk.

Milk and foods made with milk contain the bone building nutrients, calcium and vitamin D, so it's important to know how to get the nutrition in milk without making people feel gassy and bloated.

Reminder!

A milk allergy is not the same as lactose intolerance.

People who have a milk allergy should not have milk or foods containing milk. They can have symptoms such as a rash or trouble breathing after having milk or foods with milk.

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Tips for cooking for people who CAN HAVE SOME milk and foods made with milk

- Have small amounts of milk or foods with milk at one time. A small amount would be ½ cup or less of milk, pudding, ice cream or soup made with milk.
- Try yogurt and cheese. Many people can tolerate yogurt better than milk. And hard cheese is low in lactose.
- Have milk containing foods with meals instead of on its own.

Tips for cooking for people who CANNOT have milk and foods made with milk

1. Read the ingredient list.

If any of the following ingredients are there, it means the product contains some lactose. If the word is close to the beginning of the list, it means the product will contain more lactose than if it is closer to the end.

- Milk
- Milk solids
- Whey
- Curds
- Cheese flavour
- Malted milk
- Non-fat milk solids
- Non-fat milk powder
- Buttermilk
- Cream
- Sour cream

For example, here is the ingredient list for Campbell's Cream of Mushroom Soup:

Since dehydrated cream is close to the end of the list, it means the product does not contain very much lactose.

INGREDIENTS: WATER, MUSHROOMS, VEGETABLE OIL (CORN, COTTONSEED, CANOLA, AND/OR SOYBEAN), MODIFIED FOOD STARCH, WHEAT FLOUR, CONTAINS LESS THAN 2% OF: SALT, MONOSODIUM GLUTAMATE, SOY PROTEIN CONCENTRATE, DEHYDRATED CREAM (CREAM [MILK] , SOY LECITHIN), YEAST EXTRACT, FLAVORING, DEHYDRATED GARLIC.

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2. Know which foods are safe and which ones to avoid

Safe foods	Foods to avoid
Lactose-free milks (Lactaid®, Lacteeze®) Fortified plant beverages such as: • Soy beverage • Almond beverage • Rice beverage • Coconut milk (does not contain the same nutrients as milk, should only be used occasionally)	Milk, all kinds (fluid, evaporated, sweetened condensed, boxed, powdered)
Soy yogurt	Yogurt
Sherbet (check the ingredient list)	Ice cream made with milk or cream
Coco Whip! (ask the store manager to order it so you can try it)	Whipped toppings like whipped cream, Cool Whip, Dream Whip
Hard cheeses (cheddar, mozzarella, Swiss, Parmesan)	Processed cheese, cottage cheese, cheese spreads
Homemade Ranch dressing using a plant beverage of buttermilk.	Ranch style dressing

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Safe foods	Foods to avoid
Recipes made using lactose free milk or soy, almond or rice beverage instead of regular milk See https://silk.com/recipes for recipes with soy and almond beverages	Recipes made with milk or other foods in this column. These include muffins, pancakes, pudding, smoothies, quiche, lasagna, soup made with milk
Canned cream soups (these may have a very small amount of milk or cream in them, but if made using water or a plant beverage should be well tolerated)	Soups made with milk or cream

3. Serve foods that have some of the nutrients in milk, but no lactose

- Canned fish with bones such as salmon, sardines and mackerel and herring
- Fish such as char, cod, halibut, lake trout and turbot
- Fish head soup
- Bird eggs
- Fish eggs
- Liver
- Maktaaq
- Wild greens, shoots, roots and seaweed
- Tofu
- Broccoli
- Hard cheese

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Texture Modification

Soft Foods for People Who Have Trouble Chewing and Swallowing

On a soft diet, foods should be **soft** and **moist**. If not soft and moist enough, foods may need to be diced, minced or shredded.

Vegetables and Fruit

Foods to choose	Foods to avoid
• Soft cooked, diced or mashed vegetables • Mashed potatoes or other well cooked potatoes dishes • Shredded raw apples or carrots • Canned cream corn • Canned crushed pineapple • Diced or mashed soft cooked, canned or ripe fruit (no skins) • Applesauce or other fruit sauces • Stewed prunes • Fruit cocktail (NO pineapple or grapes) • Vegetable or fruit juice	• Hard, raw vegetables (even if diced) • Whole kernel corn • Fruit or veggies with tough skins or membranes (grapes, whole apple, oranges, grapefruit) • Dried fruit (raisins, cranberries, prunes) • Raspberries or blackberries • Coconut • Fresh pineapple • Canned pineapple tidbits or slice

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Grain Products

Foods to choose	Foods to avoid
• Soft breads or buttered toast • Soft baked items (muffins, biscuits) with a spread • Pancakes, waffles, French toast with applesauce or syrup to soften • Hot cereals • Cold cereals softened in milk or water • Macaroni served in a sauce • Rice or barley in a sauce or casserole • Soft crackers (soda crackers or Ritz) • Soft cereal bars	• Dry, crusty or chewy breads • Pizza crust • Grain products or cereals with chocolate chips, dried fruit, nuts or seeds • Rice with no sauce • Hard granola bars

Milk and Alternatives

Foods to choose	Foods to avoid
• All kinds of milk and smooth milkshakes • Smooth yogurt (plain or vanilla) or yogurts with small soft pieces of fruit (peach or strawberry) • All cheeses, diced, sliced or grated • Cottage cheese • Milk based soups with well-cooked diced vegetables and meat or fish	• Yogurt, custard or puddings with large fruit pieces, dried fruit, nuts, seeds or granola • Crispy, melted cheese topping

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Meat and Alternatives

Foods to choose	Foods to avoid
• Minced meat in dishes such as casseroles, Shepherd's pie, meatloaf, meatballs with a sauce or gravy • Tender, boneless fish that flakes easily • Canned fish with mashed bones • Cooked eggs, including quiche and omelettes made with allowed ingredients • Sandwiches with finely minced fillings such as egg, chicken and tuna • Cheese sandwiches • Smooth nut butters used in cooking • Soft cooked beans, peas or lentils • Soups with tender diced vegetables and meat	• Crispy or dry meat, poultry or fish • Bacon, bacon bits or beef jerky • Weiner or hamburger in a bun • Fried eggs • Plain hard cooked egg • Nuts and seeds, whole or chopped • Deli meats with hard casings (salami, Kielbasa) • Nut butters spread on food

Desserts and Snacks

Foods to choose	Foods to avoid
• Ice cream, sherbet, popsicles • Jell-O • Smooth custard or pudding (e.g. tapioca or rice pudding) • Soft baked desserts (such as moist cakes, pies, made with allowed foods) • Soft, moist easy to break cookies • Cookies dipped in tea or coffee	• Hard candy, licorice, gum • Baked desserts with chocolate chips, dried fruit, nuts or seeds • Chips, popcorn, pretzels or Cheezies • Whole, sliced or cut pickles

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Sticky foods such as cream cheese, cheese spread and honey are allowed if mixed into cooking or thinly spread on allowed foods.

Pureed Diet:

Some clients may require a pureed diet, due to difficulties chewing, swallowing, or per client preference.

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Therapeutic Nutrition Care

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PART TWO: THERAPEUTIC NUTRITION CARE

Helping Nunavummiut Eat Well with the Nunavut Food Guide

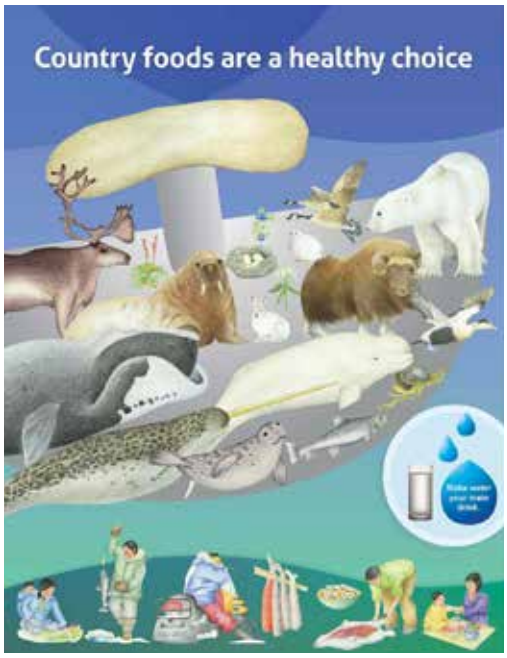
All Country Foods Are Healthy

All country foods are rich in nutrients that we need to be healthy.

Try and provide Nunavummiut with different kinds of country food.

If you can, it's good to provide different parts of the animal, like liver, heart, tongue, blubber, fish eggs and fish heads. These are all very rich in nutrients needed for health.

If your clientele have trouble chewing or swallowing, be sure to help them cut the food up small or cook it until tender and serve with gravy or cooking juices.



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Choose Healthy Store-bought Food

Not all store-bought foods are healthy.

The foods on the ulu show some healthy store-bought foods.

If there are no country food meat and fish around, store-bought is nice for a change.

Processed meats such as bologna, Klik, wieners and bacon should not be served often. They are high in salt and fat.

Try lactose free cow's milk or fortified plant beverages such as soy, almond or rice beverages for those intolerant to milk.

Bannock, oatmeal and pilot biscuits are favourites for many, bread, rice, pasta and cereal are great alternatives.

Add vegetables to soups and stews for added flavour and nutrients.

Fruit makes a great snack or dessert.

Less healthy foods such as pop, chips, and candy bars, should be enjoyed less often.

For Snacks:

Aim for foods from 1–2 food groups at each snack.

Country foods , fruits, crackers, cheese, yogurt are examples of great snack foods

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Hydration

Ensuring adequate hydration for all clients requires a collaborative, person-centered effort from the care team. When cognitively capable, clients decide when they are thirsty and how much they need to drink. Support workers provide fluids in a safe and timely manner. Nursing staff including support workers, assist clients in consuming fluids at meals and snack times, and as needed throughout the day. For clients who have cognitive challenges, additional efforts are required from the care team to encourage fluid intake to meet their individualized fluid needs.

Dehydration:

Dehydration is a serious and potentially life-threatening condition. All staff within the facility should be well trained in recognizing the signs and symptoms and risk factors associated with dehydration.

Clinical Indicators of dehydration:

- Confusion
- Headache
- Dry mucous membranes
- Loss of skin turgor
- Dry mouth (xerostomia)
- Nausea, vomiting
- Rapid weight loss
- Electrolyte abnormalities (hypernatremia, hyperchloremia)
- Increased BUN and serum Creatinine, decreased eGFR
- Tachycardia
- Low blood pressure
- Constipation
- Reduced urine output
- Dark coloured urine

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Risk Factors

Risk	Causation
Poor Oral Intake	Dementia Inability to feed independently Dysphagia Refusing oral intake
Increased Fluid Loss	Febrile illness Diarrhea Vomiting Diuretics Increased urine output (diabetes, hypercalcemia, hypokalemia) Increased perspiration
Other Factors	Female gender Older age Polypharmacy Impaired functional status Impaired cognitive status Inadequate staffing/training

Assessment:

Fluid intake should be monitored and documented by registered staff. A Registered Dietitian may provide a fluid requirement for the client upon assessment. Clients that have trouble meeting their fluid goal may require further nutrition interventions, which will be recommended by the Registered Dietitian.

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Calculating Fluid Requirements in LTC:

The goal of providing adequate hydration is to replace measurable and insensible fluid losses by offering, at minimum 1500-2000 mL fluids per day (6-8 250 mL cups of fluids). Fluids include soups and beverages. Measurable losses include outputs from urine, feces and drain tubes. Insensible losses include perspiration and respiration.

A comprehensive formula to calculate fluid requirements for older people who are at risk of dehydration:

- 100 mL fluid/kg body weight for the first 10 kg
- 50 mL fluid/kg for the next 10 kg
- 15 mL fluid/kg for each kg after 20 kg

Table 2 simplifies the above recommended fluid requirements formula.

Table 2: Recommended fluid requirements

Patient weight (kg)	Fluid requirement (L/day)	Patient weight (kg)	Fluid requirement (L/day)
<30	1.7	70	2.3
35	1.7	75	2.3
40	1.8	80	2.4
45	1.9	85	2.5
50	2	90	2.6
55	2	95	2.6
60	2.1	100	2.7
65	2.2	105	2.8

Alternatively, fluids can be calculated using 25-30 mL/kg/day or 1 mL/kcal consumed. However, this formula is less accurate and may underestimate fluid requirements; especially for clients with a low body weight.

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Strategies to Maintain/Increase Fluid Intake:

1. **Staff training:** all staff should receive training on recognizing the signs/ symptoms of dehydration
2. **Regularly offer fluids:** breakfast, lunch, dinner, AM, PM and HS snacks, with medication pass. Keep fluids available for patients and staff at all nursing stations, especially in the warmer summer months.
3. **Offer client-centered care:** survey clients and determine what kinds of fluids they prefer; engage clients and their family members when designing a menu/purchasing foods. Consider fluid temperature; as people age they often prefer warmer beverages. Offering warm milk and hot water at meals may be preferred to cold.
4. **Encourage fluids at social gatherings:** ensure a variety of fluids are offered at social events.
5. **Offer "wet" foods:** soups should be offered at lunch and supper. Desserts such as jell-o, custard, yogurt, pureed fruit are good options for dessert.

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Implementing Fluid Restrictions

Background:

Q What is a fluid restriction?

Fluid restrictions are medically supervised diets which restrict the amount of fluids a person can consume per day. Fluids from solid food intake are generally not included in the restriction, unless a person is on a full fluid diet.

Q When are fluid restrictions clinically indicated?

The following conditions may require a fluid restriction:

- Hyponatremia secondary to syndrome of inappropriate antidiuretic hormone (SIADH)
- End-stage renal disease (ESRD) with or without dialysis
- Congestive heart failure (CHF)
- Hyponatremia NYD (hyponatremia is defined as serum sodium level less than 136 mmol/L)

Fluid restrictions are individualized for each person and the amount of fluid recommended is dependent on the person's medical history, and weight. Physicians will recommend a fluid restriction and Registered Dietitians will design a fluid pattern that is specific to the person's dietary preferences and nutritional goals. Nurses, health care aides/ support workers and dietary aides are responsible for ensuring the client is given the appropriate amount of fluids, as recommended by the Registered Dietitian.

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Steps to implement:

6. Inform your client/substitute decision maker (SDM) that the doctor has ordered a fluid restriction; explain the purpose of the restriction and the importance to complying with the recommendation.
7. Work with the client/SDM in designing a fluid restriction that suits their preferences and dietary needs.
8. Inform dietary and nursing staff of fluid pattern; provide copies of fluid pattern for the nursing station, kitchen, and nourishment carts. The person/SDM may want a copy as well if the patient leaves the facility for meals.
9. Ensure dietary aides are aware of the volume of the glasses, mugs and bowls in the facility.

Sample fluid restriction pattern: 1500 mL per day

Meal	Fluid	Total
Breakfast	125 mL milk, 125 mL juice, 175 mL tea/coffee	425 mL
AM snack	175 mL tea/coffee	175 mL
Lunch	125 mL milk, 125 mL water, 175 mL tea/coffee	425 mL
PM snack	175 mL tea/coffee	175 mL
Dinner	125 mL milk, 125 mL water	250 mL
HS snack	125 mL milk, 175 mL tea/coffee	300 mL
Miscellaneous fluids	100 mL	100 mL

Clients on fluid restrictions may experience excessive thirst and dry mouth. Try these tips to alleviate these symptoms include:

- Send ice chips to patient on the nourishment cart —include ice chips in "Miscellaneous" fluid allowance
- Suck on sugar-free candy
- Chew gum
- When clinically feasible, recommend a salt shaker on the patient's meal tray

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Wound Care

Background:

Malnutrition is common in the chronically ill, aging population, and is defined as a deficiency of essential nutrients, caused by inadequate intake and/or improper absorption and use of essential nutrients. Malnutrition contributes to tissue breakdown and can delay or impair wound healing.

Protein is especially important in wound healing. Protein Energy Malnutrition (PEM) is the inadequate absorption and distribution of protein, often caused by low intake of dietary protein. PEM causes the body to breakdown existing protein stores, and contributes to poor wound healing. Wound healing also requires adequate intake of calories, fluids and some key nutrients, since nutrient needs are increased by wound healing.

In general, clients with wounds have increased and unique nutrition needs, and should be **referred to a registered dietitian** for assessment. The following pages provide general guidelines for nutrition in wound care.

Use the guide below to determine the nutritional needs for your patient, specific to their wound state.

Table 1. Guidelines for Nutrition in Wound Care

Skin Integrity	Protein	Fluids	Calories
Intact Skin-Preventative Wound Care	0.8-1.0 g/kg/day	30 mL/kg/day	30 kcal/kg/day
Stage I and II Pressure Ulcers	1.2-1.5 g/kg/day	35 mL/kg/day	35 kcal/kg/day Multivitamin + minerals
Stage III Pressure Ulcers/Burns	1.5-2.0 g/kg/day	35-40 mL/kg/day	40 kcal/kg/day Multivitamin + minerals
Stage IV Pressure Ulcers/ Severe Burns	Up to 3.0* g/kg/day	40 mL/kg/day	40+kcal/kg/day Multivitamin + minerals
Multiple/Non Healing Hypoalbuminemia (<27 g/L) Pre Albumin (<0.10 g/L) Venous Ulcers Multiple Non Healing Stage II Ulcers	2.0-3.0* g/kg/day	40+ mL/kg/day	35-40 kcal/kg/day Multivitamin + minerals

*Use clinical judgement when increasing protein intake. Always ensure adequate fluid intake with increasing protein needs. Consider kidney function in patients with renal failure; protein needs may need to be adjusting according to eGFR.

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Table 2. Food sources for key macronutrients involved in wound healing

Key Macronutrients	Sources	Increase	Supplement
Calories Calories are needed to sustain proper nutrition. Caloric needs increase with the severity of the skin impairment.	All food and beverages Exception: water, tea, coffee, low-calorie/diet beverages.	Portion size (if patient has good appetite) High calorie sauces, gravy Cream in coffee, high fat milk in cereals Calorically dense foods: cheese, ice cream, full-fat yogurt.	Nutritional shakes (Ensure, Boost, Glucerna) Homemade smoothies Oral Nutritional Supplements (2Cal HN, Resource 2.0)
Protein Protein is needed for maintenance and repair of tissues. Protein needs increase with the severity of the skin impairment.	Meat, fish, poultry, pulses, dairy products, grains, nuts, seeds.	Portion size (if patient has good appetite) High protein snacks: cheese, nuts and nut butter, meat (non-processed) Country Food	Nutritional shakes (Ensure, Boost, Glucerna) Homemade smoothies with added protein (milk powder, soy powder, whey protein supplements) Oral Nutritional Supplements (2Cal HN, Resource 2.0)
Hydration Hydration is needed to sustain cellular fluid balance, cell and nerve functioning. Fluid needs increase with the severity of the skin impairment.	Water, juice, milk (and non-dairy milk alternatives), jell-o, sherbet, ice cream, yogurt, soup, popsicles, coffee, tea.	Use 250 ml glasses instead of 125 mL Add jell-o as a snack on the nourishment cart Provide clear soup (low sodium) at lunch and supper Ensure water is available at all meals and snacks	If unable to take PO fluids, consider IV fluids or hypodermoclysis

Table 3. Food sources for key vitamins and minerals required for wound healing.

Zinc	Vitamin C	Vitamin A
Meat, fish, seafood, liver, eggs, beans.	Maktaaq, fish eggs, cloudberries, citrus fruits, strawberries, tomatoes, broccoli, cantaloupe, sweet peppers, qunguliit, liver (seal, caribou), seaweed, broccoli, potatoes	Liver, blubber, maktaaq, spinach, carrots, clams, eggs, milk, cheese, fish, red bell peppers.

[1] Wound Care Canada. Nutrition and Wound-Care Management/Prevention; [cited 2018 July 11]. Available from: https://www.woundscanada.ca/docman/public/wound-care-canada-magazine/2004-vol-2-no-2/251-wcc-2004-vol2n2-nutrition-and-wound-care-management-prevention/file

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Enteral Feeding

Q What is enteral feeding?

Enteral feeding is used when clients cannot feed orally, due to impaired swallowing ability (dysphagia), impaired cognitive status or if they cannot meet their nutrition requirements through oral feeding alone. Enteral feeding requires a tube that is surgically inserted into the client's stomach (gastrostomy tube) or small intestine (jejunostomy tube). Some clients may have a temporary tube that is inserted through their nasal cavity and placed into either their stomach (nasogastric tube) or their small intestine (nasojejunal tube). However, most clients in LTC requiring enteral feeding would have a gastrostomy tube, or a jejunostomy tube. The initiation of an enteral feed should follow a discussion with the client their family and/or substitute decision maker (if applicable), most responsible physician, and nursing and allied health staff. Client's wishes and their advanced care planning should be taken into consideration.

Nutrition considerations for enteral feeding:

1. **Enteral feed formula:** many different enteral feed formulas exist, and the Registered Dietitian will select the most appropriate formula for the client based on their nutrition assessment, medical history, and client/family preference.
2. **Enteral feed modality:** Enteral feeds can be administered continually, intermittently or as large volume bolus feeds. The type of modality selected can be dependent on the volume of feed that the client can tolerate at a given time, their intestinal motility, and their estimated nutritional needs. Other considerations include nursing staff time and availability, and client/family preferences.
3. **Enteral feed rate:** the rate of feed delivered to the client is determined by the enteral feed modality, the client's nutrition requirements, client/family preference, and client's medical history. Often clinicians are inclined to start clients on a slow feed rate, and gradually increase it as tolerated until the desired feeding outcome is achieved.
4. **Fluids:** most enteral feed formulas are calorically dense, and do not provide sufficient amounts of free water to meet client's fluid needs. Thus, water flushes throughout the day are often required. The Registered Dietitian will calculate the volume and frequency of water flushes needed to meet the client's estimated fluid needs. Some enteral feeding pumps automatically deliver water flushes while others do not, and nurses will need to administer water flushes manually using a syringe.

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Monitoring and Assessment:

1. Client's anthropometric measurements, pertinent lab values, and signs and symptoms of intolerance should be monitored on every shift by interdisciplinary care team members.
2. Signs of intolerance include frequent vomiting, regurgitation, and in some cases aspiration of solids into the lungs. Enteral feed orders can be adjusted to provide optimal and safe care for the client.

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Nutritional Management in Palliative Care

Definition:

Palliative care is the total care of patients whose conditions do not respond to curative treatment (WHO, 2002). The goal of palliative care is to emphasize quality of life, accept that dying is a natural process and to provide relief from pain or other distressing symptoms (WHO, 2002).

Palliative care includes physical care, spiritual care, and symptom management. Palliative care involves a multidisciplinary care team, with the patient and their families guiding the decision-making.

Nutritional Support:

The emphasis should be on quality of life rather than medical nutrition therapy. Nutritional support in palliative care is a balance between mitigating risk and delivering food that provides an enjoyable experience for the patient. Food is a source of comfort, is symbolic of culture and traditions, and can provide physical relief from symptoms. Often patients undergoing palliative care experience a loss of appetite, weight loss and an altered sense of taste and smell due to disease progression. It is important to consider the patient's preferences, culture, and diet history when delivering food service. Often patients require a combination of oral feeding, nutritional supplements, and in some circumstances hypodermoclysis to maintain adequate nutrition and hydration.

Oral Feeding:

- Individual preferences
- Culturally appropriate foods
- Comfort foods
- Flexible meal times
- Family involvement
- Texture-modification if required
- Staff participation in feeding assistance

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Oral Supplementation:

- Increases energy and protein intake
- Frequent bolus of high calorie formula reduces the overall volume for patients experiencing a loss of appetite, or an inability to consume solids
- A small amount (120 mL) of 2 kcal/mL formula (such as Resource 2.0- Nestle Health Sciences) spread throughout the day (6x daily) can meet patient's basic energy and protein needs

Hypodermoclysis:

- Hydration delivered subcutaneously for patients who cannot safely swallow liquids, or cannot meet their basic hydration needs through oral intake alone
- Subcutaneous sites last 7 days
- This is not a long term solution but often can provide time for the patient and their families to make decisions about end of life care
- Typically 2/3 glucose (5%) , 1/3 saline is used to maintain fluid needs but normal saline can also be used for rehydration
- The feasibility of hypodermoclysis in palliative care should be discussed with the multidisciplinary health care team, the patient, and their families/ substitute decision maker if applicable
- Hydration should be monitored through: urine output, blood pressure, and mental status
- Subcutaneous sites should be monitored for infection

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Oral Nutritional Supplements

Q What are oral nutritional supplements?

Oral nutritional supplements (ONS) are hypercaloric formulas used to supplement poor food intake, or to provide additional calories and protein when clinically indicated. Older adults living in long term care are specifically vulnerable to weight loss due to physical, psychological, sociocultural factors that interfere with the ability to consume an adequate diet.

Q Why are they prescribed?

ONS can provide supplemental calories and protein and are used when clinically indicated. Common situations when ONS are prescribed include: palliative care, wound healing, malabsorption disorders, malignancy, bowel disorders, dysphagia, chronic obstructive airway disease, and dementia (1). ONS are also prescribed when food intake is low (due to multifactorial reasons), or when unfavourable weight loss has occurred.

Q What is a med pass program?

A med pass programs combines ONS and medications. Instead of providing water to take with medications, 60-120 mL of hypercaloric supplement can be provided to the patient. For example, a 60 mL 2 kcal/mL supplement four times daily can provide an additional 480 kcal and 22 g protein. Small doses of hypercaloric formula can improve nutritional status without compromising appetite and satiety. Alternatively, larger doses of hypercaloric formula can be provided in a single dose instead of a meal or snack, if patient's intake is low or is not tolerating solid foods.

Q What other supplements are used?

1. Protein

Protein (powder or liquid preparations) are available and are to be used as clinically indicated. Protein powders are most commonly used for clients at risk of or who have skin breakdown, low serum albumin or cannot attain protein needs via oral intake.

2. Fibre

Fibre supplements can come in many forms including: ground flax, prunes and prune juice, and a high fibre fruit spread ("Fruit Rite"). Fibre supplements are most commonly used for constipation, however ground flax (and other foods high in soluble fibre) are also effective to treat diarrhea.

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Q When should a referral be sent to initiate or discontinue a supplement?

Referrals should be sent to the Dietitian to initiate a supplement if:

1. Weight loss has occurred and is evident by monthly weight monitoring
2. Intake at meals and snacks has decreased
3. In the presence of pressure ulcers
4. If requested by client or family/SDM

Referrals should be sent to discontinue a supplement if:

1. Patient's appetite has returned to normal
2. Weight gain exceeds goal weight range
3. Pressure ulcers have healed with no risk for re-opening
4. If requested by client or family/SDM

Q What about "food first?"

ONS can be an effective nutritional intervention for definite period however, it is always important to try and promote caloric intake through food, independently or in conjunction with ONS. High calorie snacks are effective to promote weight gain and wound healing. Examples include: high protein pudding (pudding mixed with protein powder), cheese and crackers, peanut butter, ice cream, full fat cream sauces, gravies, house milkshakes, greek yogurt and high calorie baked goods.

References:

1. Johnson S, Nasser R, Banow T, Cockburn T, Voegeli L, Wilson E, Coleman J. Use of Oral Nutrition Supplements in Long-term Care Facilities. Can J Diet Prac Res. 2009; 70: 194-198.

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Dining

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PART THREE: DINING

Meal and Snack Times

Providing optimal nutrition care extends beyond simply serving safe and nutritious food. Food service management also includes considering the timing and frequency of meals, and the ambiance of the dining room.

The following are helpful tips to provide an acceptable dining experience for the client:

- Meals should be offered at reasonable times and should allow for an appropriate amount of time for clients to consume and enjoy their meal
- Typically, three meals are served per day, with 2-3 snacks offered in between meals. Water should always be available, and coffee/tea should be offered with each snack
- Snacks should be nutrient-dense and culturally relevant
- Some clients may require more flexible meal times and so easy to prepare meals such as sandwiches should be available to cater to the client's needs
- Provide a relaxed work environment including culturally-appropriate music, artwork, and an adequate space to relax and enjoy the meal
- Ensuring dining space is clean
- Provide assistive devices as needed
- Provide dining supervision and meal assistance as needed. Clients that require feeding assistance would do so with their designated support worker
- Provide any required clothing guards, cloth napkins or aprons as required
- Encourage dining in the dining room rather than in the client's room. Clients that would prefer to dine in their room should have their preference outlined in their plan of care
- Keep food at appropriate and safe temperatures as per HACCP guidelines

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Assistive Devices in Long Term Care

The ability to feed independently often declines with age. Often in LTC clients are provided specialized devices to facilitate independent feeding; which improves the dining experience and promotes dignified care.

The following devices are commonly used in LTC:

Built up Utensils

The thicker base of these utensils allows for improved grip and control. They are especially useful for those with compromised strength or muscle weakness.

Curved Spoons

Curved spoons, like built up utensils allow for improved control especially for those with compromised wrist and shoulder range of motion.

Lipped Plate

Lipped plates have a ridge which helps the diner to scoop up food. Those with hemiparesis and eat with only one hand may benefit from a lipped plate.

Nosey Cup

Nosey cups, as the name implies, has a groove which sits along the ridge of the nose as the person drinks. Nosey cups allow for improved swallowing without neck extension (which can increase the risk of aspiration). Those with dysphagia, compromised neck range of motion or postural issues (i.e. kyphosis) may benefit.

Sippy Cup

Sippy cups allow for improved control of liquid flow and are especially useful for those with compromised swallowing function or overall muscle weakness. The handles provide two-handed control when drinking.

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Appendix

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Appendix 1

Sample 3-Week Menu, Week 1

Week 1	Sunday	Monday	Tuesday
Breakfast	Cran/Grape Juice Hot cereal* Whole grain ** Scrambled egg Sausages (optional)	Orange Juice Hot cereal* Whole grain** Fried egg	Apple Juice Hot cereal* Whole grain** Boiled egg Fried ham (optional)
AM Snack	Water Fruit	Water Fruit	Water Fruit
Lunch	Water Cream of Broccoli Soup Ham and Cheese Sandwich	Water Corn Chowder Warm Pizza Sub Cookie	Water One Pot Chicken Stew Bun/roll (HM or SB)
PM Snack	Water Canned Seafood	Water Local fish	Water HM Muffin
Supper	Water Caribou or Beef Stew or any CF Meal Bannock Applesauce Carrot Cake	Water Beef Stroganoff w/ Noodles Peas Green Salad	Water HM Meatballs with choice of sauce (double recipe) Power Pasta Salad w/Cheese
To Do:	o Put chicken pieces and gr meat (double recipe) in fridge to thaw for Tues	o Put whole chicken and gr meat in fridge for Wed.	o Put gr meat in fridge to thaw for Thurs.

HM = Homemade SB = Store-bought CF = Country food LO = Left over

*Hot cereal like oatmeal, Red River cereal, HM Apple cinnamon oatmeal, cream of wheat

**Whole grain item like whole wheat toast, English muffin, bread, bagel, raisin toast or rye bread, buns/rolls (SB or HM)

Beverages: Water, tea and coffee to be available at all meals and snacks, and throughout the day

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	Wednesday	Thursday	Friday	Saturday
	Cran/Grape Juice Cold cereal Whole grain** Peanut butter Cheese cubes	Orange juice Hot cereal* Whole grain** Scrambled egg Bacon (optional)	Apple Juice Hot cereal* Whole grain ** Fried egg	Orange juice Cold cereal Pancakes with berry sauce (HM)
	Water Fruit	Water Fruit	Water Local Fish	Water Yogurt
	Water Hamburger Soup Bannock Peach Blueberry Cobbler with Cloud Topping	Water Baked beans (SB) Wieners Tropical coleslaw (HM)	Water Country Food Meal with Vegetables Bannock Vanilla pudding	Water Cream of Carrot Soup Devilled Eggs Whole grain **
	Water Canned seafood or LO baked goods	Water Creamy HM YOP	Water Fruit	Water Soft Oatmeal Raisin Cookie
	Roast Chicken with Stuffing and Gravy Creamy Mashed Carrots or Turnip	Water Beef, Corn, Potato Casserole Bun/roll Cheese	Water Stir Fry Rice Yogurt	Water Saucy Ribs Mashed potatoes Green beans Creamy Fruit Jello
	o Put CF and other meat in fridge to thaw for Friday	o Put ribs in fridge to thaw for Sat supper	o Cook eggs for Sat lunch o Put gr meat in fridge for Sun supper	o Make Berry Trifle o Put chicken in fridge to thaw for Mon supper

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Appendix 1

Sample 3-Week Menu, Week 2

Week 2	Sunday	Monday	Tuesday	
Breakfast	Cran/Grape Juice Hot cereal* Whole grain ** Scrambled egg Sausages (optional)	Orange Juice Hot cereal* Whole grain ** Fried egg	Apple Juice Hot cereal* LO Muffins Boiled egg Bacon (optional)	
AM Snack	Water Fruit	Water Creamy HM YOP	Water Fruit	
Lunch	Water Cheesy Broccoli Omelette Pickled beets Buns/rolls	Water Creamy Potato Chowder Roast Beef Deli Meat Sandwich	Water Split Pea Soup Grilled Cheese Sandwich	
PM Snack	Water Imitation crab Crackers	Water Homemade Muffins	Water Shrimp Ring or Local Fish	
Supper	Water Caribou Meatloaf with Gravy Mashed Potatoes Peas Berry Trifle	Water Chicken Alfredo with Green Beans Stewed Prunes with Yogurt	Water Spaghetti with Meat Sauce or Meatballs Canned peaches	
To Do:	o Put shrimp ring or fish, and gr meat in fridge to thaw for Tues	o Put pork roast and gr beef in fridge to thaw for Wed	o Put chicken wings in fridge to thaw for Thurs	

HM = Homemade SB = Store-bought CF = Country food LO = Left over

*Hot cereal like oatmeal, Red River cereal, HM Apple cinnamon oatmeal, cream of wheat

**Whole grain item like whole wheat toast, English muffin, bread, bagel, raisin toast or rye bread, buns/rolls (SB or HM)

Return to TOC

Wednesday	Thursday	Friday	Saturday
Cran/Grape Juice Cold cereal Whole grain** Peanut butter or Cheese cubes	Orange juice Hot cereal* Whole grain** Scrambled egg Fried ham (optional)	Apple Juice Hot cereal* Whole grain ** Fried egg	Cold cereal French toast with sliced banana or berry sauce (HM)
Water Fruit	Water Cheese and crackers	Water Yogurt	Water Fruit
Water Tender Pork Roast with Vegetables Applesauce Pudding	Water Saucy Chicken Wings Creamy Pasta Salad	Water Baked Fish w/Mayo Topping Jamey's Fried Rice Mixed Vegetables	Water Homemade Pizza Green Salad with Shredded Carrot
Water Fruit	Water Yogurt	Water Apple cinnamon cookie (Homemade)	Water Chocolate banana bread
Water Hashbrown Casserole	Water Ham and Pierogi Bake Canned Pears	Water Chicken N' Dumplings w/ Broccoli Canned Peaches	Water Easy Shepherd's Pie
o Put fish and chicken pieces in fridge to thaw for Fri	o Put gr meats in fridge to thaw for Sat lunch and supper	o Put fish for Sunday's chowder in fridge to thaw o Put CF or pot roast in fridge to thaw	o Put chicken pieces in fridge to thaw for Mon supper

Beverages: Water, tea and coffee to be available at all meals and snacks, and throughout the day

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Appendix 1

Sample 3-Week Menu, Week 3

Week 3	Sunday	Monday	Tuesday	
Breakfast	Cran/Grape Juice Hot cereal* Whole grain ** Scrambled egg Sausages (optional)	Orange Juice Hot cereal* Whole grain ** Fried egg	Apple Juice Hot cereal* Whole grain ** Boiled egg Fried ham (optional)	
AM Snack	Water Fruit	Water Fruit	Water Fruit	
Lunch	Water Fish or Clam Chowder Bannock or Whole grain **	Water Carrot Slaw Ham Deli Meat Sandwich	Water Beef and Barley Soup Cheese toast	
PM Snack	Social tea cookies or graham crackers	Water Canned Seafood Seaweed snacks	Water YOP	
Supper	Water Country Food Meal or Beef Pot Roast with Vegetables Bannock	Water Easy Chicken Pot Pie Pudding	Water Boiled Ham Scalloped Potatoes Glazed Carrots	
To Do:	o Put gr meat in fridge to thaw for Tues lunch	o Put pork in fridge to thaw for Wed supper	o Put chicken thighs in fridge to thaw for Thurs supper.	

HM = Homemade SB = Store-bought CF = Country food LO = Left over

*Hot cereal like oatmeal, Red River cereal, HM Apple cinnamon oatmeal, cream of wheat

**Whole grain item like whole wheat toast, English muffin, bread, bagel, raisin toast or rye bread, buns/rolls (SB or HM)

Return to TOC

	Wednesday	Thursday	Friday	Saturday
	Cran/Grape Juice Cold cereal Whole grain** Peanut butter, cheese cubes	Orange juice Hot cereal* Whole grain ** Scrambled egg Bacon (optional)	Apple Juice Hot cereal* Whole grain ** Fried egg	Cold cereal or Pancakes with berry sauce (HM)
	Water Applesauce	Water Fruit	Water Yogurt	Water Cheese and crackers
	Water Hearty Mushroom Soup Potato Salad	Water LO Pork Stew with Apples Roll/bun	Water Sweet and Sour Pineapple Meatballs Green salad with Pickled Beets Apricot Almond Bars	Water Cream of Broccoli Soup Tuna or Salmon Sandwiches
	Water Local fish	Water Yogurt	Water Cheese and crackers	Water Fruit
	Water Pork Stew with Apples Roll/Bun Blueberry Cake	Water Roasted Chicken Thighs Stuffing with Vegetables Ice cream with canned pears	Water Fish burgers Whole grain** Tropical Coleslaw	Water Creamy Chicken Noodles Ambrosia Salad
	○ Put gr beef in fridge to thaw for Friday lunch		○ Put CF or beef stew meat in fridge to thaw for Sun supper	○ Put gr beef in fridge to thaw for Mon supper

Beverages: Water, tea and coffee to be available at all meals and snacks, and throughout the day

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Appendix 2

Food Order Sheet, Weeks 1–3

Food Ordering Guide – MENU WEEK 1

Perishables	How often on menu	Purchase?
Breads		
Bread (variety of white, whole wheat, rye, raisin, bagel, English muffin)	6 breakfasts, 1 lunch	
Submarine sandwich or hot dog buns (whole wheat, if possible)	1 lunch	
Bun or roll	1 lunch, 1 supper	

Deli section		
Eggs	6 breakfasts + 1 lunch main + 7 eggs for desserts, pancakes, muffins, desserts and meatballs	
Sausages	1 breakfast	
Ham	1 breakfast	
Bacon	1 breakfast	
Deli meat roast beef	1 lunch	
Deli meat ham	1 lunch	
Wieners	1 lunch	

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Perishables	How often on menu	Purchase?
Refrigerated case		
Cheese, any kind	1 cup shredded, 1 cup mozzarella, 1 breakfast, 1 lunch	
Cream cheese	1 block (for pizza sub and carrot cake frosting)	
Sour cream	¾ cup	
Vanilla yogurt (Greek style if possible)	1 cup	
Yogurt	1 snack, 1 dessert + 2 tubs (any flavour)	
Milk	7 breakfasts + 9 cups for recipes	
Margarine	For recipes and breakfast	

Frozen foods		
Frozen concentrated 100% fruit juice (a variety)	7 breakfasts and HM YOP	
Frozen berries	5 ½ cups	
Frozen peas	4 cups	
Frozen mixed veggies	750 gram bag (for stir fry)	
Frozen green beans	4 cups	
Frozen broccoli	500 gram bag	

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Perishables	How often on menu	Purchase?
Fresh fruits and veggies		
Fresh fruit	6 snacks	
Potatoes	12 pounds (about 40 medium potatoes)	
Onions	8	
Carrots	14	
Celery	2 stalks	
Cole slaw mix	454 gram bag	
Green onions	4	
Tomato	1	
Lettuce	1 supper	

Meats		
Ground beef	7 pounds	
Whole chicken	1 whole plus 2 legs	
Chicken pieces	8	
Caribou or muskox stew meat (or beef or pork if CF not available)	1 kg Sunday supper	
Caribou, musk ox, other lean meat for stir fry	1 kg	
Country food	1 kg Friday lunch	
Ribs pork or caribou	2.5 kg	

Non perishables	How often on menu	Purchase?
Hot cereal	5 breakfasts	
Cold cereal	2 breakfasts	
Peanut butter	1 breakfast	

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Non perishables	How often on menu	Purchase?
Canned goods		
Pizza or pasta sauce	½ cup	
Cream style corn	2 cans	
Canned tomatoes	1 can (796 ml)	
Tomato soup	1 can	
Canned mushrooms	3 cans (284 ml)	
Evaporated milk	4 cans	
Baked beans	1 lunch (3 cans)	
Crushed pineapple	1 can	

Basic Seasonings and Baking Products		
Flour	2.5 kg (for bannock, muffins, cobbler, carrot cake, pancakes and cookies)	
Sugar	3.5 cups (around 730g) for desserts, muffins, berry sauce, tea and coffee	
Brown sugar	1.5 cups (around 350g)	
Skim milk powder	2 cups	
Coffee whitener	122 grams (56 teaspoons or 4.7 cups)	
Baking powder	16 T	
Baking soda	1 T	
Cinnamon and nutmeg	3 tsp	
Nutmeg	½ tsp	
Vanilla extract	4 tsp	
Chicken bouillon	6 tsp	
Dried herbs	1 T	
Garlic powder	1 T	

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Non perishables	How often on menu	Purchase?
Basic Seasonings and Baking Products		
Cornstarch	2 T	
Onion soup mix, dry	1 packet	
Soya sauce	¼ cup	
Vinegar	½ cup	
Ketchup	½ cup	
Pickle relish	¼ cup	

Fats		
Oil for bannock, baking, etc	540ml	
Lard for bannock	?	
Mayonnaise	1 cup, plus more for sandwiches	

Grains		
Barley	¼ cup	
Crackers	1 snack	
Bread crumbs	2 cups	
Noodles	750 grams or 4 cups	
Stuffing mix	1 supper (2 packages?)	
Rice	1 supper (8 cups or 400 g?)	

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Non perishables	How often on menu	Purchase?
Canned/jarred goods		
Tuna or salmon	4 cans 213 grams or 2 cans 418 grams, + 1 can 213 gram	
Kidney beans	1 can	
Canned sardines or other fish	1 snack (3 cans?)	
Cranberry sauce	2 cans	
Cream of mushroom soup	1 can	
Applesauce, unsweetened	1 cup	

Other dry goods		
Raisins	½ cup	
Dates	2 cups, pitted	
Dream Whip dessert topping	3 pouches	
Vanilla pudding, dry mix	2 pouches	
Jello	2 boxes	
Coffee	1.12 kg	
Tea	112 bags	

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Food Ordering Guide – MENU WEEK 2 or 3

(circle correct week)

Perishables, Week 2 or 3	How often on menu or how much to buy	Purchase?
Breads		
Deli section		
Refrigerated case		

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Perishables, Week 2 or 3	How often on menu or how much to buy	Purchase?
Frozen foods		
Fresh fruits and veggies		
Meats		

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Appendix 3

Staff Notes on Menus and Recipes, Week 1

Week 1	Sunday	Monday	Tuesday	
Breakfast	Cran/Grape Juice Hot cereal* Whole grain ** Scrambled egg Sausages (optional)	Orange Juice Hot cereal* Whole grain** Fried egg	Apple Juice Hot cereal* Whole grain** Boiled egg Fried ham (optional)	
Cook's Notes about Breakfast				
AM Snack	Water Fruit	Water Fruit	Water Fruit	
Lunch	Water Cream of Broccoli Soup Ham and Cheese Sandwich	Water Corn Chowder Warm Pizza Sub Cookie	Water One Pot Chicken Stew Bun/roll (HM or SB)	
Cook's Notes about Lunch and AM Snack				
PM Snack	Water Canned Seafood	Water Local fish	Water HM Muffin	
Supper	Water Caribou or Beef Stew or any CF Meal Bannock Applesauce Carrot Cake	Water Beef Stroganoff w/ Noodles Peas Green Salad	Water HM Meatballs with choice of sauce (double recipe) Power Pasta Salad w/Cheese	
Cook's Notes about PM Snack and Supper				

Return to TOC

	Wednesday	Thursday	Friday	Saturday
	Cran/Grape Juice Cold cereal Whole grain** Peanut butter Cheese cubes	Orange juice Hot cereal* Whole grain** Scrambled egg Bacon (optional)	Apple Juice Hot cereal* Whole grain ** Fried egg	Orange juice Cold cereal Pancakes with berry sauce (HM)
	Water Fruit	Water Fruit	Water Local Fish	Water Yogurt
	Water Hamburger Soup Bannock Peach Blueberry Cobbler with Cloud Topping	Water Baked beans (SB) Wieners Tropical coleslaw (HM)	Water Country Food Meal with Vegetables Bannock Vanilla pudding	Water Cream of Carrot Soup Devilled Eggs Whole grain **
	Water Canned seafood or LO baked goods	Water Creamy HM YOP	Water Fruit	Water Soft Oatmeal Raisin Cookie
	Roast Chicken with Stuffing and Gravy Creamy Mashed Carrots or Turnip	Water Beef, Corn, Potato Casserole Bun/roll Cheese	Water Stir Fry Rice Yogurt	Water Saucy Ribs Mashed potatoes Green beans Creamy Fruit Jello

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Appendix 3

Staff Notes on Menus and Recipes, Week 2

Week 2	Sunday	Monday	Tuesday	
Breakfast	Cran/Grape Juice Hot cereal* Whole grain ** Scrambled egg Sausages (optional)	Orange Juice Hot cereal* Whole grain ** Fried egg	Apple Juice Hot cereal* LO Muffins Boiled egg Bacon (optional)	
Cook's Notes about Breakfast				
AM Snack	Water Fruit	Water Creamy HM YOP	Water Fruit	
Lunch	Water Cheesy Broccoli Omelette Pickled beets Buns/rolls	Water Creamy Potato Chowder Roast Beef Deli Meat Sandwich	Water Split Pea Soup Grilled Cheese Sandwich	
Cook's Notes about Lunch and AM Snack				
PM Snack	Water Imitation crab Crackers	Water Homemade Muffins	Water Shrimp Ring or Local Fish	
Supper	Water Caribou Meatloaf with Gravy Mashed Potatoes Peas Berry Trifle	Water Chicken Alfredo with Green Beans Stewed Prunes with Yogurt	Water Spaghetti with Meat Sauce or Meatballs Canned peaches	
Cook's Notes about PM Snack and Supper				

Return to TOC

	Wednesday	Thursday	Friday	Saturday
	Cran/Grape Juice Cold cereal Whole grain** Peanut butter or Cheese cubes	Orange juice Hot cereal* Whole grain** Scrambled egg Fried ham (optional)	Apple Juice Hot cereal* Whole grain ** Fried egg	Cold cereal French toast with sliced banana or berry sauce (HM)
	Water Fruit	Water Cheese and crackers	Water Yogurt	Water Fruit
	Water Tender Pork Roast with Vegetables Applesauce Pudding	Water Saucy Chicken Wings Creamy Pasta Salad	Water Baked Fish w/Mayo Topping Jamey's Fried Rice Mixed Vegetables	Water Homemade Pizza Green Salad with Shredded Carrot
	Water Fruit	Water Yogurt	Water Apple cinnamon cookie (Homemade)	Water Chocolate banana bread
	Water Hashbrown Casserole	Water Ham and Pierogi Bake Canned Pears	Water Chicken N' Dumplings w/ Broccoli Canned Peaches	Water Easy Shepherd's Pie

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Appendix 3

Staff Notes on Menus and Recipes, Week 3

Week 3	Sunday	Monday	Tuesday	
Breakfast	Cran/Grape Juice Hot cereal* Whole grain ** Scrambled egg Sausages (optional)	Orange Juice Hot cereal* Whole grain** Fried egg	Apple Juice Hot cereal* Whole grain** Boiled egg Fried ham (optional)	
Cook's Notes about Breakfast				
AM Snack	Water Fruit	Water Fruit	Water Fruit	
Lunch	Water Fish or Clam Chowder Bannock or Whole grain**	Water Carrot Slaw Ham Deli Meat Sandwich	Water Beef and Barley Soup Cheese toast	
Cook's Notes about Lunch and AM Snack				
PM Snack	Social tea cookies or graham crackers	Water Canned Seafood Seaweed snacks	Water YOP	
Supper	Water Country Food Meal or Beef Pot Roast with Vegetables Bannock	Water Easy Chicken Pot Pie Pudding	Water Boiled Ham Scalloped Potatoes Glazed Carrots	
Cook's Notes about PM Snack and Supper				

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	Wednesday	Thursday	Friday	Saturday
	Cran/Grape Juice Cold cereal Whole grain** Peanut butter, cheese cubes	Orange juice Hot cereal* Whole grain ** Scrambled egg Bacon (optional)	Apple Juice Hot cereal* Whole grain ** Fried egg	Cold cereal or Pancakes with berry sauce (HM)
	Water Applesauce	Water Fruit	Water Yogurt	Water Cheese and crackers
	Water Hearty Mushroom Soup Potato Salad	Water LO Pork Stew with Apples Roll/bun	Water Sweet and Sour Pineapple Meatballs Green salad with Pickled Beets Apricot Almond Bars	Water Cream of Broccoli Soup Tuna or Salmon Sandwiches
	Water Local fish	Water Yogurt	Water Cheese and crackers	Water Fruit
	Water Pork Stew with Apples Roll/Bun Blueberry Cake	Water Roasted Chicken Thighs Stuffing with Vegetables Ice cream with canned pears	Water Fish burgers Whole grain** Tropical Coleslaw	Water Creamy Chicken Noodles Ambrosia Salad

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Appendix 4

Foods to order by sealift and at the local stores

Foods to order via sealift, if possible All are good for at least 9 months, unopened.	Foods to buy locally Most are subsidized by Nutrition North and are perishable.
Meat and Alternatives	
	Fresh and frozen meat, poultry, fish and seafood (plain, not breaded or battered)
Peanut butter	Nuts
	Eggs and egg substitutes
WOW butter (spread made from soy beans)	Soy products like tofu
	Deli meats such as ham, roast beef and turkey (are not subsidized but must be purchased locally)
Canned tuna, salmon, sardines, clams, oysters, mussels	
Canned beans (baked beans, kidney beans, lentils, etc.)	

Milk and Alternatives	
UHT milk	
Skim milk powder	
Canned evaporated milk	Fresh milk
Parmesan cheese	Hard cheese and processed cheese
	Cottage cheese
	Yogurt and drinkable yogurt
	Cream, cream cheese, sour cream, cheese spread like Cheez Whiz and ice cream have a lower subsidy level

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Foods to order via sealift, if possible All are good for at least 9 months, unopened.	Foods to buy locally Most are subsidized by Nutrition North and are perishable.
Vegetables and Fruit	
	All fresh and frozen fruits and vegetables without sauces
	Instant mashed potatoes
Dried cranberries	
Dates	
Prunes	
Apricots	Raisins
100% fruit juice in containers over 250 ml	
Canned unsweetened juice	Frozen concentrated 100% fruit juice
100% unsweetened fruit juice in containers over 250 ml get a lower subsidy.	
Jarred or canned pasta sauce	
Jarred or canned fruit and vegetables	

Grain Products	
Flour, rice, split peas, barley, dry pasta	
Cold cereal	
Hot cereal (oats, Cream of Wheat, Red River)	Bread and bread products without filling or coating
Stuffing mix	
Macaroni and cheese dry mix (like KD)	
Pancake mix and Bisquick	
Crackers, Pilot biscuits	

Return to TOC

Foods to order via sealift, if possible All are good for at least 9 months, unopened.	Foods to buy locally Most are subsidized by Nutrition North and are perishable.
Other foods	
Canned soups	
Lard	
Vegetable oil	Mayonnaise
Bottled salad dressings	
Muffin and cake mixes	
Ketchup	
Soya sauce	
Hard cookies	
Instant pudding	
Dream Whip	Liquid fresh cream (has a low subsidy)
Salt and pepper, cinnamon, nutmeg, cloves	Dried herbs
Baking powder	
Baking soda	
Vanilla extract	
White sugar and honey	Brown sugar
Tea and coffee	
Coffee whitener	

Other kitchen items	
Food storage containers – 1 cup size	
Food storage containers – 8 cups or 2 litres	
Sticky labels for food containers	
Markers	

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Appendix 5

Calculating the sealift Order for the Week 1 Menu

Sealift items on menu	Weekly amount needed	Unit measure	Yearly amount (unit measure x 17.3)	Notes
Week 1				
Oats	33 cups	1.3kg	22.5kg	
Flour, all purpose	18.5 cups	2.5 kg	43.25kg	
Cold cereal	12 cups	480g	8.3kg	
Social tea cookie	24 cookies	192g	3.2kg	1 cookie =5 g; svg = 3
Noodles, dry	8 cups	750g	13kg	
Barley	¼ cup	50g		
Stuffing mix	2 packages		34 packages	
Rice	8 cups	400g	6.8 kg	
Evaporated milk	2 cans	354ml x2	34 cans	
Milk powder	1 cup	72 g	1.2 kg	
Canned tuna	1 can	213g	17 cans	
Canned sardines, mussels or oysters	106 x3	318g	51 cans	
Cream style canned corn	2 cans	398ml x2	34 cans	
Cream of mushroom soup	1 can	284ml	17 cans	
Canned mushrooms	284 x 2	284ml x2	34 cans	
Cranberry sauce	1 can	348ml	17 cans	
Kidney beans	1 can	540ml	17 cans	
Baked beans	3x 398 ml	3 cans	52 cans	
Canned tomatoes	1 can	796 ml	17 cans	
Canned tomato soup	1 can	284 ml	17 cans	
Canned crushed pineapple	1 can	540ml	17 cans	

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Sealift items on menu	Weekly amount needed	Unit measure	Yearly amount (unit measure x 17.3)	Notes
Canned peaches	4 cups	796ml	17 cans	
Oil	2¼ cups	540ml	9.2 litres	
Lard	1½ cups	312 g	5.4kg	
Mayonnaise	½ cup	120g	2 kg	
Vinegar	½ cup	120ml	2 L	
Raisins	1 cup	153g	2.6 kg	
Dream whip	1 pouch	½ 85g package	9 packages	
Ketchup	½ cup	120ml	2 L	
Soya sauce	8 T	120 ml	2 L	
Onion soup mix	1 packet		17 packets	
Cinnamon	3 tsp	6.9	119g	
White sugar	3 ¼ cups	731	12.6 kg	For recipes, plus 1 tsp/cup of coffee and tea
Brown sugar	2 cups	466	8kg	
Vanilla	3 tsp	15 ml	260ml	
Baking powder	12T	180g	3kg	
Dried herbs	1 T	15g	255g	
Garlic powder	3 tsp	15g	255g	
Chicken bouillon powder	4 tsp	18g	306g	
Cornstarch	2T	30g	510	
Coffee, ground	112 cups	1.120 kg	19 kg	Assume 2 cups/ person/day and 8 consumers. Coffee (ground) 10 g/cup or 2T/6oz cup)
Tea, bags	112 cups	112 bags	1,904 bags	Assume 2 cups/ person/day and 8 consumers
Coffee whitener	224 tsp	112 g	1.9 kg	Assume 1 tsp/cup of coffee and tea

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Appendix 6

Education and Training Attendance Form

Date: DD / MM / YY	
Presenter:	Length of education session:
Location:	
Objectives of education session:	
Name and Position of Staff Member	Comments

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Appendix 7

Emergency Menu

Emergency Plan	Day 1 (still some food in fridge/freezer)	Day 2 (Little food in fridge/ freezer)	Day 3 (no food in fridge/ freezer)
Breakfast	Orange Juice (frozen/jar) Dry cereal or Pancakes made with tetra, canned milk or milk powder	Apple Juice (frozen/jar) Oatmeal with raisins Boiled eggs (optional)	Orange Juice (frozen/jar) Crackers/Toast Peanut butter, cheese spread
Lunch	Water Hamburger Soup Bun/roll/bread	Water Leftover hamburger soup or Better for you Chicken Noodle Soup Crackers	Water Split pea soup (SB) Chicken/turkey salad made into sandwiches or spread on crackers
Supper	Saucy Salmon Noodles	Water Creamy Turkey Pasta	Water Tomato Spaghetti
Snack A	Water Canned Fruit Yogurt (if available)	Water Jello topped with Dream whip made with tetra, canned milk or milk powder	Water Canned fruit Pudding (any flavour) made from powder with tetra, canned milk or milk powder
Snack B	Water Applesauce	Water Canned seafood	Water Social tea or graham cookies
To do:	To be completed	To be completed	To be completed

SB = Store-bought

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Appendix 8

RECIPES

MAIN COURSES

Baked Fish with Mayonnaise Topping

Preparation time:	Cooking time:	Yield:
10 minutes	20 minutes	12 servings

Ingredients:

- 12 thawed fish fillets, local fish or store bought (about 1 whole 5-pound char or 2½ pounds fish fillets)
- ¾ cup mayonnaise
- 1 onion or 4 green onions, very finely chopped
- 12 tablespoons plain breadcrumbs
- 1 teaspoon curry powder or dried dill or dried parsley (optional)
- Pinch of salt and pepper
- 1 cup of shredded cheese

Steps

1. Preheat oven to 350°F. Cut fish into fillets and place on an oiled cookie sheet.
2. Spread a small amount of mayonnaise (about 1 tablespoon) on top of each fillet.
3. Sprinkle onion over each fillet.
4. In a bowl, mix breadcrumbs with seasonings. Spread over fish fillets.
5. Cover with aluminum foil. Bake for 15 minutes.
6. Remove from oven and remove foil.
7. Return to oven for five minutes, or until breadcrumbs are golden brown.

Recipe Source: Adapted from Nordic Fish with Cheese. Web. 20 Nov 2017. http://publicationsnunavik.com/book/nunavik-family-cookbook.

Image. Web. 03 Dec 2017. http://www.geniuskitchen.com/recipe/easy-cheese-baked-fish-88405?photo=cGhvdG8tMTc20DM0

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Beef n' Broccoli Skillet Dinner

Preparation time:	Cooking time:	Yield:
10 minutes	25–30 minutes	12 servings

Ingredients:

- 2 lbs. ground beef or caribou
- 2 cans (398 mL) tomato sauce
- Homemade white sauce (recipe doubled – see sauces section)
- 4 cups broccoli, chopped (fresh or frozen)
- 4 cups minute rice, uncooked
- 4 cups water
- 1 ½ tsp dried herbs like basil, oregano, parsley
- ½ tsp pepper
- 1 ½ cups cheese, grated
- 2 cups water

Steps

1. Brown meat in a large pot. Drain off fat.
2. Add tomato sauce, soup or white sauce, dried herbs and pepper to cooked meat. Mix well.
3. Add water to meat mixture. Bring mixture up to a boil, cover and simmer for 10.
4. Add broccoli and rice. Cover and simmer 5 minutes or until the broccoli and the rice are tender and the water is absorbed.
5. Sprinkle grated cheese on top. Replace lid and let stand for 5 minutes or until cheese melts.

Recipe Source: Adapted from "A Pound of Ground," Winnipeg Hydro Home Economists. Courtesy of Bag Manual 2010 Feeding Stomachs and Souls, by FNIHB, Health Canada, Manitoba Region.

Picture Source: Cheesy Burger, Rice and Broccoli Skillet. Image. Web. 30 Nov 2017. https://www.pillsbury.com/recipes/cheesy-burger-rice-and-broccoli-skillet/a9b1d82c-651b-4395-ae4c-84fb1bf01972.

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Beef Stew

Preparation time:	Cooking time:	Yield:
15 minutes	1 hour	8 servings

Ingredients:

- 3 tbsp. vegetable oil
- 1 large onion, chopped
- 2 lbs lean stew beef, cut into small cubes
- ¼ cup all purpose flour
- 2 ½ cups water
- 2 cloves garlic, minced or ½ teaspoon garlic powder
- 2 cups sliced fresh or canned mushrooms (drained if canned)
- 3 carrots, chopped
- 1 package onion soup mix
- 2 tbsp. tomato paste
- Seasonings: 1 bay leaf (optional), 2 tsp dried parsley, 1 tsp dried thyme, ¼ tsp black pepper

Steps

1. In a large pot, fry the onion in the oil until softened.
2. Sprinkle the beef with the flour. Add to the pot and fry until the beef is browned.
3. Add the rest of the ingredients.
4. Bring up to a boil. Lower the heat and cover with lid.
5. Cook stirring occasionally for 60 minutes or until the beef is tender. Add water during cooking if the stew becomes too dry.

Recipe Source: Adapted from "Slow-Cooked Beef Stew" Simply Great Food Cookbook, by Dietitians of Canada 2007.

Picture Source: Jerk Beef Stew with Carrots. Image. Web. 11 Nov 2017.
http://www.80twentynutrition.com/recipe/jerk-beef-stew/

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Beef Stroganoff

Preparation time:	Cooking time:	Yield:
5 minutes	20–25 minutes	8–10 servings

Ingredients:

- 2 pounds of lean ground beef (fresh or thawed if frozen) or 2 pounds of frozen, store-bought meatballs
- 1 can cream of mushroom soup (284 mL)
- 2 cans of mushroom pieces, drained (2x 284 mL)
- 1 can 2% evaporated milk (370 mL)
- 1 packet onion soup mix (40 g)
- 3 soup cans water
- 2 cups of peas (canned or frozen)
- 1 small box or bag of whole wheat spaghetti or egg noodles (375 g)

Steps

1. Open the cans. Drain the water from the peas and mushrooms.
2. Add water to the pea and mushroom cans and drain again to take away salt.
3. Put the thawed beef or frozen store-bought meatballs in the pot. Add ¼ cup of water and cook on high heat for 5 minutes, breaking the meat into smaller pieces.
4. Add mushroom soup, mushroom pieces, evaporated milk and onion soup mix to the pot. Add 3 empty soup cans filled with water and stir.
5. Bring to a boil, add the noodles. Stir well. Place lid and lower the heat to medium.
6. Stir with a clean stirring spoon every 2–3 minutes. After 10 minutes add the peas. Cook until the noodles are soft (about 10–12 minutes).

Recipe and Image Source: Adapted from "Beef Stroganoff," by the Government of Nunavut. Image. Web. 17 Nov 2017. http://www.livehealthy.gov.nu.ca/en/food/recipes.

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Beef, Corn and Potato Casserole

Preparation time:	Cooking time:	Yield:
20 minutes	50 minutes	8 servings

Ingredients:

- 8 medium potatoes, peeled, washed and cut into chunks
- 2 lbs lean ground beef
- 2 onions, chopped
- 1 cup milk
- 3 tbsp. margarine
- 1 can (12 oz/341 mL) cream corn
- Salt and ¼ teaspoon pepper to taste
- ½ tsp. paprika (optional)

Steps

1. Turn on oven to 350°F (180°C). Put potatoes in a large pot, cover with water and heat to boiling. Lower heat, cover saucepan and boil potatoes until tender, about 20 minutes.
2. While potatoes are cooking, cook and stir beef and onion in a large frypan until beef is browned. Drain off fat. Place meat mixture in a large baking dish, about 10"x12".
3. Drain potatoes. Put potatoes back in saucepan. Use a potato masher and mash with milk and margarine. Add salt and pepper to taste. Set aside.
4. Pour corn on top of meat. Spread potatoes over corn. Sprinkle lightly with paprika.
5. Bake for about 30 minutes or until heated through.

Recipe Source: Adapted from "The Basic Shelf Cookbook," by Canadian Public Health Association 1994. Picture Source: Easy Shepherd's Pie. Image. Web. 6 Nov 2017. http://www.simplyrecipes.com/recipes/easy_shepherds_pie/

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Caribou or Beef Roast

Preparation time:	Cooking time:	Yield:
20 minutes	2–2½ hours	8 servings

Ingredients:

- 2 lb. boneless or 3-3.5 lb. bone-in caribou OR beef roast
- 2 large onions
- 2 cloves garlic, minced or ½ teaspoon garlic powder
- 2 tbsp. brown sugar
- ½ tsp dried herbs like thyme, basil, oregano
- ½ tsp freshly ground black pepper
- 1 cup water
- ½ cup barbecue sauce
- 1 tbsp. mustard
- 4 medium potatoes, washed and diced (Leave skin on off if using new or red potatoes)
- 2 cups thickly sliced carrots

Steps

1. Preheat the oven to 325°F. Trim off silverskin and any visible fat from the roast.
2. Cut 1 onion into rings, set aside. Chop the other onion and place on the bottom of a roasting pan (big enough for the meat and vegetables).
3. Place the meat on top of the onions.
4. In a small bowl, mix the garlic, brown sugar, dried herbs, water, barbecue sauce and mustard. Pour over the meat. Arrange onion rings on top.
5. Cover with aluminum foil and cook for 1 hour. After an hour, place the potatoes and carrots around the roast. Spoon drippings over the roast and the vegetables.
6. Cover with foil and bake another 1-2 hours or until meat is very tender.
   Boneless roasts take less time.

Recipe Source: Adapted from "Slow-Roasted Venison" Cook Cookbook! by Dietitians of Canada 2011.

Picture Source: Venison Slow Cooker Roast. Image. Web. 1 Dec 2017. https://recipes.sparkpeople.com/recipe-detail.asp?recipe=191493

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Cheesy Broccoli Omelette

Preparation time:	Cooking time:	Yield:
10 minutes	35 minutes	8 servings

Ingredients:

- 1 onion, finely chopped
- 2 tsp oil
- 1 large package (750g) frozen broccoli
- 12 eggs
- 1 can evaporated milk (14 oz/ 396 mL)
- 1 ½ cups shredded cheddar cheese
- 1 tsp salt
- ½ tsp ground pepper

Steps

1. Turn the oven on to 350°F.
2. Coat a 9" x 13" baking dish with oil.
3. Add oil to frying pan and cook onion on medium-high heat, stirring frequently.
4. When the onion is soft, add the frozen broccoli and cook for another 2 or 3 minutes, until the broccoli is thawed and there is not much moisture in pan. Turn the stove off.
5. In a large bowl, beat together the eggs, evaporated milk, salt and pepper.
6. Stir the onion, broccoli and cheese into the egg mixture.
7. Pour this mixture into the greased baking dish or dishes.
8. Place the baking dish into the oven and bake for 35 to 40 minutes, until the top of the omelette is turning brown.

Recipe and Image Source: Adapted from Cheesy Baked Omelette with Broccoli. Web. 20 Nov 2017. http://www.livehealthy.gov.nu.ca/en/food/recipes

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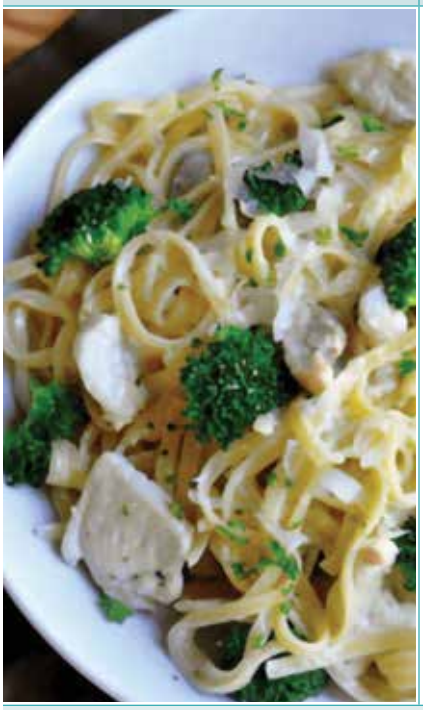
Chicken Alfredo

Preparation time:	Cooking time:	Yield:
5–10 minutes	10–20 minutes	6–8 servings



Ingredients:

- 1 small bag/box fettuccine or spaghetti
- noodles (375 g), 100% whole wheat if available
- 3 tbsp. vegetable oil
- 3 garlic cloves, chopped very finely or
- ¾ tsp garlic powder
- ¼ cup flour
- 1 ¼ cup water
- 1 can 2% evaporated milk (370 mL)
- 2 tsp instant chicken bouillon powder
- ¼ cup parmesan cheese
- 2 large cooked chicken breasts or 4 cooked chicken legs, skin removed and shredded (about 1 ½ cups)
- 2 cups frozen broccoli or green beans, thawed and finely chopped

Steps

1. Put a large pot of water on the stove to boil. In another medium size pot, add the oil and garlic.
2. Cook for about 1 minute on medium heat. Stirring quickly using a fork or a whisk, add the flour. Cook and stir for about 2-3 minutes.
3. Add the water and milk to the flour paste, stirring constantly. Continuing stirring until the mixture is thickened and smooth. Add the chicken bouillon powder.
4. Meanwhile, once the pot of water boils, add in the noodles. Stir occasionally so the noodles do not stick together. Cook until soft, then drain. Set aside.
5. Once the sauce is thick, add the rest of the ingredients. Cook for another 5 minutes.
6. Pour the sauce into the pot used for cooking the noodles, then toss the drained noodles back in. Using two big spoons, combine until the noodles are well-coated in the creamy sauce.

Adapted from "Cheesy Broccoli Fettuccine," with permission by The NorthWest Company.

Image Source: Cheesy Broccoli Fettuccine. Image. Web. 26 Nov 2017. http://www.realfoodgirlunmodified.com/30-minute-mondays-fettuccine-alfredo/

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Chicken N' Dumpling Stew

Preparation time:	Cooking time:	Yield:
10 minutes	30 minutes	8 servings

Ingredients:

Stew

- 8 pieces chicken thighs or drumsticks, skin removed
- 2 teaspoons canola oil
- 2 litres (8 cups) water
- 1 tablespoon onion powder
- ¼ teaspoon pepper
- 2 teaspoons instant chicken bouillon powder
- 4 cups or 500 g bag frozen vegetables, any blend but the one with broccoli works best.

Dumplings

- 1 ½ cup flour
- ½ cup pancake mix
- 1 can cream corn (small can 341 mL)
- ¼ cup milk

Steps

Stew

1. In a large soup pot, fry chicken in oil until golden brown.
2. Add remaining ingredients except vegetables. Cook on rolling boil for 20 minutes.
3. Turn heat to medium and add vegetables. Let simmer while you make the dumplings.

Dumplings

1. In a medium mixing bowl, mix dry ingredients. Make a well in the middle, add 1 can cream corn and the milk. Blend until sticky. Add a little more milk if too dry.
2. Using 2 spoons, make about 12 dumplings. They should be the shape of a slightly flattened ball.
3. Place the dumplings on top of the stew.
4. Cover and simmer for about 10 minutes.
5. They are ready when the middle is still a little hard but the outside is fluffy.

Recipe Source: Adapted from "Chicken n' Dumplings Stew," with permission by The NorthWest Company.

Picture Source: Chicken Stew and Dumplings. Image. Web. 9 Nov 2017. http://www.myrecipes.com/recipe/chicken-stew-dumplings

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Chicken, Turkey, Tuna or Salmon Salad Sandwich Filling

Preparation time:	Cooking time:	Yield:
5 minutes	0 minutes	8 servings

Ingredients:

- 4 cans (156 g) flaked chicken, turkey, tuna or salmon
- 3 small celery stalks or 2 carrots or 2 apples (for chicken or turkey salad), grated
- ½ cup mayonnaise or whipped salad dressing, low fat if available
- ½ teaspoon mustard
- Pepper to taste

Steps

1. Open the cans. Drain any liquid.
2. Put the canned meat in a bowl. Mash well with a fork until all the pieces are broken up.
3. Mix in the rest of the ingredients and it's ready for your sandwich.

Recipe Source: Adapted from "Chicken or Turkey Salad Sandwich," with permission by The NorthWest Company.

Picture Source: Chicken and Celery Salad Sandwich. Image. Web. 9 Nov 2017. http://www.enjoyyourcooking.com/salads/chicken-celery-salad-sandwich.html

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Creamy Turkey or Chicken with Noodles

Preparation time:	Cooking time:	Yield:
10 minutes	30 minutes	12 servings

Ingredients:

- 6 cups noodles like macaroni, whole wheat if available
- 2 tsp oil
- 1 large onion, chopped
- 2 cans (156 g) turkey or chicken, broken into small pieces, or 2 cups cooked chicken meat (much lower in salt)
- 2 cans (284 mL) cream of broccoli soup or double white sauce recipe (see under Sauces for less salt)
- 2/3 cup milk
- 3 cups frozen vegetables or 2 cans (284 mL) peas & carrots, rinsed and drained
- 4 tbsp. parmesan or block cheese, grated
- Seasonings: 1 tsp garlic powder, pepper to taste

Steps

1. In a large pot of boiling water add noodles. Cook for about 10 minutes or until noodles are tender. Drain and set aside.
2. In a separate pot add oil and chopped onion. Cook and stir on medium heat until onion is soft.
3. Add the rest of the ingredients. Stir constantly over medium heat until hot. If you like a thinner sauce, add a little more milk. Pour sauce over pasta and mix together.

Recipe Source: Adapted from "Creamy Turkey Rotini," Campbell's Soup Cookbook. Courtesy of Healthy Start for Mom & Me Program Winnipeg. June 2010. Picture Source: Skinny Chicken and Broccoli Alfredo.

Image source: Web. 30 Nov 2017. https://mykitchencraze.com/skinny-chicken-and-broccoli-alfredo

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Easy Chicken Pot Pie

Preparation time:	Cooking time:	Yield:
20 minutes	30 minutes	6–8 servings (picture below is the recipe doubled)

Ingredients:

- 3 chicken breasts or 4 thighs, meat cut into bite-sized pieces
- 2 onions, chopped
- 2 carrots, chopped
- 1 tablespoon oil
- 1 ½ cup frozen green beans, thawed then chopped
- 1 cup frozen peas, thawed
- 300 ml homemade white sauce + ¼ cup milk
- 1 ¼ cup Bisquick™ baking mix
- ½ cup milk
- 1 egg

Steps

1. Preheat oven to 400°F.
2. In a large skillet, heat up onion and fry onion until soft.
3. Mix chicken and carrots and cook until chicken is no longer pink.
4. Stir in the other veggies, white sauce and ¼ cup milk. Spread into bottom of non-greased 9-inch round pie pan. If doubling the recipe use a 9" x 13" baking dish.
5. Mix remaining ingredients (Bisquick, milk and egg) and pour on top of chicken mixture.
6. Bake in oven for 30 minutes or until top turns golden brown.

Recipe Source: Recipe source unknown.

Picture Source: Taken from Let's Cook It Up group offered by Anishnawbe Health Toronto 2016.

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Easy Seafood Burgers

Preparation time:	Cooking time:	Yield:
10 minutes	10 minutes	8 burgers

Ingredients:

- 2 tablespoons vegetable oil
- 2 cups canned tuna or salmon, drained and mashed
- ½ cup celery or green pepper, finely chopped
- ¼ cup relish
- 4 eggs, lightly beaten
- 1 cup bread crumbs
- 4 green onions, chopped or ¼ cup white onion, grated

Steps

1. In a large mixing bowl, combine all ingredients.
2. Shape into 8 patties.
3. Turn on stove to medium-high heat, in a non-stick pan, cook patties in oil until both sides are golden brown – about 3 minutes per slide.

Recipe Source: Adapted from "Recipe Name" The Basic Shelf Cookbook 2011 Edition, by The Canadian Public Health Agency.
Picture Source: Tuna Patties Recipe. Image. Web. 7 Nov 2017. http://www.simplyrecipes.com/recipes/tuna_patties/

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Easy Shepherd's Pie

Preparation time:	Cooking time:	Yield:
15 minutes	60 minutes	12 servings

Ingredients:

- 8 medium potatoes, peeled and cut into chunks OR use instant mashed potatoes.
- 3 tbsp. non-hydrogenated margarine
- ¾ cup milk
- 2 tsp. oil
- 2 lbs. lean ground meat (caribou, musk-ox, or any other ground meat)
- 2 onions, chopped
- 4 cups frozen mixed vegetables
- 1 cup water
- 2 teaspoons beef bouillon powder

Steps

1. Preheat your oven to 400°F.
2. If making homemade mashed potatoes, place potatoes in pot and add water to cover. Put lid on pot and boil until soft, about 20 minutes. Drain. Add margarine and milk and mash potatoes until smooth. Set aside.
3. Add oil to large frying pan. Cook and stir onions and ground meat over medium-high heat, until browned. Drain off fat.
4. Add frozen mixed vegetables, water and bouillon powder and cook until vegetables are tender, about 10 minutes.
5. Place meat mixture into one large baking dish. Spread mashed potatoes over meat mixture. Bake for 30 minutes or until the top is golden brown.

Recipe Source: Adapted from "Easy Shepherd's Pie" Healthy Family Program Collective Kitchen Recipe Book for Northern Cooks 2013, by the Government of the North West Territories. Web. 17 Oct 2017. http://www.hss.gov.nt.ca/sites/www.hss.gov.nt.ca/files/healthy-family-program-collective-kitchen.pdf.

Picture Source: Beef Shepherd's Pie. Image. Web. 20 Nov 2017. http://www.taste.com.au/recipes/beef-shepherds-pie/70d1e84f-b2c3-4894-a11d-f6036ad5960c

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Ham and Pierogi Bake

Preparation time:	Cooking time:	Yield:
10 minutes	30 minutes	8 servings

Ingredients:

- 1 bag (1 kg) frozen pierogis
- 2 cups frozen green beans or peas
- ¼ cup flour
- 1 teaspoon instant chicken bouillon powder
- Seasonings: ½ teaspoon garlic powder,
- 1 teaspoon onion powder
- 1 teaspoon Italian seasoning OR dried basil OR dried oregano
- 1 cup water
- 1 can (370 mL) 2 % evaporated milk
- 1 package (375 g) sliced deli ham, roughly chopped
- ½ cup cheddar cheese, grated
- ¼ cup parmesan cheese

Steps

1. Preheat the oven to 375°F.
2. Grease a large baking dish with vegetable oil.
3. Place the frozen pierogis into the dish and top with frozen peas or green beans.
4. In a medium sauce pan, mix together the flour and seasoning using a fork or a whisk. Cook while stirring constantly for 2-3 minutes. Slowly pour in the water. Stir until there are no lumps.
5. Slowly stir in the milk.
6. Turn the heat onto medium and continue to stir until the sauce bubbles and begins to gently boil. Let cook for 2 minutes.
7. Add the ham and shredded cheese to the sauce pan. Cook for another 2 minutes.
8. Pour over the pierogis then sprinkle the top with parmesan cheese.
9. Bake for 30 minutes until the top is bubbly and the sides have turned golden brown.

Recipe Source: Adapted from "Ham and Pierogi Bake," with permission by The NorthWest Company.
Picture Source: Suzanne Hajto RD

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Hashbrown Casserole

Preparation time:	Cooking time:	Yield:
15 minutes	60 minutes	12 servings

Ingredients:

- 2 lbs. ground meat, any type
- 1 large onion, finely chopped
- 2 cans (284 mL) condensed cream of mushroom soup (high in salt) OR use the homemade white sauce recipe, doubled (low in salt). See recipe under Sauces.
- ½ cup milk
- 3 cups frozen mixed vegetables, any type
- 1 cup shredded cheddar cheese
- 2 lbs. frozen hash browns (look on the label, pick one with less than 10% D.V. sodium)

Steps

1. Heat oven to 375°F. Grease a 4-qt. casserole dish with vegetable oil.
2. Brown meat with onions in large skillet; drain the grease. Spoon into the casserole dish. Top with the vegetables.
3. Mix the milk with the soup or the white sauce until smooth. Pour over meat and vegetables.
4. Top with hashbrowns and lastly sprinkle with shredded cheese.
5. Bake 45 minutes or until hash browns are golden brown and casserole is heated through.

Recipe and Image Source: Adapted from TATER TOTS Casserole Recipe. Image. Web. 20 Nov 2017. http://www.kraftrecipes.com/recipes/tater-tots-casserole-recipe-111257.aspx

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Impossible Pie

Preparation time:	Cooking time:	Yield:
20 minutes	40 minutes	7 servings

Ingredients:

- 2 cups frozen veggies, thawed and drained
- 1 ½ cups shredded Cheddar cheese (6 oz)
- 1 cup cut-up cooked chicken or 2 cans (5 oz each) chunk chicken, drained
- 1 medium onion, chopped (1/2 cup)
- ½ cup Bisquick mix
- 1 cup milk
- ½ teaspoon salt
- ¼ teaspoon pepper
- 2 eggs

Steps

1. Heat oven to 400°F. Coat 9-inch pie plate with oil. Sprinkle veggies, 1 cup of the cheese, the chicken and onion in pie plate.
2. In medium bowl, stir remaining ingredients with wire whisk or fork until blended. Pour on top of ingredients in pie plate.
3. Bake 35 to 38 minutes or until knife inserted in center comes out clean. Sprinkle with remaining 1/2 cup cheese. Bake 1 to 2 minutes longer or until cheese is melted.
4. Let stand 5 minutes before serving.

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Meatballs

Preparation time:	Cooking time:	Yield:
10 minutes	30 minutes	30 small meatballs

Ingredients:

- About 1-pound (454 grams) any ground meat
- 1 egg
- ¼ cup milk
- 2 slices whole wheat bread toasted and broken up into small pieces or ½ cup breadcrumbs
- 1 medium onion, grated
- 2 tablespoons vegetable oil

Steps

1. In a medium size bowl, use a fork to beat the egg into the milk. Stir in the bread and the onion. When the bread has soaked up all the liquid, add the meat.
2. Use your hands to blend the mixture until well combined.
3. Grab a tablespoon of the mixture to form into a small meatball. Set aside on a plate or tray. Repeat with the remaining mixture.
4. In a large frying pan, add 1 tablespoon of oil. Warm on medium heat then add half of the meatballs. Turn when browned on one side, about 10 minutes on each side.
5. Remove from the pan and repeat for the second batch of meatballs.
6. **Meatballs are still not cooked. Add to spaghetti sauce and cook another 10 minutes. If you are using a sauce or a glaze, add it now and cook the meatballs in the frying pan or the oven for at least another 10 minutes. If you are eating plain, cook another 10 minutes.**

Adapted from "Cranberry Glazed Party Meatballs," with permission by The NorthWest Company.

Image Source: Meatballs with Cranberry Dipping Sauce Recipe. Image. Web. 26 Nov 2017. https://www.tasteofhome.com/recipes/meatballs-with-cranberry-dipping-sauce

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Meatloaf

Preparation time:	Cooking time:	Yield:
15 minutes	45 minutes	12 servings

Ingredients:

- 2 lbs ground beef or ground/chopped caribou or mixture of both
- 2 eggs
- 2/3 cup bread crumbs or cracker crumbs or bran or oatmeal
- ½ cup ketchup or spaghetti sauce or tomato soup
- 2 medium carrots, grated
- 2 medium onions, chopped
- ½ tsp salt
- ¼ tsp pepper
- 2 tsp Worcestershire sauce (optional)
- 1 tsp dried basil (optional)
- 2 tsp ketchup for topping

Steps

1. Preheat the oven to 350°F degrees.
2. In a large bowl, mix the meat with all the rest of the ingredients except the ketchup. Mix with your hands or a large spoon.
3. Press the mixture neatly into a loaf pan or other baking dish.
4. Spread the ketchup over the top of the meatloaf.
5. Bake for 40 to 45 minutes. Making 12 servings.

Recipe Source: Adapted from "Meatloaf" Qamanituaq Cooks! Good Food...Healthy Families Cookbook, by The Baker Lake Prenatal Project 2005.

Picture Source: Easy Meatloaf Recipe. Image. Web. 20 Nov 2017. https://www.hungryforever.com/recipe/beef-meatloaf-recipe/

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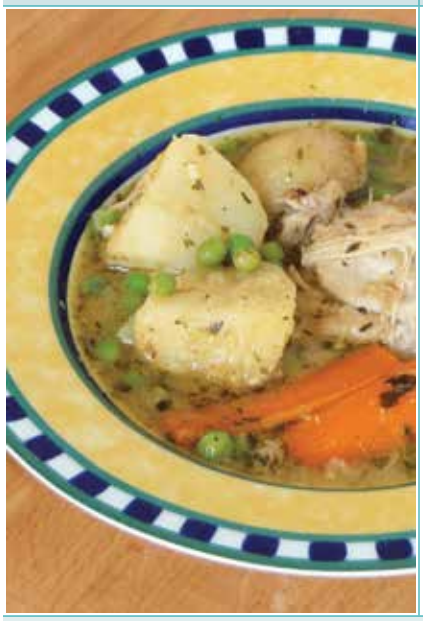
One-Pot Chicken Stew

Preparation time:	Cooking time:	Yield:
10 minutes	50 minutes	8 servings



Ingredients:

- 2 tbsp. oil
- 8 chicken thighs or drumsticks
- 1 onion, finely chopped
- 2 tbsp. flour
- 3 cups water
- 1 tsp instant chicken bouillon powder
- 2 tbsp. dried herbs (parsley, oregano, thyme)
- 4 carrots, cut into sticks
- 8 potatoes, washed and cut in half
- 2 cups frozen peas (or other vegetables)
- 1 tbsp. mustard (optional)

Steps

1. Heat oil in pot on medium high. Add chicken and cook on both sides until meat begins to brown.
2. Remove chicken from pot and set aside.
3. Add onions. Cook until soft.
4. Add flour. Cook for 2 minutes, stirring constantly.
5. Add water, chicken stock and dried herbs. Stir well.
6. Add chicken, carrots, and potatoes. Bring to a boil.
7. Turn heat to medium low, cover pot and cook for 20 minutes.
8. Remove lid and simmer for 15 minutes. Add frozen peas. If using, add mustard. Cook for 5 minutes.

Recipe and Image Source: Adapted from "Easy One Pot Chicken Stew," by the Government of Nunavut. Image. Web. 9 Nov 2017. http://www.livehealthy.gov.nu.ca/en/food/recipes

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Pizza Subs

Preparation time:	Cooking time:	Yield:
10 minutes	2 minutes	8 subs

Ingredients:

- 8 hot dog or sub buns, whole wheat if available
- ½ cup cream cheese
- ½ cup pizza sauce or pasta sauce or tomato salsa
- 12–16 slices roast beef deli meat or leftover roasted meat (about 1–2 slices of meat per sub)
- ½ cup shredded cheese

Steps

1. In a microwave-safe bowl, or in a small pot, add the cream cheese and sauce.
2. Heat until warm, less than 1 minute in the microwave and 2–3 minutes on the stovetop. Stir until smooth.
3. Spread 1–2 tablespoons of the creamy sauce onto each bun.
4. Add the roast beef and a tablespoon of shredded cheese.
5. Serve cold or warm.

Recipe and Image Source: Adapted from "Healthier Sandwiches," found in the Nutrition Activity Backpack by the Government of Nunavut 2013.

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Pizza

Preparation time:	Cooking time:	Yield:
20 minutes	15–20 minutes	12 slices

Ingredients:

- 2 ½ cups flour
- 1 tbsp. quick rise yeast
- 1 cup warm water
- 2 tsp sugar
- 2 tbsp. oil
- ½ cup pizza sauce (use more if you like a saucier pizza) or homemade white sauce
- 1 cup cheese, grated

Topping suggestions:

- Cooked ground caribou or ground beef, sliced ham
- Drained pineapple chunks, chopped into smaller pieces
- Thinly sliced mushrooms, green pepper, onions

Steps

1. Preheat the oven to 375°F. Grease a pizza pan or other large pan.
2. Put the flour in a large bowl. Add the yeast and mix well. Set aside.
3. In a measuring cup, mix together the water, sugar and oil. Pour into the flour mixture. Mix the wet and dry ingredients to form a dough and knead well.
4. Roll out the dough to fit the pizza pan. If the dough is too sticky, sprinkle on more flour or grease your hands. Place the rolled dough on to the greased pizza pan.
5. Spread the tomato sauce over the dough. Place the toppings of your choice on the pizza dough, sprinkle the cheese last.
6. Bake for 15 to 20 minutes. Do not overcook, a softer dough is easier to chew.

Recipe Source: Adapted from "Pizza" Qamanituaq Cooks! Good Food...Healthy Families Cookbook, by The Baker Lake Prenatal Project 2005.
Image Source: Homemade Pizza. Image. Web. 26 Nov 2017. http://www.manjulaskitchen.com/home-made-pizza/

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Pork Stew with Apples

Preparation time:	Cooking time:	Yield:
15 minutes	60 minutes	8 servings

Ingredients:

- 3 tablespoons oil
- 2 pounds pork, cut into cubes
- 2 onions, chopped
- 3 tbsp flour
- ½ tsp garlic powder
- 2 tsp thyme or other herb
- 2 tsp Worcestershire sauce (optional)
- 1 tsp salt
- ½ tsp pepper
- 4 potatoes, washed and cut into quarters
- 4 carrots, peeled and cut into chunks
- 3 apples, seeds removed and cut into chunks
- 4 cups water

Steps

1. Heat oil in pot over medium-high heat, add pork cubes and onions and cook until meat is brown and onions are soft, about 7 minutes.
2. Add flour, stir and cook for 2 minutes.
3. Add seasonings, potatoes, carrots, apples and water. Stir well.
4. Turn heat to high and bring to a boil.
5. Turn heat to low, cover the pot and let cook for 45 minutes, stirring occasionally.

Recipe and Image Source: Adapted from "Pork Stew with Apples" by the Government of Nunavut 2011. Web. 3 Dec 2017. http://www.livehealthy.gov.nu.ca/en/food/recipes

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Roasted Chicken

Preparation time:	Cooking time:	Yield:
5 minutes	60 minutes	8 servings

Ingredients:

- 8 chicken drumsticks or thighs
- ¼ cup Italian dressing
- 2 tablespoons water

Steps

1. Preheat the oven to 350°F.
2. In a large bowl, toss together the Italian dressing and the chicken pieces until each piece is well coated.
3. Place the chicken in a baking dish, about 9" x 12" in size.
4. Add 2 tablespoons of water. Cover with aluminum foil and bake for 40 minutes.
5. To brown the skin, uncover and broil on low heat for another 10-20 minutes or until skin is golden brown.

Recipe Source: Created for "Nutrition Planning Support to Three Elder's Facilities in Nunavut," by the Department of Health, Government of Nunavut 2017-2018.

Image Source: 7-Spice Roasted Chicken Thighs. Image. Web. 06 Dec 2017. http://sisijemimah.com/2017/01/12/7-spice-roasted-chicken-thighs/

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Saucy Chicken Pieces or Wings

Preparation time:	Cooking time:	Yield:
10 minutes	40 minutes	8 servings

Ingredients:

- 2 pounds split chicken wings OR 8 drumsticks OR 8 chicken thighs
- 1 sauce recipe - choose cranberry glaze, sweet soy garlic sauce or sweet and sour.

Steps

1. Turn on oven to 350°F.
2. Prepare one of the sauce recipes.
3. Place chicken in 9" x 13" baking dish.
4. Pour sauce over chicken and cover dish with foil.
5. For wings, bake 20 minutes. For chicken pieces, bake 40 minutes.
6. Take dish out from the oven and remove foil.
7. Bake for 20 more minutes.

Recipe Source: Created for "Nutrition Planning Support to Three Elder's Facilities in Nunavut," by the Department of Health, Government of Nunavut 2017-2018.

Image 1 Source: Sweet and Gooey Chicken Wings. Image. Web. 9 Nov 2017. http://allrecipes.com/recipe/17054/sweet-and-gooey-chicken-wings/?internalSource=hub%20recipe&referringContentType=search%20results&clickId=cardslot%203.

Image 2 Source: Baked BBQ Chicken. Image. Web. 5 Dec 2017. http://www.cozycakescottage.com/2014/01/15/baked-bbq-chicken/

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Saucy Ribs

Preparation time:	Cooking time:	Yield:
5 minutes	60 minutes	8 servings

Ingredients:

- 4–5 pounds (1.5 – 2.5 kilograms) pork or caribou ribs, preferably back ribs
- 2 cups water
- Your chosen sauce or glaze (see Sauces sections for recipes)

Steps

1. Trim the fat off the ribs and cut into sections of 2-3 ribs.
2. Place in a pot with the water. Bring up to a boil.
3. Turn heat down to low, cover with the lid and cook for 45 minutes.
4. After 45 minutes, transfer the ribs without the water into a baking pan. Pour the sauce of your choice over the ribs and mix until each piece is coated well.
5. Turn the oven on high broil.
6. Broil each side until gooey but still soft, about 5-minutes.
7. Place the leftover water from the pot in a bowl in the fridge to cool overnight. Remove the hard fat layer from the top. You will be left with flavour rich stock that can be added to soups or stews.

Recipe Source: Adapted from "Sticky Garlic Ribs," with permission by The NorthWest Company.
Picture Source: Honey Garlic Spareribs. Image. Web. 17 Oct 2017. https://www.thespruce.com/honey-garlic-spareribs-3059470

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Seal Meatloaf

Preparation time:	Cooking time:	Yield:
20 minutes	60 minutes	10–20 slices

Ingredients:

- 1 ½ cup breadcrumbs or 5 slices bread (If using bread: toast and crumble bread to make bread crumbs)
- 5 cups or 1.5 kg ground seal meat
- 1/3 cup powdered onion soup mix
- 1 cup All Bran cereal or bran flakes or ½ cups oats
- 3 eggs
- 2 cups canned diced tomatoes
- 6 slices bacon

Steps

1. Preheat oven to 350°F. In a large bowl combine all ingredients, except bacon slices.
2. Divide mixture between 2 bread pans. Spread evenly and press lightly.
3. Completely cover each loaf by placing bacon slices lengthwise (long end to long end).
4. Cover with aluminum foil and bake for 1 hour, or until the meat is well cooked.

Recipe Source: Adapted from Seal Meatloaf. Web. 20 Nov 2017. http://publicationsnunavik.com/book/nunavik-family-cookbook.

Picture Source: Bacon-Wrapped Meatloaf. Image. Web. 20 Nov 2017. https://www.cinnamonspiceandeverythingnice.com/bacon-wrapped-zucchini-meatloaf/

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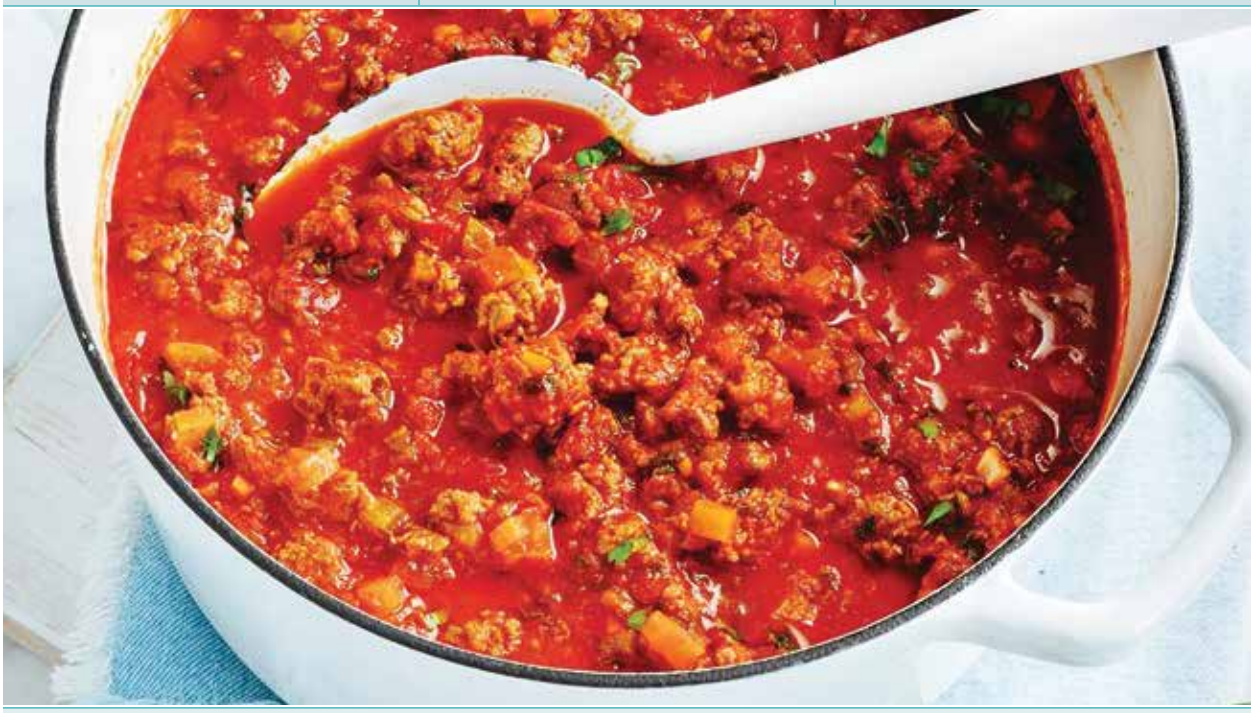
Spaghetti Meat Sauce

Preparation time:	Cooking time:	Yield:
15 minutes	45 minutes	About 8 cups



Ingredients:

- 1 lb. lean ground meat and 1 lb. mild Italian sausages OR 2 lb. lean ground meat
- 2 stalks celery, diced
- 2 carrots, diced
- 1 onion, diced
- 2 cloves garlic, minced or ½ teaspoon garlic powder
- 1 cup milk
- 2 (796 mL each) cans diced tomatoes, low or no salt if available
- 1 teaspoon dried herbs like Italian seasoning, basil, oregano

Steps

1. If using sausages, remove sausages from casings.
2. Cook and stir meat in a large pot over medium heat, until no longer pink, about 10 minutes. Carefully drain the fat.
3. Add celery, carrots, onion and garlic. Cook, stirring occasionally until tender, about 5 minutes.
4. Add milk. Gently boil, uncovered, stirring occasionally 5 minutes.
5. Add tomatoes, mashing with a potato masher to break them up. Add seasonings.
6. Simmer, uncovered, stirring occasionally 30 minutes or until the desired thickness

Recipe and Image Source: Adapted from Hearty Spaghetti Sauce. Image. Web. 7 Nov 2017. https://www.dairygoodness.ca/recipes/hearty-spaghetti-sauce2

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Stir-Fry

Preparation time:	Cooking time:	Yield:
5 minutes	20–25 minutes	8 servings

Ingredients:

- ½ cup water
- 2 tbsp. cornstarch
- 3 tbsp. oil
- 3 tbsp. soya sauce
- 1 kg (2 lbs) caribou, muskox or other lean meat
- 750 g bag of frozen mixed vegetables

Steps

1. Mix the cornstarch.
2. Brown meat strips in oil over medium-high heat with water and soya sauce.
3. Add the vegetables to the pan and cook for -5-10 minutes or until the vegetables are soft.
4. Add the cornstarch mixture to the pan and cook for 3-4 minutes on medium heat with a cover on the pan.
5. Stir often until the sauce in the pan has thickened.
6. To make 8 servings of instant (minute) rice, use 4 cups of dry rice and 4 cups of water

Recipe and Image Source: Adapted from "Stir-Fry," by the Government of Nunavut 2012-2013. Image. Web. 3 Oct 2017. http://www.livehealthy.gov.nu.ca/sites/default/files/EN%20StirFry.pdf

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Sweet and Sour Pineapple Meatballs

Preparation time:	Cooking time:	Yield:
5 minutes	30 minutes	8–12 servings

Ingredients:

- 2 pounds frozen meatballs (any kind) or homemade cooked meatballs (lower in salt)
- 2 cans (398 ml) pineapple chunks, finely chopped (keep juice) or crushed pineapple (keep juice)
- 4 cups water
- 1 small can (156 ml) tomato paste
- 1 onion, finely chopped (or 1 tablespoon onion powder)
- 4 cups frozen peas (or any other frozen chopped vegetable)
- 6 tablespoons white vinegar
- 4 tablespoons soya sauce (use low sodium, if available)
- 4 cups instant rice

Steps

1. Combine frozen or homemade cooked meatballs, pineapple, pineapple juice, water, tomato paste, onion, vinegar and soya sauce in big pot.
2. Cook over medium-high heat, stirring often for 10 minutes or until mixture comes to a boil.
3. Stir in the rice and frozen vegetable. Bring back up to a boil. Remove from the heat.
4. Cover and let stand 10 minutes.

Recipe and Image Source: Adapted from Meatball and Pineapple Rice. Image. Web. 4 Dec 2017. www.minuterice.ca/en/recipes/meatball-and-pineapple-rice

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Tender Roast Pork with Vegetables

Preparation time:	Cooking time:	Yield:
20 minutes	2 hours	8 servings

Ingredients:

- 3 tbsp. oil
- Seasonings: 1 tsp salt, 1 tsp pepper, ½ teaspoon garlic powder, 1 tsp thyme (optional)
- 2 ½ pound pork roast (boneless), for a pork roast with bones, use 3 ½ pound roast
- 4 potatoes, scrubbed and cut into four pieces
- 6 carrots, peeled and cut into chunks
- 2 onions, peeled and cut into four pieces

Steps

1. Turn oven to 325°F.
2. Mix oil, salt, pepper, garlic and thyme. Place roast in baking dish and spoon half of oil mixture over roast.
3. Put vegetables in bowl and mix with rest of oil mixture. Put in pan with roast.
4. Cover with aluminum foil to keep roast moist.
5. During cooking spoon pan juices over roast every 20 minutes.
6. Cook for 2 hours. Juices should run clear when pork is pierced or a thermometer reads 160°F (71°C).
7. Transfer roast to platter. Let it rest for 15 minutes before carving.

Recipe and Image Source: Adapted from "Roast Pork with Roasted Vegetables," by the Government of Nunavut 2011. Web. 17 Oct 2017. http://www.livehealthy.gov.nu.ca/en/food/recipes

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Whole Roasted Chicken or Turkey

Preparation time:	Cooking time:	Yield:
10 minutes	60+ minutes	6–24

Ingredients:

- 1 whole turkey or chicken (See below for the size of bird to buy)
- ¼ cup Italian dressing for each bird

Steps

1. If frozen, first thaw out the chicken or turkey. Put the chicken or turkey in the fridge the 1-3 days before you are going to use it. (See below for more information on thawing).
2. Preheat the oven to 350° F.
3. Remove the neck and giblets from inside the chicken or turkey. Cook the neck and giblets separately or put them in the fridge if you plan to use them later to make soup.
4. Place the chicken or turkey in a pan, breast side up. Rub with the dressing. Cover with foil and place in the oven. Baste the bird with pan drippings every 30 minutes to keep it moist. Roast until done. (See below for more information on cooking time).
5. To brown the skin, uncover for the last 20 minutes.
6. Let cool before cutting. Serve with stuffing, gravy and cranberry sauce, if desired.

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Whole Roasted Chicken or Turkey (continued)

Size of Bird(s) to Buy/Thawing and Cooking Times

Servings	Weight of Bird (not stuffed)	Thawing Time	Cooking Time (Estimates as oven temperatures may be different, always check with a meat thermometer*)
6 Adults	4 pounds (about 2 kilograms)	2 days	About 1 hour, 20 minutes
10 Adults	6.5 pounds (3 kilograms)	2-3 days	About 3 ½ hours if 1 large bird
24 Adults	18 pounds (about 8 kilograms)	3.5 days	About 4 ½ hours if 1 large bird, less if 2–3 smaller birds

More on Thawing

- Place it breast side up in a clean container that will hold any raw juices that may leak.
- Place container on the bottom shelf of the fridge so juices don't drip on other foods.

More on Cooking

- Cook whole birds until the temperature of the thickest part of the breast or thigh is 82°C (180°F)* using a meat thermometer. Make sure the thermometer is not touching any bones.
- Always wash the food thermometer that was used on raw or partially cooked poultry before using them to check again

Recipe Source: Adapted from "Whole Roasted Chicken or Turkey" Qamanituaq Cooks! Good Food...Healthy Families Cookbook, by The Baker Lake Prenatal Project 2005.

Picture Source: Roast Stuffed Chicken. Image. Web. 9 Nov 2017. https://www.canadianturkey.ca/whole-bird-turkey-calculator/.

Information Source: Poultry Safety. Web. 01 Dec 2017. https://www.canada.ca/en/health-canada/services/meat-poultry-fish-seafood-safety/poultry-safety.html#a6

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Appendix 8

RECIPES

SAUCES

Berry Sauce

Preparation time:	Cooking time:	Yield:
10 minutes	15 minutes	About 8 servings, 3 tablespoons each

Ingredients:

- 2 ¼ cups fresh or frozen berries
- ½ cup sugar
- 1 tbsp. lemon or orange juice
- pinch of salt

Steps

1. If using fresh berries, wash before using. Place the berries in a medium saucepan, add sugar, juice and salt. Stir until combined.
2. Bring berry mixture to a boil.
3. If using fresh berries, boil a full minute. If using frozen berries, boil for 3- 5 minutes.
4. Serve the sauce warm or cold on pancakes, French toast, over yogurt and even poured over toast.

Recipe Source: Adapted from Homemade Blueberry Sauce. Web. 1 Nov 2017. http://www.kraftrecipes.com/recipes/homemade-blueberry-sauce-155432.aspx.

Picture Source: Recipe: Easy Blueberry Compote. Image. Web. 6 Nov 2017. https://www.seattletimes.com/life/food-drink/recipe-easy-blueberry-compote/

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Cranberry Glaze – Sweet and Tangy

Great for Wings, Ribs, Meatballs, Chicken or Pork

Preparation time:	Cooking time:	Yield:
5 minutes	10 minutes	About 1 1/3 cups

Ingredients:

- 1 can (348 ml) cranberry sauce or jelly
- ¼ cup ketchup
- 1–2 teaspoons garlic powder

Steps

1. Place the cranberry sauce, ketchup and garlic in a medium size pot. Bring up to a low boil and cook for 10 minutes.
2. Pour onto cooked wings, ribs, meatballs, chicken or pork. Cook for another 10 minutes in the oven or on the stovetop.

Recipe Source: Adapted from "Cranberry Glazed Meatballs," with permission by The NorthWest Company.

Picture Source: Turkey Glazed Meatballs. Image. Web. 30 Nov 2017. https://www.davidlebovitz.com/cranberry-glazed-meatballs-recipe/

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Gravy for Roast Chicken or Turkey

Preparation time:	Cooking time:	Yield:
5 minutes	10 minutes	4 cups of gravy

Ingredients:

- 1 tbsp. flour
- Fat or meat juices from the roast chicken or turkey
- 1 cup warm water

Steps

1. Put the flour in a small bowl or container.
2. Add the fat and meat juices from the roasting pan. If you have lots of fat and meat juices in the pan, use more flour.
3. Mix with a fork until the gravy is very smooth.
4. Put the gravy back into the roasting pan. Cook on a medium heat, slowly adding the warm water. Stir all the time. Add more warm water, if needed.
5. Cook a few minutes until hot.

Recipe Source: Adapted from "Gravy for Roast Chicken or Turkey" Qamanituaq Cooks! Good Food...Healthy Families Cookbook, by The Baker Lake Prenatal Project 2005.

Picture Source: Classic Pan Gravy. Image. Web. 8 Nov 2017. http://www.finecooking.com/recipe/classic-pan-gravy

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Sweet and Sour Sauce

Great for Wings, Ribs, Meatballs, Chicken or Pork

Preparation time:	Cooking time:	Yield:
5 minutes	10 minutes	1½ cups

Ingredients:

- ½ cup ketchup
- ¼ cup vinegar
- ¾ cup water
- ¼ cup brown sugar
- 1 teaspoon mustard

Steps

1. Place all ingredients in a medium sauce pan. Mix well.
2. Turn the burner to medium and simmer a few minutes until well combined.
3. Let sit a few minutes. Use with ribs, chicken or meatballs.

Recipe Source: Adapted from "Homemade Sweet and Sour Sauce" Qamanituaq Cooks! Good Food...Healthy Families Cookbook, by The Baker Lake Prenatal Project 2005.

Picture Source: BBQ Ribs in the Oven. Image. Web. 4 Dec 2017. http://www.kraftrecipes.com/recipes/bbq-ribs-in-the-oven-162207.aspx

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Sweet Soy Garlic Sauce

Great for Wings, Ribs, Meatballs, Chicken or Pork

Preparation time: 5 minutes	**Yield:** About 1 cup

Ingredients:

- 1 ½ teaspoons garlic powder
- 2/3 cup brown sugar
- ¼ cup soya sauce, low sodium if available
- ¼ cup vinegar
- ¼ cup water

Steps

1. In a small bowl, mix together all the ingredients.
2. Pour onto cooked wings, ribs, meatballs, chicken or pork. Cook for another 10 minutes in the oven or on the stovetop.

Recipe Source: Adapted from "Sticky Garlic Ribs," with permission by The NorthWest Company.

Picture Source: Sweet soy, honey and ginger stir-fry sauce. Image. Web. 30 Nov 2017. http://www.taste.com.au/recipes/sweet-soy-honey-ginger-stir-fry-sauce/0d50378e-e2a8-41b8-83f5-f71e06616f81

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Thick White Sauce

to Replace Canned Cream Soup or as a Sauce for Homemade Macaroni & Cheese

Cooking time: 5 minutes	**Yield:** 300 ml, the same as 1 can condensed cream soup

Ingredients:

- 3 tablespoons non-hydrogenated margarine
- ¼ cup flour
- 1 ¼ cups milk (evaporated milk will make a creamier sauce)
- ¼ teaspoon garlic powder
- ¼ tsp salt
- 1/8 tsp pepper

Steps

1. In a small pot, melt margarine over low heat. Stir in flour.
2. Cook over medium heat, stirring constantly, until mixture is smooth and bubbly.
3. Gradually stir in milk. Heat to boiling, stirring constantly.
4. Add garlic powder.
5. Boil and stir 1 minute until sauce is thick and shiny. If using the sauce for macaroni and cheese, add more milk for a thinner sauce.
6. Canned cream soups like cream of mushroom are very high in salt. This thick white sauce can replace those in any recipe. This recipe can easily be doubled.

Recipe Source: Created for "Nutrition Planning Support to Three Elder's Facilities in Nunavut," by the Department of Health, Government of Nunavut 2017-2018. Picture Source: Classic Smooth and Silky Béchamel (White Sauce) Recipe. Image. Web. 6 Dec 2017. http://www.seriouseats.com/recipes/2016/09/bechamel-white-sauce-recipe.html

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Appendix 8

RECIPES

SIDES, SANDWICHES and SALADS

Broccoli Salad

Preparation time:	Cooking time:	Yield:
20 minutes	5 minutes	9 (½ cup) servings

Ingredients:

Salad

- 4 ½ cups broccoli, chopped small (about 1 head)
- ½ cup dried cranberries or raisins
- ¼ cup grated onion
- ¼ cup sunflower seeds
- ¼ cup cheese, grated (optional)

Dressing

- 2 tbsp. vinegar
- 2 tbsp. water
- 1 ½ tbsp. white sugar
- 1 teaspoon mustard
- ½ cup mayonnaise or whipped salad spread

Steps

1. In a large pot of boiling water, boil broccoli for 5 minutes. Drain and rinse under cold water, drain again.
2. Transfer broccoli to a large bowl. Add the rest of the salad ingredients.
3. In a small bowl, whisk together the dressing ingredients.
4. Toss salad with dressing. Keep in fridge until ready to serve.

Recipe Source: Adapted from "Broccoli Salad with Cranberries" Atlantic Superstore 2005.

Picture Source: Broccoli & Cranberry Salad – Low Fat Version. Image. Web. 3 Dec 2017. https://allmyeggs.com/2009/12/30/broccoli-cranberry-salad-low-fat-version/

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Carrot Slaw

Preparation time:	Cooking time:	Yield:
10 minutes	0 minutes	8 (½ cup) servings

Ingredients:

Salad

- 4 medium-size carrots, grated
- ¼ medium-size onion, grated
- ½ cup dried cranberries
- ¼ cup sunflowers seeds or chopped nuts

Dressing

- 1 teaspoon honey or sugar
- ¼ teaspoon salt
- 3 tablespoons mayonnaise or whipped dessert topping (low fat if available)
- 4 tablespoons white vinegar

*Add a tablespoon of water if the dressing is too thick

Steps

1. In a medium bowl, add grated onion and carrot.
2. Top with cranberries and sunflower seeds.
3. In a small bowl, whisk the dressing ingredients together using a fork until smooth.
4. Top salad with dressing and toss. Make at least 2 hours before serving to soften the slaw. Store in the fridge.

Recipe Source: Adapted from "Crunchy Carrot Slaw," with permission by The NorthWest Company.

Picture Source: Serious Salads: Carrot Slaw with Cranberries and Toasted Walnuts Recipe. Image. Web. 3 Dec 2017. http://www.seriouseats.com/recipes/2011/11/carrot-slaw-with-cranberries-and-toasted-walnut-recipe.html

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Chicken, Turkey, Tuna or Salmon Salad Sandwich Filling

Preparation time:	Cooking time:	Yield:
5 minutes	0 minutes	8 servings

Ingredients:

- 4 cans (156 g) flaked chicken, turkey, tuna or salmon
- 3 small celery stalks or 2 carrots or 2 apples (for chicken or turkey salad), grated
- ½ cup mayonnaise or whipped salad dressing, low fat if available
- ½ teaspoon mustard
- Pepper to taste

Steps

1. Open the cans. Drain any liquid.
2. Put the canned meat in a bowl. Mash well with a fork until all the pieces are broken up.
3. Mix in the rest of the ingredients and it's ready for your sandwich.

Recipe Source: Adapted from "Chicken or Turkey Salad Sandwich," with permission by The NorthWest Company.

Picture Source: Chicken and Celery Salad Sandwich. Image. Web. 9 Nov 2017. http://www.enjoyyourcooking.com/salads/chicken-celery-salad-sandwich.html.

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Creamy Mashed Carrots

Preparation time:	Cooking time:	Yield:
10 minutes	30–35 minutes	5–6 cups or 10–12 ½ cup servings

Ingredients:

- 4 medium to large carrots, peeled and cubed
- 2 large white potatoes, peeled and cubed
- 2 tablespoons non-hydrogenated margarine
- ¼ cup milk
- ½ cup shredded cheese, any type

Steps

1. Place about 3 inches of water in the bottom of a large pot.
2. Add in the vegetables.
3. Bring up to a boil, and cover.
4. Cook for about 30 minutes or until the carrot is tender.
5. Remove from heat and carefully drain the hot water.
6. Add the milk and margarine to the pot. Using a potato masher, mash until smooth.
7. Stir in the shredded cheese. Serve.

Recipe Source: Created for "Nutrition Planning Support to Three Elder's Facilities in Nunavut," by the Department of Health, Government of Nunavut 2017-2018.

Picture Source: Creamy Mashed Carrots. Image. Web. 9 Nov 2017. http://www.kraftcanada.com/recipes/creamy-mashed-carrots-137337

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Creamy Pasta Salad

Preparation time:	Cooking time:	Yield:
20 minutes	10 minutes	8 servings

Ingredients:

Creamy Dressing

- 1 ½ cups milk
- ¾ cup mayonnaise
- 1 tbsp. mustard
- ¼ teaspoon garlic powder
- ½ tsp salt, ½ tsp pepper
- 1 tablespoon dried herbs like parsley, oregano, basil
- ¼ cup vinegar

Pasta Salad

- 12 oz. (375 g) box or bag of pasta, like macaroni
- 2 cups canned green beans, rinsed and drained
- 2 cups carrots, shredded
- 1 green or red bell pepper, shredded or thinly sliced

Steps

1. For the dressing, stir together all the ingredients. Let stand for 10 minutes or until thickened.
2. In large pot of boiling water, cook pasta for 8 to 10 minutes or until tender.
3. Drain. Rinse under cold running water until cool. Drain well.
4. In a large bowl, combine pasta, green beans, carrots and green or red pepper and the dressing.

Recipe and Picture Source: Adapted from Pasta Salad with Creamy Herb Dressing. Image. Web. 20 Nov 2017 https://www.dairygoodness.ca/recipes/pasta-salad-with-creamy-herb-dressing.

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Creamy Veggie Rice

Preparation time:	Cooking time:	Yield:
10 minutes	20 minutes	8 (1 cup) servings

Ingredients:

- 1 tbsp. vegetable oil
- 3 cups fresh sliced mushrooms OR 2 cans (284 mL) sliced mushrooms (rinsed and drained) OR 2 cups frozen vegetables
- 1 ½ cups (about 1 medium) onion, chopped
- ½ teaspoon garlic powder
- 2 ½ cups minute rice
- 2 ½ cups water
- 2 teaspoons vegetable or chicken bouillon powder
- 1 teaspoon dried parsley or any dried herb like thyme
- 3 cups milk, any type (evaporated will make it creamier)
- 1 cup shredded cheddar cheese, any type

Steps

1. Warm oil in medium size pot. Stir in mushrooms or vegetables and onion. Cook for about 5 minutes.
2. Stir in rice, water, bouillon powder and seasoning. Bring up to a boil, reduce to low and cover.
3. Stir every few minutes, slowly adding the milk.
4. Once the rice is soft (about 10 minutes), turn off the heat and stir in the cheese.

Make this a one-dish meal! At step 4, add cooked meatballs, meat or canned seafood

Recipe Source: Adapted from "Mushroom and Cheese Risotto" Cook Cookbook! by Dietitians of Canada 2011.
Picture Source: Mushroom Risotto. Image. Web. 20 Nov 2017. http://www.simplyrecipes.com/recipes/mushroom_risotto/

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Devilled Eggs

Preparation time:	Cooking time:	Yield:
15 minutes	15 minutes	12 servings

Ingredients:

- 12 hard-cooked eggs, peeled
- ¼ cup mayonnaise or whipped salad dressing, low fat if available
- 1 tsp mustard
- ¼ tsp salt
- ¼ tsp pepper
- Pinch paprika (optional)

Steps

1. Cut eggs in half lengthwise.
2. Remove yolks and place in medium bowl; set egg whites aside.
3. Mash yolks with fork; stir in mayonnaise, mustard, salt and pepper.
4. Spoon or pipe yolk mixture into egg white halves.
5. Sprinkle paprika over top, if desired.
6. Serve immediately or cover and store in refrigerator. Serve within 2 days.

Recipe Source: Adapted from Basic Devilled Eggs. Web. 7 Nov 2017. https://www.eggs.ca/recipes/basic-devilled-eggs.

Picture Source: Deliciously Tempting Devilled Eggs Appetizer Recipe. Image. Web. 6 Nov 2017. https://avocadopesto.com/deviled-eggs-recipe/

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Glazed Carrots

Preparation time:	Cooking time:	Yield:
5 minutes	25 minutes	8 servings

Ingredients:

- 2 pounds carrots (baby carrots or regular carrots, peeled, washed and cut into chunks)
- ¼ teaspoon salt
- 3 tablespoons margarine
- 3 tablespoons brown sugar

Steps

1. Place carrots in pot and add water to cover. Put lid on pot and bring water to a boil, then lower heat and cook about 20 minutes, or until soft.
2. Drain carrots.
3. Add salt, margarine and brown sugar to pot and cook over low heat until the carrots are covered with the mixture.

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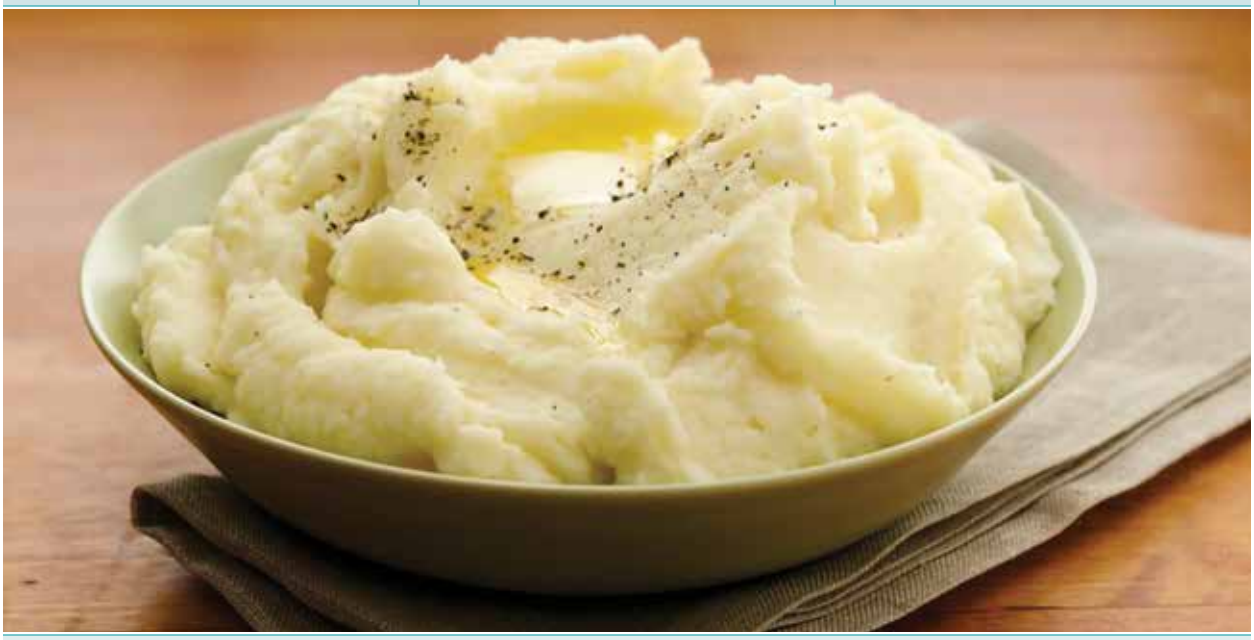
Mashed Potatoes Using Potatoes

Preparation time:	Cooking time:	Yield:
10 minutes	20–30 minutes	8–16 servings



Number of Potatoes Needed

Weight	Number of Potatoes	Cups of mashed potatoes	Number of ½ cup Servings	Milk to add	Non-Hydrogenated Margarine to add
2 pounds	6 medium	4	8	½ cup	2 tablespoons
3 pounds	9 medium	6	12	¾ cup	3 tablespoons
4 pounds	12 medium	8	16	1 cup	4 tablespoons (same as ¼ cup)

Steps

1. Wash, peel and cut potatoes into four.
2. Place in a pot. Add enough water to cover the potatoes.
3. Heat to boiling then lower heat. Cover and cook on low boil for 20 to 30 minutes or until potatoes are soft.
4. Drain well. In the same pot, add the margarine. Add the milk slowly and mash the potatoes until smooth. If dry, add more milk. Season to taste.

Information Source: The Old Farmers Almanac. Web. 6 Dec 2017.
https://www.almanac.com/content/measuring-vegetables-recipes-pounds-cups.

Recipe Source: Adapted from Betty's Best Mashed Potatoes. Web. 6 Dec 2017.
https://www.bettycrocker.com/recipes/bettys-best-mashed-potatoes/f8374114-214d-4f09-bfa1-96bcc43fbdd0

Picture Source: Velvet Mashed Potatoes. Image. Web. 06 Dec 2017.
https://www.bettycrocker.com/recipes/velvet-mashed-potatoes/351e286a-e61e-4b38-8cfd-82d4f3f63ec2

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Mashed Potatoes Using Instant Potato Flakes

Preparation time:	Cooking time:	Yield:
–	5–10 minutes	8–16 servings

"Plain" or "Unseasoned" are better choices.

They are lower in salt than flavoured potatoes like "Buttery" or "Butter and Herb".

Number of Packages or Pouches Needed

Number of packages/ pouches	Number of ½ cup Servings
2	8
3	12
4	16

Ingredients

Number of Servings	Water	Milk	Non-Hydrogenated Margarine
8	2 cups	2 cups	2 tablespoons
12	3 cups	3 cups	¼ cup
16	4 cups	4 cups	¼ cup + 2 tablespoons

Steps

1. Heat water, milk and margarine in a pot just until boiling.
2. Turn off heat. Stir in potatoes.
3. Let sit 2 minutes then whip quickly until smooth and fluffy.

Recipe Source: Adapted from "Betty Crocker's Instant Mashed Potatoes" Directions from the box. 6 Dec 2017.

Picture Source: Kroger Instant Mashed Potatoes Reviews. Image. Web. 6 Dec 2017. http://www.viewpoints.com/Kroger-Instant-Mashed-Potatoes-reviews.

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Power Pasta Salad

Preparation time:	Cooking time:	Yield:
10 minutes	15 minutes	9 (½ cup) servings

Ingredients:

- 1 box (375 g) or 4 cups pasta, any type
- 1 large can (540 ml) or 2 cups canned kidney beans, rinsed then drained (optional)
- 1 small can (170 g) flaked tuna/chicken or turkey, drained (optional)
- 1 cup skim milk mozzarella cheese, shredded
- ½ cup onion, grated
- 1 medium tomato, diced very small
- 1 green pepper or 2 celery stalks or 2 carrots, shredded
- 1 teaspoon Italian seasoning, or dried basil or dried oregano
- 3 tablespoons oil
- 4 tablespoons vinegar

Steps

1. Boil 16 cups of water then add pasta. Boil for 10-12 minutes stirring every few minutes.
2. While the pasta is boiling, combine all the other ingredients in a large bowl.
3. When the pasta is cooked, drain, rinse and let cool for 10 minutes.
4. Add cooked pasta to the mixture and stir well.

Recipe Source: Adapted from "Power Pasta Salad," with permission by The NorthWest Company.
Picture Source: Healthy Pasta Salad!. Image. Web. 9 Nov 2017. https://www.pinterest.ca/pin/540502392748880164/.

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Scalloped Potatoes

Preparation time:	Cooking time:	Yield:
20 minutes	65–70 minutes	8 servings

Ingredients:

- 2 tbsp. margarine
- 1 cup finely chopped onion
- ½ tsp garlic powder
- 3 cups milk
- ½ tsp salt
- ½ tsp dried herbs like basil or oregano
- ¼ tsp pepper
- ¼ cup bread crumbs
- ¾ cup shredded cheese
- 6 medium potatoes, peeled and thinly sliced

Steps

1. Turn on oven to 350°F (180°C). Lightly grease one large or 2 small casserole dishes.
2. Melt margarine in a frypan. Add onion and garlic powder. Cook until onion is soft, about 3 to 5 minutes. Set aside.
3. Meanwhile, heat milk, salt, dried herbs and pepper in a large saucepan. Set aside.
4. Combine bread crumbs and cheese in a small bowl. Set aside.
5. Arrange one third of the potatoes on the bottom of the dish(s). Put half of the onion mixture on top of the potatoes. Sprinkle with half of the bread crumb mixture.
6. Repeat two more times except for the very last layer of breadcrumb mixture.
7. Pour hot milk mixture into casserole. Now sprinkle the last of the breadcrumb mixture.
8. Cover with aluminum foil and bake until potatoes are tender, about 45 minutes. Remove foil and cook until the top is golden. Let stand 10 minutes before serving.

Recipe Source: Adapted from "Scalloped Potatoes with Cheese and Herbs" The Basic Shelf Cookbook 2011 Edition, by The Canadian Public Health Agency.

Picture Source: Homemade Scalloped Potatoes with Goat Cheese and Garlic. Image. Web. 30 Nov 2017. https://www.wellplated.com/homemade-scalloped-potatoes-recipe/.

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Stuffing for Roasted Chicken or Turkey

Preparation time:	Cooking time:	Yield:
5 minutes	10–15 minutes	12 (½) servings

Ingredients:

- 4 cups frozen vegetables like peas and carrots
- 2 apples, chopped
- 2 tablespoons non-hydrogenated margarine
- 1 ½ cups water
- 2 packages (120 grams or about 3 ½ cups) stuffing mix

Steps

1. Place frozen vegetables, margarine and water in a pot.
2. Bring up to a boil and cook for 5 minutes.
3. Add the stuffing mix.
4. Lower heat and cook for 5-10 minutes stirring often until stuffing is hot.
5. Add more water if dry.

Recipe and Image Source: Adapted from Stuffing with Vegetables. Image. Web. 18 Nov 2017. https://spendsmart.extension.iastate.edu/recipe/stuffing-with-vegetables/

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Sweet Mashed Turnip

Preparation time:	Cooking time:	Yield:
10 minutes	30–35 minutes	7 cups or 14 (½ cup) servings

Ingredients:

- 1 large turnip (about 6 cups), peeled and cubed
- 2 medium sweet potatoes (about 4 cups), peeled and cubed or 4 medium carrots, peeled and cubed
- 2 tablespoons non-hydrogenated margarine
- ¼ cup milk
- Salt and pepper to taste

Steps

1. Place about 3 inches of water in the bottom of a large pot.
2. Add in the turnip and sweet potatoes.
3. Bring up to a boil, and cover.
4. Cook for about 30 minutes or until the turnip is tender.
5. Remove from heat and carefully drain the hot water.
6. Add the milk and margarine to the pot. Using a potato masher, mash until smooth.
7. Season with salt and pepper to taste.

Recipe Source: Adapted from "Sweet Mashed Turnips," with permission by The NorthWest Company.

Picture Source: Yukon Gold and Sweet Potato Mash Recipe. Image. Web. 9 Nov 2017. https://www.pinterest.ca/pin/268456827767372689/

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Tropical Coleslaw

Preparation time:	Cooking time:	Yield:
15 minutes	–	8–10 servings

Ingredients:

- 454 g bag coleslaw mix
- 2 shredded carrots
- 1 cup canned crushed pineapple, drained or canned diced pineapple, drained and chopped finely
- Dressing Ingredients
- ¾ cup sour cream, low fat if available
- ½ cup mayonnaise, low fat if available
- 1 tablespoon sugar
- 2 tablespoons vinegar
- 1 tablespoon water

Steps

1. Put the coleslaw, carrots and pineapple in a large bowl.
2. In a small bowl, mix together all the dressing ingredients.
3. Pour the dressing over the coleslaw and stir well. Cover and refrigerate until ready to serve. Any foods made with sour cream should not be left out of the fridge for more than 2 hours. In hotter months, this should be shortened to 30 minutes.

Recipe Source: Adapted from "Tropical Coleslaw," with permission by The NorthWest Company.
Picture Source: Pineapple Yogurt Cole Slaw. Image. Web. 8 Nov 2017. https://www.savoryexperiments.com/greek-pineapple-cole-slaw/

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Beef Barley Soup

Preparation time:	Cooking time:	Yield:
15 minutes	50–60 minutes	12 (1 cup) servings

Ingredients:

- 1 pound lean ground meat
- 2 tablespoons oil
- 2 onions, chopped
- 5 stalks of celery, chopped
- 6 cups water
- 1 teaspoon instant chicken bouillon powder
- ½ cup barley
- 2 cans sliced (284 mL) mushrooms, rinsed and drained
- 1 large can (28oz/796mL) diced tomatoes
- ¼ teaspoon pepper, or to taste

Steps

1. Put meat in pot over medium heat and cook until brown.
2. Add oil, chopped onions and celery and stir. Cook until vegetables have softened, about 5-10 minutes.
3. Add the rest of the ingredients. Bring to a boil.
4. Reduce heat so that the soup is just bubbling very slowly. Cover and cook for 30-40 minutes, until barley is tender. Stir once in a while.
5. Add pepper to taste.

Recipe and Image Source: Adapted from "Beef and Barley Soup," by the Government of Nunavut 2011. Web. 3 Dec 2017. http://www.livehealthy.gov.nu.ca/en/food/recipes.

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Corn Chowder

Preparation time:	Cooking time:	Yield:
10 minutes	60–65 minutes	12 servings

Ingredients:

- 1 tbsp. non-hydrogenated margarine
- 1 onion, chopped
- 1 ½ cups potatoes, diced into small cubes
- 2 cups water
- 2 teaspoons instant chicken bouillon powder
- 1 ½ cups milk
- 1 can (19 oz/540 mL) cream style corn
- Salt and pepper to taste

Steps

1. Turn on stove to medium heat. Melt margarine in a large pot. Add chopped onion and cook until soft, about 5 to 7 minutes.
2. Add diced potatoes, water and chicken soup bouillon. Heat to boiling. Turn down the heat, cover and simmer until potatoes are almost tender, about 20 minutes.
3. Add milk and corn. Cook and stir mixture constantly over medium-low for 4 to 5 minutes.
4. Add salt and pepper to taste. Add water if soup is too thick.

Recipe Source: Adapted from "Corn Chowder" The Basic Shelf Cookbook 2011 Edition, by Canadian Public Health Association.
Picture Source: Roasted Corn Chowder. Image. Web. 13 Nov 2017. https://food52.com/recipes/16414-roasted-corn-chowder

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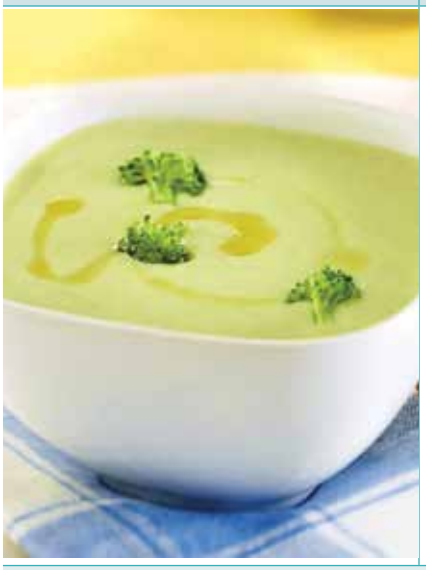
Cream of Broccoli Soup

Preparation time:	Cooking time:	Yield:
10 minutes	30 minutes	8 servings



Ingredients:

- 2 tbsp. oil
- 1 onion, chopped
- ¼ tsp garlic powder
- 3 cups potatoes, peeled and cubed
- 4 cups water
- 3 tsp chicken bouillon powder
- ¼ tsp garlic powder
- ¼ tsp pepper
- 1 bag (500 grams) frozen broccoli
- 2 cans evaporated milk

Steps

1. In a large pot, warm oil over medium heat. Add onion and cook until soft.
2. Add the rest of the ingredients, except the evaporated milk.
3. Turn heat up, cover and bring to a boil. Once boiling, reduce heat to medium. Keep covered stirring occasionally, until vegetables are tender, about 20 minutes.
4. Add the evaporated milk and heat through.
5. Use a hand blender to purée the soup until smooth right in the pot. Or use potato masher to make it smoother.

Recipe and Image Source: Adapted from Cream of Broccoli Soup. Image. Web. 10 Dec 2017. http://www.arcticgardens.ca/en/recipes/cream-broccoli-soup/Arctic Gardens

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Cream of Carrot Soup

Preparation time:	Cooking time:	Yield:
10 minutes	30 minutes	8 cups

Ingredients:

- 1 tbsp. vegetable oil
- 1 large onion, chopped
- 1 large garlic clove, chopped or 1/4 tsp garlic powder
- 6 carrots, washed, peeled and chopped
- 3 apples, washed, peeled and chopped
- 4 cups water
- 2 tsp white or brown sugar
- 2 teaspoons instant chicken bouillon powder
- 1 can (354 mL) evaporated milk

Steps

1. In a large pot, warm oil over medium heat. Add onion and garlic. Cook until onion has softened. Add the rest of the ingredients except the evaporated milk.
2. Cover and bring to a boil. Once boiling, reduce heat to a low boil. Stir occasionally, until carrots are tender, about 30 minutes.
3. Turn off the heart. Add the evaporated milk.
4. Use a hand blender to purée the soup until smooth right in the pot or transfer in small batches to purée in a standard blender. Be careful, the steam can be very hot.

Recipe Source: Adapted from "Cream of Carrot Soup," with permission by The NorthWest Company.

Picture Source: Squash and Carrot Soup. Image. Web. 6 Nov 2017. https://www.saltandlavender.com/acorn-squash-and-carrot-soup/

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Creamy Potato Chowder

Preparation time:	Cooking time:	Yield:
10 minutes	30 minutes	10 servings

Ingredients:

- 1 tablespoon oil
- 1 onion, chopped
- 2 carrots, peeled and chopped small
- 2 celery stalks, washed and chopped small
- 2 pounds potatoes, peeled and cut into 1 inch pieces
- 5 cups water
- 4 teaspoons instant chicken bouillon powder
- ½ teaspoon garlic powder
- 2 cans (371 mL) evaporated milk

Steps

1. Heat oil in large saucepan over medium heat. Add chopped onion, carrots and celery; cook, stirring occasionally, for 5 minutes or until soft.
2. Add potatoes, water, bouillon and garlic powder; put pot on lid and bring to a boil.
3. Simmer over medium heat, for 15 minutes or until tender.
4. Add milk and cook for 5 more minutes
5. If desired, mash mixture with fork or potato masher.

Recipe and Image Source: Adapted from Creamy Potato Chowder. Web. 11 Dec 2017. http://www.carnationmilk.ca/recipe-details.aspx?rid=

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Fish or Clam Chowder

Preparation time:	Cooking time:	Yield:
20 minutes	40 minutes	12 cup servings

Ingredients:

- 2 tablespoons oil
- 1 onion, chopped
- 4 carrots, peeled and chopped
- 2 celery stalks, chopped
- 1 Bay leaf (optional)
- 2 tablespoons flour
- 4 cups water
- 3 potatoes, scrubbed and cubed
- 1 can cream of mushroom soup
- 1 can evaporated milk (354ml)
- 1 small to medium Arctic char, filleted (or around 3 pounds of other fish or 3 cans (142 grams each)clams, drained
- 1 can cream corn (342mL)
- 1 tsp pepper

Steps

1. Heat oil on medium high. Add onion, carrots and celery to pot. Cook, stirring often, until the onion is soft, but not brown.
2. Add flour and stir and cook for about 3 minutes.
3. Add water, cream of mushroom soup, potatoes and bay leaf.
4. Bring to a boil, then turn down to low and simmer for about 15 minutes, until the potatoes are starting to get soft.
5. While the chowder is cooking on low heat, if using whole fish, fillet fish and remove skin. Cut into bite sized pieces.
6. Add evaporated milk, fish or clams, corn and pepper to pot, and then simmer for about 10 more minutes.

Recipe and Image Source: Adapted from "Fish or Clam Chowder," by the Government of Nunavut 2011. Web. 3 Dec 2017. http://www.livehealthy.gov.nu.ca/en/food/recipes

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Hamburger Soup

Preparation time:	Cooking time:	Yield:
15 minutes	30–40 minutes	Twelve 1-cup servings

Ingredients:

- 1-pound ground beef, or any ground meat like caribou or seal
- 1 can (796 mL) diced tomatoes, no salt added if available
- 1 can (284 mL) tomato soup
- 1 medium onion, chopped
- 2 medium carrots, finely chopped
- 2 stalks celery or 1 green pepper, finely chopped
- 1 can (284 mL) sliced mushrooms, drained and rinsed
- 4 cups water
- ¼ cup barley or ½ cup noodles, any type like macaroni
- 1 teaspoon dried herbs (oregano, basil, or parsley)

Steps

1. Brown meat in a large pot. Drain off fat.
2. Add all ingredients to pot and bring to a boil. Reduce heat. Cover and simmer for 30 minutes or until the vegetables and noodles or barley are tender. Stir occasionally while cooking. Season with more spices if desired. Add extra water if soup becomes too thick.

Recipe Source: Adapted from "Healthy Hamburger Soup" Meal Bag Manual 2010 Feeding Stomachs and Souls, by FNIHB, Health Canada, Manitoba Region.

Picture Source: Quick and Easy Hamburger Soup. Image. Web. 23 Nov 2017. http://www.simplyrecipes.com/recipes/quick_easy_hamburger_soup/

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Hearty Mushroom Soup

Preparation time:	Cooking time:	Yield:
5 minutes	5–10 minutes	8 ¾ cup servings

Ingredients:

- 2 cans (284 ml) cream of mushroom soup
- 2 cans sliced mushrooms (284 mL), rinsed and drained
- 2 cans (284 ml) water and 1 can (284 mL) milk

Steps

1. Empty soup cans and mushrooms into a pot.
2. Add the water and milk.
3. Heat stirring often until the soup reaches a low boil, about 5-10 minutes.
4. Add some water if soup is too thick.

Recipe Source: Created for "Nutrition Planning Support to Three Elder's Facilities in Nunavut," by the Department of Health, Government of Nunavut 2017-2018.

Picture Source: Mushroom Soup. Image. Web. 3 Dec 2017. https://leeandmarias.com/recipes/mushroom-soup/.

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Split Pea Soup

Preparation time:	Cooking time:	Yield:
10 minutes	60–70 minutes	12 servings

Ingredients:

- 1 ½ tbsp. vegetable oil
- 1 cup chopped onion
- 1 ½ cup diced carrot
- 1 ½ cup diced peeled potato
- 2 cups green split peas 250 mL (yellow split peas will work too)
- 8 cups water
- 3 teaspoons instant chicken bouillon powder, low sodium if available
- 1 cup diced cooked ham
- 1 bay leaf
- ¼ tsp ground black pepper

Steps

1. In a pot, heat oil over medium-high heat and add onion, carrot and potato. Fry until vegetables are soft.
2. Add split peas, water, bouillon, ham and bay leaf.
3. Bring to boil; reduce heat; cover and allow to simmer for about 45-60 minutes or until peas are tender and soup has thickened. Stir occasionally.
4. Remove bay leaf. Add pepper just before serving.

Recipe and Image Source: Adapted from Classic Split Pea Soup. Image. Web. 20 Nov 2017. https://www.canolainfo.org/recipes/classic-split-pea-soup

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Appendix 9

Substitutions for Recipe Ingredients

Ingredient	Amount	Substitution
Baking powder	1 teaspoon	¼ teaspoon baking soda, plus ½ teaspoon cream of tartar
Baking soda	1 teaspoon	2 teaspoons double-acting baking powder (must replace acidic liquid such as sour milk or buttermilk with non-acidic liquid, such as water or milk), minus the salt in the recipe
Bread crumbs	1 cup	1 cup cracker crumbs **OR** 1 cup ground oats **OR** 1 cup crushed corn flakes or other plain cereal
Brown sugar	1 cup, packed	1 cup white sugar
Buttermilk or sour milk	1 cup	1 cup yogurt **OR** 1 cup milk and 1 tablespoon vinegar. Let stand 5 minutes, til curdled.
Chocolate (unsweetened)	1 ounce	3 tablespoons unsweetened cocoa, plus 1 tablespoon shortening or vegetable oil
Cocoa	¼ cup	1 (1-ounce) square unsweetened chocolate
Corn syrup	1 cup	1 ¼ cup white sugar, plus 1/3 cup water, **OR** 1 cup honey
Cream (15% or 35%)	1 cup	1 cup evaporated milk
Cream of tartar	1 teaspoon	2 teaspoons lemon juice or vinegar
Egg	1 whole	half a banana mashed with ½ teaspoon baking powder **OR** 2 ½ tablespoons of powdered egg substitute, plus 2 ½ tablespoons water, **OR** ¼ cup liquid egg substitute

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Ingredient	Amount	Substitution
Fats for baking	1 cup	1 cup applesauce **OR** 1 cup fruit puree
Garlic	1 clove	1/8 teaspoon garlic powder **OR** ½ teaspoon garlic salt. Reduce salt in recipe by ½ teaspoon
Herbs – fresh	1 tablespoon chopped fresh	1 teaspoon (chopped or whole leaf) dried herbs
Honey	1 cup	1 ¼ cup white sugar, plus 1/3 cup water **OR** 1 cup corn syrup
Ketchup	1 cup	1 cup tomato sauce, plus 1 teaspoon vinegar and 1 tablespoon sugar
Lemon juice	1 teaspoon	½ teaspoon vinegar
Milk, fresh	1 cup	1/3 cup dry milk powder plus 1 cup water ½ cup evaporated milk, plus ½ cup water 1 cup UHT milk
Mustard, prepared	1 tablespoon	Mix together 1 tablespoon dried mustard, 1 teaspoon water, 1 teaspoon vinegar and 1 teaspoon sugar
Onion, fresh	1 medium onion	1 tablespoon onion powder or 3 tablespoons dried onion flakes
Sour cream	1 cup	1 cup plain yogurt **OR** 1 tablespoon lemon juice or vinegar, plus enough cream to make 1 cup, **OR** ¾ cup buttermilk, mixed with 1/3 cup butter

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Appendix 10

Dietitian Support

Regional Clinical Dietitians

There are registered dietitian (RD) positions that provide clinical nutrition service in all Department of Health regions. Here are guidelines to refer patients to a clinical dietitian in your region.

When to refer to a Dietitian:

a. Unintended weight loss: >5% body weight in 1 month, >7.5% body weight in 3 months, and >10% body weight in 6 months (Appendix 13: Calculating percent body weight)

b. Subjective Global Assessment Score of B, C or presence of cachexia and/or sarcopenia (see Appendix 12 for SGA form)

c. Pressure wounds (All Stages of Braden Scale)

d. Dysphagia (refer to Speech Language Pathologist, and Dietitian), chewing difficulties due to poor dentition or all other etiology

e. Poor food intake >72 hours (complete 72 hour food/fluid intake form, Appendix 11)

f. Poor fluid intake > 72 hours (complete 72 hour food/fluid intake form, Appendix 11)

g. Dysgeusia

h. Condition requiring a therapeutic diet: diabetes, cardiovascular disease, COPD, neurodegenerative diseases, tuberculosis (active and latent)

i. Food Insecurity

j. Difficulty feeding (refer to Occupational Therapist and Dietitian)

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Appendix 11

72 Hour Food Intake Record

Purpose: to track the food and fluid intake of a client. Food intake records are a useful when evaluating any changes in appetite, determining if a client is at risk for dehydration or malnutrition.

- Keep a record of all foods and fluids at meals the client eats within the 72 hour period
- Include any oral nutritional supplements
- Include snacks, and fluids consumed throughout the day
- Include the portion size for foods and the amount of fluids in millilitres, or ounces
- Include sauces such as gravy, ketchup, jam, margarine and butter

Tips:

Food: use measuring cups if possible, or your hands to estimate portion sizes. A portion of starch such as rice, mashed potatoes, pasta the size of an adult's fist is approximately ½ cup. A piece of meat the size of an adults palm is approximately 3–4 oz.

Fluids: Measure fluids in millilitres or ounces.

1 cup = 250 mL = 8 oz

Count the number of food items is applicable: i.e. 12 baby carrots, 2 Oreo cookies, 4 Pilot biscuits, 6 medium-sized shrimp

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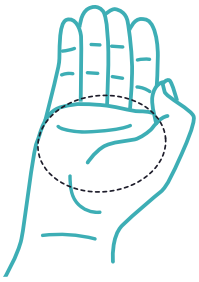
Food	About how much to offer
Fruit juice	½ cup
Rice and pasta	1 cup
Bannock	About the size of half a slice of bread
Meat and Fish	About the size of the palm of your hand 

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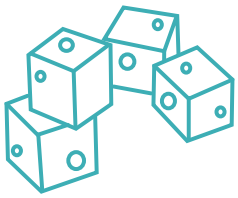
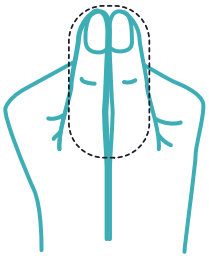
Food	About how much to offer	
Vegetables and Fruit	½ cup	
Yogurt	½ cup	
Cheese		

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Sample:
72 Hour Food Intake Record

Time	Amount	Description	Notes
		Juice-orange	Client appeared less hungry than usual at breakfast
	1 slice	White bread, strawberry jam added (1 tbsp)	
	1 egg	Boiled egg	Client only ate half
1000	2 cookies	Voortman brand, strawberry wafer	
	1 cup	Coffee with cream added	
1200	1 cup	Hot water	Client refused lunch
1430	½ cup	Apple juice	
1700	1 cup	Coffee with cream	
	½ cup	Sautéed greens	
	2 oz	Steamed chicken with mushroom gravy	
	½ cup	Rice	Client ate half portion
2000	½ cup	Apple juice	
2000	1 small muffin	Blueberry muffin	Client ate half muffin

Return to TOC

For Facility Use:
72 Hour Food Intake Record

Facility: _____

Completed by: _____ Designation: _____

Date: _____

Time	Amount	Description	Notes

Return to TOC

Time	Amount	Description	Notes

Return to TOC

Time	Amount	Description	Notes

Return to TOC

Subjective Global Assessment Form

MEDICAL HISTORY

Patient name: _____ Date: _____ /_____ /_____

NUTRIENT INTAKE

1. ☐ No change; adequate
2. Inadequate; duration of inadequate intake _____
   ☐ Suboptimal solid diet ☐ Full fluids or only oral nutrition supplements ☐ Minimal intake, clear fluids or starvation
3. **Nutrient Intake in past 2 weeks***
   ☐ Adequate _____ ☐ Improved but not adequate _____ ☐ No improvement or inadequate _____

WEIGHT

Usual weight _____ **Current weight** _____

1. **Non fluid weight change past 6 months** Weight loss (kg) _____
   ☐ <5% loss or weight stability ☐ 5-10% loss without stabilization or increase ☐ >10% loss and ongoing
   If above not known, has there been a subjective loss of weight during the past six months?
   ☐ None or mild ☐ Moderate ☐ Severe
2. **Weight change past 2 weeks*** Amount (if known) _____
   ☐ Increased ☐ No change ☐ Decreased

SYMPTOMS (Experiencing symptoms affecting oral intake)

1. ☐ Pain on eating ☐ Anorexia ☐ Vomiting ☐ Nausea ☐ Dysphagia ☐ Diarrhea
   ☐ Dental problems ☐ Feels full quickly ☐ Constipation
2. ☐ None ☐ Intermittent/mild/few ☐ Constant/severe/multiple
3. **Symptoms in the past 2 weeks***
   ☐ Resolution of symptoms ☐ Improving ☐ No change or worsened

FUNCTIONAL CAPACITY (Fatigue and progressive loss of function)

1. No dysfunction
2. Reduced capacity; duration of change _____
   ☐ Difficulty with ambulation/normal activities ☐ Bed/chair-ridden
3. **Functional Capacity in the past 2 weeks***
   ☐ Improved ☐ No change ☐ Decrease

METABOLIC REQUIREMENT

High metabolic requirement ☐ No ☐ Yes

PHYSICAL EXAMINATION

Loss of body fat	☐ No	☐ Mild/Moderate	☐ Severe
Loss of muscle mass	☐ No	☐ Mild/Moderate	☐ Severe
Presence of edema/ascites	☐ No	☐ Mild/Moderate	☐ Severe

SGA RATING

☐ **A** Well-nourished Normal ☐ **B** Mildly/moderately malnourished Some progressive nutritional loss ☐ **C** Severely malnourished Evidence of wasting and progressive symptoms

CONTRIBUTING FACTOR

☐ **CACHEXIA -** (fat and muscle wasting due to disease and inflammation) ☐ **SARCOPENIA -** (reduced muscle mass and strength)

*See page 2 SGA Rating for more description.

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Subjective Global Assessment Guidance For Body Composition

SUBCUTANEOUS FAT

Physical examination	Normal	Mild/Moderate	Severe
Under the eyes	Slightly bulging area	Somewhat hollow look, Slightly dark circles,	Hollowed look, depression, dark circles
Triceps	Large space between fingers	Some depth to fat tissue, but not ample. Loose fitting skin.	Very little space between fingers, or fingers touch
Ribs, lower back, sides of trunk	Chest is full; ribs do not show. Slight to no protrusion of the iliac crest	Ribs obvious, but indentations are not marked. Iliac Crest somewhat prominent	Indentation between ribs very obvious. Iliac crest very prominent

MUSCLE WASTING

Physical examination	Normal	Mild/Moderate	Severe
Temple	Well-defined muscle	Slight depression	Hollowing, depression
Clavicle	Not visible in males; may be visible but not prominent in females	Some protrusion; may not be all the way along	Protruding/prominent bone
Shoulder	Rounded	No square look; acromion process may protrude slightly	Square look; bones prominent
Scapula/ribs	Bones not prominent; no significant depressions	Mild depressions or bone may show slightly; not all areas	Bones prominent; significant depressions
Quadriceps	Well defined	Depression/atrophy medially	Prominent knee, Severe depression medially
Interosseous muscle between thumb and forefinger (back of hand)**	Muscle protrudes; could be flat in females	Slightly depressed	Flat or depressed area

FLUID RETENTION

Physical examination	Normal	Mild/Moderate	Severe
Edema	None	Pitting edema of extremities / pitting to knees, possible sacral edema if bedridden	Pitting beyond knees, sacral edema if bedridden, may also have generalized edema
Ascites	Absent	Present (may only be present on imaging)	

A - Well-nourished no decrease in food/nutrient intake; < 5% weight loss; no/minimal symptoms affecting food intake; no deficit in function; no deficit in fat or muscle mass **OR** *an individual with criteria for SGA B or C but with recent adequate food intake; non-fluid weight gain; significant recent improvement in symptoms allowing adequate oral intake; significant recent improvement in function; and chronic deficit in fat and muscle mass but with recent clinical improvement in function.

B - Mildly/moderately malnourished definite decrease in food/nutrient intake; 5% - 10% weight loss without stabilization or gain; mild/some symptoms affecting food intake; moderate functional deficit or recent deterioration; mild/moderate loss of fat and/or muscle mass **OR** *an individual meeting criteria for SGA C but with improvement (but not adequate) of oral intake, recent stabilization of weight, decrease in symptoms affecting oral intake, and stabilization of functional status.

C - Severely malnourished severe deficit in food/nutrient intake; > 10% weight loss which is ongoing; significant symptoms affecting food/nutrient intake;severe functional deficit **OR** *recent significant deterioration obvious signs of fat and/or muscle loss.

Cachexia – If there is an underlying predisposing disorder (e.g. malignancy) and there is evidence of reduced muscle and fat and no or limited improvement with optimal nutrient intake, this is consistent with cachexia.

Sarcopenia – If there is an underlying disorder (e.g. aging) and there is evidence of reduced muscle and strength and no or limited improvement with optimal nutrient intake.

****In the elderly prominent tendons and hollowing is the result of aging and may not reflect malnutrition.**

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Appendix 13

Calculating Percent Weight Change

Client's current weight: _____ A

Client's weight 1 month ago: _____ B

Client's weight 3 months ago: _____ C

Client's weight 6 months ago: _____ D

To calculate percent weight change:

Subtract current body weight (**A**)
from previous body weight (**B**, **C** or **D**) _____

Multiply by 100 _____

Divide by current weight (**A**) _____

= [(Current weight – Previous weight) ×100] ÷
Previous weight _____

The following changes in weight are considered <u>significant weight loss</u>:

- **5% in 1 month**
- **7.5% in 3 months**
- **10% in 6 months**

Return to TOC

Sample:

Client's current weight:	67 kg
Client's weight 1 month ago:	66.5 kg
Client's weight 3 months ago:	72 kg
Client's weight 6 months ago:	72.5 kg
Client's weight 12 months ago:	75 kg

Percent weight change:

1 month	0.8%
3 months	7.5%
6 months	8.2%
12 months	12%

significant weight loss, refer to RD

Return to TOC

Appendix 14

GN Food and Beverage Guidelines

Guidelines for Foods and Drinks Served at GN-Funded Community Wellness Programs

Your community program should provide the best foods available to support the health of your community and to provide examples of healthy choices at every event. These guidelines support a healthy eating pattern and describe the GN's expectations for foods served in your programs.

1. **Serve country foods as often as you can.** Follow recommendations in the "Serving Country Food in Government-Funded Facilities and Community Programs" guidebook.

2. **At the store and on sea lift, purchase a variety of nutritious foods: vegetables, fruits, grains, and protein foods.**

3. **Unhealthy foods cannot be purchased with GN Health funds.**

Healthy Ideas

Have different foods from day to day. A variety of foods is important for health. Try something new!

Country foods are VERY healthy! Serve a variety of country food as often as you can!
Your program funding can be used to buy country food from • Hunters and Trappers Organizations • Experienced hunters • Stores and fish/meat processing facilities If you have concerns about serving country food during your program, talk to your Regional nutritionist or Regional Environmental Health Officer.

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Store bought foods	
Meals and snacks should be made up of • Variety of vegetables and fruits ○ Fresh, frozen, or canned fruits and vegetables are all healthy choices. • Mainly whole grains • Protein-rich foods	
Meals should include at least 3-4 different items. Ex. Whole grain cereal, milk, apple, and a hard-boiled egg.	**Snacks** should include at least 2-3 different items. Ex. Banana, yogurt, and homemade muffin.

Drinks
• Make water and plain milk your program's main drinks. • Sugary drinks should not be bought or served. • Coffee and tea can be purchased for serving to adults if water is also offered.

"Unhealthy foods" cannot be purchased with GN program funds.

Look for store-bought foods with less salt, sugar, and saturated fats. Talk to your Community Health Representative (CHR) or Nutritionist to learn more.

Unhealthy drinks include:

× Fruit drinks (including 100%), punches, cocktails, or juice crystals
× Pop, energy drinks, sports drinks (like Gatorade)
× Sweetened milks (chocolate, strawberry, milkshakes)
× Flavoured waters with added sugars
× Sweetened hot or cold drinks, like ice tea and slushies

Unhealthy foods include:

× Cake, ice cream, Jello, pastry (like pop-tarts), store-bought muffins
× Sugary cereals (like Froot Loops or Frosted Flakes)
× Cookies with chocolate chips or filled with icing
× Granola bars with chocolate or candy
× Granola bars with sugars as one of the first 2-3 ingredients
× Syrup, chocolate sandwich spread (like *Nutella*)
× Potato chips, cheesies, pretzels, popsicles
× Processed meats (like hot dogs, Pogos, Klik, bologna, pepperoni, salami, bacon, chicken nuggets)
× Store-bought and frozen pizza
× Lard, shortening, and fried foods

Return to TOC

Nunavut Food Guide

Choose country foods and healthy store-bought foods for a strong body

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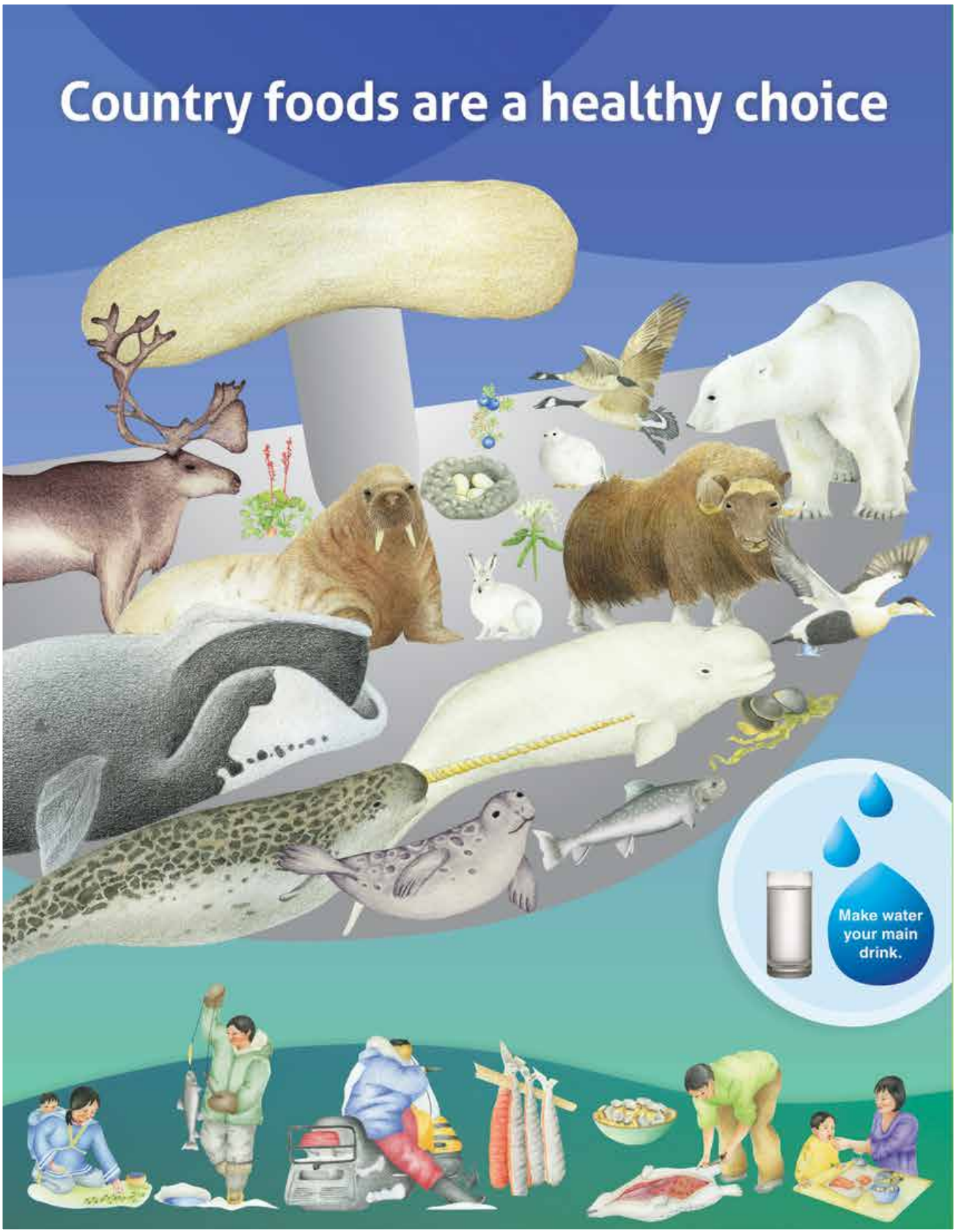

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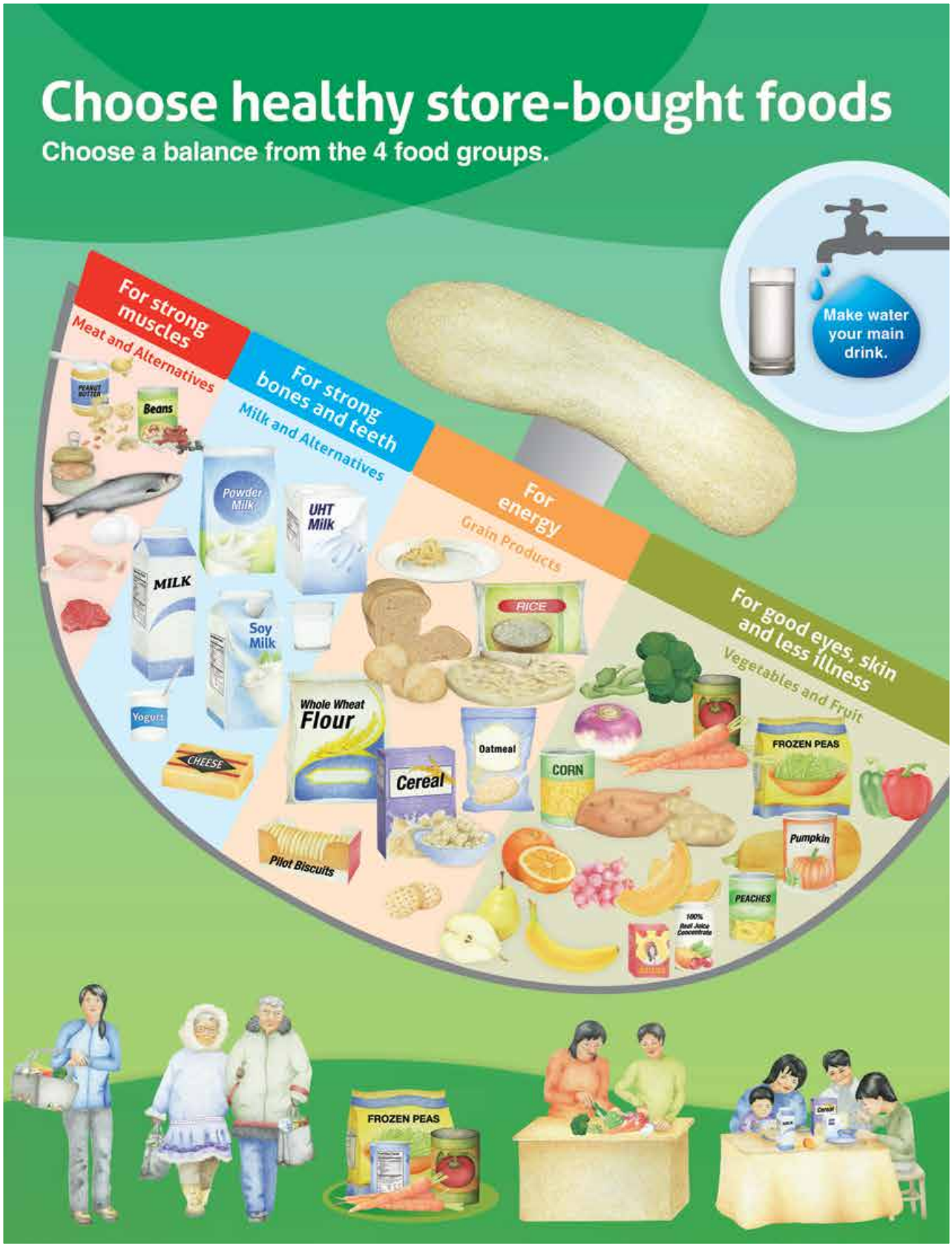

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Unhealthy

If you don't buy these, you will have more money for healthy food.

Choose fats wisely

Fats from fish and sea animals are very good for you.

Choose healthy store-bought fats.

Eat less of these:

Variety is important

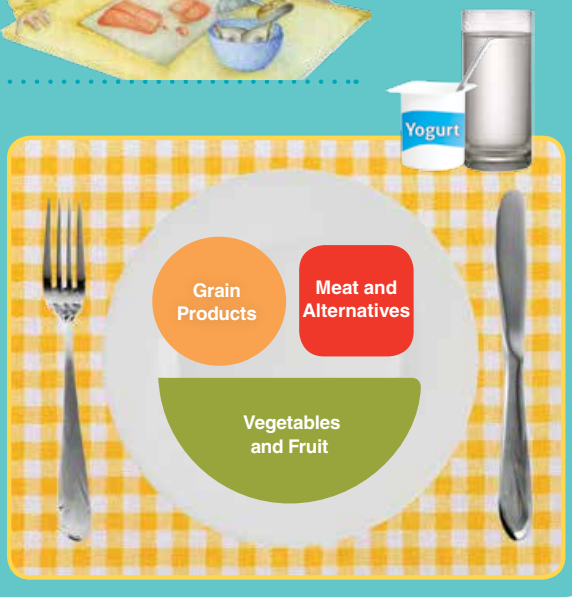
Traditional values teach us to eat a variety of country foods.

A traditional way of eating is balanced.

When you eat store-bought foods...

A balanced meal has 3 to 4 food groups.
Healthy snacks have 2 to 3 food groups.

Meat and Alternatives	Milk and Alternatives	Grain Products	Vegetables and Fruit



For more information on health and nutrition visit
www.hss.gov.nu.ca

Nunavut

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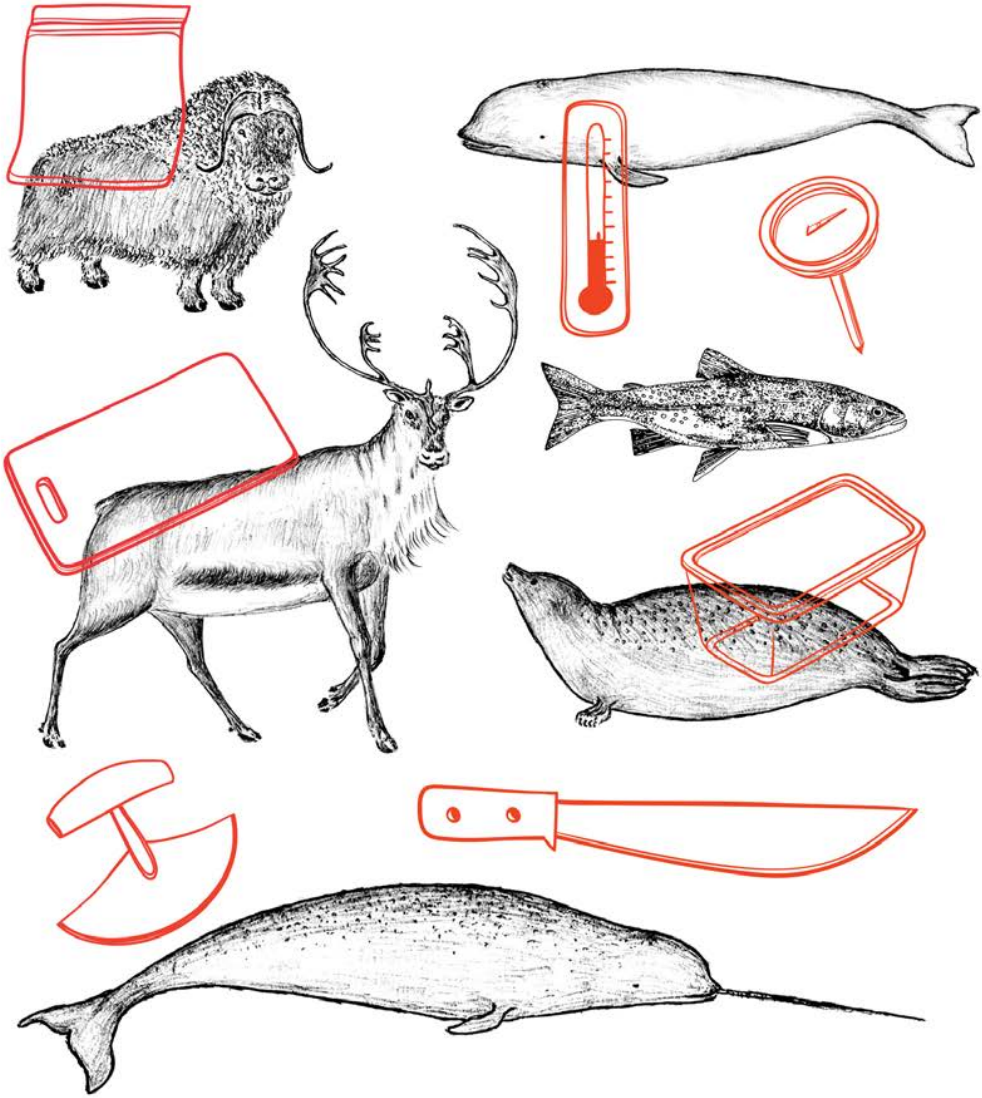
Nunavut



Serving Country Food

in Government-Funded Facilities and Community Programs

Nunavut

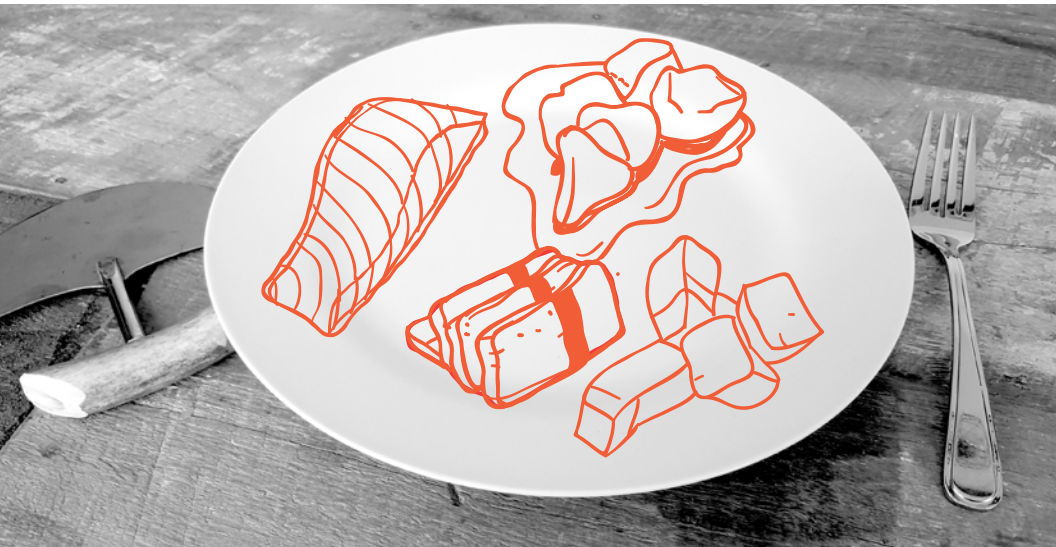
NUNAVUT FOOD SECURITY COALITION

Country food is a healthy choice!

Government of Nunavut (GN)-funded facilities and community programs are encouraged to serve more country food. The suggestions in this booklet are made specifically for GN community programs and facilities that serve country food.

If you are a GN-funded facility or community program, you may be able to get support to buy more country food. To find out more, talk to:

- your regional nutritionist
- your community economic development officer or the regional economic development and transportation office



Introduction

Part 1 of this guide shows ways for GN-funded facilities and community programs to keep country food safe. The information in Part 1 is useful for keeping all foods safe.

Part 2 of this guide provides information about specific country food like char and caribou. It provides recommendations for GN community programs and facilities that serve these country food.

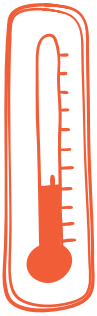
The recommendations in this book are for food being served to high-risk populations, like people who are already sick or who have weak immune systems.

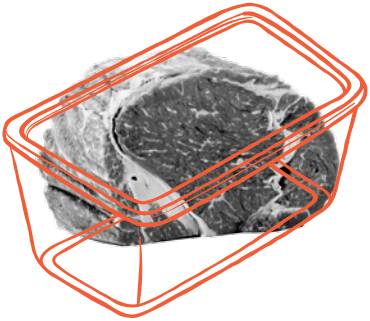
Introduction to
Part 1

Country food harvested by experienced hunters is safe!

But, even safe food can be put at risk:

Changing weather, like warmer temperatures, can increase the risk of food going bad or causing sickness.





Some ways of storing food increases the risk of food causing sickness. For example, it is not safe to age meat or fat in a plastic container with a tight lid at room temperature.

Experienced Hunters

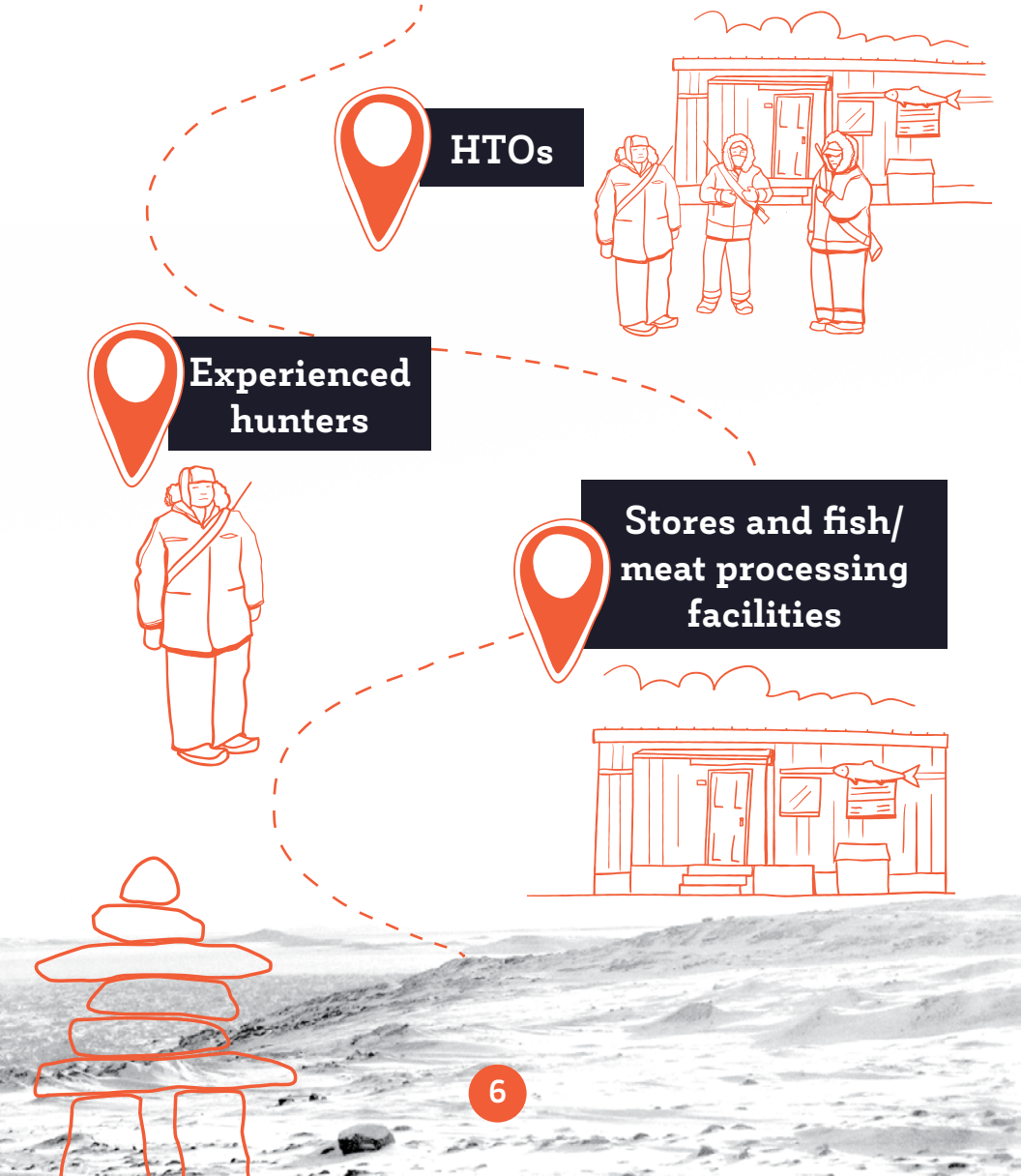
Experienced hunters use Inuit traditional knowledge when harvesting. This has kept food safe for a long time. Programs and facilities should buy country food from experienced hunters.

Together with Inuit traditional knowledge, this guide provides steps to keep food safe.

To find out who the experienced hunters are in your community, contact your local hunters and trappers organization (HTO).

Buying country food

You can buy country food from:

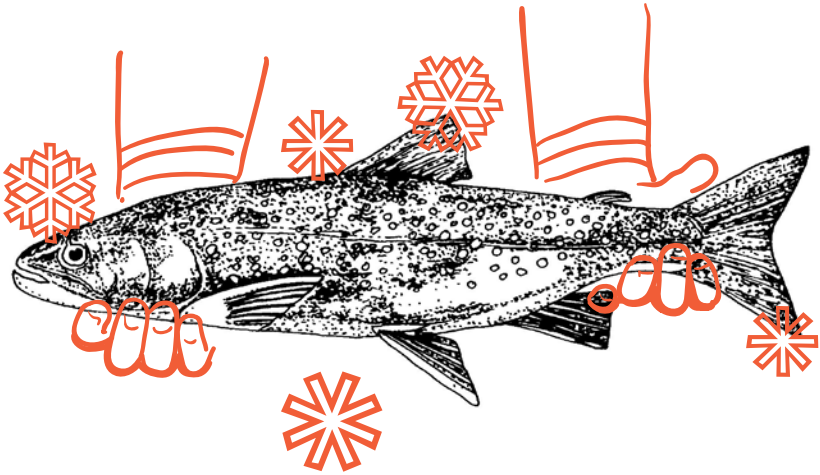


Donations

GN-funded facilities should accept donations of country food.

Donations from HTOs and experienced hunters are encouraged.

You should handle and track country food donations in the same way as country food that you buy.

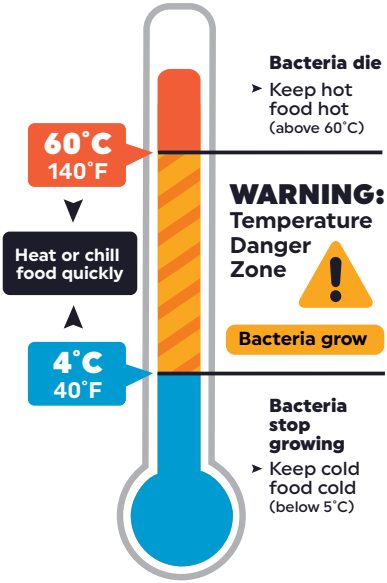


Inspection

You should look at the country food when you receive it to make sure it is in good condition. It should be clean and not bruised. It should be at a temperature of 4°C or colder (or completely frozen).

Don't accept country food that is over the temperature of 4°C. Food that is over 4 °C may have started to spoil.

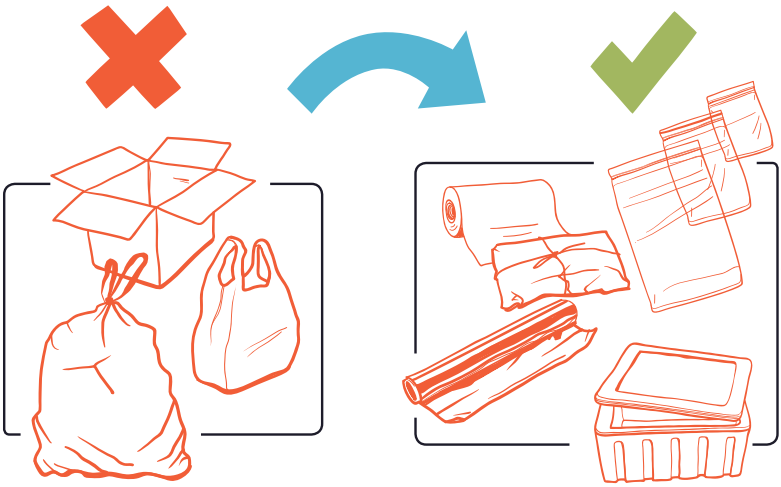
Facilities and programs should have thermometers to check the temperature of meat.



Food Safe

Packaging

- Food-safe packaging is material that is safe for storing food, including butcher paper, aluminum foil and food-safe plastics (like resealable bags).
- Packaging that is not safe for storing food is cardboard, grocery bags and garbage bags.
- At your facility or program, if you receive country food that is not in food-safe packaging , you should put it in food-safe packaging for storage. For example, if country food arrives in garbage bags, it should be repackaged in food-safe wrapping.
- Garbage bags and grocery bags have chemicals in the plastic that can get into the food. Grocery bags and cardboard that have been used before may also have germs from other foods.



Labelling and Tracking

- Whenever you receive country food in your facility or program, you need to fill out a tracking form. Fill out the country food tracking form that is found on p. 42-43.
- After the country food is in food-safe packaging, label it. The label should have:
  - ✔ the date the country food was received
  - ✔ the animal
  - ✔ the animal part
- The information on the label should be the same information that is on the country food tracking form, so it is easy to keep track of where all of your country food comes from.
- Photocopy the label on this page.

COUNTRY FOOD

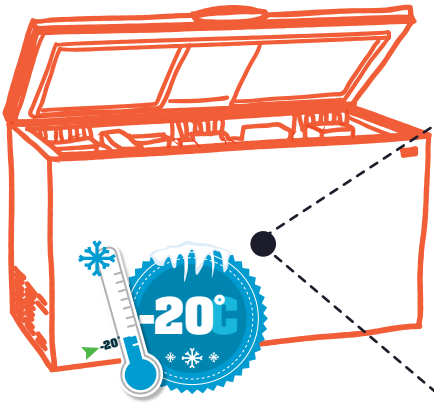
Food Safe Label ✔

Date received: _____

Animal: _____

Animal part : _____

Storing country food

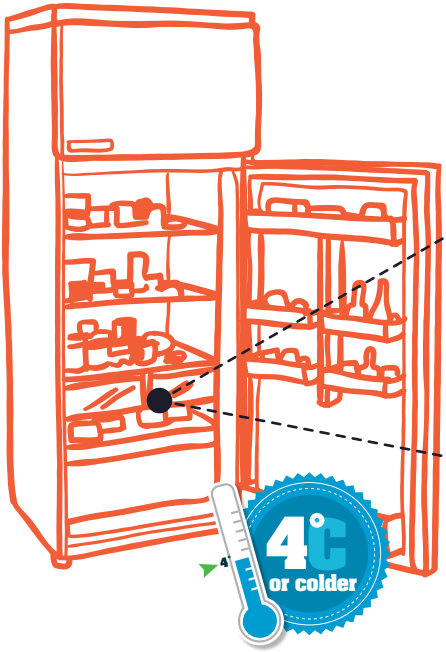


Store country food

in a country-food freezer. Country food can also be stored in a freezer with store-bought food. It is good to keep country food separate from store-bought food in the freezer.

Frozen country food

should be stored at -20°C (deep freezer).



Fresh country food

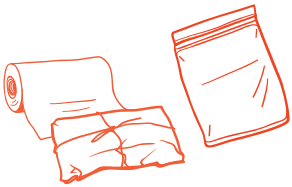
should be stored at 4°C or colder (refrigerator temperature).

Uncooked meat should always be stored on the bottom shelf of a refrigerator to make sure it does not drip on other foods.

Equipment

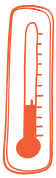
These things are useful for keeping country food safe:

- food-grade packaging (like butcher paper, food-safe plastic bags)



- thermometers to keep track of the temperature of meat

- thermometers to make sure refrigerators and freezers are at a safe temperature



- country food tracking form (found at the back of this guide)

- labels for country food

Contact your Environmental Health Officer to find out how to get this equipment.

Preparing and Serving County Food

Country food should be served in ways that people like to eat it. Ask what the local customs are!

Here are ways to find out more about cooking with country food:

- recipes under "Resources" at www.livehealthy.gov.nu.ca

- Inuit Broadcasting Corporation's country-food recipe book *Niqitsiat*!

- recipes from programs like the Canada Prenatal Nutrition Program

Seal Broth

Recipe

(Provided by Pitsiula Kilabuk, Pangnirtung)

Cut up seal meat and put in stockpot.

Add at least 8 cups (2 liters) of water to cover, then add:

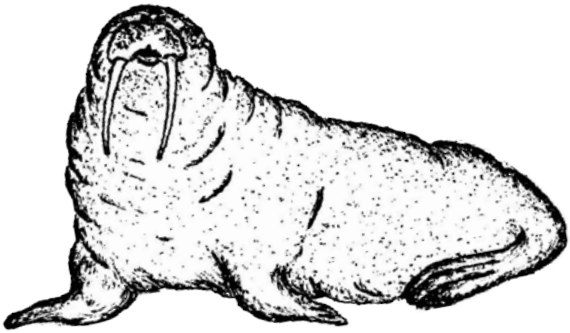
- **2 packages dry soup mix** (such as tomato vegetable) or low sodium vegetable broth
- **1 chopped onion**
- **4-5 potatoes, carrots or turnips**, chopped

Boil until the seal meat is cooked and the vegetables are tender. Seaweed dipped in seal broth is delicious!

Fermented or Aged Food

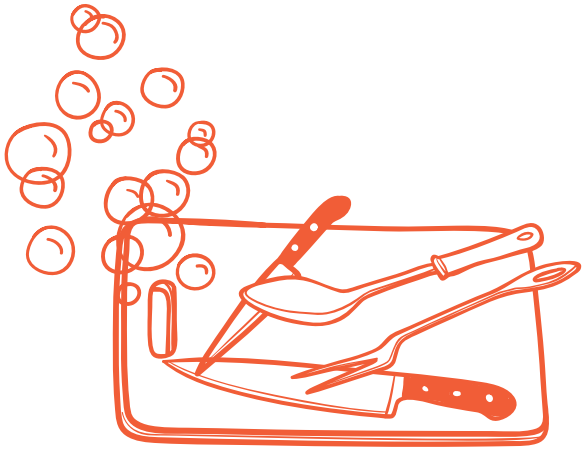
Fermented and aged country food that is not prepared in the right way can cause serious sickness. This is a concern especially for people who are already sick.

It is recommended that facilities and programs **do not** buy or accept donations of fermented or aged country food (like igunaq).



Preparing Food - Kitchen

- Facilities and programs should prepare country food in the kitchen of the facility. Country food can also be prepared in a clean space that is reserved for country food.
- Country food should be butchered on surfaces that are clean and can be cleaned after. For example, a good surface is a cutting board that can be washed. You can also use clean ice and snow to butcher meat.
- Some surfaces are hard to clean and trap germs (like plywood and tarps). These are not recommended to use for cutting meat that will be served to people in programs and facilities.



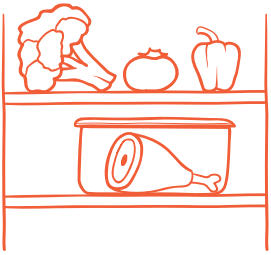
Food safety reminders

for all foods

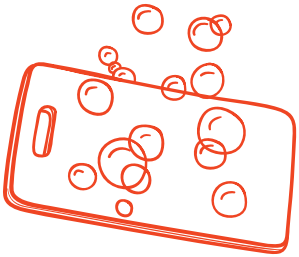
1. **Keep foods separated.**
Raw foods should be kept separate from cooked foods.

2. **Clean tools and disinfect them (get rid of germs on tools).**
Knifes, ulu and cutting boards should be cleaned after butchering or preparing foods. It is a good idea to have cutting boards that are only used for cutting meat and separate cutting boards for cutting vegetables. Running a dishwasher on the hot cycle is a good way to disinfect kitchen tools.

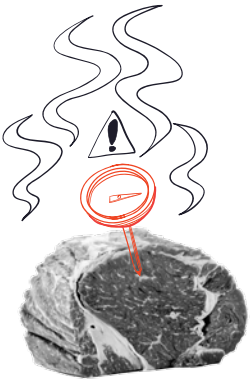
3. **Thaw meat properly.**
A safe way to thaw meat is to put it on the bottom shelf of a refrigerator on a plate or tray. Food should not be thawed at room temperature. Talk to an Environmental Health Officer about the best way to thaw meat in your facility.

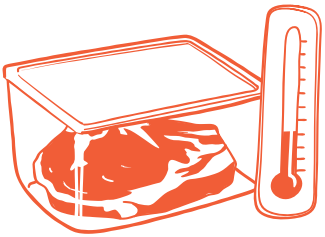


4. Clean and disinfect all surfaces after cutting meat. It is best to cut meat on cutting boards. Wash cutting boards using soap and run through the dishwasher if possible.



5. Keep track of temperatures using thermometers. Use thermometers to know when food is cooked, and to make sure that it is stored at the right temperature.





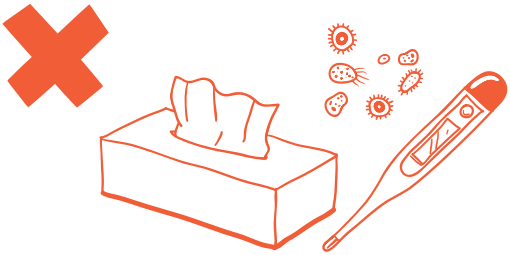
6. **Wash your hands often when handling food.** You should wash your hands with soap at these times:

- before you handle food
- after you handle raw food
- after you use the washroom
- after you smoke or use the telephone
- after you sneeze or cough
- any time you wonder if you should wash your hands

7. **Do not handle food if you are sick.**

You should not handle food if you have any of these:

- fever
- coughing and sneezing a lot
- diarrhea or vomiting



Serving Country Food

Checklist

- [ ] **Buy** country food or accept donations from HTOs, experienced hunters, or stores/fish and meat processing facilities.

- [ ] **Inspect** country food that you receive.

- [ ] **Track** country food. Fill out tracking form and labels before storing or serving country food.

- [ ] **Store** country food properly.

- [ ] **Prepare** country food the way people like it.

- [ ] **Follow food safety rules** in the kitchen or where you prepare foods. Remember to keep foods separate, check temperatures, clean and disinfect (get rid of germs).

Keeping country food safe at feasts

Here are things to keep in mind when having a feast:

- Keep country food at room temperature for no longer than two hours. It is a good idea to put out the food right before the feast starts. If food is to be thawed (or partially thawed) before it is eaten, it should be thawed in a refrigerator.

- Keep hot food hot, and cold food cold. Hot food (like stew) should be kept on the stove until right before it is served. Put any leftovers in the fridge right away.

- It is important to know what country food is being served. Label country food when it is put into a freezer, so you know what is being served at the feast.

Introduction to Part 2

This section of the guidebook talks about how to serve country food at government facilities and community programs. There are recommendations for:

- fish
- caribou
- muskox
- seal
- whale

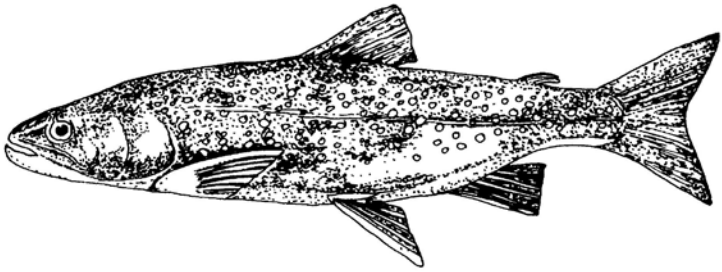
There is also some information about walrus and polar bear.

Fish

At GN facilities and programs:

- You can serve cooked fish. Cooking fish will kill any roundworms that might be in the fish. Cook fish to an internal temperature of more than 70°C.

- You can serve uncooked fish. To serve uncooked fish, first freeze the fish for seven days at -20°C. Freezing for this length of time should kill any roundworms, so the fish will be safer to eat raw.



Important information

about fish

- The roundworm larva (immature roundworms) in fish can make people sick. Eating the larva can cause illness in the stomach and intestines. It is not known how often roundworms are found in fish in Nunavut, and they are sometimes too small to see.

- It is not known if drying fish kills the roundworms.

When fish is served frozen, like Arctic char, it should not be served partially thawed. Many people enjoy fish when it is well frozen. Some people like to cut frozen fish by themselves.

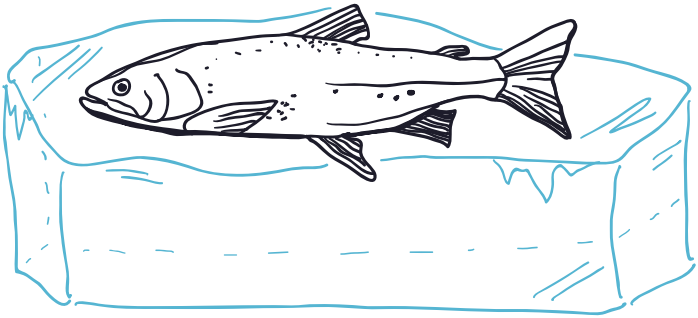
Do not store frozen fish for longer than three months. If possible, fish should only be stored for one month for best taste.

Suggestions from veterinarians about fish:

Fish harvested from nets must be alive when taken from the net. It is suggested that nets be checked every three hours.

In winter: After removing fish from the net, let the fish freeze on clean ice. Do not gut the fish in winter. Pack the frozen fish in food-grade boxes or bags.

In summer: Gut the fish immediately to stop any worms in the guts from moving into the flesh. Keep fish at a temperature of 4° Celsius or colder with clean ice, in clean food-grade containers.



Caribou

At GN facilities and programs:

- You can serve cooked caribou. Cooking caribou kills all the germs that caribou might have. Cook caribou until juices run clear and the meat is no longer pink in colour. Caribou should be cooked to an internal temperature of more than 75°C.
- You can serve uncooked caribou to some people. People who are immunocompromised (cannot fight off infections) should not be served raw caribou.
- Before serving uncooked caribou, freeze the caribou for at least three days at -20°Celsius. Freezing caribou for three days kills a germ called toxoplasma that might be a risk to pregnant women.
- Freezing caribou does not kill all germs that may be found in caribou. Make sure to read the information on the next page when planning to serve uncooked caribou.

Caribou meat can be stored in a freezer at -20°Celsius for 6-12 months.

Immunocompromised

Some sickness can cause a person to become immunocompromised, which means they have trouble fighting off germs and infections. People who are immunocompromised need to be more careful about what foods they eat. These are some examples of people who are considered to be immunocompromised:

- people who are having cancer treatment like chemotherapy
- people with HIV/AIDS

Important information
about caribou:

Brucella

Brucella is a germ (bacteria) that has been found in some caribou herds in Nunavut. Brucella can cause sickness in humans. The only way to kill brucella is to cook the caribou. Freezing, drying or smoking caribou will not kill brucella.

Government facilities and community-based programs should follow these guidelines:

- ✔ Do not serve uncooked caribou if the caribou is from a herd that is known to have brucella. Some animals in that herd might be infected with brucella but not show signs of sickness.
- ✔ Do not accept or handle caribou with brucella because it could contaminate the kitchen or other food. Wash your hands with soap if you do.

Suggestions from veterinarians about caribou:

If there is swelling in the knuckles, joints or reproductive organs of the caribou, these are signs of brucella. The caribou should not be eaten. Cutting off the infected knuckle or joint and eating the rest of the caribou is not safe because there is likely brucella in all parts of the animal.

Important information

about caribou

Toxoplasma

Toxoplasma is a germ (parasite) that has been found in caribou. Toxoplasma can cause serious illness for people who cannot fight infections and for pregnant women. Cooking caribou meat kills toxoplasma. Freezing meat for three days also kills toxoplasma. At facilities and programs, make sure to freeze caribou meat for three days at -20°Celsius before serving it raw.

Giardia

Giardia is a germ (parasite) that has been found in caribou. Giardia can cause sickness in humans. The only way to kill giardia is to cook the meat.

Hydatid disease

Hydatid disease shows up in caribou as cysts in the organs or meat. Usually the caribou do not appear sick, but you can see the cysts in the caribou after butchering. Do not feed meat with cysts to dogs. Humans do not get the disease from caribou, but can get the disease from contact with dog feces if dogs have been fed caribou meat with cysts in it.

Suggestions from veterinarians about caribou:

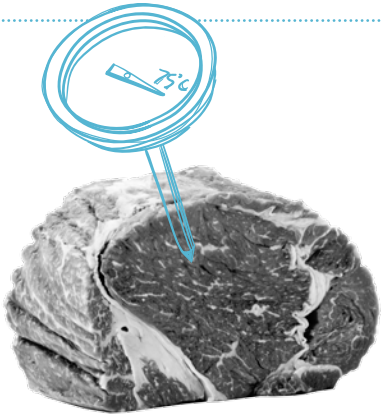
Feces (stool) from the caribou can have giardia, so it is important to keep caribou feces away from the meat and be careful not to cut into the intestines while butchering. Even a small cut of the intestines can expose the meat to giardia.

Muskox

At GN facilities and programs:

- You should serve muskox cooked. Cook muskox until juices run clear and the meat is no longer pink in colour. Muskox should be cooked to an internal temperature of more than 75°C.

People in Nunavut have said that they prefer eating muskox cooked. Cooking muskox kills the germs that might be found in muskox. Muskox should be cooked when served in GN facilities and community programs.



Important information

about muskox

Germs that have been found in some muskox in Nunavut are brucella, erysipelothrix, giardia and toxoplasma.

Government facilities and programs should not accept or handle muskox with erysipelothrix. Touching a muskox with erysipelothrix can cause a rash and other health issues in humans.

Muskox has been shown to carry brucella, but brucella is less common in muskox than in caribou. Muskox with brucella may have swollen knuckles or joints. If there is swelling in the knuckles or joints, the muskox should not be eaten. Government facilities and community-based programs should not handle muskox with brucella because it could contaminate the kitchen or other food.

Muskox can be stored in freezers at -20° C for 6-12 months.

Suggestions from veterinarians about muskox:

- Some muskox in Nunavut have a disease called erysipelothrix. This may show up in muskox as abnormal hair or skin. Humans can catch erysipelothrix by touching muskox that have the disease.

- Some muskox do not show any signs of illness, but may die from erysipelothrix very suddenly. People should avoid touching dead muskox. Erysipelothrix can cause painful skin sores in humans.

- If a muskox shows signs of illness, do not touch it, especially with your bare hands. Wash or disinfect your hands with soap if you do touch parts of the muskox showing illness.

- Muskox with erysipelothrix should not be eaten.

Seal and Whale

At GN facilities and programs:

- You can serve cooked seal and whale. Cooking kills the germs that have been found in some seal and whales in Nunavut. Cook seal or whale to an internal temperature of hotter than 75 °C. If the meat or juice is still red, it has not been cooked long enough. Cook seal or whale until juices run clear and the meat is no longer pink.

- You can serve uncooked seal and whale to some people. People who are immunocompromised (cannot fight off infections) should not be served raw seal or whale.

  - Before serving uncooked seal and whale, freeze for at least three days at -20°Celsius. Freezing seal or whale for three days kills a germ called toxoplasma that might be a risk to pregnant women.

  - Freezing seal and whale does not kill all germs that may be found in the animal. Make sure to read the information on the next page when planning to serve uncooked seal or whale.

Immunocompromised

Some sickness can cause a person to become immunocompromised, which means they have trouble fighting off germs and infections. People who are immunocompromised need to be more careful about what foods they eat. These are some examples of people who are considered to be immunocompromised:

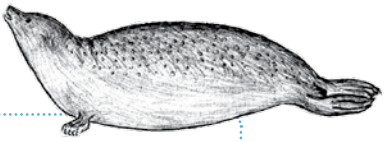
- people who are having cancer treatment like chemotherapy
- people with HIV/AIDS

Important information

about seal and whale:

- Some seal and whales in Nunavut may carry germs that can cause sickness in humans (including botulism, giardia, toxoplasma, and brucella). It is not known how often trichinella occurs in seal in Nunavut. More information is needed to know how often these germs appear in seal and whale.

- Freezing does not kill some of the germs that have been found in seal and whale (botulism, brucella, trichinella and giardia). Cooking kills all of these germs. Seal and whale should be cooked when it is served to people who are not able to fight off infection.



The Department of Health recommends that women of childbearing age who may become pregnant, are planning to get pregnant, or are pregnant eat ringed seal meat instead of ringed seal liver. This is suggested because of some environmental contaminants found in seal liver.

Seal and whale can be stored in freezers at -20°C. There are no reported guidelines on how long seal and whale should be stored in a freezer.

Suggestions from veterinarians about seal:

- Signs of illness or weakness in seal may be a bald coat or parasites on the skin. Seals that are sick may also have white dots on liver or inside the liver. Seals showing signs of illness or weakness should not be eaten.
- Gut a seal immediately after it is killed (or within several hours) to stop any bacteria in the intestines from getting into the meat or fat. Butcher seals on clean surfaces, like clean snow and ice.
- Even if the seal appears healthy:
  1. Do not cut into the gut during butchering
  2. Make sure that none of the contents of organs or intestines are in contact with the meat or the fat of the seal

Walrus and Polar Bear

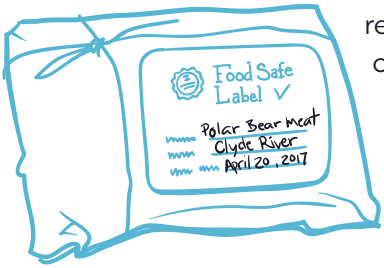
Walrus can have a roundworm called trichinella. These worms can make people very sick. Testing a walrus tongue can show if the walrus has trichinella or not.

Walrus should always be tested for trichinella before it is served uncooked or fermented.
Testing a walrus tongue for trichinella is the best way to know if that animal is safe to eat uncooked.

Walrus tongue testing is free. For more information on walrus tongue testing, contact your Environmental Health Officer.

Most polar bear carry trichinella. Polar bear should always be very well cooked if it is being served in facilities and programs. Polar bear should be cooked to 75°C or hotter.

Polar bear meat should be cooked until there is no pink or red in the meat and no blood coming out of the meat.



Always make sure polar bear meat is labelled so no one eats raw polar bear meat by mistake.

Information from veterinarians:

- The majority of polar bears may carry the trichinella germ. This means that if polar bear meat is eaten uncooked, there is a good chance that people could become sick with trichinella.
- Trichinella is not killed by freezing, drying or fermenting meat. It is only killed by cooking the meat.

Keeping Country Food Safe

Suggested practices

The following recommendations are based on ways that veterinarians suggest handling animals to keep food safe. Nunavut hunters already take many of these actions based on their own knowledge of traditional practices. Inuit traditional knowledge keeps food safe. Many traditional practices that keep food safe are not written down.

These recommendations are here to make sure that the highest quality country food is served in facilities and programs in Nunavut.

Harvesting

- Harvest using Inuit harvesting practices (by an experienced hunter, or under the guidance of an experienced hunter).
- Do not harvest animals if there are any signs of illness, weakness or abnormal appearance.
- Visually inspect the animal after harvest to identify any signs of illness, weakness or abnormalities.
- Report sick, weak or abnormal animals to the conservation officer.

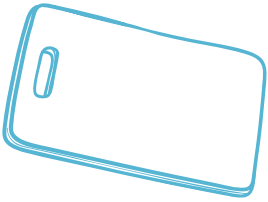
Maintaining Temperatures

- Chill meat to 4°C or colder within three to four hours of harvest.
- If the air temperature is above 4°C, ice or snow may be used to keep carcasses cool.

Butchering Country Food

- Meat should be butchered on surfaces that are clean. If the surface is going to be used again, it is important that it is easy to clean after butchering

- These are good surfaces for butchering:
  - clean snow and ice
  - skin of harvested animal
  - clean tundra
  - trays and cutting boards made for food



- The following surfaces are hard to clean and are not good for butchering: cardboard, wooden boards, painted surfaces, polypropylene tarps and canvas.

- Clean and disinfect butchering tools and equipment after each use.

- Do not cut into the guts of an animal when butchering the animal because there can be exposure to giardia and other germs from animal feces. Even a small cut of the intestines can expose the meat to giardia.

- Do not feed meat with cysts to dogs. Humans can catch disease from parasites that are in dog feces after a dog eats meat with cysts.

Transportation

- No fuel or other contaminants should come into contact with harvested animals during transport.
- Harvested animals and butchered meat should be transported in a sled and/or boat that is only used for transporting animals.
- If animals are shipped between communities, carcasses should stay frozen at all times. If country food is not frozen when shipped, the temperature should always be 4°C or colder.

Appendix 1

It is important to keep track of country food that is bought and donated. Use one of these country food tracking tools (form or table) to keep a record of the country food at your facility.

Country Food
Tracking Form

This form should be completed each time a program or facility receives country food. Keep all forms in one confidential location. The information will help to keep food in facilities and programs safe.

Facility Name	Community
Name of hunter	
Location of harvest (place name or GPS coordinates)	Date animal was harvested DD MM YY
Date country food was received DD MM YY	Check one: ☐ Purchase ☐ Donation
Please describe the country food (type, part of animal, quantity) and any observations regarding the animal:	
Who butchered this animal?	☐ Hunter named above ☐ Facility/ program staff ☐ Other person (name: _____)
What was the temperature of this food when it was received?	
For walrus, was the animal tested for trichinella?	☐ Yes ☐ No
Form completed by	Date DD MM YY

Country Food Tracking Table

This table should be completed each time a program or facility receives country food. Keep this table after it is completed. The information will help to keep food in facilities and programs safe.

Facility Name: _____ **Community:** _____

Name of Hunter Purchase? Donation?	Location of Harvest (place name or GPS coordinates)	Date animal harvested	Date animal received at facility	Temperature when received	If walrus, was it tested for trichinella?	Describe country food (appearance, type, quantity of country food)
☐ Purchase ☐ Donation		DD MM YY	DD MM YY		☐ Yes ☐ No	
☐ Purchase ☐ Donation		DD MM YY	DD MM YY		☐ Yes ☐ No	
☐ Purchase ☐ Donation		DD MM YY	DD MM YY		☐ Yes ☐ No	
☐ Purchase ☐ Donation		DD MM YY	DD MM YY		☐ Yes ☐ No	
☐ Purchase ☐ Donation		DD MM YY	DD MM YY		☐ Yes ☐ No	
☐ Purchase ☐ Donation		DD MM YY	DD MM YY		☐ Yes ☐ No	

Appendix 2

Zoonotic disease

Zoonotic disease is a disease that can be passed between animals and humans. Zoonotic diseases can be caused by viruses, bacteria, parasites and fungi.

Germ name and animal it is found in	How to tell if an animal is sick and how to prevent sickness in humans	Killed by	Effect on human health
Anasakid Nematodes (roundworms) • Arctic char may be infected with immature roundworms (larvae) that can cause disease in humans. • Seal and whale may carry adult roundworms, which do not cause disease in humans.	• Higher risk if fish are not frozen before eating or if they are not gutted right after harvest. • Immature roundworms (larvae) may or may not be visible. If you see larvae, freeze fish for seven days before eating it.	Cooking to an internal temperature of 70°C or freezing at -20°C for seven days.	This can cause mild to moderate gastrointestinal (stomach) illness.
Botulism • Fish, seals, walrus, whales. • It is not known how often botulism-causing bacteria are in an animal. When meat has no oxygen (when no air can get in) the bacteria can make a toxin that causes human illness.	• There are no signs of illness in animals that have the botulism bacteria. • Botulism may happen if food is not properly aged, canned, dried or pickled. • Food should NOT be stored at room temperature or at temperatures warmer than a refrigerator (above 4°C). • Food should NOT be stored in airtight containers (such as plastic bins with tight fitting lids).	Cooking to an internal temperature of 75°C.	Botulism causes a life-threatening sickness that can develop very quickly.
Brucella • Caribou (somewhat common) • Muskoxen (less common than in caribou) • Possible in marine mammals	• Brucella is not killed by freezing, smoking, pickling or drying meat. • In animals, brucella may be associated with abortions in caribou, low fertility in animals, swollen joints or reproductive organs, or poor body condition (weak or thin animals). Sometimes animals show no signs that they are ill with brucella.	Cooking to an internal temperature of 75°C.	Brucella in humans can range from mild flu-like symptoms to severe fevers that keep coming back.

Germ name and animal it is found in	How to tell if an animal is sick and how to prevent sickness in humans	Killed by	Effect on human health
***Echinococcus granulosus* (Hydatid disease)** • Caribou (not known how often this happens) • Muskox (not known how often this happens)	• Generally there are no signs of illness in animals, but cysts are seen in organs (and sometimes meat) after harvest. • Cut out areas with cysts and throw away. • DO NOT FEED cysts to DOGS. Humans can get the disease from contact with dog feces that has the cysts. • Do not eat or cut into fluid filled cysts.		Humans get infected from contact with dog feces (of dogs that have eaten cysts in caribou). Humans do not get infected directly from the cysts. Generally mild symptoms, may lead to formation of large cysts (mostly in the liver).
Erysipelothrix rhusiopathiae • Muskox (common on Victoria Island and Banks Island)	• Touching the skin or hide of animals with skin sores and abnormal hide, hair or coat.	Animals should not be eaten.	Painful skin sores, occasionally arthritis or septicaemia (blood infection).
Giardia • Any species except fish (How often an animal has giardia depends on the location. Giardia is common.) • Exposure to *Giardia* occurs from the contact of meat with feces	• There are no signs of illness in animals. • To prevent sickness in humans, make sure that meat does not get feces on it during gutting. Also, gutting an animal as soon as possible after harvesting helps to lower risks of getting giardia.	Cooking to an internal temperature of 75°C.	Generally mild gastrointestinal (stomach) illness.
Toxoplasma • Polar bear (common) • Seal (varies) • Walrus (less common than in polar bear) • Caribou (common) • Muskoxen (not very common) • Whale	• There are usually no signs of illness in animals. • It may be linked to abortions in the animals.	Cooking to an internal temperature of 75°C, or freezing the meat at -20°C for at least three days.	There are mild (or no) signs of sickness in adults. Toxoplasma can cause severe disabilities for babies when the mother is exposed for the first time when she is pregnant.
Trichinella • Polar bear (common) • Walrus (somewhat common) • Seal (not very common)	• There are no signs of illness in animals that have Trichinella, and it is not visible in the meat. • Tests are available for walrus if the meat will be eaten raw. • *Trichinella* is not killed by freezing, drying or fermenting meat.	Cooking	Illness in humans ranges from mild to severe.

Germ name and animal it is found in	How to tell if an animal is sick and how to prevent sickness in humans	Killed by	Effect on human health
NOT ZOONOTIC			
Muskox lungworm (NOT ZOONOTIC – IS NOT TRANSFERRED TO HUMANS) • Commonly seen when butchered. • Muskox with lungworm may appear sick or weak, can be associated with muskox die-offs.	None	N/A	Lungworm from muskoxen does not cause illness in humans or in dogs.

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Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Nutrition, Hydration, and Country Foods		Client Care	H3C 03-008-01
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
04/01/2024	04/01/2025	2.6	218
APPLIES TO:			
Nurse Managers of Continuing Care, Cooks, Supervisors of Home and Continuing Care			

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   2. **HEALTH Elder Nutrition Guidebook** pages 5-171
   3. **Serving Country food** pages 172-222

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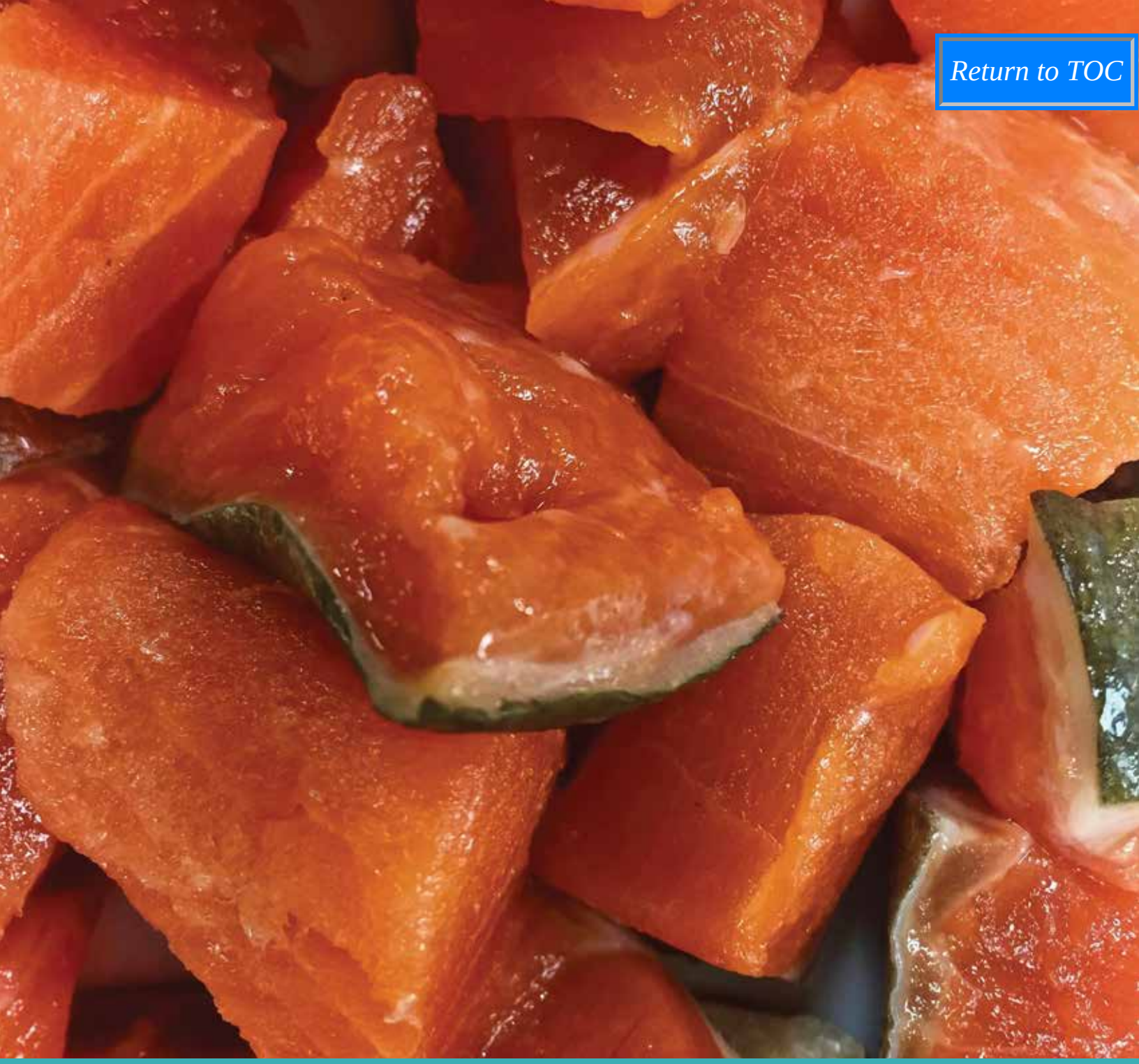

Nutrition for Elders & Long-Term Care

A Guidebook for Facilities in Nunavut

Nunavut

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Message from the Minister of Health

The Department of Health is committed to strengthening nutrition care and food services in Government of Nunavut funded facilities and community programs. I would like to take this opportunity to recognize the Department of Health staff who have created this guidebook and commend those individuals working with Nunavummiut living in care, who provided their valuable input.

Keeping true to the vision and priorities of Turaaqtavut, the Government of Nunavut will continue to work towards the well-being and self-reliance of our people and our communities through Inuusivut, by paying attention and valuing traditional knowledge while enhancing health care services throughout the territory.

Honourable George Hickes
MINISTER OF HEALTH

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Introduction

This guidebook will provide a resource for staff to support optimal health by meeting the nutrition and hydration needs of Nunavummiut in care. A critical component of this includes ensuring access to country food for clients. This guidebook can be used in conjunction with the booklet *Serving Country Foods in Government-Funded Facilities and Community Programs.* The facilities that may benefit from this guidebook include, but are not limited to:

- Regional long term care facilities
- Regional elders' homes
- Home care
- Residential care for mental health and addictions

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Food Service

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Best Practices

PART ONE: FOOD SERVICE

Providing the best care possible for Nunavummiut in government-funded facilities is a priority of the Department of Health. One important way to care for Nunavummiut is to ensure they are provided food that is tasty and healthy, and served in a way that suits their needs and wishes. A 3–4 week cycle menu is the way these goals are usually achieved in an institutional setting. A menu helps make sure that a variety of tasty and nutritious food is offered, and that managers and cooks know ahead of time what food to order and prepare. It is also very useful when there are new or replacement staff. A 3-week sample menu is provided in Appendix 1.

Staffing needs and the cycle menu

The sample menu included is based on cooking from scratch and therefore requires a full time cook 7 days a week for meal and snack preparation and associated duties. Support staff are needed to assist with meal and snack delivery, clean up and service of the evening meal. Support staff contribute to a pleasant and social eating environment by sitting with clients at meal time and assisting when needed. The manager, with input from the cook, orders and shops for food and ensures that kitchen appliances are working properly and required kitchen equipment is available.

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Tips for helping staff transition to using the 3-week cycle menu

Have a meeting to let all staff know that you will be using a new menu that has different meals every day for 3 weeks, and then starts over. Since support workers may also serve or prepare meals and snacks, it's important that they, too, know about the new 3-week cycle menu. Encourage staff to observe clients' acceptance of new menu items and share their observations with the cooks. Using a new menu can seem overwhelming at first because it means learning new recipes and creating a new work flow, and there may be some resistance, so it's important to provide support and encouragement. Typically, after 3-4 months, things will flow more smoothly.

To help clients know what will be served each day, purchase a whiteboard and marker (or chalkboard and chalk) and put it up where it can be seen by everyone. Ask a staff member to write down what will be served for lunch and supper every day.

To begin using the 3 week cycle menu, encourage cooks and staff to try out Week 1 as it is written. With staff, decide on a week to start Week 1. Use the *Food Order Sheet, Week 1* (Appendix 2) to help you make a food order at the store for Week 1. Check the fridges and freezers to make sure you don't order things that you have already. Check the dry storage area to make sure the non-perishables needed are in the facility.

Client and Staff Satisfaction with Menu

Ask the cook and other staff to write down the things that are working or not working with the new menu and recipes on the sheet called *Staff Notes on Menu Week 1* (Appendix 3). Encourage them to repeat Week 1, changing things that did not work well. Write any changes on the menu.

Once Week 1 is working smoothly, try out Week 2. Again, agree with staff on a week to try out Week 2 and use the *Food Order Sheet, Week 2* to make the local food order and check what is on hand in dry storage. Again, ask staff to write down the things that are working or not working with the Week 2 menu and recipes on the sheet called *Staff Notes on Menu Week 2* (Appendix 3). Encourage them to repeat Week 2 the following week, making changes as necessary. Do the same thing for Week 3.

Once a year, a meeting with staff and clients (and their families, if possible) should be held to get feedback about the menu and food service. The regional dietitian may be able to do this during his or her visit.

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Menu Substitutions

If a recipe is not enjoyed by clients and staff, it can be changed. There are several ways to do this. The recipe can be modified to make it more appealing. For example, if the Hamburger Soup recipe has too much tomato in it, cooks can reduce the amount of tomato and add another ingredient to make it tasty. Or, if a recipe is not enjoyed or does not turn out well, it can be replaced. In both cases, it is important to replace it with recipes or meals that have similar kinds of ingredients. For example, if the Fish Chowder recipe is not popular, it should be replaced with a recipe or meal that contains fish, milk and vegetables. For example, instead of Fish Chowder, you might serve fried fish, macaroni and cheese and glazed carrots or a tuna noodle casserole, with yogurt for dessert.

Tips for Ordering, Purchasing and Receiving Food Locally

Use the *Food Order Sheets, Week 1, 2 and 3* (Appendix 2) to help you place your order at the local store. The Iqaluit Week 1 order sheet has been completed. Use it as an example of how you can make your shopping list for Weeks 2 and 3.

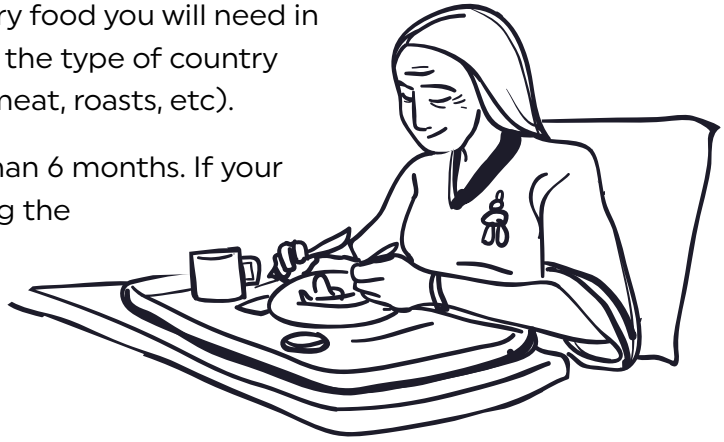
When fresh fruit and vegetables are on the menu, be sure they are inspected when you receive them to make sure they are good quality. If they are rotting or bruised, return them, and ask for a substitute.

Perishable foods such as meat and fish, eggs, fresh milk, yogurt, cheeses, fresh and frozen vegetables and fruit should be put in the fridge or freezer as soon as they are received.

When country food is donated, put it in a food storage bag and use a marker to write the name of the food and the date you received it. If possible, find out when the food was harvested and write down the date of harvest. See the GN Country Food Guidelines for more information and discuss safe handling of country food with the Environmental Health Officer or the Regional Dietitian during their visits.

If some country foods are not available locally, consider ordering them from commercial suppliers such as Kivalliq Arctic Foods or the Iqaluit Country Food Store. Use the menu to know much country food you will need in the next 6 months, and place an order for the type of country food and the desired cuts (ground, stew meat, roasts, etc).

Try not to store country food for longer than 6 months. If your country food freezer is full, consider asking the hunter to give the food to another community group such as the prenatal program, daycare or schools.



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Ordering by sealift

If you have storage space for non-perishable foods, a sealift order can help save money. Consult with the regional dietitian about your sealift order if you have question about amount and kinds of food to order. See Appendix 4 for suggestions on which foods to order by sealift, and which to buy locally.

Some advantages of ordering on sealift

- Saves money on non-perishable foods such as pasta, rice, flour, canned fish, canned fruits and vegetables, stuffing mix, vegetable oil, UHT milk, powdered milk, cereal, etc.
- Food is available in the facility, even during an unexpected storm or power outage.
- Provide a better choice of healthier foods that might be hard to find in the local store such as:
  - Lower sodium versions of soya sauce, soups, canned, flaked meats, etc.
  - Canned fruit packed in fruit juice or water instead of in heavy syrup
  - Whole grain products such as whole wheat flour, brown rice, whole wheat crackers
- Offer bigger sized packages of foods such as canned salmon, vegetable oil, flour, etc. which are usually cheaper.
- Offer wider choice of brands.

Here are some things to think about when making your sealift order:

1. **How much food to order.** Use the 3-week menu and the sealift order template to help figure out how much to order. For example, a menu may have hot cereal 5 mornings per week. You would need around 52 kilograms of oats to serve 8 people oatmeal this often for a year. If only 6 people eat oatmeal every morning, you would only need 39 kilograms of oats. If oats are used for other things such as muffins or cakes, you would need to add more.
2. **Brands.** Some brands are cheaper than others. For example, at Marché Daoust, a 10 kilogram bag of Selection all-purpose flour is around $14. The same amount of Five Roses flour is around $20. A case of Cloverleaf pink salmon (418 gram cans) is around $140. The same amount of Selection brand is around $103. These prices don't take into account shipping and crating costs.
3. **Type of packaging.** For example cello wrapped pasta is usually cheaper than boxed pasta. Plus it weighs a little less so shipping costs are less.
4. **Size of package.** Usually bigger package sizes are cheaper per serving. For example, the cost per serving is cheaper for bigger cans of salmon (418 grams vs 213 grams) and bigger bags of flour (10 vs 5 kilogram bags).

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What about ordering milk?

Fresh milk

Fresh milk is the cheapest way to get milk. Ordering the biggest container (4 litres) might be a better deal, but only if you are going to use it all during the week. For example, in the Week 2 Iqaluit menu, about 7 cups of fresh milk is called for in 4 recipes (mashed potatoes, creamy veggie rice, French toast and pudding). Other recipes call for evaporated milk because it gives a creamier result. If we estimate that the 8 clients and staff use ½ cup per day for their breakfast cereal, that would make a total of 28 cups of milk per week, plus the7 cups for recipes, for a total of 35 cups of milk per week. Each 4 litre container of milk is equal to 16 cups, so the facility would need two 4 litre containers and one 1 litre container for the Week 2 menu. Once milk is opened it needs to get used fairly quickly, so the big containers should be used first and the smaller container last.

Evaporated milk

Evaporated milk is more expensive than fresh milk, even when ordered on sealift, but it is called for in many of the recipes. It gives a creamier result than fresh milk because it is more concentrated. For example in the 3 weeks of the Iqaluit menu, 9 cans of evaporated milk are needed. For the whole year, this would be 156 cans or 6.5 cases of 24 cans.

When you add a can of water to a can of evaporated milk, it has the same nutrition and can be used the same way as fresh milk. Once opened it needs to be kept in the fridge.

UHT milk (Grand Pré)

UHT milk is even more expensive than evaporated milk, but it is probably a good idea to have
a case in dry storage for days when you cannot get out to purchase fresh milk. It does not need to have water added to it, so would also be good if ever there is a problem with the water.
When unopened, it can be kept in dry storage. Once opened, it must be kept in the fridge.

Powdered milk

Milk made from skim milk powder is usually less expensive than fresh milk, especially if it is ordered on sealift. It has the same nutrition as fresh skim milk. Some of the recipes in the menu, such as muffins and some desserts, call for skim milk powder, so it would be good to have some in dry storage. It is a great way to boost the nutrition value of baked goods.

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Tips for placing a sealift order based on the 3-week cycle menu

Use the *sealift Ordering Sheet* (Appendices 5) to help you estimate how much non-perishable food to order, for each week of the 3-week cycle menu. Since the new menu may be different from what was served last year, the kinds and amounts of food you need will probably be different. It is important to allow some time to make a new sealift order. It will help you save money and avoid unnecessary trips to the store.

A sample order sheet based on the facility's sample menu have been prepared as an example (Appendix 5). The amounts of each non-perishable food item needed for Weeks 1 and 2 were estimated and then multiplied by 17 since the Week 1 and 2 menus will each occur 17 times in the year. Managers will need to do the same thing for Week 3. This requires looking at each day and each recipe and writing in the ingredients and amounts. It requires some time and patience, but should help you have a good sealift order. The regional dietitian can help you with this task.

In Appendix 5, there are columns for the yearly amounts of sealifted foods needed for Weeks 1, 2 and 3. Weeks 1 and 2 have been filled in for you, but you will need to make the estimate for the Week 3 menu. By adding up the columns for Weeks 1, 2 and 3 you will get the total amounts needed for the year. Then, based on the sealift company you are working with, calculate how many bags or cases of each item you need to order. For example, if you use about 129 kilograms of flour for the year, you could order thirteen 10 kilogram bags of flour, if your provider has 10 kilogram bags available.

Tips for staff training

When the dietitian is visiting your facility, organize a staff meeting so that she can provide a training session on topics such as the importance of nutrition and hydration for the clients, special diets (low sodium, lactose intolerance, thickened fluids, etc), menu substitutions, allergy awareness, assisted feeding techniques, food safety, choking prevention, dysphagia, recording food and fluid intake, constipation, feeding clients with dementia, height and weight measures.

Look for opportunities for training of cooks and other staff members on food safety, nutrition and cooking. Food safety courses may be given by the Environmental Health Officer in your region.

Keep a record of the formal and informal training the staff receive (see Appendix 6).

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Look for opportunities for professional development for staff in early dementia care.

Examples are:

- The Alzheimer Society of Canada (http://alzheimer.ca/en/Home) has information on networks such as NICE (network for care of the elderly) and resources such as webinars by brainxchange, e-learning opportunities and education modules. http://alzheimer.ca/en/Home/We-can-help/Resources/For-health-care-professionals
- The Alzheimer Society of Montreal offers various in person educational modules for health care professional, ranging from 30 – 6 hours of training. http://alzheimer.ca/sites/default/files/%5Bzaboutme%3Adirectory%5D/alz_formations_spring2018_en.pdf
- Alzheimer Society of Alberta and the Northwest Territories maintains a help line and offers other support services. They have a regional office in Yellowknife. http://alzheimer.ca/en/ab/We-can-help/Education.
- Alzheimer Society of Manitoba offers Telehealth seminars (https://alzheimer.mb.ca/events/)
- Alzheimer Society of Ontario (http://alzheimer.ca/en/on/We-can-help/Education) offers *U-First* an online or in-person training program for caregivers and the First Link learning series for groups.

Emergency Menu

Canadian guidelines for long term care recommend that a 3-day emergency menu be developed. The Emergency Menu for your facility is included in the guidebook in Appendix 7. The food necessary to carry out the menu should always be available.

Kitchen equipment need for menu

- Immersion blender (for easily blending soups)
- Digital instant read thermometers (at least 2) Thermoworks Thermopop ($70) , Thermopro TP02S $11,
- Storage containers for 1-2 servings (1–2 cups, or 250–500millilitres)
- Storage containers for 8 servings (8 cups or 2 litres)
- Markers for the storage containers and sticky labels
- White board and markers or chalk board and chalk

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Recipes

Sixty recipes have been created to assist your facility in creating a menu that includes nutritious and appetizing food. The recipes can be found in Appendix 8.

- 30 main courses
- 6 sauce recipes
- 24 Soup, salad and sides recipes

Substitutions for common ingredients can be found in Appendix 9.

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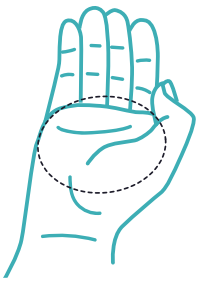
Examples of how much food to offer

Food	About how much to offer
Fruit juice	½ cup
Rice and pasta	1 cup
Bannock	About the size of half a slice of bread
Meat and Fish	About the size of the palm of your hand 

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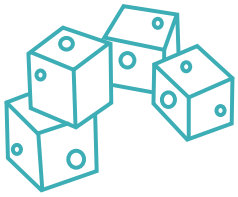
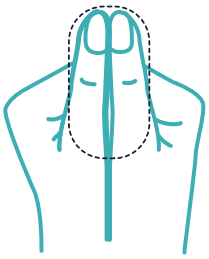
Food	About how much to offer	
Vegetables and Fruit	½ cup	
Yogurt	½ cup	
Cheese		

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Sodium

Sodium is part of salt. Another name for salt is sodium chloride. Our bodies need sodium, but only a little bit. Too much sodium isn't good for health. Sodium is in many store-bought foods.

For those with health problems such as COPD and high blood pressure, getting less sodium is important.

Country food is low in sodium and is always a good choice.

Here are some tips for getting less sodium.

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Tips When Cooking:

1. Measure carefully!

The ingredients below contain a lot of sodium. It's best to measure them with measuring spoons or cups.

- Salt
- Bouillon powder, cube or liquid
- Soya sauce (even the low sodium kind)
- Worcestershire sauce
- Ketchup
- Seasoning salts such as onion, garlic and celery salt (onion and garlic powders usually do not contain sodium)
- Baking powder
- Baking soda

2. Read the Nutrition Fact Table

Choose foods that have less than 15% Daily Value for Sodium

Which one of the instant mashed potato brands has less sodium?

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One serving of the No Name brand has only **4%** of the Daily Value for sodium.

One serving of the Betty Crocker brand has **18%**.

The no name brand has much less sodium.

3. Substitute for lower sodium options

Choose less often	Choose more often
Canned or dried soup mixes	Homemade soups with a small amount of salt or bouillon powder added. For a recipe that serves 8, aim for less than 1 teaspoon of salt or less than 3 teaspoons bouillon powder. Low sodium store-bought soups. If using canned or dried soup mixes, add more water or milk than is called for.
Dried noodles with seasoning mix (for example: Mr Noodles, Cup of Noodles, Ramen Noodles)	Noodles made without using seasoning mix. For one serving, use ½ teaspoon or less bouillon powder.
Frozen meats such as batter coated and seasoned chicken pieces or chicken wings	Homemade *Shake and Bake* style chicken Tender baked chicken wings (see recipe in Guidebook)

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Choose less often	Choose more often
Canned or dried gravy	Homemade gravy (see recipe in Guidebook) Low sodium store bought gravy
Store-bought pizza	Homemade pizza using ground meat instead of pepperoni and not too much cheese.
Some instant mixes for mashed potatoes and stuffing	Compare packages and choose one with less sodium. Homemade mashed potatoes or stuffing mix (see recipes)
Canned vegetables and vegetables in sauces	Plain frozen vegetables For canned foods, drain away the liquid, then rinse and drain again. This removes some sodium.
Soya sauce as a dip or other dips	See other recipes for lower sodium dips in Guidebook. Dilute soya sauce with water.

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Trouble Digesting Milk and Milk Products

(Lactose Intolerance)

Milk contains a kind of sugar called lactose. Some people don't digest this sugar well.

People who don't digest lactose can feel gassy and have diarrhea after having milk or foods made with milk.

Some people can have a small amount of milk and foods made with milk and still feel good. Others have to avoid milk and foods made with milk.

Milk and foods made with milk contain the bone building nutrients, calcium and vitamin D, so it's important to know how to get the nutrition in milk without making people feel gassy and bloated.

Reminder!

A milk allergy is not the same as lactose intolerance.

People who have a milk allergy should not have milk or foods containing milk. They can have symptoms such as a rash or trouble breathing after having milk or foods with milk.

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Tips for cooking for people who CAN HAVE SOME milk and foods made with milk

- Have small amounts of milk or foods with milk at one time. A small amount would be ½ cup or less of milk, pudding, ice cream or soup made with milk.
- Try yogurt and cheese. Many people can tolerate yogurt better than milk. And hard cheese is low in lactose.
- Have milk containing foods with meals instead of on its own.

Tips for cooking for people who CANNOT have milk and foods made with milk

1. Read the ingredient list.

If any of the following ingredients are there, it means the product contains some lactose. If the word is close to the beginning of the list, it means the product will contain more lactose than if it is closer to the end.

- Milk
- Milk solids
- Whey
- Curds
- Cheese flavour
- Malted milk
- Non-fat milk solids
- Non-fat milk powder
- Buttermilk
- Cream
- Sour cream

For example, here is the ingredient list for Campbell's Cream of Mushroom Soup:

Since dehydrated cream is close to the end of the list, it means the product does not contain very much lactose.

INGREDIENTS: WATER, MUSHROOMS, VEGETABLE OIL (CORN, COTTONSEED, CANOLA, AND/OR SOYBEAN), MODIFIED FOOD STARCH, WHEAT FLOUR, CONTAINS LESS THAN 2% OF: SALT, MONOSODIUM GLUTAMATE, SOY PROTEIN CONCENTRATE, DEHYDRATED CREAM (CREAM [MILK] , SOY LECITHIN), YEAST EXTRACT, FLAVORING, DEHYDRATED GARLIC.

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2. Know which foods are safe and which ones to avoid

Safe foods	Foods to avoid
Lactose-free milks (Lactaid®, Lacteeze®) Fortified plant beverages such as: • Soy beverage • Almond beverage • Rice beverage • Coconut milk (does not contain the same nutrients as milk, should only be used occasionally)	Milk, all kinds (fluid, evaporated, sweetened condensed, boxed, powdered)
Soy yogurt	Yogurt
Sherbet (check the ingredient list)	Ice cream made with milk or cream
Coco Whip! (ask the store manager to order it so you can try it)	Whipped toppings like whipped cream, Cool Whip, Dream Whip
Hard cheeses (cheddar, mozzarella, Swiss, Parmesan)	Processed cheese, cottage cheese, cheese spreads
Homemade Ranch dressing using a plant beverage of buttermilk.	Ranch style dressing

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Safe foods	Foods to avoid
Recipes made using lactose free milk or soy, almond or rice beverage instead of regular milk See https://silk.com/recipes for recipes with soy and almond beverages	Recipes made with milk or other foods in this column. These include muffins, pancakes, pudding, smoothies, quiche, lasagna, soup made with milk
Canned cream soups (these may have a very small amount of milk or cream in them, but if made using water or a plant beverage should be well tolerated)	Soups made with milk or cream

3. Serve foods that have some of the nutrients in milk, but no lactose

- Canned fish with bones such as salmon, sardines and mackerel and herring
- Fish such as char, cod, halibut, lake trout and turbot
- Fish head soup
- Bird eggs
- Fish eggs
- Liver
- Maktaaq
- Wild greens, shoots, roots and seaweed
- Tofu
- Broccoli
- Hard cheese

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Texture Modification

Soft Foods for People Who Have Trouble Chewing and Swallowing

On a soft diet, foods should be **soft** and **moist**. If not soft and moist enough, foods may need to be diced, minced or shredded.

Vegetables and Fruit

Foods to choose	Foods to avoid
• Soft cooked, diced or mashed vegetables • Mashed potatoes or other well cooked potatoes dishes • Shredded raw apples or carrots • Canned cream corn • Canned crushed pineapple • Diced or mashed soft cooked, canned or ripe fruit (no skins) • Applesauce or other fruit sauces • Stewed prunes • Fruit cocktail (NO pineapple or grapes) • Vegetable or fruit juice	• Hard, raw vegetables (even if diced) • Whole kernel corn • Fruit or veggies with tough skins or membranes (grapes, whole apple, oranges, grapefruit) • Dried fruit (raisins, cranberries, prunes) • Raspberries or blackberries • Coconut • Fresh pineapple • Canned pineapple tidbits or slice

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Grain Products

Foods to choose	Foods to avoid
• Soft breads or buttered toast • Soft baked items (muffins, biscuits) with a spread • Pancakes, waffles, French toast with applesauce or syrup to soften • Hot cereals • Cold cereals softened in milk or water • Macaroni served in a sauce • Rice or barley in a sauce or casserole • Soft crackers (soda crackers or Ritz) • Soft cereal bars	• Dry, crusty or chewy breads • Pizza crust • Grain products or cereals with chocolate chips, dried fruit, nuts or seeds • Rice with no sauce • Hard granola bars

Milk and Alternatives

Foods to choose	Foods to avoid
• All kinds of milk and smooth milkshakes • Smooth yogurt (plain or vanilla) or yogurts with small soft pieces of fruit (peach or strawberry) • All cheeses, diced, sliced or grated • Cottage cheese • Milk based soups with well-cooked diced vegetables and meat or fish	• Yogurt, custard or puddings with large fruit pieces, dried fruit, nuts, seeds or granola • Crispy, melted cheese topping

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Meat and Alternatives

Foods to choose	Foods to avoid
• Minced meat in dishes such as casseroles, Shepherd's pie, meatloaf, meatballs with a sauce or gravy • Tender, boneless fish that flakes easily • Canned fish with mashed bones • Cooked eggs, including quiche and omelettes made with allowed ingredients • Sandwiches with finely minced fillings such as egg, chicken and tuna • Cheese sandwiches • Smooth nut butters used in cooking • Soft cooked beans, peas or lentils • Soups with tender diced vegetables and meat	• Crispy or dry meat, poultry or fish • Bacon, bacon bits or beef jerky • Weiner or hamburger in a bun • Fried eggs • Plain hard cooked egg • Nuts and seeds, whole or chopped • Deli meats with hard casings (salami, Kielbasa) • Nut butters spread on food

Desserts and Snacks

Foods to choose	Foods to avoid
• Ice cream, sherbet, popsicles • Jell-O • Smooth custard or pudding (e.g. tapioca or rice pudding) • Soft baked desserts (such as moist cakes, pies, made with allowed foods) • Soft, moist easy to break cookies • Cookies dipped in tea or coffee	• Hard candy, licorice, gum • Baked desserts with chocolate chips, dried fruit, nuts or seeds • Chips, popcorn, pretzels or Cheezies • Whole, sliced or cut pickles

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Sticky foods such as cream cheese, cheese spread and honey are allowed if mixed into cooking or thinly spread on allowed foods.

Pureed Diet:

Some clients may require a pureed diet, due to difficulties chewing, swallowing, or per client preference.

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Therapeutic Nutrition Care

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PART TWO: THERAPEUTIC NUTRITION CARE

Helping Nunavummiut Eat Well with the Nunavut Food Guide

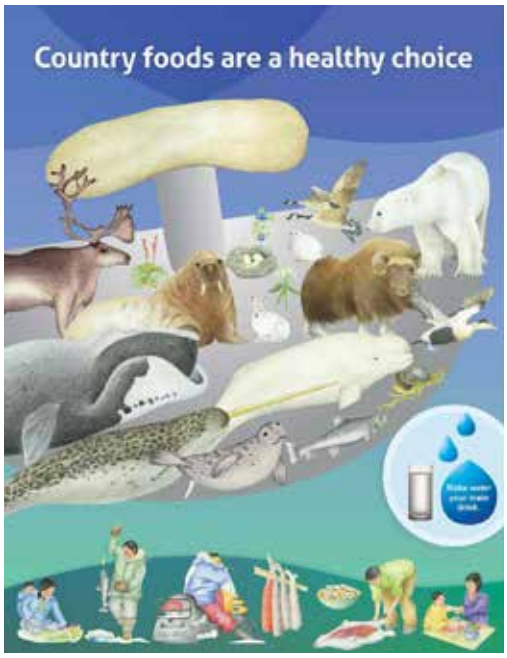
All Country Foods Are Healthy

All country foods are rich in nutrients that we need to be healthy.

Try and provide Nunavummiut with different kinds of country food.

If you can, it's good to provide different parts of the animal, like liver, heart, tongue, blubber, fish eggs and fish heads. These are all very rich in nutrients needed for health.

If your clientele have trouble chewing or swallowing, be sure to help them cut the food up small or cook it until tender and serve with gravy or cooking juices.



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Choose Healthy Store-bought Food

Not all store-bought foods are healthy.

The foods on the ulu show some healthy store-bought foods.

If there are no country food meat and fish around, store-bought is nice for a change.

Processed meats such as bologna, Klik, wieners and bacon should not be served often. They are high in salt and fat.

Try lactose free cow's milk or fortified plant beverages such as soy, almond or rice beverages for those intolerant to milk.

Bannock, oatmeal and pilot biscuits are favourites for many, bread, rice, pasta and cereal are great alternatives.

Add vegetables to soups and stews for added flavour and nutrients.

Fruit makes a great snack or dessert.

Less healthy foods such as pop, chips, and candy bars, should be enjoyed less often.

For Snacks:

Aim for foods from 1–2 food groups at each snack.

Country foods , fruits, crackers, cheese, yogurt are examples of great snack foods

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Hydration

Ensuring adequate hydration for all clients requires a collaborative, person-centered effort from the care team. When cognitively capable, clients decide when they are thirsty and how much they need to drink. Support workers provide fluids in a safe and timely manner. Nursing staff including support workers, assist clients in consuming fluids at meals and snack times, and as needed throughout the day. For clients who have cognitive challenges, additional efforts are required from the care team to encourage fluid intake to meet their individualized fluid needs.

Dehydration:

Dehydration is a serious and potentially life-threatening condition. All staff within the facility should be well trained in recognizing the signs and symptoms and risk factors associated with dehydration.

Clinical Indicators of dehydration:

- Confusion
- Headache
- Dry mucous membranes
- Loss of skin turgor
- Dry mouth (xerostomia)
- Nausea, vomiting
- Rapid weight loss
- Electrolyte abnormalities (hypernatremia, hyperchloremia)
- Increased BUN and serum Creatinine, decreased eGFR
- Tachycardia
- Low blood pressure
- Constipation
- Reduced urine output
- Dark coloured urine

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Risk Factors

Risk	Causation
Poor Oral Intake	Dementia Inability to feed independently Dysphagia Refusing oral intake
Increased Fluid Loss	Febrile illness Diarrhea Vomiting Diuretics Increased urine output (diabetes, hypercalcemia, hypokalemia) Increased perspiration
Other Factors	Female gender Older age Polypharmacy Impaired functional status Impaired cognitive status Inadequate staffing/training

Assessment:

Fluid intake should be monitored and documented by registered staff. A Registered Dietitian may provide a fluid requirement for the client upon assessment. Clients that have trouble meeting their fluid goal may require further nutrition interventions, which will be recommended by the Registered Dietitian.

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Calculating Fluid Requirements in LTC:

The goal of providing adequate hydration is to replace measurable and insensible fluid losses by offering, at minimum 1500-2000 mL fluids per day (6-8 250 mL cups of fluids). Fluids include soups and beverages. Measurable losses include outputs from urine, feces and drain tubes. Insensible losses include perspiration and respiration.

A comprehensive formula to calculate fluid requirements for older people who are at risk of dehydration:

- 100 mL fluid/kg body weight for the first 10 kg
- 50 mL fluid/kg for the next 10 kg
- 15 mL fluid/kg for each kg after 20 kg

Table 2 simplifies the above recommended fluid requirements formula.

Table 2: Recommended fluid requirements

Patient weight (kg)	Fluid requirement (L/day)	Patient weight (kg)	Fluid requirement (L/day)
<30	1.7	70	2.3
35	1.7	75	2.3
40	1.8	80	2.4
45	1.9	85	2.5
50	2	90	2.6
55	2	95	2.6
60	2.1	100	2.7
65	2.2	105	2.8

Alternatively, fluids can be calculated using 25-30 mL/kg/day or 1 mL/kcal consumed. However, this formula is less accurate and may underestimate fluid requirements; especially for clients with a low body weight.

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Strategies to Maintain/Increase Fluid Intake:

1. **Staff training:** all staff should receive training on recognizing the signs/ symptoms of dehydration
2. **Regularly offer fluids:** breakfast, lunch, dinner, AM, PM and HS snacks, with medication pass. Keep fluids available for patients and staff at all nursing stations, especially in the warmer summer months.
3. **Offer client-centered care:** survey clients and determine what kinds of fluids they prefer; engage clients and their family members when designing a menu/purchasing foods. Consider fluid temperature; as people age they often prefer warmer beverages. Offering warm milk and hot water at meals may be preferred to cold.
4. **Encourage fluids at social gatherings:** ensure a variety of fluids are offered at social events.
5. **Offer "wet" foods:** soups should be offered at lunch and supper. Desserts such as jell-o, custard, yogurt, pureed fruit are good options for dessert.

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Implementing Fluid Restrictions

Background:

Q What is a fluid restriction?

Fluid restrictions are medically supervised diets which restrict the amount of fluids a person can consume per day. Fluids from solid food intake are generally not included in the restriction, unless a person is on a full fluid diet.

Q When are fluid restrictions clinically indicated?

The following conditions may require a fluid restriction:

- Hyponatremia secondary to syndrome of inappropriate antidiuretic hormone (SIADH)
- End-stage renal disease (ESRD) with or without dialysis
- Congestive heart failure (CHF)
- Hyponatremia NYD (hyponatremia is defined as serum sodium level less than 136 mmol/L)

Fluid restrictions are individualized for each person and the amount of fluid recommended is dependent on the person's medical history, and weight. Physicians will recommend a fluid restriction and Registered Dietitians will design a fluid pattern that is specific to the person's dietary preferences and nutritional goals. Nurses, health care aides/ support workers and dietary aides are responsible for ensuring the client is given the appropriate amount of fluids, as recommended by the Registered Dietitian.

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Steps to implement:

6. Inform your client/substitute decision maker (SDM) that the doctor has ordered a fluid restriction; explain the purpose of the restriction and the importance to complying with the recommendation.
7. Work with the client/SDM in designing a fluid restriction that suits their preferences and dietary needs.
8. Inform dietary and nursing staff of fluid pattern; provide copies of fluid pattern for the nursing station, kitchen, and nourishment carts. The person/SDM may want a copy as well if the patient leaves the facility for meals.
9. Ensure dietary aides are aware of the volume of the glasses, mugs and bowls in the facility.

Sample fluid restriction pattern: 1500 mL per day

Meal	Fluid	Total
Breakfast	125 mL milk, 125 mL juice, 175 mL tea/coffee	425 mL
AM snack	175 mL tea/coffee	175 mL
Lunch	125 mL milk, 125 mL water, 175 mL tea/coffee	425 mL
PM snack	175 mL tea/coffee	175 mL
Dinner	125 mL milk, 125 mL water	250 mL
HS snack	125 mL milk, 175 mL tea/coffee	300 mL
Miscellaneous fluids	100 mL	100 mL

Clients on fluid restrictions may experience excessive thirst and dry mouth. Try these tips to alleviate these symptoms include:

- Send ice chips to patient on the nourishment cart —include ice chips in "Miscellaneous" fluid allowance
- Suck on sugar-free candy
- Chew gum
- When clinically feasible, recommend a salt shaker on the patient's meal tray

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Wound Care

Background:

Malnutrition is common in the chronically ill, aging population, and is defined as a deficiency of essential nutrients, caused by inadequate intake and/or improper absorption and use of essential nutrients. Malnutrition contributes to tissue breakdown and can delay or impair wound healing.

Protein is especially important in wound healing. Protein Energy Malnutrition (PEM) is the inadequate absorption and distribution of protein, often caused by low intake of dietary protein. PEM causes the body to breakdown existing protein stores, and contributes to poor wound healing. Wound healing also requires adequate intake of calories, fluids and some key nutrients, since nutrient needs are increased by wound healing.

In general, clients with wounds have increased and unique nutrition needs, and should be **referred to a registered dietitian** for assessment. The following pages provide general guidelines for nutrition in wound care.

Use the guide below to determine the nutritional needs for your patient, specific to their wound state.

Table 1. Guidelines for Nutrition in Wound Care

Skin Integrity	Protein	Fluids	Calories
Intact Skin-Preventative Wound Care	0.8-1.0 g/kg/day	30 mL/kg/day	30 kcal/kg/day
Stage I and II Pressure Ulcers	1.2-1.5 g/kg/day	35 mL/kg/day	35 kcal/kg/day Multivitamin + minerals
Stage III Pressure Ulcers/Burns	1.5-2.0 g/kg/day	35-40 mL/kg/day	40 kcal/kg/day Multivitamin + minerals
Stage IV Pressure Ulcers/ Severe Burns	Up to 3.0* g/kg/day	40 mL/kg/day	40+kcal/kg/day Multivitamin + minerals
Multiple/Non Healing Hypoalbuminemia (<27 g/L) Pre Albumin (<0.10 g/L) Venous Ulcers Multiple Non Healing Stage II Ulcers	2.0-3.0* g/kg/day	40+ mL/kg/day	35-40 kcal/kg/day Multivitamin + minerals

*Use clinical judgement when increasing protein intake. Always ensure adequate fluid intake with increasing protein needs. Consider kidney function in patients with renal failure; protein needs may need to be adjusting according to eGFR.

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Table 2. Food sources for key macronutrients involved in wound healing

Key Macronutrients	Sources	Increase	Supplement
Calories Calories are needed to sustain proper nutrition. Caloric needs increase with the severity of the skin impairment.	All food and beverages Exception: water, tea, coffee, low-calorie/diet beverages.	Portion size (if patient has good appetite) High calorie sauces, gravy Cream in coffee, high fat milk in cereals Calorically dense foods: cheese, ice cream, full-fat yogurt.	Nutritional shakes (Ensure, Boost, Glucerna) Homemade smoothies Oral Nutritional Supplements (2Cal HN, Resource 2.0)
Protein Protein is needed for maintenance and repair of tissues. Protein needs increase with the severity of the skin impairment.	Meat, fish, poultry, pulses, dairy products, grains, nuts, seeds.	Portion size (if patient has good appetite) High protein snacks: cheese, nuts and nut butter, meat (non-processed) Country Food	Nutritional shakes (Ensure, Boost, Glucerna) Homemade smoothies with added protein (milk powder, soy powder, whey protein supplements) Oral Nutritional Supplements (2Cal HN, Resource 2.0)
Hydration Hydration is needed to sustain cellular fluid balance, cell and nerve functioning. Fluid needs increase with the severity of the skin impairment.	Water, juice, milk (and non-dairy milk alternatives), jell-o, sherbet, ice cream, yogurt, soup, popsicles, coffee, tea.	Use 250 ml glasses instead of 125 mL Add jell-o as a snack on the nourishment cart Provide clear soup (low sodium) at lunch and supper Ensure water is available at all meals and snacks	If unable to take PO fluids, consider IV fluids or hypodermoclysis

Table 3. Food sources for key vitamins and minerals required for wound healing.

Zinc	Vitamin C	Vitamin A
Meat, fish, seafood, liver, eggs, beans.	Maktaaq, fish eggs, cloudberries, citrus fruits, strawberries, tomatoes, broccoli, cantaloupe, sweet peppers, qunguliit, liver (seal, caribou), seaweed, broccoli, potatoes	Liver, blubber, maktaaq, spinach, carrots, clams, eggs, milk, cheese, fish, red bell peppers.

[1] Wound Care Canada. Nutrition and Wound-Care Management/Prevention; [cited 2018 July 11]. Available from: https://www.woundscanada.ca/docman/public/wound-care-canada-magazine/2004-vol-2-no-2/251-wcc-2004-vol2n2-nutrition-and-wound-care-management-prevention/file

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Enteral Feeding

Q What is enteral feeding?

Enteral feeding is used when clients cannot feed orally, due to impaired swallowing ability (dysphagia), impaired cognitive status or if they cannot meet their nutrition requirements through oral feeding alone. Enteral feeding requires a tube that is surgically inserted into the client's stomach (gastrostomy tube) or small intestine (jejunostomy tube). Some clients may have a temporary tube that is inserted through their nasal cavity and placed into either their stomach (nasogastric tube) or their small intestine (nasojejunal tube). However, most clients in LTC requiring enteral feeding would have a gastrostomy tube, or a jejunostomy tube. The initiation of an enteral feed should follow a discussion with the client their family and/or substitute decision maker (if applicable), most responsible physician, and nursing and allied health staff. Client's wishes and their advanced care planning should be taken into consideration.

Nutrition considerations for enteral feeding:

1. **Enteral feed formula:** many different enteral feed formulas exist, and the Registered Dietitian will select the most appropriate formula for the client based on their nutrition assessment, medical history, and client/family preference.
2. **Enteral feed modality:** Enteral feeds can be administered continually, intermittently or as large volume bolus feeds. The type of modality selected can be dependent on the volume of feed that the client can tolerate at a given time, their intestinal motility, and their estimated nutritional needs. Other considerations include nursing staff time and availability, and client/family preferences.
3. **Enteral feed rate:** the rate of feed delivered to the client is determined by the enteral feed modality, the client's nutrition requirements, client/family preference, and client's medical history. Often clinicians are inclined to start clients on a slow feed rate, and gradually increase it as tolerated until the desired feeding outcome is achieved.
4. **Fluids:** most enteral feed formulas are calorically dense, and do not provide sufficient amounts of free water to meet client's fluid needs. Thus, water flushes throughout the day are often required. The Registered Dietitian will calculate the volume and frequency of water flushes needed to meet the client's estimated fluid needs. Some enteral feeding pumps automatically deliver water flushes while others do not, and nurses will need to administer water flushes manually using a syringe.

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Monitoring and Assessment:

1. Client's anthropometric measurements, pertinent lab values, and signs and symptoms of intolerance should be monitored on every shift by interdisciplinary care team members.
2. Signs of intolerance include frequent vomiting, regurgitation, and in some cases aspiration of solids into the lungs. Enteral feed orders can be adjusted to provide optimal and safe care for the client.

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Nutritional Management in Palliative Care

Definition:

Palliative care is the total care of patients whose conditions do not respond to curative treatment (WHO, 2002). The goal of palliative care is to emphasize quality of life, accept that dying is a natural process and to provide relief from pain or other distressing symptoms (WHO, 2002).

Palliative care includes physical care, spiritual care, and symptom management. Palliative care involves a multidisciplinary care team, with the patient and their families guiding the decision-making.

Nutritional Support:

The emphasis should be on quality of life rather than medical nutrition therapy. Nutritional support in palliative care is a balance between mitigating risk and delivering food that provides an enjoyable experience for the patient. Food is a source of comfort, is symbolic of culture and traditions, and can provide physical relief from symptoms. Often patients undergoing palliative care experience a loss of appetite, weight loss and an altered sense of taste and smell due to disease progression. It is important to consider the patient's preferences, culture, and diet history when delivering food service. Often patients require a combination of oral feeding, nutritional supplements, and in some circumstances hypodermoclysis to maintain adequate nutrition and hydration.

Oral Feeding:

- Individual preferences
- Culturally appropriate foods
- Comfort foods
- Flexible meal times
- Family involvement
- Texture-modification if required
- Staff participation in feeding assistance

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Oral Supplementation:

- Increases energy and protein intake
- Frequent bolus of high calorie formula reduces the overall volume for patients experiencing a loss of appetite, or an inability to consume solids
- A small amount (120 mL) of 2 kcal/mL formula (such as Resource 2.0- Nestle Health Sciences) spread throughout the day (6x daily) can meet patient's basic energy and protein needs

Hypodermoclysis:

- Hydration delivered subcutaneously for patients who cannot safely swallow liquids, or cannot meet their basic hydration needs through oral intake alone
- Subcutaneous sites last 7 days
- This is not a long term solution but often can provide time for the patient and their families to make decisions about end of life care
- Typically 2/3 glucose (5%) , 1/3 saline is used to maintain fluid needs but normal saline can also be used for rehydration
- The feasibility of hypodermoclysis in palliative care should be discussed with the multidisciplinary health care team, the patient, and their families/ substitute decision maker if applicable
- Hydration should be monitored through: urine output, blood pressure, and mental status
- Subcutaneous sites should be monitored for infection

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Oral Nutritional Supplements

Q What are oral nutritional supplements?

Oral nutritional supplements (ONS) are hypercaloric formulas used to supplement poor food intake, or to provide additional calories and protein when clinically indicated. Older adults living in long term care are specifically vulnerable to weight loss due to physical, psychological, sociocultural factors that interfere with the ability to consume an adequate diet.

Q Why are they prescribed?

ONS can provide supplemental calories and protein and are used when clinically indicated. Common situations when ONS are prescribed include: palliative care, wound healing, malabsorption disorders, malignancy, bowel disorders, dysphagia, chronic obstructive airway disease, and dementia (1). ONS are also prescribed when food intake is low (due to multifactorial reasons), or when unfavourable weight loss has occurred.

Q What is a med pass program?

A med pass programs combines ONS and medications. Instead of providing water to take with medications, 60-120 mL of hypercaloric supplement can be provided to the patient. For example, a 60 mL 2 kcal/mL supplement four times daily can provide an additional 480 kcal and 22 g protein. Small doses of hypercaloric formula can improve nutritional status without compromising appetite and satiety. Alternatively, larger doses of hypercaloric formula can be provided in a single dose instead of a meal or snack, if patient's intake is low or is not tolerating solid foods.

Q What other supplements are used?

1. Protein

Protein (powder or liquid preparations) are available and are to be used as clinically indicated. Protein powders are most commonly used for clients at risk of or who have skin breakdown, low serum albumin or cannot attain protein needs via oral intake.

2. Fibre

Fibre supplements can come in many forms including: ground flax, prunes and prune juice, and a high fibre fruit spread ("Fruit Rite"). Fibre supplements are most commonly used for constipation, however ground flax (and other foods high in soluble fibre) are also effective to treat diarrhea.

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Q When should a referral be sent to initiate or discontinue a supplement?

Referrals should be sent to the Dietitian to initiate a supplement if:

1. Weight loss has occurred and is evident by monthly weight monitoring
2. Intake at meals and snacks has decreased
3. In the presence of pressure ulcers
4. If requested by client or family/SDM

Referrals should be sent to discontinue a supplement if:

1. Patient's appetite has returned to normal
2. Weight gain exceeds goal weight range
3. Pressure ulcers have healed with no risk for re-opening
4. If requested by client or family/SDM

Q What about "food first?"

ONS can be an effective nutritional intervention for definite period however, it is always important to try and promote caloric intake through food, independently or in conjunction with ONS. High calorie snacks are effective to promote weight gain and wound healing. Examples include: high protein pudding (pudding mixed with protein powder), cheese and crackers, peanut butter, ice cream, full fat cream sauces, gravies, house milkshakes, greek yogurt and high calorie baked goods.

References:

1. Johnson S, Nasser R, Banow T, Cockburn T, Voegeli L, Wilson E, Coleman J. Use of Oral Nutrition Supplements in Long-term Care Facilities. Can J Diet Prac Res. 2009; 70: 194-198.

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Dining

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PART THREE: DINING

Meal and Snack Times

Providing optimal nutrition care extends beyond simply serving safe and nutritious food. Food service management also includes considering the timing and frequency of meals, and the ambiance of the dining room.

The following are helpful tips to provide an acceptable dining experience for the client:

- Meals should be offered at reasonable times and should allow for an appropriate amount of time for clients to consume and enjoy their meal
- Typically, three meals are served per day, with 2-3 snacks offered in between meals. Water should always be available, and coffee/tea should be offered with each snack
- Snacks should be nutrient-dense and culturally relevant
- Some clients may require more flexible meal times and so easy to prepare meals such as sandwiches should be available to cater to the client's needs
- Provide a relaxed work environment including culturally-appropriate music, artwork, and an adequate space to relax and enjoy the meal
- Ensuring dining space is clean
- Provide assistive devices as needed
- Provide dining supervision and meal assistance as needed. Clients that require feeding assistance would do so with their designated support worker
- Provide any required clothing guards, cloth napkins or aprons as required
- Encourage dining in the dining room rather than in the client's room. Clients that would prefer to dine in their room should have their preference outlined in their plan of care
- Keep food at appropriate and safe temperatures as per HACCP guidelines

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Assistive Devices in Long Term Care

The ability to feed independently often declines with age. Often in LTC clients are provided specialized devices to facilitate independent feeding; which improves the dining experience and promotes dignified care.

The following devices are commonly used in LTC:

Built up Utensils

The thicker base of these utensils allows for improved grip and control. They are especially useful for those with compromised strength or muscle weakness.

Curved Spoons

Curved spoons, like built up utensils allow for improved control especially for those with compromised wrist and shoulder range of motion.

Lipped Plate

Lipped plates have a ridge which helps the diner to scoop up food. Those with hemiparesis and eat with only one hand may benefit from a lipped plate.

Nosey Cup

Nosey cups, as the name implies, has a groove which sits along the ridge of the nose as the person drinks. Nosey cups allow for improved swallowing without neck extension (which can increase the risk of aspiration). Those with dysphagia, compromised neck range of motion or postural issues (i.e. kyphosis) may benefit.

Sippy Cup

Sippy cups allow for improved control of liquid flow and are especially useful for those with compromised swallowing function or overall muscle weakness. The handles provide two-handed control when drinking.

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Appendix 1

Sample 3-Week Menu, Week 1

Week 1	Sunday	Monday	Tuesday
Breakfast	Cran/Grape Juice Hot cereal* Whole grain ** Scrambled egg Sausages (optional)	Orange Juice Hot cereal* Whole grain** Fried egg	Apple Juice Hot cereal* Whole grain** Boiled egg Fried ham (optional)
AM Snack	Water Fruit	Water Fruit	Water Fruit
Lunch	Water Cream of Broccoli Soup Ham and Cheese Sandwich	Water Corn Chowder Warm Pizza Sub Cookie	Water One Pot Chicken Stew Bun/roll (HM or SB)
PM Snack	Water Canned Seafood	Water Local fish	Water HM Muffin
Supper	Water Caribou or Beef Stew or any CF Meal Bannock Applesauce Carrot Cake	Water Beef Stroganoff w/ Noodles Peas Green Salad	Water HM Meatballs with choice of sauce (double recipe) Power Pasta Salad w/Cheese
To Do:	o Put chicken pieces and gr meat (double recipe) in fridge to thaw for Tues	o Put whole chicken and gr meat in fridge for Wed.	o Put gr meat in fridge to thaw for Thurs.

HM = Homemade SB = Store-bought CF = Country food LO = Left over

*Hot cereal like oatmeal, Red River cereal, HM Apple cinnamon oatmeal, cream of wheat

**Whole grain item like whole wheat toast, English muffin, bread, bagel, raisin toast or rye bread, buns/rolls (SB or HM)

Beverages: Water, tea and coffee to be available at all meals and snacks, and throughout the day

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	Wednesday	Thursday	Friday	Saturday
	Cran/Grape Juice Cold cereal Whole grain** Peanut butter Cheese cubes	Orange juice Hot cereal* Whole grain** Scrambled egg Bacon (optional)	Apple Juice Hot cereal* Whole grain ** Fried egg	Orange juice Cold cereal Pancakes with berry sauce (HM)
	Water Fruit	Water Fruit	Water Local Fish	Water Yogurt
	Water Hamburger Soup Bannock Peach Blueberry Cobbler with Cloud Topping	Water Baked beans (SB) Wieners Tropical coleslaw (HM)	Water Country Food Meal with Vegetables Bannock Vanilla pudding	Water Cream of Carrot Soup Devilled Eggs Whole grain **
	Water Canned seafood or LO baked goods	Water Creamy HM YOP	Water Fruit	Water Soft Oatmeal Raisin Cookie
	Roast Chicken with Stuffing and Gravy Creamy Mashed Carrots or Turnip	Water Beef, Corn, Potato Casserole Bun/roll Cheese	Water Stir Fry Rice Yogurt	Water Saucy Ribs Mashed potatoes Green beans Creamy Fruit Jello
	o Put CF and other meat in fridge to thaw for Friday	o Put ribs in fridge to thaw for Sat supper	o Cook eggs for Sat lunch o Put gr meat in fridge for Sun supper	o Make Berry Trifle o Put chicken in fridge to thaw for Mon supper

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Appendix 1

Sample 3-Week Menu, Week 2

Week 2	Sunday	Monday	Tuesday	
Breakfast	Cran/Grape Juice Hot cereal* Whole grain ** Scrambled egg Sausages (optional)	Orange Juice Hot cereal* Whole grain ** Fried egg	Apple Juice Hot cereal* LO Muffins Boiled egg Bacon (optional)	
AM Snack	Water Fruit	Water Creamy HM YOP	Water Fruit	
Lunch	Water Cheesy Broccoli Omelette Pickled beets Buns/rolls	Water Creamy Potato Chowder Roast Beef Deli Meat Sandwich	Water Split Pea Soup Grilled Cheese Sandwich	
PM Snack	Water Imitation crab Crackers	Water Homemade Muffins	Water Shrimp Ring or Local Fish	
Supper	Water Caribou Meatloaf with Gravy Mashed Potatoes Peas Berry Trifle	Water Chicken Alfredo with Green Beans Stewed Prunes with Yogurt	Water Spaghetti with Meat Sauce or Meatballs Canned peaches	
To Do:	o Put shrimp ring or fish, and gr meat in fridge to thaw for Tues	o Put pork roast and gr beef in fridge to thaw for Wed	o Put chicken wings in fridge to thaw for Thurs	

HM = Homemade SB = Store-bought CF = Country food LO = Left over

*Hot cereal like oatmeal, Red River cereal, HM Apple cinnamon oatmeal, cream of wheat

**Whole grain item like whole wheat toast, English muffin, bread, bagel, raisin toast or rye bread, buns/rolls (SB or HM)

Return to TOC

Wednesday	Thursday	Friday	Saturday
Cran/Grape Juice Cold cereal Whole grain** Peanut butter or Cheese cubes	Orange juice Hot cereal* Whole grain** Scrambled egg Fried ham (optional)	Apple Juice Hot cereal* Whole grain ** Fried egg	Cold cereal French toast with sliced banana or berry sauce (HM)
Water Fruit	Water Cheese and crackers	Water Yogurt	Water Fruit
Water Tender Pork Roast with Vegetables Applesauce Pudding	Water Saucy Chicken Wings Creamy Pasta Salad	Water Baked Fish w/Mayo Topping Jamey's Fried Rice Mixed Vegetables	Water Homemade Pizza Green Salad with Shredded Carrot
Water Fruit	Water Yogurt	Water Apple cinnamon cookie (Homemade)	Water Chocolate banana bread
Water Hashbrown Casserole	Water Ham and Pierogi Bake Canned Pears	Water Chicken N' Dumplings w/ Broccoli Canned Peaches	Water Easy Shepherd's Pie
o Put fish and chicken pieces in fridge to thaw for Fri	o Put gr meats in fridge to thaw for Sat lunch and supper	o Put fish for Sunday's chowder in fridge to thaw o Put CF or pot roast in fridge to thaw	o Put chicken pieces in fridge to thaw for Mon supper

Beverages: Water, tea and coffee to be available at all meals and snacks, and throughout the day

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Appendix 1

Sample 3-Week Menu, Week 3

Week 3	Sunday	Monday	Tuesday	
Breakfast	Cran/Grape Juice Hot cereal* Whole grain ** Scrambled egg Sausages (optional)	Orange Juice Hot cereal* Whole grain ** Fried egg	Apple Juice Hot cereal* Whole grain ** Boiled egg Fried ham (optional)	
AM Snack	Water Fruit	Water Fruit	Water Fruit	
Lunch	Water Fish or Clam Chowder Bannock or Whole grain **	Water Carrot Slaw Ham Deli Meat Sandwich	Water Beef and Barley Soup Cheese toast	
PM Snack	Social tea cookies or graham crackers	Water Canned Seafood Seaweed snacks	Water YOP	
Supper	Water Country Food Meal or Beef Pot Roast with Vegetables Bannock	Water Easy Chicken Pot Pie Pudding	Water Boiled Ham Scalloped Potatoes Glazed Carrots	
To Do:	o Put gr meat in fridge to thaw for Tues lunch	o Put pork in fridge to thaw for Wed supper	o Put chicken thighs in fridge to thaw for Thurs supper.	

HM = Homemade SB = Store-bought CF = Country food LO = Left over

*Hot cereal like oatmeal, Red River cereal, HM Apple cinnamon oatmeal, cream of wheat

**Whole grain item like whole wheat toast, English muffin, bread, bagel, raisin toast or rye bread, buns/rolls (SB or HM)

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	Wednesday	Thursday	Friday	Saturday
	Cran/Grape Juice Cold cereal Whole grain** Peanut butter, cheese cubes	Orange juice Hot cereal* Whole grain ** Scrambled egg Bacon (optional)	Apple Juice Hot cereal* Whole grain ** Fried egg	Cold cereal or Pancakes with berry sauce (HM)
	Water Applesauce	Water Fruit	Water Yogurt	Water Cheese and crackers
	Water Hearty Mushroom Soup Potato Salad	Water LO Pork Stew with Apples Roll/bun	Water Sweet and Sour Pineapple Meatballs Green salad with Pickled Beets Apricot Almond Bars	Water Cream of Broccoli Soup Tuna or Salmon Sandwiches
	Water Local fish	Water Yogurt	Water Cheese and crackers	Water Fruit
	Water Pork Stew with Apples Roll/Bun Blueberry Cake	Water Roasted Chicken Thighs Stuffing with Vegetables Ice cream with canned pears	Water Fish burgers Whole grain** Tropical Coleslaw	Water Creamy Chicken Noodles Ambrosia Salad
	○ Put gr beef in fridge to thaw for Friday lunch		○ Put CF or beef stew meat in fridge to thaw for Sun supper	○ Put gr beef in fridge to thaw for Mon supper

Beverages: Water, tea and coffee to be available at all meals and snacks, and throughout the day

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Appendix 2

Food Order Sheet, Weeks 1–3

Food Ordering Guide – MENU WEEK 1

Perishables	How often on menu	Purchase?
Breads		
Bread (variety of white, whole wheat, rye, raisin, bagel, English muffin)	6 breakfasts, 1 lunch	
Submarine sandwich or hot dog buns (whole wheat, if possible)	1 lunch	
Bun or roll	1 lunch, 1 supper	

Deli section		
Eggs	6 breakfasts + 1 lunch main + 7 eggs for desserts, pancakes, muffins, desserts and meatballs	
Sausages	1 breakfast	
Ham	1 breakfast	
Bacon	1 breakfast	
Deli meat roast beef	1 lunch	
Deli meat ham	1 lunch	
Wieners	1 lunch	

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Perishables	How often on menu	Purchase?
Refrigerated case		
Cheese, any kind	1 cup shredded, 1 cup mozzarella, 1 breakfast, 1 lunch	
Cream cheese	1 block (for pizza sub and carrot cake frosting)	
Sour cream	¾ cup	
Vanilla yogurt (Greek style if possible)	1 cup	
Yogurt	1 snack, 1 dessert + 2 tubs (any flavour)	
Milk	7 breakfasts + 9 cups for recipes	
Margarine	For recipes and breakfast	

Frozen foods		
Frozen concentrated 100% fruit juice (a variety)	7 breakfasts and HM YOP	
Frozen berries	5 ½ cups	
Frozen peas	4 cups	
Frozen mixed veggies	750 gram bag (for stir fry)	
Frozen green beans	4 cups	
Frozen broccoli	500 gram bag	

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Perishables	How often on menu	Purchase?
Fresh fruits and veggies		
Fresh fruit	6 snacks	
Potatoes	12 pounds (about 40 medium potatoes)	
Onions	8	
Carrots	14	
Celery	2 stalks	
Cole slaw mix	454 gram bag	
Green onions	4	
Tomato	1	
Lettuce	1 supper	

Meats		
Ground beef	7 pounds	
Whole chicken	1 whole plus 2 legs	
Chicken pieces	8	
Caribou or muskox stew meat (or beef or pork if CF not available)	1 kg Sunday supper	
Caribou, musk ox, other lean meat for stir fry	1 kg	
Country food	1 kg Friday lunch	
Ribs pork or caribou	2.5 kg	

Non perishables	How often on menu	Purchase?
Hot cereal	5 breakfasts	
Cold cereal	2 breakfasts	
Peanut butter	1 breakfast	

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Non perishables	How often on menu	Purchase?
Canned goods		
Pizza or pasta sauce	½ cup	
Cream style corn	2 cans	
Canned tomatoes	1 can (796 ml)	
Tomato soup	1 can	
Canned mushrooms	3 cans (284 ml)	
Evaporated milk	4 cans	
Baked beans	1 lunch (3 cans)	
Crushed pineapple	1 can	

Basic Seasonings and Baking Products		
Flour	2.5 kg (for bannock, muffins, cobbler, carrot cake, pancakes and cookies)	
Sugar	3.5 cups (around 730g) for desserts, muffins, berry sauce, tea and coffee	
Brown sugar	1.5 cups (around 350g)	
Skim milk powder	2 cups	
Coffee whitener	122 grams (56 teaspoons or 4.7 cups)	
Baking powder	16 T	
Baking soda	1 T	
Cinnamon and nutmeg	3 tsp	
Nutmeg	½ tsp	
Vanilla extract	4 tsp	
Chicken bouillon	6 tsp	
Dried herbs	1 T	
Garlic powder	1 T	

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Non perishables	How often on menu	Purchase?
Basic Seasonings and Baking Products		
Cornstarch	2 T	
Onion soup mix, dry	1 packet	
Soya sauce	¼ cup	
Vinegar	½ cup	
Ketchup	½ cup	
Pickle relish	¼ cup	

Fats		
Oil for bannock, baking, etc	540ml	
Lard for bannock	?	
Mayonnaise	1 cup, plus more for sandwiches	

Grains		
Barley	¼ cup	
Crackers	1 snack	
Bread crumbs	2 cups	
Noodles	750 grams or 4 cups	
Stuffing mix	1 supper (2 packages?)	
Rice	1 supper (8 cups or 400 g?)	

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Non perishables	How often on menu	Purchase?
Canned/jarred goods		
Tuna or salmon	4 cans 213 grams or 2 cans 418 grams, + 1 can 213 gram	
Kidney beans	1 can	
Canned sardines or other fish	1 snack (3 cans?)	
Cranberry sauce	2 cans	
Cream of mushroom soup	1 can	
Applesauce, unsweetened	1 cup	

Other dry goods		
Raisins	½ cup	
Dates	2 cups, pitted	
Dream Whip dessert topping	3 pouches	
Vanilla pudding, dry mix	2 pouches	
Jello	2 boxes	
Coffee	1.12 kg	
Tea	112 bags	

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Food Ordering Guide – MENU WEEK 2 or 3

(circle correct week)

Perishables, Week 2 or 3	How often on menu or how much to buy	Purchase?
Breads		
Deli section		
Refrigerated case		

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Perishables, Week 2 or 3	How often on menu or how much to buy	Purchase?
Frozen foods		
Fresh fruits and veggies		
Meats		

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Appendix 3

Staff Notes on Menus and Recipes, Week 1

Week 1	Sunday	Monday	Tuesday	
Breakfast	Cran/Grape Juice Hot cereal* Whole grain ** Scrambled egg Sausages (optional)	Orange Juice Hot cereal* Whole grain** Fried egg	Apple Juice Hot cereal* Whole grain** Boiled egg Fried ham (optional)	
Cook's Notes about Breakfast				
AM Snack	Water Fruit	Water Fruit	Water Fruit	
Lunch	Water Cream of Broccoli Soup Ham and Cheese Sandwich	Water Corn Chowder Warm Pizza Sub Cookie	Water One Pot Chicken Stew Bun/roll (HM or SB)	
Cook's Notes about Lunch and AM Snack				
PM Snack	Water Canned Seafood	Water Local fish	Water HM Muffin	
Supper	Water Caribou or Beef Stew or any CF Meal Bannock Applesauce Carrot Cake	Water Beef Stroganoff w/ Noodles Peas Green Salad	Water HM Meatballs with choice of sauce (double recipe) Power Pasta Salad w/Cheese	
Cook's Notes about PM Snack and Supper				

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	Wednesday	Thursday	Friday	Saturday
	Cran/Grape Juice Cold cereal Whole grain** Peanut butter Cheese cubes	Orange juice Hot cereal* Whole grain** Scrambled egg Bacon (optional)	Apple Juice Hot cereal* Whole grain ** Fried egg	Orange juice Cold cereal Pancakes with berry sauce (HM)
	Water Fruit	Water Fruit	Water Local Fish	Water Yogurt
	Water Hamburger Soup Bannock Peach Blueberry Cobbler with Cloud Topping	Water Baked beans (SB) Wieners Tropical coleslaw (HM)	Water Country Food Meal with Vegetables Bannock Vanilla pudding	Water Cream of Carrot Soup Devilled Eggs Whole grain **
	Water Canned seafood or LO baked goods	Water Creamy HM YOP	Water Fruit	Water Soft Oatmeal Raisin Cookie
	Roast Chicken with Stuffing and Gravy Creamy Mashed Carrots or Turnip	Water Beef, Corn, Potato Casserole Bun/roll Cheese	Water Stir Fry Rice Yogurt	Water Saucy Ribs Mashed potatoes Green beans Creamy Fruit Jello

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Appendix 3

Staff Notes on Menus and Recipes, Week 2

Week 2	Sunday	Monday	Tuesday	
Breakfast	Cran/Grape Juice Hot cereal* Whole grain ** Scrambled egg Sausages (optional)	Orange Juice Hot cereal* Whole grain ** Fried egg	Apple Juice Hot cereal* LO Muffins Boiled egg Bacon (optional)	
Cook's Notes about Breakfast				
AM Snack	Water Fruit	Water Creamy HM YOP	Water Fruit	
Lunch	Water Cheesy Broccoli Omelette Pickled beets Buns/rolls	Water Creamy Potato Chowder Roast Beef Deli Meat Sandwich	Water Split Pea Soup Grilled Cheese Sandwich	
Cook's Notes about Lunch and AM Snack				
PM Snack	Water Imitation crab Crackers	Water Homemade Muffins	Water Shrimp Ring or Local Fish	
Supper	Water Caribou Meatloaf with Gravy Mashed Potatoes Peas Berry Trifle	Water Chicken Alfredo with Green Beans Stewed Prunes with Yogurt	Water Spaghetti with Meat Sauce or Meatballs Canned peaches	
Cook's Notes about PM Snack and Supper				

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	Wednesday	Thursday	Friday	Saturday
	Cran/Grape Juice Cold cereal Whole grain** Peanut butter or Cheese cubes	Orange juice Hot cereal* Whole grain** Scrambled egg Fried ham (optional)	Apple Juice Hot cereal* Whole grain ** Fried egg	Cold cereal French toast with sliced banana or berry sauce (HM)
	Water Fruit	Water Cheese and crackers	Water Yogurt	Water Fruit
	Water Tender Pork Roast with Vegetables Applesauce Pudding	Water Saucy Chicken Wings Creamy Pasta Salad	Water Baked Fish w/Mayo Topping Jamey's Fried Rice Mixed Vegetables	Water Homemade Pizza Green Salad with Shredded Carrot
	Water Fruit	Water Yogurt	Water Apple cinnamon cookie (Homemade)	Water Chocolate banana bread
	Water Hashbrown Casserole	Water Ham and Pierogi Bake Canned Pears	Water Chicken N' Dumplings w/ Broccoli Canned Peaches	Water Easy Shepherd's Pie

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Appendix 3

Staff Notes on Menus and Recipes, Week 3

Week 3	Sunday	Monday	Tuesday	
Breakfast	Cran/Grape Juice Hot cereal* Whole grain ** Scrambled egg Sausages (optional)	Orange Juice Hot cereal* Whole grain** Fried egg	Apple Juice Hot cereal* Whole grain** Boiled egg Fried ham (optional)	
Cook's Notes about Breakfast				
AM Snack	Water Fruit	Water Fruit	Water Fruit	
Lunch	Water Fish or Clam Chowder Bannock or Whole grain**	Water Carrot Slaw Ham Deli Meat Sandwich	Water Beef and Barley Soup Cheese toast	
Cook's Notes about Lunch and AM Snack				
PM Snack	Social tea cookies or graham crackers	Water Canned Seafood Seaweed snacks	Water YOP	
Supper	Water Country Food Meal or Beef Pot Roast with Vegetables Bannock	Water Easy Chicken Pot Pie Pudding	Water Boiled Ham Scalloped Potatoes Glazed Carrots	
Cook's Notes about PM Snack and Supper				

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	Wednesday	Thursday	Friday	Saturday
	Cran/Grape Juice Cold cereal Whole grain** Peanut butter, cheese cubes	Orange juice Hot cereal* Whole grain ** Scrambled egg Bacon (optional)	Apple Juice Hot cereal* Whole grain ** Fried egg	Cold cereal or Pancakes with berry sauce (HM)
	Water Applesauce	Water Fruit	Water Yogurt	Water Cheese and crackers
	Water Hearty Mushroom Soup Potato Salad	Water LO Pork Stew with Apples Roll/bun	Water Sweet and Sour Pineapple Meatballs Green salad with Pickled Beets Apricot Almond Bars	Water Cream of Broccoli Soup Tuna or Salmon Sandwiches
	Water Local fish	Water Yogurt	Water Cheese and crackers	Water Fruit
	Water Pork Stew with Apples Roll/Bun Blueberry Cake	Water Roasted Chicken Thighs Stuffing with Vegetables Ice cream with canned pears	Water Fish burgers Whole grain** Tropical Coleslaw	Water Creamy Chicken Noodles Ambrosia Salad

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Appendix 4

Foods to order by sealift and at the local stores

Foods to order via sealift, if possible All are good for at least 9 months, unopened.	Foods to buy locally Most are subsidized by Nutrition North and are perishable.
Meat and Alternatives	
	Fresh and frozen meat, poultry, fish and seafood (plain, not breaded or battered)
Peanut butter	Nuts
	Eggs and egg substitutes
WOW butter (spread made from soy beans)	Soy products like tofu
	Deli meats such as ham, roast beef and turkey (are not subsidized but must be purchased locally)
Canned tuna, salmon, sardines, clams, oysters, mussels	
Canned beans (baked beans, kidney beans, lentils, etc.)	

Milk and Alternatives	
UHT milk	
Skim milk powder	
Canned evaporated milk	Fresh milk
Parmesan cheese	Hard cheese and processed cheese
	Cottage cheese
	Yogurt and drinkable yogurt
	Cream, cream cheese, sour cream, cheese spread like Cheez Whiz and ice cream have a lower subsidy level

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Foods to order via sealift, if possible All are good for at least 9 months, unopened.	Foods to buy locally Most are subsidized by Nutrition North and are perishable.
Vegetables and Fruit	
	All fresh and frozen fruits and vegetables without sauces
	Instant mashed potatoes
Dried cranberries	
Dates	
Prunes	
Apricots	Raisins
100% fruit juice in containers over 250 ml	
Canned unsweetened juice	Frozen concentrated 100% fruit juice
100% unsweetened fruit juice in containers over 250 ml get a lower subsidy.	
Jarred or canned pasta sauce	
Jarred or canned fruit and vegetables	

Grain Products	
Flour, rice, split peas, barley, dry pasta	
Cold cereal	
Hot cereal (oats, Cream of Wheat, Red River)	Bread and bread products without filling or coating
Stuffing mix	
Macaroni and cheese dry mix (like KD)	
Pancake mix and Bisquick	
Crackers, Pilot biscuits	

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Foods to order via sealift, if possible All are good for at least 9 months, unopened.	Foods to buy locally Most are subsidized by Nutrition North and are perishable.
Other foods	
Canned soups	
Lard	
Vegetable oil	Mayonnaise
Bottled salad dressings	
Muffin and cake mixes	
Ketchup	
Soya sauce	
Hard cookies	
Instant pudding	
Dream Whip	Liquid fresh cream (has a low subsidy)
Salt and pepper, cinnamon, nutmeg, cloves	Dried herbs
Baking powder	
Baking soda	
Vanilla extract	
White sugar and honey	Brown sugar
Tea and coffee	
Coffee whitener	

Other kitchen items	
Food storage containers – 1 cup size	
Food storage containers – 8 cups or 2 litres	
Sticky labels for food containers	
Markers	

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Appendix 5

Calculating the sealift Order for the Week 1 Menu

Sealift items on menu	Weekly amount needed	Unit measure	Yearly amount (unit measure x 17.3)	Notes
Week 1				
Oats	33 cups	1.3kg	22.5kg	
Flour, all purpose	18.5 cups	2.5 kg	43.25kg	
Cold cereal	12 cups	480g	8.3kg	
Social tea cookie	24 cookies	192g	3.2kg	1 cookie =5 g; svg = 3
Noodles, dry	8 cups	750g	13kg	
Barley	¼ cup	50g		
Stuffing mix	2 packages		34 packages	
Rice	8 cups	400g	6.8 kg	
Evaporated milk	2 cans	354ml x2	34 cans	
Milk powder	1 cup	72 g	1.2 kg	
Canned tuna	1 can	213g	17 cans	
Canned sardines, mussels or oysters	106 x3	318g	51 cans	
Cream style canned corn	2 cans	398ml x2	34 cans	
Cream of mushroom soup	1 can	284ml	17 cans	
Canned mushrooms	284 x 2	284ml x2	34 cans	
Cranberry sauce	1 can	348ml	17 cans	
Kidney beans	1 can	540ml	17 cans	
Baked beans	3x 398 ml	3 cans	52 cans	
Canned tomatoes	1 can	796 ml	17 cans	
Canned tomato soup	1 can	284 ml	17 cans	
Canned crushed pineapple	1 can	540ml	17 cans	

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Sealift items on menu	Weekly amount needed	Unit measure	Yearly amount (unit measure x 17.3)	Notes
Canned peaches	4 cups	796ml	17 cans	
Oil	2¼ cups	540ml	9.2 litres	
Lard	1½ cups	312 g	5.4kg	
Mayonnaise	½ cup	120g	2 kg	
Vinegar	½ cup	120ml	2 L	
Raisins	1 cup	153g	2.6 kg	
Dream whip	1 pouch	½ 85g package	9 packages	
Ketchup	½ cup	120ml	2 L	
Soya sauce	8 T	120 ml	2 L	
Onion soup mix	1 packet		17 packets	
Cinnamon	3 tsp	6.9	119g	
White sugar	3 ¼ cups	731	12.6 kg	For recipes, plus 1 tsp/cup of coffee and tea
Brown sugar	2 cups	466	8kg	
Vanilla	3 tsp	15 ml	260ml	
Baking powder	12T	180g	3kg	
Dried herbs	1 T	15g	255g	
Garlic powder	3 tsp	15g	255g	
Chicken bouillon powder	4 tsp	18g	306g	
Cornstarch	2T	30g	510	
Coffee, ground	112 cups	1.120 kg	19 kg	Assume 2 cups/ person/day and 8 consumers. Coffee (ground) 10 g/cup or 2T/6oz cup)
Tea, bags	112 cups	112 bags	1,904 bags	Assume 2 cups/ person/day and 8 consumers
Coffee whitener	224 tsp	112 g	1.9 kg	Assume 1 tsp/cup of coffee and tea

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Appendix 6

Education and Training Attendance Form

Date: DD / MM / YY	
Presenter:	Length of education session:
Location:	
Objectives of education session:	
Name and Position of Staff Member	Comments

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Appendix 7

Emergency Menu

Emergency Plan	Day 1 (still some food in fridge/freezer)	Day 2 (Little food in fridge/ freezer)	Day 3 (no food in fridge/ freezer)
Breakfast	Orange Juice (frozen/jar) Dry cereal or Pancakes made with tetra, canned milk or milk powder	Apple Juice (frozen/jar) Oatmeal with raisins Boiled eggs (optional)	Orange Juice (frozen/jar) Crackers/Toast Peanut butter, cheese spread
Lunch	Water Hamburger Soup Bun/roll/bread	Water Leftover hamburger soup or Better for you Chicken Noodle Soup Crackers	Water Split pea soup (SB) Chicken/turkey salad made into sandwiches or spread on crackers
Supper	Saucy Salmon Noodles	Water Creamy Turkey Pasta	Water Tomato Spaghetti
Snack A	Water Canned Fruit Yogurt (if available)	Water Jello topped with Dream whip made with tetra, canned milk or milk powder	Water Canned fruit Pudding (any flavour) made from powder with tetra, canned milk or milk powder
Snack B	Water Applesauce	Water Canned seafood	Water Social tea or graham cookies
To do:	To be completed	To be completed	To be completed

SB = Store-bought

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Appendix 8

RECIPES

MAIN COURSES

Baked Fish with Mayonnaise Topping

Preparation time:	Cooking time:	Yield:
10 minutes	20 minutes	12 servings

Ingredients:

- 12 thawed fish fillets, local fish or store bought (about 1 whole 5-pound char or 2½ pounds fish fillets)
- ¾ cup mayonnaise
- 1 onion or 4 green onions, very finely chopped
- 12 tablespoons plain breadcrumbs
- 1 teaspoon curry powder or dried dill or dried parsley (optional)
- Pinch of salt and pepper
- 1 cup of shredded cheese

Steps

1. Preheat oven to 350°F. Cut fish into fillets and place on an oiled cookie sheet.
2. Spread a small amount of mayonnaise (about 1 tablespoon) on top of each fillet.
3. Sprinkle onion over each fillet.
4. In a bowl, mix breadcrumbs with seasonings. Spread over fish fillets.
5. Cover with aluminum foil. Bake for 15 minutes.
6. Remove from oven and remove foil.
7. Return to oven for five minutes, or until breadcrumbs are golden brown.

Recipe Source: Adapted from Nordic Fish with Cheese. Web. 20 Nov 2017. http://publicationsnunavik.com/book/nunavik-family-cookbook.

Image. Web. 03 Dec 2017. http://www.geniuskitchen.com/recipe/easy-cheese-baked-fish-88405?photo=cGhvdG8tMTc20DM0

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Beef n' Broccoli Skillet Dinner

Preparation time:	Cooking time:	Yield:
10 minutes	25–30 minutes	12 servings

Ingredients:

- 2 lbs. ground beef or caribou
- 2 cans (398 mL) tomato sauce
- Homemade white sauce (recipe doubled – see sauces section)
- 4 cups broccoli, chopped (fresh or frozen)
- 4 cups minute rice, uncooked
- 4 cups water
- 1 ½ tsp dried herbs like basil, oregano, parsley
- ½ tsp pepper
- 1 ½ cups cheese, grated
- 2 cups water

Steps

1. Brown meat in a large pot. Drain off fat.
2. Add tomato sauce, soup or white sauce, dried herbs and pepper to cooked meat. Mix well.
3. Add water to meat mixture. Bring mixture up to a boil, cover and simmer for 10.
4. Add broccoli and rice. Cover and simmer 5 minutes or until the broccoli and the rice are tender and the water is absorbed.
5. Sprinkle grated cheese on top. Replace lid and let stand for 5 minutes or until cheese melts.

Recipe Source: Adapted from "A Pound of Ground," Winnipeg Hydro Home Economists. Courtesy of Bag Manual 2010 Feeding Stomachs and Souls, by FNIHB, Health Canada, Manitoba Region.

Picture Source: Cheesy Burger, Rice and Broccoli Skillet. Image. Web. 30 Nov 2017. https://www.pillsbury.com/recipes/cheesy-burger-rice-and-broccoli-skillet/a9b1d82c-651b-4395-ae4c-84fb1bf01972.

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Beef Stew

Preparation time:	Cooking time:	Yield:
15 minutes	1 hour	8 servings

Ingredients:

- 3 tbsp. vegetable oil
- 1 large onion, chopped
- 2 lbs lean stew beef, cut into small cubes
- ¼ cup all purpose flour
- 2 ½ cups water
- 2 cloves garlic, minced or ½ teaspoon garlic powder
- 2 cups sliced fresh or canned mushrooms (drained if canned)
- 3 carrots, chopped
- 1 package onion soup mix
- 2 tbsp. tomato paste
- Seasonings: 1 bay leaf (optional), 2 tsp dried parsley, 1 tsp dried thyme, ¼ tsp black pepper

Steps

1. In a large pot, fry the onion in the oil until softened.
2. Sprinkle the beef with the flour. Add to the pot and fry until the beef is browned.
3. Add the rest of the ingredients.
4. Bring up to a boil. Lower the heat and cover with lid.
5. Cook stirring occasionally for 60 minutes or until the beef is tender. Add water during cooking if the stew becomes too dry.

Recipe Source: Adapted from "Slow-Cooked Beef Stew" Simply Great Food Cookbook, by Dietitians of Canada 2007.

Picture Source: Jerk Beef Stew with Carrots. Image. Web. 11 Nov 2017.
http://www.80twentynutrition.com/recipe/jerk-beef-stew/

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Beef Stroganoff

Preparation time:	Cooking time:	Yield:
5 minutes	20–25 minutes	8–10 servings

Ingredients:

- 2 pounds of lean ground beef (fresh or thawed if frozen) or 2 pounds of frozen, store-bought meatballs
- 1 can cream of mushroom soup (284 mL)
- 2 cans of mushroom pieces, drained (2x 284 mL)
- 1 can 2% evaporated milk (370 mL)
- 1 packet onion soup mix (40 g)
- 3 soup cans water
- 2 cups of peas (canned or frozen)
- 1 small box or bag of whole wheat spaghetti or egg noodles (375 g)

Steps

1. Open the cans. Drain the water from the peas and mushrooms.
2. Add water to the pea and mushroom cans and drain again to take away salt.
3. Put the thawed beef or frozen store-bought meatballs in the pot. Add ¼ cup of water and cook on high heat for 5 minutes, breaking the meat into smaller pieces.
4. Add mushroom soup, mushroom pieces, evaporated milk and onion soup mix to the pot. Add 3 empty soup cans filled with water and stir.
5. Bring to a boil, add the noodles. Stir well. Place lid and lower the heat to medium.
6. Stir with a clean stirring spoon every 2–3 minutes. After 10 minutes add the peas. Cook until the noodles are soft (about 10–12 minutes).

Recipe and Image Source: Adapted from "Beef Stroganoff," by the Government of Nunavut. Image. Web. 17 Nov 2017. http://www.livehealthy.gov.nu.ca/en/food/recipes.

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Beef, Corn and Potato Casserole

Preparation time:	Cooking time:	Yield:
20 minutes	50 minutes	8 servings

Ingredients:

- 8 medium potatoes, peeled, washed and cut into chunks
- 2 lbs lean ground beef
- 2 onions, chopped
- 1 cup milk
- 3 tbsp. margarine
- 1 can (12 oz/341 mL) cream corn
- Salt and ¼ teaspoon pepper to taste
- ½ tsp. paprika (optional)

Steps

1. Turn on oven to 350°F (180°C). Put potatoes in a large pot, cover with water and heat to boiling. Lower heat, cover saucepan and boil potatoes until tender, about 20 minutes.
2. While potatoes are cooking, cook and stir beef and onion in a large frypan until beef is browned. Drain off fat. Place meat mixture in a large baking dish, about 10"x12".
3. Drain potatoes. Put potatoes back in saucepan. Use a potato masher and mash with milk and margarine. Add salt and pepper to taste. Set aside.
4. Pour corn on top of meat. Spread potatoes over corn. Sprinkle lightly with paprika.
5. Bake for about 30 minutes or until heated through.

Recipe Source: Adapted from "The Basic Shelf Cookbook," by Canadian Public Health Association 1994. Picture Source: Easy Shepherd's Pie. Image. Web. 6 Nov 2017. http://www.simplyrecipes.com/recipes/easy_shepherds_pie/

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Caribou or Beef Roast

Preparation time:	Cooking time:	Yield:
20 minutes	2–2½ hours	8 servings

Ingredients:

- 2 lb. boneless or 3-3.5 lb. bone-in caribou OR beef roast
- 2 large onions
- 2 cloves garlic, minced or ½ teaspoon garlic powder
- 2 tbsp. brown sugar
- ½ tsp dried herbs like thyme, basil, oregano
- ½ tsp freshly ground black pepper
- 1 cup water
- ½ cup barbecue sauce
- 1 tbsp. mustard
- 4 medium potatoes, washed and diced (Leave skin on off if using new or red potatoes)
- 2 cups thickly sliced carrots

Steps

1. Preheat the oven to 325°F. Trim off silverskin and any visible fat from the roast.
2. Cut 1 onion into rings, set aside. Chop the other onion and place on the bottom of a roasting pan (big enough for the meat and vegetables).
3. Place the meat on top of the onions.
4. In a small bowl, mix the garlic, brown sugar, dried herbs, water, barbecue sauce and mustard. Pour over the meat. Arrange onion rings on top.
5. Cover with aluminum foil and cook for 1 hour. After an hour, place the potatoes and carrots around the roast. Spoon drippings over the roast and the vegetables.
6. Cover with foil and bake another 1-2 hours or until meat is very tender.
   Boneless roasts take less time.

Recipe Source: Adapted from "Slow-Roasted Venison" Cook Cookbook! by Dietitians of Canada 2011.

Picture Source: Venison Slow Cooker Roast. Image. Web. 1 Dec 2017. https://recipes.sparkpeople.com/recipe-detail.asp?recipe=191493

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Cheesy Broccoli Omelette

Preparation time:	Cooking time:	Yield:
10 minutes	35 minutes	8 servings

Ingredients:

- 1 onion, finely chopped
- 2 tsp oil
- 1 large package (750g) frozen broccoli
- 12 eggs
- 1 can evaporated milk (14 oz/ 396 mL)
- 1 ½ cups shredded cheddar cheese
- 1 tsp salt
- ½ tsp ground pepper

Steps

1. Turn the oven on to 350°F.
2. Coat a 9" x 13" baking dish with oil.
3. Add oil to frying pan and cook onion on medium-high heat, stirring frequently.
4. When the onion is soft, add the frozen broccoli and cook for another 2 or 3 minutes, until the broccoli is thawed and there is not much moisture in pan. Turn the stove off.
5. In a large bowl, beat together the eggs, evaporated milk, salt and pepper.
6. Stir the onion, broccoli and cheese into the egg mixture.
7. Pour this mixture into the greased baking dish or dishes.
8. Place the baking dish into the oven and bake for 35 to 40 minutes, until the top of the omelette is turning brown.

Recipe and Image Source: Adapted from Cheesy Baked Omelette with Broccoli. Web. 20 Nov 2017. http://www.livehealthy.gov.nu.ca/en/food/recipes

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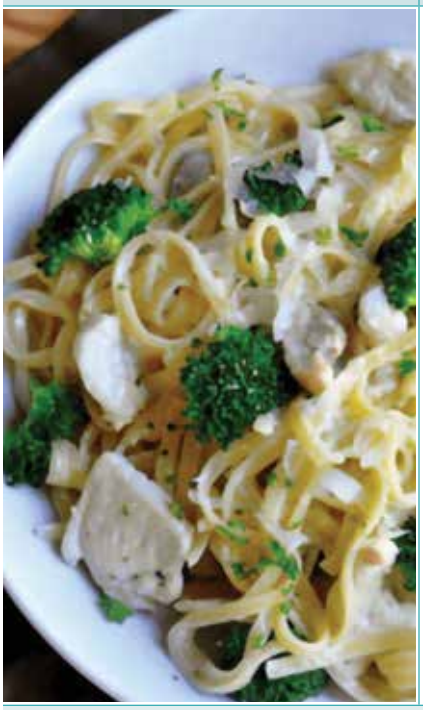
Chicken Alfredo

Preparation time:	Cooking time:	Yield:
5–10 minutes	10–20 minutes	6–8 servings



Ingredients:

- 1 small bag/box fettuccine or spaghetti
- noodles (375 g), 100% whole wheat if available
- 3 tbsp. vegetable oil
- 3 garlic cloves, chopped very finely or
- ¾ tsp garlic powder
- ¼ cup flour
- 1 ¼ cup water
- 1 can 2% evaporated milk (370 mL)
- 2 tsp instant chicken bouillon powder
- ¼ cup parmesan cheese
- 2 large cooked chicken breasts or 4 cooked chicken legs, skin removed and shredded (about 1 ½ cups)
- 2 cups frozen broccoli or green beans, thawed and finely chopped

Steps

1. Put a large pot of water on the stove to boil. In another medium size pot, add the oil and garlic.
2. Cook for about 1 minute on medium heat. Stirring quickly using a fork or a whisk, add the flour. Cook and stir for about 2-3 minutes.
3. Add the water and milk to the flour paste, stirring constantly. Continuing stirring until the mixture is thickened and smooth. Add the chicken bouillon powder.
4. Meanwhile, once the pot of water boils, add in the noodles. Stir occasionally so the noodles do not stick together. Cook until soft, then drain. Set aside.
5. Once the sauce is thick, add the rest of the ingredients. Cook for another 5 minutes.
6. Pour the sauce into the pot used for cooking the noodles, then toss the drained noodles back in. Using two big spoons, combine until the noodles are well-coated in the creamy sauce.

Adapted from "Cheesy Broccoli Fettuccine," with permission by The NorthWest Company.

Image Source: Cheesy Broccoli Fettuccine. Image. Web. 26 Nov 2017. http://www.realfoodgirlunmodified.com/30-minute-mondays-fettuccine-alfredo/

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Chicken N' Dumpling Stew

Preparation time:	Cooking time:	Yield:
10 minutes	30 minutes	8 servings

Ingredients:

Stew

- 8 pieces chicken thighs or drumsticks, skin removed
- 2 teaspoons canola oil
- 2 litres (8 cups) water
- 1 tablespoon onion powder
- ¼ teaspoon pepper
- 2 teaspoons instant chicken bouillon powder
- 4 cups or 500 g bag frozen vegetables, any blend but the one with broccoli works best.

Dumplings

- 1 ½ cup flour
- ½ cup pancake mix
- 1 can cream corn (small can 341 mL)
- ¼ cup milk

Steps

Stew

1. In a large soup pot, fry chicken in oil until golden brown.
2. Add remaining ingredients except vegetables. Cook on rolling boil for 20 minutes.
3. Turn heat to medium and add vegetables. Let simmer while you make the dumplings.

Dumplings

1. In a medium mixing bowl, mix dry ingredients. Make a well in the middle, add 1 can cream corn and the milk. Blend until sticky. Add a little more milk if too dry.
2. Using 2 spoons, make about 12 dumplings. They should be the shape of a slightly flattened ball.
3. Place the dumplings on top of the stew.
4. Cover and simmer for about 10 minutes.
5. They are ready when the middle is still a little hard but the outside is fluffy.

Recipe Source: Adapted from "Chicken n' Dumplings Stew," with permission by The NorthWest Company.

Picture Source: Chicken Stew and Dumplings. Image. Web. 9 Nov 2017. http://www.myrecipes.com/recipe/chicken-stew-dumplings

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Chicken, Turkey, Tuna or Salmon Salad Sandwich Filling

Preparation time:	Cooking time:	Yield:
5 minutes	0 minutes	8 servings

Ingredients:

- 4 cans (156 g) flaked chicken, turkey, tuna or salmon
- 3 small celery stalks or 2 carrots or 2 apples (for chicken or turkey salad), grated
- ½ cup mayonnaise or whipped salad dressing, low fat if available
- ½ teaspoon mustard
- Pepper to taste

Steps

1. Open the cans. Drain any liquid.
2. Put the canned meat in a bowl. Mash well with a fork until all the pieces are broken up.
3. Mix in the rest of the ingredients and it's ready for your sandwich.

Recipe Source: Adapted from "Chicken or Turkey Salad Sandwich," with permission by The NorthWest Company.

Picture Source: Chicken and Celery Salad Sandwich. Image. Web. 9 Nov 2017. http://www.enjoyyourcooking.com/salads/chicken-celery-salad-sandwich.html

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Creamy Turkey or Chicken with Noodles

Preparation time:	Cooking time:	Yield:
10 minutes	30 minutes	12 servings

Ingredients:

- 6 cups noodles like macaroni, whole wheat if available
- 2 tsp oil
- 1 large onion, chopped
- 2 cans (156 g) turkey or chicken, broken into small pieces, or 2 cups cooked chicken meat (much lower in salt)
- 2 cans (284 mL) cream of broccoli soup or double white sauce recipe (see under Sauces for less salt)
- 2/3 cup milk
- 3 cups frozen vegetables or 2 cans (284 mL) peas & carrots, rinsed and drained
- 4 tbsp. parmesan or block cheese, grated
- Seasonings: 1 tsp garlic powder, pepper to taste

Steps

1. In a large pot of boiling water add noodles. Cook for about 10 minutes or until noodles are tender. Drain and set aside.
2. In a separate pot add oil and chopped onion. Cook and stir on medium heat until onion is soft.
3. Add the rest of the ingredients. Stir constantly over medium heat until hot. If you like a thinner sauce, add a little more milk. Pour sauce over pasta and mix together.

Recipe Source: Adapted from "Creamy Turkey Rotini," Campbell's Soup Cookbook. Courtesy of Healthy Start for Mom & Me Program Winnipeg. June 2010. Picture Source: Skinny Chicken and Broccoli Alfredo.

Image source: Web. 30 Nov 2017. https://mykitchencraze.com/skinny-chicken-and-broccoli-alfredo

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Easy Chicken Pot Pie

Preparation time:	Cooking time:	Yield:
20 minutes	30 minutes	6–8 servings (picture below is the recipe doubled)

Ingredients:

- 3 chicken breasts or 4 thighs, meat cut into bite-sized pieces
- 2 onions, chopped
- 2 carrots, chopped
- 1 tablespoon oil
- 1 ½ cup frozen green beans, thawed then chopped
- 1 cup frozen peas, thawed
- 300 ml homemade white sauce + ¼ cup milk
- 1 ¼ cup Bisquick™ baking mix
- ½ cup milk
- 1 egg

Steps

1. Preheat oven to 400°F.
2. In a large skillet, heat up onion and fry onion until soft.
3. Mix chicken and carrots and cook until chicken is no longer pink.
4. Stir in the other veggies, white sauce and ¼ cup milk. Spread into bottom of non-greased 9-inch round pie pan. If doubling the recipe use a 9" x 13" baking dish.
5. Mix remaining ingredients (Bisquick, milk and egg) and pour on top of chicken mixture.
6. Bake in oven for 30 minutes or until top turns golden brown.

Recipe Source: Recipe source unknown.

Picture Source: Taken from Let's Cook It Up group offered by Anishnawbe Health Toronto 2016.

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Easy Seafood Burgers

Preparation time:	Cooking time:	Yield:
10 minutes	10 minutes	8 burgers

Ingredients:

- 2 tablespoons vegetable oil
- 2 cups canned tuna or salmon, drained and mashed
- ½ cup celery or green pepper, finely chopped
- ¼ cup relish
- 4 eggs, lightly beaten
- 1 cup bread crumbs
- 4 green onions, chopped or ¼ cup white onion, grated

Steps

1. In a large mixing bowl, combine all ingredients.
2. Shape into 8 patties.
3. Turn on stove to medium-high heat, in a non-stick pan, cook patties in oil until both sides are golden brown – about 3 minutes per slide.

Recipe Source: Adapted from "Recipe Name" The Basic Shelf Cookbook 2011 Edition, by The Canadian Public Health Agency.
Picture Source: Tuna Patties Recipe. Image. Web. 7 Nov 2017. http://www.simplyrecipes.com/recipes/tuna_patties/

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Easy Shepherd's Pie

Preparation time:	Cooking time:	Yield:
15 minutes	60 minutes	12 servings

Ingredients:

- 8 medium potatoes, peeled and cut into chunks OR use instant mashed potatoes.
- 3 tbsp. non-hydrogenated margarine
- ¾ cup milk
- 2 tsp. oil
- 2 lbs. lean ground meat (caribou, musk-ox, or any other ground meat)
- 2 onions, chopped
- 4 cups frozen mixed vegetables
- 1 cup water
- 2 teaspoons beef bouillon powder

Steps

1. Preheat your oven to 400°F.
2. If making homemade mashed potatoes, place potatoes in pot and add water to cover. Put lid on pot and boil until soft, about 20 minutes. Drain. Add margarine and milk and mash potatoes until smooth. Set aside.
3. Add oil to large frying pan. Cook and stir onions and ground meat over medium-high heat, until browned. Drain off fat.
4. Add frozen mixed vegetables, water and bouillon powder and cook until vegetables are tender, about 10 minutes.
5. Place meat mixture into one large baking dish. Spread mashed potatoes over meat mixture. Bake for 30 minutes or until the top is golden brown.

Recipe Source: Adapted from "Easy Shepherd's Pie" Healthy Family Program Collective Kitchen Recipe Book for Northern Cooks 2013, by the Government of the North West Territories. Web. 17 Oct 2017. http://www.hss.gov.nt.ca/sites/www.hss.gov.nt.ca/files/healthy-family-program-collective-kitchen.pdf.

Picture Source: Beef Shepherd's Pie. Image. Web. 20 Nov 2017. http://www.taste.com.au/recipes/beef-shepherds-pie/70d1e84f-b2c3-4894-a11d-f6036ad5960c

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Ham and Pierogi Bake

Preparation time:	Cooking time:	Yield:
10 minutes	30 minutes	8 servings

Ingredients:

- 1 bag (1 kg) frozen pierogis
- 2 cups frozen green beans or peas
- ¼ cup flour
- 1 teaspoon instant chicken bouillon powder
- Seasonings: ½ teaspoon garlic powder,
- 1 teaspoon onion powder
- 1 teaspoon Italian seasoning OR dried basil OR dried oregano
- 1 cup water
- 1 can (370 mL) 2 % evaporated milk
- 1 package (375 g) sliced deli ham, roughly chopped
- ½ cup cheddar cheese, grated
- ¼ cup parmesan cheese

Steps

1. Preheat the oven to 375°F.
2. Grease a large baking dish with vegetable oil.
3. Place the frozen pierogis into the dish and top with frozen peas or green beans.
4. In a medium sauce pan, mix together the flour and seasoning using a fork or a whisk. Cook while stirring constantly for 2-3 minutes. Slowly pour in the water. Stir until there are no lumps.
5. Slowly stir in the milk.
6. Turn the heat onto medium and continue to stir until the sauce bubbles and begins to gently boil. Let cook for 2 minutes.
7. Add the ham and shredded cheese to the sauce pan. Cook for another 2 minutes.
8. Pour over the pierogis then sprinkle the top with parmesan cheese.
9. Bake for 30 minutes until the top is bubbly and the sides have turned golden brown.

Recipe Source: Adapted from "Ham and Pierogi Bake," with permission by The NorthWest Company.
Picture Source: Suzanne Hajto RD

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Hashbrown Casserole

Preparation time:	Cooking time:	Yield:
15 minutes	60 minutes	12 servings

Ingredients:

- 2 lbs. ground meat, any type
- 1 large onion, finely chopped
- 2 cans (284 mL) condensed cream of mushroom soup (high in salt) OR use the homemade white sauce recipe, doubled (low in salt). See recipe under Sauces.
- ½ cup milk
- 3 cups frozen mixed vegetables, any type
- 1 cup shredded cheddar cheese
- 2 lbs. frozen hash browns (look on the label, pick one with less than 10% D.V. sodium)

Steps

1. Heat oven to 375°F. Grease a 4-qt. casserole dish with vegetable oil.
2. Brown meat with onions in large skillet; drain the grease. Spoon into the casserole dish. Top with the vegetables.
3. Mix the milk with the soup or the white sauce until smooth. Pour over meat and vegetables.
4. Top with hashbrowns and lastly sprinkle with shredded cheese.
5. Bake 45 minutes or until hash browns are golden brown and casserole is heated through.

Recipe and Image Source: Adapted from TATER TOTS Casserole Recipe. Image. Web. 20 Nov 2017. http://www.kraftrecipes.com/recipes/tater-tots-casserole-recipe-111257.aspx

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Impossible Pie

Preparation time:	Cooking time:	Yield:
20 minutes	40 minutes	7 servings

Ingredients:

- 2 cups frozen veggies, thawed and drained
- 1 ½ cups shredded Cheddar cheese (6 oz)
- 1 cup cut-up cooked chicken or 2 cans (5 oz each) chunk chicken, drained
- 1 medium onion, chopped (1/2 cup)
- ½ cup Bisquick mix
- 1 cup milk
- ½ teaspoon salt
- ¼ teaspoon pepper
- 2 eggs

Steps

1. Heat oven to 400°F. Coat 9-inch pie plate with oil. Sprinkle veggies, 1 cup of the cheese, the chicken and onion in pie plate.
2. In medium bowl, stir remaining ingredients with wire whisk or fork until blended. Pour on top of ingredients in pie plate.
3. Bake 35 to 38 minutes or until knife inserted in center comes out clean. Sprinkle with remaining 1/2 cup cheese. Bake 1 to 2 minutes longer or until cheese is melted.
4. Let stand 5 minutes before serving.

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Meatballs

Preparation time:	Cooking time:	Yield:
10 minutes	30 minutes	30 small meatballs

Ingredients:

- About 1-pound (454 grams) any ground meat
- 1 egg
- ¼ cup milk
- 2 slices whole wheat bread toasted and broken up into small pieces or ½ cup breadcrumbs
- 1 medium onion, grated
- 2 tablespoons vegetable oil

Steps

1. In a medium size bowl, use a fork to beat the egg into the milk. Stir in the bread and the onion. When the bread has soaked up all the liquid, add the meat.
2. Use your hands to blend the mixture until well combined.
3. Grab a tablespoon of the mixture to form into a small meatball. Set aside on a plate or tray. Repeat with the remaining mixture.
4. In a large frying pan, add 1 tablespoon of oil. Warm on medium heat then add half of the meatballs. Turn when browned on one side, about 10 minutes on each side.
5. Remove from the pan and repeat for the second batch of meatballs.
6. **Meatballs are still not cooked. Add to spaghetti sauce and cook another 10 minutes. If you are using a sauce or a glaze, add it now and cook the meatballs in the frying pan or the oven for at least another 10 minutes. If you are eating plain, cook another 10 minutes.**

Adapted from "Cranberry Glazed Party Meatballs," with permission by The NorthWest Company.

Image Source: Meatballs with Cranberry Dipping Sauce Recipe. Image. Web. 26 Nov 2017. https://www.tasteofhome.com/recipes/meatballs-with-cranberry-dipping-sauce

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Meatloaf

Preparation time:	Cooking time:	Yield:
15 minutes	45 minutes	12 servings

Ingredients:

- 2 lbs ground beef or ground/chopped caribou or mixture of both
- 2 eggs
- 2/3 cup bread crumbs or cracker crumbs or bran or oatmeal
- ½ cup ketchup or spaghetti sauce or tomato soup
- 2 medium carrots, grated
- 2 medium onions, chopped
- ½ tsp salt
- ¼ tsp pepper
- 2 tsp Worcestershire sauce (optional)
- 1 tsp dried basil (optional)
- 2 tsp ketchup for topping

Steps

1. Preheat the oven to 350°F degrees.
2. In a large bowl, mix the meat with all the rest of the ingredients except the ketchup. Mix with your hands or a large spoon.
3. Press the mixture neatly into a loaf pan or other baking dish.
4. Spread the ketchup over the top of the meatloaf.
5. Bake for 40 to 45 minutes. Making 12 servings.

Recipe Source: Adapted from "Meatloaf" Qamanituaq Cooks! Good Food...Healthy Families Cookbook, by The Baker Lake Prenatal Project 2005.

Picture Source: Easy Meatloaf Recipe. Image. Web. 20 Nov 2017. https://www.hungryforever.com/recipe/beef-meatloaf-recipe/

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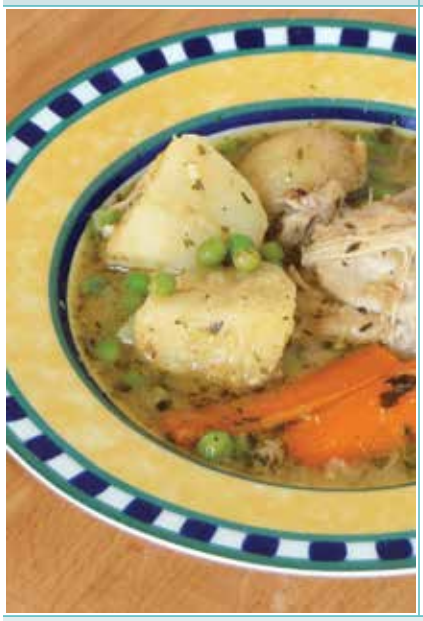
One-Pot Chicken Stew

Preparation time:	Cooking time:	Yield:
10 minutes	50 minutes	8 servings



Ingredients:

- 2 tbsp. oil
- 8 chicken thighs or drumsticks
- 1 onion, finely chopped
- 2 tbsp. flour
- 3 cups water
- 1 tsp instant chicken bouillon powder
- 2 tbsp. dried herbs (parsley, oregano, thyme)
- 4 carrots, cut into sticks
- 8 potatoes, washed and cut in half
- 2 cups frozen peas (or other vegetables)
- 1 tbsp. mustard (optional)

Steps

1. Heat oil in pot on medium high. Add chicken and cook on both sides until meat begins to brown.
2. Remove chicken from pot and set aside.
3. Add onions. Cook until soft.
4. Add flour. Cook for 2 minutes, stirring constantly.
5. Add water, chicken stock and dried herbs. Stir well.
6. Add chicken, carrots, and potatoes. Bring to a boil.
7. Turn heat to medium low, cover pot and cook for 20 minutes.
8. Remove lid and simmer for 15 minutes. Add frozen peas. If using, add mustard. Cook for 5 minutes.

Recipe and Image Source: Adapted from "Easy One Pot Chicken Stew," by the Government of Nunavut. Image. Web. 9 Nov 2017. http://www.livehealthy.gov.nu.ca/en/food/recipes

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Pizza Subs

Preparation time:	Cooking time:	Yield:
10 minutes	2 minutes	8 subs

Ingredients:

- 8 hot dog or sub buns, whole wheat if available
- ½ cup cream cheese
- ½ cup pizza sauce or pasta sauce or tomato salsa
- 12–16 slices roast beef deli meat or leftover roasted meat (about 1–2 slices of meat per sub)
- ½ cup shredded cheese

Steps

1. In a microwave-safe bowl, or in a small pot, add the cream cheese and sauce.
2. Heat until warm, less than 1 minute in the microwave and 2–3 minutes on the stovetop. Stir until smooth.
3. Spread 1–2 tablespoons of the creamy sauce onto each bun.
4. Add the roast beef and a tablespoon of shredded cheese.
5. Serve cold or warm.

Recipe and Image Source: Adapted from "Healthier Sandwiches," found in the Nutrition Activity Backpack by the Government of Nunavut 2013.

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Pizza

Preparation time:	Cooking time:	Yield:
20 minutes	15–20 minutes	12 slices

Ingredients:

- 2 ½ cups flour
- 1 tbsp. quick rise yeast
- 1 cup warm water
- 2 tsp sugar
- 2 tbsp. oil
- ½ cup pizza sauce (use more if you like a saucier pizza) or homemade white sauce
- 1 cup cheese, grated

Topping suggestions:

- Cooked ground caribou or ground beef, sliced ham
- Drained pineapple chunks, chopped into smaller pieces
- Thinly sliced mushrooms, green pepper, onions

Steps

1. Preheat the oven to 375°F. Grease a pizza pan or other large pan.
2. Put the flour in a large bowl. Add the yeast and mix well. Set aside.
3. In a measuring cup, mix together the water, sugar and oil. Pour into the flour mixture. Mix the wet and dry ingredients to form a dough and knead well.
4. Roll out the dough to fit the pizza pan. If the dough is too sticky, sprinkle on more flour or grease your hands. Place the rolled dough on to the greased pizza pan.
5. Spread the tomato sauce over the dough. Place the toppings of your choice on the pizza dough, sprinkle the cheese last.
6. Bake for 15 to 20 minutes. Do not overcook, a softer dough is easier to chew.

Recipe Source: Adapted from "Pizza" Qamanituaq Cooks! Good Food...Healthy Families Cookbook, by The Baker Lake Prenatal Project 2005.
Image Source: Homemade Pizza. Image. Web. 26 Nov 2017. http://www.manjulaskitchen.com/home-made-pizza/

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Pork Stew with Apples

Preparation time:	Cooking time:	Yield:
15 minutes	60 minutes	8 servings

Ingredients:

- 3 tablespoons oil
- 2 pounds pork, cut into cubes
- 2 onions, chopped
- 3 tbsp flour
- ½ tsp garlic powder
- 2 tsp thyme or other herb
- 2 tsp Worcestershire sauce (optional)
- 1 tsp salt
- ½ tsp pepper
- 4 potatoes, washed and cut into quarters
- 4 carrots, peeled and cut into chunks
- 3 apples, seeds removed and cut into chunks
- 4 cups water

Steps

1. Heat oil in pot over medium-high heat, add pork cubes and onions and cook until meat is brown and onions are soft, about 7 minutes.
2. Add flour, stir and cook for 2 minutes.
3. Add seasonings, potatoes, carrots, apples and water. Stir well.
4. Turn heat to high and bring to a boil.
5. Turn heat to low, cover the pot and let cook for 45 minutes, stirring occasionally.

Recipe and Image Source: Adapted from "Pork Stew with Apples" by the Government of Nunavut 2011. Web. 3 Dec 2017. http://www.livehealthy.gov.nu.ca/en/food/recipes

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Roasted Chicken

Preparation time:	Cooking time:	Yield:
5 minutes	60 minutes	8 servings

Ingredients:

- 8 chicken drumsticks or thighs
- ¼ cup Italian dressing
- 2 tablespoons water

Steps

1. Preheat the oven to 350°F.
2. In a large bowl, toss together the Italian dressing and the chicken pieces until each piece is well coated.
3. Place the chicken in a baking dish, about 9" x 12" in size.
4. Add 2 tablespoons of water. Cover with aluminum foil and bake for 40 minutes.
5. To brown the skin, uncover and broil on low heat for another 10-20 minutes or until skin is golden brown.

Recipe Source: Created for "Nutrition Planning Support to Three Elder's Facilities in Nunavut," by the Department of Health, Government of Nunavut 2017-2018.

Image Source: 7-Spice Roasted Chicken Thighs. Image. Web. 06 Dec 2017. http://sisijemimah.com/2017/01/12/7-spice-roasted-chicken-thighs/

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Saucy Chicken Pieces or Wings

Preparation time:	Cooking time:	Yield:
10 minutes	40 minutes	8 servings

Ingredients:

- 2 pounds split chicken wings OR 8 drumsticks OR 8 chicken thighs
- 1 sauce recipe - choose cranberry glaze, sweet soy garlic sauce or sweet and sour.

Steps

1. Turn on oven to 350°F.
2. Prepare one of the sauce recipes.
3. Place chicken in 9" x 13" baking dish.
4. Pour sauce over chicken and cover dish with foil.
5. For wings, bake 20 minutes. For chicken pieces, bake 40 minutes.
6. Take dish out from the oven and remove foil.
7. Bake for 20 more minutes.

Recipe Source: Created for "Nutrition Planning Support to Three Elder's Facilities in Nunavut," by the Department of Health, Government of Nunavut 2017-2018.

Image 1 Source: Sweet and Gooey Chicken Wings. Image. Web. 9 Nov 2017. http://allrecipes.com/recipe/17054/sweet-and-gooey-chicken-wings/?internalSource=hub%20recipe&referringContentType=search%20results&clickId=cardslot%203.

Image 2 Source: Baked BBQ Chicken. Image. Web. 5 Dec 2017. http://www.cozycakescottage.com/2014/01/15/baked-bbq-chicken/

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Saucy Ribs

Preparation time:	Cooking time:	Yield:
5 minutes	60 minutes	8 servings

Ingredients:

- 4–5 pounds (1.5 – 2.5 kilograms) pork or caribou ribs, preferably back ribs
- 2 cups water
- Your chosen sauce or glaze (see Sauces sections for recipes)

Steps

1. Trim the fat off the ribs and cut into sections of 2-3 ribs.
2. Place in a pot with the water. Bring up to a boil.
3. Turn heat down to low, cover with the lid and cook for 45 minutes.
4. After 45 minutes, transfer the ribs without the water into a baking pan. Pour the sauce of your choice over the ribs and mix until each piece is coated well.
5. Turn the oven on high broil.
6. Broil each side until gooey but still soft, about 5-minutes.
7. Place the leftover water from the pot in a bowl in the fridge to cool overnight. Remove the hard fat layer from the top. You will be left with flavour rich stock that can be added to soups or stews.

Recipe Source: Adapted from "Sticky Garlic Ribs," with permission by The NorthWest Company.
Picture Source: Honey Garlic Spareribs. Image. Web. 17 Oct 2017. https://www.thespruce.com/honey-garlic-spareribs-3059470

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Seal Meatloaf

Preparation time:	Cooking time:	Yield:
20 minutes	60 minutes	10–20 slices

Ingredients:

- 1 ½ cup breadcrumbs or 5 slices bread (If using bread: toast and crumble bread to make bread crumbs)
- 5 cups or 1.5 kg ground seal meat
- 1/3 cup powdered onion soup mix
- 1 cup All Bran cereal or bran flakes or ½ cups oats
- 3 eggs
- 2 cups canned diced tomatoes
- 6 slices bacon

Steps

1. Preheat oven to 350°F. In a large bowl combine all ingredients, except bacon slices.
2. Divide mixture between 2 bread pans. Spread evenly and press lightly.
3. Completely cover each loaf by placing bacon slices lengthwise (long end to long end).
4. Cover with aluminum foil and bake for 1 hour, or until the meat is well cooked.

Recipe Source: Adapted from Seal Meatloaf. Web. 20 Nov 2017. http://publicationsnunavik.com/book/nunavik-family-cookbook.

Picture Source: Bacon-Wrapped Meatloaf. Image. Web. 20 Nov 2017. https://www.cinnamonspiceandeverythingnice.com/bacon-wrapped-zucchini-meatloaf/

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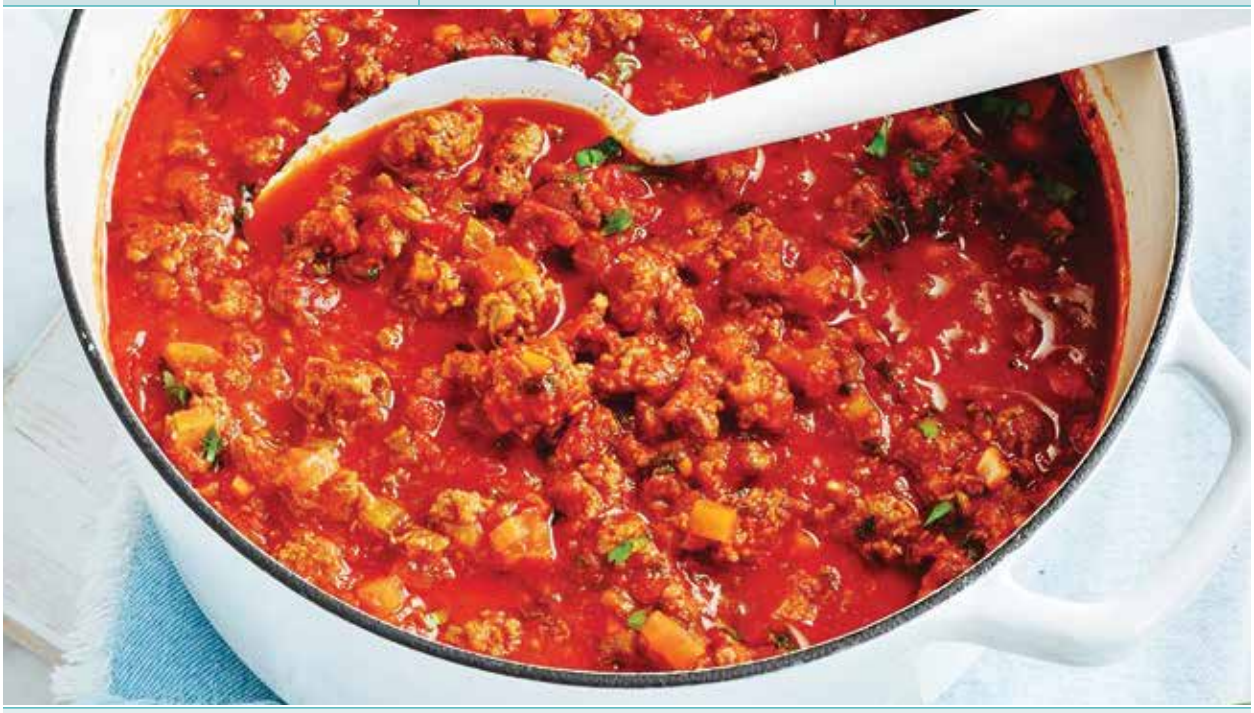
Spaghetti Meat Sauce

Preparation time:	Cooking time:	Yield:
15 minutes	45 minutes	About 8 cups



Ingredients:

- 1 lb. lean ground meat and 1 lb. mild Italian sausages OR 2 lb. lean ground meat
- 2 stalks celery, diced
- 2 carrots, diced
- 1 onion, diced
- 2 cloves garlic, minced or ½ teaspoon garlic powder
- 1 cup milk
- 2 (796 mL each) cans diced tomatoes, low or no salt if available
- 1 teaspoon dried herbs like Italian seasoning, basil, oregano

Steps

1. If using sausages, remove sausages from casings.
2. Cook and stir meat in a large pot over medium heat, until no longer pink, about 10 minutes. Carefully drain the fat.
3. Add celery, carrots, onion and garlic. Cook, stirring occasionally until tender, about 5 minutes.
4. Add milk. Gently boil, uncovered, stirring occasionally 5 minutes.
5. Add tomatoes, mashing with a potato masher to break them up. Add seasonings.
6. Simmer, uncovered, stirring occasionally 30 minutes or until the desired thickness

Recipe and Image Source: Adapted from Hearty Spaghetti Sauce. Image. Web. 7 Nov 2017. https://www.dairygoodness.ca/recipes/hearty-spaghetti-sauce2

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Stir-Fry

Preparation time:	Cooking time:	Yield:
5 minutes	20–25 minutes	8 servings

Ingredients:

- ½ cup water
- 2 tbsp. cornstarch
- 3 tbsp. oil
- 3 tbsp. soya sauce
- 1 kg (2 lbs) caribou, muskox or other lean meat
- 750 g bag of frozen mixed vegetables

Steps

1. Mix the cornstarch.
2. Brown meat strips in oil over medium-high heat with water and soya sauce.
3. Add the vegetables to the pan and cook for -5-10 minutes or until the vegetables are soft.
4. Add the cornstarch mixture to the pan and cook for 3-4 minutes on medium heat with a cover on the pan.
5. Stir often until the sauce in the pan has thickened.
6. To make 8 servings of instant (minute) rice, use 4 cups of dry rice and 4 cups of water

Recipe and Image Source: Adapted from "Stir-Fry," by the Government of Nunavut 2012-2013. Image. Web. 3 Oct 2017. http://www.livehealthy.gov.nu.ca/sites/default/files/EN%20StirFry.pdf

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Sweet and Sour Pineapple Meatballs

Preparation time:	Cooking time:	Yield:
5 minutes	30 minutes	8–12 servings

Ingredients:

- 2 pounds frozen meatballs (any kind) or homemade cooked meatballs (lower in salt)
- 2 cans (398 ml) pineapple chunks, finely chopped (keep juice) or crushed pineapple (keep juice)
- 4 cups water
- 1 small can (156 ml) tomato paste
- 1 onion, finely chopped (or 1 tablespoon onion powder)
- 4 cups frozen peas (or any other frozen chopped vegetable)
- 6 tablespoons white vinegar
- 4 tablespoons soya sauce (use low sodium, if available)
- 4 cups instant rice

Steps

1. Combine frozen or homemade cooked meatballs, pineapple, pineapple juice, water, tomato paste, onion, vinegar and soya sauce in big pot.
2. Cook over medium-high heat, stirring often for 10 minutes or until mixture comes to a boil.
3. Stir in the rice and frozen vegetable. Bring back up to a boil. Remove from the heat.
4. Cover and let stand 10 minutes.

Recipe and Image Source: Adapted from Meatball and Pineapple Rice. Image. Web. 4 Dec 2017. www.minuterice.ca/en/recipes/meatball-and-pineapple-rice

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Tender Roast Pork with Vegetables

Preparation time:	Cooking time:	Yield:
20 minutes	2 hours	8 servings

Ingredients:

- 3 tbsp. oil
- Seasonings: 1 tsp salt, 1 tsp pepper, ½ teaspoon garlic powder, 1 tsp thyme (optional)
- 2 ½ pound pork roast (boneless), for a pork roast with bones, use 3 ½ pound roast
- 4 potatoes, scrubbed and cut into four pieces
- 6 carrots, peeled and cut into chunks
- 2 onions, peeled and cut into four pieces

Steps

1. Turn oven to 325°F.
2. Mix oil, salt, pepper, garlic and thyme. Place roast in baking dish and spoon half of oil mixture over roast.
3. Put vegetables in bowl and mix with rest of oil mixture. Put in pan with roast.
4. Cover with aluminum foil to keep roast moist.
5. During cooking spoon pan juices over roast every 20 minutes.
6. Cook for 2 hours. Juices should run clear when pork is pierced or a thermometer reads 160°F (71°C).
7. Transfer roast to platter. Let it rest for 15 minutes before carving.

Recipe and Image Source: Adapted from "Roast Pork with Roasted Vegetables," by the Government of Nunavut 2011. Web. 17 Oct 2017. http://www.livehealthy.gov.nu.ca/en/food/recipes

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Whole Roasted Chicken or Turkey

Preparation time:	Cooking time:	Yield:
10 minutes	60+ minutes	6–24

Ingredients:

- 1 whole turkey or chicken (See below for the size of bird to buy)
- ¼ cup Italian dressing for each bird

Steps

1. If frozen, first thaw out the chicken or turkey. Put the chicken or turkey in the fridge the 1-3 days before you are going to use it. (See below for more information on thawing).
2. Preheat the oven to 350° F.
3. Remove the neck and giblets from inside the chicken or turkey. Cook the neck and giblets separately or put them in the fridge if you plan to use them later to make soup.
4. Place the chicken or turkey in a pan, breast side up. Rub with the dressing. Cover with foil and place in the oven. Baste the bird with pan drippings every 30 minutes to keep it moist. Roast until done. (See below for more information on cooking time).
5. To brown the skin, uncover for the last 20 minutes.
6. Let cool before cutting. Serve with stuffing, gravy and cranberry sauce, if desired.

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Whole Roasted Chicken or Turkey (continued)

Size of Bird(s) to Buy/Thawing and Cooking Times

Servings	Weight of Bird (not stuffed)	Thawing Time	Cooking Time (Estimates as oven temperatures may be different, always check with a meat thermometer*)
6 Adults	4 pounds (about 2 kilograms)	2 days	About 1 hour, 20 minutes
10 Adults	6.5 pounds (3 kilograms)	2-3 days	About 3 ½ hours if 1 large bird
24 Adults	18 pounds (about 8 kilograms)	3.5 days	About 4 ½ hours if 1 large bird, less if 2–3 smaller birds

More on Thawing

- Place it breast side up in a clean container that will hold any raw juices that may leak.
- Place container on the bottom shelf of the fridge so juices don't drip on other foods.

More on Cooking

- Cook whole birds until the temperature of the thickest part of the breast or thigh is 82°C (180°F)* using a meat thermometer. Make sure the thermometer is not touching any bones.
- Always wash the food thermometer that was used on raw or partially cooked poultry before using them to check again

Recipe Source: Adapted from "Whole Roasted Chicken or Turkey" Qamanituaq Cooks! Good Food...Healthy Families Cookbook, by The Baker Lake Prenatal Project 2005.

Picture Source: Roast Stuffed Chicken. Image. Web. 9 Nov 2017. https://www.canadianturkey.ca/whole-bird-turkey-calculator/.

Information Source: Poultry Safety. Web. 01 Dec 2017. https://www.canada.ca/en/health-canada/services/meat-poultry-fish-seafood-safety/poultry-safety.html#a6

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Appendix 8

RECIPES

SAUCES

Berry Sauce

Preparation time:	Cooking time:	Yield:
10 minutes	15 minutes	About 8 servings, 3 tablespoons each

Ingredients:

- 2 ¼ cups fresh or frozen berries
- ½ cup sugar
- 1 tbsp. lemon or orange juice
- pinch of salt

Steps

1. If using fresh berries, wash before using. Place the berries in a medium saucepan, add sugar, juice and salt. Stir until combined.
2. Bring berry mixture to a boil.
3. If using fresh berries, boil a full minute. If using frozen berries, boil for 3- 5 minutes.
4. Serve the sauce warm or cold on pancakes, French toast, over yogurt and even poured over toast.

Recipe Source: Adapted from Homemade Blueberry Sauce. Web. 1 Nov 2017. http://www.kraftrecipes.com/recipes/homemade-blueberry-sauce-155432.aspx.

Picture Source: Recipe: Easy Blueberry Compote. Image. Web. 6 Nov 2017. https://www.seattletimes.com/life/food-drink/recipe-easy-blueberry-compote/

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Cranberry Glaze – Sweet and Tangy

Great for Wings, Ribs, Meatballs, Chicken or Pork

Preparation time:	Cooking time:	Yield:
5 minutes	10 minutes	About 1 1/3 cups

Ingredients:

- 1 can (348 ml) cranberry sauce or jelly
- ¼ cup ketchup
- 1–2 teaspoons garlic powder

Steps

1. Place the cranberry sauce, ketchup and garlic in a medium size pot. Bring up to a low boil and cook for 10 minutes.
2. Pour onto cooked wings, ribs, meatballs, chicken or pork. Cook for another 10 minutes in the oven or on the stovetop.

Recipe Source: Adapted from "Cranberry Glazed Meatballs," with permission by The NorthWest Company.

Picture Source: Turkey Glazed Meatballs. Image. Web. 30 Nov 2017. https://www.davidlebovitz.com/cranberry-glazed-meatballs-recipe/

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Gravy for Roast Chicken or Turkey

Preparation time:	Cooking time:	Yield:
5 minutes	10 minutes	4 cups of gravy

Ingredients:

- 1 tbsp. flour
- Fat or meat juices from the roast chicken or turkey
- 1 cup warm water

Steps

1. Put the flour in a small bowl or container.
2. Add the fat and meat juices from the roasting pan. If you have lots of fat and meat juices in the pan, use more flour.
3. Mix with a fork until the gravy is very smooth.
4. Put the gravy back into the roasting pan. Cook on a medium heat, slowly adding the warm water. Stir all the time. Add more warm water, if needed.
5. Cook a few minutes until hot.

Recipe Source: Adapted from "Gravy for Roast Chicken or Turkey" Qamanituaq Cooks! Good Food...Healthy Families Cookbook, by The Baker Lake Prenatal Project 2005.

Picture Source: Classic Pan Gravy. Image. Web. 8 Nov 2017. http://www.finecooking.com/recipe/classic-pan-gravy

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Sweet and Sour Sauce

Great for Wings, Ribs, Meatballs, Chicken or Pork

Preparation time:	Cooking time:	Yield:
5 minutes	10 minutes	1½ cups

Ingredients:

- ½ cup ketchup
- ¼ cup vinegar
- ¾ cup water
- ¼ cup brown sugar
- 1 teaspoon mustard

Steps

1. Place all ingredients in a medium sauce pan. Mix well.
2. Turn the burner to medium and simmer a few minutes until well combined.
3. Let sit a few minutes. Use with ribs, chicken or meatballs.

Recipe Source: Adapted from "Homemade Sweet and Sour Sauce" Qamanituaq Cooks! Good Food...Healthy Families Cookbook, by The Baker Lake Prenatal Project 2005.

Picture Source: BBQ Ribs in the Oven. Image. Web. 4 Dec 2017. http://www.kraftrecipes.com/recipes/bbq-ribs-in-the-oven-162207.aspx

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Sweet Soy Garlic Sauce

Great for Wings, Ribs, Meatballs, Chicken or Pork

Preparation time: 5 minutes	**Yield:** About 1 cup

Ingredients:

- 1 ½ teaspoons garlic powder
- 2/3 cup brown sugar
- ¼ cup soya sauce, low sodium if available
- ¼ cup vinegar
- ¼ cup water

Steps

1. In a small bowl, mix together all the ingredients.
2. Pour onto cooked wings, ribs, meatballs, chicken or pork. Cook for another 10 minutes in the oven or on the stovetop.

Recipe Source: Adapted from "Sticky Garlic Ribs," with permission by The NorthWest Company.

Picture Source: Sweet soy, honey and ginger stir-fry sauce. Image. Web. 30 Nov 2017. http://www.taste.com.au/recipes/sweet-soy-honey-ginger-stir-fry-sauce/0d50378e-e2a8-41b8-83f5-f71e06616f81

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Thick White Sauce

to Replace Canned Cream Soup or as a Sauce for Homemade Macaroni & Cheese

Cooking time: 5 minutes	**Yield:** 300 ml, the same as 1 can condensed cream soup

Ingredients:

- 3 tablespoons non-hydrogenated margarine
- ¼ cup flour
- 1 ¼ cups milk (evaporated milk will make a creamier sauce)
- ¼ teaspoon garlic powder
- ¼ tsp salt
- 1/8 tsp pepper

Steps

1. In a small pot, melt margarine over low heat. Stir in flour.
2. Cook over medium heat, stirring constantly, until mixture is smooth and bubbly.
3. Gradually stir in milk. Heat to boiling, stirring constantly.
4. Add garlic powder.
5. Boil and stir 1 minute until sauce is thick and shiny. If using the sauce for macaroni and cheese, add more milk for a thinner sauce.
6. Canned cream soups like cream of mushroom are very high in salt. This thick white sauce can replace those in any recipe. This recipe can easily be doubled.

Recipe Source: Created for "Nutrition Planning Support to Three Elder's Facilities in Nunavut," by the Department of Health, Government of Nunavut 2017-2018. Picture Source: Classic Smooth and Silky Béchamel (White Sauce) Recipe. Image. Web. 6 Dec 2017. http://www.seriouseats.com/recipes/2016/09/bechamel-white-sauce-recipe.html

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Appendix 8

RECIPES

SIDES, SANDWICHES and SALADS

Broccoli Salad

Preparation time:	Cooking time:	Yield:
20 minutes	5 minutes	9 (½ cup) servings

Ingredients:

Salad

- 4 ½ cups broccoli, chopped small (about 1 head)
- ½ cup dried cranberries or raisins
- ¼ cup grated onion
- ¼ cup sunflower seeds
- ¼ cup cheese, grated (optional)

Dressing

- 2 tbsp. vinegar
- 2 tbsp. water
- 1 ½ tbsp. white sugar
- 1 teaspoon mustard
- ½ cup mayonnaise or whipped salad spread

Steps

1. In a large pot of boiling water, boil broccoli for 5 minutes. Drain and rinse under cold water, drain again.
2. Transfer broccoli to a large bowl. Add the rest of the salad ingredients.
3. In a small bowl, whisk together the dressing ingredients.
4. Toss salad with dressing. Keep in fridge until ready to serve.

Recipe Source: Adapted from "Broccoli Salad with Cranberries" Atlantic Superstore 2005.

Picture Source: Broccoli & Cranberry Salad – Low Fat Version. Image. Web. 3 Dec 2017. https://allmyeggs.com/2009/12/30/broccoli-cranberry-salad-low-fat-version/

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Carrot Slaw

Preparation time:	Cooking time:	Yield:
10 minutes	0 minutes	8 (½ cup) servings

Ingredients:

Salad

- 4 medium-size carrots, grated
- ¼ medium-size onion, grated
- ½ cup dried cranberries
- ¼ cup sunflowers seeds or chopped nuts

Dressing

- 1 teaspoon honey or sugar
- ¼ teaspoon salt
- 3 tablespoons mayonnaise or whipped dessert topping (low fat if available)
- 4 tablespoons white vinegar

*Add a tablespoon of water if the dressing is too thick

Steps

1. In a medium bowl, add grated onion and carrot.
2. Top with cranberries and sunflower seeds.
3. In a small bowl, whisk the dressing ingredients together using a fork until smooth.
4. Top salad with dressing and toss. Make at least 2 hours before serving to soften the slaw. Store in the fridge.

Recipe Source: Adapted from "Crunchy Carrot Slaw," with permission by The NorthWest Company.

Picture Source: Serious Salads: Carrot Slaw with Cranberries and Toasted Walnuts Recipe. Image. Web. 3 Dec 2017. http://www.seriouseats.com/recipes/2011/11/carrot-slaw-with-cranberries-and-toasted-walnut-recipe.html

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Chicken, Turkey, Tuna or Salmon Salad Sandwich Filling

Preparation time:	Cooking time:	Yield:
5 minutes	0 minutes	8 servings

Ingredients:

- 4 cans (156 g) flaked chicken, turkey, tuna or salmon
- 3 small celery stalks or 2 carrots or 2 apples (for chicken or turkey salad), grated
- ½ cup mayonnaise or whipped salad dressing, low fat if available
- ½ teaspoon mustard
- Pepper to taste

Steps

1. Open the cans. Drain any liquid.
2. Put the canned meat in a bowl. Mash well with a fork until all the pieces are broken up.
3. Mix in the rest of the ingredients and it's ready for your sandwich.

Recipe Source: Adapted from "Chicken or Turkey Salad Sandwich," with permission by The NorthWest Company.

Picture Source: Chicken and Celery Salad Sandwich. Image. Web. 9 Nov 2017. http://www.enjoyyourcooking.com/salads/chicken-celery-salad-sandwich.html.

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Creamy Mashed Carrots

Preparation time:	Cooking time:	Yield:
10 minutes	30–35 minutes	5–6 cups or 10–12 ½ cup servings

Ingredients:

- 4 medium to large carrots, peeled and cubed
- 2 large white potatoes, peeled and cubed
- 2 tablespoons non-hydrogenated margarine
- ¼ cup milk
- ½ cup shredded cheese, any type

Steps

1. Place about 3 inches of water in the bottom of a large pot.
2. Add in the vegetables.
3. Bring up to a boil, and cover.
4. Cook for about 30 minutes or until the carrot is tender.
5. Remove from heat and carefully drain the hot water.
6. Add the milk and margarine to the pot. Using a potato masher, mash until smooth.
7. Stir in the shredded cheese. Serve.

Recipe Source: Created for "Nutrition Planning Support to Three Elder's Facilities in Nunavut," by the Department of Health, Government of Nunavut 2017-2018.

Picture Source: Creamy Mashed Carrots. Image. Web. 9 Nov 2017. http://www.kraftcanada.com/recipes/creamy-mashed-carrots-137337

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Creamy Pasta Salad

Preparation time:	Cooking time:	Yield:
20 minutes	10 minutes	8 servings

Ingredients:

Creamy Dressing

- 1 ½ cups milk
- ¾ cup mayonnaise
- 1 tbsp. mustard
- ¼ teaspoon garlic powder
- ½ tsp salt, ½ tsp pepper
- 1 tablespoon dried herbs like parsley, oregano, basil
- ¼ cup vinegar

Pasta Salad

- 12 oz. (375 g) box or bag of pasta, like macaroni
- 2 cups canned green beans, rinsed and drained
- 2 cups carrots, shredded
- 1 green or red bell pepper, shredded or thinly sliced

Steps

1. For the dressing, stir together all the ingredients. Let stand for 10 minutes or until thickened.
2. In large pot of boiling water, cook pasta for 8 to 10 minutes or until tender.
3. Drain. Rinse under cold running water until cool. Drain well.
4. In a large bowl, combine pasta, green beans, carrots and green or red pepper and the dressing.

Recipe and Picture Source: Adapted from Pasta Salad with Creamy Herb Dressing. Image. Web. 20 Nov 2017 https://www.dairygoodness.ca/recipes/pasta-salad-with-creamy-herb-dressing.

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Creamy Veggie Rice

Preparation time:	Cooking time:	Yield:
10 minutes	20 minutes	8 (1 cup) servings

Ingredients:

- 1 tbsp. vegetable oil
- 3 cups fresh sliced mushrooms OR 2 cans (284 mL) sliced mushrooms (rinsed and drained) OR 2 cups frozen vegetables
- 1 ½ cups (about 1 medium) onion, chopped
- ½ teaspoon garlic powder
- 2 ½ cups minute rice
- 2 ½ cups water
- 2 teaspoons vegetable or chicken bouillon powder
- 1 teaspoon dried parsley or any dried herb like thyme
- 3 cups milk, any type (evaporated will make it creamier)
- 1 cup shredded cheddar cheese, any type

Steps

1. Warm oil in medium size pot. Stir in mushrooms or vegetables and onion. Cook for about 5 minutes.
2. Stir in rice, water, bouillon powder and seasoning. Bring up to a boil, reduce to low and cover.
3. Stir every few minutes, slowly adding the milk.
4. Once the rice is soft (about 10 minutes), turn off the heat and stir in the cheese.

Make this a one-dish meal! At step 4, add cooked meatballs, meat or canned seafood

Recipe Source: Adapted from "Mushroom and Cheese Risotto" Cook Cookbook! by Dietitians of Canada 2011.
Picture Source: Mushroom Risotto. Image. Web. 20 Nov 2017. http://www.simplyrecipes.com/recipes/mushroom_risotto/

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Devilled Eggs

Preparation time:	Cooking time:	Yield:
15 minutes	15 minutes	12 servings

Ingredients:

- 12 hard-cooked eggs, peeled
- ¼ cup mayonnaise or whipped salad dressing, low fat if available
- 1 tsp mustard
- ¼ tsp salt
- ¼ tsp pepper
- Pinch paprika (optional)

Steps

1. Cut eggs in half lengthwise.
2. Remove yolks and place in medium bowl; set egg whites aside.
3. Mash yolks with fork; stir in mayonnaise, mustard, salt and pepper.
4. Spoon or pipe yolk mixture into egg white halves.
5. Sprinkle paprika over top, if desired.
6. Serve immediately or cover and store in refrigerator. Serve within 2 days.

Recipe Source: Adapted from Basic Devilled Eggs. Web. 7 Nov 2017. https://www.eggs.ca/recipes/basic-devilled-eggs.

Picture Source: Deliciously Tempting Devilled Eggs Appetizer Recipe. Image. Web. 6 Nov 2017. https://avocadopesto.com/deviled-eggs-recipe/

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Glazed Carrots

Preparation time:	Cooking time:	Yield:
5 minutes	25 minutes	8 servings

Ingredients:

- 2 pounds carrots (baby carrots or regular carrots, peeled, washed and cut into chunks)
- ¼ teaspoon salt
- 3 tablespoons margarine
- 3 tablespoons brown sugar

Steps

1. Place carrots in pot and add water to cover. Put lid on pot and bring water to a boil, then lower heat and cook about 20 minutes, or until soft.
2. Drain carrots.
3. Add salt, margarine and brown sugar to pot and cook over low heat until the carrots are covered with the mixture.

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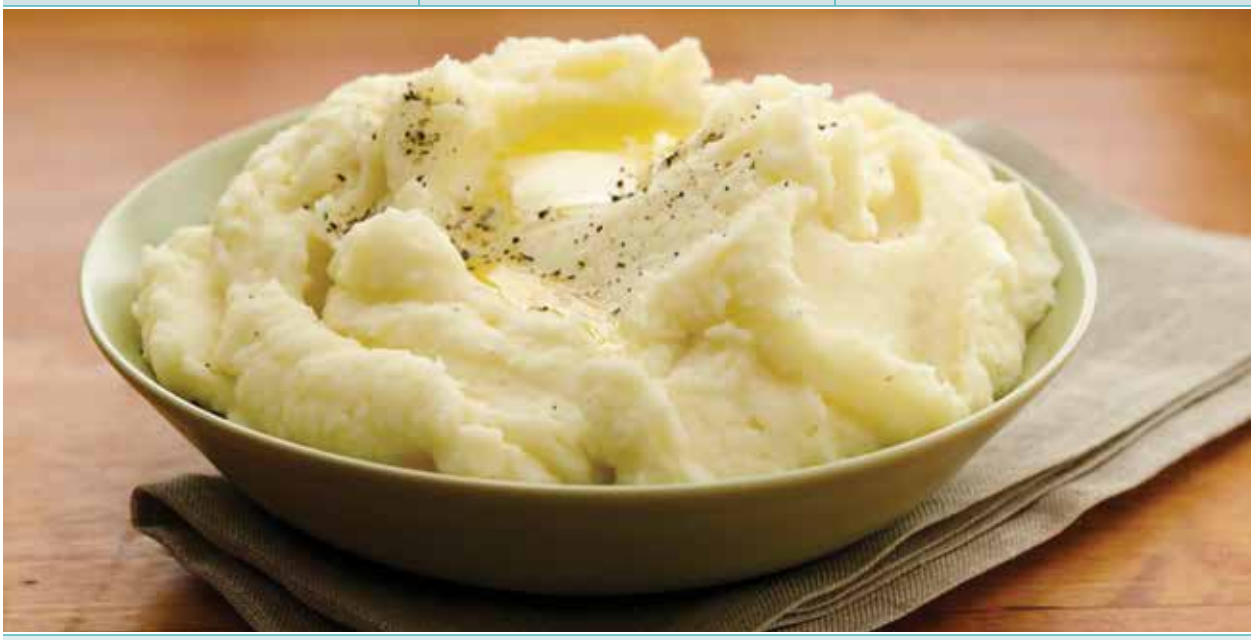
Mashed Potatoes Using Potatoes

Preparation time:	Cooking time:	Yield:
10 minutes	20–30 minutes	8–16 servings



Number of Potatoes Needed

Weight	Number of Potatoes	Cups of mashed potatoes	Number of ½ cup Servings	Milk to add	Non-Hydrogenated Margarine to add
2 pounds	6 medium	4	8	½ cup	2 tablespoons
3 pounds	9 medium	6	12	¾ cup	3 tablespoons
4 pounds	12 medium	8	16	1 cup	4 tablespoons (same as ¼ cup)

Steps

1. Wash, peel and cut potatoes into four.
2. Place in a pot. Add enough water to cover the potatoes.
3. Heat to boiling then lower heat. Cover and cook on low boil for 20 to 30 minutes or until potatoes are soft.
4. Drain well. In the same pot, add the margarine. Add the milk slowly and mash the potatoes until smooth. If dry, add more milk. Season to taste.

Information Source: The Old Farmers Almanac. Web. 6 Dec 2017.
https://www.almanac.com/content/measuring-vegetables-recipes-pounds-cups.

Recipe Source: Adapted from Betty's Best Mashed Potatoes. Web. 6 Dec 2017.
https://www.bettycrocker.com/recipes/bettys-best-mashed-potatoes/f8374114-214d-4f09-bfa1-96bcc43fbdd0

Picture Source: Velvet Mashed Potatoes. Image. Web. 06 Dec 2017.
https://www.bettycrocker.com/recipes/velvet-mashed-potatoes/351e286a-e61e-4b38-8cfd-82d4f3f63ec2

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Mashed Potatoes Using Instant Potato Flakes

Preparation time:	Cooking time:	Yield:
–	5–10 minutes	8–16 servings

"Plain" or "Unseasoned" are better choices.

They are lower in salt than flavoured potatoes like "Buttery" or "Butter and Herb".

Number of Packages or Pouches Needed

Number of packages/ pouches	Number of ½ cup Servings
2	8
3	12
4	16

Ingredients

Number of Servings	Water	Milk	Non-Hydrogenated Margarine
8	2 cups	2 cups	2 tablespoons
12	3 cups	3 cups	¼ cup
16	4 cups	4 cups	¼ cup + 2 tablespoons

Steps

1. Heat water, milk and margarine in a pot just until boiling.
2. Turn off heat. Stir in potatoes.
3. Let sit 2 minutes then whip quickly until smooth and fluffy.

Recipe Source: Adapted from "Betty Crocker's Instant Mashed Potatoes" Directions from the box. 6 Dec 2017.

Picture Source: Kroger Instant Mashed Potatoes Reviews. Image. Web. 6 Dec 2017. http://www.viewpoints.com/Kroger-Instant-Mashed-Potatoes-reviews.

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Power Pasta Salad

Preparation time:	Cooking time:	Yield:
10 minutes	15 minutes	9 (½ cup) servings

Ingredients:

- 1 box (375 g) or 4 cups pasta, any type
- 1 large can (540 ml) or 2 cups canned kidney beans, rinsed then drained (optional)
- 1 small can (170 g) flaked tuna/chicken or turkey, drained (optional)
- 1 cup skim milk mozzarella cheese, shredded
- ½ cup onion, grated
- 1 medium tomato, diced very small
- 1 green pepper or 2 celery stalks or 2 carrots, shredded
- 1 teaspoon Italian seasoning, or dried basil or dried oregano
- 3 tablespoons oil
- 4 tablespoons vinegar

Steps

1. Boil 16 cups of water then add pasta. Boil for 10-12 minutes stirring every few minutes.
2. While the pasta is boiling, combine all the other ingredients in a large bowl.
3. When the pasta is cooked, drain, rinse and let cool for 10 minutes.
4. Add cooked pasta to the mixture and stir well.

Recipe Source: Adapted from "Power Pasta Salad," with permission by The NorthWest Company.
Picture Source: Healthy Pasta Salad!. Image. Web. 9 Nov 2017. https://www.pinterest.ca/pin/540502392748880164/.

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Scalloped Potatoes

Preparation time:	Cooking time:	Yield:
20 minutes	65–70 minutes	8 servings

Ingredients:

- 2 tbsp. margarine
- 1 cup finely chopped onion
- ½ tsp garlic powder
- 3 cups milk
- ½ tsp salt
- ½ tsp dried herbs like basil or oregano
- ¼ tsp pepper
- ¼ cup bread crumbs
- ¾ cup shredded cheese
- 6 medium potatoes, peeled and thinly sliced

Steps

1. Turn on oven to 350°F (180°C). Lightly grease one large or 2 small casserole dishes.
2. Melt margarine in a frypan. Add onion and garlic powder. Cook until onion is soft, about 3 to 5 minutes. Set aside.
3. Meanwhile, heat milk, salt, dried herbs and pepper in a large saucepan. Set aside.
4. Combine bread crumbs and cheese in a small bowl. Set aside.
5. Arrange one third of the potatoes on the bottom of the dish(s). Put half of the onion mixture on top of the potatoes. Sprinkle with half of the bread crumb mixture.
6. Repeat two more times except for the very last layer of breadcrumb mixture.
7. Pour hot milk mixture into casserole. Now sprinkle the last of the breadcrumb mixture.
8. Cover with aluminum foil and bake until potatoes are tender, about 45 minutes. Remove foil and cook until the top is golden. Let stand 10 minutes before serving.

Recipe Source: Adapted from "Scalloped Potatoes with Cheese and Herbs" The Basic Shelf Cookbook 2011 Edition, by The Canadian Public Health Agency.

Picture Source: Homemade Scalloped Potatoes with Goat Cheese and Garlic. Image. Web. 30 Nov 2017. https://www.wellplated.com/homemade-scalloped-potatoes-recipe/.

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Stuffing for Roasted Chicken or Turkey

Preparation time:	Cooking time:	Yield:
5 minutes	10–15 minutes	12 (½) servings

Ingredients:

- 4 cups frozen vegetables like peas and carrots
- 2 apples, chopped
- 2 tablespoons non-hydrogenated margarine
- 1 ½ cups water
- 2 packages (120 grams or about 3 ½ cups) stuffing mix

Steps

1. Place frozen vegetables, margarine and water in a pot.
2. Bring up to a boil and cook for 5 minutes.
3. Add the stuffing mix.
4. Lower heat and cook for 5-10 minutes stirring often until stuffing is hot.
5. Add more water if dry.

Recipe and Image Source: Adapted from Stuffing with Vegetables. Image. Web. 18 Nov 2017. https://spendsmart.extension.iastate.edu/recipe/stuffing-with-vegetables/

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Sweet Mashed Turnip

Preparation time:	Cooking time:	Yield:
10 minutes	30–35 minutes	7 cups or 14 (½ cup) servings

Ingredients:

- 1 large turnip (about 6 cups), peeled and cubed
- 2 medium sweet potatoes (about 4 cups), peeled and cubed or 4 medium carrots, peeled and cubed
- 2 tablespoons non-hydrogenated margarine
- ¼ cup milk
- Salt and pepper to taste

Steps

1. Place about 3 inches of water in the bottom of a large pot.
2. Add in the turnip and sweet potatoes.
3. Bring up to a boil, and cover.
4. Cook for about 30 minutes or until the turnip is tender.
5. Remove from heat and carefully drain the hot water.
6. Add the milk and margarine to the pot. Using a potato masher, mash until smooth.
7. Season with salt and pepper to taste.

Recipe Source: Adapted from "Sweet Mashed Turnips," with permission by The NorthWest Company.

Picture Source: Yukon Gold and Sweet Potato Mash Recipe. Image. Web. 9 Nov 2017. https://www.pinterest.ca/pin/268456827767372689/

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Tropical Coleslaw

Preparation time:	Cooking time:	Yield:
15 minutes	–	8–10 servings

Ingredients:

- 454 g bag coleslaw mix
- 2 shredded carrots
- 1 cup canned crushed pineapple, drained or canned diced pineapple, drained and chopped finely
- Dressing Ingredients
- ¾ cup sour cream, low fat if available
- ½ cup mayonnaise, low fat if available
- 1 tablespoon sugar
- 2 tablespoons vinegar
- 1 tablespoon water

Steps

1. Put the coleslaw, carrots and pineapple in a large bowl.
2. In a small bowl, mix together all the dressing ingredients.
3. Pour the dressing over the coleslaw and stir well. Cover and refrigerate until ready to serve. Any foods made with sour cream should not be left out of the fridge for more than 2 hours. In hotter months, this should be shortened to 30 minutes.

Recipe Source: Adapted from "Tropical Coleslaw," with permission by The NorthWest Company.
Picture Source: Pineapple Yogurt Cole Slaw. Image. Web. 8 Nov 2017. https://www.savoryexperiments.com/greek-pineapple-cole-slaw/

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Beef Barley Soup

Preparation time:	Cooking time:	Yield:
15 minutes	50–60 minutes	12 (1 cup) servings

Ingredients:

- 1 pound lean ground meat
- 2 tablespoons oil
- 2 onions, chopped
- 5 stalks of celery, chopped
- 6 cups water
- 1 teaspoon instant chicken bouillon powder
- ½ cup barley
- 2 cans sliced (284 mL) mushrooms, rinsed and drained
- 1 large can (28oz/796mL) diced tomatoes
- ¼ teaspoon pepper, or to taste

Steps

1. Put meat in pot over medium heat and cook until brown.
2. Add oil, chopped onions and celery and stir. Cook until vegetables have softened, about 5-10 minutes.
3. Add the rest of the ingredients. Bring to a boil.
4. Reduce heat so that the soup is just bubbling very slowly. Cover and cook for 30-40 minutes, until barley is tender. Stir once in a while.
5. Add pepper to taste.

Recipe and Image Source: Adapted from "Beef and Barley Soup," by the Government of Nunavut 2011. Web. 3 Dec 2017. http://www.livehealthy.gov.nu.ca/en/food/recipes.

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Corn Chowder

Preparation time:	Cooking time:	Yield:
10 minutes	60–65 minutes	12 servings

Ingredients:

- 1 tbsp. non-hydrogenated margarine
- 1 onion, chopped
- 1 ½ cups potatoes, diced into small cubes
- 2 cups water
- 2 teaspoons instant chicken bouillon powder
- 1 ½ cups milk
- 1 can (19 oz/540 mL) cream style corn
- Salt and pepper to taste

Steps

1. Turn on stove to medium heat. Melt margarine in a large pot. Add chopped onion and cook until soft, about 5 to 7 minutes.
2. Add diced potatoes, water and chicken soup bouillon. Heat to boiling. Turn down the heat, cover and simmer until potatoes are almost tender, about 20 minutes.
3. Add milk and corn. Cook and stir mixture constantly over medium-low for 4 to 5 minutes.
4. Add salt and pepper to taste. Add water if soup is too thick.

Recipe Source: Adapted from "Corn Chowder" The Basic Shelf Cookbook 2011 Edition, by Canadian Public Health Association.
Picture Source: Roasted Corn Chowder. Image. Web. 13 Nov 2017. https://food52.com/recipes/16414-roasted-corn-chowder

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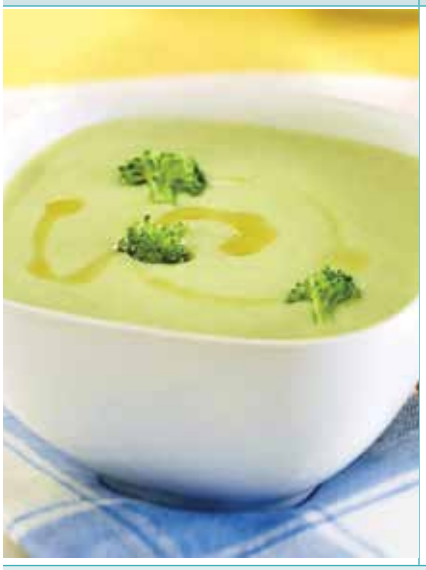
Cream of Broccoli Soup

Preparation time:	Cooking time:	Yield:
10 minutes	30 minutes	8 servings



Ingredients:

- 2 tbsp. oil
- 1 onion, chopped
- ¼ tsp garlic powder
- 3 cups potatoes, peeled and cubed
- 4 cups water
- 3 tsp chicken bouillon powder
- ¼ tsp garlic powder
- ¼ tsp pepper
- 1 bag (500 grams) frozen broccoli
- 2 cans evaporated milk

Steps

1. In a large pot, warm oil over medium heat. Add onion and cook until soft.
2. Add the rest of the ingredients, except the evaporated milk.
3. Turn heat up, cover and bring to a boil. Once boiling, reduce heat to medium. Keep covered stirring occasionally, until vegetables are tender, about 20 minutes.
4. Add the evaporated milk and heat through.
5. Use a hand blender to purée the soup until smooth right in the pot. Or use potato masher to make it smoother.

Recipe and Image Source: Adapted from Cream of Broccoli Soup. Image. Web. 10 Dec 2017. http://www.arcticgardens.ca/en/recipes/cream-broccoli-soup/Arctic Gardens

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Cream of Carrot Soup

Preparation time:	Cooking time:	Yield:
10 minutes	30 minutes	8 cups

Ingredients:

- 1 tbsp. vegetable oil
- 1 large onion, chopped
- 1 large garlic clove, chopped or 1/4 tsp garlic powder
- 6 carrots, washed, peeled and chopped
- 3 apples, washed, peeled and chopped
- 4 cups water
- 2 tsp white or brown sugar
- 2 teaspoons instant chicken bouillon powder
- 1 can (354 mL) evaporated milk

Steps

1. In a large pot, warm oil over medium heat. Add onion and garlic. Cook until onion has softened. Add the rest of the ingredients except the evaporated milk.
2. Cover and bring to a boil. Once boiling, reduce heat to a low boil. Stir occasionally, until carrots are tender, about 30 minutes.
3. Turn off the heart. Add the evaporated milk.
4. Use a hand blender to purée the soup until smooth right in the pot or transfer in small batches to purée in a standard blender. Be careful, the steam can be very hot.

Recipe Source: Adapted from "Cream of Carrot Soup," with permission by The NorthWest Company.

Picture Source: Squash and Carrot Soup. Image. Web. 6 Nov 2017. https://www.saltandlavender.com/acorn-squash-and-carrot-soup/

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Creamy Potato Chowder

Preparation time:	Cooking time:	Yield:
10 minutes	30 minutes	10 servings

Ingredients:

- 1 tablespoon oil
- 1 onion, chopped
- 2 carrots, peeled and chopped small
- 2 celery stalks, washed and chopped small
- 2 pounds potatoes, peeled and cut into 1 inch pieces
- 5 cups water
- 4 teaspoons instant chicken bouillon powder
- ½ teaspoon garlic powder
- 2 cans (371 mL) evaporated milk

Steps

1. Heat oil in large saucepan over medium heat. Add chopped onion, carrots and celery; cook, stirring occasionally, for 5 minutes or until soft.
2. Add potatoes, water, bouillon and garlic powder; put pot on lid and bring to a boil.
3. Simmer over medium heat, for 15 minutes or until tender.
4. Add milk and cook for 5 more minutes
5. If desired, mash mixture with fork or potato masher.

Recipe and Image Source: Adapted from Creamy Potato Chowder. Web. 11 Dec 2017. http://www.carnationmilk.ca/recipe-details.aspx?rid=

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Fish or Clam Chowder

Preparation time:	Cooking time:	Yield:
20 minutes	40 minutes	12 cup servings

Ingredients:

- 2 tablespoons oil
- 1 onion, chopped
- 4 carrots, peeled and chopped
- 2 celery stalks, chopped
- 1 Bay leaf (optional)
- 2 tablespoons flour
- 4 cups water
- 3 potatoes, scrubbed and cubed
- 1 can cream of mushroom soup
- 1 can evaporated milk (354ml)
- 1 small to medium Arctic char, filleted (or around 3 pounds of other fish or 3 cans (142 grams each)clams, drained
- 1 can cream corn (342mL)
- 1 tsp pepper

Steps

1. Heat oil on medium high. Add onion, carrots and celery to pot. Cook, stirring often, until the onion is soft, but not brown.
2. Add flour and stir and cook for about 3 minutes.
3. Add water, cream of mushroom soup, potatoes and bay leaf.
4. Bring to a boil, then turn down to low and simmer for about 15 minutes, until the potatoes are starting to get soft.
5. While the chowder is cooking on low heat, if using whole fish, fillet fish and remove skin. Cut into bite sized pieces.
6. Add evaporated milk, fish or clams, corn and pepper to pot, and then simmer for about 10 more minutes.

Recipe and Image Source: Adapted from "Fish or Clam Chowder," by the Government of Nunavut 2011. Web. 3 Dec 2017. http://www.livehealthy.gov.nu.ca/en/food/recipes

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Hamburger Soup

Preparation time:	Cooking time:	Yield:
15 minutes	30–40 minutes	Twelve 1-cup servings

Ingredients:

- 1-pound ground beef, or any ground meat like caribou or seal
- 1 can (796 mL) diced tomatoes, no salt added if available
- 1 can (284 mL) tomato soup
- 1 medium onion, chopped
- 2 medium carrots, finely chopped
- 2 stalks celery or 1 green pepper, finely chopped
- 1 can (284 mL) sliced mushrooms, drained and rinsed
- 4 cups water
- ¼ cup barley or ½ cup noodles, any type like macaroni
- 1 teaspoon dried herbs (oregano, basil, or parsley)

Steps

1. Brown meat in a large pot. Drain off fat.
2. Add all ingredients to pot and bring to a boil. Reduce heat. Cover and simmer for 30 minutes or until the vegetables and noodles or barley are tender. Stir occasionally while cooking. Season with more spices if desired. Add extra water if soup becomes too thick.

Recipe Source: Adapted from "Healthy Hamburger Soup" Meal Bag Manual 2010 Feeding Stomachs and Souls, by FNIHB, Health Canada, Manitoba Region.

Picture Source: Quick and Easy Hamburger Soup. Image. Web. 23 Nov 2017. http://www.simplyrecipes.com/recipes/quick_easy_hamburger_soup/

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Hearty Mushroom Soup

Preparation time:	Cooking time:	Yield:
5 minutes	5–10 minutes	8 ¾ cup servings

Ingredients:

- 2 cans (284 ml) cream of mushroom soup
- 2 cans sliced mushrooms (284 mL), rinsed and drained
- 2 cans (284 ml) water and 1 can (284 mL) milk

Steps

1. Empty soup cans and mushrooms into a pot.
2. Add the water and milk.
3. Heat stirring often until the soup reaches a low boil, about 5-10 minutes.
4. Add some water if soup is too thick.

Recipe Source: Created for "Nutrition Planning Support to Three Elder's Facilities in Nunavut," by the Department of Health, Government of Nunavut 2017-2018.

Picture Source: Mushroom Soup. Image. Web. 3 Dec 2017. https://leeandmarias.com/recipes/mushroom-soup/.

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Split Pea Soup

Preparation time:	Cooking time:	Yield:
10 minutes	60–70 minutes	12 servings

Ingredients:

- 1 ½ tbsp. vegetable oil
- 1 cup chopped onion
- 1 ½ cup diced carrot
- 1 ½ cup diced peeled potato
- 2 cups green split peas 250 mL (yellow split peas will work too)
- 8 cups water
- 3 teaspoons instant chicken bouillon powder, low sodium if available
- 1 cup diced cooked ham
- 1 bay leaf
- ¼ tsp ground black pepper

Steps

1. In a pot, heat oil over medium-high heat and add onion, carrot and potato. Fry until vegetables are soft.
2. Add split peas, water, bouillon, ham and bay leaf.
3. Bring to boil; reduce heat; cover and allow to simmer for about 45-60 minutes or until peas are tender and soup has thickened. Stir occasionally.
4. Remove bay leaf. Add pepper just before serving.

Recipe and Image Source: Adapted from Classic Split Pea Soup. Image. Web. 20 Nov 2017. https://www.canolainfo.org/recipes/classic-split-pea-soup

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Appendix 9

Substitutions for Recipe Ingredients

Ingredient	Amount	Substitution
Baking powder	1 teaspoon	¼ teaspoon baking soda, plus ½ teaspoon cream of tartar
Baking soda	1 teaspoon	2 teaspoons double-acting baking powder (must replace acidic liquid such as sour milk or buttermilk with non-acidic liquid, such as water or milk), minus the salt in the recipe
Bread crumbs	1 cup	1 cup cracker crumbs **OR** 1 cup ground oats **OR** 1 cup crushed corn flakes or other plain cereal
Brown sugar	1 cup, packed	1 cup white sugar
Buttermilk or sour milk	1 cup	1 cup yogurt **OR** 1 cup milk and 1 tablespoon vinegar. Let stand 5 minutes, til curdled.
Chocolate (unsweetened)	1 ounce	3 tablespoons unsweetened cocoa, plus 1 tablespoon shortening or vegetable oil
Cocoa	¼ cup	1 (1-ounce) square unsweetened chocolate
Corn syrup	1 cup	1 ¼ cup white sugar, plus 1/3 cup water, **OR** 1 cup honey
Cream (15% or 35%)	1 cup	1 cup evaporated milk
Cream of tartar	1 teaspoon	2 teaspoons lemon juice or vinegar
Egg	1 whole	half a banana mashed with ½ teaspoon baking powder **OR** 2 ½ tablespoons of powdered egg substitute, plus 2 ½ tablespoons water, **OR** ¼ cup liquid egg substitute

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Ingredient	Amount	Substitution
Fats for baking	1 cup	1 cup applesauce **OR** 1 cup fruit puree
Garlic	1 clove	1/8 teaspoon garlic powder **OR** ½ teaspoon garlic salt. Reduce salt in recipe by ½ teaspoon
Herbs – fresh	1 tablespoon chopped fresh	1 teaspoon (chopped or whole leaf) dried herbs
Honey	1 cup	1 ¼ cup white sugar, plus 1/3 cup water **OR** 1 cup corn syrup
Ketchup	1 cup	1 cup tomato sauce, plus 1 teaspoon vinegar and 1 tablespoon sugar
Lemon juice	1 teaspoon	½ teaspoon vinegar
Milk, fresh	1 cup	1/3 cup dry milk powder plus 1 cup water ½ cup evaporated milk, plus ½ cup water 1 cup UHT milk
Mustard, prepared	1 tablespoon	Mix together 1 tablespoon dried mustard, 1 teaspoon water, 1 teaspoon vinegar and 1 teaspoon sugar
Onion, fresh	1 medium onion	1 tablespoon onion powder or 3 tablespoons dried onion flakes
Sour cream	1 cup	1 cup plain yogurt **OR** 1 tablespoon lemon juice or vinegar, plus enough cream to make 1 cup, **OR** ¾ cup buttermilk, mixed with 1/3 cup butter

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Appendix 10

Dietitian Support

Regional Clinical Dietitians

There are registered dietitian (RD) positions that provide clinical nutrition service in all Department of Health regions. Here are guidelines to refer patients to a clinical dietitian in your region.

When to refer to a Dietitian:

a. Unintended weight loss: >5% body weight in 1 month, >7.5% body weight in 3 months, and >10% body weight in 6 months (Appendix 13: Calculating percent body weight)

b. Subjective Global Assessment Score of B, C or presence of cachexia and/or sarcopenia (see Appendix 12 for SGA form)

c. Pressure wounds (All Stages of Braden Scale)

d. Dysphagia (refer to Speech Language Pathologist, and Dietitian), chewing difficulties due to poor dentition or all other etiology

e. Poor food intake >72 hours (complete 72 hour food/fluid intake form, Appendix 11)

f. Poor fluid intake > 72 hours (complete 72 hour food/fluid intake form, Appendix 11)

g. Dysgeusia

h. Condition requiring a therapeutic diet: diabetes, cardiovascular disease, COPD, neurodegenerative diseases, tuberculosis (active and latent)

i. Food Insecurity

j. Difficulty feeding (refer to Occupational Therapist and Dietitian)

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Appendix 11

72 Hour Food Intake Record

Purpose: to track the food and fluid intake of a client. Food intake records are a useful when evaluating any changes in appetite, determining if a client is at risk for dehydration or malnutrition.

- Keep a record of all foods and fluids at meals the client eats within the 72 hour period
- Include any oral nutritional supplements
- Include snacks, and fluids consumed throughout the day
- Include the portion size for foods and the amount of fluids in millilitres, or ounces
- Include sauces such as gravy, ketchup, jam, margarine and butter

Tips:

Food: use measuring cups if possible, or your hands to estimate portion sizes. A portion of starch such as rice, mashed potatoes, pasta the size of an adult's fist is approximately ½ cup. A piece of meat the size of an adults palm is approximately 3–4 oz.

Fluids: Measure fluids in millilitres or ounces.

1 cup = 250 mL = 8 oz

Count the number of food items is applicable: i.e. 12 baby carrots, 2 Oreo cookies, 4 Pilot biscuits, 6 medium-sized shrimp

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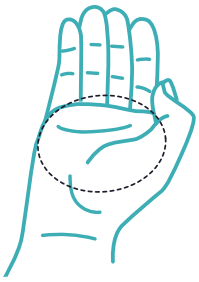
Food	About how much to offer
Fruit juice	½ cup
Rice and pasta	1 cup
Bannock	About the size of half a slice of bread
Meat and Fish	About the size of the palm of your hand 

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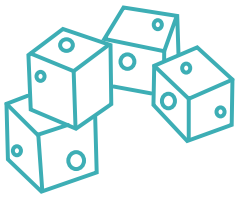
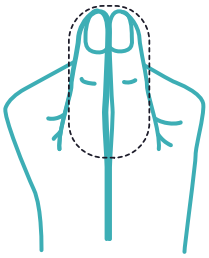
Food	About how much to offer	
Vegetables and Fruit	½ cup	
Yogurt	½ cup	
Cheese		

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Sample:
72 Hour Food Intake Record

Time	Amount	Description	Notes
		Juice-orange	Client appeared less hungry than usual at breakfast
	1 slice	White bread, strawberry jam added (1 tbsp)	
	1 egg	Boiled egg	Client only ate half
1000	2 cookies	Voortman brand, strawberry wafer	
	1 cup	Coffee with cream added	
1200	1 cup	Hot water	Client refused lunch
1430	½ cup	Apple juice	
1700	1 cup	Coffee with cream	
	½ cup	Sautéed greens	
	2 oz	Steamed chicken with mushroom gravy	
	½ cup	Rice	Client ate half portion
2000	½ cup	Apple juice	
2000	1 small muffin	Blueberry muffin	Client ate half muffin

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For Facility Use:
72 Hour Food Intake Record

Facility: _____

Completed by: _____ Designation: _____

Date: _____

Time	Amount	Description	Notes

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Time	Amount	Description	Notes

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Time	Amount	Description	Notes

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Subjective Global Assessment Form

MEDICAL HISTORY

Patient name: _____ Date: _____ /_____ /_____

NUTRIENT INTAKE

1. ☐ No change; adequate
2. Inadequate; duration of inadequate intake _____
   ☐ Suboptimal solid diet ☐ Full fluids or only oral nutrition supplements ☐ Minimal intake, clear fluids or starvation
3. **Nutrient Intake in past 2 weeks***
   ☐ Adequate _____ ☐ Improved but not adequate _____ ☐ No improvement or inadequate _____

WEIGHT

Usual weight _____ **Current weight** _____

1. **Non fluid weight change past 6 months** Weight loss (kg) _____
   ☐ <5% loss or weight stability ☐ 5-10% loss without stabilization or increase ☐ >10% loss and ongoing
   If above not known, has there been a subjective loss of weight during the past six months?
   ☐ None or mild ☐ Moderate ☐ Severe
2. **Weight change past 2 weeks*** Amount (if known) _____
   ☐ Increased ☐ No change ☐ Decreased

SYMPTOMS (Experiencing symptoms affecting oral intake)

1. ☐ Pain on eating ☐ Anorexia ☐ Vomiting ☐ Nausea ☐ Dysphagia ☐ Diarrhea
   ☐ Dental problems ☐ Feels full quickly ☐ Constipation
2. ☐ None ☐ Intermittent/mild/few ☐ Constant/severe/multiple
3. **Symptoms in the past 2 weeks***
   ☐ Resolution of symptoms ☐ Improving ☐ No change or worsened

FUNCTIONAL CAPACITY (Fatigue and progressive loss of function)

1. No dysfunction
2. Reduced capacity; duration of change _____
   ☐ Difficulty with ambulation/normal activities ☐ Bed/chair-ridden
3. **Functional Capacity in the past 2 weeks***
   ☐ Improved ☐ No change ☐ Decrease

METABOLIC REQUIREMENT

High metabolic requirement ☐ No ☐ Yes

PHYSICAL EXAMINATION

Loss of body fat	☐ No	☐ Mild/Moderate	☐ Severe
Loss of muscle mass	☐ No	☐ Mild/Moderate	☐ Severe
Presence of edema/ascites	☐ No	☐ Mild/Moderate	☐ Severe

SGA RATING

☐ **A** Well-nourished Normal ☐ **B** Mildly/moderately malnourished Some progressive nutritional loss ☐ **C** Severely malnourished Evidence of wasting and progressive symptoms

CONTRIBUTING FACTOR

☐ **CACHEXIA -** (fat and muscle wasting due to disease and inflammation) ☐ **SARCOPENIA -** (reduced muscle mass and strength)

*See page 2 SGA Rating for more description.

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Subjective Global Assessment Guidance For Body Composition

SUBCUTANEOUS FAT

Physical examination	Normal	Mild/Moderate	Severe
Under the eyes	Slightly bulging area	Somewhat hollow look, Slightly dark circles,	Hollowed look, depression, dark circles
Triceps	Large space between fingers	Some depth to fat tissue, but not ample. Loose fitting skin.	Very little space between fingers, or fingers touch
Ribs, lower back, sides of trunk	Chest is full; ribs do not show. Slight to no protrusion of the iliac crest	Ribs obvious, but indentations are not marked. Iliac Crest somewhat prominent	Indentation between ribs very obvious. Iliac crest very prominent

MUSCLE WASTING

Physical examination	Normal	Mild/Moderate	Severe
Temple	Well-defined muscle	Slight depression	Hollowing, depression
Clavicle	Not visible in males; may be visible but not prominent in females	Some protrusion; may not be all the way along	Protruding/prominent bone
Shoulder	Rounded	No square look; acromion process may protrude slightly	Square look; bones prominent
Scapula/ribs	Bones not prominent; no significant depressions	Mild depressions or bone may show slightly; not all areas	Bones prominent; significant depressions
Quadriceps	Well defined	Depression/atrophy medially	Prominent knee, Severe depression medially
Interosseous muscle between thumb and forefinger (back of hand)**	Muscle protrudes; could be flat in females	Slightly depressed	Flat or depressed area

FLUID RETENTION

Physical examination	Normal	Mild/Moderate	Severe
Edema	None	Pitting edema of extremities / pitting to knees, possible sacral edema if bedridden	Pitting beyond knees, sacral edema if bedridden, may also have generalized edema
Ascites	Absent	Present (may only be present on imaging)	

A - Well-nourished no decrease in food/nutrient intake; < 5% weight loss; no/minimal symptoms affecting food intake; no deficit in function; no deficit in fat or muscle mass **OR** *an individual with criteria for SGA B or C but with recent adequate food intake; non-fluid weight gain; significant recent improvement in symptoms allowing adequate oral intake; significant recent improvement in function; and chronic deficit in fat and muscle mass but with recent clinical improvement in function.

B - Mildly/moderately malnourished definite decrease in food/nutrient intake; 5% - 10% weight loss without stabilization or gain; mild/some symptoms affecting food intake; moderate functional deficit or recent deterioration; mild/moderate loss of fat and/or muscle mass **OR** *an individual meeting criteria for SGA C but with improvement (but not adequate) of oral intake, recent stabilization of weight, decrease in symptoms affecting oral intake, and stabilization of functional status.

C - Severely malnourished severe deficit in food/nutrient intake; > 10% weight loss which is ongoing; significant symptoms affecting food/nutrient intake;severe functional deficit **OR** *recent significant deterioration obvious signs of fat and/or muscle loss.

Cachexia – If there is an underlying predisposing disorder (e.g. malignancy) and there is evidence of reduced muscle and fat and no or limited improvement with optimal nutrient intake, this is consistent with cachexia.

Sarcopenia – If there is an underlying disorder (e.g. aging) and there is evidence of reduced muscle and strength and no or limited improvement with optimal nutrient intake.

****In the elderly prominent tendons and hollowing is the result of aging and may not reflect malnutrition.**

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Appendix 13

Calculating Percent Weight Change

Client's current weight: _____ A

Client's weight 1 month ago: _____ B

Client's weight 3 months ago: _____ C

Client's weight 6 months ago: _____ D

To calculate percent weight change:

Subtract current body weight (**A**)
from previous body weight (**B**, **C** or **D**) _____

Multiply by 100 _____

Divide by current weight (**A**) _____

= [(Current weight – Previous weight) ×100] ÷
Previous weight _____

The following changes in weight are considered <u>significant weight loss</u>:

- **5% in 1 month**
- **7.5% in 3 months**
- **10% in 6 months**

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Sample:

Client's current weight:	67 kg
Client's weight 1 month ago:	66.5 kg
Client's weight 3 months ago:	72 kg
Client's weight 6 months ago:	72.5 kg
Client's weight 12 months ago:	75 kg

Percent weight change:

1 month	0.8%
3 months	7.5%
6 months	8.2%
12 months	12%

significant weight loss, refer to RD

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Appendix 14

GN Food and Beverage Guidelines

Guidelines for Foods and Drinks Served at GN-Funded Community Wellness Programs

Your community program should provide the best foods available to support the health of your community and to provide examples of healthy choices at every event. These guidelines support a healthy eating pattern and describe the GN's expectations for foods served in your programs.

1. **Serve country foods as often as you can.** Follow recommendations in the "Serving Country Food in Government-Funded Facilities and Community Programs" guidebook.

2. **At the store and on sea lift, purchase a variety of nutritious foods: vegetables, fruits, grains, and protein foods.**

3. **Unhealthy foods cannot be purchased with GN Health funds.**

Healthy Ideas

Have different foods from day to day. A variety of foods is important for health. Try something new!

Country foods are VERY healthy! Serve a variety of country food as often as you can!
Your program funding can be used to buy country food from • Hunters and Trappers Organizations • Experienced hunters • Stores and fish/meat processing facilities If you have concerns about serving country food during your program, talk to your Regional nutritionist or Regional Environmental Health Officer.

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Store bought foods	
Meals and snacks should be made up of • Variety of vegetables and fruits ○ Fresh, frozen, or canned fruits and vegetables are all healthy choices. • Mainly whole grains • Protein-rich foods	
Meals should include at least 3-4 different items. Ex. Whole grain cereal, milk, apple, and a hard-boiled egg.	**Snacks** should include at least 2-3 different items. Ex. Banana, yogurt, and homemade muffin.

Drinks
• Make water and plain milk your program's main drinks. • Sugary drinks should not be bought or served. • Coffee and tea can be purchased for serving to adults if water is also offered.

"Unhealthy foods" cannot be purchased with GN program funds.

Look for store-bought foods with less salt, sugar, and saturated fats. Talk to your Community Health Representative (CHR) or Nutritionist to learn more.

Unhealthy drinks include:

× Fruit drinks (including 100%), punches, cocktails, or juice crystals
× Pop, energy drinks, sports drinks (like Gatorade)
× Sweetened milks (chocolate, strawberry, milkshakes)
× Flavoured waters with added sugars
× Sweetened hot or cold drinks, like ice tea and slushies

Unhealthy foods include:

× Cake, ice cream, Jello, pastry (like pop-tarts), store-bought muffins
× Sugary cereals (like Froot Loops or Frosted Flakes)
× Cookies with chocolate chips or filled with icing
× Granola bars with chocolate or candy
× Granola bars with sugars as one of the first 2-3 ingredients
× Syrup, chocolate sandwich spread (like *Nutella*)
× Potato chips, cheesies, pretzels, popsicles
× Processed meats (like hot dogs, Pogos, Klik, bologna, pepperoni, salami, bacon, chicken nuggets)
× Store-bought and frozen pizza
× Lard, shortening, and fried foods

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Nunavut Food Guide

Choose country foods and healthy store-bought foods for a strong body

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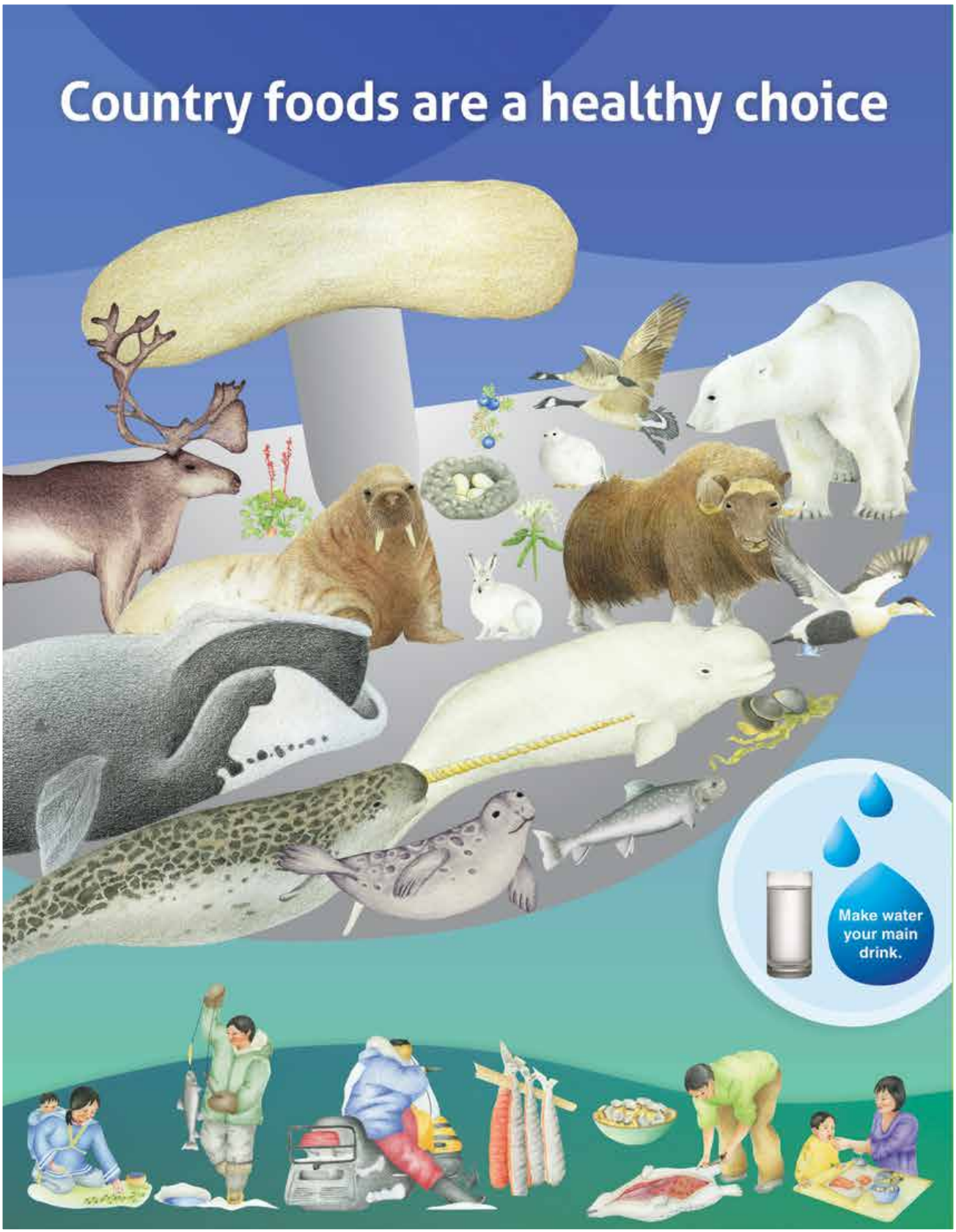

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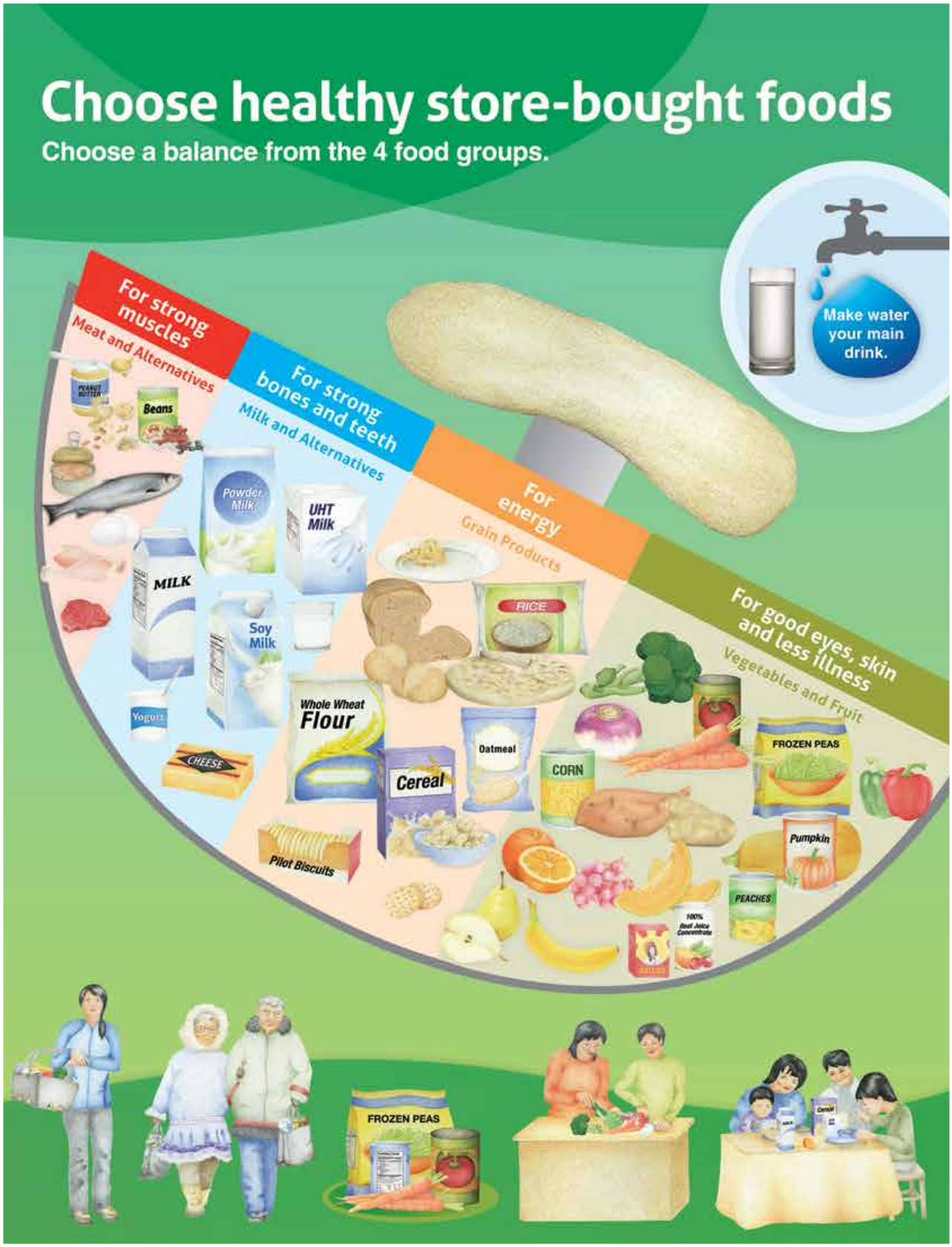

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Unhealthy

If you don't buy these, you will have more money for healthy food.

Choose fats wisely

Fats from fish and sea animals are very good for you.

Choose healthy store-bought fats.

Eat less of these:

Variety is important

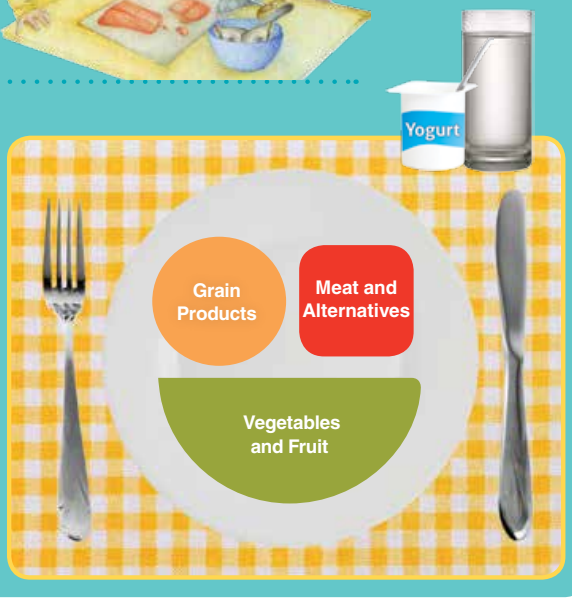
Traditional values teach us to eat a variety of country foods.

A traditional way of eating is balanced.

When you eat store-bought foods...

A balanced meal has 3 to 4 food groups.
Healthy snacks have 2 to 3 food groups.

Meat and Alternatives	Milk and Alternatives	Grain Products	Vegetables and Fruit



For more information on health and nutrition visit
www.hss.gov.nu.ca

Nunavut

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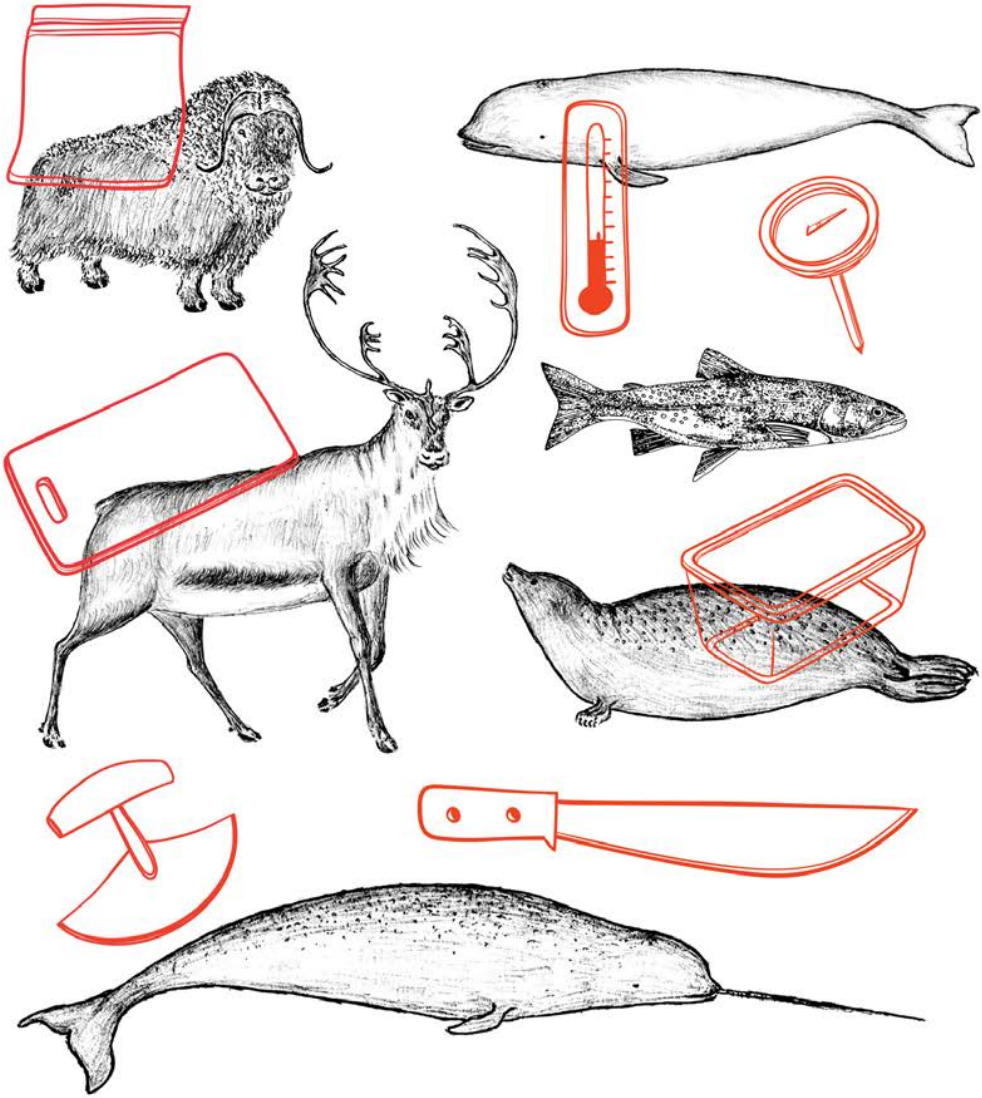
Nunavut



Serving Country Food

in Government-Funded Facilities and Community Programs

Nunavut

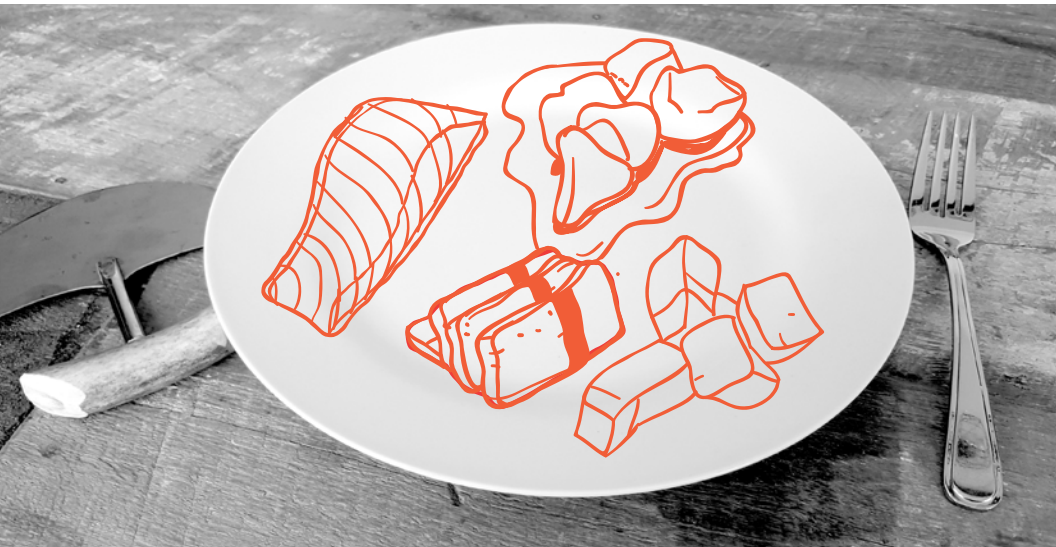
NUNAVUT FOOD SECURITY COALITION

Country food is a healthy choice!

Government of Nunavut (GN)-funded facilities and community programs are encouraged to serve more country food. The suggestions in this booklet are made specifically for GN community programs and facilities that serve country food.

If you are a GN-funded facility or community program, you may be able to get support to buy more country food. To find out more, talk to:

- your regional nutritionist
- your community economic development officer or the regional economic development and transportation office



Introduction

Part 1 of this guide shows ways for GN-funded facilities and community programs to keep country food safe. The information in Part 1 is useful for keeping all foods safe.

Part 2 of this guide provides information about specific country food like char and caribou. It provides recommendations for GN community programs and facilities that serve these country food.

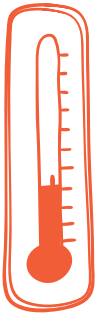
The recommendations in this book are for food being served to high-risk populations, like people who are already sick or who have weak immune systems.

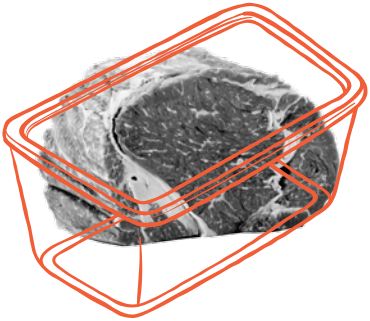
Introduction to
Part 1

Country food harvested by experienced hunters is safe!

But, even safe food can be put at risk:

Changing weather, like warmer temperatures, can increase the risk of food going bad or causing sickness.





Some ways of storing food increases the risk of food causing sickness. For example, it is not safe to age meat or fat in a plastic container with a tight lid at room temperature.

Experienced Hunters

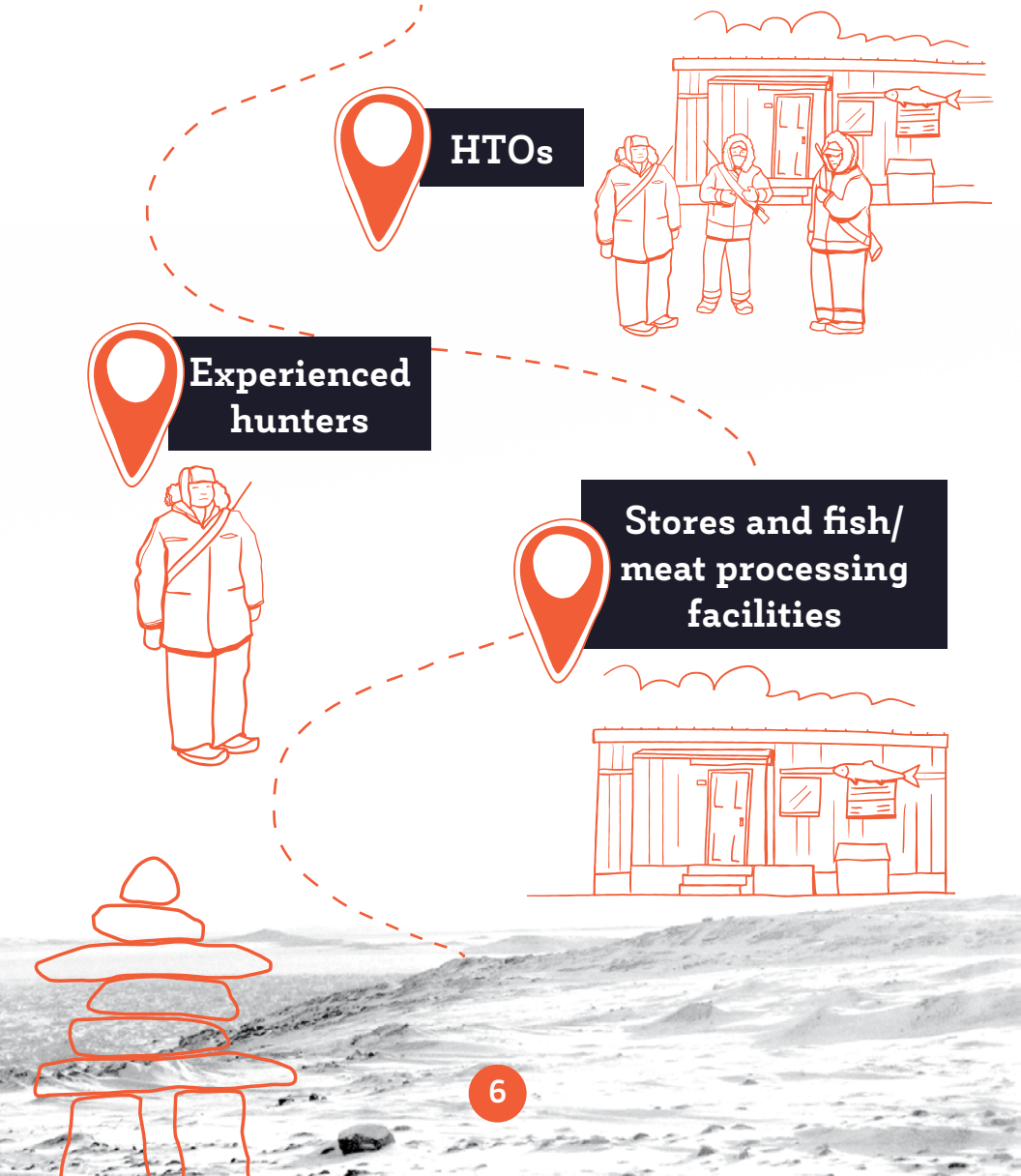
Experienced hunters use Inuit traditional knowledge when harvesting. This has kept food safe for a long time. Programs and facilities should buy country food from experienced hunters.

Together with Inuit traditional knowledge, this guide provides steps to keep food safe.

To find out who the experienced hunters are in your community, contact your local hunters and trappers organization (HTO).

Buying country food

You can buy country food from:

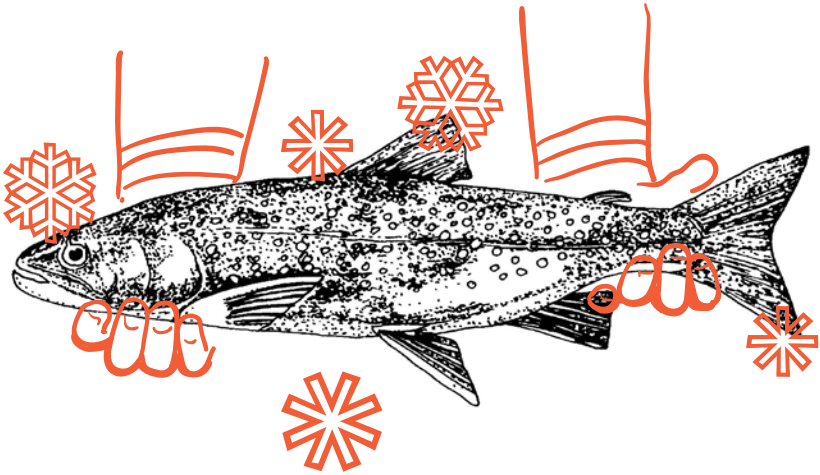


Donations

GN-funded facilities should accept donations of country food.

Donations from HTOs and experienced hunters are encouraged.

You should handle and track country food donations in the same way as country food that you buy.

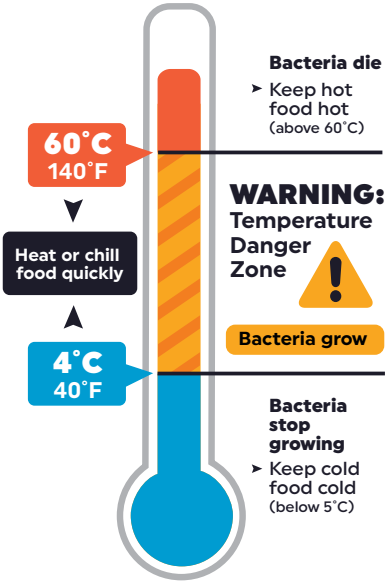


Inspection

You should look at the country food when you receive it to make sure it is in good condition. It should be clean and not bruised. It should be at a temperature of 4°C or colder (or completely frozen).

Don't accept country food that is over the temperature of 4°C. Food that is over 4 °C may have started to spoil.

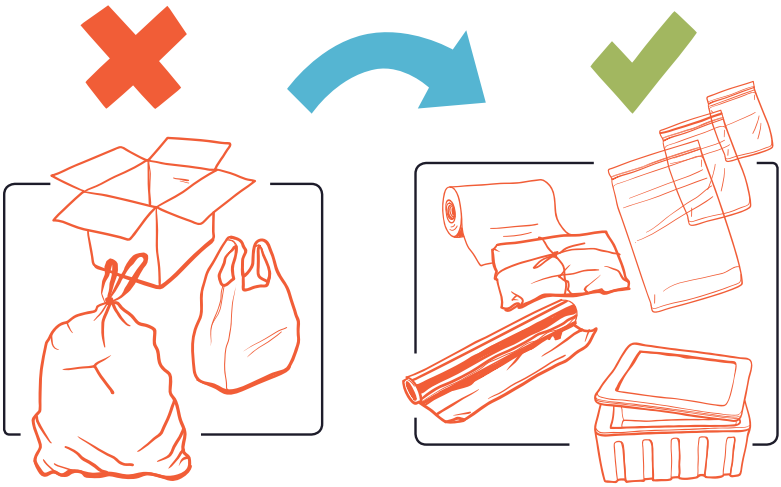
Facilities and programs should have thermometers to check the temperature of meat.



Food Safe

Packaging

- Food-safe packaging is material that is safe for storing food, including butcher paper, aluminum foil and food-safe plastics (like resealable bags).
- Packaging that is not safe for storing food is cardboard, grocery bags and garbage bags.
- At your facility or program, if you receive country food that is not in food-safe packaging , you should put it in food-safe packaging for storage. For example, if country food arrives in garbage bags, it should be repackaged in food-safe wrapping.
- Garbage bags and grocery bags have chemicals in the plastic that can get into the food. Grocery bags and cardboard that have been used before may also have germs from other foods.



Labelling and Tracking

- Whenever you receive country food in your facility or program, you need to fill out a tracking form. Fill out the country food tracking form that is found on p. 42-43.
- After the country food is in food-safe packaging, label it. The label should have:
  - ✔ the date the country food was received
  - ✔ the animal
  - ✔ the animal part
- The information on the label should be the same information that is on the country food tracking form, so it is easy to keep track of where all of your country food comes from.
- Photocopy the label on this page.

COUNTRY FOOD

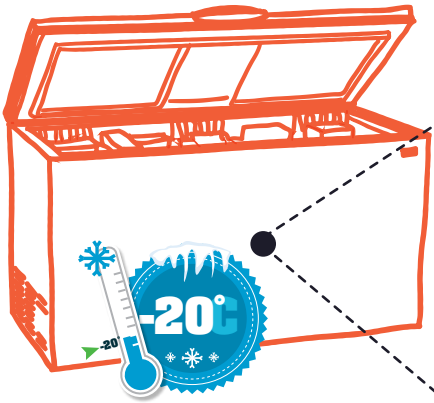
Food Safe Label ✔

Date received: _____

Animal: _____

Animal part : _____

Storing country food

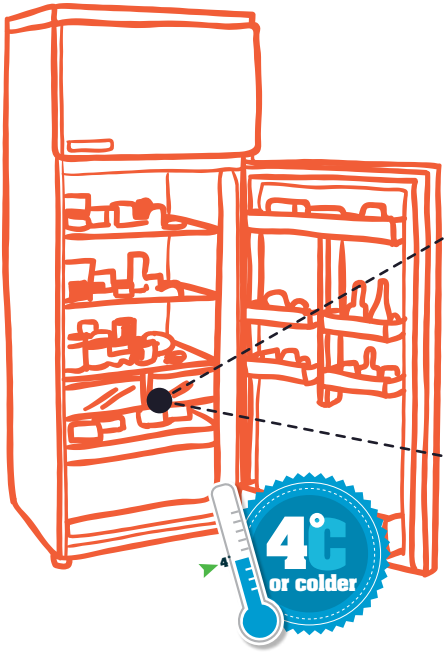


Store country food

in a country-food freezer. Country food can also be stored in a freezer with store-bought food. It is good to keep country food separate from store-bought food in the freezer.

Frozen country food

should be stored at -20°C (deep freezer).



Fresh country food

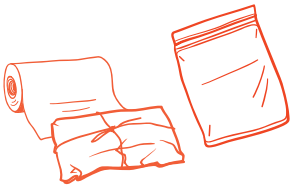
should be stored at 4°C or colder (refrigerator temperature).

Uncooked meat should always be stored on the bottom shelf of a refrigerator to make sure it does not drip on other foods.

Equipment

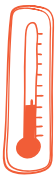
These things are useful for keeping country food safe:

- food-grade packaging (like butcher paper, food-safe plastic bags)



- thermometers to keep track of the temperature of meat

- thermometers to make sure refrigerators and freezers are at a safe temperature



- country food tracking form (found at the back of this guide)

- labels for country food

Contact your Environmental Health Officer to find out how to get this equipment.

Preparing and Serving County Food

Country food should be served in ways that people like to eat it. Ask what the local customs are!

Here are ways to find out more about cooking with country food:

- recipes under "Resources" at www.livehealthy.gov.nu.ca

- Inuit Broadcasting Corporation's country-food recipe book *Niqitsiat*!

- recipes from programs like the Canada Prenatal Nutrition Program

Seal Broth

Recipe

(Provided by Pitsiula Kilabuk, Pangnirtung)

Cut up seal meat and put in stockpot.

Add at least 8 cups (2 liters) of water to cover, then add:

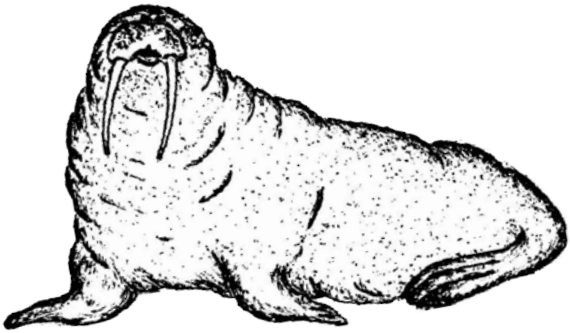
- **2 packages dry soup mix** (such as tomato vegetable) or low sodium vegetable broth
- **1 chopped onion**
- **4-5 potatoes, carrots or turnips**, chopped

Boil until the seal meat is cooked and the vegetables are tender. Seaweed dipped in seal broth is delicious!

Fermented or Aged Food

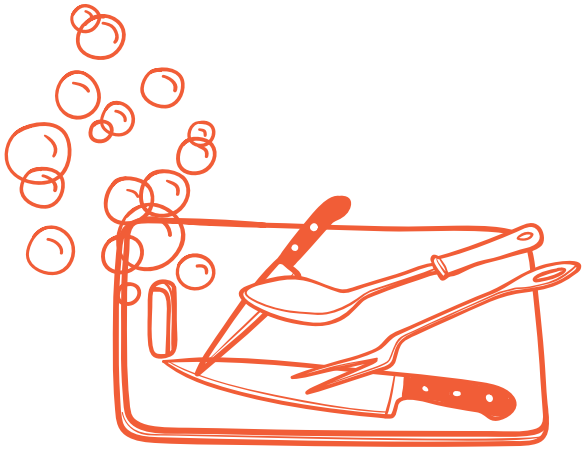
Fermented and aged country food that is not prepared in the right way can cause serious sickness. This is a concern especially for people who are already sick.

It is recommended that facilities and programs **do not** buy or accept donations of fermented or aged country food (like igunaq).



Preparing Food - Kitchen

- Facilities and programs should prepare country food in the kitchen of the facility. Country food can also be prepared in a clean space that is reserved for country food.
- Country food should be butchered on surfaces that are clean and can be cleaned after. For example, a good surface is a cutting board that can be washed. You can also use clean ice and snow to butcher meat.
- Some surfaces are hard to clean and trap germs (like plywood and tarps). These are not recommended to use for cutting meat that will be served to people in programs and facilities.



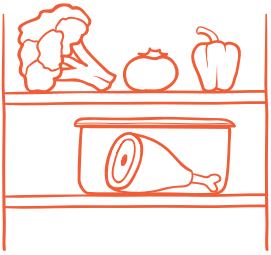
Food safety reminders

for all foods

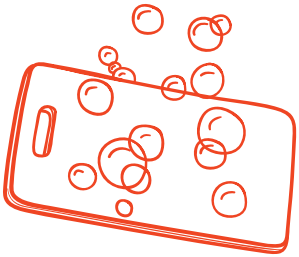
1. **Keep foods separated.**
Raw foods should be kept separate from cooked foods.

2. **Clean tools and disinfect them (get rid of germs on tools).**
Knifes, ulu and cutting boards should be cleaned after butchering or preparing foods. It is a good idea to have cutting boards that are only used for cutting meat and separate cutting boards for cutting vegetables. Running a dishwasher on the hot cycle is a good way to disinfect kitchen tools.

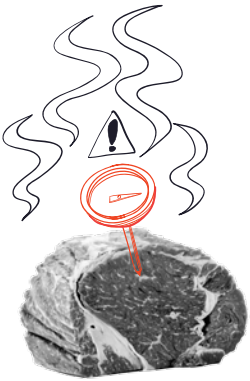
3. **Thaw meat properly.**
A safe way to thaw meat is to put it on the bottom shelf of a refrigerator on a plate or tray. Food should not be thawed at room temperature. Talk to an Environmental Health Officer about the best way to thaw meat in your facility.

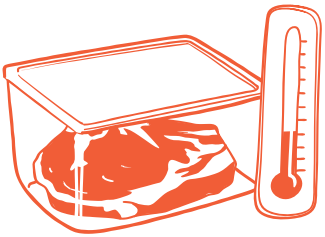


4. Clean and disinfect all surfaces after cutting meat. It is best to cut meat on cutting boards. Wash cutting boards using soap and run through the dishwasher if possible.



5. Keep track of temperatures using thermometers. Use thermometers to know when food is cooked, and to make sure that it is stored at the right temperature.





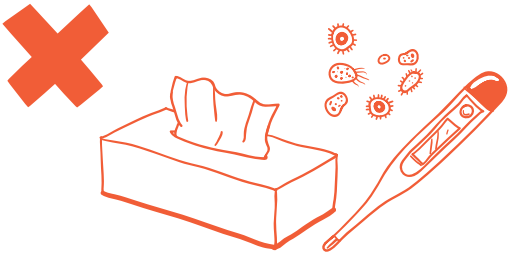
6. **Wash your hands often when handling food.** You should wash your hands with soap at these times:

- before you handle food
- after you handle raw food
- after you use the washroom
- after you smoke or use the telephone
- after you sneeze or cough
- any time you wonder if you should wash your hands

7. **Do not handle food if you are sick.**

You should not handle food if you have any of these:

- fever
- coughing and sneezing a lot
- diarrhea or vomiting



Serving Country Food

Checklist

- [ ] **Buy** country food or accept donations from HTOs, experienced hunters, or stores/fish and meat processing facilities.

- [ ] **Inspect** country food that you receive.

- [ ] **Track** country food. Fill out tracking form and labels before storing or serving country food.

- [ ] **Store** country food properly.

- [ ] **Prepare** country food the way people like it.

- [ ] **Follow food safety rules** in the kitchen or where you prepare foods. Remember to keep foods separate, check temperatures, clean and disinfect (get rid of germs).

Keeping country food safe at feasts

Here are things to keep in mind when having a feast:

- Keep country food at room temperature for no longer than two hours. It is a good idea to put out the food right before the feast starts. If food is to be thawed (or partially thawed) before it is eaten, it should be thawed in a refrigerator.

- Keep hot food hot, and cold food cold. Hot food (like stew) should be kept on the stove until right before it is served. Put any leftovers in the fridge right away.

- It is important to know what country food is being served. Label country food when it is put into a freezer, so you know what is being served at the feast.

Introduction to Part 2

This section of the guidebook talks about how to serve country food at government facilities and community programs. There are recommendations for:

- fish
- caribou
- muskox
- seal
- whale

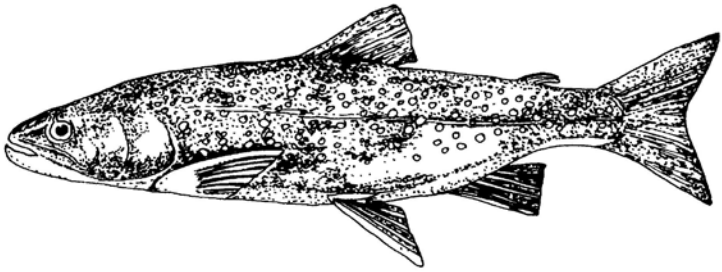
There is also some information about walrus and polar bear.

Fish

At GN facilities and programs:

- You can serve cooked fish. Cooking fish will kill any roundworms that might be in the fish. Cook fish to an internal temperature of more than 70°C.

- You can serve uncooked fish. To serve uncooked fish, first freeze the fish for seven days at -20°C. Freezing for this length of time should kill any roundworms, so the fish will be safer to eat raw.



Important information

about fish

- The roundworm larva (immature roundworms) in fish can make people sick. Eating the larva can cause illness in the stomach and intestines. It is not known how often roundworms are found in fish in Nunavut, and they are sometimes too small to see.

- It is not known if drying fish kills the roundworms.

When fish is served frozen, like Arctic char, it should not be served partially thawed. Many people enjoy fish when it is well frozen. Some people like to cut frozen fish by themselves.

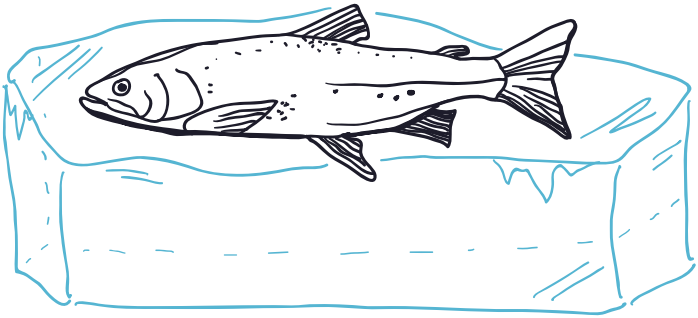
Do not store frozen fish for longer than three months. If possible, fish should only be stored for one month for best taste.

Suggestions from veterinarians about fish:

Fish harvested from nets must be alive when taken from the net. It is suggested that nets be checked every three hours.

In winter: After removing fish from the net, let the fish freeze on clean ice. Do not gut the fish in winter. Pack the frozen fish in food-grade boxes or bags.

In summer: Gut the fish immediately to stop any worms in the guts from moving into the flesh. Keep fish at a temperature of 4° Celsius or colder with clean ice, in clean food-grade containers.



Caribou

At GN facilities and programs:

- You can serve cooked caribou. Cooking caribou kills all the germs that caribou might have. Cook caribou until juices run clear and the meat is no longer pink in colour. Caribou should be cooked to an internal temperature of more than 75°C.
- You can serve uncooked caribou to some people. People who are immunocompromised (cannot fight off infections) should not be served raw caribou.
- Before serving uncooked caribou, freeze the caribou for at least three days at -20°Celsius. Freezing caribou for three days kills a germ called toxoplasma that might be a risk to pregnant women.
- Freezing caribou does not kill all germs that may be found in caribou. Make sure to read the information on the next page when planning to serve uncooked caribou.

Caribou meat can be stored in a freezer at -20°Celsius for 6-12 months.

Immunocompromised

Some sickness can cause a person to become immunocompromised, which means they have trouble fighting off germs and infections. People who are immunocompromised need to be more careful about what foods they eat. These are some examples of people who are considered to be immunocompromised:

- people who are having cancer treatment like chemotherapy
- people with HIV/AIDS

Important information
about caribou:

Brucella

Brucella is a germ (bacteria) that has been found in some caribou herds in Nunavut. Brucella can cause sickness in humans. The only way to kill brucella is to cook the caribou. Freezing, drying or smoking caribou will not kill brucella.

Government facilities and community-based programs should follow these guidelines:

- ✔ Do not serve uncooked caribou if the caribou is from a herd that is known to have brucella. Some animals in that herd might be infected with brucella but not show signs of sickness.
- ✔ Do not accept or handle caribou with brucella because it could contaminate the kitchen or other food. Wash your hands with soap if you do.

Suggestions from veterinarians about caribou:

If there is swelling in the knuckles, joints or reproductive organs of the caribou, these are signs of brucella. The caribou should not be eaten. Cutting off the infected knuckle or joint and eating the rest of the caribou is not safe because there is likely brucella in all parts of the animal.

Important information

about caribou

Toxoplasma

Toxoplasma is a germ (parasite) that has been found in caribou. Toxoplasma can cause serious illness for people who cannot fight infections and for pregnant women. Cooking caribou meat kills toxoplasma. Freezing meat for three days also kills toxoplasma. At facilities and programs, make sure to freeze caribou meat for three days at -20°Celsius before serving it raw.

Giardia

Giardia is a germ (parasite) that has been found in caribou. Giardia can cause sickness in humans. The only way to kill giardia is to cook the meat.

Hydatid disease

Hydatid disease shows up in caribou as cysts in the organs or meat. Usually the caribou do not appear sick, but you can see the cysts in the caribou after butchering. Do not feed meat with cysts to dogs. Humans do not get the disease from caribou, but can get the disease from contact with dog feces if dogs have been fed caribou meat with cysts in it.

Suggestions from veterinarians about caribou:

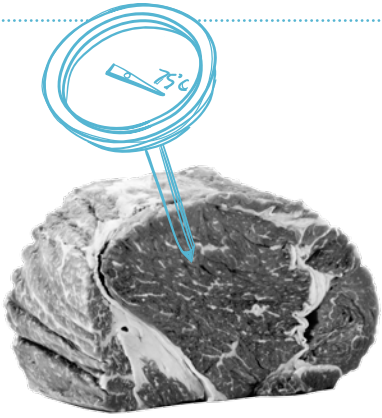
Feces (stool) from the caribou can have giardia, so it is important to keep caribou feces away from the meat and be careful not to cut into the intestines while butchering. Even a small cut of the intestines can expose the meat to giardia.

Muskox

At GN facilities and programs:

- You should serve muskox cooked. Cook muskox until juices run clear and the meat is no longer pink in colour. Muskox should be cooked to an internal temperature of more than 75°C.

People in Nunavut have said that they prefer eating muskox cooked. Cooking muskox kills the germs that might be found in muskox. Muskox should be cooked when served in GN facilities and community programs.



Important information

about muskox

Germs that have been found in some muskox in Nunavut are brucella, erysipelothrix, giardia and toxoplasma.

Government facilities and programs should not accept or handle muskox with erysipelothrix. Touching a muskox with erysipelothrix can cause a rash and other health issues in humans.

Muskox has been shown to carry brucella, but brucella is less common in muskox than in caribou. Muskox with brucella may have swollen knuckles or joints. If there is swelling in the knuckles or joints, the muskox should not be eaten. Government facilities and community-based programs should not handle muskox with brucella because it could contaminate the kitchen or other food.

Muskox can be stored in freezers at -20° C for 6-12 months.

Suggestions from veterinarians about muskox:

- Some muskox in Nunavut have a disease called erysipelothrix. This may show up in muskox as abnormal hair or skin. Humans can catch erysipelothrix by touching muskox that have the disease.

- Some muskox do not show any signs of illness, but may die from erysipelothrix very suddenly. People should avoid touching dead muskox. Erysipelothrix can cause painful skin sores in humans.

- If a muskox shows signs of illness, do not touch it, especially with your bare hands. Wash or disinfect your hands with soap if you do touch parts of the muskox showing illness.

- Muskox with erysipelothrix should not be eaten.

Seal and Whale

At GN facilities and programs:

- You can serve cooked seal and whale. Cooking kills the germs that have been found in some seal and whales in Nunavut. Cook seal or whale to an internal temperature of hotter than 75 °C. If the meat or juice is still red, it has not been cooked long enough. Cook seal or whale until juices run clear and the meat is no longer pink.

- You can serve uncooked seal and whale to some people. People who are immunocompromised (cannot fight off infections) should not be served raw seal or whale.

  - Before serving uncooked seal and whale, freeze for at least three days at -20°Celsius. Freezing seal or whale for three days kills a germ called toxoplasma that might be a risk to pregnant women.

  - Freezing seal and whale does not kill all germs that may be found in the animal. Make sure to read the information on the next page when planning to serve uncooked seal or whale.

Immunocompromised

Some sickness can cause a person to become immunocompromised, which means they have trouble fighting off germs and infections. People who are immunocompromised need to be more careful about what foods they eat. These are some examples of people who are considered to be immunocompromised:

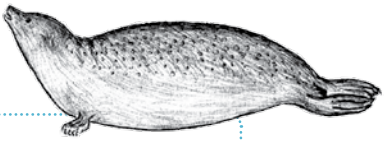
- people who are having cancer treatment like chemotherapy
- people with HIV/AIDS

Important information

about seal and whale:

- Some seal and whales in Nunavut may carry germs that can cause sickness in humans (including botulism, giardia, toxoplasma, and brucella). It is not known how often trichinella occurs in seal in Nunavut. More information is needed to know how often these germs appear in seal and whale.

- Freezing does not kill some of the germs that have been found in seal and whale (botulism, brucella, trichinella and giardia). Cooking kills all of these germs. Seal and whale should be cooked when it is served to people who are not able to fight off infection.



The Department of Health recommends that women of childbearing age who may become pregnant, are planning to get pregnant, or are pregnant eat ringed seal meat instead of ringed seal liver. This is suggested because of some environmental contaminants found in seal liver.

Seal and whale can be stored in freezers at -20°C. There are no reported guidelines on how long seal and whale should be stored in a freezer.

Suggestions from veterinarians about seal:

- Signs of illness or weakness in seal may be a bald coat or parasites on the skin. Seals that are sick may also have white dots on liver or inside the liver. Seals showing signs of illness or weakness should not be eaten.
- Gut a seal immediately after it is killed (or within several hours) to stop any bacteria in the intestines from getting into the meat or fat. Butcher seals on clean surfaces, like clean snow and ice.
- Even if the seal appears healthy:
  1. Do not cut into the gut during butchering
  2. Make sure that none of the contents of organs or intestines are in contact with the meat or the fat of the seal

Walrus and Polar Bear

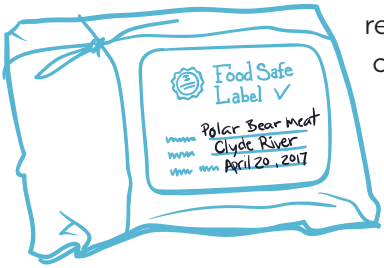
Walrus can have a roundworm called trichinella. These worms can make people very sick. Testing a walrus tongue can show if the walrus has trichinella or not.

Walrus should always be tested for trichinella before it is served uncooked or fermented.
Testing a walrus tongue for trichinella is the best way to know if that animal is safe to eat uncooked.

Walrus tongue testing is free. For more information on walrus tongue testing, contact your Environmental Health Officer.

Most polar bear carry trichinella. Polar bear should always be very well cooked if it is being served in facilities and programs. Polar bear should be cooked to 75°C or hotter.

Polar bear meat should be cooked until there is no pink or red in the meat and no blood coming out of the meat.



Always make sure polar bear meat is labelled so no one eats raw polar bear meat by mistake.

Information from veterinarians:

- The majority of polar bears may carry the trichinella germ. This means that if polar bear meat is eaten uncooked, there is a good chance that people could become sick with trichinella.
- Trichinella is not killed by freezing, drying or fermenting meat. It is only killed by cooking the meat.

Keeping Country Food Safe

Suggested practices

The following recommendations are based on ways that veterinarians suggest handling animals to keep food safe. Nunavut hunters already take many of these actions based on their own knowledge of traditional practices. Inuit traditional knowledge keeps food safe. Many traditional practices that keep food safe are not written down.

These recommendations are here to make sure that the highest quality country food is served in facilities and programs in Nunavut.

Harvesting

- Harvest using Inuit harvesting practices (by an experienced hunter, or under the guidance of an experienced hunter).
- Do not harvest animals if there are any signs of illness, weakness or abnormal appearance.
- Visually inspect the animal after harvest to identify any signs of illness, weakness or abnormalities.
- Report sick, weak or abnormal animals to the conservation officer.

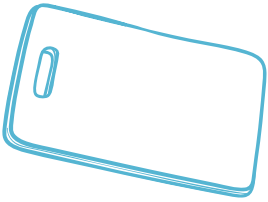
Maintaining Temperatures

- Chill meat to 4°C or colder within three to four hours of harvest.
- If the air temperature is above 4°C, ice or snow may be used to keep carcasses cool.

Butchering Country Food

- Meat should be butchered on surfaces that are clean. If the surface is going to be used again, it is important that it is easy to clean after butchering

- These are good surfaces for butchering:
  - clean snow and ice
  - skin of harvested animal
  - clean tundra
  - trays and cutting boards made for food



- The following surfaces are hard to clean and are not good for butchering: cardboard, wooden boards, painted surfaces, polypropylene tarps and canvas.

- Clean and disinfect butchering tools and equipment after each use.

- Do not cut into the guts of an animal when butchering the animal because there can be exposure to giardia and other germs from animal feces. Even a small cut of the intestines can expose the meat to giardia.

- Do not feed meat with cysts to dogs. Humans can catch disease from parasites that are in dog feces after a dog eats meat with cysts.

Transportation

- No fuel or other contaminants should come into contact with harvested animals during transport.
- Harvested animals and butchered meat should be transported in a sled and/or boat that is only used for transporting animals.
- If animals are shipped between communities, carcasses should stay frozen at all times. If country food is not frozen when shipped, the temperature should always be 4°C or colder.

Appendix 1

It is important to keep track of country food that is bought and donated. Use one of these country food tracking tools (form or table) to keep a record of the country food at your facility.

Country Food
Tracking Form

This form should be completed each time a program or facility receives country food. Keep all forms in one confidential location. The information will help to keep food in facilities and programs safe.

Facility Name	Community
Name of hunter	
Location of harvest (place name or GPS coordinates)	Date animal was harvested DD MM YY
Date country food was received DD MM YY	Check one: ☐ Purchase ☐ Donation
Please describe the country food (type, part of animal, quantity) and any observations regarding the animal:	
Who butchered this animal?	☐ Hunter named above ☐ Facility/ program staff ☐ Other person (name: _____)
What was the temperature of this food when it was received?	
For walrus, was the animal tested for trichinella?	☐ Yes ☐ No
Form completed by	Date DD MM YY

Country Food Tracking Table

This table should be completed each time a program or facility receives country food. Keep this table after it is completed. The information will help to keep food in facilities and programs safe.

Facility Name: _____ **Community:** _____

Name of Hunter Purchase? Donation?	Location of Harvest (place name or GPS coordinates)	Date animal harvested	Date animal received at facility	Temperature when received	If walrus, was it tested for trichinella?	Describe country food (appearance, type, quantity of country food)
☐ Purchase ☐ Donation		DD MM YY	DD MM YY		☐ Yes ☐ No	
☐ Purchase ☐ Donation		DD MM YY	DD MM YY		☐ Yes ☐ No	
☐ Purchase ☐ Donation		DD MM YY	DD MM YY		☐ Yes ☐ No	
☐ Purchase ☐ Donation		DD MM YY	DD MM YY		☐ Yes ☐ No	
☐ Purchase ☐ Donation		DD MM YY	DD MM YY		☐ Yes ☐ No	
☐ Purchase ☐ Donation		DD MM YY	DD MM YY		☐ Yes ☐ No	

Appendix 2

Zoonotic disease

Zoonotic disease is a disease that can be passed between animals and humans. Zoonotic diseases can be caused by viruses, bacteria, parasites and fungi.

Germ name and animal it is found in	How to tell if an animal is sick and how to prevent sickness in humans	Killed by	Effect on human health
Anasakid Nematodes (roundworms) • Arctic char may be infected with immature roundworms (larvae) that can cause disease in humans. • Seal and whale may carry adult roundworms, which do not cause disease in humans.	• Higher risk if fish are not frozen before eating or if they are not gutted right after harvest. • Immature roundworms (larvae) may or may not be visible. If you see larvae, freeze fish for seven days before eating it.	Cooking to an internal temperature of 70°C or freezing at -20°C for seven days.	This can cause mild to moderate gastrointestinal (stomach) illness.
Botulism • Fish, seals, walrus, whales. • It is not known how often botulism-causing bacteria are in an animal. When meat has no oxygen (when no air can get in) the bacteria can make a toxin that causes human illness.	• There are no signs of illness in animals that have the botulism bacteria. • Botulism may happen if food is not properly aged, canned, dried or pickled. • Food should NOT be stored at room temperature or at temperatures warmer than a refrigerator (above 4°C). • Food should NOT be stored in airtight containers (such as plastic bins with tight fitting lids).	Cooking to an internal temperature of 75°C.	Botulism causes a life-threatening sickness that can develop very quickly.
Brucella • Caribou (somewhat common) • Muskoxen (less common than in caribou) • Possible in marine mammals	• Brucella is not killed by freezing, smoking, pickling or drying meat. • In animals, brucella may be associated with abortions in caribou, low fertility in animals, swollen joints or reproductive organs, or poor body condition (weak or thin animals). Sometimes animals show no signs that they are ill with brucella.	Cooking to an internal temperature of 75°C.	Brucella in humans can range from mild flu-like symptoms to severe fevers that keep coming back.

Germ name and animal it is found in	How to tell if an animal is sick and how to prevent sickness in humans	Killed by	Effect on human health
***Echinococcus granulosus* (Hydatid disease)** • Caribou (not known how often this happens) • Muskox (not known how often this happens)	• Generally there are no signs of illness in animals, but cysts are seen in organs (and sometimes meat) after harvest. • Cut out areas with cysts and throw away. • DO NOT FEED cysts to DOGS. Humans can get the disease from contact with dog feces that has the cysts. • Do not eat or cut into fluid filled cysts.		Humans get infected from contact with dog feces (of dogs that have eaten cysts in caribou). Humans do not get infected directly from the cysts. Generally mild symptoms, may lead to formation of large cysts (mostly in the liver).
Erysipelothrix rhusiopathiae • Muskox (common on Victoria Island and Banks Island)	• Touching the skin or hide of animals with skin sores and abnormal hide, hair or coat.	Animals should not be eaten.	Painful skin sores, occasionally arthritis or septicaemia (blood infection).
Giardia • Any species except fish (How often an animal has giardia depends on the location. Giardia is common.) • Exposure to *Giardia* occurs from the contact of meat with feces	• There are no signs of illness in animals. • To prevent sickness in humans, make sure that meat does not get feces on it during gutting. Also, gutting an animal as soon as possible after harvesting helps to lower risks of getting giardia.	Cooking to an internal temperature of 75°C.	Generally mild gastrointestinal (stomach) illness.
Toxoplasma • Polar bear (common) • Seal (varies) • Walrus (less common than in polar bear) • Caribou (common) • Muskoxen (not very common) • Whale	• There are usually no signs of illness in animals. • It may be linked to abortions in the animals.	Cooking to an internal temperature of 75°C, or freezing the meat at -20°C for at least three days.	There are mild (or no) signs of sickness in adults. Toxoplasma can cause severe disabilities for babies when the mother is exposed for the first time when she is pregnant.
Trichinella • Polar bear (common) • Walrus (somewhat common) • Seal (not very common)	• There are no signs of illness in animals that have Trichinella, and it is not visible in the meat. • Tests are available for walrus if the meat will be eaten raw. • *Trichinella* is not killed by freezing, drying or fermenting meat.	Cooking	Illness in humans ranges from mild to severe.

Germ name and animal it is found in	How to tell if an animal is sick and how to prevent sickness in humans	Killed by	Effect on human health
NOT ZOONOTIC			
Muskox lungworm (NOT ZOONOTIC – IS NOT TRANSFERRED TO HUMANS) • Commonly seen when butchered. • Muskox with lungworm may appear sick or weak, can be associated with muskox die-offs.	None	N/A	Lungworm from muskoxen does not cause illness in humans or in dogs.

NUNAVUT
FOOD SECURITY
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www.livehealthy.gov.nu.ca

www.nunavutfoodsecurity.ca

Return to TOC

Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Bedbugs – Identification, Prevention, and Eradication		Client Care	H3C 03-009-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
04/01/2024	0/01/2025	NEW	4
APPLIES TO:			
Home, Community, and Continuing Care Team Members			

1. BACKGROUND:

Home, Community, and Continuing Care (HCCC) recognizes that bedbugs (Cimex lectularius) are public health pests that do not spread disease but may cause emotional and physical distress to residents in continuing care facilities.

Bedbugs are blood-feeding human ectoparasites that feed on the blood of people and animals while they sleep. They do not spread disease, but their bites sometimes cause painful reactions in sensitive individuals.

HCCC provides the following policy and guidelines for the identification, prevention, and eradication of bedbugs.

2. POLICY:

2.1. All staff shall report all bedbug outbreaks to the Nurse Manager or the Supervisor of Home and Community Care.

2.1.1. The Nurse Manager or Supervisor of Home and Community Care shall advise the regional Environmental Health Officer, Territorial Director, Home, Community, and Continuing Care, and the Director.

2.2. Staff providing personal care to residents and housekeeping staff shall routinely follow the prevention guideline below.

2.3. Home Care Workers providing care in-home will support the client and their family in following the prevention and eradication guidelines below.

2.4. Staff finding bedbugs in a client's home will inform the occupants of the presence of bedbugs, provide information on eradication and prevention, and work with community-partners to support the eradication.

3. PRINCIPLES:

3.1. Bedbugs are not known to spread disease, but some people may have mild to severe allergic reactions to bites and scratching bites can lead to secondary infections of the skin.

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3.2. Some people may suffer from loss of sleep and anxiety, which may lead to or exacerbate existing mental health problems.

4. DEFINITIONS:

Ectoparasite: a parasite, such as a flea, that lives on the outside of its host.

Exoskeleton: a hard supporting or protective structure (as of an insect, spider, or crustacean) on the outside of the body.

5. GUIDELINE: IDENTIFICATION:

5.1. Bedbugs are yellowish- white to reddish-brown with six legs and two antennae.
5.2. Adult size is about ¼ inch long – size of an apple seed.
5.3. Eggs can be seen with a magnifying glass; elongated in shape and clear – to – white in colour.
5.4. Bedbugs leave dark feces marks in hiding places (mattresses, cracks, and crevices).
5.5. Bedbugs leave nearly clear exoskeletons behind every time they shed, as well as blood spots on bedsheets after they feed.
5.6. Bedbugs come out at night to feed, attracted by the carbon dioxide exhaled in breathing.
5.7. Bedbugs hide in extremely small locations: under wallpaper, behind picture frames, in electrical outlets, inside box springs, in mattress pads, and in night tables.
5.8. Bedbugs have five stages of development and can live for over one year.
5.9. Eggs are laid in clusters and are more difficult to kill than adults.

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5.10. A bedbug bite can take as long as 14 days to appear, depending on the person. While bites can happen anywhere on the skin, they are often found on the face, neck, arms, legs, and chest.

5.11. Bedbugs tend to leave groups of bites in a straight row or zigzag pattern, but they can also be in a random pattern. There will be an itchy spot on the skin ranging from red on light skin tones to purple on darker skin. There is no red centre to the bite. Some people will have no reaction, while others may be allergic and have a severe reaction.

6. GUIDELINE: ERADICATION:

6.1. Wash bedding, curtains, and clothing in hot water and dry them at the highest dryer setting. Place stuffed animals, shoes, and other items that can't be washed in the dryer and run it on high for 30 minutes or more.

6.2. Use a stiff brush to scrub mattress seams to remove bedbugs and their eggs before vacuuming.

6.3. Vacuum the bed and everything around it every day, including windows and molding. Afterward, put the vacuum cleaner bag in a plastic bag and place it in the garbage outdoors right away.

6.4. Put a tightly woven, zippered cover on the mattress and box springs to keep bedbugs from entering or escaping.

6.5. Repair cracks in plaster and glue down peeling wallpaper to get rid of places bedbugs hide.

6.6. Get rid of clutter around the bed and move the bed away from walls and other furniture.

6.7. If the mattress is infested, dispose of it, and replace it with a new one.

7. GUIDELINE: PREVENTION:

7.1. Use protective covers on mattresses and box springs. Check regularly for holes.

7.2. Reduce clutter in resident rooms so bedbugs don't have many places to hide.

7.3. Vacuum regularly, including mattress, curtains, and upholstered furniture.

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7.4. Ensure residents wear pajamas with long sleeves and long pants to protect the skin from bites.

8. REFERENCES:

Evans School of Public Policy and Governance, University of Washington. (2016, Nat). *Tackling Bed Bugs: A Starter Guide for Local Government*. Retrieved from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/http://npic.orst.edu/pest/bedbug/tacklingbbsterguide.pdf

Government of Canada. (2022, 12 15). *Bedbugs - what are they?* Retrieved from https://www.canada.ca/en/health-canada/services/pest-control-tips/bedbugs-what-are-they.html

Approved By:	Date: 4 January 2024
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date: 4 January 2024
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

Return to TOC

Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Application and Admission to Home, Community, and Continuing Care		Client Services	H3C 04-001-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
05/01/2024	05/01/2027	NEW	5
APPLIES TO:			
All Home, Community, and Continuing Care Team Members			

1. BACKGROUND:

Home, Community, and Continuing Care (HCCC) recognizes that a standardized application and admission process is necessary to ensure that all eligible Nunavummiut have access to the full range of HCCC services available.

Currently, the provided services consist of:

- Home and Community Care Program in each community providing care to Nunavummiut of all ages with a valid Nunavut Health card and assessed long-term chronic needs, palliative care, or short-term acute needs.
- Territorial Continuing Care Centres (CCCs) and Long-Term Care Centres available to eligible Nunavummiut 55 years of age and older who have a valid Nunavut Health card.
- Territorial Elders Homes available to eligible Nunavummiut 55 years of age and older who have a valid Nunavut Health card.
- Placement in residential long-term care out of territory – available to eligible Nunavummiut 55 years of age and older with needs that cannot be met in territory and who have a valid Nunavut Health card.
- There is no cost to the individual for these services.

2. POLICY:

2.1. Applications for Continuing Care shall be completed by a health care provider who is familiar with the client's abilities and needs. Applications are submitted to the Territorial Home, Community, and Continuing Care Division (HCCC).

- The Territorial Division is the single-entry point for admissions to continuing care in order to ensure timely and appropriate admissions to available beds both in and out of territory. The Division also manages the waitlist for admission to continuing care.

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2.2 Applications for Home and Community Care Programs are submitted directly to the Supervisor of Home and Community Care (SHCC) or the Regional Manager of Home Care.

3. PRINCIPLES:

3.1. The goals of the Home Care Program are to provide services to Nunavummiut in order to promote independent living and support families in caring for people at home, in their community, rather than in a facility.

3.2. Older Canadians overwhelmingly want to age with dignity and autonomy in their homes and communities with appropriate care and support for them and their families. (National Institute on Ageing, 2019)

3.3. Long-term care homes are an integral part of Canada's housing system, designed to provide a home and necessary health care to adults who require a range of health and support services.

4. DEFINITIONS:

Healthcare Provider: refers to regulated healthcare professionals – physician, nurse practitioner, registered nurse, licensed practical nurse, advanced care, or primary care paramedic.

5. GUIDELINE: ADMISSION TO HOME CARE PROGRAM

5.1. All Nunavummiut enrolled in the Nunavut Health Care Plan are eligible for referral to the Home and Community Care Program. See Appendix A Home Care Referral.

5.2. Referrals for admission to the Home and Community Care Program can be made by Community Health Nurses (CHNs), Nurse Practitioners (NPs), physicians, hospital discharge planners, Licenced Practical Nurses, Advanced Care Paramedics, and other regulated healthcare workers. Clients and/or guardians can self refer to the program.

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5.3. Once a referral is received, an assessment will be completed to determine care needs, and eligibility for the services available within the program. The assessment is completed by the SHCC or their designate within the program.

5.4. The SHCC or designate works with the client and family to develop an individualized plan of care based on community resources.

- The care plan shall include the timing, frequency, and duration of visits, whether by a nurse or Home and Community Care Worker (HCCW), and the services to be provided.
- The plan for personal care services or home-making services shall be documented on the homemaking and/or personal care agreement forms. See Appendix B and C.
- The SHCC or delegate will review the document(s) with the HCCW.
- The HCCW shall complete the home-making flow sheet for each client. The HCCW shall not perform any duties not outlined on the agreement form. See Appendix D.

5.5. The client or legal guardian must sign a home care consent form prior to commencement of home care services.

6. GUIDELINE: APPLICATION AND ADMISSION TO LONG-TERM CARE:

6.1. Eligibility for continuing care service is determined based on the following:

- Age 55 years or older.
- Valid Nunavut Health card.
- Be medically, functionally, and behaviourally stable and able to be supported by Continuing Care.
- Care needs exceed the resources available in the community that keep the client independent in community.

6.2. A Healthcare Provider (HCP) completes the Continuing Care Placement Referral (CCPR) form, see Appendix E, guided by Nunavut's Level of Care document, see Appendix F.

6.3. The completed CCPR is submitted to the Territorial Home, Community Continuing Care Division.

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6.4. The HCCC Coordinator offers placement at the most appropriate facility, based on the client's assessed level of care, and bed availability, guided by the Prioritization Criteria See Appendix G.

- If a bed is available, the client will be asked to sign the residential care agreement form. See Appendix H.
- If a bed is not available, the client's name is added to the waitlist.

6.5. Available community, regional, and territorial resources and services are maximized to provide support to the client and their family/caregiver, e.g., respite care through community home care program or a respite placement at a territorial facility where resources are available, until appropriate placement is available.

6.6. If a client on the waitlist is offered a permanent (meaning non-respite or temporary) placement at a facility, the client has three (3) business days to accept or reject the placement offer.

6.7. If the client declines the bed, the name is moved to the bottom of the waitlist.

7. Guideline for Appealing of Declined Applications:

In the event that an admission is declined, the applicant may appeal to the Territorial Director of Home, Community, and Continuing Care for review.

8. Associated Policies and Legislation:

04-004-00 Client Rights and Responsibilities
03-002-00 Client Assessment and Reassessment

9. References:

Canadian Nurses Association. (2020, May). *2020 Vision: Improving Long-Term Care for People in Canada.* Retrieved from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://hl-prod-ca-oc-download.s3-ca-central-1.amazonaws.com/CNA/2f975e7e-4a40-45ca-863c-5ebf0a138d5e/UploadedImages/documents/2020-Vision_Improving-Long-Term-Care-for-People-in-Canada_e.pdf

Centre for Equality Rights in Accommodation. (2022, April). *Older Persons Living in Long-Term Care Homes and the Right to Adequate Housing in Canada*. Retrieved from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.ohchr.org/sites/default/files/documents/issues/olderpersons/2022-report-right-housing/ngos-csos/2022-08-03/submissions-older-persons-right-to-adequate-housing-CERA-en.pdf

National institute on Ageing. (2019). *Enabling the Future Provision of Long-Term Care in Canada.* Retrieved from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://static1.squarespace.com/static/5c2fa7b03917eed9b5a436d8/t/5d9de15a38dca21e46009548/1570627931078/Enabling+the+Future+Provision+of+Long-Term+Care+in+Canada.pdf

Return to TOC

Approved By:	Date: 5 January 2024
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date: 5 January 2024
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

Return to TOC

Home and Community Care

Referral Form/Intake Form

Department of Health
Government of Nunavut

Client Surname	Client Given Name	Date of Birth
Address- House Number	Community Select a Community	Postal Code
Telephone # Home	Telephone # Work	Health Card Number

Language

Inuktitut ☐ Inuinnaqtun ☐ English ☐ French ☐

Reason for Referral:

Referral Status Urgent ☐ Non-Urgent ☐

Services Required (Select all that applies)

Assessment of Client Status	☐	Assistance with ADLs	☐
Assistance with Personal Care	☐	Basic Foot Care	☐
Catheter Care	☐	Chronic Disease Management	☐
Educating Caregivers and Family Members	☐	Fall Risk and Prevention Management	☐
Infusion Therapy	☐	Injections and Home Injection Management	☐
Medication Management	☐	Ostomy Care	☐
Palliative and End of Life Care	☐	Peritoneal Dialysis Support	☐
Post Surgical Care	☐	Preventative Health Promotion	☐
Suture and Staple Removal	☐	Teaching and Supervising Self Care	☐
Toileting and Incontinence Management	☐	Wound/Trauma Care Management	☐
Other	☐		

Referral Source:

Name: _____ Signature:_____

Phone #_____ Date of Referral:_____

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NUNAVUT HOME & CO ROGRAM
Homemaking Duties Agreement Form

Print Client Surname	Given Name(s)	Health Care No.	Date of Birth dd/mm/yy
Address (with directions to the home)		**Phone No.** -	
Emergency contact		**Phone No.** -	

Schedule	Staff Member Assigned (may be different if primary staff not available)	Start Date dd/mm/yy
Reason for Service		

Many of the following tasks are given under the direction and supervision of professional staff such as Nurses, OTs and Physiotherapists.

Meal Preparation

- ☐ Client — Breakfast, Lunch, Dinner/Supper, Snacks
- ☐ Family — Breakfast, Lunch, Dinner/Supper, Snacks
- ☐ Special Diet _____
- ☐ Grocery Shopping
- ☐ Other _____

Housekeeping

- ☐ *Heavy Housework*
  - ☐ Floor cleaning
  - ☐ Vacuuming, with furniture moving
  - ☐ Window/wall washing
  - ☐ Cleaning stove/fridge
  - ☐ Clean Bathroom
  - ☐ Clean Kitchen
  - ☐ _____
- ☐ *Light Housework*
  - ☐ Tidy up
  - ☐ Dusting
  - ☐ Vacuuming, no furniture moving
  - ☐ Wash dishes, dry and put away

Laundry and Other /Duties

- ☐ Client laundry
- ☐ Family laundry
- ☐ In-home
- ☐ Laundromat
- ☐ Ironing
- ☐ Folding and putting away

Special Instructions, e.g. Child Care

Print Name of Authorizing Case Co-ordinator	Signature	Date dd/mm/yy

Overview of Reassessment Process ☐ **Date for Reassessment of Services**

Client Declaration: I understand and agree with this care plan. I will notify the Program (Tel. No._____) if I will not be at home or wish to change the time or date of a visit. I will let the Program staff know of any changes in my condition or treatment, or home circumstances.	**Client Signature/Mark**	
	Print Interpreter Name	**Interpreter Signature**

Revised December 9, 2009

Return to TOC

Notes for the Homemaking Duties Agreement

- The case co-ordinator and the client/representative must discuss, and agreed to, the homemaking duties to be performed, the frequency of visits and the time per visit.
- The case co-ordinator checks off the tasks on this form and may indicate frequency agreed to beside each task e.g. 3X/wk, 1X/2wks in addition to the general schedule indicated in the upper part of the form.
- The case co-ordinator and the client/representative must sign and date the agreement. Minor changes can be noted/dated/initialled by the case co-ordinator on the same form, however the result of a complete reassessment or readmission must have a new form.
- This is a three part form:
  - Client file copy
  - Client copy
  - Assigned staff copy

Community	Code	Community	Code	Community	Code	Community	Code
Baffin Region	*222*	Iqaluit	235	*Kivalliq Region*	*333*	*Kitikmeot Region*	*444*
Arctic Bay	200	Kimmirut	240	Arviat	300	Bathurst Inlet	400
Qikiqtarjuaq	205	Nanisivik	245	Baker Lake	305	Bay Chimo	405
Cape Dorset	210	Pangnirtung	250	Chesterfield Inlet	310	Cambridge Bay	410
Clyde River	215	Pond Inlet	255	Coral Harbour	315	Gjoa Haven	415
Grise Fiord	220	Resolute Bay	260	Rankin Inlet	320	Kugluktuk	420
Hall Beach	225	Sanikiluaq	265	Repulse Bay	325	Kugaaruk (Pelly Bay)	425
Igloolik	230			Whale Cove	330	Taloyoak	430

Nunavut

Return to TOC

Department of Health And Social Services – Home Care
Personal Care Duties

Community Code: _____

Client Surname	Given Name(s)	Health Care No.	Date of Birth dd/mon/yy / /
Address (with directions to the home)			**Phone No.** -
Emergency contact			**Phone No.** -

Schedule	Staff Member Assigned (may be different if primary staff not available)	Start Date dd/mon/yy / /
Reason for Service		

Many of the following tasks are given under the direction and supervision of professional staff such as Nurses, OTs and Physiotherapists.

Personal Care

- ☐ Bathing (bed, tub or shower)
- ☐ Toiletting
- ☐ Mouth and tooth care
- ☐ Shaving
- ☐ Shampoo
- ☐ Routine skin care
- ☐ Routine hand and foot care
- ☐ Temperature, pulse, respiration
- ☐ _____

Activities of Daily Living

- ☐ Assist with transfers or positioning
- ☐ Assist with walking
- ☐ Assist with dressing
- ☐ Assist with feeding
- ☐ Encourage and record fluid intake
- ☐ Encourage independence
- ☐ Provide stimulation
- ☐ _____
- ☐ _____

Duties related to Social or Mental Health

- ☐ Parenting (modeling) for high risk families
- ☐ Assist with special needs children in the home
- ☐ Supervise medication for mental health clients
- ☐ Spot check high risk clients as required
- ☐ Support clients

Other Care/Duties

- ☐ Assist with exercises or braces/other devices
- ☐ Change basic non-sterile dressings
- ☐ Provide reminders about medication
- ☐ Simple ostomy care
- ☐ _____
- ☐ _____
- ☐ _____

Name of Authorizing Case Co-ordinator	Signature	Date dd/mon/yy / /

Client Declaration:	Client Signature/Mark	
I understand and agree with this care plan. I will notify the Program (Tel. No._____) if I will not be at home or wish to change the time or date of a visit. I will let the Program staff know of any changes in my condition or treatment, or home circumstances.	**Print Interpreter Name**	**Interpreter Signature**

Notes for the Personal Care Agreement

Return to TOC

- The case co-ordinator and the client/representative must discuss, and agreed to, the personal care duties to be performed, the frequency of visits and the time per visit.
- The case co-ordinator checks off the tasks on this form and may indicate frequency agreed to beside each task e.g. 3X/wk, 1X/2wks in addition to the general schedule indicated in the upper part of the form.
- The case manager and the client/representative must sign and date the agreement. Minor changes can be noted/dated/initialled by the case manager on the same form, however the result of a complete reassessment or readmission must have a new form.
- This is a three part form:
  - Client file copy
  - Client copy
  - Assigned staff copy

Community Codes

Code	Community	Code	Community	Code	Community	Code	Community
200	Arctic Bay	240	Kimmirut	300	Arviat	400	Bathurst Inlet
205	Broughton Island (Qikiqtarjuaq)	245	Nanisivik	305	Baker Lake	405	Bay Chimo
210	Cape Dorset	250	Pangnirtung	310	Chesterfield Inlet	410	Cambridge Bay
215	Clyde River	255	Pond Inlet	315	Coral Harbour	415	Gjoa Haven
220	Grise Fiord	260	Resolute Bay	320	Rankin Inlet	420	Kugluktuk
225	Hall Beach	265	Sanikiliuaq	325	Repulse Bay	425	Kugaaruk (Pelly Bay)
230	Igloolik			330	Whale Cove	430	Taloyoak
235	Iqaluit	222	**Baffin Region**	333	**Kivalliq Region**	444	**Kitikmeot Region**

Nunavut

NUNAVUTHOME & CO ROGRAM
Personal Care/H Sheet

Return to TOC

Community Code: _ _ _ _ _

Print Client Last Name	Given Name(s)	Health Care No.	Date of Birth dd/mm/yy

Page ___ of___

Date/Initial 20__															
Time Arr./Dep.	/	/	/	/	/	/	/	/	/	/	/	/		/	/
Bath/Shave/Shampoo															
Toileting															
Mouth and tooth care															
Skin/hand/foot care															
Temp/pulse/resp. rates															
Change dressings															
Walking assist															
Exercise															
Positioning/comfort															
Dressing															
Feeding/fluids monitor															
Medication reminders															
Meal preparation															
Grocery Shopping															
Light Housework															
Dishes															
Laundry															
Ironing															
Other															
Other															
Other															

Signature Samples	Print Name	Initial	Print Name	Initial	Print Name	Initial

Building Nunavut Together
Nunavuliuqatigiingniq
Bâtir le Nunavut ensemble

Return to TOC

CONTINUING CARE PLACEMENT REFERRAL
Please forward completed referral to LTC@gov.nu.ca
Incomplete forms will be returned

Eligibility and Process:

Client's may be eligible for long-term care (LTC) if they are 55 and older, have a valid NU health card, and have an assessed need for LTC. Clients with a confirmed diagnosis of dementia can be referred at any age.

Once all information is received, referrals will be reviewed to determine client needs, and a member of the LTC team will respond within five business days. If a bed is not available, the client will be placed on the territorial waitlist. When a bed becomes available that meets the client's needs, a bed offer will be made. The client has three working days to accept or decline the bed. If declined, the client will go to the bottom of the waitlist.

Please complete all questions.

Date: Assessment completed by:

Request for ☐ Permanent placement ☐ Respite placement (28 day maximum in-territory)

CLIENT PROFILE:

Surname: First name: Date of Birth:

Community: House#: Mailing address:

NU Health Card #: NTI Card #:

Pharmacy: Address: Phone:

Next of Kin: Relationship:

Phone: Email:

Alternate Contact: Phone/Email:

Legal Guardian: Phone/Email:

Legal Trustee: Phone/Email:

****Primary reason for referral****

☐ Accident or Illness
☐ Gradual Loss of Functional Abilities
☐ Death or Serious Illness of client's Spouse/Support
☐ Breakdown in Support Previously Provided by others
☐ Client Needs Exceed Home Care/Facility
☐ Respite for family in Community
☐ Homelessness/Unstable housing
☐ Other, Explain:

Return to TOC

DIAGNOSES/MEDICAL HISTORY:

ALLERGIES:

Is there a confirmed diagnosis of dementia? ☐ Yes ☐ No ☐ Query

Is there concern that the individual lacks capacity to make decisions ☐ Yes ☐ No

Does the client have an advanced care directive in place? ☐ Yes ☐ No

Code Status:

FUNCTIONAL STATUS:

Height:	**Weight:**
Hearing ☐ Good ☐ Fair ☐ Poor Hearing aids ☐ Left ☐ Right	
Communication ☐ Communicates verbally ☐ Communicates in writing ☐ Unable to communicate	
Languages spoken ☐ Inuktitut ☐ Inuinnaqtun ☐ English ☐ French ☐ Other:	
Vision ☐ Good ☐ Fair ☐ Poor ☐ Uses glasses	
Substances (indicate amounts and frequency) ☐ Nicotine ☐ Cannabis ☐ Alcohol ☐ Other	
Dental ☐ No concerns ☐ Full dentures ☐ Partial dentures ☐ Missing teeth	
Diet ☐ DAT ☐ Soft ☐ Minced ☐ Puree ☐ Swallowing concerns ☐ Fluids: ☐ Special Diet: ☐ Tube feeds	
Skin ☐ Intact ☐ Wounds ☐ Comments:	

Return to TOC

Pain

☐ Verbalizes pain ☐ Evidence of pain ☐ Location:

☐ Type: ☐ Severity: ☐ Cause:

Sleep

☐ Regular sleep patterns ☐ Periodic waking at night ☐ Frequent waking ☐ Difficulty falling asleep

☐ Recent changes in sleep ☐ Excessive sleep Comment:

Dressing

☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent ☐ Uses aids

Bathing

☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent ☐ Uses aids

Feeding

☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent ☐ Uses aids

Hygiene (oral, grooming)

☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent ☐ Uses aids

Toileting

☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent ☐ Uses aids

Continence – Bladder

☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent ☐ Catheter ☐ Brief

Incontinent: ☐ Occasionally ☐ Frequently

Continence - Bowel

☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent ☐ Ostomy ☐ Brief

Incontinent: ☐ Occasionally ☐ Frequently

Mobility

☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent ☐ Recent falls

Cause/Comments:

Transfers

☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent ☐ Mechanical lift

Stairs

☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent

Medication management

☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent ☐ Frequent errors

Managing Finances

☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent ☐ Frequent errors

Return to TOC

Housekeeping

☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent

Grocery Shopping

☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent

Meal preparation

☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent

Using Telephone

☐ Independent ☐ Supervision ☐ Assistance ☐ Dependent

Social

☐ Socializes regularly ☐ Socializes minimally ☐ Does not socialize ☐ Caregiver distress

Living Situation

☐ Lives alone ☐ Lives with family ☐ Other:

Equipment and special requirements

☐ Walker ☐ Manual Wheelchair ☐ Power Wheelchair ☐ Prosthesis ☐ PICC ☐ Central line

☐ IV ☐ Wound Care ☐ Oxygen ☐ Concentrator ☐ Portable Rate:

☐ CPAP/BPAP ☐ Comments/Other:

Responsive Behaviours

☐ Physical aggression ☐ Verbal aggression ☐ Damages property ☐ Hurts self ☐ Vocal

☐ Sexually expressive ☐ Wanders, responds to redirection ☐ Elopes ☐ Resistant to care

☐ Agitated ☐ Suspicious ☐ Repetitive movements

Frequency:

Last occurrence:

Triggers:

Strategies:

Thought Processes

☐ Suspicious ☐ Delusional ☐ Confusion ☐ Hallucinations ☐ Obsessive

☐ Slow to respond ☐ Other:

Cognition and orientation

☐ Mild memory loss ☐ Moderate memory loss ☐ Significant memory loss

☐ Lack of judgement ☐ Lack of insight Disoriented to ☐ person ☐ place ☐ time

Emotional State

☐ Flat affect ☐ Labile ☐ Euphoric ☐ Depressed ☐ Anxious ☐ Other:

☐ Suicidal ideation ☐ History of suicide attempt – date/method:

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Additional comments:

CURRENT SERVICES

☐ Home making HCCW1 ☐ Personal Care HCCWII ☐ Home Care Nursing

☐ Mental Health Worker ☐ Family Services/Social Worker ☐ Other:

READINESS FOR PLACEMENT

Is the client currently stable: ☐ Yes ☐ No

If the client is medically unstable, please indicate plan for investigations and stabilization prior to transfer:

PRIOR TO PLACEMENT PLEASE PROVIDE:

☐ MARS (including pharmacy contact information)

☐ Recent Labs

☐ Relevant specialist reports (psychiatry, neurology, rehabilitation, etc.)

☐ Vaccination Record, including COVID-19

☐ TB status

☐ Recent notes from hospitalization or clinic visit

☐ Advanced care directive (if completed)

☐ Referral form sent to office of the public guardian (if required)

LEVEL OF CARE

Based on level of care placement is requested at

☐ Elders' Home: Assisted Living facility – Level 2-3

☐ Continuing Care Centre: Long-term care – Level 3-4

☐ Complex Care/Dementia Care – Level 5

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RELEASE OF INFORMATION CONSENT

I consent to the sharing of my/the client's confidential personal information which may include social and health history, present illness and medications, with the clinical staff of the residential care facility. I understand that the Government of Nunavut and the residential care facility will protect my privacy and personal information and not disclose it to others for any reason other than that which it was collected without my consent.

Pursuant to section 48 of the Access to Information and Protection of Privacy Act (Nunavut), this form must be completed by the individual who is the subject of the personal health information to be disclosed or the individual's parent or guardian if the individual is under the age of majority (19). Results of oral consent requests must be documented on this form by the individual authorized to seek consent. Information collected is authorized by section 40(c) of the Access to Information and Protection of Privacy Act (ATIPP). If you have any questions about how the Department of Health collects, uses, and discloses your personal information, contact the Department's ATIPP Coordinator at (867) 975-5729 or the Territorial ATIPP Office at (867) 975-6044 or atipp@gov.nu.ca.

Name of Client	Date of birth
Signature of Client	Date
Signature of Witness	Date

If client is under a legal guardianship order, please provide proof of guardianship and have guardian provide consent.

Name of Legal Guardian	
Signature of Legal Guardian	Date
Signature of Witness	Date

Government of Nunavut
Department of Health
Home, Community, and Continuing Care

LEVELS OF C

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Level 1

Pauloosie, 43, lives alone in his own home. He has arthritis and can manage most tasks, but receives support for light housekeeping.

LEVEL 1: The client lives independently with occasional support from family/home care. He is mostly independent with his personal care activities and instrumental activities of daily living (e.g. medication management and shopping).

Level 2

Mary, 55, has a heart condition. She needs help with bathing and meal preparation.

LEVEL 2: The client requires assistance for daily activities. The appropriate level of support can be provided at home from family and the home care program, or in a facility that provides supportive care, such as an Elders' Home.

Level 3

Jacobie, 62, requires assistance with medications, bed transfers, and some nursing care for his diabetes.

LEVEL 3: The client requires moderate care. The client may live at home with moderate support from family/ home care. Care may also be provided in an Elders' Home, or as needs increase, in a Continuing Care Centre.

Level 4

Solomon, 92, had a stroke. He now has physical disabilities, cognitive impairment, and requires daily nursing care.

LEVEL 4: The client requires significant care and support that exceeds what can be provided at home and requires placement in a Continuing Care Centre.

Level 5

Rita, 76, is in the late stage of dementia. She is non-verbal, wanders, and requires significant nursing care.

LEVEL 5: The client requires 24-hour supervision and care. They may have conditions that are medically complex, have a diagnosis of dementia, or display responsive behaviours that require the support of trained staff. Requires placement in a long-term care facility that provides dementia care.

Respite Care

Services that provide caregivers with temporary relief from tasks associated with caregiving. Depending on the client's care needs, respite may be available in their home through the home care program, or in a care facility such as an Elders' Home or Continuing Care Centre for up to 28 days.

DEPARTMENT OF HEALTH
PRIORITIZATION CRITERIA
ADMISSION TO ELDERS' HOMES AND LONG-TERM CARE

Priority 1

A. Client who is awaiting placement and requires immediate admission as a result of;
   a. a crisis arising from the person's condition or circumstances;
   b. the absence of an available caregiver;
   c. the absence of community-based supports to meet the person's care needs to remain at home safely in their community.

B. Client occupying a bed in another facility that is temporarily or permanently closing.

C. Client occupying a bed an acute care bed, who is not able to return home safely to their community.

Priority 2

A. Client awaiting long-term care placement; however, admission is not considered urgent given the supports in place:
   - The client's condition is not currently putting the person at risk of physical or emotional harm to self or others;
   - The client's caregiver(s) is able to continue to provide care without risk of harm to the person requiring care or to themselves;
   - Community-based programs and supports, such as home care, can provide support within the program's guidelines to meet the person's care needs while awaiting placement.

Priority 3

A. Spousal Reunification: Spouses/partners of current residents who are eligible for placement because of their assessed care needs and wish to reside in the same facility.

B. Cultural Reasons: Language or dialect preference by a resident that cannot be offered at another facility.

C. Person who is already residing in a facility that is not their preferred long-term care site, and who expresses a preference to move to another care facility.

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Building Nunavut Together
Nunavuliuqatigiingniq
Bâtir le Nunavut ensemble

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Department of Health
Munaqhiliqiyitkut
Ministère de la Santé

Residential Care Agreement

Client Name: _____ **DOB:** _____

You have been offered**:**

☐ respite (maximum 28 days)

☐ permanent placement at

Facility:

Elders' Home:

☐ Iqaluit ☐ Arviat

Continuing Care Centre:

☐ Igloolik ☐ Cambridge Bay ☐ Gjoa Haven

☐ Embassy West Senior Living in Ottawa, ON.

☐ Other: _____

It has been determined by your health care team, in consultation with you/family/guardian that your care needs can best be met in a care facility.

As a resident of the above-named care facility, your care will be managed by the Territorial Continuing Care Division, Department of Health, Government of Nunavut. Case managers can be reached at LTC@gov.nu.ca or 867-975-5941

If your care needs change, you may require more care than can be offered in your current setting. In this situation, your health care team will make a referral to a care facility that can best meet your assessed needs.

I understand and agree to admission into the care facility indicated above.

_____ _____

Signature of Client/Guardian Date

_____ _____

Signature of Witness Date

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Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Home Care Program Services		Client Services	H3C 04-001-01
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
05/01/2024	05/01/2027	NEW	2
APPLIES TO:			
All Home, Community, and Continuing Care Team Members			

See Below

Return to TOC

Home Care Program Services

The Home Care Program provides health care and support services in the comfort of an individual's home. The main services provided by the Home Care Program in Nunavut include:

Nursing care:

- Chronic health condition requiring monitoring, education routine lab work and monitoring;
- Chronic medication management including injections;
- Dressing changes, wound care;
- Ostomy Care;
- Basic foot care;
- Catheter care;
- Assessment for potential admission to long-term care setting;
- Palliative and end of life care;
- Help to support Peritoneal Dialysis clients;
- Suture removal;
- Pronouncement of expected death;
- Assessment of ADLs and mobility;
- Physical assessments; and
- Monitoring vital signs, and blood sugar levels.

Personal care:

- Assistance with activities of daily living like bathing, dressing, using the bathroom;
- Medication assistance; and
- Respite Care

Homemaking services

- Meal planning and preparation;
- Cleaning living area to ensure safe mobility; and
- light laundry duties.

Return to TOC

Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Client Orientation to Home, Community and Continuing Care Programs		Client Services	H3C 04-002-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
04/01/2024	04/01/2027	NEW	2
APPLIES TO:			
All Home, Community, and Continuing Care Team Members			

1. BACKGROUND:

The Division of Home, Community, and Continuing Care (HCCC) recognizes that client satisfaction improves when clients are provided with the necessary information for optimal use of available programs.

HCCC provides the following policy and guidelines for client orientation to HCCC programs.

2. POLICY:

2.1. The healthcare provider completing the admission assessment of a potential client shall provide the following information to the client:

- Eligibility criteria for the program including home-making services in the home care program.
- That the development of an individualized care plan is client centred and may include input from family or supports that the client wishes to include.
- Confidentiality and the requirements for release of information.
- The roles and responsibilities of healthcare providers, home and community care workers, and continuing care workers, as appropriate.
- Client rights and responsibilities while enrolled in the program.

2.2. Program staff will provide orientation to new clients following the guidelines below as appropriate.

3. PRINCIPLES:

3.1. Orientation to programs and services involves clients in decision-making, recognizing their own unique values and preferences.

3.2. Proper coordination and integration of care empowers clients in the face of illness.

3.3. Provision of information facilitates autonomy and self-care.

3.4. Clients need to know they can access care when it is needed.

4. DEFINITIONS:

Healthcare Provider: refers to Registered Nurse, Licensed Practical Nurse, or Nurse Practitioner

Return to TOC

5. Guideline: Orientation to Home and Community Care

5.1. The Supervisor of Home and Community Care (SHCC) or delegate shall, following admission of the client and development of the individualized care plan, and in the client's preferred language:

5.1.1. Review the care plan with the client.

5.1.2. Advise the client of their rights and responsibilities per Policy 04-002-00 *Client Rights and Responsibilities.*

5.1.3. Provide information regarding hours of service.

5.1.4. Introduce the client to the staff providing services.

5.1.5. Provide information regarding who to contact in emergency (i.e., SHCC or Community Health Nurse on call).

5.1.6. Request written release of information for any family or supporters to whom information can be given in an emergency situation.

5.1.7. Discuss advanced care planning if appropriate.

6. Guideline: Orientation to Continuing Care:

6.1. The Nurse Manager or delegate shall, in the resident's preferred language:

6.1.1. Provide the resident with a tour of the facility and the resident's room.

6.1.2. Orient the resident to facility procedures – mealtimes, diet, bathing, rest periods, etc.

6.1.3. Obtain written release of information for those family members or supporters to whom the resident wishes information to be released in routine or emergency situations.

6.1.4. Discuss advanced care planning.

6.1.5. Provide information regarding recreational pursuits and requirements if and when leaving the facility for short or more extended periods.

6.1.6. Provide the resident with an opportunity to ask questions or articulate concerns.

7. Associated Policies and Legislation:

4-004-00 Client Rights and Responsibilities

CHN Policy 06-013-00 Interpreter Services

Approved By: CNolan	Date: 4 January 2024
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date: 4 January 2024
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

Return to TOC

Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Delivery of Culturally Appropriate Services		Client Services	H3C 04-003-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
16/11/2023	16/11/2026	2.59	2
APPLIES TO:			
Home, community and continuing care team members			

1. Background:

1.1. Home, Community, and Continuing Care (HCCC) is committed to providing Nunavummiut with evidence based, client centred care which upholds Inuit Qaujimajatuqangit and ensures service delivery is well aligned with Inuuqatigiitsiarniq and Tunnganarniq.

1.2. HCCC acknowledges, respects, and upholds that the delivery of healthcare services needs to be culturally safe and appropriate for all clients.

2. Policy:

2.1. HCCC Leadership, Management, and Supervisors will ensure that all HCCC team members receive instruction in culturally safe service delivery.

2.2. HCCC team members will be respectful of the diverse and specific cultural needs of each individual client including respect for dietary preferences, spirituality, normal modes of social engagement, recreation activities, decision making processes, and language.

2.3. HCCC team members involved in the development, implementation, and/or delivery of programming and/or services will ensure that the programming is as inclusive of all clients as possible.

2.4. HCCC team members will be supported by supervisors, managers, and leadership in accessing the necessary resources and materials to ensure that they are able to understand a client's specific cultural needs and norms and provide service delivery which is culturally safe and appropriate.

3. Principles:

3.1. HCCC is committed to providing Nunavummiut with supports, services, and programs that are responsive to the cultural needs and norms of the client.

Return to TOC

3.2. HCCC is committed to providing Nunavummiut with supports, services, and programs which uphold Tunnganarniq.

4. DEFINITIONS:

Inuuqatigiitsiarniq: Respecting others, relationships and caring for people.

Tunnganarniq: Fostering good spirits by being open, welcoming, and inclusive.

5. GUIDELINE:

5.1. HCCC team members will refrain from imposing their own cultural norms and expectations on clients, recognizing, and respecting the unique cultural needs and norms of the client.

5.2. HCCC team members will treat each client with dignity and respect.

5.3. HCCC team members will work with supervisors, managers, and leadership to identify necessary resources and supports to provide culturally safe and appropriate programming and support for clients.

REFERENCES:

Government of Nunavut. (2021, 10 14). *About Nunavut*. Retrieved from Government of Nunavut: www.gov.nu.ca

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Approved By: CNolan	Date: 16 Nov 2023
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date: 16 November 2023
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

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Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Client Rights and Responsibilities		Client Services	H3C 04-004-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
15/11/2023	15/11/2026	2.3	3
APPLIES TO:			
All Healthcare Providers and Healthcare Workers			

1. **BACKGROUND:**
   The Division of Home, Community, and Continuing Care (HCCC) is responsible for ensuring that clients in the community and in long-term care settings are aware of their rights and responsibilities and that processes are in place to support their rights and investigate and resolve claims regarding a violation of those rights.
2. **POLICY:**
   2.1. All staff within the Division will uphold the rights of their clients:
   The right to:
   - Be assured of the confidentiality of their personal health information and healthcare records.
   - To identify an individual to act as a spokesperson.
   - To identify family members that they want to participate in their care planning.
   - To make an Advance Directive.
   - Be treated with respect, dignity, and fairness and in a culturally safe manner, respecting the client's cultural and spiritual beliefs.
   - Receive safe, appropriate, and timely service.
   - Be treated with consideration and kindness in all interactions with their care providers, free from abuse, neglect, or exploitation.
   - Receive information about their care and treatment, honestly and openly and in their preferred language.
   - Participate in the assessment process and choose with whom information may be shared during this process.
   - Have their concerns or the concerns of their guardians heard, reviewed, and where possible, resolved.
   - Refuse treatment.

   2.2. The Regulated Healthcare Worker (RHW) completing the admission will advise the client of their rights in the client's preferred language.
   2.2.1. The admitting RHW will advise the client of possible impacts of exercising their rights, e.g., the consequences of refusing to participate in the assessment may impact the ability to provide comprehensive service.
   2.2.2. The RHW will also advise the client of the process for submitting concerns regarding violation of their rights to the supervisor or the Office of Patient Relations.

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2.3. The RHW completing the admission will advise the client or their guardian of their responsibilities:

- To participate in developing and implementing a service plan.
- To be available at agreed times of service and/or give timely notice of change to plans.
- To notify care providers of changes that may affect service provision.
- To maintain a safe working environment for service providers.
- To treat service providers with respect and to refrain from abusive language or actions.
- To agree to and use equipment necessary for staff/client safety in a safe and proper manner.

3. PRINCIPLES:

3.1. People can usually retain greater independence and control over their own lives in their own homes.
3.2. Services should assist individuals and families to retain maximum independence and avoid unnecessary dependencies.
3.3. Individuals and their supporters should help identify their needs, establish goals, and develop plans to meet goals.
3.4. Individuals have the right to be treated with kindness, dignity, and respect.
3.5. Services should be provided respecting the client's cultural values and, whenever possible, by staff who are of the client's language and culture.

4. DEFINITIONS:

Abuse:

- Emotional/psychological abuse – infliction of distress through verbal or non-verbal acts; verbal assaults including yelling, searing, threats, derogatory comments, humiliation, intimidation; social isolation including giving the 'silent treatment,' treating like a child, isolating from family/friends/regular activities.
- Financial abuse – misuse of client's funds, property, or assets.
- Sexual abuse – molestation, sexual harassment, or sexual assault.

Neglect: abandonment of the client by the caregiver; failure or refusal to provide necessities.

Regulated Healthcare Workers: Nurses employed as Supervisors of Home and Community Care, Licensed Practical Nurses working in Home Care or Long-term Care settings and Nurse Managers in Long-term Care settings.

Unregulated Healthcare Workers: refers to Home and Community Care Workers and Continuing Care Workers who are not licensed by a governing body.

5. RELATED POLICIES AND LEGISLATION:

CHN Policy 06-013-00 Interpreter Services
CHN Policy 06-019-00 Informed Consent
CHN Policy 07-016-00 Advance Directive
CHN Policy 07-039-00 Informed Refusal of Treatment

6. REFERENCES:

Return to TOC

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The United Nations Department of Economic and Social Affairs. (2007, September). *The United Nations Declaration on the Rights of Indigenous Peoples.* Retrieved from https://www.justice.gc.ca/eng/declaration/decl_doc.html

Approved By: CNolan	Date: 15 November 2023
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date: 15 November 2023
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

Return to TOC

Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Respite Care Services		Client Services	H3C 04-005-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
05/01/2024	05/01/2027	2.73	3
APPLIES TO:			
Supervisors of Home and Community Care			

1. BACKGROUND:

The Division of Home, Community, and Continuing Care (HCCC) recognizes that caregivers may sometimes need relief from the physical and emotional demands involved in their caregiving roles and acknowledges that the consequences of not providing respite can include caregiver burnout, crisis, neglect, and abuse.

HCCC provides respite services based on assessed needs and may be arranged for planned breaks, short holidays, or emergencies. Services can be provided in the client's home or in a continuing care setting.

HCCC provides the following policy for the provision of respite care.

2. POLICY:

2.1. Clients admitted into the home care program are eligible for respite services.

2.1.1. Clients over the age of 55 may be temporarily admitted into an available continuing care bed following assessment of needs.

2.1.2. Clients, regardless of age, are eligible for in-home respite based on available community resources.

2.1.3. The potential for Out-of-Territory respite for clients may be considered on a case-to-case basis, such clients must be able to travel with an escort. Clients requiring a medevac will be reviewed by the Director, Home, Community, and Continuing Care in consultation with the community physician, nurse practitioner, or on-call physician/nurse practitioner.

2.2. The Supervisor of Home and Community Care (SHCC) shall complete a Continuing Care Placement Referral (CCPR) for all in-facility respite requests.

In the event that a community does not have a SHCC, the assessment will be completed by a CHN, NP, or Physician in community. If there are no CHNs, NPs, or Physicians in community, the home care team will connect with the Territorial Home and Continuing Care Team for further direction and support.

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2.2.1. The referral is submitted to the Territorial Coordinator of Home, Community, and Continuing Care by email to LTC@gov.nu.ca
2.2.2 A planned admission and discharge date, not exceeding 28 days, must be included with the assessment. Extensions may be granted based on available resources.
2.2.3. The Territorial Coordinator will review the referral and approve or deny the request, providing reasons and alternatives as appropriate.

2.3. The SHCC may provide in-home respite services to the caregivers of home care clients based on assessed needs and available resources.
2.3.1 A request can be submitted directly to the SHCC.

2.4. Once approved, the SHCC or delegate shall document the respite service in the client record, including:

- Reason for request
- Approval or denial, including reason for denial
- Hours of respite care provided
- Days of use per month
- Feedback from client, family, or caregiver.

2.5. If a client requires in-facility respite more than twice in the same calendar year, the SHCC or their designate will initiate a conversation with the client and/or their guardian about the potential need for ongoing supports.
2.5.1 After a in-facility respite admission, the manager of the Continuing Care Centre or Elders Home will complete a post-placement summary which is then provided to the Territorial Home and Continuing Care Team by email to LTC@gov.nu.ca
This summary provides an overview of the care level needs. See Appendix A.

3. PRINCIPLES:

3.1. Respite is a combination of medical and/or social care, that is, care that helps people with daily living, personal care, and independence.

3.2. Respite strengthens families by reducing stress and improving long-term functioning of both caregivers and care recipients.

3.3. Respite maintains or enhances the quality of life for families whose members have disabilities or chronic conditions.

4. DEFINITIONS:

Respite Care: the provision of short-term and/or temporary relief to those who are caring for family members or loved ones who might otherwise require permanent placement in a facility outside the home.

5. ASSOCIATED POLICIES AND LEGISLATION:

04-004-00 Client Rights and Responsibilities

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03-002-00 Client Assessment and Reassessment
04-001-00 Application and Admission to Home, Community and Continuing Care
03-001-00 Individual Care Plan Development and Communication

6. REFERENCES:

Canadian Healthcare Association. (2012). *Respite Care in Canada.* Retrieved from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/http://www.healthcarecan.ca/wp-content/themes/camyno/assets/document/PolicyDocs/2012/External/EN/RespiteCare_EN.pdf

Health Canada. (2003, February). *Respite for Family Caregivers - an Environmental Scan of Publicly-funded Programs in Canada.* Retrieved from https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/home-continuing-care/respite-family-caregivers-environmental-scan-publicly-funded-programs-canada.html

Approved By:	Date: 5 January 2024
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date: 5 January 2024
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

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CONTINUING CARE POST PLACEMENT SUMMARY

Please forward completed referral to Territorial Division of Home and Continuing Care c/o LTC@gov.nu.ca as well as the referral source.

CLIENT PROFILE:

Name: **Date of Birth:**

Home Community: **Health Care #:**

Reason for respite admission:

DIAGNOSES (please list)

MEDICATION CHANGES DURING PLACEMENT:

ACTIVITIES OF DAILY LIVING / INSTRUMENTAL ACTIVITIES OF DAILY LIVING: Please describe level of independence or assistance with ADLs and IALDs:

MOBILITY

Please describe mobility and transfers

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RESPONSIVE BEHAVIOURS

- ☐ Physical aggression
- ☐ Hitting
- ☐ Grabbing
- ☐ Verbal aggression
- ☐ Other:
- ☐ Damages property
- ☐ Hurting self or others
- ☐ Wandering
- ☐ Sexually expressive

Please describe causes of behaviours and any successful interventions:

OVERALL ROUTINE AND DESCRIPTION OF PLACEMENT

RECOMMENDATIONS FOR DISCHARGE BACK TO COMMUNITY

LEVEL OF CARE

Based on observations during placement, please indicate the level of care required. Please see attached Levels of Care document for reference.

- ☐ Able to manage in the community with home care supports – Level 1
- ☐ Elders' Home: Assisted Living facility – Level 2-3
- ☐ Continuing Care Centre: Long-term care – Level 3-4
- ☐ Complex Care/Dementia Care – Level 5, or

Name of Assessor: _____

Phone number: _____ Email: _____

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Department of Health Government of Nunavut		Home, Community, and Continuing Care Programs and Standards	
TITLE:		**SECTION:**	**POLICY NUMBER:**
Client Discharge		Client Services	H3C 04-006-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
04/07/2024	04/01/2027	2.36	5
APPLIES TO:			
Home, Community and Continuing Care Team Members			

1. BACKGROUND:

1.1. Home, Community, and Continuing Care (HCCC) recognizes that individuals receiving care under HCCC may, for various reasons, be discharged from HCCC service provision. A standardized approach to discharge ensures the best possible outcome.

2. POLICY:

2.1. Clients may be discharged from receiving HCCC services and supports for any of the following reasons (see Appendix A, Discharge form):

- Self-Discharge;
- Services no longer required, including death or relocation;
- Needs exceed HCCC capacity; and/or
- Persistent and egregious behavioural challenges.

2.2. HCCC team members follow the appropriate procedures when discharging a client as outlined in this policy.

2.3. Individuals receiving HCCC services and support have the right to appeal the decision to be discharged.

> Clients receiving care and support at long-term care locations in jurisdictions outside of Nunavut are subject to the discharge policies of the respective facility, as well as Nunavut's Medical Travel policy.

3. PRINCIPLES:

3.1. HCCC recognizes and acknowledges that the health status of an individual changes overtime and that the services and supports that a client requires will change accordingly. HCCC provides the correct supports, delivered in the correct way, for the correct amount of time to all Nunavummiut making use of supports and/or services offered, with the goal of maximizing client independence.

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4. PROCEDURE

SELF - DISCHARGE

1. A client who wishes to discharge themselves from HCCC services and supports may do so provided they are competent and capable of making their own healthcare decisions. If an individual is not capable of making their own healthcare decisions, the decision to self-discharge must be made by their guardian.
2.
   - **Home Care –** The client or their guardian will make the request to the Supervisor or Manager for Home Care Services in their community.
   - **Continuing Care Facility -** The client, or their guardian, can make the request to the Facility Manager for Long Term Care Facilities.

> Additional resources that may help when navigating self-discharge:
> HCCC Policy – Autonomy and Right to Live at Risk
> CHN Policy – 07-039-00 – Informed Refusal of Treatment

3. The manager meets with the client/guardian to discuss the reasons for the discharge and ascertain if changes to service provision can be made which will meet the needs of the client or their proxy.
4. The manager records the outcome of the meeting in the client's health record.
5. In the event the client/guardian decides to discharge, they are provided with all necessary information about potential risks to self-discharge in plain language which they can understand either directly or through a qualified interpreter/translator.
6. For clients in residential care, the client or guardian is required to sign a discharge document indemnifying the Government of Nunavut (GN), Department of Health (Health), HCCC, and any individuals contracted or employed by them. The original document is placed in the client's health record and a copy is provided to the client or their guardian. See Appendix B, Waiver form.
7. The client/guardian must be informed that should they change their mind after discharge they will be placed on a waiting list as though they were a new admission, if requiring HCCC services in the future.
8. The nurse or manager arranges for follow-up with the community health centre as needed.
9. The nurse or manager organizes a post-discharge meeting with the care team to identify ways of improving service provision, if applicable.

SERVICES NO LONGER REQUIRED

1. When the care team identifies that a client no longer requires HCCC services, the discharge process is initiated.
   - Improvement of client health status;
   - Reasons for this include relocation outside of the jurisdiction of HCCC; and
   - Death of client.
2. The care team meets with the client to discuss discharge from HCCC service. The client

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may choose to invite their family to participate at their discretion.

3. A timeline for complete termination of service delivery is established and recorded in the client's health record.
4. At the time and date of discharge, the client is provided with the relevant information related to ongoing care for any chronic conditions they may have.
5. At the time and date of discharge, the care team or manager informs the community health centre that the individual is no longer receiving support through HCCC.

In the event of client death please refer to Community Health Nursing Manual Policies: 07-012-000; 07-013-000; and 07-014-000.

DISCHARGE DUE TO EGREGIOUS BEHAVIOUR

The behaviour identified as challenging must present a real risk to the team members that provide care and support to the client.

The discharge of a client due to egregious behaviour cannot occur until the following steps have been completed:

1. The care team has documented the specific behaviour and all attempts to address it, including physician or Nurse Practitioner (NP) review, referral to counselling or mental health services, or other attempts to identify and resolve behaviours.

2. Step 1: Verbal Warning - the client or their guardian is provided with a verbal warning that their behaviour presents a risk to the care provider and/or others and that if it continues, services may be withdrawn. The verbal warning must include an explanation of the steps taken prior to service withdrawal including written warning and meeting.

3. Step 2: Written Warning - the client or their guardian is provided a letter informing them that the specific behaviour presents a risk to the care provider and/or others and that if it continues services will be withdrawn. The written warning must include information of the steps which will occur should the behaviour continue, including a meeting and finally discharge from services.

4. A meeting with the client, the care team, and any other relevant stakeholders occurs and is documented. The meeting is facilitated by the HCCC Manager or in the case that the client is a long-term care resident, the facility manager. The client's family is invited with consent of the client or where appropriate their guardian.

5. When all these steps have been completed and no solution has been found, the care team may initiate the discharge process.

6. Step 3: Discharge from service - the client or their guardian is provided with written confirmation of when services will be withdrawn, instances of the egregious behaviour, as well as all attempts to address the behaviour.

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They will also be provided with information on the appeal process. The client may appeal to the following senior managers:

- Home Care: Regional Director
- Contracted facilities: Territorial Director of Home and Continuing Care
- Continuing Care Centres: Regional Director
- All decisions are final.

7. With consent of the client or their guardian, the care team arranges for a referral to the community health centre to communicate discharge and to ensure the client continues to have access to supports.

8. The care team, where and when appropriate, provides a referral to other resources to help support the client provided the client or their guardian consents.

9. The care team provides the client or their guardian, as well as the community health centre or other resource, with all necessary documentation provided the client or their guardian signs an information release form.

ASSESSED CARE NEEDS EXCEED CAPACITY:

HCCC recognises that over the course of an individual's life their care needs fluctuate. When the care needs of a client exceed the capacity of the location of care the following steps must be taken:

1. The care team meets with the client and/or their guardian to discuss the limitations of care available and identify other potential resources in-community. The client and/or their guardian may choose to invite family members to participate in the meeting.

2. If community-based resources are insufficient, the care team facilitates a referral for the next level of care, with the consent of the client or their guardian, which may include Elders Homes, Continuing Care Centres (CCCs), and long-term care facilities outside of Nunavut.

3. Once arrangements are made to meet the client's assessed care needs, the care team completes a transfer of information and discharges the client from current HCCC services.

Approved By: CNolan	Date: 4 Jan 2024
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date: 4 January 2024
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

Government of Nunavut
Department of Health

NUNAVUT HOME & COMMUNITY CARE PROGRAM
Discharge Form

Client Last Name	Given Name(s)	Health Care No.	Date of Birth dd/mm/yy
Address			Date of Discharge

Diagnosis and Referral Information:

Reason For Discharge	*Alternative Arrangements*
☐ *Recovered*	☐ *Transfer to Acute Care*
☐ *Functional Improvement*	☐ *Transfer to Long Term Care*
☐ *Support System Improved*	☐ *Transfer to Other Care Home*
☐ *Service Refused by Client*	☐ *Self/Family Care*
☐ *Moved to Another Community*	☐ *Other Care – Specify:*
☐ *Care Beyond Program Capacity*	
☐ *Deceased*	
☐ *Withdrawal of Services*	
☐ *Other: Specify*	

Discharge Summary:

Print Surname	First Name(s)	Title	Date
Signature			

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DEPARTMENT OF HEALTH

WAIVER: DISCHARGE FROM CONTINUING CARE FACILITY

Name of Client: _____ Date: _____

Date of Birth: _____

Name of Facility where client is placed: _____

Date of Admission: _____

Level of Care: _____

INSTRUCTIONS:

PLEASE PRINT EXCEPT FOR INDICATED SIGNATURES.

WITNESS SIGNATURE MUST NOT BE THE HEALTH CARE PROVIDER INVOLVED IN RECOMMENDING CARE.

Community Supports Currently Available for the Client (to be completed by health care provider):

_____

_____

_____

_____

_____

Guardianship:

(check one)

Private Guardianship ☐ Public Guardianship Order ☐ None ☐

Health care provider name: _____

Health care provider contact (phone and email):_____

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CLIENT STATEMENT -- (PRIVATE & PUBLIC GUARDIANSHIP):

I, _____(PRINT NAME), acknowledge that I am the decision-maker for _____ (PRINT NAME), and that:

I have received medical advice that _____ 's current health condition requires them to receive care in a residential long-term care facility.

I have been advised that my decision to remove _____ from the care facility is my decision, and that it is contrary to the treatment plan that has been developed, approved, and provided for them by the Department of Health and the Nunavut Health Insurance Plan.

Since the decision to leave the care facility is contrary to _____ 's treatment plan, I understand that they will no longer be eligible for medical travel coverage, and may lose coverage under the Nunavut Health Insurance Plan if they are unable to maintain their Nunavut residency.

I understand the risks of my decision and that it may have a negative impact on _____ 's health. These risks include:

[ ] High cost of return travel to home community
[ ] Lack of professional long-term care in home community
[ ] Difficulties in accessing medical treatment in home community
[ ] Impact of future applications by the Public Guardian of Nunavut
[ ] Other:

_____

_____

I acknowledge that I have been given the opportunity to consider this information and to make an informed decision.

I hereby release the Government of Nunavut, as well as any employees of the Government of Nunavut, from all responsibility and for the risks that may result from my decision.

I am 19 years or older, I have read this document and I am signing it freely.

Decision maker (print name)			
Signature			
Relationship to client		Date	
Contact information	Address: Telephone: Email:		

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CLIENT STATEMENT -- (NO GUARDIANSHIP):

I, _____(PRINT NAME), acknowledge that:

I have received medical advice that my current health condition requires me to receive care in a residential long-term care facility.

I have been advised that my decision to leave the care facility is my decision, and that it is contrary to the treatment plan that has been developed, approved, and provided for me by the Department of Health and the Nunavut Health Insurance Plan.

Since the decision to leave the care facility is contrary to my treatment plan, I understand that I will no longer be eligible for medical travel coverage, and may lose coverage under the Nunavut Health Insurance Plan if I am unable to maintain my Nunavut residency.

I understand the risks of my decision and that it may have a negative impact on my health. These risks include:

[ ] High cost of return travel to home community
[ ] Lack of professional long-term care in home community
[ ] Difficulties in accessing medical treatment in home community
[ ] Impact of future applications by the Public Guardian of Nunavut
[ ] Other:

_____

_____

I acknowledge that I have been given the opportunity to consider this information and to make an informed decision.

I hereby release the Government of Nunavut, as well as any employees of the Government of Nunavut, from all responsibility and for the risks that may result from my decision.

I am 19 years or older, I have read this document and I am signing it freely.

Client Name	
Signature	
Date	
Contact information	Address: Telephone: Email:

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Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Autonomy and the Right to Live at Risk		Client Care	H3C 04-007-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
04/01/2024	04/01/2027	New	5
APPLIES TO:			
All Home, Community, and Continuing Care Team Members			

1. BACKGROUND:

The Home, Community, and Continuing Care Program (HCCC) recognizes and respects the autonomy of individuals in its care. This includes a person's right to knowingly live at risk and to accept or refuse services.

"What might be recognized as harmful or even irrational behaviour (i.e., excessive drinking, recreational and illicit drug use), may actually be the only available strategy a client can use to mitigate a more painful harm in their life (i.e., trauma, psychic pain." (De Bono, 2016)

HCCC provides the following policy to ensure as much autonomy as possible to clients and the following guidelines to assist the healthcare team in developing risk management plans with clients and their families or supports in keeping with the ethical principles of autonomy, beneficence, non-maleficence, and justice while recognising that risks that impact the safety of others cannot be supported.

2. POLICY:

2.1. All members of the healthcare team shall respect the right of capable clients to make decisions about the care they receive.

2.2. All members of the healthcare team shall respect the right of capable clients to live at risk while ensuring the safety of others, including the safety of staff.

3. PRINCIPLES:

Autonomy: Respecting individual choice, even if it is one with which we disagree.

Beneficence: how best to achieve good for all involved; how to support the client in their choice, while, for example, effectively presenting some safer options.

Non-maleficence: Avoiding harm to the client/resident, including the harm that may be caused by damaged trust from too paternalistic an intervention; avoiding direct or vicarious harm to staff.

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Justice: How individual choices may impact on others, including other clients, staff, and the public; for example, how to act if a client chooses to engage in behaviour which puts others at risk for contracting a communicable disease. (Winnipeg Regional Health Authority, 2017)

4. DEFINITIONS:

Capable clients: All adults are considered to be capable unless proven otherwise. A capable client is deemed to be capable if they are able to understand the information that is relevant to making a decision and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

Living at Risk: Is what happens when a client knowingly and willingly acts in a way that impacts the person (risk to self) or others (risk to others) in physical, emotional, or psychological ways, e.g., eating when at risk for aspiration, living at home without adequate support, smoking around oxygen supplies, refusing to use a walker needed to prevent falls, etc.

5. GUIDELINE:

Capable adults have the right to make decisions for themselves. Healthcare teams are obliged to advise the client how to reduce risks and may coax, persuade, or possibly offer incentives, but a capable client must never be forced to accept interventions.

The goal of any intervention is to achieve a tolerable level of risk.

Interventions must:
Be effective – is the goal clear and if it infringes on the client's autonomy, will it achieve the goal? (e.g., will use of bed rails prevent falls or might they be ineffective and actually increase risk by client climbing over the rails?)
Be least intrusive: Are there less intrusive ways of meeting the goal?
Not cause greater harm than it prevents. (e.g., restricting activity may lead to depression and lower quality of life)
Be non-discriminatory: is the client held to a higher standard than similarly situated members of the public?
Be fair: should the client be involved in the discussions, and if not, why not?

6. HOME CARE:

6.1. The healthcare team responsible for developing a risk management approach may be composed of

- Supervisor of Home and Community Care (SHCC)
- LPN
- Home and Community Care Workers (HCCWs)

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- Client
- Family or supporters with client consent.
- Supervisor of Health Programs (SHP)
- CHNs involved in the care of the client.

6.2. The SHCC facilitates, when required, a meeting or discussion, and opens with introducing all members of the team and identifying the activity that poses a risk to the client and/or others including staff.

6.3. The team considers how the wish for this activity may be met and assesses the nature of the potential harm, who will be affected, and probability, and severity of possible harm.

- Is the risk significant – one that is highly likely to occur with major effect?

6.3.1. If the answer is NO, the only requirement is ongoing monitoring by the SHCC and HCCWs.
6.3.2. If the answer is YES – the team identifies all options to reduce risk to a tolerable level.
6.3.3. Is the proposed intervention acceptable to the client/family/supporters?
6.3.4. If the answer is YES, the intervention is implemented.
6.3.5. If the answer is NO:

6.3.5.1. The team decides if harm to others is possible and makes the decision and implements the appropriate intervention.
6.3.5.2. If harm to self only is possible, the team assesses the patient's capacity regarding the risk activity.
6.3.5.3. If the client is clearly capable, the client makes the decision, and the team is obligated to offer advice about how to reduce the harm.
6.3.5.4. If the client is clearly incapable, the team and guardian make the decision and implement the appropriate intervention.
6.3.5.5. If there is uncertainty as to the client's capacity, the team may request a capacity assessment.
6.3.5.6. The SHCC or delegate documents the meeting details and decisions made in the client's health record.

7. LONG-TERM CARE:

7.1. The healthcare team responsible for developing a risk management plan may be composed of:

- Nurse Manager
- Licensed Practical Nurses (LPNs)
- Continuing Care Workers
- The resident and/or guardian

7.2. The Nurse Manager facilitates the meeting or discussion as required, introducing all team members and identifies the activity that poses a risk to the client and/or others.

7.2.1. The Nurse Manager follows the process outlined in 5.1.3. to 5.1.8.6.

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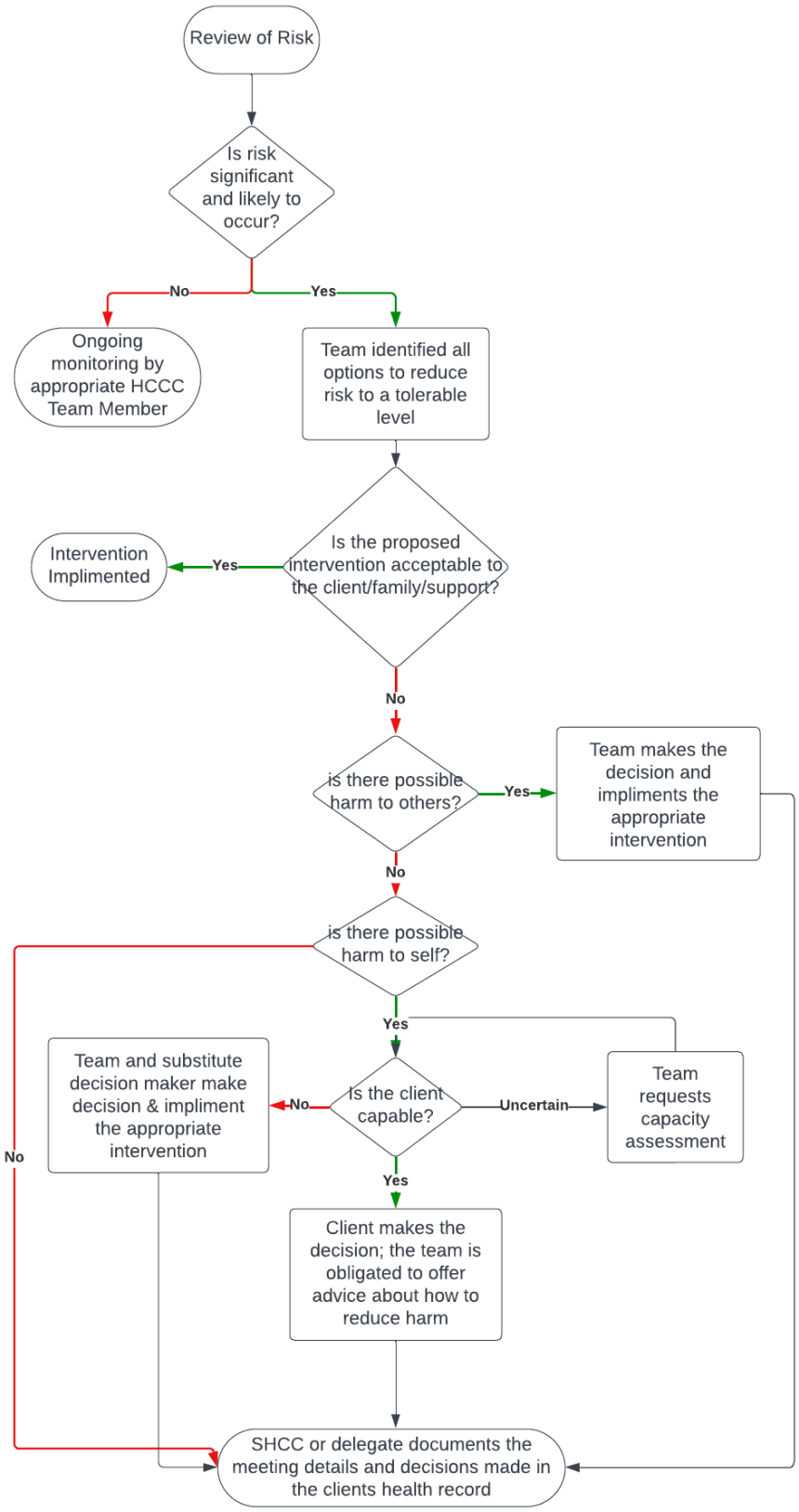
8. Decision Making Tree:



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9. References:

Danda, M. (2019, August 19). *The Right to Live at Risk.* Retrieved from Canadian Nurse: https://community.cna-aiic.ca/dev-cn-en/blogs/cn-content/2019/08/19/the-right-to-live-at-risk#:~:text=People%20have%20the%20right%20to,and%20beliefs%20about%20substance%20use.

De Bono, C. H. (2016, September). *A positive risk approach when clients choose to live at risk: a palliative case discussion.* Retrieved from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.eapon.ca/wp-content/uploads/2015/02/Positive-Risk-Approach.pdf

Faith, K. (2023). Caring for Those Choosing to Live at Risk. *Rehab & Community Care Medicine*.

Trillium Health Partners Regional Ethics Program. (2013, August). *IDEA: Ethical Decision-Making Framework.* Retrieved from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://trilliumhealthpartners.ca/aboutus/Documents/IDEA-Framework-THP.pdf

Winnipeg Regional Health Authority. (2017, October). *Living at Risk: Ethics Issue Quick Reference Guide.* Retrieved from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://wrha.mb.ca/files/ethics-living-at-risk.pdf

Winnipeg Regional Health Authority. (2019). *Ethical Decision Guide for Difficult Clinical and Non Clinical Situations.* Retrieved from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://wrha.mb.ca/files/ethical-decision-guide.pdf

Young, J. E. (2018). When patients choose to live at risk: What is an ethical approach to intervention. *BCMJ*, 314-318.

Approved By:	Date: 4 January 2024
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date: 4 January 2024
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

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Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Developing Client Educational Materials		Care Services	H3C 04-009-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
16/11/2023	06/11/2026	NEW	2
APPLIES TO:			
Home, Community, and Continuing Care Team Members			

1. BACKGROUND:

1.1. The Division of Home, Community, and Continuing Care (HCCC) recognizes that providing clients with appropriate, necessary, and individualised educational materials improves healthcare outcomes.

1.1.1. Individualized educational materials are different from the standard pamphlets and end information sheets which are generally available from healthcare practitioners, pharmacies, and similar. Individualised educational materials are specifically designed and created to support and individual clients and uses language and examples which are both specific and accessible to the client.

1.2. Client education materials in general, should always be designed with the target audience in mind. HCCC recognizes that there are numerous health education materials produced and that these materials can be modified, updated, translated, and/or used as is to support client education.

1.3. HCCC provides the following policy and guideline for the development of educational materials for clients in their care.

2. POLICY:

2.1. The HCCC division in Iqaluit is responsible for the development, review, approval, and distribution of all educational materials used in HCCC programs.

2.1.1. Educational materials developed by local HCCC staff must be submitted to the Territorial Coordinator of Home, Community, and Continuing Care, and approved by the division staff.

2.2. All written educational material must be provided in all official languages.

3. PRINCIPLES:

3.1. Education empowers clients to improve their health status.

3.2. Education empowers clients to retain their independence by learning self-sufficiency.

4. GUIDELINE: DEVELOPING CLIENT EDUCATION MATERIAL

4.1. Keep it simple: avoid using medical terminology and abbreviations.

4.2. Provide written material in the client's preferred language.

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4.3. Provide educational content in various forms to meet the needs of visual learners, auditory learners, and tactile learners.

4.4. Understand the needs and capacity of the targeted audience.

5. REFERENCES:

Morris, G. B. (2022, August 29). *10 Ways Nurses and Nurse Leaders Can Improve Patient Education.* Retrieved from NurseJournal: https://nursejournal.org/articles/tips-to-improve-patient-education/

National Library of Medicine. (2021, October 17). *Choosing Effective Patient Education Materials*. Retrieved from Medline Plus: https://medlineplus.gov/ency/patientinstructions/000455.htm

Approved By:	Date: 16 Nov 2023
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date: 16 November 2023
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

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Department of Health Government of Nunavut		Home, Community, and Continuing Care Programs and Standards	
TITLE:		**SECTION:**	**POLICY NUMBER:**
Using Client Educational Materials		Client Services	H3C 04-010-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
03/01/2024	03/01/2027	NEW	3
APPLIES TO:			
All Home, Community, and Continuing Care Team Members			

1. Background:

The internet has become a valuable source of health information with many educational materials available for clients. The accuracy and appropriateness of health resources can vary widely, and not all information is reliable or culturally appropriate for Nunavummiut. Healthcare providers have a responsibility to help clients to navigate this complex landscape and ensure they provide educational materials that are high quality and appropriate to the population being served. This policy provides a framework for Home, Community, and Continuing Care (HCCC) team members to evaluate the appropriateness of healthcare resources.

2. Policy:

2.1. HCCC team members will provide up-to-date, high-quality, and culturally appropriate health information to clients in accordance with the procedure outlined in this policy.

2.2. HCCC team members will review available Government of Nunavut (GN) health educational materials to determine if an appropriate GN-produced resource exists prior to providing material to clients from third-party providers.

2.3. To support accessibility, HCCC will ensure client education materials are translated into the official language of the client's choice using GN translation services.

2.4. HCCC team members will provide plain language health education materials to clients.

2.5. HCCC will follow procedures outlined in Policy Developing Client Education Materials when producing health education materials for clients.

3. Definitions:

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- **Home, Community, and Continuing Care team members:** Home Care Nurses, Licenced Practical Nurses, Home Care Supervisors, Continuing Care Managers, Continuing Care Workers, and other clinical positions employed by Home, Community, and Continuing Care.
- **Client:** individuals receiving care in their own home or community settings, including those residing in continuing care facilities.
- **Third-party provider**: an external entity that provides services and expertise that the GN does not possess in-house.
- **Plain language:** communication that is clear, concise, and free of unnecessary jargon.

4. PRINCIPLES:

4.1. Providing clients with plain language health education materials in the language of their choice demonstrates respect for communication between clients and healthcare providers.

4.2. Educational materials provided to HCCC clients will be culturally sensitive and inclusive, respecting diversity and promoting equal access to healthcare education.

5. PROCEDURE:

5.1. HCCC team members will discuss literacy levels with clients and families prior to the provision of educational materials to ensure resources are appropriate for the individual.

5.2. Educational materials obtained from internet sources should be from reputable sources, unverified or non-peer-reviewed websites generally should not be used, and websites that do not clearly state their authorship, sources, and/or affiliations should be avoided.

5.3. HCCC team members will consult with the GN Department of Health librarian as needed to ensure consumer health educational materials intended for HCCC clients are up-to-date, high quality, and from a reputable third-party provider.

5.4. HCCC team members will use the Teach-Back Method to ensure information has been explained clearly and clients and/or family members understand and have the opportunity to ask questions - http://www.teachbacktraining.org/home

6. REFERENCES:

Government of Nunavut. (n.d.). *Official languages*. Retrieved June 7, 2023, from https://www.gov.nu.ca/programs-services/official-languages

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Approved By:	Date: 3 Jan 2024
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date: 3 January 2024
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

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Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Expected Behaviour - Visitors		Client Services	H3C 04-011-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
14/04/2023	14/04/2026	1.21	4
APPLIES TO:			
All Home, Community, and Continuing Care Team Members			

1. BACKGROUND:

1.1. Home, Community, and Continuing Care (HCCC) provides service, supports, and programming to clients and their families throughout Nunavut. Clients may receive visitors while receiving care either in a centre operated by HCCC or one of its contracted vendors or while receiving services in their home or another care setting.

1.2. HCCC upholds its responsibility to both HCCC team members and to HCCC clients to ensure a safe and supportive environment. To that end, visitors are expected to behave in a way as to foster an environment that is free from violence, threats of violence, harassment, intimidation, and other disruptive behaviours including acute intoxication.

1.3. HCCC expects that all visitors engage with HCCC team members, clients, families, and other visitors in a manner that upholds the values of *Pijitsirniq, Piliriqatigiinniq*, and *Aajiiqatigiinniq*.

2. POLICY:

2.1. HCCC staff have the right to a workplace free of harassment and harm as outlined in the *Department of Human Resources Harassment Free Workplace Policy*. This includes harassment, violence, or threats of violence from clients, visitors, and other HCCC team members.

2.2. Visitors who behave inappropriately as determined by a HCCC team member will be asked politely to immediately stop the offending behaviour.

Should the behaviour continue, HCCC staff are to:

- Ensure their own safety;
- Ensure the safety of the client;
- Leave the premises if necessary to ensure safety;
- Contact their supervisor to report the situation and request direction;
- Notify the appropriate law enforcement agency if necessary; and
- Complete an incident report.

2.3. Visitors who consistently display inappropriate and/or disruptive behaviours in an HCCC care location or a contracted facility may be barred from entering at the discretion of the HCCC

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facility manager in consultation with the Territorial HCCC team.

2.4. Consistent inappropriate and/or disruptive behaviours by one or more visitors within a client's home may result in the termination of home-based services.

2.5. HCCC team members are to behave respectfully towards visitors and allow them all reasonable access to the client(s) they are visiting provided the access does not interfere with HCCC activities and access does not place the client in a compromising position.

2.6. The expected behaviour of visitors, in either the home or a HCCC facility setting, includes the following:

- The visitor treats clients, other visitors, staff, and volunteers respectfully and courteously;
- The visitor respects the privacy, rights, and freedoms of others; and
- The visitor follows the procedures for initiating complaints.

HCCC team members must be cognisant that at times visitors may react intensely and emotionally to a given situation and may use profane or otherwise inappropriate language. HCCC team members should work to address the underlying cause of the reaction before addressing the reaction.

3. PRINCIPLES:

3.1. HCCC recognises and supports the importance for clients to maintain connections with family and friends regardless of the care setting.

3.2. HCCC recognises and supports its role in ensuring a safe workplace and location of care for both HCCC team members, clients, visitors, and families.

3.3. HCCC upholds the values of *Pijitsirniq, Piliriqatigiinniq*, and *Aajiiqatigiinniq* and expects all visitors, families, clients, and team members to behave in accordance with these principles.

4. DEFINITIONS:

Pijitsirniq: Serving and providing for family and/or community.

Piliriqatigiinniq: Working together for a common cause.

Aajiiqatigiinniq: Decision making through discussion and consensus.

5. GUIDELINE:

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HCCC team members encountering challenging or disruptive behaviours from visitors, regardless of the location of care, must ensure their own safety first. If the HCCC team member suspects they are in immediate danger or there is a threat of violence against their person, they are to leave the location of care immediately and contact their immediate supervisor to inform them of the incident and seek further direction. Depending on the nature of the situation, the HCCC team member may wish to contact the appropriate law enforcement agency.

5.1. Visitors who display unwanted, inappropriate, or offensive behaviours will be asked to immediately stop the behaviour. Such behaviours include, but are not limited to:

- Bullying or inappropriate demands of client or HCCC staff;
- Sexual and/or romantic advances;
- Racist or sexist remarks directed at the client, HCCC staff, or other parties that are present;
- Use of pejoratives directed at the client, HCCC staff, or other parties that are present;
- Violence or threats of violence;
- Use of illicit drugs; and
- Yelling and/or screaming.

5.2. In the event that one or more visitors continue to behave inappropriately, the attending HCCC team member may:

- Suspend services until the behaviour is terminated;
- Leave the location of care if it is a client's home;
- Contact security or law enforcement if there is a credible and immediate threat to their safety or the safety of the client; and/or
- Refuse to return to the location of care if it is a client's home.
- HCCC team members who encounter unwanted or inappropriate behaviours from a visitor must inform their immediate supervisor and complete an incident report.

6. References:

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6. FORMS:

- Incident Report Form
- Home Care Contract for Visitors in the Home

Approved By:	Date:
	14/04/2023
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date:
	14/04/2023
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

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Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		SECTION:	POLICY NUMBER:
Cannabis, Tobacco, and Alcohol Use - Clients		Client Services	H3C 04-012-00
EFFECTIVE DATE:	REVIEW DUE:	REPLACES NUMBER:	NUMBER OF PAGES:
16/11/2023	16/11/2026	NEW	4
APPLIES TO:			
All Home, Community, and Continuing Care Team Members			

1. BACKGROUND:

1.1. Home, Community, and Continuing Care (HCCC) recognises that individuals receiving care and support at Government of Nunavut (GN) operated and/or contracted facilities or in their own home through the Homecare Program may use Cannabis, Tobacco, and/or Alcohol recreationally and that it is necessary to outline conditions for use in accordance with Human Resources Policies 1005 Smoke-Free Workplace and the Tobacco and Smoking Act (TSA) to ensure that client autonomy is respected while simultaneously ensuring a safe working environment for HCCC team members.

1.2. HCCC recognizes that the use of controlled, legal, and/or illegal substances can have a detrimental effect on the health and wellbeing of residents and can put residents, employees, and visitors at risk.

1.3. To ensure the safety and wellbeing of all residents, visitors, and employees it is necessary to put in place a policy to limit/restrict the use of cannabis, tobacco, and alcohol at GN-operated and/or contracted facilities or when HCCC employees are working in a client's home environment.

1.4. HCCC employees are bound by the Human Resources Policies 1005 Smoke-Free Workplace and 1006 Alcohol, Cannabis, and Other Drugs in addition to any applicable Territorial regulations and legislation including TSA.

2. POLICY:

2.1. HCCC leadership, management, supervisors, and staff may limit or deny services to an individual only if they pose a risk to themselves, co-residents, staff, and/or visitors.

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Such a refusal to provide services is never punitive and is only done to ensure the safety of all parties.

Long Term Care - GN- Operated and/or Contracted Facilities:

2.2. Clients who consume cannabis for therapeutic purposes may do so within a GN-operated/contracted facility under the supervision/direction of a healthcare professional provided:

- The cannabis is not smoked, including vaporisers or e-cigarettes;
- The resident has been given a prescription by a healthcare professional qualified to provide the prescription.
- The cannabis product is given to the client by an appropriate HCCC employee who is able to give medications to a client;
- The cannabis use does not result in acute intoxication which places the resident, co-residents, visitors, and/or staff at risk;
- The cannabis is legally procured in accordance with legislation governing the jurisdiction in which the facility operates; and
- The cannabis is stored securely along with other medication in the facility.

2.3. In accordance with the Tobacco and Smoking Act (TSA) Residents of GN-operated and/or contracted facilities who wish to consume cannabis, tobacco products, or alcohol outside of GN-operated and/or contracted facilities, may do so provided the following conditions are met:

- The use does not violate Human Resources Policies 1005 Smoke-Free Workplace and 1006 Alcohol, Cannabis, and Other Drugs;
- The substances are obtained legally;
- The use of the cannabis, tobacco products, or alcohol is legal for recreational purposes in the jurisdiction in which the resident lives/is being cared for;
- The resident does not pressure any co-resident or HCCC employee to procure the cannabis, tobacco, or alcohol for them or consume it with them; and
- The resident does not present a threat to themselves, visitors, staff, and/or co-residents.
- The Workers' Safety and Compensation Commission (WSCC) guidelines are adhered to when smoking cannabis or tobacco products outside facility premises.
- There is no violation of the TSA.

2.4. Prescribed cannabis will be stored with other medication in GN-operated and/or contracted facilities according to the specific storage requirements of the substance.

2.4.1. Legal recreational cannabis acquired legally by a resident in a GN-operated and/or contracted facility must be securely stored in a locked container in the resident's living space. The location of care is responsible for providing the lock box.

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2.5. Residents who consume cannabis, alcohol, and/or tobacco products recreationally outside of a GN-operated and/or contracted facilities may return to GN-operated and/or contracted facilities where HCCC employees will assess the resident for acute intoxication and provide appropriate supports and monitoring dependent on the resident's condition.

Homecare – Client's Own Home:

2.6. Clients who consume cannabis, tobacco, or alcohol in their home may be asked to suspend consumption a minimum of two-hours prior to the arrival of an HCCC team member.

2.6.1. HCCC team members have the right to refuse service if they feel the environment is unsafe or if they feel that the client is acutely intoxicated and proceeding with care would pose a risk to the client and/or themselves.

3. PRINCIPLES:

3.1. HCCC acknowledges and upholds the importance of individual autonomy and agency. It is recognised that every individual has a right to decide whether or not they will consume substances whether it is therapeutically or recreationally. HCC leadership, management, supervisors, and staff will not infringe on the right of HCC residents to choose to consume substances recreationally or for therapeutic purposes.

4. GUIDELINE:

- HCCC ensures that residents do not consume tobacco or cannabis by smoking, including e-cigarettes or vaporisers inside GN-operated and/or contracted facilities.
- If a resident is to consume cannabis for therapeutic purposes, HCCC employees:
    1. Ensure the substance is not smoked;
    2. Ensure that the substance has been legally acquired;
    3. Monitor the health and wellbeing of the resident during the consumption of the cannabis and afterwards until they are no longer under the influence to ensure resident safety;
    4. The client will be given only the amount prescribed;
    5. Monitor the resident for the development of dependency and take such actions as are appropriate to limit the risk of developing dependency; and

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6. Ensure the safety of the resident, co-residents, visitors, and other employees at the HCCC by monitoring the behaviour of the resident.

- In the event a resident consumes cannabis or alcohol outside of a GN-operated and/or contracted facility, HCCC employees will assess the resident for acute intoxication.
    1. If the resident is acutely intoxicated and at risk to themselves, co-residents, visitors, or employees, HCCC employees will take the necessary steps to ensure the resident's safety including monitoring the resident and if necessary, arranging for acute care.
    2. If the resident is not acutely intoxicated but is visibly under the influence, HCCC employees will ensure resident and co-resident safety, and will ensure the resident is closely monitored until intoxication resolves.

- HCCC employees actively support any client who requests support in accessing the appropriate mental health and addiction supports.
- HCCC employees may temporarily deny visits from any individual who is, or has a documented history of, purposefully violating this policy and providing a resident with cannabis, alcohol, or other intoxicants that are illegal in the jurisdiction where the facility operates or were illegally obtained.

- HCCC employees may temporarily deny visits from any individual who is, or has a documented history of, facilitating the consumption of intoxicants by residents inside and on the premises of a GN-operated and/or contracted facility.

- HCCC employees may refuse entry to any visitor who is obviously under the influence of intoxicants and who wishes to enter the facility.

Approved By: CNolan	Date: 16 Nov 2023
Chris Nolan - Assistant Deputy Minister- Programs & Standards, Department of Health	
Approved By:	Date: 16 November 2023
Stephen Jackson - Territorial Director Home, Community, and Continuing Care	

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Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS **Safe Storage for Electronic Bank Cards**		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Safe Storage of Electronic Bank Cards		Client Services	H3C 04-013-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
12/09/2023	12/09/2026	NEW	2
APPLIES TO:			
Continuing Care Centers and Residential Care Centers			

1. BACKGROUND:

The Department of Health aims to ensure the best care for our ageing population. Health provides residential long-term care services to Nunavummiut who have complex care needs, require level 4 or 5 care and can no longer be supported in their own homes or assisted living residential facilities. Currently, there is no legislation in Nunavut to provide a framework for Continuing Care services. There are Continuing Care Standards for the Continuing Care Centers and Residential Care Standards for the Elders Homes.

This policy will provide the procedural guidelines for the safe storage of a client's electronic bank card.

2. POLICY:

2.1. Upon request, the facility will secure and provide authenticated access to a resident's electronic bank card (Northern We Financial cards included).

2.2. The facility will not, under any circumstances, agree to secure physical cash, coins, credit cards, e-currency, or other valuables. If the resident chooses to keep those items in their resident bedroom, or on their person, they do so at their own risk.

3. PRINCIPLES:

3.1. The Department of Health is committed to ensuring a high standard of client centred care and supporting both health and activities of daily living.

3.2. The Department of Health recognizes the importance of aligning policy with the Inuit Societal Values and incorporates Piliriqatigiinniq/Ikajuqtigiinniq (Working together for a common cause) and Aajiiqatigiinniq (Decision making through discussion and consensus) within the body of this policy.

4. PROTOCOL/PROCEDURE

4.1. Upon admission to the facility, the resident will be offered the option of having their electronic bank card safely stored by the facility. Safely stored means in a locked filing cabinet behind a locked door.

4.1.1. If the client (or power of attorney/legal guardian) choses to have their electronic bank card safely stored by the facility, the client will sign the consent form.

4.2. A Resident or designated person with Power of Attorney (or legal guardian) can access the electronic bank card at any time, except for Hamlet closures due to weather and/or emergency. Requests are to be made to the Manager of the facility or, in their absence, the Acting Manager, or in their absence, the Nurse in Charge (LPN).

4.3. The Resident or designated person with Power of Attorney (or legal guardian) must present photo ID and sign a logbook that includes the following information:

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- Name of the Resident or designated person;
- Signature of the Resident or designated person;
- Date and time (24-hour clock) that the bank card was given to the Resident or designated person; and
- Date and time (24-hour clock) that the bank card was returned by the Resident or designated person.

4.3.1. If the designated person with Power of Attorney (or legal guardian) is not located in the same community as the resident, they are to email the Manager of the facility or, in their absence, the Acting Manager, or in their absence, the Nurse In Charge (LPN), to request that the card be provided to the resident who will then be accompanied by a staff member to the retail establishment where the electronic bank card is to be used.

4.3.2. The Manager will keep a record/list of all the out of community designated persons email addresses to verify the request as an added security measure.

4.3.3. Upon returning to the facility, the Manager of the facility (or Acting Manager or Nurse in Charge (LPN)) is to email the designated person to indicate that the card has been returned to the locked storage cabinet.

4.4. The logbook is to include a specimen record of the Resident's or designated person's signature for comparison purposes.

4.5. The logbook is to be kept in a locked filing cabinet behind a locked door.

4.6. If a Resident leaves the facility, or is discharged due to death, the electronic bank card is returned to the Resident, the estate, or designated person with Power of Attorney (or legal guardian).

4.7. The designated person or resident will certify that they understand and have read the policy by signing an acknowledgement form.

5. References

Government of Nunavut: Igloolik Continuing Care Centre Investigation Report (MNP LLP)

6. Contained in 04-013-01 Appendix A electronic bank card log& APPENDIX B safe storage for electronic bank cards

Jennifer Berry	Date: 2023-09-12
Jennifer Berry, Assistant Deputy Minister – Department of Health	
Approved By:	Date: 2023-09-13
Stephen Jackson, Territorial Director of Home and Continuing Care	

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Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS **Safe Storage for Electronic Bank Cards**		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Electronic Bank Card Log & Safe Storage for Electronic Bank Cards		Client Services	H3C 04-013-01
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
12/09/2023	12/09/2026	NEW	3
APPLIES TO:			
Continuing Care Centers and Residential Care Centers			

See below

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Appendix A: Electronic bank card log

Resident first name:_____

Resident last name:_____

		Bank card out		Bank card returned			
Date (yyyy-mm-dd)	**Time** (24 hr clock)	**Signature of LPN signing out card**	**Signature of Resident or designated person/NIC**	**Date** (yyyy-mm-dd)	**Time** (24 hr clock)	**Signature of Resident or designated person/NIC**	**Signature of LPN receiving card**

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Department of Health
Government of Nunavut

Safe Storage Policy Acknowledgement

I, _____, have received and read the **Safe Storage for Electronic Bank Cards Policy**, and agree to adhere to the provisions provided. I understand that if I have questions regarding any element of the policy, I am able to consult with the Manager, Acting Manager or Nurse In Charge.

Please sign below acknowledging that you have received and read the **Safe Storage for Electronic Bank Cards Policy.**

Signature of Resident or Designated Person	Date
Witness name (print)	Witness signature Date

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Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Home Care Motor Vehicle Usage Policy		Operations	H3C 04-014-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
15/04/2025	15/04/2027	NEW	3
APPLIES TO:			
Home, Community, and Continuing Care Team Members			

BACKGROUND:

Department of Health is committed to providing a standardization of home care motor vehicle usage. The policy applies to employees who use the vehicles and sets out the terms and conditions for work related purposes.

DEFINITIONS:

Motor Vehicle

Any vehicle or mobile equipment which has been purchased, leased, or rented with GN funds for the Home Care Program. This includes but is not limited to the pickup trucks, SUVs, and ATVs (e.g. snow mobiles, and side by sides).

Client

An individual formally accepted into the Home Care Program and receiving home care services.

Home and Community Care Staff

An individual employed by the GN working within the Home and Community Care Program. This includes Home Care Managers, Supervisor of Home and Community Care Nurses, Home Care Nurses, Home and Community Care Workers (HCCWs), Home and Community Care Representatives (HCCRs), and agency nurses.

Home Care Services

Provision of health care and support services in the comfort of an individual's home. The main services provided in Nunavut include nursing care, personal care, respite care, and homemaking services. It also includes delivering client medical supplies and medical equipment.

Work Purposes

Using the home care vehicle for any function or activity that is part of delivering home care services.

POLICY:

2.1 Home care vehicles are to be used during operational hours by staff for delivering home care services, and not for personal use. This includes on-call or overtime hours.

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2.2 Home care vehicles are strictly for the use of home care related activities. Clients and families are to seek other alternate transportation for personal and medical appointments outside of the home.

2.3 Any transportation of a client by GN and contracted staff, puts the employees and clients at a safety and liability risk, and as such may result in disciplinary action. The insurance coverage provided by the GN is dependent on the employee following the GN policy and department guidelines.

2.4 In an emergency, clients should be contacting the health centre for assistance, and not the Home and Community Care staff.

2.5 For safety reasons, an employee driving a vehicle must:

- Wear a seat belt when the vehicle is in use, as this is a mandatory legislated requirement.
- Conduct normal safety checks (such as checking the vehicle's tires, and fluid levels, including gasoline levels), and report identified problems and unsafe vehicles to the Supervisor.
- Refrain from smoking, vaping, or consuming alcohol while in the vehicle, or texting while driving.
- Operate the vehicle in a manner compatible with weather, traffic, road and vehicle conditions, and obey speed limits. Do not operate the vehicle when conditions are hazardous. Any traffic violations shall be the responsibility of the operator of the vehicle. Under no circumstances will the GN pay any parking tickets or fines related to traffic violations that occurred while an employee was operating a government vehicle. Infractions related to GN motor vehicle usage must be addressed immediately by the driver.
- Obey all traffic laws.
- Report all accidents to your Supervisor.

2.6 Home Care vehicles are to be maintained in a safe, clean, and roadworthy condition. They should be serviced as per the manufacturer's schedule, as maintenance services allow for in each community. Failure to adhere to manufacturer's guidelines may compromise employee safety.

2.7 It is the driver's responsibility to ensure that their license remains current and valid, and is carried on him or her during use of vehicle.

2.8 In the case of an accident involving Government vehicles, the operator must notify his or her Supervisor.

2.9 Operators are responsible for keeping Government vehicles clean and tidy at all times.

2.10 GN staff are to use the log in sheet to identify the sign-out time before using the vehicle, and identify sign-in time and the odometer reading upon returning the vehicle.

PRINCIPLES:

To ensure that GN vehicles are used by GN and Contracted Home and Community Care Staff solely for work-related purposes.

To ensure safety and promote use of vehicle in a manner that addresses liability concerns.

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RELATED POLICIES:

Community and Government Services Motor Vehicle Policy
Government of Nunavut Motor Vehicle Management Guidelines

REFERENCES:

Motor Vehicle Act
Government of Nunavut Motor Vehicle Policy
CGS Motor Vehicle Policy

Approved By: Greg Babstock	Date: April 9 2025
, Assistant Deputy Minister – Department of Health	
Approved By:	Date: April 08, 2025
, Territorial Director Home, Community, and Continuing Care	

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Department of Health Government of Nunavut	HOME, COMMUNITY, AND CONTINUING CARE Programs and Standards		
TITLE:		**SECTION:**	**POLICY NUMBER:**
CCC/LTC Pressure Injury Prevention, Assessment and Monitoring		Client Care	H3C 04-015-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
August 17, 2026	August 17, 2029	NEW	10
APPLIES TO:			
Setting: Continuing Care Centres (CCC); Long-Term Care (LTC) **Providers:** Registered Nurses (RN); Licenced Practical Nurses (LPN); Physicians (MD); Nurse Practitioners (NP); Continuing Care Workers (CCW); Personal Support Workers (PSW)			

1. **BACKGROUND:**

A pressure injury (formerly referred to as pressure ulcer) is defined as localized damage to the skin and/or underlying soft tissue, usually over a bony prominence or related to a medical or other device. Damage can be caused by prolonged pressure, shear or friction. This injury can appear as intact skin or an open ulcer and may cause pain. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, moisture, nutrition, perfusion, comorbidities and condition of the soft tissue (Wounds Canada).

Effective pressure injury prevention and early management is essential to promote healing, prevent complications, and ensure optimal client outcomes. This policy defines standard prevention procedures and provides assessment and monitoring guidance to support individualized pressure injury management and healing.

2. **POLICY:**

2.1 **Pressure Injury Prevention:** Each resident will receive a completed Braden Scale assessment by an RN or LPN within the first 8 hours of admission, and every 72 hours thereafter. Refer to **Appendix A: Braden Scale for Predicting Pressure Sore Risk.** Braden Scale assessments will be documented in Meditech under the *'Braden Scale Template'***.**

2.1.1 RNs and LPNs will follow **Appendix B: Braden Scale Risk Profile Interventions** to implement and document interventions based on the resident's Braden Scale risk profile to support the prevention of pressure injuries and skin breakdown.

2.2 **Admission and Routine Screening Assessments:** Each resident will receive a comprehensive head-to-toe integumentary assessment by an RN or LPN within the first 8 hours of admission and routinely every 7 days thereafter, or sooner if they are assessed as 'high' or 'severe' risk on the

Return to TOC

Braden Scale. If a pressure injury is identified, head-to-toe integumentary assessment will occur every 24 hours.

2.2.1 If a new pressure injury is identified, RNs and LPNs will use **Appendix C: Pressure Injury Staging** as a reference for staging along with completing an assessment and documentation as described in Section 6.3.

2.2.2 The MD or NP must be notified (either in person, by phone or by email) within 12 hours for all new pressure injuries identified. The MD or NP must provide confirmation back to the RN or LPN on the diagnosis along with providing supportive management/dressing orders.

2.3 **Pressure Injury Monitoring:** Following the identification of a pressure injury, staging (using **Appendix C**) and monitoring assessments as described in Section 6.2 will be performed daily.

2.3.1 Routine status MD or NP updates will occur routinely every 7 days or sooner if there are signs of deterioration (refer to 6.4.1 for more details on signs of deterioration) to support ongoing management/dressing orders.

3. PRINCIPLES:

3.1. The principles of *Pilimmaksarniq* will be used to strengthen the knowledge, judgment, and skills of RNs, LPNs, CCWs, and PSWs through ongoing observation, mentorship, and practice.

3.2. Head-to-toe integumentary assessments can be intrusive; it is essential to communicate the value of this assessment to the client based on the client's Braden Scale risk profile and respect their autonomy.

4. DEFINITIONS:

4.1. **Braden Scale**: Structured risk assessment tool to identify individuals at risk for pressure injury. Comprised of six subscales scored from 1-3 or 1-4, for a total score that ranges from 6-23. A lower Braden Scale score indicates a lower level of functioning and thus a higher risk of pressure injury development.

4.2. **Friction**: A frictional force, or resistance to motion in a parallel direction that occurs with repeated dragging or movement over surfaces such as bed linens. Frictional forces result in the loss of the protective layers of skin and reduces the amount of pressure needed to cause breakdown.

4.3. **Shear**: A mechanical force that moves underlying bony structures in an opposite direction to overlying tissue leading to tissue ischemia and ulceration or undermining/tunneling and possibly deep sinus tracts beneath a pressure injury.

4.4. **Moisture:** Excess moisture (i.e. incontinence, perspiration) may contribute to skin breakdown and maceration, which can initiate ulceration and worsen pressure injuries.

5. PROCEDURE – PRESSURE INJURY PREVENTION:

5.1. Each resident will receive a completed Braden Scale assessment by an RN or LPN within the first 8 hours of admission, and every 72 hours thereafter. **Refer to Appendix A**.

5.1.1 Braden Scale assessments will be documented in Meditech under the *'Braden Scale*

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Template'

5.2. RNs and LPNs will follow **Appendix B** to implement and document interventions based on the resident's Braden Scale risk profile to support the prevention of pressure injuries and skin breakdown.

5.2.1 Residents with a Braden Scale of 'high' or 'severe' risk require an update to their supervisor/manager along with the MD or NP to further support the pressure injury prevention management.

6. PROCEDURE – SCREENING ASSESSMENTS AND PRESSURE INJURY MONITORING & FOLLOW UP:

6.1. Each resident will receive a comprehensive head-to-toe integumentary assessment by an RN or LPN within the first 8 hours of admission and routinely every 7 days thereafter, or sooner if they are assessed as 'high' or 'severe' risk on the Braden Scale. If a pressure injury is identified, head-to-toe integumentary assessment will occur every 24 hours.

6.1.1 RNs and LPNs will pay particular attention to vulnerable areas of skin, especially over bony prominences and under medical devices. Refer to **Appendix D: Pressure Injury Locations**, to guide high risk areas of skin.

6.2. CCWs and PSWs are expected to complete opportunistic skin observation while caring for residents during activities of daily living (dressing, bathing, transferring, etc.) and notify the attending RN or LPN of any changes in skin integrity or to previously identified pressure injuries.

6.3. If a new pressure injury is identified, RNs and LPNs will conduct an assessment following the 'MEASURE' acronym (supported by Wounds Canada, 2021) and include the location and staging (based **on Appendix C**):

- Measure: Length in cm; width in cm, depth in mm
- Exudate**:** The presence of discharge? Quality; quantity?
- Appearance: Wound bed (intact, ulcerated, tissue type and amount, exposure of underlying structures, etc.)
- Suffering: Pain – PQRST (**P**rovocation /Palliation; **Q**uality ; **R**egion/Radiation; **S**everity; **T**iming)
- Undermining: Presence or absence; tunneling/sinus tracts: Presence or absence
- Re-evaluation: Ensure follow up monitoring is established (Kardex up to date; handover provided)
- Edge/Peri-wound: Edge approximated vs not approximated. Peri-wound: Colour? Swelling? Moisture? Temperature?

6.3.1 The MD or NP must be notified (either in person, phone or email) within 12 hours for all new pressure injuries identified. The MD or NP must provide confirmation back to the RN or LPN on the diagnosis along with providing supportive management/dressing orders.

6.4. Following the identification of a pressure injury, staging (using **Appendix C**) and monitoring assessments as described in Section 6.2 will be performed daily.

6.4.1 Routine status updates to the MD or NP will occur every 7 days, or sooner if there are signs of deterioration (i.e. increased pain; signs of infection such as redness, swelling, warmth, or discharge; undermining or tunneling; an increase in wound length, width, or depth) to support ongoing management/dressing orders.

6.4.2 MDs and NPs will utilize eConsult as required to support the plan of care. Refer to Figure 1

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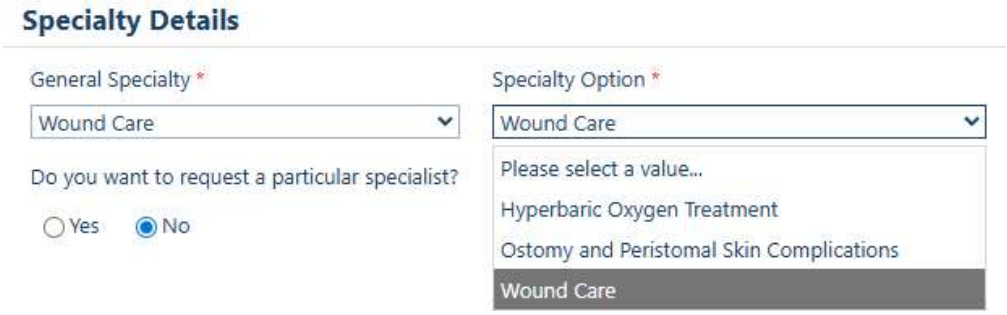
for locating Wound Care support.

Figure 1: eConsult Wound Care



7. **INCIDENT REPORTING**

7.1. An incident report must be completed in the Meditech Quality and Risk Management (QRM) System within 24 hours of a new CCC/LTC acquired pressure injuries and must be addressed to the immediate supervisor/manager.

> Any staged III or IV pressure injury acquired after admission to the CCC/LTC is considered a 'Never Event' and requires a new incident report within 24 hours along with updating the MD/NP and the supervisor/manager who will notify their director. This will trigger a Quality Review.

8. **DOCUMENTATION:**

8.1. Braden Scale assessments will be documented every 72 hours using the Meditech 'Braden Scale Template' along with documenting the implemented interventions as outlined in **Appendix B.**

8.2. Documentation of pressure injuries/skin breakdown will follow Section 6.3.

8.3. Photographs of pressure injuries should be taken every 7 days and uploaded to Meditech or sooner if there are signs of deterioration. This will allow the MD or NP to objectively monitor progress. Resident consent must be obtained prior to taking an image and the *'Acceptable Use of Mobile Devices Policy'* must be followed when taking images. If a patient is unable to provide consent due to impaired cognitive function, the RN or LPN will obtain consent from the Substitute Decision Maker.

8.3.1 Images are NOT permitted to be taken on a personal mobile device.

8.3.2 Photos are permitted to be taken on a GN mobile secured device overseen by the IM/IT Division. Once the photo is uploaded on Meditech, it must be deleted from the GN mobile device immediately following.

9. **EDUCATION AND TRAINING**

9.1. **GN Training:** Education is available for RNs and LPNs by accessing the 'Wound Assessments' Webinar, located in Nunavut Nurses Education SharePoint > Training and Webinars.

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9.2. **External Training (NSWOC Courses):** External wound and pressure injury courses are available for RNs and LPNs via the 'Wound, Ostomy & Continence Institute' by accessing their website: https://go.dualcode.com/nu-wound

10. APPENDIX

Appendix A: Braden Scale for Predicting Pressure Sore Risk

Appendix B: Braden Scale Risk Profile Intervention

Appendix C: Pressure Ulcer Stages

Appendix D: Pressure Injury Locations

11. REFERENCES:

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12. APPROVALS

Approved By: Heather Hair	Date: August 20, 2026
Heather Hair, Assistant Deputy Minister – Programs and Standards, Department of Health	
Approved By:	Date: August 17/2026
Stephen Jackson, Territorial Director of Home and Continuing Care	
Approved By: J. Busse	Date: March 31/2026
Janet Busse, Chief Nursing Officer – on behalf of the Nursing Leadership Advisory Committee	

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Appendix A: Braden Scale for Predicting Pressure Sore Risk

BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK								
Patient's Name:		**Evaluator's Name:**		**DATE OF ASSESSMENT:**				
Sensory perception Ability to respond meaningfully to pressure-related discomfort	**1. Completely limited**: Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation, OR Limited ability to feel pain over most of body surface	**2. Very limited**: Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness, OR Has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body.	**3. Slightly limited**: Responds to verbal commands but cannot always communicate discomfort or need to be turned, OR Has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.				
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist**: Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. Moist:** Skin is often but not always moist. Linen must be changed at least once a shift.	**3. Occasionally moist:** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely moist:** Skin is usually dry; linen requires changing only at routine intervals.				
Activity Degree of physical activity	**1. Bedfast:** Confined to bed.	**2. Chairfast**: Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks occasionally:** Walks occasionally during day but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. Walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.				
Mobility Ability to change and control body position	**1. Completely Immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited**: Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly limited**: Makes frequent though slight changes in body extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.				
Nutrition Usual food intake pattern	**1. Very poor:** Never eats a complete meal. Rarely eats more than ⅓ of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement, OR Is NPO[1] and/or maintained on clear liquids or IV[2] for more than 5 days.	**2. Probably Inadequate**: Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement, OR Receives less than optimum amount of liquid diet or tube feeding.	**3. Adequate:** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement of offered, OR Is on a tube feeding or TPN[3] regimen, which probably meets most of nutritional needs.	**4. Excellent:** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.				
Friction and Shear	**1. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequent slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures, or agitation leads to almost constant friction.	**2. Potential problem:** Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No apparent problem:** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in be or chair at all times.					
Risk Stratification: Mild Risk: 15-18; Moderate Risk: 13-14; High Risk: 10-12; Severe Risk: Less than 9 SOURCE: Barbara Braden and Nancy Bergstrom. Copyright, 1988. Reprinted with permission.				**TOTAL SCORE:**				

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Pressure Injury Prevention Interventions by Risk Level

LOW to MODERATE RISK (Braden 13–18)

- Offer toilet as necessary to maintain continence or check every 2–4 hours and change briefs if soiled or wet.
- Elevate heels off the bed at all times, even with therapeutic support surfaces.
- If not on a therapeutic support surface, reposition every 2 hours.
- If on a therapeutic support surface, reposition every 2–4 hours.
- Use pillows/foam slabs to avoid contact between bony prominences.
- Use devices to optimize independent repositioning and transfers.
- Inspect skin during repositioning, toileting, and assisting with ADLs.
- Provide routine skin care and moisturize daily.
- Use elbow and heel protectors.

HIGH to VERY HIGH RISK (Braden ≤12)

- Include all interventions in Low to Moderate Risk category as appropriate PLUS:
- Use a Therapeutic Support
- Regardless of support surface, reposition every 1–2 hours with frequent small shifts.
- Use foam wedges or pillows to support lateral 15–30° tilt.
- Reposition chair-bound or immobile client every 1 hour; limit sitting to 1–2 hour intervals.
- For bedfast clients elevate HOB ≤30° for short periods only.
- Protect sacral/perineal wounds from feces and infected urine.
- Remove slings, transfer aids, or therapeutic aids from under client.

Sub-Scale Interventions Based on Risk Level

Sensory ≤3

- If mobility and sensory sub-scales both score 1/4, consider support surface.
- Eliminate pressure from bony prominences on extremities.
- Communicate to MD/NP about OT/PT consult

Friction/Shear ≤2

- Raise knee gatch 10–20° before raising head of bed.
- Limit HOB elevation to ≤30°.
- Use transfer assistive devices.
- Communicate to MD/NP about OT/PT consult

Mobility/Activity ≤3

- Avoid repositioning on a red area.
- Mobilize clients to support independent mobility and function.
- Remove transfer sling/sheet/board from under client.
- Communicate to MD/NP about OT/PT consult

Moisture ≤3

- Keep skin folds clean and dry.
- Use wicking material to separate skin folds.
- Avoid multiple layering (continence brief, soaker pad, slider sheet).
- Use moisture barrier cream.
- Use fecal collector or urinary catheter if indicated.
- Consider support surface.

Nutrition ≤2

- Maximize nutritional status with adequate protein and calorie intake.
- Offer fluids every 2 hours (1500–2000 mL daily unless contraindicated).
- Set up and assist with meals as required.
- Communicate to MD/NP about Dietician consult

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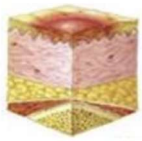
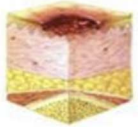
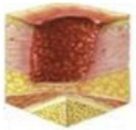
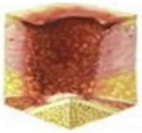
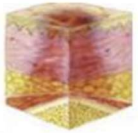
Appendix C: Pressure Ulcer Stages

British Columbia Patient Safety & Learning System

Pressure Ulcer Stages

Stage I	Stage II	Stage III	Stage IV	Suspected Deep Tissue Injury (SDTI)	Unstageable
• Intact skin with localized, non-blanchable erythema over a bony prominence. • The area may be painful, firm or soft and warmer or cooler when compared to surrounding tissue. • Darkly pigmented skin may not show visible blanching, however the colour of the Stage I ulcer will appear different than the colour of surrounding skin. • Indicates the patient is at risk for further tissue damage if pressure is not relieved.	• Partial thickness wound presenting as a shallow, open ulcer with a red/pink wound bed. • May also present as an intact or open/ruptured serum-filled or serosanguinous-filled blister. • Slough may be present but does not obscure the depth of tissue loss.	• Full thickness wound. • Subcutaneous tissue may be visible but bone, tendon and muscle are not exposed. • May include undermining or sinus tracks. • Slough or eschar may be present but does not obscure the depth of tissue loss.	• Full thickness wound with exposed bone, tendon or muscle. • Often includes undermining and/or sinus tracks. • Slough or eschar may be present on some parts of the wound bed but does not obscure the depth of tissue loss.	• A localized purple or maroon area of intact skin or a blood-filled blister that occurs when underlying soft tissue is damaged from friction or shear. • SDTI may start as an area that is painful, firm or mushy/ boggy and warmer or cooler than the surrounding tissue but can deteriorate into a thin blister over a dark wound bed or a wound covered in thin eschar. • Deterioration of SDTI may be rapid, exposing additional layers of tissue even with optimal treatment and may be difficult to detect in individuals with dark skin tones.	• A wound in which the wound bed is covered by sufficient slough and/or eschar to preclude staging.
					

Source: Developed by the BC Provincial Nursing Skin & Wound Care Committee. Image 1, 2, 3 retrieved June 14, 2012 from www.npuap.org. Image Stage 4, SDTI, Unstageable and the definitions are from the BC Provincial Skin & Wound Committee Guideline: Pressure Uler Management Decision Support Tool found at www.clwk.ca.

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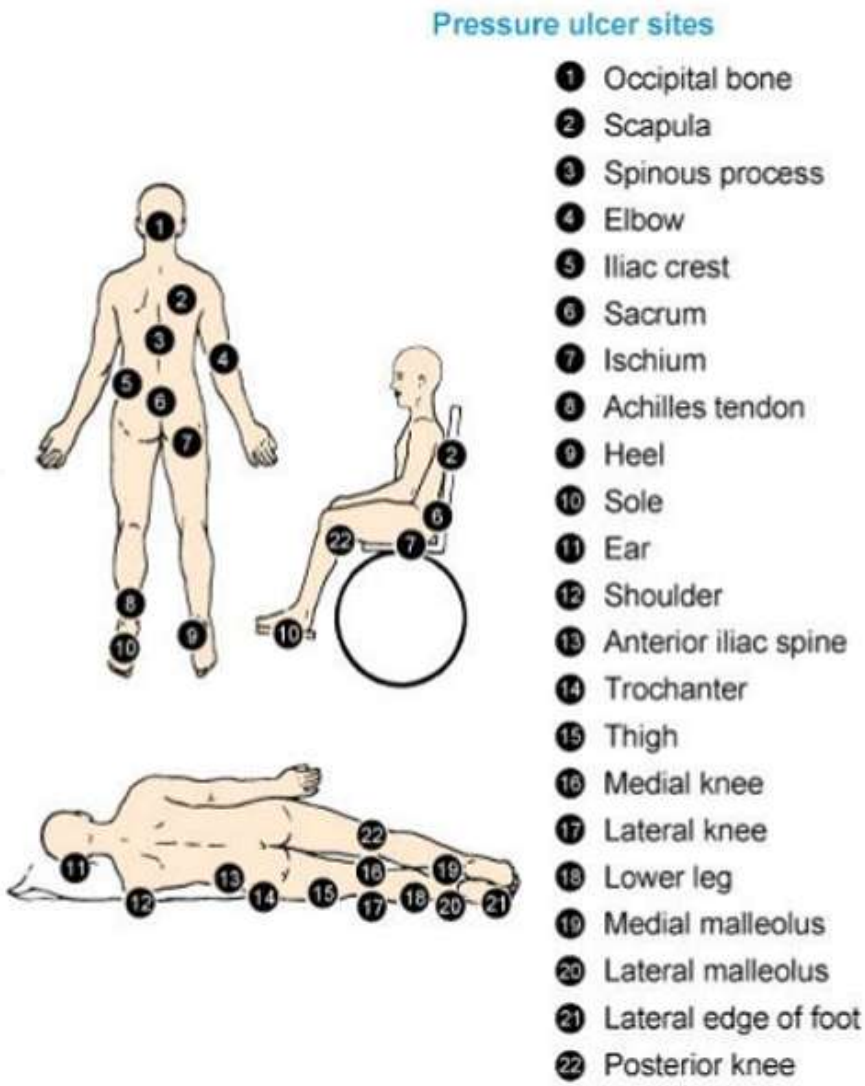
Appendix D: Pressure Injury Locations



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