Section 5: Administration

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

POLICY:

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

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

PRINCIPLES:

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

Standardizing policies and guidelines will:

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

RELATED POLICIES, GUIDELINES AND LEGISLATION:

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

GUIDELINE 05-001-01

GUIDELINES:

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

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

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

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

TEMPLATE 05-001-02

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

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

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

NURSING POLICY CHANGE REQUEST FORM

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

FOR USE BY REVIEW COMMITTEE

GUIDELINES 05-001-03

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

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

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

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

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

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

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

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

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

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

2.1 Create a draft file to track progress and changes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.2 Review draft policy with the Originator

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

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

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

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

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

4. SIGNATURE

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

GUIDELINES 05-001-04

1. ARCHIVING

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

2. INVENTORY

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

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

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

TITLE:		SECTION:	POLICY NUMBER:
Critical Incident Stress Management		Administration	05-005-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		4

APPLIES TO:
Community Health Nurses

POLICY:

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

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

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

DEFINITIONS:

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

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

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

PRINCIPLES:

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

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

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Guideline 05-005-01 Critical Incident Stress Management Guidelines

Guideline 05-004-04 Disclosure of Critical Incident

REFERENCES:

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

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

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

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

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

2. The continuum of responses includes:

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

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

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

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

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

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

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

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

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

REFERENCES:

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

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

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

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

GUIDELINES 05-004-04

1. The Regional Director of Health and Social Services will gather a disclosure team within 2 working days of the incidents and should consist of:
    a. The healthcare provider directly involved
    b. Director of Health and Social Services
    c. Supervisor of health programs
    d. Family/attending physician
    e. Other healthcare providers and /or management as appropriate

2. The disclosure team will arrange an in-person meeting with the client and family/substitute decision-maker for the purpose of disclosing the Critical Incident.

3. It is recommended that the role of spokesperson for the disclosure team be assumed by the Regional Director, Director of Health Programs, Supervisor of health programs, or physician and that the selection be based on:
    a. Appropriateness
    b. Communication skills
    c. Professional judgment

4. The disclosure meeting consists of the following information:
    a. Information regarding the fact of the error which is:
        Objective and factual and free from speculation or blame
        Presented in a caring compassionate manner
    b. The factors that contributed to the error
    c. Assurances that an in-depth analysis will be undertaken with the goal of preventing recurrence
    d. How change resulting from the analysis will be communicated to the client
    e. The impact of the error on the health of the client
    f. Recommendations as to what might be done to deal with the medical condition including alternatives, risks and benefits of each
    g. An apology for the event

5. The client/family is provided the opportunity to ask questions or seek clarification. It is determined who will be the primary contact person for the client/family and will be the primary contact for the Community Health Centre.

6. Support for the client/family is offered and may include:
    a. Referral to or assignment of another healthcare provider
    b. A specified Social Worker or spiritual care provider and their contact information
    c. The disclosure teams designated primary contact number
    d. Regular updates from the disclosure team's designated primary contact

7. A copy of the health record is made available to the affected person or authorized designate.

8. Support for the healthcare provider is offered and may include meetings with supervisor/manager and/or referrals to:
    a. Critical Incident Stress Management
    b. Spiritual Care
    c. Employee Assistance Program

9. The spokesperson for the disclosure team documents the facts of the disclosure which is forwarded the Regional Director.

10. The Critical Incident Review Committee shall ensure that a root cause analysis is conducted on all critical incidents with action plans identified to mitigate the critical incident from happening again and identifying learning opportunities.

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

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

2. The continuum of responses includes:

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

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

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

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

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

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

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

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

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

REFERENCES:

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

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

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

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

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

TITLE:		**SECTION:**	**POLICY NUMBER:**
Nursing Practice – Employer Responsibilities		Administration	05-006-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		2
APPLIES TO:			
Community Health Nurses			

POLICY 1:

The Department of Health and Social Services (HSS) have the following responsibilities when hiring Registered Nurses for the purpose of providing health care and related services:

1) **The Department of Health and Social Services shall hire registered nurses as prescribed by the Nunavut *Nursing Act* (S.Nu. 2003, c.17).**

2) **The Department of Health and Social Services shall ensure registered nurses are aware of:**
   - **Employer policies, procedures, and protocols**
   - **Performance expectations**
   - **Nunavut legislation and regulations related to nursing practice**

3) **The Department of Health and Social Services shall adhere to Government of Nunavut policies and protocols.**

4) **The Department of Health and Social Services shall determine the minimum educational requirements and educational equivalencies for nursing positions.**

PRINCIPLES:

The Registered Nurses Association of Northwest Territories and Nunavut (RNANTNU) sets the minimum standards of practice for registered nurses and nurse practitioners, gives guidance to registrants, employers and educators, and provides information for the general public as evidence of basic expectations for all registered nurses. Registration is a legal requirement.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 05-015-00 Statutes and Legislation

POLICY 2:

The Department of Health and Social Services shall have in place:

1) **Written job descriptions that describe the nurse's role and responsibility.**

2) **A method for determining the required nursing competencies to deliver safe care.**

3) **A systematic method of keeping policies and nursing job descriptions current.**

4) **A written performance review method.**

5) **A support mechanism is available to provide expert guidance in order for a nurse to fulfill his/her responsibilities.**

6) **Policies that outline the parameters for the Registered Nurse to perform basic nursing functions.**

7) **Policies that outline the parameters for the Registered Nurse to perform additional nursing functions and transferred functions.**

PRINCIPLES:

Registered Nurses are members of a self-regulating profession who possess substantial specialized knowledge, skill and judgment. There are nursing functions that can be regarded as basic to the profession that any nurse should be able to perform competently, whether he/she is a new graduate, an experienced nurse, someone transferring to a new setting, or someone returning to practice. Each nurse exercises judgment in accepting responsibility in applying such functions.

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

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS		
	Community Health Nursing		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Nursing Practice – Employee Responsibilities		Administration	05-007-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		2
APPLIES TO:			
Community Health Nurses			

Registered Nurses have the following responsibilities when they have been hired for the purpose of providing health care and related services.

POLICY 1:

Must be registered with the Registered Nurses Association of Northwest Territories and Nunavut (RNANTNU) as prescribed by the Nunavut *Nursing Act* (S.Nu. 2003, c.17).

PRINCIPLES:

RNANTNU sets the minimum standards of practice for registered nurses, gives guidance to registrants, employers and educators, and provides information for the general public as evidence of basic expectations for all registered nurses. Registration is a legal requirement.

POLICY 2:

Must be responsible for maintaining a safe level of practice and aware that no statement or policy by a professional association or employer relieves the responsibility for the nurse's own action.

PRINCIPLES:

No Registered Nurse is compelled to perform any medical-nursing function for which he/she does not meet the necessary level of competence. Registered Nurses are responsible for maintaining a safe level of practice and must be aware that no statement of policy by a professional association or an employing agency relieves the individual nurse of responsibility and accountability for his/her own acts.
A.A.R.N., A.H.A., A.M.A., C.P.S.A., 1987.

POLICY 3:

All Registered Nurses must practice within the policies, procedures, and protocols of their employer and within professional standards and code of ethics.

PRINCIPLES:

To safeguard client care and competency of practice.

Registered Nurses are accountable for their own actions and each registered nurse must exercise judgment in accepting responsibility for applying any additional nursing or sanctioned medical function. (A.A.R.N., A.H.A., A.M.A., C.P.S.A., 1987)

RNANTNU (2004) outlines the decision-making model for registered nurses performing additional nursing functions (see reference sheet 05-008-03).

POLICY 4:

Registered Nurses are responsible for clarifying employer performance expectations and familiarizing themselves with how nursing is practiced within the Department.

PRINCIPLES:

Nurses are responsible for their own actions within such guidelines.

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

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

POLICY:

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

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

PRINCIPLES:

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

RELATED POLICIES, GUIDELINES AND LEGISLATION:

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

REFERENCES:

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

GUIDELINE 05-008-01

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

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

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

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

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

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

GUIDELINE 05-008-02

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

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

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

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

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

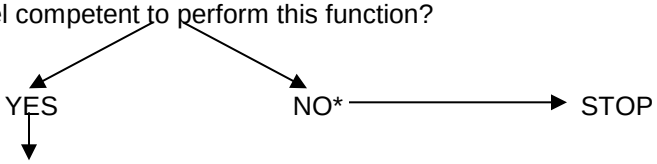
5) A monitoring system has been set up by the department to make sure that the function is performed only by those nurses who are certified. And, there must be a process for ongoing instruction and re-certification.

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

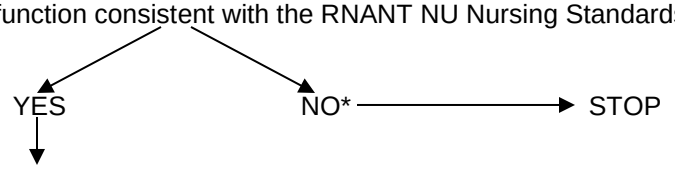
Approved by:	Effective Date:
11 FEB 2011 **Chief Nursing Officer** **Date**	April 1, 2011
February 11, 2011 **Deputy Minister of Health and Social Services** **Date**	

REFERENCE SHEET 05-008-03

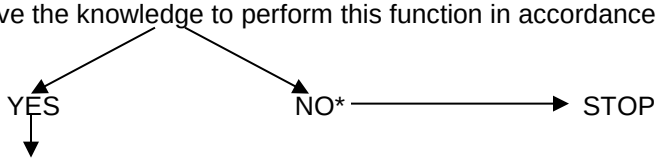
1. Do I feel competent to perform this function?



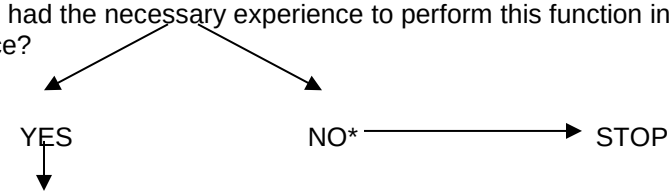
2. Is this function consistent with the RNANT NU Nursing Standards?



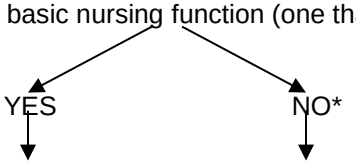
3. Do I have the knowledge to perform this function in accordance with current practice?



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



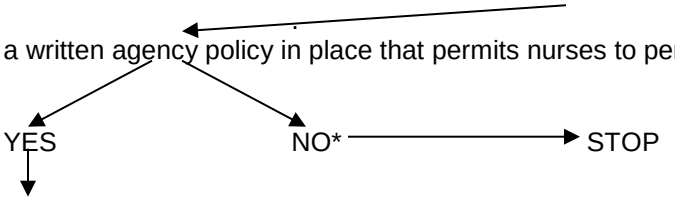
5. Is this a basic nursing function (one that was taught in the basic nursing program)?



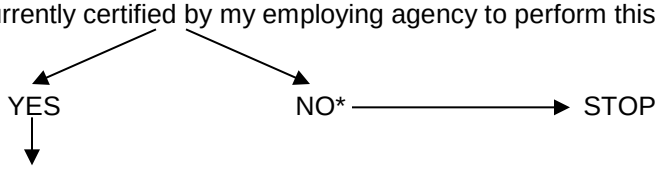
Perform the function

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

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



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



Perform the function

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

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

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

TITLE:		SECTION:	POLICY NUMBER:
Transferred Functions		Administrations	05-009-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		3
APPLIES TO:			
Community Health Nurses			

HSS may sanction transferred functions for nursing, providing that the following conditions are met:

POLICY 1:

The function is authorized by the Department of Health and Social Services in a written policy statement developed in partnership with the profession in which the function is being transferred. This departmental policy must be reviewed every three years or more frequently as legislation, best practices, or policies change.

PRINCIPLES:

The development of policies for transferred functions is the shared responsibility of nursing, administrative and the profession in which the function is being transferred. The authorization and maintenance of transferred functions to a registered nurse are the responsibility of the Department of Health and Social Services.

POLICY 2:

The Department of Health and Social Services' policy will address the parameters for which sanctioned functions may be transferred to a registered nurse.

PRINCIPLES:

Primary concern in the transfer of functions is that client safety be maintained.

Transferring of functions does not change the legal responsibility of the employer, the profession transferring the function or the registered nurse.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

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

GUIDELINES 05-009-01

When drafting a policy to transfer functions to the registered nurse, the following points are considered:

1. Ensure a profession has sanctioned functions to be transferred and develop the policy in collaboration with the profession transferring the function.
2. The need to transfer a function is documented and substantiated.
3. Possible complications and/or consequences of the delegation are reviewed and a protocol for safe transfer of function is established.
4. Evidence that the transferred function will be practiced often enough to maintain competence must be supplied.
5. There must be provision for review and, where indicated, recertification to assure competency is maintained.
6. Verification of competence should be recorded so that both the registered nurse and the Department of Health and Social Services possess an up-to-date record of authorization to perform the function.

A guideline of functions considered appropriate for transfer to nursing, along with recommended locations for implementation, has been developed and is located in Section 4.

Registered nurses are accountable for their own actions and each registered nurse must exercise judgement in accepting responsibility for applying transferred functions. Appropriateness of transferring specific functions will vary with the requirements of individual health centres.

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

Registered Nurses may perform transferred functions providing that:

1. The nurse successfully completes a program of instruction leading to specialized competence in the function.
2. That the nurse is appropriately certified if required and maintains such certification.
3. The nurse meets and feels the necessary competence level to perform the function
4. The nurse is authorized by the employing agency to perform the function and maintains an up-to-date record of such authorization.

See the decision-making model for performing additional nursing functions and transferred functions (Reference Sheet 05-008-03), adapted from the *Guidelines for Nursing Practice (*Registered Nurses Association of Northwest Territories and Nunavut, 2004).

The instruction program for transferred functions shall:

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

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

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS **Community Health Nursing**		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Competency for Transferred Functions		Administration	05-010-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		2
APPLIES TO:			
Community Health Nurses			

POLICY:

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

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

No registered nurse is compelled to perform any transferred function for which the nurse does not feel the necessary level of competence.

PRINCIPLES:

The development of policies for transferred functions is the shared responsibility of nursing, administrative and the profession in which the function is being transferred.

The authorization and maintenance of transferred functions to a registered nurse are the responsibility of the Department of Health and Social Services.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 05-008-00	Nursing Practice- Additional Nursing Functions
Guideline 05-008-01	Developing a Policy for Additional Nursing Function
Reference Sheet 05-008-03	Decision-Making Model for Performing Additional Functions and Transferred Functions
Policy 05-009-00	Transferred Functions
Guideline 05-009-01	Policy Guidelines for Transferred Functions
Guideline 05-009-02	Parameters for Performing Transferred Functions

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

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

TITLE:		SECTION:	POLICY NUMBER:
Reduction of Core Community Health Nursing Services		Administration	05-011-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		5
APPLIES TO:			
Community Health Nurses			

POLICY:

In the event of temporary nursing shortages or an adverse community event, it may be necessary to reduce the services normally provided by Community Health Nurses. The reduction however, shall never affect emergency and urgent services.

The Regional Health and Social Services office will collaborate with the Supervisor of Community Health Program (SHP) to arrange an alternate health care service delivery plan. The adjusted nursing services will aim to minimize the impact on the clients and personnel.

A designated HSS staff will ensure the Assistant Deputy Minister of Operations, community and other stakeholders are informed of the proposed health care delivery adjustments, preferably before the reduction occurs.

ASSUMPTIONS:

In each community health centre, the present complement of registered nursing staff is required for delivery of the core community health nursing programs (core programs are outlined in the Nunavut *Community Health Nursing Program Standards and Protocols*). Thus, a deficit in nursing staff results in a decreased capacity to deliver the core community health nursing programs.

DEFINITIONS:

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

- Maternal health
- Infant and child health
- School-age health
- Adult health
- Chronic care
- Communicable disease control
- Treatment and emergency services

Reduction of Community Health Nursing Services – The regional HSS office, in collaboration with the SHP, will determine what essential services will be provided during the period of reduction.

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

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

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

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

PRINCIPLES:

- It is the responsibility of the Government of the Nunavut (GN) through the Department of Health and Social Services (HSS) to work collaboratively with other departments in establishing policies, guidelines and business contingency plans. These plans shall be consistent with risk management strategies and ensure the continued safety of the community and Health and Social Services employees.

- Establishing a territorial standardized process for **reducing community health nursing services** supports comprehensive business contingency plans through all levels of government.

RELATED POLICIES, GUIDELINES OR LEGISLATION:

Guideline 05-011-01	Guidelines for Reducing Community Health Nursing Services
Guideline 05-012-01	Guideline for Suspending Community Health Nursing Services
Guideline 05-012-02	Procedure for Suspending Core Community Health Nursing Services
Policy 05-003-00	Risk Management

REFERENCES:

Canadian Council on Health Services Accreditation (2006). *Glossary 6th Edition.*

Canadian Council on Health Services Accreditation (2006). *Leadership and Partnerships* (Standards 10 & 14). Ottawa, ON.

Canadian Patient Safety Institute. (2005). *Resources.*

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

Government of the Nunavut (2010). *Community Health Nursing Program Standards and Protocols.* Iqaluit, NU.

GUIDELINE 05-011-01

Reduction of Community Health Nursing Services – The regional HSS office, in collaboration with the SHP, will determine what essential services will be provided during the period of reduction.

PROCEDURE:

The Regional Health and Social Services staff responsibilities:

1. If the anticipated reduction of services will be less than 24 hours, the Regional Director, Director of Health Programs and the Supervisor of health programs will determine who will be notified of the decision to reduce services.

2. Prompt correspondence with the Assistant Deputy Minister of Operation is required with all service reductions.

3. The decision to reduce the core community health nursing services for a period greater than 24 hours, is made in timely manner and after collaboration with:

    - Deputy Minister of HSS
    - Assistant Deputy Minister of Operations
    - Chief Nursing Officer
    - Regional Director
    - Director of Health Programs
    - Supervisor of health programs (SHP)
    - Director of Medical Affairs where applicable
    - Representative of Hamlet counsel
    - Manager of Risk Management where applicable

4. The Director of Community Health Programs shall advise at a minimum the following persons/agencies in writing about the decision to reduce community health nursing services:

    - SHP, other health centre staff and allied professionals
    - Community Leader (mayor or representative)
    - Hamlet Health Committee representative
    - Deputy Minister of Health and Social Services
    - Minister of Health and Social Services
    - MLA representing the affected community
    - RCMP in the community
    - Human Resources: Nursing Officer
    - Regional Referral Centre

5. Visiting clinics such as physicians, rehabilitation teams, dental, or eye clinics may be deferred at the discretion of the Regional Director and the SHP.

The SHP and/or delegated health centre staff responsibilities:

1. Notices will be announced through the local community radio and local Health Centre telephone answering services. The notice is to include an alternate phone number for emergencies.

2. Written notices will be posted in highly visible sites within the Health Centre and the community. All written notices will also be printed in all official languages and to include an alternate phone number for emergencies.

3. Other Health and Social Services employees, who provide community services in the same facility as

the nursing services, are expected to continue to provide their program services within the limitations (if any) created by the reduced nursing services.

4. In consultation with the Director of Health Programs, the Supervisor of health programs and/or Community Health Nurse will organize daily and weekly clinics based on a safe and manageable work load.
   - The SHP and/or designate shall be responsible for determining which appointments should be delayed, postponed or retained.
   - To reduce potential periods of congestion and long wait times, appointments should be grouped together in short blocks of time.
   - Consults may be made through Telehealth services if required

5. Questions or concerns shall be directed to the Director of Health Programs.

CRITERIA FOR REDUCING CORE COMMUNITY HEALTH NURSING SERVICES:

Deficit in Staffing Levels:

Six (6) Nurse Health Centre:

- Where staffing is at 4 nurses (66%)

Five (5) Nurse Health Centre:

- Where staffing is at 3 nurses (70%)

Four (4) Nurse Health Centre:

- Where staffing is at 3 nurses (75%)

Three (3) Nurse Health Centre:

- Where staffing is at 2 nurses (66%)

Two (2) Nurse Health Centre:

- Where staffing is at 1 nurse (50%)

Adverse Community Event:

- Implement Community Health Centre Disaster/Emergency Plan.

RELATED POLICIES, GUIDELINES OR LEGISLATION:

Community Health Nursing Programs Standards and Protocols

REFERENCES:

Canadian Council on Health Services Accreditation (2006). *Leadership and Partnerships* (Standards 10 & 14). Ottawa, ON.

Government of Nunavut (2010). *Community Health Nursing Program Standards and Protocols.* Iqaluit, NU.

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

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

TITLE:		**SECTION:**	**POLICY NUMBER:**
Suspension of Core Community Health Nursing Services		Administration	05-012-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		7
APPLIES TO:			
Community Health Nurses			

POLICY:

In the event of temporary nursing shortages or an adverse community event, it may be necessary to suspend the services normally provided by Community Health Nurses.

The Regional Health and Social Services office will collaborate with the Supervisor of Community Health Program (SHP) to arrange an alternate health care service delivery plan. The adjusted nursing services will aim to minimize the impact on the clients and personnel.

A designated HSS staff will ensure the Assistant Deputy Minister of Operations, the community and other stakeholders are informed of the proposed health care delivery adjustments, preferably before the suspension occurs.

ASSUMPTIONS:

In each community health centre, the present complement of registered nursing staff is required for delivery of the core community health nursing programs (core programs are outlined in the Nunavut *Community Health Nursing Program Standards and Protocols*). Thus, a deficit in nursing staff results in a decreased capacity to deliver the core community health nursing programs.

DEFINITIONS:

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

1. Maternal health
2. Infant and child health
3. School-age health
4. Adult health
5. Chronic care
6. Communicable disease control
7. Treatment and emergency services

Suspension of Community Health Nursing Services – Temporary discontinuance of ALL core community health nursing services and no registered nursing staff will be on site.

Personal Safety - The prevention and mitigation of unsafe acts including risk of personal injury or danger to the individual. Strategies for improving personal safety include increased situational awareness, creating a culture that supports the identification and reporting of unsafe acts, effective measurement of personal injuries of staff and other relevant outcome indicators, and tools for developing or adapting structures and processes to improve personal safety. (Canadian Council on Health Services Accreditation (CCHSA, 2006)

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

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

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

PRINCIPLES:

- It is the responsibility of the Government of the Nunavut (GN) through the Department of Health and Social Services (HSS) to work collaboratively with other departments in establishing policies, guidelines and business contingency plans. These plans shall be consistent with risk management strategies and ensure the continued safety of the community and Health and Social Services employees.
- Establishing a territorial standardized process for **suspending community health nursing services** supports comprehensive business contingency plans through all levels of government.

RELATED POLICIES, GUIDELINES OR LEGISLATION:

Guideline 05-011-01	Guidelines for Reducing Community Health Nursing Services
Guideline 05-012-01	Guideline for Suspending Community Health Nursing Services
Guideline 05-012-02	Procedure for Suspending Core Community Health Nursing Services
Policy 05-003-00	Risk Management

REFERENCES:

Canadian Council on Health Services Accreditation (2006). *Glossary 6th Edition.*

Canadian Council on Health Services Accreditation (2006). *Leadership and Partnerships* (Standards 10 & 14). Ottawa, ON.

Canadian Patient Safety Institute. (2005). *Resources.*

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

Government of the Nunavut (2010). *Community Health Nursing Program Standards and Protocols.* Iqaluit, NU.

GUIDELINE 05-012-01

The Health Centre will not be closed during the suspension or temporary discontinuance of the core community health nursing services. Programs and services which do not require the direct involvement or supervision of a registered nurse will continue to be offered through the health centre.

PROCEDURE:

The Regional Health and Social Services staff responsibilities:

1. The decision to suspend the core community health nursing services is made in a timely manner in collaboration with the following stakeholders:
    - Deputy Minister of Health and Social Services
    - Assistant Deputy Minister of Operations
    - Chief Nursing Officer
    - Regional Director
    - Director of Health Programs
    - Supervisor of health programs (SHP)
    - Director of Medical Affairs where applicable
    - Representative of Hamlet counsel
    - Manager of Risk Management where applicable

2. The Director of Community Health Programs shall advise at a minimum the following persons/agencies in writing about the decision to reduce community health nursing services:

    - SHP, other health centre staff and allied professionals
    - Community Leader (mayor or representative)
    - Hamlet Health Committee representative
    - Deputy Minister of Health and Social Services
    - Minister of Health and Social Services
    - MLA representing the affected community
    - RCMP in the community
    - Human Resources: Nursing Officer
    - Regional Referral Centre
    - Community Government Services

3. Visiting clinics such as physicians, rehabilitation teams, dental, or eye clinics may be deferred at the discretion of the Regional Director and the SHP.

4. Suspension of core nursing services means there will be no access to the pharmacy in the health centre. In collaboration with the Territorial Pharmacist and ADM of Operations, alternate arrangements will be made to ensure clients continue to receive their medications in the community.

The SHP and/or delegated health centre staff responsibilities:

1. Notices will be announced through the local community radio and local Health Centre telephone answering services. The notice is to include an alternate phone number for emergencies.

2. Written notices will be posted in highly visible sites within the Health Centre and the community. All written notices will also be printed in all official languages and to include an alternate phone number for emergencies.

3. Other Health and Social Services employees, who provide community services in the same facility as the nursing services, are expected to continue to provide their program services within the limitations (if any) created by the reduced nursing services.

4. In consultation with the Regional Director, Director of Health Programs, and the ADM of Operations will determine how health services will be delivered.

5. Questions or concerns shall be directed to the Director of Health Programs.

If community health nursing services are suspended and a registered nurse is in the community, the Department of Health and Social Services may temporarily relocate the nurse from the community (if appropriate). It may not be reasonable to relocate the nurse from the community due to personal obligations. Mechanisms need to be in place to ensure the staff and clients adhere to the decision to suspend community health nursing services.

RELATED POLICIES, GUIDELINES OR LEGISLATION:

Policy 05-012-02 Procedure for Preparing for Suspension of Community Health Nursing Service.

REFERENCES:

Canadian Council on Health Services Accreditation (2006). *Leadership and Partnerships* (Standards 10 & 14). Ottawa, ON.

Government of Nunavut (2010). *Community Health Nursing Program Standards and Protocols.* Iqaluit, NU.

Government of Nunavut *Emergency Response Plans*

GUIDELINE 05-012-02

PROCEDURE:

1. The Regional Director will notify, as soon as possible, the Assistant Deputy Minister (ADM) of Operations of the pending suspension of core community health nursing services.

2. The Regional Director or delegate will submit a Briefing Note to the ADM of Operations as soon as possible, outlining the details of the service suspension.

3. The ADM of Operations will be responsible for briefing the Deputy Minister.

4. The Regional Director and the Director of Health Programs, in consultation with the ADM of Operations, shall establish a plan to:

    - Advise Health Centre staff of the situation
    - Prepare a formal notice and advise the Community leadership of the pending suspension
    - Work with community leadership to develop a contingency plan

5. The Supervisor of health programs or delegate shall ensure the formal notice and contingency plan is posted in highly visible sites within the Health Centre and the community. All written notices will be printed in all official languages and include an alternate phone number for emergencies.

6. The Director of Health Programs (or delegate) shall:

    - Notify other health and social services centres in the affected region, as well as the regional referral sites.
    - Collaborate with physicians, specialists, mental health and social workers, and other allied health professionals in the region who provide services to the region to reschedule planned visits.
    - Collaborate with the regional and community based HSS employees to determine a plan of action for emergency clients, high risk pregnancies and other clients with high risk, chronic or mental/emotional health conditions.

7. The support staff within the affected health centre shall continue their regular duties. The doors to the health centre shall not be opened for service except in emergency situations, and/or if a client does not have access to a phone in the community and needs to call for help.

    The Director of Health Program shall hold teleconferences at least once a day during the suspension of nursing services to review concerns with the support staff and allied health professionals working in the affected health centre.

8. The Director of Health Program shall establish a reporting system with the referral facilities identified in the business contingency plan to monitor sick/emergency calls and any medivacs.

9. A designated health centre employee shall keep the Director of Health Programs fully apprised of any urgent matters or potential medivacs on a continuous basis.

10. Keys to the pharmacy and narcotic cupboard shall remain in the hands of a Registered Nurse (RN) if the nurse stays in the community. There shall be no expectation of the nurse supplying medications during the suspension of services.

11. The Director of Health Programs shall make arrangements with the RCMP to patrol the Health Centre on a regular basis.

Where all registered nurses are leaving the community:

1. If a second nurse is not available, the registered nurse shall receive written instructions from the Director of Health Programs, in consultation with the Territorial Pharmacist, on conducting the narcotic count as per the *Nunavut Controlled Substances Policy and Procedures.*
2. The Director of Health Programs, in consultation with the Territorial Pharmacist shall determine and implement the process for securing the narcotics and narcotic keys.
3. If no other HSS employees will be working in the facility during the suspension of nursing services, a process for securing the keys to the Health Centre shall be determined. Community Government Services must be notified. Doors and windows (if applicable) to the facility shall be kept locked.

REFERENCES:

Canadian Council on Health Services Accreditation (2006). *Leadership and Partnerships* (Standards 10 & 14). Ottawa, ON.

Pharmacy & Therapeutics Committee (2002). *Nunavut Controlled Substances Policy and Procedures,* Iqaluit, NU.

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

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

TITLE:		**SECTION:**	**POLICY NUMBER:**
Orientation		Administration	05-013-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		2
APPLIES TO:			
Community Health Nurses			

POLICY:

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

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

DEFINITION:

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

PRINCIPLES:

A standardized, structured and organized orientation program:

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

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

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Government of Nunavut *Human Resource Manual: Employee Orientation*

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

Nunavut Employee's Union *Collective Agreement*

REFERENCES:

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

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

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

POLICY:

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

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

PRINCIPLES:

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

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

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

Author	Title	Ed.	Copyright	Publisher
GENERAL				
Barber, K.	Canadian Oxford Dictionary of Current English		2005	Oxford University Press
	Stedman's Medical Dictionary for the Health Professions and Nursing	6	2007	Lippincott Williams and Wilkins
OPERATIONAL				
	Anti-infective Guidelines for Community-Acquired Infections		2009	Mums Guidelines Clearinghouse
Gray, J.	Therapeutic Choices	5	2008	Canadian Pharmacists Association
Ottawa Hospital	Parenternal Drug Therapy Manual	30	2009	Ottawa Hospital
Hale, T.	Medications and Mother's Milk	13	2008	Hale Publishing
CLINICAL				
Health Canada	FNIHB Clinical Practice Guidelines			
Tortora, G.	Principles of Human Anatomy	11	2008	Wiley
Jarvis, C.	Physical Health Examination and Assessment	1	Can. Ed. 2008	Saunders
Beer, M	Merck Manual of Diagnosis and Therapy	18	2006	John Wiley and Sons
McPhee, S	Current Medical Diagnosis and Treatment 2009	48	2009	McGraw-Hill
Lang, G.	Ophthalmology: A Pocket Textbook Atlas	2	2007	Thieme Medical Publisher
Kanaski, J.	Clinical Ophthalmology: A Systematic Approach	6	2007	Butterworth-Heinemann

Author	Title	Ed.	Copyright	Publisher
CLINICAL				
Goldberg, S	Clinical Ophthalmology Made Ridiculously Simple	3	2005	MedMaster Inc
Wilson, W	Clinical Handbook of Ear, Nose and Throat Disorders		2002	Parthenon Pub. Group
Lucente, F	Essentials of Otolaryngology	5	2004	Lippincott
Wolff, K	Fitzpatrick's Color Atlas and Synopsis of Clinical Dermatology	6	2009	McGraw-Hill
Canadian Diabetes Association	**2008** Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada		2008	Canadian Diabetes Association
Chan, Paul D	Treatment Guidelines for Medicine and Primary Care		2008	Current Clinical Strategies
EMERGENCY CARE				
Tintinalli, J	Emergency Medicine	6	2003	McGraw Hill
Buttaravoli, P	Minor Emergencies: Splinters to Fractures	2	2007	Saunders
Emergency Nurses Association	Emergency Nursing Core Curriculum	6	2007	Elsevier Health Science
Proehl,J.A.	Emergency Nursing Procedures	4	2008	Elsevier Health Science
PAEDIATRICS				
Health Canada	FNHIB Pediatric Clinical Practice Guidelines			FNIHB
Hay, W	Current Pediatric Diagnosis and Management	19	2008	McGraw Hill

Author	Title	Ed.	Copyright	Publisher
PAEDIATRICS				
Zitelli, B	Atlas of Pediatric Physical Diagnosis	5	2007	Mosby
Fleisher, G	Textbook of Pediatric Emergency Medicine	5	2005	Lippincott, Williams and Wilkins
Schneewei	Hospital for Sick Children Handbook of Pediatric Emergency		2007	Jones & Bartlett
OBSTETRICS / GYNECOLOGY				
Baskett, T	Essential Management of Obstetric Emergencies	4	2004	Gazelle Drake Publishing
Fraser, D	Myles Textbook of Midwives	15	2009	Churchill Livingston
Fortner, K	Johns Hopkins Manual of Gynecology and Obstetrics	3	2006	Lippincott
Schorge, J	Williams' Gynecology		2008	Mc-Graw-Hill Professional
Chan, Paul D	Current Clinical Strategies: Gynecology and Obstetrics		2008	Current Clinical Strategies
MENTAL HEALTH				
American Psychiatric Association	Diagnostic and Statistical Manual of Mental Disorders IV	4	2000	American Psychiatric Publishing
Petit, J. R.	Handbook of Emergency Psychiatry		2003	Lippincott, Williams & Wilkins
Oootoova, I.	Perspectives on Traditional Health		2004	Nunavut Arctic College
Burns, D. D.	The Feeling Good Handbook	Rev	1999	Plume

Author	Title	Ed.	Copyright	Publisher
MENTAL HEALTH				
Greenberger, D	Mind Over Mood: Change How You Feel by Changing the Way You Think	rev.	1995	Guilford
Tsuang, M	Schizophrenia: The Facts	2	2005	Oxford University Press
Bourne, E J	The Anxiety & Phobia Workbook	4	2005	New Harbinger
Berman, A L	Adolescent Suicide: Assessment and Intervention	2	2006	American Psychiatric Association
Jones, A	104 Activities That Build: Self-Esteem, Teamwork, Communications, Anger Management, Self-Discovery, Coping Skills		1998	Rec Room Publishing
Robinson, David J.	Psychiatric Interview Explained	2	2007	RAPID PSYCHLER PRESS
Robinson, David J.	Mental Status Exam Explained	2	2002	RAPID PSYCHLER PRESS
Mitchell, Jeff	Integrative Crisis Intervention and Disaster Mental Health		2008	Chevron
Linehan, Marsha	Skills Training Manual for Treating Borderline Personality Disorder	1	1993	Guilford
Council on Remote Area Nurses Australia	Avoiding Burn-out in remote areas: surviving the day to day hassles, a guide for remote health practitioners		2000	
National Native Addictions Partnership Foundations	Conducting Assessments in First Nations and Inuit Communities: A Training Reference Guide for Front Line Workers		2004	
Council on Remote Area Nurses Australia	Surviving Traumatic Stress: A Guide for Multi-disciplinary remote and rural health practitioners and their families		2001	

Author	Title	Ed.	Copyright	Publisher
MENTAL HEALTH				
Pauktuutit	There is a Need, So We Help: Services for Survivors of Child Sexual Abuse		2003	
Franklin, Cynthia	The School Practitioner's Concise Companion to Mental Health		2008	Oxford University Press
Thompson, G	Verbal Judo: The Gentle Art of Persuasion		2004	Harper Collins
PUBLIC HEALTH				
Last, J	A Dictionary of Epidemiology	5	2008	Oxford University Press
Diem, E	Community Health Nursing Projects: Making a Difference		2004	Lippincott, Williams & Wilkins
Gold, R	Your Child's Best Shot: A Parent's Guide to Vaccination	3	2006	Canadian Pediatric Society
Wong, D	Maternal Child Nursing Care	4	2009	Mosby
Stone, J	The Pregnancy Bible: Your Complete Guide to pregnancy and Early Parenthood	2	2008	Firefly Book
COMMUNICABLE DISEASE				
	Canadian Immunization Guide	7	2006	Public Health Agency of Canada
	Canadian Guidelines on Sexually Transmitted Infections		2006	Public Health Agency of Canada
Toman	Toman's Tuberculosis: Case Detection, Treatment and Monitoring	2	2004	World Health Organization
Heymann, David	Control of Communicable Diseases Manual	19	2008	American Public Health Association

Author	Title	Ed.	Copyright	Publisher
COMMUNICABLE DISEASE				
	Epidemiology and Prevention of Vaccine Preventable Disease	11	2009	Public Health Foundation
	Canadian Tuberculosis Standards	6	2008	Canadian Lung Association
NUTRITION				
Newman, J	Dr. Jack Newman's Guide to Breastfeeding	rev.	2003	Harpers
HOME CARE				
Rice, Robin	Handbook of Home Health Nursing Procedures	2	2000	Mosby
Macmillan, K	A Caregiver's Guide: A Handbook About End of Life Care		2004	Military and Hospitaller Order of St. Lazarus of Jerusalem
	99 Common Questions (and More) About Palliative Care: A Nurse's Handbook	3	2006	Edmonton, Regional Palliative Care Program
Bickley, L S	Bates Pocket Guide to Physical Examination and History Taking	6	2008	Lippincott, Williams & Wilkins
Edelman, Carole	Health Promotion Throughout the Lifespan	6	2005	Mosby
Rice, Robyn	Home Care Nursing Practice: Concepts and Applications	4	2005	Mosby
Perry, Anne	Clinical Nursing Skills and Techniques	7	2009	Mosby
LABORATORY				
Fischbach, F	A Manual of Laboratory and Diagnostic Tests	8	2008	Lippincott, Williams & Wilkins

Author	Title	Ed.	Copyright	Publisher
RADIOLOGY				
McRae, R	Practical Fracture Treatment	5	2008	Churchill Livingstone
Ouellette, H.	Clinical Radiology Made Ridiculously Simple	2	2007	McGraw-Hill
MANAGEMENT				
Nunavut Employees Union	Collective Agreement		2008	
Government of Nunavut	Human Resources Manual			
Government of Nunavut	GN Administrator's Manual			
Liebler, J	Management Principles for Health Professionals	5	2008	Jones and Bartlett
Jones, R.	Managing and Leading in the Allied Health Profession		2006	Radcliffe Publishing
Hewison, A	Management for Nurses and Health Professionals: Theory into Practice		2004	Blackwell Science
Daft, R.	The Leadership Experience	4	2007	Thompson Southwestern
OCCUPATIONAL HEALTH AND SAFETY				
	Emergency Response Guidebook		2008	Transport Canada
Canadian Standards Association	Occupational Health and Safety Management		2006	Canadian Standards Association

REFERENCE SHEET 05-014-02

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

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

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

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

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

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

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS **Community Health Nursing**		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Statutes and Legislation		Administration	05-015-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		2
APPLIES TO:			
Community Health Nurses			

POLICY:

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

PRINCIPLES:

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

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Reference Sheet 05-015-01 Statutes and Legislation

REFERENCES:

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

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

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

REFERENCE SHEET 05-015-01

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

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

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

POLICY 1:

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

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

POLICY 2:

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

PRINCIPLES:

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

RELATED POLICIES, GUIDELINES OR LEGISLATION:

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

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

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

TITLE:		SECTION:	POLICY NUMBER:
Equipment Management System		Administration	05-017-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		1
APPLIES TO:			
Community Health Nurses			

POLICY:

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

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

PRINCIPLES:

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

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

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 05-018-00 Standard Emergency Equipment

REFERENCES:

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

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

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS Community Health Nursing		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Standard Emergency Equipment		Administration	05-018-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		1
APPLIES TO:			
Community Health Nurses			

POLICY 1:

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

Policy 2:

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

PRINCIPLES:

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

RELATED POLICIES, GUIDELINES OR LEGISLATION:

Nunavut Pharmacy & Therapeutics Committee (2007). Nunavut Formulary

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

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

POLICY:

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

PRINCIPLES:

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

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Guideline 05-019-01 Basic Nursing Equipment

GUIDELINE 05-019-01

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

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

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

TITLE:		**SECTION:**	**POLICY NUMBER:**
Equipment – Advanced Nursing		Administration	05-020-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		2

APPLIES TO:
Community Health Nurses

POLICY:

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

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

PRINCIPLES:

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

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

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Guideline 05-020-01 Advanced Nursing Equipment

GUIDELINE 05-020-01

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

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

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS	
	Community Health Nursing	
TITLE:	**SECTION:**	**POLICY NUMBER:**
Occupational Health and Safety	Administration	05-021-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018 / February 2021		3
APPLIES TO:		
Community Health Nurses		

POLICY:

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

PRINCIPLES:

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

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Nunavut Safety Act and Regulations

GUIDELINES 05-021-01

DEPARTMENT OF HEALTH AND SOCIAL SERVICES RESPONSIBILITIES

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

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

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

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

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

SUPERVISOR RESPONSIBILITIES

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

SUPERVISOR RESPONSIBILITIES (CONT'D)

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

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

WORKERS RESPONSIBILITIES

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

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

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

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

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

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

POLICY:

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

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

DEFINITIONS:

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

PRINCIPLES:

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

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Government of Nunavut. *Human Resource Manual*

Nunavut Tobacco Control Act

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

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

TITLE:		**SECTION:**	**POLICY NUMBER:**
Treating Immediate Family Members		Administration	05-023-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		1
APPLIES TO:			
Community Health Nurses			

POLICY:

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

DEFINITIONS:

Immediate Family includes spouse, children, parents and siblings.

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

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

Policy 1:

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

Policy 2:

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

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

Policy 3:

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

Definitions:

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

Principles:

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

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

Related Policies, Guidelines And Legislation:

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

GUIDELINE 05-011-01

Ambulatory Services

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

Restraints

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

Visitors

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

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

Release of Information

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

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

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

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

References

Adapted from the University Health Network manual

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

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

TITLE:		**SECTION:**	**POLICY NUMBER:**
Provisions of Care to Clients in Police Custody		Administration	05-024-01
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		2

APPLIES TO:
Community Health Nurses

Ambulatory Services

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

Restraints

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

Visitors

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

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

Release of Information

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

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

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

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

References

Adapted from the University Health Network manual

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

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

TITLE:		**SECTION:**	**POLICY NUMBER:**
Gifts		Administration	05-025-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		4
APPLIES TO:			
Community Health Nurses			

POLICY:

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

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

DEFINITIONS:

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

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

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

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

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

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

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

PRINCIPLES:

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

PRINCIPLES:

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

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Guideline 05-025-01 Guidelines for Accepting Gifts

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

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

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

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

Gifts from Clients

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

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

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

Gifts from Existing or Potential Vendors/Suppliers

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

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

Exceptions

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

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

Vendor/Supplier Sponsored Entertainment and Events

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

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

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

Reporting

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

Related Policies, Guidelines and Legislation

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

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

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

TITLE:		**SECTION:**	**POLICY NUMBER:**
Loss or Theft of Property		Administration	05-026-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		1
APPLIES TO:			
Community Health Nurses			

POLICY:

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

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

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Government of Nunavut. *Human Resources Manual.*

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

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

TITLE:		SECTION:	POLICY NUMBER:
Contacting Clients Through Local Radio		Administration	05-027-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		1
APPLIES TO:			
Community Health Nurses			

POLICY:

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

Principles:

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

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Government of Nunavut. *Human Resources Manual.*

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

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

TITLE:		**SECTION:**	**POLICY NUMBER:**
Scent-Free Workplace		Administration	05-028-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		1
APPLIES TO:			
Community Health Nurses			

POLICY:

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

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

Principles:

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

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Government of Nunavut. *Human Resources Manual.*

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

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

TITLE:		SECTION:	POLICY NUMBER:
Violence in the Workplace		Administration	05-029-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		1
APPLIES TO:			
Community Health Nurses			

POLICY:

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

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

DEFINITIONS:

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

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

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

POLICIES, GUIDELINES AND LEGISLATION:

Human Resource Manual

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

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS **Community Health Nursing**	
TITLE:	**SECTION:**	**POLICY NUMBER:**
Motor Vehicles	Administration	05-030-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018 / February 2021		1
APPLIES TO:		
Community Health Nurses		

POLICY:

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

DEFINITIONS:

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

RELATED POLICIES, GUIDELINES AND LEGISLATION:

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

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

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS **Community Health Nursing**		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Fire Response and Evacuation		Administration	05-031-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		1
APPLIES TO:			
Community Health Nurses			

POLICY:

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

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

PRINCIPLES:

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

RELATED POLICIES, GUIDELINES AND LEGISLATION:

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

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

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

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

TITLE:		SECTION:	POLICY NUMBER:
Compressed Gas		Administration	05-032-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		2

APPLIES TO:
Community Health Nurses

POLICY:

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

PRINCIPLES:

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

RELATED POLICIES, GUIDELINES AND LEGISLATION:

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

GUIDELINE 05-032-01

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

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

    - Radiology department
    - Emergency treatment room
    - Clinic rooms

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

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

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

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

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

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

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

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS	
	Community Health Nursing	
TITLE:	**SECTION:**	**POLICY NUMBER:**
Managing Nursing Practice and Professional Conduct	Administration	05-033-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018 / February 2021		10
APPLIES TO:		
All Health Staff		

1. BACKGROUND:

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

2. POLICY:

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

3. PRINCIPLES:

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

4. DEFINITIONS:

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

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

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

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

5. GUIDELINE:

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

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

Validating the Concern

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

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

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

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

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

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

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

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

Analyzing the Professional Practice Concern

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

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

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

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

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

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

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

Acting upon Professional Practice Concerns

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

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

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

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

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

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

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

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

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

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

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

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

External Reporting of the Practice Concern

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

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

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

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

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

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

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

Follow-up Plan

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

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

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

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

Practice Restrictions Imposed by the Nursing Regulatory Body

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

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

6. RELATED POLICIES, PROTOCOLS AND LEGISLATION:

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

7. REFERENCES:

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

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

Appendix: Professional Development Learning Plan

Learning plans include the following statements:

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

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

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

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

SAMPLE Nursing Professional Development Learning Plan

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

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

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

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

Department of Health Government of Nunavut	**Department of Health Policy , Procedure and Protocol** **Operations**

TITLE:		**SECTION:**	**POLICY NUMBER:**
Client Safety Events – Reporting and Management		Administration	05-034-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
October 01, 2017	October 2019	05-002-00 05-003-00 05-004-00	13
APPLIES TO:			
All Department of Health Staff/Service Providers			

1. BACKGROUND

The Department of Health (Health) has established a client safety events reporting and management system that ensures a timely, consistent process for the notification, review and follow-up of client safety events. Having a department response plan for events will have a positive impact on public trust and staff morale.

The purpose of this policy is to standardize the process of identifying, reporting and managing client safety events. Event management includes several components: (1) Immediate response; (2) Preliminary review; (3) Disclosure; (4) Analysis process; (5) Follow-through; and (6) Closing the loop/ shared learning.

2. POLICY

2.1 It is the responsibility of all staff and service providers to report events through the client safety events reporting and management system. It is their duty to report those events in which they are directly involved and those of which they are aware.

2.2 All events reported will be reviewed in a timely manner. The analysis process will vary according to the severity and complexity of the event:

a. Level 1: Primary review
b. Level 2: Root Cause Analysis
c. Level 3: An external review

2.3 Health will maintain a confidential and non-punitive events reporting and learning system that facilitates consistent management of events in its health facilities and supports the Risk Management and Continuous Quality Improvement Program**.**

3. PRINCIPLES

3.1 This policy is based on the following principles:

a. *Tunnganarniq,* fostering good spirits by being open, welcoming and inclusive;
b. *Inuuqatigiitsiarniq,* respecting others, relationships and caring for people; and
c. *Piliriqatigiinniq,* working together for a common cause, and more specifically, for the health and safety of clients of the Department of Health;

3.2 The client has the right to safe and effective health care and the health care provider has the right to a safe working environment.

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

4. DEFINITIONS

Client: refers to a person who receives health services or a visitor in a health facility.

Client safety event: means an event or circumstance which could have resulted, or did result, in harm to the client and it includes; near miss, no harm event and harmful event.

Director: refers to program directors (i.e. Health Programs, Population Health, Iqaluit Health Services) and facility directors (i.e. Kivalliq and Kitikmeot Health Centres; and Qikiqtani General Hospital).

Harm: means an unexpected or normally avoidable outcome that:

a. negatively affects a client's health or quality of life;
b. occurs or occurred in the course of health care treatment; and
c. is not due directly to the client's underlying illness.

Harmful event: means an event or circumstance that resulted in permanent harm/damage or death to the client.

Health care professional: means a person who provides health services in Nunavut for the Department, either as an employee or a contractor and, for greater certainty, includes physicians.

Immediate supervisor: means

a. the Supervisor of Community Health Programs for the community or equivalent if the event is reported by a member of the public; and
b. the superior of the health care professional who reported the event if the report was made by a health care professional.

Event Report: Is a confidential document and is neither part of the medical record nor the health care professional's file.

Near miss: means an event or circumstance which could have resulted in harm to the client but did not reach the client.

No harm event: means an event or circumstance which could have resulted in harm to the client, reached the client, but did not cause discernable harm to the client.

Root Cause Analysis: means a retrospective review of an event undertaken by health care professionals in order to understand what happened, why it happened and determine what changes need to be made to prevent future occurrence.

5. SCOPE OF APPLICATION

This Policy applies to all Department of Health staff and service providers.

6. PROCEDURE

6.1 Reporting an Event

Table 1: Reporting an Event	
What to Report?	Any event or circumstance arising in the workplace that resulted, or could have resulted, in unexpected physical or psychological harm to client, visitor or staff.
Who is to Report?	All staff and service providers are required to report events. It is recommended the reporter of the event be: a. the most involved staff (preferred); b. the witness of the event; or c. the person who discovers or is informed of the event.
How to Report?	Events are reported on the *Events Reporting Form*. In addition to the *Events Reporting Form*, the following reports may be required based on the circumstances of the event: *a.* Work related events: The GN has a duty to report employee events within three days, as per *WSCC Act*. Use *WSCC forms*. *b.* Vaccine adverse reaction: All vaccine related adverse reactions are to be reported using the *Report of adverse events following Immunization Form.* *c.* Blood exposure: All events related to Blood exposure are to be reported using the *Blood and body fluid exposure Form.* Consult the immediate supervisor when it is unclear whether an *Event Reporting Form* or other documentation needs to be completed.
Where to send the report?	Submit the required report(s) to the immediate supervisor **within 24 hours.** Note: All staff and service providers are responsible for ensuring event reports are submitted through proper channels and only to those who are entitled to receive them.
Tips for completing the Events Reporting Form	• Document the type and severity of the event as per Severity Scale Categorizing Degree of Harm (See QI Resource Kit); • Identify all persons involved; • Include factual and objective information only; • Identify contributing factors; • State actions taken to prevent similar events in the future; • Ensure handwriting is legible; and • Avoid opinions and abbreviations.

6.1 Initial Response and Analysis

Once reported, a series of tasks are triggered, as per Table 2. The roles and responsibilities in the follow-up management of an event will vary according to the complexity and severity of the event.

Table 2: Roles and Responsibilities for Follow-up Management of Client Safety Events:		
IMMEDIATE RESPONSE: Take immediate action to protect the health and safety of clients, visitors and staff as indicated by the type of event that occurred ▪ Respond to client's and staff's immediate emotional and physical needs; document all assessment and treatments in their health care record; ▪ Arrange coverage of duties, facilitate access to counselling, and peer support; ▪ Ensure the environment is safe for clients and service providers; ▪ Secure and remove equipment, medication, supplies, or other hazards involved • Remove specific lot numbers from circulation, arrange for defective equipment to be serviced, and notify building maintenance; ▪ Contact Coroner and RCMP as required; ▪ Secure the health record in a restricted area in the SCHP's office following a harmful event; and ▪ Preserve evidence as required (e.g. take photos, retrieve data).		
Staff	**Near Miss – No Harm Events**	**Harmful Events**
Note: Flowcharts for notification of Near Miss- No Harm and Harmful events are provided in Appendix A		
Most Involved Staff	▪ Complete the *Events Report Form* and submit to the immediate supervisor within 24 hours. ▪ Initiate maintenance or biomed work order as required.	▪ Notify immediate supervisor as soon as reasonable. ▪ Notify the coroner and RCMP as clinically indicated. ▪ Complete & submit the *Events Report Form* to the immediate supervisor before the end of the work shift. ▪ Initiate maintenance or biomed work order as required.
Immediate Supervisor	▪ Verify appropriate form(s) have been completed. ▪ Conduct Level 1 primary review (see Appendix B). ▪ Email a copy of the *Events Report Form* within 72 hours to the director.	▪ Notify director as soon as possible. ▪ Secure health record in the supervisor's office and make a copy. ▪ Conduct Level 1 primary review as soon as reasonable (see Appendix B). ▪ Verify appropriate form(s) have been completed and submit copy of the *Events Report Form* to the director within 24 hours. ▪ Ensure staff are aware of the Employee and Family Assistance Program. ▪ Initiate the disclosure process as per the *Client Safety Disclosure Policy*.
Director	▪ Verify the form(s) for accuracy and completeness. ▪ Review the actions taken, consult content experts (e.g. Communicable Disease Consultant), and recommend additional actions as warranted. ▪ Notify the Executive Director (ED) and send a copy of the *Events Report Form* to the CQI unit. ▪ Initiate Level 2 review - Root Cause Analysis (RCA) (Appendix B), in conjunction with the RCA team when warranted.	▪ Notify the ED promptly and provide ongoing updates. ▪ Verify the form(s) for accuracy and completeness. ▪ Review the actions taken, consult content experts, and recommend additional actions as warranted. ▪ Send a copy of the *Events Report Form* to CQI unit. ▪ Initiate *Level 2 review*- RCA, in conjunction with the RCA team. ▪ Direct and monitor any follow-up actions and recommendations in collaboration with the Risk Management Lead.

Staff	Near Miss – No Harm Events	Harmful Events
Executive Director	▪ Review the *Events Report Form* and secure file at regional office as per GN record management policy.	▪ Notify Assistant Deputy Minister – Operations (ADM-Ops), CQI unit, and the co-chairs of the Quality Improvement Committees (QIC). ▪ Submit a briefing note and ongoing updates to the ADM-Ops. ▪ Review the *Events Report Form* and secure file at regional office.
Risk Management Lead	▪ Review the *Events Report Form*, actions taken and recommend additional actions as warranted. ▪ Enter *Events Report Form* into the data base. ▪ Notify Risk Management (Department of Finance) as warranted.	▪ Notify Territorial Quality Improvement Manager, GN legal department, and Territorial Director of Mental Health and Addictions. ▪ Notify Risk Management (Finance) and submit liability form. ▪ Coordinate retrieval of all relevant health records and maintain a central and secure electronic repository for these documents. ▪ Review, in collaboration with other CQI staff, the event, actions taken and recommend additional actions as warranted. ▪ Enter *Events Report Form* into the data base.
Territorial QI Manager	▪ Provide leadership in relation to client safety events management processes. ▪ Assists the Director, as required, to determine whether a Level 2 investigation is warranted.	▪ Provide leadership on RCA process and assemble RCA team. ▪ Provide regular updates to the Chief Nursing Officer (CNO) and Chief of Staff (COS) – frequency determined by the severity of the harmful event. ▪ Bring RCA findings to the QIC meeting for review and feedback.
Chief Nursing Officer	▪ Review the case and primary findings as requested.	▪ Review the draft RCA report, provides feedback prior to submission to QIC.
Chief of Staff	▪ Review the case and primary findings as requested.	▪ Conduct chart review. ▪ Review the draft RCA report, provides feedback prior to submission to QIC.
ADM - Operations		▪ Provide briefing to Deputy Minister within 24 hours. ▪ Notify Communications Division as soon as event has been reported. ▪ Decide, in collaboration with the co-chairs of QIC, whether the event is closed or require further review.
ED – Operations		▪ Assist with ongoing operational needs as required (e.g. staffing support). ▪ Assist communications division with preparation of briefing materials.
Communications		▪ Assist in briefing material. ▪ Prepare communication announcements. ▪ Respond to media requests.
Territorial Director of Mental Health and Addictions		▪ Initiate critical event response process, as required.

6.2 Follow - through

6.2.1 QI manager will present the case and findings of all harmful events to the QIC.

6.2.2 QIC members in collaboration with the CQI unit will take the lead on assigning the implementation of recommended actions to the most appropriate division/unit.

6.2.3 The CQI team, in collaboration with the regional administrative staff and QIC members will monitor and assess the effectiveness of these actions as they are implemented.

6.3 Close the loop/share learning

6.3.1 The program director and a delegate from the CQI unit shares information with staff about what was learned and the recommended follow up actions.

6.3.2 For Harmful events and other events whereby a Level 2 review was conducted, the Territorial Chief of Staff and Chief Nursing Officer are to request the case be discussed at the Morbidity and Mortality rounds.

6.3.3 The disclosure team shares information with the client / family about what was learned and the actions taken in accordance with the *Client Safety Disclosure Policy.*

6.4 Communication with media

6.4.1 All communication with media shall be co-ordinated by the communication division staff as directed by the ADM–Ops and ADM-Programs and Standards.

6.4.2 Any staff approached by the media are not to share any information relating to the event. Notify your supervisor immediately of any such requests.

6.5 Events involving more than one unit or division

Where event involves more than one unit, client safety event management shall be a common effort:

6.5.1 Only one *Events Report Form* is completed by the unit where the event was discovered.

6.5.2 The director where the event was discovered will lead the review in collaboration with the other director(s).

6.5.3 The final report shall be approved by all delegates of the involved units.

6.5.4 Sharing the learnings will be a common effort with each supervisor, manager and/or director ensuring that the learnings are shared with their respective staff.

7. Continuous Quality Improvement

7.1 To evaluate this policy, the Risk Management Lead, in collaboration with other CQI members, will conduct audits to seek feedback from health care professional and service providers regarding the events management process. This can be completed through the use of the *After Action Report* (Appendix C).

7.2 The Department of Health will offer training on this policy at the time this Policy comes into force and on an ongoing basis.

8. RELATED POLICIES, PROTOCOLS AND LEGISLATION

Appendix A:	Notification Process for Client Safety Events
Appendix B:	Client Safety Event Analysis
Appendix C:	Department of Health *After Action Report*
Policy 05-005-00	Critical Incidents Stress Management
Policy 05-033-00	Client Safety Disclosure Policy

Consolidation of Evidence Act R.S.N.W.T. 1988, c.E-8

9. References

Consolidation of Evidence Act R.S.N.W.T. 1988, c.E-8

WSCC Act s.Nu 2007, c.15 in force April, 2008:S1-003-2008
http://www.wscc.nt.ca/claim-services/claim-workers/report-injury.

Accreditation Canada's Qmentum – ROPs and Standards – 2016

Adler L, Moore J, Federico F. *IHI* Skilled Nursing Facility Trigger Tool for Measuring Adverse Events. Cambridge, MA: Institute for Healthcare Improvement; November 2015. (Available at ihi.org)

Approved By: Colleen Stockley	Date: Dec 18/17
Colleen Stockley, Deputy Minister – Department of Health	
Approved By:	Date: Dec 21/17
Jennifer Berry, Chief Nursing Officer	

Appendix A: Notification Process for Client Safety Events

Notification of Near Miss and No Harm Events

Involved staff

- Notifies immediate Supervisor

Immediate Supervisor

- Notifies Director

Director

- Notifies Executive Director
- Notifies Risk Managment Lead

Risk Management Lead

- Notifies Finance Risk Management according to the type of event
- Notifies other Departments that may be affected by the event

Appendix A: Notification Algorithm of Client Safety Events

Notification of Harmful Events

Involved staff

- Notifies immediate Supervisor
- Notifies RCMP and Coroner as indicated by the type of event

Immediate Supervisor

- Notifies Director

Director

- Notifies Executive Director
- Notifies Risk Managment Lead
- Notifies other Program Managers and Directors that may be impacted by the event

Executive Director

- Notifies ADM-operations
- Notifies Co-chairs of Quality Improvement Committee

Risk Management Lead

- Notifes Finance Risk Management and GN legal team
- Notifies Territorial QI Manager and Director of Mental Health & Addictions
- Notifies other Departments that may be affected by the event

ADM - Operations

- Notifies Deputy Minister
- Notifies Communications

Appendix B: Client Safety Event Analysis

Level 1: Primary Review	
Application	Primary review is conducted as soon as possible after an event is reported, and in any case, no longer than 72 hours. Primary reviews are required after Near Miss/No harm events and harmful events.
Lead Responsibility	Immediate Supervisor (E.g. Supervisor Community Health Programs, Home Care Manager)
Purpose	Review is kept short and concise to: ▪ Gain an initial understanding of the facts; ▪ State prevention / safety measures taken; ▪ Identify learnings; and ▪ Determine if Level 2 review is warranted.
Anticipated Outcomes	▪ Event is closed; ▪ Event is closed with learning; or ▪ Event requires level 2 or level 3 review.
Documentation	▪ Primary findings are documented on the *Events Report Form*.
Process Overview	▪ Interview staff involved and witnesses to the event. ▪ Review relevant client health records, data from QA reports, equipment, etc. as required. ▪ Consult content experts (e.g. Communicable Disease Consultant), best practices, policies. ▪ Complete and submit the *Events Report Form* as per the *Events Reporting Policy*. ▪ Formulate recommendations and develop a corrective action plan. ▪ Share learnings.
Level 2: Root Cause Analysis (RCA)	
Application	▪ All harmful events require RCA review as soon as reasonably possible. ▪ RCA review may be warranted for near miss / no harm events, as informed by the findings of the primary investigation.
Lead Responsibility	▪ Director ▪ May also be led by the Territorial QI Manager or RM Lead as directed by the CNO.
Purpose	Review elicits more detail and is conducted through a quality improvement lens to: ▪ Better understand the contributing factors of the event. ▪ Identify areas for system improvements and learnings for staff. ▪ Prevent similar events in the future. ▪ Determine if Level 3 review is warranted.
Anticipated Outcomes	▪ Event considered closed with learning; or ▪ Event required level 3 review.
Documentation	▪ RCA interviews and evidence collected are to be documented in the GN approved template.
Process Overview	▪ Interview staff, client(s) and witnesses. ▪ Assess the scene including medical equipment and other physical environment factors. ▪ Review health Records, data from QA reports; policies, protocols and best practices. ▪ Consult clinical experts. ▪ Analyse the information gathered- use quality improvement tools to analyse the information. ▪ Identify contributing factors. ▪ Formulate recommendations. ▪ Develop a corrective action plan and share learnings.

Appendix B: Client Safety Event Analysis

Level 3: External Review	
Application	▪ External review will be ordered by the ADM-Operations, in consultation with the DM and co-chairs of the Quality Improvement Committee. ▪ May be required for complex cases. For example: cases that involve many levels of the system within the GN and the community; or cases which require technical expertise to adequately investigate the root cause (e.g. radiology review).
Lead Responsibility	▪ The co-chairs for the Quality Improvement Committee will maintain department lead with the consultant conducting the external review.
Purpose	Review elicits more detail and is conducted through a quality improvement lens to: ▪ Better understand the contributing factors of the event. ▪ Identify areas for system improvements and learnings for staff. ▪ Prevent similar events in the future.
Anticipated Outcomes	▪ Event considered closed with learning.
Documentation	▪ RCA interviews and evidence collected are to be documented in the GN approved template.
Process Overview	▪ Interview staff, client(s) and witnesses. ▪ Assess the scene including medical equipment and other physical environment factors. ▪ Review health Records, data from QA reports; policies, protocols and best practices. ▪ Consult clinical experts. ▪ Analyse the information gathered- use tools to analyse the information. ▪ Identify contributing factors. ▪ Formulate recommendations. ▪ Develop a corrective action plan and share learnings.

Department of Health
After Action Report

Event: **Title the event with date**

Summary

If this report is longer than 2 pages, please complete a brief summary.

Situation

Provide a brief synopsis of the situation. Include key events, relevant environmental conditions, emergent issues, other organizations (resources) involved, and efforts underway, length of event/incident (total number of hours, days).

Background

Identify any relevant historical or situational information (such as: past events/incidents, age/physical status of equipment, or staffing levels), also include past practices and intelligence information impacting planning and response.

Chronology of Events

Provide a brief description of the situation, as it emerged, and the actions taken to address the situation. Professional observations and assessment of the event are included here.

Strengths of the Response

Identify which aspects of the response worked well. This could include pre-planning, unexpected resources that were available, or direct response activities.

Gaps in response

Identify any shortcomings in response to the event. For example, lacking technical assistance, resources, and information related to the situation, lack of skills / knowledge, equipment malfunction, staff shortage, communication challenges.

Recommendations

Provide recommendations for follow-up action: for example: training, policy review (or modification), points of contact for future events, information to support future planning/response, prevention measures. Include suggested action regarding each recommendation.

Recovery

Describe any post event/incident follow up required. For example: media requests, communications, mental health supports, ministerial briefings, etc.

Financial impact

Indicate whether any financial expenses were associated with the event/incident, or if any future financial implications.

Report completed by:

Name:

Position:

Date:

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

PREAMBLE

Clients are entitled to information about themselves and about their medical condition including the risk inherent in healthcare delivery. Independently, the client has the right to control what happens to his or her body. This requires that information be provided about possible unexpected client safety incidents.

The obligation to disclose is a key part of the client safety management system and a requirement by Accreditation Canada. Current Healthcare literature commonly recognizes that having a clear framework in place is necessary for health care professionals to feel comfortable carrying out disclosure; furthermore, an effective acknowledgement and apology can have a profound healing effect, restore relationship and even strengthen them.

The Legal Treatment of the *Apologies Act* in Nunavut establishes that apologizing does not constitute an admission of guilt or civil liability, and cannot be used against the person giving the apology in legal proceedings. Bearing in mind this statement along with best practices and those principles highlighted in section 2 of this policy, the department of health reinstates the need and its determination to train health care professionals on disclosure and its requirements through development and adoption of the following policy:

1. POLICY

1.1 Disclosure of incidents shall take place, as soon as it is practical. The following are incidents:

1. Harmful incidents;
2. No harm incidents when the immediate supervisor decides, according to section 5.1 of this Policy, that disclosure is to take place; and
3. Near miss incidents when the immediate supervisor decides, according to section 5.1 of this Policy, that disclosure is to take place.

2. PRINCIPLES

2.1 This Policy is based on the following principles:

1. *Tunnganarniq,* fostering good spirits by being open, welcoming and inclusive;
2. *Inuuqatigiitsiarniq,* respecting others, relationships and caring for people;
3. *Piliriqatigiinniq,* working together for a common cause, and more specifically, for the health and safety of client s of the Department of Health;
4. Client s deserve a high standard of care and transparency from the Department of Health;
5. Disclosure is a non-punitive activity that does not seek to blame individuals; and

6. The Department of Health is a learning organization that continuously seeks to improve its processes.

3. DEFINITIONS

Apology: means an expression of sympathy or regret, a statement that a person is sorry or any other words indicating contrition or commiseration;

Client: means the client of the Department associated with the disclosable incident;

Client safety incident: means an event or circumstance which could have resulted or did result in harm to the client and it includes a near miss, a no harm incident and a harmful incident;

Department: means the Government of Nunavut's Department of Health;

Disclosee(s): means the person(s) entitled to information about a disclosable incident under section 8 of this Policy;

Disclosure: means the communication of information about a disclosable incident to the disclosee(s);

Disclosure meeting: includes the initial disclosure meeting and any subsequent disclosure meeting about the same disclosable incident;

Harm: means an unexpected or normally avoidable outcome that

1. negatively affects a client 's health or quality of life;
2. occurs or occurred in the course of health care treatment; and
3. is not due directly to the client 's underlying illness;

Harmful incident: means an event or circumstance that resulted in permanent harm/damage or death to the client;

Health care professional: means a person who provides health services in Nunavut for the Department, either as an employee or a contractor and, for greater certainty, includes physicians;

Immediate supervisor: means

1. the Supervisor of Community Health Programs for the community or equivalent if the disclosable incident is reported by a member of the public; and
2. the supervisor of the health care professional who reported the client safety incident if the report was made by a health care professional.

Initial disclosure meeting: means the first meeting through which a disclosable incident is communicated to the disclosee(s);

Most responsible professional: means the health care professional based at the facility where the client is receiving health services who has the final responsibility and accountability for the care of the client at the facility;

Near miss: means an event or circumstance which could have resulted in harm to the client but did not reach the client;

No harm incident: means an event or circumstance which could have resulted in harm to the client, reached the client, but did not cause discernable harm to the client;

Subsequent disclosure meeting: means a meeting that takes place after the initial disclosure meeting to provide the disclosee(s) with further information about a disclosable incident;

Substitute decision maker: means a person other than the client who is legally authorized to consent to medical treatment or receive personal health information on behalf of the client;

Risk: means the chance that someone could be harmed by a client safety incident.

4. SCOPE OF APPLICATION

This Policy applies to all health care professionals.

5. PROCEDURE

5.1 Which Incidents Must be Disclosed

Table 1: When to Disclose an Incident

Type of Incident	Is Disclosure Required?
Harmful Incidents	Disclosure is mandatory
Near Miss Incidents or No Harm Incidents	Disclosure may be required. The immediate supervisor shall consider the following when deciding whether disclosure is required: i. whether an ongoing risk to the client exists; and ii. whether being informed of the incident would be beneficial for the client.

Note: Resources have been provided in the Appendices to assist health care professionals determine whether a client safety incident qualifies as a disclosable incident.

- Appendix A: Assists with classifying the type of client safety incident
- Appendix B: Assists with determining whether the incident is a disclosable incident based on the degree of harm.

If there is uncertainty as to whether a particular client safety incident is a disclosable incident, consultation with the appropriate supervisor must take place

5.2 Recipients of Disclosure

5.2.1 Disclosee: The following person(s) are entitled to information about a disclosable incident:

a. The client; or

b. The client's parent, legal guardian, next of kin or substitute decision maker, as appropriate, if the client is unable to consent to medical treatment.

5.2.2 When the person(s) entitled to information under section 5.2.1 of this Policy change(s) between disclosure meetings, the disclosure team must provide the person(s) newly entitled to information with the information previously disclosed.

5.2.3 When the client requests that a friend, relative or elder participate in a disclosure meeting, the disclosure team will make accommodations for the client's request.

5.3 **Refusal of disclosee(s) to participate in disclosure**

5.3.1 If there is no risk to third parties, a disclosee may, on his or her own initiative, refuse to participate in the disclosure process.

5.3.2 When a disclosee declines to participate, the disclosure team shall

a. Inform the disclosee that the disclosure process will remain available to discuss the matter at a later time;
b. Document the refusal to participate in the client 's health record; and
c. Document the refusal in a secure file at the Regional Office.

5.4 **The Disclosure Team**

5.4.1 The supervisor is to assemble the disclosure team as soon as possible after the incident occurred. The supervisor is to consider the following when selecting the team:

a. The health care professionals' qualifications, training and knowledge of the incident;
b. The team should be comprised of at least two health care professionals;
c. It is preferable to have the most responsible provider on the team;
d. It is preferable to have at least one physician and one nurse on the team;

5.4.2 Health care professionals can refuse to be a member of a disclosure team in certain circumstances such as:

a. Emotional or physical stress preventing them from carrying out disclosure professionally; or
b. Concerns or fears that participating in disclosure may threaten their own safety.

5.4.3 Every attempt is to be made to keep the disclosure team membership the same between disclosure meeting(s) to provide continuity for the disclosee. The immediate supervisor may be required to change the team composition under certain circumstances such as:

a. One of its members is no longer a department employee or contractor; or
b. One of its members is refusing to remain part of the disclosure team as per section 5.4.2 of this Policy.

5.4.4 When the disclosure team membership is changed, the immediate supervisor must ensure that all relevant information about the disclosable incident is given to the new disclosure team member(s) before the next disclosure meeting takes place.

5.4.5 *Postponing Disclosure*

The disclosure meeting may be postponed if there are reasonable grounds to believe that holding the meeting at the time envisioned by this Policy could result in immediate and grave danger to the mental or physical health or safety of the disclosee(s) or another person.

a. The disclosure team shall collaborate with the Regional Executive Director, the Territorial Chief of Staff and the Chief Nursing Officer before making the decision to postpone the disclosure meeting.
b. The disclosure team shall document, in a secure file at the Regional Office, the following information:

i. Names and functions of all persons who participated in making the decision;
ii. Date of the decision; and
iii. Detailed reason(s) for postponing the meeting.

c. The disclosure team shall re-evaluate the status at frequent intervals to determine when the disclosure meeting can be held without immediate and grave danger to the disclosee or other person.

5.5 **The Initial Disclosure Meeting**

5.5.1 *Preparing for the initial disclosure meeting*

As soon as possible after forming a disclosure team, the immediate supervisor shall arrange a disclosure team meeting during which the team will

a. review all relevant records and facts about the disclosable incident, as available at that point in time;
b. assess the client 's health care needs and prepare treatment options and recommendations, as appropriate;
c. determine which disclosure team member will be the main communicator. It is preferable for the most responsible provider to play that role;
d. assess the potential need(s) of the client and disclosure team members for the supports listed in section 5.10 of this Policy and develop plans to meet those needs;
e. set a time and location for the initial disclosure meeting that meets accessibility and privacy needs;
f. arrange for the services of an interpreter, as required.

5.5.2 *Informing disclosee(s) of initial disclosure meeting*

The main communicator for the team will inform the disclosee(s) of the time and location for the initial disclosure meeting.

5.5.3 *Key items to cover at initial disclosure meeting*

a. acknowledge that the most responsible provider is not present, should that be the case;
b. share the objective facts about the incident, as known at that point;
c. explain the consequences of the incident for the client , as known at that point;
d. offer an apology for what happened;
e. explain the actions taken to address the consequences of the incident;
f. explain treatment options and recommendations, as appropriate;
g. explain the investigative process that is to follow and how the resulting findings will be communicated;
h. explain that the disclosure team remains accessible for ongoing communication and provide appropriate contact information;
i. offer, based on needs, the supports listed under section 5.10 of this Policy;
j. leave ample time for the disclosee(s) to ask questions and the team to respond;
k. offer to research any questions that the disclosure team cannot answer immediately and arrange for a timely follow-up.

5.6 **Subsequent Disclosure Meeting(s)**

5.6.1 The immediate supervisor shall organise subsequent disclosure meetings under the following circumstances:

a. each time new significant facts regarding the incident become known following the initial disclosure meeting; and
b. upon completion of the investigative process for the incident where an investigation took place.

5.6.2 *Preparing subsequent disclosure meeting(s)*

The disclosure team will meet prior to the subsequent meeting to:

a. review the findings of the investigative process or the new significant facts about the incident that have emerged but have yet to be disclosed;
b. develop an action plan to reduce the risk of a similar incident reoccurring by considering the findings of the investigative process if it has been completed;
c. reassess the client 's health care needs and prepares treatment options and recommendations, as appropriate;
d. reassess the potential needs for the and develop plans to fulfill them ;
e. sets a time and location for the subsequent disclosure meeting; and
f. arrange for the services of an interpreter, if required.

5.6.3 The main communicator informs the disclosee(s) of the time and location for the subsequent disclosure meeting(s).

5.6.4 *Key items to cover at subsequent disclosure meeting(s)*

At a subsequent disclosure meeting(s), the disclosure team must

a. acknowledge that the most responsible provider is not present, when applicable;
b. explain the new significant facts about the incident that have emerged or what has been learned from the investigative process;
c. explain the steps taken to reduce the risk of a similar incident reoccurring;
d. provide an overview of the action plan developed;
e. offer further apology for what happened;
f. explain that the disclosure team remains accessible for ongoing communication and provide appropriate contact information;
g. offer, based on needs identified, the supports to the client ;
h. leave ample time for the disclosee(s) to ask questions and the disclosure team to respond; and
i. offer to research any questions that the disclosure team cannot answer immediately and arrange a timely follow-up.

5.7 **Strategies for disclosure meeting**

Table 2: Best Practices for Disclosure Meetings
▪ Hold the conversation face to face unless there are extenuating circumstances; ▪ Adopt a transparent, ethical, and sincere approach; ▪ Use active listening skills, such as empathy; ▪ Use terminology and words likely to be understood by the disclosee(s); ▪ Confirm that the information is understood by the disclosee(s) and allow time for questions; ▪ Demonstrate sensitivity to the culture and language of the disclosee(s); ▪ Encourage disclosee(s) to speak from their own perspective and in their own words about their experience; ▪ Foster good spirits by being open, welcoming and inclusive; and ▪ Respect others as well as relationships and care for people

5.8 **Follow-up**

5.8.1 The disclosure team, involving other staff members as appropriate, must implement the action plan created under sections 5.6.2 and 5.6.3.e of this Policy in order to reduce the risk of a similar incident reoccurring.

5.8.2 The disclosure team, in collaboration with the continuous quality improvement division staff, monitor and evaluate the effectiveness of the action plan.

5.9 **Documentation**

5.9.1 The disclosure team shall document the following about the disclosure meeting(s) in a secure file at the Regional Office:

a. Time, place, and date of disclosure meeting(s);
b. Names and functions of all persons in attendance;
c. The material facts presented;
d. The actions taken to address the consequences of the incident to the client;
e. Treatment options and recommendations presented as well as those agreed upon;
f. Questions asked by the disclosee(s) and the responses; and
g. Expected follow-up, if any.

5.9.2 The disclosure team must document the following about every disclosure meeting in the client 's health record:

a. Time, place, and date of the meeting;
b. Names and functions of all persons in attendance; and
c. Treatment options agreed upon.

5.10 **Support**

5.10.1 The disclosure team may offer the client(s) a referral to mental health or social work services, as required.

5.10.2 The immediate supervisor will offer support to the disclosure team members by

a. providing each member with the contact information for the employee assistance program;
b. offering to arrange for mental health or social work services if needed; and
c. referring them to professional legal assistance services if required.

6. Continuous Quality Improvement

6.1 To evaluate the disclosure policy, designated Department of Health staff (for example, client relations manager or quality improvement lead) may randomly select participants of a disclosure meeting to seek their feedback on the disclosure process.

6.2 The Department will deliver training on this Policy at the time this Policy comes into force and on an ongoing basis.

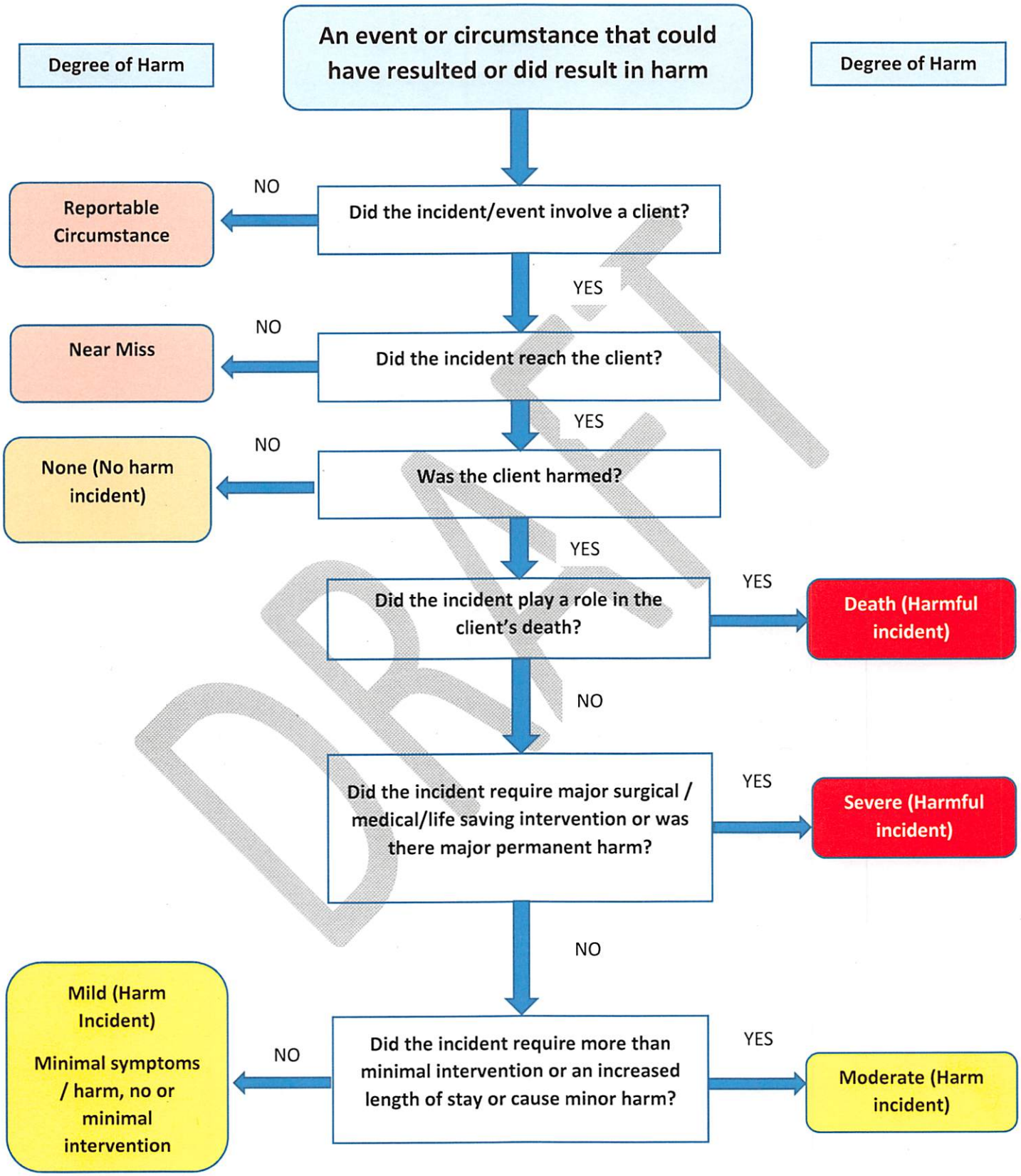
7. Related Policies, Protocols and Legislation

Consolidation of Legal Treatment of Apologies Act (S.Nu. 2010, c.12)

Policy 05-002-00	Continuous Quality Improvement Program
Policy 05-003-00	Risk Management
Policy 05-004-00	Risk Management Incident Reporting
Policy 05-005-00	Critical Incident Stress Management
Policy 06-001-00	Confidentiality
Policy 06-003-01	Release of Information

Approved By: Colleen Stockley	Date: Nov 15/16
Colleen Stockley, Deputy Minister – Department of Health	
Approved By: W D Macdonald	Date: 30/11/2016
Dr. William Macdonald, Medical Chief of Staff	
Approved By:	Date: Nov 15/16
Jennifer Berry, Chief Nursing Officer	

Appendix A: Understanding harm and no harm incidents



Appendix A: Understanding harm and no harm incidents

Severity's Scale Categorizing Degree of Harm

CATEGORY	DESCRIPTION	Degree of Harm	Type of incident
A	A situation that has potential for harm and does not involve a client.	Reportable circumstance	Reportable incident
B	An incident that has potential for harm is intercepted or corrected prior to reaching the client.	Near Miss	Near Miss
C	Outcome is not symptomatic or no symptoms are detected and no treatment is required.	None	No Harm
D	Outcome is symptomatic, symptoms are mild, harm is minimal and no or minimal intervention (for example extra observation, investigation, review or minor treatment) is required.	Mild	Harm Incident
E	Outcome is symptomatic, requiring intervention (for example, additional operative procedure, additional therapeutic treatment) or an increased length of stay, or causing minor harm.	Moderate	
F	Outcome is symptomatic, requiring life – saving intervention or major surgical / medical intervention, or shortening life expectancy or causing major permanent, long – term harm or loss of function.	Severe	Harmful incident
G	Incident contributed or resulted in the dealth of the client.	Death	

Appendix B: Disclosure Flowchart – When to disclose?