Section 7: Nursing Practice

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

TITLE:		**SECTION:**	**POLICY NUMBER:**
Community Health Nursing		Nursing Practice	07-001-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
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APPLIES TO:			
Community Health Nurses			

POLICY 1:

Registered nurses who are employed by the Department of Health and Social Services to provide health care and related services shall be responsible for:

- **Registering with Registered Nurses Association of the Northwest Territories and Nunavut (RNANT/NU) as prescribed by the Nunavut *Nursing Act* (*S.Nu. 2003, c.17)*.**
- **Maintaining a good standing of his/her registration with Registered Nurses Association of the Northwest Territories and Nunavut (RNANT/NU) as prescribed by the Nunavut *Nursing Act* (*S.Nu. 2003, c.17)*.**
- **Shall be responsible for maintaining a safe level of practice and shall be aware that no statement of policy by a professional association or any employing agency relieves the responsibility for the nurse's own acts.**
- **Shall practice within the policies, procedures, guidelines and protocols of their employing agency and within professional standards and code of ethics.**
- **Are responsible for clarifying employer performance expectations and familiarizing themselves with how nursing is practiced within the Government of Nunavut.**

POLICY 2:

The Department of Health and Social Services shall ensure that all Registered Nurses are successfully registered with RNANT/NU prior to commencement of the nurse's orientation and placement.

PRINCIPLES:

RNANT/NU 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 with RNANT/NU is a legal requirement to safeguard client care and maintain competency of practice.

Through the Nunavut *Nursing Act* (*S.Nu. 2003, c.17)* registered nurses are held accountable for upholding the standards of practice and code of ethics as set out by RNANT/NU.

Scope of practice is a continuum of learning and development. Performing a nursing function responsibly requires an understanding of the theory behind the function, the manual skill to perform the function, and the judgment when it is to be performed.

Nurses must practice within their own level of competence. When aspects of care are beyond the level of the nurse's competence, the nurse must seek additional information or knowledge, seek help from a supervisor or a competent practitioner, and/or request a different work assignment. In the interim, the nurse shall provide reasonable care within her/his level of competency until another nurse is available to do so.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 05-006-00	Employer Responsibilities
Policy 05-007-00	Employee Responsibilities
Policy 05-008-00	Nursing Practice- Additional Nursing Function
Guideline 05-008-01	Developing a Policy for Additional Nursing Functions
Guideline 05-008-02	Performing Additional Nursing Functions
Reference 05-008-03	Decision making Model for Performing Additional Nursing Functions and Delegated Medical 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

REFERENCES:

Alberta Association of Registered Nurses, Alberta Health Authorities, Alberta Medical Association, & College of Physicians and Surgeons of Alberta. (1987). *Joint Statement: Nursing Practice.* Edmonton, AB: Alberta Association of Registered Nurses.

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

Registered Nurses association of the Northwest Territories and Nunavut. *Standards of Practice for Registered Nurses: Professional Responsibility and Accountability.* Yellowknife, NT.

Registered Nurses Association of Northwest Territories and Nunavut (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**	

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS	
	Community Health Nursing	
TITLE:	**SECTION:**	**POLICY NUMBER:**
Basic Nursing Procedures	Nursing Practice	07-002-00
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APPLIES TO:		
Community Health Nurses		

POLICY 1:

Registered nurses are required to be knowledgeable and skilful in the implementation of basic nursing procedures.

POLICY 2:

Registered Nurses shall refer to the textbook *Clinical Nursing Skills and Techniques 7th edition* (Perry and Potter, 2010) for instruction on basic nursing skill procedures.

PRINCIPLES:

Ability to perform basic nursing procedures and follow protocols is expected of a registered nurse. Additional nursing and delegated medical functions require the development of specialized competence.

Related Policies, Guidelines and Legislation:

Policy 07-003-00 Nursing Skill Certification

REFERENCES:

Perry, A. G. and Potter, P.A. (2010). *Clinical Nursing Skills and Techniques 7th ed*. Mosby.

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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 Skills Certification		Nursing Practice	07-003-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
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APPLIES TO:
Community Health Nurses

POLICY:

The Department of Health and Social Services shall develop and/or adopt a process for Registered Nurses to develop competence in specialized nursing functions or transferred functions from other professions. This certification program shall incorporate the following elements:

1. **Competency standards are identified**
2. **Provisions are made for the specialized function to be practiced often enough to maintain competence**
3. **Protocols are established for safe implementation**
4. **Instructional programs conform to national standards and include:**
    a. **Knowledge of underlying principles**
    b. **Possible complications or risks**
    c. **Conditions under which it may be performed**
    d. **Supervised practice**
    e. **Method to demonstrate competence**
5. **Provisions are maintained for the review and recertification of the specialized function**
6. **Offers a record of certification**

PRINCIPLES:

- Utilization of the same format for all certification programs is an important element for continuous quality improvement programs.

- Certification validates your nursing specialty knowledge.

RELATED POLICIES, GUIDELINES AND LEGISLATION
Guidelines 07-003-01 Skills Recommended for Certification

REFERENCES:
Registered Nurses Association of the Northwest Territories and Nunavut (1992). *Guidelines for Nursing Practice Decisions*. RNANTNU: Yellowknife.

GUIDELINES 07-003-01

Certification is recommended for, but not limited to, the following skills/functions:

- Administration of Anti-Neoplastic Agents
- Advanced Cardiac Life Support
- Endo Tracheal Intubation
- Neonatal Resuscitation Program
- CPR Level C
- Basic Trauma Life Support / Trauma Nursing Core Course
- Pediatric Advanced Life Support or Emergency Nurses Pediatric Course
- ALARM – Advances in Labour and Risk Management course or other emergency obstetrical courses
- Arterial puncture (where possible)
- Basic Cardiac Life Support
- Cardiac Defibrillation
- Cardiac Monitoring and Interpretation
- Cast Application
- Electronic Fetal Monitoring
- Immunizations
- Phlebotomy
- Intrauterine Contraceptive Device removal
- Intravenous Therapy
- Accessing and maintaining umbilical lines
- X-ray Equipment Operation
- WHMIS
- Transportation of Dangerous Goods
- Suicide Intervention training
- Breastfeeding

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 05-006-00	Community Health Nursing Practice — Employer Responsibilities
Policy 05-007-00	Community Health Nursing Practice — Employee Responsibilities

PRINCIPLES:

- The need for certification is easily documented and substantiated.
- Establishing certification processes for these skills/functions should not pose operational hardship. Consistent certification processes for specialized nursing skills enhances client care and promotes continuous quality improvement.

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Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS		
	Community Health Nursing		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Chief Medical Officer of Health		Nursing Practice	07-004-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
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APPLIES TO:			
Community Health Nurses			

POLICY

Registered Nurses are expected to follow public health policies and protocols as sanctioned by the Chief Medical Officer of Health (CMOH) or Deputy Chief Medical Officer of Health (DCMOH).

PRINCIPLES

The CMOH is responsible for determining policies and protocols for public health functions in Nunavut.

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

TITLE:		**SECTION:**	**POLICY NUMBER:**
Immunizations		Nursing Practice	07-005-00
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APPLIES TO:			
Community Health Nurses			

POLICY 1:

It is the policy of the Department of Health and Social Services (HSS) that all nurses (indeterminate, term, casual and contract) and student nurses must successfully obtain the Nunavut Immunization Certificate, upon hire. Immunizations may only be administered by nurses and student nurses who have successfully completed the exam.

POLICY 2:

The nurse must report all immunization-related adverse reactions to the Chief Medical Officer of Health in accordance with the *User Guide: Report of Adverse Events Following Immunization* (included in the appendix of this manual).

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Public Health Agency of Canada (2006). *Canadian Immunization Guide 7th ed.* Public Health Agency of Canada.
Appendix: *User Guide: Report of Adverse Events Following Immunization*
Policy 07-003-00 Nursing Skills Certification
Guideline 07-003-01 Skills Recommended for Certification

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Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS	
	Community Health Nursing	
TITLE:	**SECTION:**	**POLICY NUMBER:**
Unregulated Healthcare Workers – Employer Responsibilities	Nursing Practice	07-009-00
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APPLIES TO:		
Community Health Nurses		

POLICY:

The Department of Health and Social Services shall clearly describe the core competencies, educational requirements, roles and responsibilities necessary for the practice of Unregulated Healthcare Workers in the Community Health Nursing Program.

The Department of Health and Social Services shall identify the roles, responsibilities and accountability of the Registered Nurses involved with assigning and delegating tasks to Unregulated Healthcare Workers. Nurses have a professional responsibility to delegate appropriately to other members of the health care team and therefore, shall receive training and direction from the HSS for delegating and assigning specific tasks to Unregulated Healthcare Workers.

DEFINITIONS:

Unregulated Healthcare Workers: It is an umbrella term used to describe care providers who provide a form of health service and are not registered or licensed by a regulatory body. Unregulated Healthcare Workers carry numerous position titles and may include, but are not limited to: Community Health Representatives, Home and Community Care Workers, Personal Care Aides, Mental Health Workers, Maternal Care Workers, family members, or students training in a health profession.

PRINCIPLES:

- The responsibility for the practice of a Registered Nurse cannot be delegated to someone who is not a Registered Nurse. Under certain conditions, a nurse may delegate selected tasks for a specific client to an unregulated care provider.
- Unregulated Healthcare Workers are valuable resources and must receive sufficient employer training, supervision and support
- Employer and unregulated care workers share accountability with nurse for safe delegation.
- Shortages of professional health-care providers, a shift in care settings from acute to home and community, an aging population and the burgeoning costs of health care have led health-care teams to rely increasingly on Unregulated Healthcare Workers.
- When health-care providers operate in teams, workloads, wait times and client outcomes improve

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 07-010-00	Working with Unregulated Healthcare Workers: Nurse Responsibilities
Guideline 07-010-01	Working with Unregulated Healthcare Workers
Guideline 07-010-02	Deciding to Teach or Delegate a Procedure
Policy 07-011-00	Working with Unregulated Healthcare Workers: Worker's Responsibilities

REFERENCES:

Canadian Nurses Association (2009). *Increasing Use of Unregulated Health Workers.*

Canadian Nurses Association (2008). *Unregulated Health Workers: A Canadian and global perspective. Ottawa: CNA*

Canadian Nurses Association (2008). *Valuing Health-Care Team Members: Working with unregulated health workers.* Ottawa: CNA

Canadian Nurses Association (2003). *Position Statement: Staffing decision for the delivery of safe nursing care.* CNA: Ottawa.

College of Registered Nurses of British Columbia (2005). *Practice Standard for Registered Nurses and Nurse Practitioners: Delegating Tasks to Unregulated Care Providers.* Vancouver: CRNBC.

College and Association of Registered Nurses of Alberta (2005). *Standards for Supervision of Nursing Students and Undergraduate Nursing Employees Providing Client Care.* CARNA: Edmonton.

College of Nurses of Ontario (2005). *Practice Guideline: Utilization of unregulated care providers.* CNO: Toronto.

Government of Nova Scotia (2006). *Principles and Guidelines: A framework for continuing care assistants in acute care.* Government of Nova Scotia Health: Halifax.

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:**
Unregulated Healthcare Workers – Registered Nurse Responsibilities		Nursing Practice	07-010-00
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APPLIES TO:			
Community Health Nurses			

POLICY:

A Registered Nurse may delegate selected tasks to Unregulated Healthcare Workers. The delegated tasks must be client specific and cannot include the practice of nursing or the nursing process.

The registered nurse shall continue to be responsible for the overall assessment, determination of client status, care planning, interventions and care evaluation when tasks are delegated to an unregulated Healthcare Worker.

Before delegating a task the Registered Nurse must ascertain the Unregulated Healthcare Worker has the knowledge, skills and abilities to perform the task to be transferred.

The Registered Nurse who delegates a client-specific task to an Unregulated Healthcare Worker is the accountable for the health and safety of that client and must ensure the worker has the required competence to safely perform the task.

DEFINITIONS:

Unregulated Healthcare Workers: It is an umbrella term used to describe care providers who provide a form of health service and are not registered or licensed by a regulatory body. Unregulated Healthcare Workers carry numerous position titles and may include, but are not limited to: Community Health Representatives, Home and Community Care Workers, Personal Care Aides, Mental Health Workers, Maternal Care Workers, family members, or students training in a health profession.

PRINCIPLES:

- The responsibility for the practice of a Registered Nurse cannot be delegated to someone who is not a Registered Nurse. Some tasks carried out by registered nurses are not in themselves the practice of nursing and therefore, under specific conditions, the task may be delegated to an Unregulated Healthcare Worker.
- Unregulated Healthcare Workers are valuable resources and may give the registered nurse the opportunity to expand their services to a larger population.
- Unregulated care workers share accountability with nurse for safe delegation.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 07-009-00	Working with Unregulated Healthcare Workers: Employer Responsibilities
Guideline 07-010-01	Working with Unregulated Healthcare Workers
Guideline 07-010-02	Deciding to Teach or Delegate a Procedure
Policy 07-011-00	Working with Unregulated Healthcare Workers: Worker's Responsibilities

REFERENCES:

Canadian Nurses Association (2009). *Increasing Use of Unregulated Health Workers.*

Canadian Nurses Association (2008). *Unregulated Health Workers: A Canadian and global perspective. Ottawa: CNA*

Canadian Nurses Association (2008). *Valuing Health-Care Team Members: Working with unregulated health workers.* Ottawa: CNA

Canadian Nurses Association (2003). *Position Statement: Staffing decision for the delivery of safe nursing care.* CNA: Ottawa.

College of Registered Nurses of British Columbia (2005). *Practice Standard for Registered Nurses and Nurse Practitioners: Delegating Tasks to Unregulated Care Providers.* Vancouver: CRNBC.

College and Association of Registered Nurses of Alberta (2005). *Standards for Supervision of Nursing Students and Undergraduate Nursing Employees Providing Client Care.* CARNA: Edmonton.

College of Nurses of Ontario (2005). *Practice Guideline: Utilization of unregulated care providers.* CNO: Toronto.

Government of Nova Scotia (2006). *Principles and Guidelines: A framework for continuing care assistants in acute care.* Government of Nova Scotia Health: Halifax.

GUIDELINES 07-010-01

DEFINITIONS

Unregulated Healthcare Workers: It is an umbrella term used to describe care providers who provide a form of health service and are not registered or licensed by a regulatory body. Unregulated Healthcare Workers carry numerous position titles and may include, but are not limited to: Community Health Representatives, Home and Community Care Workers, Personal Care Aides, Mental Health Workers, Maternal Care Workers, family members, or students training in a health profession.

Routine Activity of Living: Procedures are considered to be routine activities of living when:

1. The need for the procedure, and
2. The response to the procedure, and
3. The outcomes of performing the procedure,
   Have been established over time and, as a result, are quite predictable (College of Nurses of Ontario, 2009).

Delegation: Delegation is a process where the Registered Nurse transfers the responsibility for the performance of a task to an unregulated Healthcare Worker or another regulated health professional yet retains accountability for the outcome (Federation of Health Regulatory Colleges of Ontario, 2007). Delegation is client-specific and not a general authorization to perform the task, as the delegated task must be determined to be in the client's best interest.

Assignment: Assignment refers to distributing care, activities, tasks and functions that are within the worker's scope of practice or description of duties defined by the employer.

Supervision: Supervising refers to activities of monitoring and directing the activities of Unregulated Healthcare Workers and does not refer to ongoing managerial responsibilities. Supervision may be direct or indirect.

LIABILITY

Each member of the team must be assured that colleagues have the skill and competencies needed to carry out assigned tasks

TEACHING A PROCEDURE TO AN UNREGULATED HEALTHCARE WORKER

The Registered Nurse may teach a procedure to an Unregulated Healthcare Worker when the delegating nurse:

1. Has the knowledge, skill and judgment to perform the procedure competently.
2. Has the additional knowledge, skill and judgment to teach the procedure.
3. Accepts accountability for the decision to teach the procedure after considering the risks and benefits.
4. Has determined that the unregulated healthcare worker has acquired the knowledge, skill and judgment to perform the procedure safely, effectively and ethically.
5. Teaches the procedure to an unregulated healthcare worker who will perform the procedure for one specific client.
6. Evaluates the continuing competence of the Unregulated Healthcare worker to perform the procedure.

DELEGATING A PROCEDURE TO AN UNREGULATED HEALTHCARE WORKER

A Registered Nurse may delegate a procedure to an Unregulated Healthcare worker when the delegating nurse:

1. Has the knowledge, skill and judgment to perform the procedure competently;
2. Has the additional knowledge, skill and judgment to delegate the procedure;
3. Accepts sole accountability for the decision to delegate the procedure after considering the following:
    - The known risks and benefits to the client of performing the procedure;
    - The predictability of the outcomes of performing the procedure;
    - The safeguards and resources available in the situation; and
    - Other factors specific to the client or the setting.
4. Has determined that the unregulated healthcare worker has acquired the knowledge, skill and judgment to perform the procedure;
5. Delegates the procedure to an unregulated healthcare worker who will perform the procedure for one specific client;
6. Evaluates the continuing competence of the unregulated healthcare worker to perform the procedure.

ASSIGNING ACTIVITIES, TASKS AND FUNCTIONS TO UNREGULATED HEALTHCARE WORKERS

The employer is responsible and accountable for:

1. Developing the role descriptions which clearly describe the tasks that can be assigned to an Unregulated Healthcare Worker.
2. Ensuring the Unregulated Healthcare Worker has received appropriate training and must supplement this training if needed.

The Registered Nurse who assigns activities and tasks to the Unregulated Healthcare Worker is responsible and accountable for:

1. Ongoing assessment, care planning and evaluation of the client's needs and health status
2. Determining the needs of the client before assigning tasks to the Unregulated Healthcare Worker
3. Assigning only those tasks which fall within the Unregulated Healthcare Worker
4. Knowing the worker is competent to meet the needs of the client
5. Establishing parameters for performing the procedure and providing guidance as needed.
6. Intervening when the worker's competence to perform the assigned procedure(s) is questioned

SUPERVISING THE UNREGULATED HEALTHCARE WORKER

The Registered Nurse who supervises the activities of the Unregulated Healthcare Worker is responsible for:

1. Knowing the worker is competent to meet to perform the assigned task(s).
2. Verifying the worker understands the conditions and parameters for performing a procedure
3. Providing the appropriate degree of direct or indirect supervision, based on the client's condition, the nature of the procedure, the resources available in the setting and the degree of competence of the worker
4. Intervening in a procedure, when necessary

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 07-009-00	Working with Unregulated Healthcare Workers: Employer Responsibilities
Policy 07-010-00	Working with Unregulated Healthcare Workers: Nurse Responsibilities
Guideline 07-010-02	Deciding to Teach or Delegate a Procedure
Policy 07-011-00	Working with Unregulated Healthcare Workers: Worker's Responsibilities

REFERENCES:

College and Association of Registered Nurses of Alberta. (2005). *Standards for Supervision of Nursing Students and Undergraduate Nursing Employees Providing Client Care. CARNA:* Edmonton.

College of Nurses of Ontario (2009). *Practice Guideline: Working with unregulated care providers.* CNO: Toronto.

College of Registered Nurses of British Columbia (2008). *Practice Support: Assigning and delegating to unregulated care providers.* CRNBC: Vancouver.

Pan-Canadian Planning Committee on Unregulated Health Workers (2008). *Valuing Health-Care Team Members: Working with unregulated health workers.* Canadian Nurses Association: Ottawa.

Registered Nurses Association of Northwest Territories and Nunavut (1992). *Guidelines for Nursing Practice Decisions.* RNANTNU: Yellowknife.

Saskatchewan Registered Nurse Association. (2002). *Practice of Nursing: RN Assignment and Delegation.* Regina, SK.

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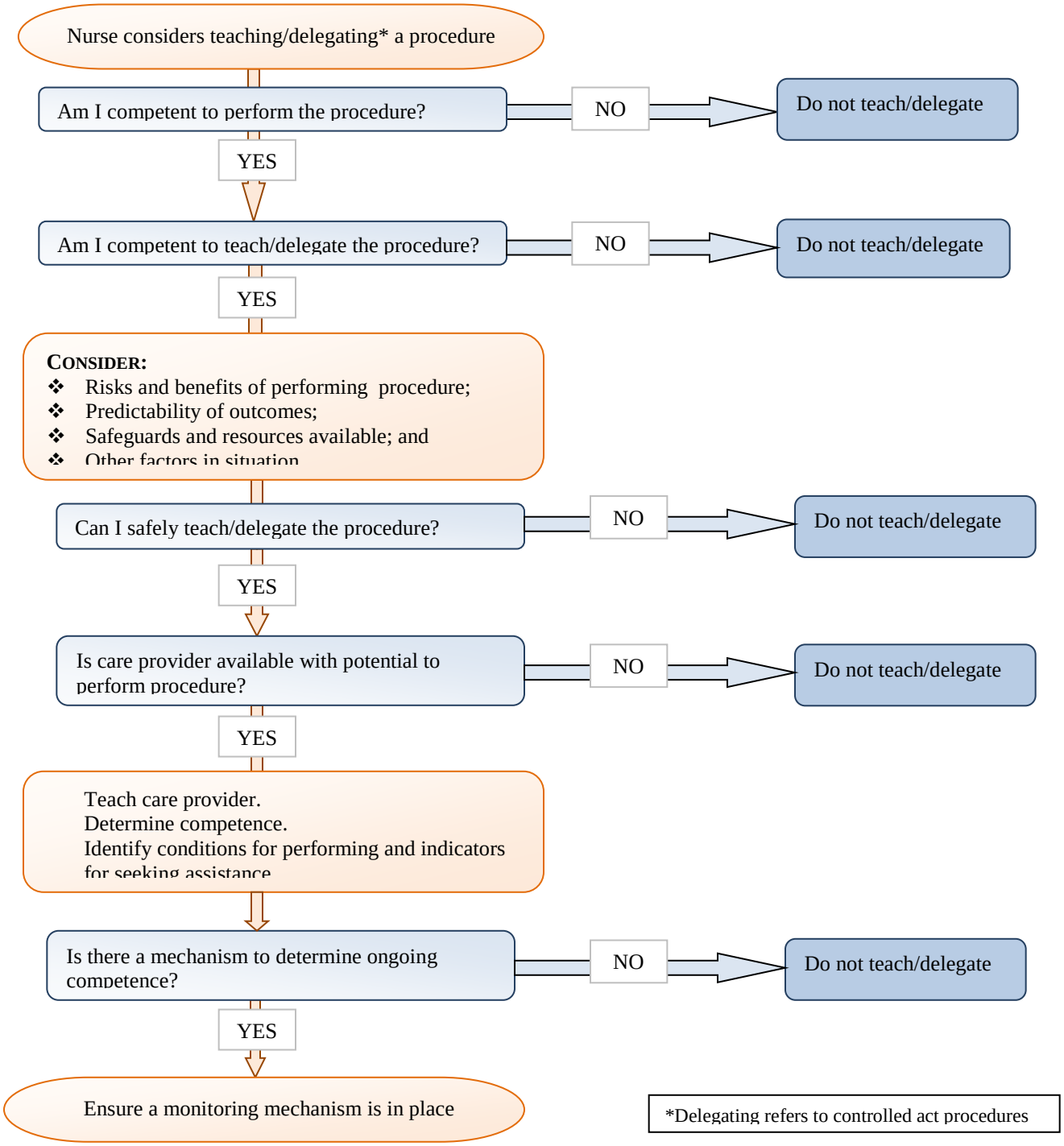
11 FEB 2011 **Chief Nursing Officer** **Date**	April 1, 2011
February 11, 2011 **Deputy Minister of Health and Social Services** **Date**	

GUIDELINE 07-010-02

DECISION TREE: TEACHING OR DELEGATING THE PERFORMANCE OF A PROCEDURE



Adapted from College of Nurses of Ontario (2009). *Working with Unregulated Care Providers.*

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

TITLE:		**SECTION:**	**POLICY NUMBER:**
Unregulated Healthcare Workers – Workers Responsibilities		Nursing Practice	07-011-00
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APPLIES TO:			
Community Health Nurses			

POLICY:

The Unregulated Healthcare Worker must ensure he/she has sufficient training, supervision and support to perform the delegated task safely. The Unregulated Healthcare Worker shares accountability with the employer and the Registered Nurse for safe delegation.

The Unregulated Healthcare Worker is responsible and accountable for:

1. **Seeking guidance and support as needed to safely perform the delegated or assigned task.**
2. **Knowing which tasks can be assigned as described in their roles, responsibilities and scope of practice.**
3. **Not performing any delegated tasks until authorized by the Registered Nurse.**
4. **Performing the delegated task as trained**
5. **Reporting to the Registered Nurse responsible for delegating the task(s).**

The Unregulated Healthcare Worker shall comply with all established agency policies, procedures and guidelines and work within the scope of practice defined in their job descriptions.

DEFINITIONS:

Unregulated Healthcare Workers: It is an umbrella term used to describe care providers who provide a form of health service and are not registered or licensed by a regulatory body. Unregulated Healthcare Workers carry numerous position titles and may include, but are not limited to: Community Health Representatives, Home and Community Care Workers, Personal Care Aides, Mental Health Workers, Maternal Care Workers, family members, or students training in a health profession.

PRINCIPLES:

- The responsibility for the practice of nursing cannot be delegated. Tasks carried out by registered nurses are not in themselves the practice of nursing and therefore, under specific conditions, the task may be delegated to an Unregulated Healthcare Worker.
- Unregulated Healthcare Workers are valuable resources and may give the registered nurse the opportunity to expand their services to a larger population.
- The Registered Nurse, employer and Unregulated Healthcare Worker share the responsibility for the delivery of safe client care.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 07-009-00	Working with Unregulated Healthcare Workers: Employer Responsibilities
Policy 07-010-00	Working with Unregulated Healthcare Workers: Nurse Responsibilities
Guideline 07-010-01	Working with Unregulated Healthcare Workers
Guideline 07-010-02	Deciding to Teach or Delegate a Procedure

REFERENCES:

Canadian Nurses Association (2009). *Increasing Use of Unregulated Health Workers.*

Canadian Nurses Association (2008). *Unregulated Health Workers: A Canadian and global perspective. Ottawa: CNA*

Canadian Nurses Association (2008). *Valuing Health-Care Team Members: Working with unregulated health workers.* Ottawa: CNA

Canadian Nurses Association (2003). *Position Statement: Staffing decision for the delivery of safe nursing care.* CNA: Ottawa.

College of Registered Nurses of British Columbia (2005). *Practice Standard for Registered Nurses and Nurse Practitioners: Delegating Tasks to Unregulated Care Providers.* Vancouver: CRNBC.

College and Association of Registered Nurses of Alberta (2005). *Standards for Supervision of Nursing Students and Undergraduate Nursing Employees Providing Client Care.* CARNA: Edmonton.

College of Nurses of Ontario (2005). *Practice Guideline: Utilization of unregulated care providers.* CNO: Toronto.

Government of Nova Scotia (2006). *Principles and Guidelines: A framework for continuing care assistants in acute care.* Government of Nova Scotia Health: Halifax.

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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:**
Certification of Death		Nursing Practice	07-012-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
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APPLIES TO:			
Community Health Nurses			

POLICY:

The medical practitioner who was last in attendance during the last illness of the deceased shall sign the medical certificate in the prescribed form, stating in it the cause of death according to the International List of Causes of Death.

Where a death occurs without attendance by a medical practitioner or where a medical practitioner is not available to complete the medical certificate, the prescribed form shall be completed and signed by the Registered Nurse. The original copy is sent to the office of Registrar General of Vital Statistics where the registrar shall co-sign and certify the form in accordance with the *Vital Statistics Act*.

In circumstances where the coroner has conducted an investigation or held an inquest respecting the death, the coroner shall be responsible for signing the certificate of death.

DEFINITIONS:

Medical Practitioner: Refers to a physician

PRINCIPLES:

- The *Vital Statistics Act (R.S.N.W.T. 1998*, c.17, s.29, as duplicated for Nunavut by s.29 of the *Nunavut Ac*t, S.C. 1993, c.28) requires that the certificate of death be signed by the medical practitioner last in attendance during the last illness of the deceased or by the coroner where there has been an inquest or inquiry. Where a death occurs without medical attendance, or where a medical practitioner is not available to sign the medical certificate, the Supervisor of Community Health Programs may complete the certificate.

- Due to staffing resources in isolated communities, it is customarily the Registered Nurse who is most likely to complete and sign the Certificate of Death.

- If an autopsy is completed and the pathology and/or autopsy report contains additional information than originally entered on the medical certificate, then the certificate will be amended by Vital Statistics as outlined in the *Vital Statistics Act (R.S.N.W.T. 1998*, c.17, s.29, as duplicated for Nunavut by s.29 of the *Nunavut Ac*t, S.C. 1993, c.28)

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 07-013-00	Pronouncing a Death
Guideline 07-013-01	Guidelines for Pronouncing a Death
Policy 07-014-00	Reporting a death to the coroner

REFERENCES:

Coroners Act R.S.N.W.T. 1988, c.C-20, as amended by Nunavut Statutes s.Nu.2007, c.15, s.177

Vital Statistics Act (R.S.N.W.T. 1998, c.17, s.29, as duplicated for Nunavut by s.29 of the *Nunavut Ac*t, S.C. 1993, c.28)

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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:**
Pronouncing Death	Nursing Practice	07-013-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018 / February 2021		6
APPLIES TO:		
Community Health Nurses		

POLICY:

In the event of an expected and anticipated death, the Registered Nurse is authorized to pronounce the death of a client. The Nurse shall record the time and date of the death on the client record.

In the event of an unexpected death, the on-call physician shall pronounce the death. If the physician is not available in the community, the Registered Nurse employed as a Community Health Nurse, may pronounce the death. In such circumstances, the on-call physician must be promptly notified.

Pronouncement of death is not a legal entity but rather a declaration that death has occurred as evidenced by absence of pulse, respirations, fixed dilated pupils and no response to painful stimuli.

DEFINITIONS:

Pronouncement of Death: means the determination that death has occurred. It is a legal action based on a physical assessment.

PRINCIPLES:

- The pronouncement of death is not a reserved medical act or a delegated medical function. There are no laws governing the event when death is expected or are there laws defining who is qualified to pronounce death in such circumstances. An unexpected death must be reported to the coroner in accordance with the *Coroners Act* and Policy 07-014-00 *Reporting a Death to the Coroner*.

- In the case of a sudden and/or unexpected death, the RCMP along with the coroner conducts an investigation as defined in the *Coroners Act*. The coroner authorizes an autopsy if necessary. The coroner is the only person who has the authority to order an autopsy without consent.

- Where the death is considered a reportable death as per the *Coroners Act,* the coroner and RCMP are responsible for the body. The responsibility of the community health nurse ends after a pronouncement of death has been made and the details of the case discussed with the coroner or RCMP.

- If a nurse is in doubt of how to proceed, the registered nurse may call the coroner's office in Iqaluit.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 07-012-00	Certification of Death
Guideline 07-013-01	Guidelines for Pronouncing Death
Policy 07-014-00	Reporting a death to the Coroner
Policy 08-004-00	Post Mortem Samples

REFERENCES:

Coroners Act R.S.N.W.T. 1988, c.C-20, as amended by Nunavut Statutes s.Nu.2007, c.15, s.177

Vital Statistics Act (R.S.N.W.T. 1998, c.17, s.29, as duplicated for Nunavut by s.29 of the *Nunavut Ac*t, S.C. 1993, c.28)

GUIDELINES 07-013-01

Death may be pronounced when the following criteria are met:

1. Client is in cardiac arrest (absence of apical pulse, absence of respirations, fixed and dilated pupils, and no response to painful stimuli)

2. The client was discovered in a state of cardiac arrest AND was not known to be alive in the preceding fifteen (15) minutes. If DO NOT Resuscitate advance directive is present, witness to the arrest does not preclude pronouncement of death.

3. Asystole has been documented in two monitoring leads for at least one (1) minute.

    a. If only an AED is available with single lead capabilities, personnel should note it on client's health record.

    b. Verification of asystole is not necessary if one of the following are present
        i. Death is being pronounced pursuant to a properly executed Do Not Resuscitate advance directive.
        ii. Decomposition of body tissues
        iii. Decapitation
        iv. Incineration
        v. Separation of or massive destruction to heart or brain
        vi. Rigor is present

The client MEETS the criteria for the pronouncement of death:

1. Do not initiate CPR

1. Notify the Supervisor of Community Health Programs and the on-call physician, if not present.

2. Notify a member of the RCMP of all deaths in the community, expected or unexpected. The Coroner shall be promptly notified in accordance with the *Coroners Act*.

3. If the death occurred in the health centre, the Registered Nurse, attending physician, or Supervisor of Community Health Programs will notify the family. If the death occurred in the community and not inside the health centre, the RCMP shall notify the family of the client's death.

4. The Vial Statistics *Registration of Death* form must be completed as per Policy 07-012-00. A photocopy of the completed form is placed in the client's health record. The original is forwarded to Vital Statistics as outlined on the Registration of Death form.

5. Document the pronouncement of death in the client's health record.

Health Record Documentation

The following nursing assessment must be documented in the client's health record:

1. No apical pulse
2. No respiration
3. Pupils fixed / dilated
4. No response to painful stimuli
5. Time the pronouncement of death
6. Name of physician and supervisor notified AND time of notification
7. Name of the coroner notified and time of notification
8. Time the body was transferred to the morgue
9. Name and time next of kin was notified.

Client does NOT meet the criteria for pronouncement of death (e.g. family requests, etc.)

1. Begin Life Support measures
2. Establish contact with Supervisor of Community Health Programs and on-call physician immediately to determine appropriate action. The physician may elect to pronounce death or to administer additional interventions.
3. Proceed accordingly

GUIDELINES 07-013-02

1. When death is pronounced by a Physician or Registered Nurse:

- Pronounce death as per criteria listed in Guideline 07-013-01
- Notify a member of the RCMP, the Coroner and the Director of Health Programs of all deaths in the community, expected or unexpected. The Coroner shall be promptly notified in accordance with the *Coroners Act*.
- Process necessary lab tests as ordered by the physician. If applicable, collect post mortem samples as directed by the Coroner and in accordance with Policy 08-004-00 *Post Mortem Samples*. The Coroner must complete and sign a Form 11 of the schedule in order to authorize a Registered Nurse to obtain post mortem samples. (Note: Collecting post mortem samples is the responsibility of the Coroner's office and therefore, the nurse is not compelled to obtain post mortem samples)
- Provides support to the family
- Complete and sign the Vital Statistics Registration of Death form as per Policy 07-012-00.
- The details of the pronouncement of death, including date and time, must be documented in the client's health record.

2. Nursing staff (may or may not pertain to the nurse who pronounced the death):

- Provide holistic, supportive care to the family based on a comprehensive assessment of wishes and needs.
- Assemble appropriate forms for completion by appropriate members of the team and ensure the forms have been submitted to Vital Statistics as indicated.
- Complete the client's medial record and ensure the following details are included: name of the practitioner who pronounced the death; the time of death; information given to the family about their responsibilities; care of the body; responses of the family; and support given to the family after death.
- Contact other team members as needed to assist in supporting the family and to meet the family's spiritual needs.
- Prepare the body for viewing by family members.
  If the death is a coroner's case with autopsy:
  i. Do not proceed with post mortem care until permission received from coroner.

ii. Do not remove any tubes, drains and catheters, etc. (Tie them off to avoid leakage). The endo-tracheal tube can be removed once placement of the tube is confirmed and documented. Do not send IV bags or drainage bags to the morgue.

- If the family has not yet viewed the body of an infant/child, consider wrapping the young child/infant in warm blankets or place him/her in an incubator before giving to the parents. If this case is a Coroner's case, the Coroner should be consulted first as these actions may compromise evidence.

- Complete lab tests as ordered

- Discuss the family's wishes for preparing the body for the funeral and support their participation in such activities (e.g. dressing the body in client's own clothing).

- A plastic shroud is necessary to meet standards for universal precautions for bodies if there are any potential for fluid leakage. The families may request blankets from home be used as a shroud and is acceptable. The plastic shroud may be applied overtop of the blankets if fluid leakage is anticipated.

- Ensure all personal belongings not accompanying the body are returned to the family and documented in the client's health record. After the family has had an opportunity to complete any death rituals and agreeable to the transfer, contact the Hamlet to notify them that the body is ready for transport to the community morgue.

- Re-stock the clinic room as required

3. <u>Housekeeping:</u>

- Responsible for cleaning the clinic room where the death occurred (if applicable)

- Responsible for sterilization of emergency equipment as required

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:**
Reporting a Death to Coroner	Nursing Practice	07-014-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018 / February 2021		2
APPLIES TO:		
Community Health Nurses		

POLICY 1:

The Registered Nurse shall report a death to the Coroner, in accordance to the *Nunavut Coroners Act*. (R.S.N.W.T. 1998, c. C-20, as amended by Nunavut Statutes S.Nu. 2007, c.15), under the following circumstances:

1. **Occurs as a result of apparent violence, accident, suicide or other apparent cause other than disease, sickness or old age.**

2. **Occurs as a result of apparent negligence, misconduct or malpractice;**

3. **Occurs suddenly and unexpectedly when the deceased was in apparent good health;**

4. **Occurs within 10 days after a medical procedure or while the deceased is under or recovering from anesthesia;**

5. **Occurs as a result of**

    i. **A disease or sickness incurred or contracted by the deceased,**
    ii. **An injury sustained by the deceased, or**
    iii. **An exposure of the deceased to a toxic substance, as a result or in the course of any employment or occupation of the deceased,**

6. **Is a stillbirth that occurs without the presence of a medical practitioner;**

7. **Occurs while the deceased is detained or in custody involuntarily pursuant to law in a jail, lock-up, correctional facility, medical facility or other institution; or**

8. **Occurs while the deceased is detained by or in the custody of a police office.**

POLICY 2:

The client's record is a confidential document and shall only be photocopied for the Coroner when presented with a completed Form H (coroner's authorization form).

PRINCIPLES:

- In the case of a sudden and/or unexpected death, the RCMP along with the coroner conducts an investigation as defined in the *Coroners Act*. The coroner authorizes an autopsy if necessary. The coroner is the only person who has the authority to order an autopsy without consent.

- Where the death is considered a reportable death as per the *Coroners Act,* the coroner and RCMP are responsible for the body. The responsibility of the community health nurse ends after a pronouncement of death has been made and the details of the case discussed with the coroner or RCMP.

- If a nurse is in doubt of how to proceed, the registered nurse may call the coroner's office in Iqaluit.

REFERENCES:

Coroners Act R.S.N.W.T. 1988, c.C-20, as amended by Nunavut Statutes s.Nu.2007, c.15, s.177

GUIDELINE 07-014-01

The Coroner is responsible for completing the forms related to a Coroner's case, as outlined in the Nunavut *Coroner's Act* and *Coroner's Forms Regulations*.

The Coroner's forms which are applicable to the health centre include:

- Form 1: Warrant to Take Possession of the Body
- Form 2: Authorization to Release the Body
- Form 3: Certificate of Coroner Regarding Inquest.
- Form 4: Authorization to Perform Post-Mortem
- Form 5: Authorization to Transport Body out of Nunavut
- Form 11: Authorization to Take a Sample of Bodily Fluids
- Form 12: Authorization to Examine Bodily Fluids

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:**
Stillbirth		Nursing Practice	07-015-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
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APPLIES TO:			
Community Health Nurses			

POLICY:

The Registered Nurse, employed as a Community Health Nurse, shall report and document a stillbirth which occurs within the community in accordance with the *Vital Statistics Act (R.S.N.W.T. 1998*, c.17, s.29, as duplicated for Nunavut by s.29 of the *Nunavut Act*, S.C. 1993, c.28*)* and the *Coroners Act* (R.S.N.W.T. 1988, c.C-20, as amended by Nunavut Statutes s.Nu.2007, c.15, s.177).

The on-call Physician or Registered Nurse shall complete the Stillbirth Certificate in accordance to the *Vital Statistics Act*.

Each Regional office of Health and Social Services shall establish guidelines for the handling of a stillbirth in its respective communities.

DEFINITION:

Stillbirth involves the complete expulsion or extraction of a fetus more than 20 weeks in gestation OR after the fetus attained a weight of 500 grams. After complete expulsion or extraction, the fetus does not show signs of breathing, beating of the heart, pulsations of the umbilical cord or movement of voluntary muscles (*Vital Statistics Act R.S.N.W.T. 1998*, c.17, s.29, as duplicated for Nunavut by s.29 of the *Nunavut Act*, S.C. 1993, c.28)

PRINCIPLES:

- The requirement to report and document is mandated by the *Vital Statistics Act* and the *Coroners Act.*

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Guideline 07-015-01 Guidelines for Handling of a Stillbirth
Guideline 07-015-02 Examination Guidelines for Handling of a Stillbirth

REFERENCES:

Coroners Act R.S.N.W.T. 1988, c.C-20, as amended by Nunavut Statutes s.Nu.2007, c.15, s.177

Vital Statistics Act (R.S.N.W.T. 1998, c.17, s.29, as duplicated for Nunavut by s.29 of the *Nunavut Ac*t, S.C. 1993, c.28)

GUIDELINES 07-015-01

1. When a stillbirth occurs in the community or in the health centre, the on-call physician and Supervisor of Community Health Programs shall be contacted.

2. Parents or caregivers shall be offered access to support services available in the community.

3. Follow additional Regional Health and Social Services guidelines for the handling of a stillbirth.

4. The Registered Nurse shall notify the Coroner and other community resources as indicated (e.g. Clergy, mental health worker, etc.).

5. The Supervisor of Community Health Programs shall notify the Regional Director of Health and Social Services.

6. The *Registration of Stillbirth Form (Vital Statistics Act*) will be completed by the physician (when available in the community), the Community Health Nurse or the Coroner.

    a. The original copy is sent to the office of Registrar General of Vital Statistics
    b. A photocopy is placed on the mother's chart

7. Complete *Labor and Delivery Record* part 1 and part 2

8. Complete *Newborn Record* part 1

9. If an autopsy is required or ordered by a medical practitioner, the Coroner will assume responsibility for completing required paperwork and arranging transportation of the body.

10. The Burial Permit is issued and completed by the community hamlet.

11. The physician (when available in the community), the Midwife (when available in the community), the Supervisor of Community Health Programs or Community Health Nurse shall discuss the details of any autopsy report with the parents during the six-week post-natal visit. If indicated, a referral can be made to an obstetrician for further consultation.

12. Provide access to Critical Incident Stress Debriefing for health care providers as per Policy 05-005-00— *Critical Incident Stress Management.*

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 05-005-00	Critical Incident Stress Management
Policy 07-014-00	Reporting a Death to Coroner
Policy 07-015-00	Stillbirth
Guideline 07-015-02	Examination Guidelines for a Stillbirth
Policy 08-004-00	Post Mortem Samples

REFERENCES:

Coroners Act R.S.N.W.T. 1988, c.C-20, as amended by Nunavut Statutes s.Nu.2007, c.15, s.177

Vital Statistics Act (R.S.N.W.T. 1998, c.17, s.29, as duplicated for Nunavut by s.29 of the *Nunavut Act*, S.C. 1993, c.28)

GUIDELINES 07-015-02

1. Perform a rapid, superficial examination, noting any abnormalities. The placenta and umbilical cord are examined as part of the initial examination.

2. Notify the Coroner for further direction.

3. Consult the physician regarding maternal care needs.

4. If the parents/caregivers request parental keepsakes (e.g. pictures, footprints or lock of hair), obtain the Coroner's consent prior collecting any keepsakes.

5. Send placenta and cord to pathology (as per HSS laboratory policy and procedure) if autopsy ordered.

REFERENCES:

Coroners Act R.S.N.W.T. 1988, c.C-20, as amended by Nunavut Statutes s.Nu.2007, c.15, s.177

Vital Statistics Act (R.S.N.W.T. 1998, c.17, s.29, as duplicated for Nunavut by s.29 of the *Nunavut Ac*t, S.C. 1993, c.28)

Leduc, L. (2006). Stillbirth and bereavement: guidelines for stillbirth investigation. *Journal of Obstetrics and Gynecology, 178,* 540-5.

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:**
Advance Directives		Nursing Practice	07-016-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
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APPLIES TO:			
Community Health Nurses			

POLICY 1:

The Department of Health and Social Services promotes an environment which respects and encourages client self-determination. Clients will be encouraged and assisted to be active participants in the decision making process regarding their care through education, inquiry and assistance as requested.

Clients will be encouraged to communicate their desires in regard to advance directives to their significant others, to allow for guidance of significant others and healthcare providers in following the client's wishes should the client become incapacitated, rendering them unable to make decisions. The existence of an advance directive, or lack thereof, will not determine the client's access to care, treatment and services.

POLICY 2:

In an advance directive, the client may provide guidance as to his/her wishes in certain situations, or may delegate decision making to another individual as permitted by relevant legislation.

The delegated individual must identify themselves through legal transfer of the client's rights/power of attorney. If such an individual has been selected by the client to make treatment decisions, relevant information shall be provided to the representative so that informed healthcare decisions can be made for the client. However, as soon as the client is able to be informed of his/her rights, the Department of Health and Social Services shall provide that information to the client.

POLICY 3:

When the registered nurse or physician discuss advanced care planning with a client/ substitute decision maker/ power of attorney, the practitioner shall use the *Nunavut Care Level Planning* form in addition to documenting the details of the discussion in the client's health record.

DEFINITIONS:

Advance Directives refer to the means used to document and communicate a person's preferences regarding life-sustaining treatment in the event that they become incapable of expressing those wishes themselves. There are two forms:

- *Instruction directive:* commonly referred to as a living will, which details what life-sustaining treatments a person would want or not want in given situations
- *Proxy directive:* which explains who is to make healthcare decisions if the person becomes incompetent

Capability: All adults are presumed to be capable of making health care decisions until there is clear evidence that the adult is incapable of making a clear decision. Capability and incapability is assessed on the client's understanding:

- Of the information being given to him/her
- That the information applies to his/her own situation.

PRINCIPLES:

- Nunavut does not have legislation governing Advance Directives
- Advance Directives encourages an atmosphere of respect and caring and maximizes the client's ability and right to participate in medical decision making.
- Advanced directives promote the ethical value of autonomy. Autonomy is the principle that a person should be free to make his or her own decisions. Individual freedom is the basis for the modern concept of bioethics.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Template 07-016-01	Nunavut Care Level Planning
Policy 07-017-00	Do Not Resuscitate Order

REFERENCES:

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

Canadian Nurses Association (2008). *Position Statement: Providing nursing care at the end of life.* Ottawa, ON.

Canadian Nurses Association (1998). Advance Directives: The Nurse's Role. *Ethics in Practice.*

GUARDIANSHIP AND TRUSTEESHIP (S.N.W.T. 1994,c.29, as as duplicated for Nunavut by s.29 of the *Nunavut Ac*t, S.C. 1993, c.28)

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**	

TEMPLATE 07-016-01

The practitioner discussing advanced care planning with a client must ensure the *Nunavut Care Level Planning* form is completed by the physician/registered nurse, client or substitute decision maker/ power of attorney, and the interpreter (if applicable).

This form is filed in the client's health record. If the client is transferred to a referral site/ hospital, then a copy of this form should accompany the client.

Nunavut Care Level Planning
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Your health care team would like to know how to provide the best care for you and your family. We would like to listen to you.

To provide the best care we need to have a difficult conversation with you and your family. We will only talk about your illnesses with your family with your permission. We would like to talk about what happens when you become sick and may be dying and what forms of care you would like to receive. We would like to know where you would like to receive your care (for example in your home community, Iqaluit, or Ottawa). If possible we would like to provide care at the end of your life with your family with you at home or in Iqaluit.

Thank you for allowing your nurses and doctors to talk about this with you.

If you do not wish to talk about your illness and care please let us know and we will not discuss it with you.

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Nunavut Care Level Planning

I, ____________________________________, would like the following level of care to be provided to me,
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________ acute medical care, including transport and care in referral hospitals in Southern Canada.
ᐋᖅᑭᒃᑕᐅᓴᕋᐃᑦᑐᒧᑦ, ᐃᓚᖃᓯᐅᑎᓗᒍ ᐃᖏᕐᕋᔪᑎᒋᓂᐊᖅᑕᒃᑲ ᐊᒻᒪᓗ ᑖᒃᑎᓕᐊᕐᕕᖕᓂᓗ ᐋᓂᐊᕐᕕᖕᓂ ᖃᓪᓗᓈᓂ.

________ acute medical care, including transport and care in referral hospitals in Southern Canada, but do not wish CPR/intubation/cardioversion.
ᐋᖅᑭᒃᑕᐅᓴᕋᐃᑦᑐᒧᑦ, ᐃᓚᖃᓯᐅᑎᓗᒍ ᐃᖏᕐᕋᔪᑎᒋᓂᐊᖅᑕᒃᑲ ᐊᒻᒪᓗ ᑖᒃᑎᓕᐊᕐᕕᖕᓂᓗ ᐋᓂᐊᕐᕕᖕᓂ ᖃᓪᓗᓈᓂ, ᑭᓯᐊᓂ ᐋᓂᖅᓵᖅᑎᑕᐅᓇᓱᐊᕈᒪᓂᐊᖏᑦᑐᖓ/ᓱᓪᓗᓕᖅᑐᖅᑕᐅᔪᒪᓇᖓᓗ ᑎᒥᒃᑯᑦ/ᐆᒻᒪᑎᒍ
ᑎᓪᓕᓕᖅᑎᑕᐅᓇᓱᐊᖅᑕᐅᕐᑯᙱᑦᑕᕋᓗ.

________ acute medical care to be provided at Qikiqtani General Hospital only, recognizing that CPR/intubation/cardioversion will not be performed as this will then involve transport to a hospital in Southern Canada. In stabilization and transport to QGH I do not wish CPR/intubation/cardioversion. I may desire transport for medically relevant investigations, but this will be reviewed with my health care team on an individual basis.
ᐋᖅᑭᒃᑕᐅᓴᕋᐃᑦᑐᒧᑦ ᐃᑲᔪᖅᑕᐅᔪᒪᔪᖓ ᕿᑭᖅᑖᓗᑉ ᐋᓂᐊᕐᕕᖕᖓᓐᓂ ᑭᓯᐊᓂ, ᖃᐅᔨᒪᑦᓱᖓᓗ
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ᖃᓄᐃᒍᓐᓃᔾᔨᒥᑎᑕᐅᓇᓱᐊᖅᑎᓪᓗᖓ ᐊᒡᔭᖅᑕᐅᑎᓪᓗᖓᓗ ᕿᑭᖅᑖᓗᑉ ᐋᓂᐊᕐᕕᐊᓄᑦ ᐆᒻᒪᑎᒍ
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ᑕᒪᓐᓇ ᕿᒥᕐᕈᔭᐅᓂᐊᖅᑐᖅ ᐊᑐᓂ ᐋᓂᐊᖅᑐᓕᕆᔨᒃᑯᓐᓄᑦ.

________ acute medical care to be provided at ______________________ only, recognizing that CPR/intubation/cardioversion will not be performed as this would then involve transport out of my community. I may desire transport for medically relevant investigations, but this will be reviewed with my health care team on an individual basis.
ᐋᖅᑭᒃᑕᐅᓴᕋᐃᑦᑐᒧᑦ ᐃᑲᔪᖅᑕᐅᔪᒪᔪᖓ ᐅᕙᓂ ___________________ ᑭᓯᐊᓂ, ᖃᐅᔨᒪᑦᓱᖓᓗ
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palliative care at _________________________. I realize I have an illness which is terminal and desire quality comfort care at _________________.
I would like my family involved with my care.

I do not wish CPR/intubation/cardioversion.

_____ ᐊᓵᓂᐊᖅᖃᓗᓄᑦ ᑲᒪᕆᐅᕕᖏᑦᑐᒍᖏᑦ _____. ᖃᐅᔨᒪᔪᖏᑦ
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ᐃᓕᓴᒃ ᐅᙵᓂᓂᒃ ᑲᒪᖃᑕᐅᕐᓂᐅᒃᖢ. ᐃᓅᔪᓵᓂᕐᕕᒃᑕᕐᕋ ᓇᓕᓂᐅᑎᒃᓕᑦ ᐊᓪᒪᓗ ᐅᓪᒪᑎᑌ
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I understand I may change my mind at any time and that this will be respected.
ᑐᑭᔪᐅᒪᑦᓂᔪᐊᖅᑐᖏᑌ ᖃᖏᑐᑐᐃᓵᓇᖅ ᑕᒪᓵᓇ ᐊᔪᔨᖅᑕᐅᔪᓵᓇᑦᓂᓵᓇᖅᑕᕋ ᐊᓪᒪᓗ ᑕᒪᓵᓇ ``ᑲᒪᔪᑎᐅᑦᓂᔪᐊᖅᓂᕋ.

Discussed at: _____ Date: _____
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Discussion in Inuuktituit: Y N
ᐅᖃᐅᔪᐅᔪᖅ ᐃᓄᒃᑎᑐᑦ: ᐃ ᐊᓪᑌ

If yes, then interpreter name: _____
ᐊᖏᑦᑕᐅᔪᓂ, ᑐᓴᔨᐅᓵ ᐊᑎᖏᑌ: _____
Signature: _____
ᐊᑎᓕᐅᑭᔪᖏᑌ: _____

Family and others present at discussion:
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_____
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Signatures:
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_____ _____ _____
Patient or POA for personal care MD or RN discussing care witness
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Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS		
	Community Health Nursing		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Do Not Resuscitate Order		Nursing Practice	07-017-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		2
APPLIES TO:			
Community Health Nurses			

POLICY 1:

A Do Not Resuscitate (DNR) order must be ordered by a physician and clearly documented in the client's health record. In the event a physician is not present in the community to document the DNR order in the client's record, a telephone order may be given. The telephone order must be verified by two staff members, one of whom shall be a Registered Nurse.

The attending physician shall discuss the issue of DNR with the client (if capable) or if the client is not capable, with the substitute decision maker/power of attorney (POA). The physician or delegate must make a reasonable attempt to identify a person capable of making decisions on behalf of the client.

The outcome of the discussions with the client / substitute decision maker/ power of attorney leading up to the DNR order shall be recorded on the client's health record. This should include:

- **Client's prognosis, including likelihood of reversing the illness, and agreement on prognosis among consulting physicians;**
- **Discussions of treatment plan and options with the client or substitute decision maker, as well as others on the health care team;**
- **Views of the client, or substitute decision maker, concerned with client's comfort**
- **Signature of the client / substitute decision maker/ POA on the *Nunavut Care Level Planning* form.**

POLICY 2:

Where a previously arranged instruction from the client exists, either as an advanced directive, living will, or written DNR order from another institution, they should be respected, providing the physician is satisfied that:

- **The document is valid;**
- **The elapsed time since the document was drafted is (in the physician's judgment) reasonable,**
- **The client's condition has not undergone enough change to warrant a new decision,**
- **The client's wishes have not changed.**

POLICY 3:

A capable client or substitute decision maker may request that a voluntary DNR order be rescinded at any time. Provided that CPR is medically supportable, such a request must be followed by a written order and an accompanying progress note explaining the change.

DEFINITIONS:

Capability: All adults are presumed to be capable of making health care decisions until there is clear evidence that the adult is incapable of making a clear decision. Capability and incapability is assessed on the Adult's understanding:

- Of the information being given to him/her
- That the information applies to his/her own situation.

DEFINITIONS:

Do Not Resuscitate: means the practitioner will not initiate basic or advanced cardiopulmonary resuscitation such as:

- Chest compression;
- Defibrillation;
- Artificial ventilation;
- Insertion of an oropharyngeal or nasopharyngeal airway;
- Endotracheal intubation;
- Transcutaneous pacing;
- Advanced resuscitation drugs such as, but not limited to, vasopressors, antiarrhythmic agents, and opiod antagonists.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 07-016-00	Advance Directive
Template 07-016-01	Nunavut Care Level Planning Form

REFERENCES:

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

Canadian Nurses Association (2008). *Position Statement: Providing nursing care at the end of life.* Ottawa, ON.

Canadian Nurses Association (1998). Advance Directives: The Nurse's Role. *Ethics in Practice.*

GUARDIANSHIP AND TRUSTEESHIP (S.N.W.T. 1994,c.29, as as duplicated for Nunavut by s.29 of the *Nunavut Ac*t, S.C. 1993, c.28)

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:**
Client Identification for Clinical Care		Nursing Practice	07-018-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		2
APPLIES TO:			
Community Health Nurses			

POLICY:

Each health care provider shall ensure that all clients are properly identified prior to any care, treatment or services provided.

PRINCIPLES:

A system for positive identification of all health centre clients fulfills four (4) basic functions:

- Provides positive identification of clients from the time of arrival.
- Provides a positive method of linking clients to their health records and treatment.
- Minimizes the possibility that identifying data can be lost or transferred from one client to another.
- Improves the accuracy of client identification.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Guidelines 07-018-01 Client Identification Strategies

GUIDELINES 07-018-01

1. When a client's health record is created, a client specific identification card to be used with the addressograph imprinter shall also be created. The card shall include the client's full name, facility identification number, health record number, date of birth, and sex. This ID card shall be securely placed in the client's health record. (Addressograph may not be available in smaller centers)

2. All health centre-approved forms and records shall have the client's identifier information entered, preferably via the addressograph imprinter. Otherwise, the information can be entered by hand. The healthcare provider should never make an entry into a client's chart which has not been completely and clearly marked with the client's critical identifying information.

3. Before any procedure is carried out, the healthcare provider shall verify the following two (2) identifiers from the health record or health card to ensure that the right client is being treated:

    - Patient name
    - Patient date of birth

4. Client identification must be confirmed using the <u>two (2) identifier</u> system prior to conducting any healthcare procedures. Procedures may include, but are not limited to:
    - Administration of medication
    - Transfusion of blood or blood components
    - Obtaining blood or other specimens from the patient
      Specimen samples obtained from the patient will be labeled using the two (2) identifier system in the presence of the patient.
    - Performing a treatment
    - Performing a diagnostic test (i.e., diagnostic radiographic study)

5. When health records are pulled, the office support staff (Clerk Interpreter, Receptionist, Records Clerk) shall verify the progress notes and flowsheets are clearly marked with the client's identifier information before delivering the chart to the healthcare provider.

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:**
Transfer of Care Between Colleagues		Nursing Practice	07-019-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		2
APPLIES TO:			
Community Health Nurses			

POLICY:

Whenever there is a change in the client's care provider, at minimum, the following client information shall be communicated in a clear and concise report between the colleagues:

1. **Accurate client information regarding care, treatment and services**
2. **Client's name, current condition, emotional state and diagnosis**
3. **Pertinent past medical and surgical history**
4. **Recent vital signs**
5. **Recent or anticipated changes in the client's condition**
6. **Allergies; current medications and time last given (to include IV infusions)**
7. **Input and output (when applicable)**
8. **Any outstanding orders to be processed and/or performed**
9. **Plan of care, including follow-up appointments afterhours**
10. **Presence of any advance directives**
11. **Contact information for the on call physician**
12. **Contact information for the client (if client follow up is anticipated after clinic hours)**
13. **Any other information which is important to the client's care**

PRINCIPLES:

- Nurses and other healthcare providers shall be allotted the time to transfer the client care with minimal interruption. It is hoped this will lessen the amount of information that might be forgotten or simply not conveyed.
- Promotes continuity of care

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:**
Conscious Sedation		Nursing Practice	07-020-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		8
APPLIES TO:			
Community Health Nurses			

Conscious sedation is to be performed for those clients who must undergo painful or difficult procedures where cooperation and/or comfort will be difficult or impossible without pharmacologic support.

POLICY:

Only physicians have the authority to administer pharmacologic agents to achieve desired levels of sedation. The physician must be qualified to rescue clients from deep sedation, and must be competent to manage a compromised airway and provide adequate oxygenation and ventilation.

The physician performing the conscious sedation is responsible for reviewing the risks, options and benefits of the selected pharmacologic agents with the client, parent and/or guardian; and documenting the client, parent or guardian's informed consent in the health record.

The registered nurse may be given the responsibility of administration and maintenance of conscious sedation in the presence of and on the order of a physician. The nurse is responsible for verifying that informed consent has been obtained before initiating the procedure for sedation. The nurse will be trained in basic EKG and current BCLS certification. Emergency resuscitation equipment will be readily available.

DEFINITIONS:

Conscious Sedation provides a minimally reduced level of consciousness in which the client retains the ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command.

PRINCIPLES:

- The Registered Nurse must have education, knowledge of medications used and skills to assess, diagnose and intervene in the event of complications. The nurse functions within the limitation of facility policies and scope of practice.

- The nurse is responsible for continuously monitoring the client with assessment findings being documented every five (5) minutes for the first 15 minutes then every fifteen (15) until the procedure is completed.

- Monitoring includes:
  1. Physical assessment
  2. Blood pressure
  3. Heart rate
  4. Respirations (frequency and volume)
  5. Oxygen saturation
  6. Cardiac monitoring
  7. Skin color
  8. Level of consciousness (sedation scale)

- A second Registered Nurse may be required to assist during complex technical procedures or in procedures that are complicated due to the severity of the client's illness.

- The Physician will screen the risk factors for each client by utilizing the American Society of Anesthesiology (ASA) Physical Status Classification (see reference sheet 07-020-02) Clients considered appropriate for moderate and deep sedation in the community health centre are ASA Class I and Class II. Clients who fall into ASA Class III or Class IV present special problems which necessitate a consultation by an anesthesiologist.

- Common agents like midazolam and fentanyl cause dose-related suppression of airway protective reflexes and ventilatory drive; therefore may provoke airway compromise, hypoventilation and hypotension. Clinicians employing these agents should be comfortable with airway management and familiar with the pertinent reversal agents, flumazenil and naloxone.
- In the low doses, ketamine induces dissociative sedation, where airway protective reflexes are preserved, ventilatory response to carbon dioxide is maintained, respirations are generally adequate and the eyes often remain open. Ketamine can, cause adverse effects, including hypersalivation, laryngospasm and apnoea.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Guidelines 07-020-01	Conscious Sedation Guidelines
Reference Sheet 07-020-02	Sedation – Physical Status Classification
Template 07-020-03	Conscious Sedation Record

REFERENCES:

Canadian Society of Gastroenterology Nurses and Associates (n.d.). *Conscious Sedation: Responsibilities of the Registered Nurse Related to Conscious Sedation*.

The Child Health Network for the Greater Toronto Area (2002). *Practice Guideline: Management of Children Receiving Conscious or Deep Sedation.*

Urbain, Ip and Anurag Saincher (2000). Safety of Pediatric Procedural Sedation in a Canadian Emergency Department. *Canadian Journal of Emergency Medicine.2*(1): 15-20.

GUIDELINES 07-020-01

Conscious Sedation Guidelines

1. The physician assesses the risk factors for each client using the American Society of Anesthesiology (ASA) Physical Status Classification (see reference sheet 07-020-02) Clients considered appropriate for moderate and deep sedation in the community health centre are ASA Class I and Class II.

2. The attending physician explains to the client and caregiver(s) the need for the procedure, the effects of medications being used, and the associated risks. Verbal consent is obtained.

3. The client is placed on NPO status. The registered nurse documents a pre-sedation assessment on the *Conscious Sedation Record* (Template07-020-03)

   Physical and baseline assessment parameters include, but are not limited to:

   - Level of consciousness
   - Anxiety level
   - Vital signs, including temperature
   - Skin color and condition
   - Sensory defects
   - Current medications and allergies
   - Relevant medical surgical history
   - Client perceptions regarding procedure and moderate sedation

4. The client is connected to an ECG monitor, oxygen saturation monitor and automated blood pressure monitor. Oxygen is applied by mask or nasal cannula.

5. The resuscitation cart is brought to the bedside. Oral airway, bag-valve-mask, suction, and reversal drugs are made immediately available.

6. IV access is established. Fluid type and rate is determined by the physician.

7. Medications are administered. The choice of agent and route of administration is at the discretion of the attending physician.

8. Vital signs are recorded every five (5) minutes for the first 15 minutes then are performed every fifteen (15) minutes until the client meets the discharge criteria. One-to-one nursing care is maintained during the monitoring period.

9. Untoward reactions or sudden/significant changes in monitoring parameters should be immediately reported to the physician.

Conscious Sedation Guidelines (cont'd)

10. Post procedure, the client should be place in the recovery position until fully awake.

11. Clients should continue to be monitored for a minimum of one (1) hour post procedure with vital signs recorded every 15-30 minutes. Readiness for discharge is assessed according to the discharge criteria key (see *Conscious Sedation Record*). Clients must achieve a score of 7 prior to discharge.

12. The entire procedure is documented on the *Conscious Sedation Record*.

13. Written and verbal after-care instructions are given to the client's caregiver prior to discharge and documented in the client's health record.

EQUIPMENT

- Oxygen and nasal cannula
- Suction
- Emergency crash cart with defibrillator
- Cardiac monitor
- Pulse oximeter
- Blood pressure monitor

EMERGENCY INTERVENTIONS

Initiate emergency interventions when the following client conditions are identified:

1. **Decreased Oxygen Saturation** < 94% (or based on individual baseline oxygen saturation) with minimal respiratory distress that does not return to baseline
   - Look, listen and feel
   - Assess colour and chest wall movement
   - Check for proper placement of oxygen saturation probe
   - Check airway patency and reposition (airway/jaw holding) if necessary
   - Apply oxygen by facemask at 100 %, and notify M.D.

2. **Dyspnea or Cyanosis**
   - Determine patency of airway and reposition, suction if necessary
   - Apply oxygen per mask or ambu-bag at highest concentration (e.g., 100%)
   - Notify M.D.
   - Call additional nursing or medical staff for assistance if condition does not improve

3. **Inability to Maintain Patient Airway Related to Copious Secretions**
   - Suction patient
   - Oral airway
   - Notify physician

4. **Laryngospasm**
   - Determine airway patency
   - Reposition, head tilt/chin lift, jaw thrust
   - Apply oxygen per mask at 100% when airway patent
   - Provide artificial ventilation with a bag and mask if necessary
   - Call physician and additional nursing staff STAT, anticipate intubation

5. **Respiratory Depression**
   - Reposition airway, head tilt/chin lift, jaw thrust
   - Ventilate with ambu-bag using 100% oxygen
   - If no response, call additional nursing and medical staff and initiate advanced life support measures
   - Anticipate use of reversal agent

6. **Symptomatic Bradycardia**
   - Ensure patent airway
   - Ventilate with ambu-bag with 100% oxygen
   - If not corrected or leads to asystole, initiate CPR and advanced life support measures

7. **Excessive Sedation**
   - Inability to rouse easily
   - Support airway by jaw holding and bagging if no air exchange
   - Notify physician STAT

8. **Persistent Agitation**
   - Paradoxical response
   - If client is agitated remain at bedside and constantly assess airway and level of consciousness, protect client from injury
   - Notify physician (e.g., possibility of using a reversal agent)

REFERENCES:

Canadian Society of Gastroenterology Nurses and Associates (n.d.). *Conscious Sedation: Responsibilities of the Registered Nurse Related to Conscious Sedation*.

The Child Health Network for the Greater Toronto Area (2002). *Practice Guideline: Management of Children Receiving Conscious or Deep Sedation.*

Urbain, Ip and Anurag Saincher (2000). Safety of Pediatric Procedural Sedation in a Canadian Emergency Department. *Canadian Journal of Emergency Medicine.2*(1): 15-20.

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 07-020-02

The Physician will screen the risk factors for each client by utilizing the American Society of Anesthesiology (ASA) Physical Status Classification. Clients considered appropriate for moderate and deep sedation in the community health centre are ASA Class I and Class II. Clients who fall into ASA Class III or Class IV present special problems which necessitate a consultation by a member of the Anesthesia Department.

ASA PHYSICAL STATUS CLASSIFICATION:

Class I	No organic, physiologic, biochemical or psychiatric disturbance. Normal, healthy client.
Class II	Mild systemic disturbance; may or may not be related to reason for surgery. (Examples: controlled hypertension, controlled diabetes mellitus)
Class III	Severe systemic disturbance, but not incapacitating. (Examples: heart disease, poorly controlled hypertension)
Class IV	Life threatening systemic disturbance. (Examples: congestive heart failure, persistent angina pectoris)
Class V	Moribund client. Little chance for survival. (Examples: uncontrolled bleeding, ruptured abdominal aortic aneurysm)
Class E	Client requires emergency procedure. (Examples: appendectomy, D&C for uncontrolled bleeding)

REFERENCES:

Canadian Society of Gastroenterology Nurses and Associates (n.d.). *Conscious Sedation: Responsibilities of the Registered Nurse Related to Conscious Sedation*.

Urbain, Ip and Anurag Saincher (2000). Safety of Pediatric Procedural Sedation in a Canadian Emergency Department. *Canadian Journal of Emergency Medicine.2*(1): 15-20.

TEMPLATE 07-020-03

When conscious sedation procedure is to be performed in the community health centre, the *Conscious Sedation Record* shall be used to document the event. Once the form is completed, the form shall be filed in the client's health record.

Adopted from:

Urbain, Ip and Anurag Saincher (2000). Safety of Pediatric Procedural Sedation in a Canadian Emergency Department. *Canadian Journal of Emergency Medicine.2*(1): 15-20.

CONSCIOUS SEDATION RECORD

GUIDELINES: (Initials)

1. _____ Client is NPO
2. _____ Client weight is obtained
3. _____ Baseline TPR and BP done
4. _____ Baseline oxygen saturation done
5. _____ Oral airway, bagging unit, oxygen, suction, pulse oximeter done
6. _____ Crash cart with cardiac monitor is readily available
7. _____ Vital signs post procedure:
   Q 5 minutes for 15 minutes
   Q 15 minutes for 45 minutes or until meets discharge criteria
8. _____ Discharge criteria are met prior to criteria

Procedure: _____

Time Begin:_____ Time End:_____

PRE-SEDATION ASSESSMENT

Airway	Breathing	Colour	Skin	Vital Signs	Oxygen Rate	IV access
□ Own □ Mask □ _____	□ Nasal □ Normal □ Shallow □ Rapid □ Laboured	□ Normal □ Pale □ _____	□ Moist □ Warm □ Dry □ Cool	BP_____ HR_____ RR_____ O2 Sat_____ T _____	□ N/A □ Cannula □ Mask □ _____ Flow:_____ Time started:_____ Discontinued:_____	□ N/A □ Saline Lock □ Peripheral IV Site_____ Solution_____ Time started:_____ Discontinued:_____

VITAL SIGNS: DURING AND POST PROCEDURE

Time									
BP									
HR									
RR									
O2 Sat									

MEDICATION

TIME	Medication	Dose	Route	Initials

DISCHARGE CRITERIA

Activity								
Breathing								
Circulation								
Conscious								
Total Scores								

COMMENTS: (Document pre-procedure information given to client/parent)

DISCHARGE CRITERIA KEY

1. **ACTIVITY**
   0 = Unable to lift head or move extremities Voluntarily or on command
   1 = Lifts head spontaneously & moves extremities voluntarily or on command
2. BREATHING
   0 = Apneic
   1 = Dyspnea or shallow, irregular breathing
   2 = Able to breathe deeply and cough on command
3. CIRCULATION
   0 = Systolic BP < 80mmHg
   1 = Systolic BP > 100mmHg
   2 = Systolic BP within normal limits for client
4. CONSCIOUSNESS
   0 = Not responding, or responding only to painful stimuli
   1 = Responds to Verbal stimuli but falls asleep readily

	2 = Awake, alert and oriented to time, person, place (child to name, parent) **TOTAL SCORE PRIOR TO DISCHARGE MUST BE SEVEN**
Verbal/written discharge instructions given to: □Client □ Parent/guardian □ Other Initials:	Signature:_____ Initials:_____ Signature:_____ Initials:_____

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

TITLE:		**SECTION:**	**POLICY NUMBER:**
Restraints		Nursing Practice	07-021-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		2
APPLIES TO:			
Community Health Nurses			

POLICY:

Any physical or chemical restraint will be used as a last resort and for the shortest time possible. Alternatives to restraints should be considered prior to restraint use. A physician must be consulted prior to the use of restraints.

PRINCIPLES:

A policy of least restraint is threefold:

- Alternatives will be explored before a restraint is used.
- In the event that alternatives have not been successful in eliminating/reducing risk factors, the least restrictive type of restraint will be used.
- The restraint will be applied for the shortest period of time.

DEFINITION:

Restraint refers to any mechanical, chemical, environmental or physical measures used to limit the activity or control the behaviour of a person or a portion of their body. (AARN Position Statement [Mar 2003]

Physical/Mechanical Restraints are the use of a device or an appliance that restricts or limits freedom of movement. (I.e. vest restraints, lap belts, pelvic restraints, mittens, and geriatric chairs with locked trays.)

Environmental Restraint involves the use of the environment, including seclusion to or in a time out room, to involuntarily confine a person and to restrict freedom of movement.

Chemical Restraint includes:

a) The use of a psychopharmologic drug not required to treat medical symptoms, for any purpose of discipline or convenience.
b) A pharmacological intervention intended to control, inhibit or restrict a person's behaviour.
c) The therapeutic use of any pharmacological interventions with the purpose of providing treatment for mental health or associated behaviour is not considered a restraint.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Alberta Association of Registered Nurses (2003). *Position Statement: The use of restraints in client care settings.*

Perry and Potter, 6th edition (2006), p.85-93

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 on Continuous Observation		Nursing Practice	07-022-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		4

APPLIES TO:
Community Health Nurses

POLICY:

Clients who are at risk to harm themselves or others may be placed on Continuous Observation. Continuous Observation may be conducted by a nurse, psychiatric nurse, mental health worker or other delegated to unregulated healthcare worker (e.g. clerk interpreter).

When an application for involuntary admission has been completed under the Mental Health Act, the client will be placed on continuous observation.

Assistance from the RCMP may be requested if there is a potential threat or actual threat to the safety of the client and/or health centre staff.

DEFINITIONS:

Continuous Observation means the client is observed by staff or other designated personnel and is in sight at all times, including while in the washroom.

Unregulated staff includes, but not limited to, clerk interpreter, maternity care worker, mental health worker, home care worker and health care aid.

Form 1: is a Medical Practitioner's Order for a Psychiatric Assessment (Mental Health Act, Sec. 8), where detention is for the purpose of an assessment. Completed by a Medical Practitioner who must assess the person being formed. Authorizes detention for 48 hours.

Form 3: is a detention for the purpose of assessment (Mental Health Act, Sec.9). A Form 3 is completed by a Justice of the Peace or Territorial Court Judge. It authorizes detention by a peace officer for 7 days and authorizes detention for 48 hours for an assessment.

Form 4: is an affidavit (Mental Health Act, Sec. 9; 19.3; 23.2; 26, 26.1;49.1) which accompanies any application to court. The applicant signs the corresponding application. The form must accompany the person to court to be filed and served on interested parties before the hearing.

Form 5: Statement by a psychologist, peace officer, nurse, psychiatric nurse, mental health worker, or other person i.e. family member etc. (Mental Health Act, Sec.10; 11; 12). This relates to the circumstances surrounding apprehension for assessment. The person who signs is the person who arranges to have the detainee seen by a medical practitioner or a hospital. It is to be completed when delivering custody of an apprehended person.

Form 6: Application of Involuntary Admission (Mental Health Act, Sec. 13; 14) when the client poses a danger to self or to others. It is also used to request transfer to another province/territory. **This is the form most frequently used by QGH and when there is physician in the community.** A Form 6 can only be completed by a Medical Practitioner who has performed an assessment or an examination; and must be completed within 24hrs of that assessment. This form authorizes detention for 48 hours while the application is being processed

Form 7: Certificate of Involuntary admission (Mental Health Act, Sec. 16) which authorizes detention because the person poses a danger to self or to others. The form is completed by a Delegate for the Minister within 24 hours of receipt of a completed Form 6. A 72 hour detention can be ordered for the purpose of a second assessment and a 48 hour detention in unusual circumstances. Once a Form 7 has been issued, detention may be authorized for up to two weeks.

Form 8: Certificate of transfer (Mental Health Act, Sec.19). This form authorizes the transfer of a client to a hospital outside of Nunavut.

Form 25: Notice of Detention to the Client and Substitute Consent Giver (Mental Health Act, Sec. 35.2; 18). This is a notice of any decision to detain and of the rights, including the right to review. The form is signed by the attending healthcare practitioner, which includes a psychiatric nurse or a community health nurse. It must be completed and conveyed within 48 hours of an assessment / examination and immediately after the Certificate of Involuntary Admission, a Certificate of Transfer or a Certificate of Renewal has been issued.

PRINCIPLES:

Under the original interpretation of the Mental Health Act (1993), a health centre may assume the role of a 'hospital' while an involuntary client is awaiting transfer to an accepting facility.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Guideline 07-022-01 Provisions of Care for Clients on Continuous Monitoring

REFERENCES:

Rights and Responsibilities: Mental Health and the Law 2002.

Jones, J., Martin, W., Nigel, W. (2000). Psychiatric inpatients' experience of nursing observation a United Kingdom perspective. Journal of Psychosocial Nursing 38(12) 10-20.

Boyd, M A., Nihart, M A., Psychiatric Nursing: Contemporary practice. Lippincott New York.

GUIDELINE 07-022-01

NURSING ALERTS:

- The client will at no time be left alone following the decision for continuous observation
- Do not leave medications at the client's beside under any circumstances**.**
- Ensure that all oral medications administered are swallowed.
- The physician's order for continuous observation will be reassessed daily, in the event the client is unable to travel out of the community (e.g. no flights due to inclement weather).
- All clients who are on continuous observation will remain in the examination room until the order for continuous observation is discontinued or the client is medivaced from the community.
- The client is not allowed any items brought into the health centre by visitors unless they have been approved by health centre nursing staff.
- The flight nurse, in consultation with the attending health centre nurse will determine the level of risk associated with on-flight procedures prior to departure from the health centre. The flight team will be responsible for accessing additional personnel for the flight (e.g. RCMP escort) or retrieving additional medication orders if the client is assessed to be moderate to high risk for injury or violence.

GUIDELINES:

1. Advise the Supervisor of Community Health Programs of the physician's order for continuous observation. If there is a Registered Psychiatric Nurse in the community, he/she should also be consulted to discuss further treatment options.

2. Remove all clients' belongings and sharps, including the client's luggage. Ensure the client's environment is free of potentially harmful objects.

3. Document in the client's health record all belongings which have been removed and the methods in which the belongings/valuables have been secured. The type of observation must also be documented in the client's health record.

2. Assign a staff member to the client until the client is discharged to the medivac team.

1. The attending nurse will instruct the staff member about any client restrictions, visitor privileges and/or precautions to be taken. The staff member will also be instructed not to leave the client until he/she is relieved by another staff member.

2. Immediately inform the health care team when the client on continuous observation attempts to leave the health centre.

3. Call RCMP if assistance is required.

4. Ensure the health care team informs the client of the limitations imposed.

GUIDELINE 07-022-02

Guidelines for Unregulated Staff - Caring for a Clients under Continuous Observation

"Continuous observation" means that you see the client at all times. This includes when the client uses the washroom.

Guidelines:

- The Registered Nurse (RN) will give you a brief report when you arrive. This private and confidential information will help you carry out your duties. It is never to be discussed with people not involved in the client's care.
- You must be within 3 meters of the client at all times.
- The client needs an environment of low stimulation. This means things like loud music and talking are to be avoided.
- Avoid talking about issues that may upset the client.
- The client must stay in the clinic room, unless otherwise instructed by the RN.
- Keep the curtains around the bed open, even if the client is sleeping. Make sure you see the client's head above the bed linens.
- Use the emergency bell/alarm in the clinic room if you require immediate help. The RN will show you how it works if you are unsure.
- Never discuss your personal issues with the client. Listen but do not give advice.
- Do not get side tracked from your duties. Avoid getting into long talks with other clients or staff.
- Call the RN if the client needs to use the washroom and you and the client are of the opposite sex. This will help protect the client's modesty.
- Make a mental note of things like the client's appearance, facial expressions, speech, mood, activity level, reaction to others, and appetite. Report all concerns or observations as they happen to the client's Nurse.
- Remain with the client until your replacement arrives for breaks and at the end of your shift. Do not leave the client alone in the care of family or friends.

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:**
Non-Urgent Evacuation of Obstetrical Clients		Nursing Practice	07-023-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		2
APPLIES TO:			
Community Health Nurses			

POLICY 1:

In communities without obstetrical services, all prenatal clients shall be transported to the nearest community which offers obstetrical services for delivery of their infant. The gestational time for evacuation will depend on:

1. **Level of pregnancy risk assessment;**
2. **History of current pregnancy;**
3. **Geographical location of the home community to the nearest facility with obstetrical services and factors such as availability of scheduled flights;**

POLICY 2:

The medical travel arrangements and approval of escorts will be in accordance with the *Nunavut Client Travel Policy*.

PRINCIPLES:

- Labour and delivery, while a natural event, is not without risk.
- Registered nurses work with the client to develop an acceptable care plan and to transfer care to an appropriate care provider.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Nunavut Client Travel Policy
07-023-01 Obstetrical Clients Refusing to Travel

GUIDELINES 07-023-01

In special circumstances where the pregnant woman refuses to travel out of her community for the delivery of her baby, the following guidelines should be applied:

1. Explore the woman's feelings and reasoning for refusing to travel out of the community for delivery. If the woman and/or family identify a specific reason preventing her from traveling out of the community (e.g. no child care for her other siblings), assist the woman in finding a solution, so she would be able to travel. Involve other team members, such as social services, as appropriate and as authorized by the woman.

2. Notify the physician and/or midwife involved in the obstetrical care of the woman.

3. If the woman continues to refuse to travel for confinement, advise the woman of the risks of delivering in the community. This should be done without coercion or threats. The nurse must be cognizant and respectful of the woman's rights.

    a. The nurse should also educate the woman on the obstetrical background and experience of the attending nurses and midwives (if applicable).

    b. The woman must be asked to sign a release of responsibility / or against medical advice form.

4. The woman should be offered weekly prenatal visits until delivered.

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:**
Home Visits – Planned		Nursing Practice	07-024-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		3
APPLIES TO:			
Community Health Nurses			

POLICY:

Health care services will be available to all community members, including those who are unable to access the health centre due to illness or mobility constraints.

PRINCIPLES:

- The safety and security of health and social services' (HSS) employees is of paramount importance.
- HSS adheres to the Government of Nunavut's Zero Tolerance Policy on violence in the workplace which includes all health facilities.
- Health care professionals are considered in the workplace during home visits that are performed as part of a plan of health care.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 05-003-00	Risk Management
Policy 05-004-00	Risk Management Incident Reporting
Policy 05-029-00	Violence in the Workplace
Policy 05-030-00	Motor Vehicles
Guideline 07-024-01	Guidelines for Planned Home Visits
Guideline 07-024-02	Guidelines for Safe Home Visits

Zero Tolerance Policy from the *Human Resources Manual*

GUIDELINE 07-024-01

PROCEDURE

1. Community members who have known illness or medical conditions and are unable to attend to the health centre will be referred to the Home and Community Care Program (HCC)

2. If the client is not accepted into the HCC program, a staff member from the HCC program will notify the practitioner who made the original referral.

3. In communities where there is no Home Care Nurse (HCN), and the health services required in the home are beyond the scope of the Home and Community Care Worker (HCCW), every effort will be made for the client to be seen at the health centre by a CHN.

4. If the client refuses to attend the health centre and the CHN determines that a home visit is not required, all reasons why the home visit was not completed and any attempts to seek alternative means of access or support to attend at the home must be documented in the client's health centre health record.

5. If the client is unable to attend at the health centre and a planned home visit is required, the home visit will be determined by the nature of the illness and the interventions required.

6. The decision to home visit is determined by the client's condition, existing external conditions, including safety of the situation, resources available and the professional judgment of the health care professional with respect to the intervention required and frequency.

7. Every effort should be made to have the client attend at the health centre

8. If during the home visit, the CHN has any concerns about their own safety DO NOT ENTER or if concerns or doubts arise during the visits LEAVE IMMEDIATELY. Do not worry about leaving supplies, equipments or anything behind, your safety is most important.

   The health care professional will NOT attend a home/site when it is determined to be UNSAFE.

9. The details of the home visit must be documented in the client's health centre health record, as per Policy 06-008-00 Documentation Standards and Policy 06-009-00 Documentation Format.

GUIDELINE 07-024-02

PLAN A SAFE VISIT

- Before your visit, enquire about pets, children, other potential visitors, etc.
- Always inform the Supervisor of Community Health Programs or other colleague that you are conducting a home visit; the time you expect to arrive and leave the residence.
- Discuss any potential dangers
- Request a partner if you feel one is necessary

PERSONAL SAFETY DURING THE VISIT

- Present yourself in a calm and confident manner
- Before entering be aware of your surroundings. If you have any concerns about your safety do not enter.
- If there are dogs or other pets which concern you, be assertive and decline providing a service until they are secured and pose no threat to you
- Avoid the kitchen (potential weapons – knives, pans, hot water, etc.)
- Do not sit if the client stands. If you sit, do so in a hard-backed chair. You can get up faster from a firm chair than a soft sofa.
- If possible, do not remove your shoes or bring a pair of indoor shoes to wear.
- Be aware of your surroundings – watch for dangerous objects
- Recognize the first signs of a change in your client's behaviour or the behaviour of others in the home. Assess the client's appearance, routine of daily living, how he or she spends the day, and any other outstanding characteristics.
- Know where doors/exits are for an escape route, and try to keep between your client and the route to safety.
- Carry a communication device (cell phone, radio phone, etc.)
- Notify the SCHP or other colleague of your return to the health centre.

HOME VISIT DO'S AND DON'TS

DO:

- Appear confident and in control
- Follow the client (do not let them follow you)
- Stand to the side of the client
- Leave the environment if your instincts tell you to
- Leave the home if the client or visitor asks you to leave
- Treat the client with respect and dignity.
- Follow up on a staff member who has not reported back at a scheduled time after conducting a home visit.
- Report any unusual incidents to the SCHP as soon as possible

DON'T:

- Don't appear fearful - it promotes the victim syndrome
- Don't enter the client's home if your instincts say not to
- Don't stand face to face with a client (it makes you vulnerable to attack)
- Don't complete a home visit where someone (a client, client's visitors or family members) is intoxicated, or abusive
- Don't complete a home visit with someone (a client, client's visitors or family members) who is inappropriately dressed, or where sexual comments and innuendoes are made or pornography is viewed in your presence.

REFERENCES

Health Care Health & Safety Association of Ontario; Ontario Workplace Safety and Insurance Board (2003)*Health and Safety in the Home Care Environment*.

Winnipeg Police Service Community Relations Unit (2009). *Professional Home Visitors.*

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:**
Home Visits – Unplanned and Urgent		Nursing Practice	07-025-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		3
APPLIES TO:			
Community Health Nurses			

POLICY:

Health care will be accessible to all community members, including those who are unable to access the health centre due to illness or mobility constraints.

PRINCIPLES:

- The safety and security of health and social services' (HSS) employees is of paramount importance.
- HSS adheres to the Government of Nunavut's Zero Tolerance Policy on violence in the workplace which includes all health facilities.
- Health care professionals are considered in the workplace during home visits that are performed as part of a plan of health care.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 05-003-00	Risk Management
Policy 05-004-00	Risk Management Incident Reporting
Policy 05-029-00	Violence in the Workplace
Policy 05-030-00	Motor Vehicles
Guideline 07-024-01	Guidelines for Planned Home Visits
Guideline 07-024-02	Guidelines for Safe Home Visits

Zero Tolerance Policy from the *Human Resources Manual*

GUIDELINE 07-025-01

PROCEDURE

For after-hours assessments or emergencies, the nurse on call (NOC) will be contacted.

1. Every effort must be made to transport the client to the health centre for further assessment.

2. All available means of the client's accessibility to health care needs to be explored when a client cannot come to the health centre.

3. Unplanned home visits need to be assessed on an individual basis.

4. The decision to attend an unplanned home or site visit is determined through a process of:

    a. Contacting the client and obtaining as much information about the client and location – full name, address, phone number, other people living in the residence;

    b. Assessing the client's condition and possible risk factors (who is in the house, listen for background noise, known domestic violence, criminal involvement/substance abuse/unstable mental illness) through telephone or radio contact. If the residence or client is known to be dangerous DO NOT ATTEND.

    c. Speaking directly with the client is preferable but not always possible;

    d. Anticipating and determining the health intervention that may be required, its timing, and urgency in obtaining health care.

    e. Assessing potential for a life threatening health condition(s) where a delay in seeking alternative transportation modes to the health centre can cause further harm.

    f. Determining if the mechanism of transport for the client requires the expertise of a health professional prior to moving (e.g. spinal immobilization).

    g. Assessing the capacity of the client to attend a the health centre; existing external conditions that may impede the client's ability to attend to the health centre (e.g. COPD exacerbated by cold weather, etc)

5. If the situation in the home or at the site is assessed to be unsafe to attend at the home / site and in the clinical decision of the health professional the client requires urgent access to health care, alternative means of access or support to attend at the home or transport to the health centre must be explored. (e.g. accompanied by RCMP, Bylaw Officer, Social Worker). **The practitioner will NOT attend a home/site when it is determined to be UNSAFE.**

6. If the health concern has been determined to be non life threatening, and does not require the expertise of a health care professional for transportation concerns (e.g. spinal immobilization) the client must attend at the health centre for assessment.

7. If the situation in the home or at the site is assessed to be safe and of an emergent nature, the NOC responding to the call will:

    a. During clinic hours: Inform the Supervisor of Community Health Programs (SCHP) about the exact location of the unplanned home visit; telephone number at the location; type of telecommunication system that will be taken with them to the home/site; the reason for attending at the home/site, and the estimated length of stay at the location.
    Inform the SCHP upon safe return back to the health centre.

    b. After clinic hours: Inform the second NOC / or other colleague about the exact location of the unplanned home visit; telephone number at the location; type of telecommunication system that will be taken with them to the home/site; the reason for attending at the home/site, and the estimated length of stay at the location.
    Inform the second NOC or other colleague upon safe return back to the health centre.

8. The nurse attending the home visit must take a means of communicating with the health centre or outside help (e.g. cell phone, satellite phone, radio phone, etc.)

9. The second NOC or colleague who was notified of the unplanned home visit should make contact with the NOC at set time intervals (e.g. every 20 minutes) until they have been notified of the safe return of the NOC back to the health centre.

10. If the NOC has not returned to the health centre and the second NOC or colleague is unsuccessful in contacting the NOC on the home visit, the second NOC will immediately contact:

    a. SCHP
    b. RCMP as directed by the SCHP or other standard procedures established for that health centre.

11. If during the home visit, the nurse has any concerns about their own safety DO NOT ENTER or if concerns or doubts arise during the visits LEAVE IMMEDIATELY. Do not worry about leaving supplies, equipments or anything behind, your safety is most important.

12. All contact with the client, family or contact person through telephone / radio conversations or home visits must be documented in the client's health centre health record.

13. If a home visit was not completed, all contact with the client, family or contact person must be documented in the client's health record, as well as the reasons why the visit was not completed and any attempts to seek alternative means of access or support.

14. If a home visit was completed, details of the home visit must be documented in the client's health centre health record, as per Policy 06-008-00 Documentation Standards and Policy 06-009-00 Documentation Format.

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

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS		
	Community Health Nursing		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Emergency Land Medivacs		Nursing Practice	07-026-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		3
APPLIES TO:			
Community Health Nurses			

POLICY 1:

Health care will be accessible to all community members, including those who are ill or injured on the land. Search and Rescue (SAR) shall be notified by the Nurse-on-Call (NOC) or Supervisor of Health Programs (SHP) of any person who is known to be ill or injured on the land.

POLICY 2:

The on call physician shall determine whether an emergency land medivac is warranted. The NOC may authorize a medivac if a physician is unavailable and after consultation with the SHP.

POLICY 3:

A nurse or physician may volunteer to attend an emergency land medivac if appropriate and if the health centre can continue to operate safely in the absence of that health care practitioner. As a volunteer, the nurse will not be insured and will not be covered for workers compensation benefits through their employment. Employees will however be covered under Workers Compensation and Safety Commission, in case of an accident, through an agreement with Nunavut Emergency Management.

PRINCIPLES:

- Each Hamlet has its own Search and Rescue Team (SAR). For each distress call out on the land for a lost, ill or injured person, the SAR notifies the Nunavut Emergency Measures in Iqaluit (for advice and coordination) and sometimes the RCMP. The contact number is 867-979-6262.
- The *Emergency Medical Aid Act* (1998) states that the RN, MD or volunteer are not liable except for gross negligence while a) rendering emergency first aid assistance and b) rendering emergency medical services or first aid assistance outside the hospital or other place having adequate medical facilities and equipment.
- It is not mandatory for a health care practitioner to attend emergency land medivacs.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Guideline 07-026-01 Guidelines for Emergency Land Medivacs
Nunavut *Emergency Medical Aid Act*

REFERENCES:

Department of Health and Social Services (2002). *Emergency Land Medivacs*.

Nunavut *Emergency Medical Aid Act*

- Each Hamlet has its own Search and Rescue Team (SAR). For each distress call out on the land for a lost, ill or injured person, the SAR notifies the Nunavut Emergency Management (NEM) in Iqaluit (for advice and coordination) and sometimes the RCMP. The contact number is 867-979-6262.

- If the person is ill or injured, the SAR notifies the Health Center. If the Health Center is notified first of the illness, the SAR should be notified by the Health Center.

- The Nurse-on-call (NOC) may communicate with the ill or injured person by CB or satellite telephone to assess the problem and provide advice.

Medivac

1. If a medivac is required, the NOC contacts the physician-on-call (as per usual health centre procedure) to discuss the situation and the person's condition.

2. Based on the information provided by the NOC, the physician will determine the urgency of the medical condition and whether a medivac is warranted. The physician will advise NEM regarding the medical urgency.

3. NEM will provide the physician with the details of the conditions for travel, time frames and available transport to the health centre. The physician and NEM will then make a joint decision regarding the appropriate mode of transportation. NEM is responsible for arranging the transportation.

4. The physician will be responsible for making clinical decisions regarding the urgency of evacuation and not the primary logistical decisions surrounding the evacuation.

5. The NOC may authorize a medivac if a physician is unavailable and after consultation with the SHP.

6. If an air medivac is required, the NEM makes arrangements for the transportation and not medical travel. Emergency land medivacs, by air, land and sea, are paid by the Department of Health and Social Services. NEM already has the authorization number for payment.

7. If a nurse, physician or community member volunteers to accompany the medivac (by air, land or sea) they are covered under NEM's agreement with Worker's Safety and Compensation Commission and the Federal Government for their safety. Note it is not mandatory for a nurse or physician to attend the medivac. The health care practitioner may attend if appropriate and if the health centre can continue to operate safely in the absence of that health care practitioner.

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:**
Certificate of Illness		Nursing Practice	07-027-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		2
APPLIES TO:			
Community Health Nurses			

POLICY 1:

Community Health Nurses may provide certificates of illness or "sick notes" to clients who present to the health centre provided that the patient has been seen and assessed by nursing staff.

POLICY 2:

During exceptional circumstances, the need for an assessment can be superseded by a directive from the department through the Deputy Minister, Assistant Deputy Minister, Chief Medical Officer, Director of Medical Affairs or Chief Nursing Officer.

PRINCIPLES:

- The nurse issuing the certificate of illness or sick note must base the content of the letter upon their assessment of the patient.
- Should a patient not require a certificate of illness after their first presentation to the health centre, and subsequently returns with the same signs and symptoms, the practitioner may note in the sick note previous clinic visits related to this immediate illness from the contents of the patient's chart.
- Sick notes may not be back dated when completed. The sick note may only document the day the patient was seen in the health centre and any further time directed as "off" for the purposes of the treatment plan. A nurse may not provide a sick note for any "sick days" incurred before the client presents to the health centre.
- All sick notes must be legibly written and contain the patient's full name and date of birth. The nurse authoring the letter must clearly sign their name and designation (RN) on the letter or note.
- A copy of all certificates of illness should be filled in the patient's chart.
- In some exceptional circumstances such as an outbreak of respiratory disease, the Department may issue a directive requesting patients not to present to the health centre for sick notes. Under these rare circumstances, a community health nurse may issue a certificate of illness without seeing the patient.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Policy 06-001-00	Confidentiality
Policy 06-006-00	Health Records Management
Policy 06-008-00	Documentation Standards
Guideline 06-008-01	Documentation Standard Guidelines
Policy 06-009-00	Documentation Format

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	Medical Directives and Delegation Tuberculosis (TB) Programming	
TITLE:	**SECTION:**	**POLICY NUMBER:**
LPN Medical Directive: TB program	Nursing Practice	07-028-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
October 2017 / October 2020		8
APPLIES TO:		
All Department of Health staff		

1. **BACKGROUND:**

The Department of Health, Professional Practice Unit acts as the regulator for Licensed Practical Nurses (LPN) in Nunavut, as authorized through legislation. This unit is responsible for setting the standards and scope of practice for LPNs working in the territory. The Department of Health has adopted the Scope of Practice and Practice Standards from the College of Licensed Practical Nurses of Alberta, which provides the foundation for LPN practice in Nunavut. The training received through Canadian LPN educational programs, coupled with the LPN practice standards, prepare LPNs to carry out the functions required to administer communicable disease programming in the territory.

This policy provides an authorizing mechanism in which LPNs may perform duties, within the context of the Tuberculosis (TB) program, which are sanctioned to another regulated health care professional (e.g. physician, nurse practitioner, public health nurse (PHN), TB nurse (TBN) and pharmacist) without a direct order from that health care professional with the purpose of supporting safe and efficient delivery of local TB programs. LPNs are not to be assigned to work independently in TB programs; rather, LPNs are to be assigned to work collaboratively with a local registered nurse (RN) trained in TB and public health programs (i.e. PHNs or TBNs).

The LPN will be operationally supervised by the SCHP; however, overall TB program leadership is the responsibility of the PHN/TBN. The PHN/TBN and LPN work collaboratively with the RCDC team to provide timely screening and control of TB in the territory. LPNs have a role in supporting patients on DOT, ensuring safe administration and monitoring of patients on TB program while working collaboratively with the DOT worker and the PHN/TBN and implementing delegated tasks from the PHN/TB in contact investigations.

2. **MEDICAL DIRECTIVE:**

2.1 SCREENING AND TESTING:

2.1.1 LPNs may perform tuberculin skin test (TST) without a direct Physician (MD) or Nurse Practitioner (NP) order for children over 5 years of age, as directed by the patient screening criteria TB Testing Flowcharts described in the *TB Manual*.
LPNs are authorized to perform tuberculin skin tests only after they have received TST training and meet the required TST competencies.

2.1.2 LPNS, working in the TB program, may initiate sputum test requisitions without a direct MD or NP order for the purpose of screening, diagnostic testing, or monitoring as outlined in the *TB Manual*.

2.1.3 Patients meeting the criteria outlined in the *TB Manual* for needing a chest x-ray or blood work, for the purpose of screening, diagnostic testing or monitoring, will be

referred to the PHN/TBN for initiation of the x-ray and blood work requisitions.
NOTE: When a PHN/TBN is not available in the community, the LPN may consult the CHN/SCHP for the required test requisitions; however, the CHN/SCHP must have completed the GN TB Training program.

2.1.4 LPNs working in the TB program may perform clinical procedures related to the collection of sputum specimens as directed by the *TB Manual* and in accordance with relevant GN Lab Manuals and GN policies and procedures.

2.2 DIAGNOSIS:

2.2.1 LPNs are authorized to read a TST result after receiving TST training and meeting the required TST competencies. All abnormal results are to be reported immediately to the PHN/TBN or SCHP and Regional Communicable Disease Coordinator (RCDC), as per established local TB program protocols.

2.2.2 All abnormal test results are to be reported to the PHN/TBN, RCDC, and/or TB MD, as per established local TB program protocols.

2.2.3 LPNs are not authorized to make medical diagnoses. Once a diagnosis is confirmed, the PHN/TBN (or CHN/SCHP when a PHN/TBN is not available) will review the diagnosis with the patient and provide support and follow-up as per established local TB program protocols and per the Nunavut TB Manual.

2.3 TREATMENT:

2.3.1 It is within the LPN scope of practice to administer TB drug therapy, once an order has been received from the TB MD. The LPN is not authorized to initiate drug therapy without such direct order.

3. LEGISLATIVE AND REGULATORY SUPPORTING DOCUMENTS:

3.1 Licensed Practical Nurses Act
3.2 Standards of practice
3.3 Scope of practice document
3.4 CNA code of ethics
3.5 Medical professions act

4. AUTHORIZED IMPLEMENTERS:

4.1 LPNs who are assigned to the TB program and possesses the knowledge, skill and judgment to do so. The LPN is required to demonstrate competency to implement this medical directive through the standard TB orientation, training and certification process.

4.2 Sub delegation is not permitted to another regulated or non-regulated health care professional (i.e. to DOT workers in communities).

5. PRINCIPLES:

5.1 LPNs are expected to practice within their own level of competence and seek guidance from PHN/TBN, their supervisor (SCHP), RCDC, CHN, physician and/or NP as needed. Decision making model is included in Appendix A to assist with the decision to perform additional skills and delegated functions. Guidelines set out in the TB manual must be followed.

5.2 As described in the *Licensed Practical Nurses Act*, LPNs are authorized to provide practical nursing services:

(a) Independently, for patients considered stable with predictable outcomes (i.e. Routine screening (school screening/employment screening/walk-ins and low risk contacts); and

(b) Under the guidance or direction of a registered nurse (ie, PHN/TBN, CHN, SCHP, nurse practitioner, medical practitioner or other health care professional) authorized to provide such guidance or direction, for patients considered unstable with unpredictable outcomes.

5.3 In the community health centre settings, the LPN works under the supervision of the SCHP, with support and guidance on the TB program from the PHN/TBN; while the regional TB team provides the specific TB program expertise and guidance to both the LPN and the PHN/TBN. All health center staff including the PHNs, TBNs and LPN report to the SCHP.

5.4 During instances when a PHN/TBN is not available in the community for consultation, the LPN will consult a CHN/SCHP who has completed the GN TB Training program.

5.5 Guidelines do not replace clinical judgement. Management decisions regarding patient care must be individualized.

6. **CONTRAINDICATIONS:**

Consult the PH/TBN, MD, NP, SCHP, or RCDC before enacting this medical directive when any of the following conditions exist:

6.1 The LPN cannot confirm all conditions of this directive and the *TB Manual* have been met.

6.2 The patient's history or physical exam does not match the criteria described in the *TB Manual* for specific investigations, interventions and/or treatment.

6.3 The patient has contraindication to the recommended test, treatment or clinical procedure, as outlined in the *TB Manual*.

6.4 The *TB Manual* recommends physician consultation first.

7. **DEFINITION:**

Practical Nursing Services: means the application of practical nursing theory in the

(a) Assessment of patients;
(b) Collaboration in the development of a nursing plan of care for a patient;
(c) Implementation of a nursing plan of care for a patient; and
(d) Ongoing evaluation of a patient

8. **PROCEDURE:**

Patient Assessment

8.1 For stable, low risk patients, the LPN, as per legislative scope of practice, conducts comprehensive patient history and physical, as per the screening and monitoring guidelines in the *TB Manual*.

(a) The LPN references the *TB Manual* to determine if the conditions of this directive have been met (e.g. the patient's presenting condition meets the screening criteria in the *TB Manual*). The Algorithm in Appendix A provides guidance to the LPN when determining if the medical directive is appropriate to enact.

(b) If the LPN determines the conditions have not been met, or is unsure if the patient's history and physical meets the criteria for screening, diagnostic testing, or monitoring or for complex care then the PHN/TBN, SCHP, RCDC, MD or NP shall be consulted, as per established local TB program protocols.

TST, Lab and Diagnostic Imaging

8.2 *Tuberculin Skin Test*: TST competencies (planting and reading) must be met per NU TB program standards.

(a) When directed by the guidelines in the *TB Manual*, LPNs may perform a tuberculin skin test (TST) without a direct MD or NP order for patients over 5 years of age. PHN/TBN shall be promptly notified for all patients under the age of 5 years of age who require a TST. The LPN is authorized to read TST results in patients of all ages (including children under 5 years of age), as per their scope of practice and training.

(b) The LPN is to promptly report to the PHN/TBN (or CHN/SCHP when a PHN/TBN is not available) all cases where induration is noted – regardless of size. The PHN/TBN will assess the TST result, document findings, and provide guidance to the LPN on reporting and next steps – as per *TB Manual*.

8.3 *Sputum Specimens*:

(a) When directed by the guidelines in the *TB Manual*, LPNs may initiate a requisition for sputum specimens without a direct MD or NP order for patients of all ages.

(b) In conditions where sputum specimens are warranted, the LPN may collect and prepare the specimens as per the procedures outlined in the *TB Manual* and relevant GN Lab Manuals as well as provide all patient collection instructions.

(c) For symptomatic patients, the LPN can collect sputum specimens using airborne precautions and collect specimens for GeneXpert under the advisement of the PHN/TBN and RCDC.

8.4 Chest X-rays:

(a) When a patient requires a chest x-ray, as directed by the *TB Manual*, the LPN will promptly notify the PHN/TBN (or CHN/SCHP when a PHN/TBN is not available in the community), who in turn reviews the case and initiates the x-ray requisition in accordance with the *TB Manual* and *CHN Manual* policy: *CHN Initiating X-Ray Requests.*

(b) The LPN will arrange the x-ray appointment and follow up to confirm the test is completed.

8.5 *Blood Work*:

(a) When a patient requires blood work, as directed by the *TB Manual*, the LPN will promptly notify the PHN/TBN (or CHN/SCHP when a PHN/TBN is not available in the community), who in turn reviews the case and initiates the blood work requisition in accordance with the TB Manual and CHN Manual policy: *Requisitioning Laboratory Studies.*

(b) The LPN will arrange for blood work to be drawn and follow up to confirm test completed. Note: LPNs who completed competency training for phlebotomy can perform blood draws.

8.6 Follow up of Test Results:

(a) The LPN is responsible for receiving and reviewing all lab and diagnostic imaging reports which were generated within the TB program.

(b) The PHN/TBN (or CHN/SCHP) who initiated the lab and x-ray requisitions are also required to review the reports and ensure appropriate follow up care is instituted, as per *TB manual* baseline assessment and routine monitoring guidelines as well as the *CHN Manual* policies: *Acknowledgement of Diagnostic Test Results* and *Follow-up of Abnormal Diagnostic Test results.* The LPN will consult with the ordering PHN/TBN (or CHN/SCHP) once the report is received to ensure each report has been reviewed and direction is provided to the LPN on next steps.

(c) It is not within the role of the LPN to interpret lab and DI results; therefore, all abnormal test results are to be reported promptly to PHN/TBN (or CHN/SCHP when the PHN/TBN is not available) who will report abnormalities to RCDC, as per established local TB program protocols.

Treatment:

8.7 LPN requires a direct TB MD order for the administration of medications, which in most cases will be in the form of a physician prescription. The LPN shall refer to the textbook *Clinical Nursing Skills and Techniques* (Perry and Potter) for instruction on basic nursing medication administration procedures as well as the *Nunavut TB Manual* for guidelines on Direct Observed Therapy.

Note: For medications to be administered by the LPN via Intravenous, intramuscular, intradermal or subcutaneous routes, the LPN must have either (1) completed a post-graduate

medication administration course if the LPN graduated prior to 2001 or (2) have graduated from a Canadian LPN educational program after 2001, whereby the competency training for these medication administration routes were considered part of the basic educational curriculum.

8.8 LPNs are authorized to verify blister packs cross referenced with the current prescription for the DOT workers. It is a shared responsibility between the LPN and PHN/TBN to review all incoming blister packs (BBP) from pharmacy against the prescription orders and verify BBPs are correct by initialling and dating the back of the blister packs, as per Nunavut TB program protocols and outlined in the *Nunavut TB Manual.*

Documentation:

8.9 All patient encounters are to be documented in the patient's chart, using the appropriate forms as described in the *TB Manual (*e.g. DOT medication records and TB Assessment Form).

8.10 All TB documentation is to be submitted to RCDC in accordance with the procedures described in the *TB Manual.*

Contact Investigations and Public Health Follow up

8.11 Contact Investigations and public health follow up are advanced practice nursing skills and the LPN role in contact investigations are to follow up with tasks delegated by a PHN/TBN (or CHN/SCHP when a PHN/TBN is not available in the community) trained in public health contact investigations.

8.12 The LPN can be delegated tasks for following up in contact investigations that include assessing patients who have been identified as high risk by the PHN/TBN and following protocols outlined in the *TB Manual.*

8.13 Patient risk assessments and contact investigation including public health follow up must be overseen by the PHN/TBN (or CHN/SCHP when the PHN/TBN is not available in the community) and in collaboration with RCDC as outline in the *NU TB Manual.*

School Screening

8.14 LPNs will work in collaboration with the PHN/TBN (or CHN/SCHP when the PHN/TBN is not available in the community) in school screening programs. Follow up actions from the screening initiative may be delegated to the LPN by the PHN/TBN; except for collating the data from the school screening program, which will remain the PHN/TBN responsibility.

9. **RELATED POLICIES, PROTOCOLS AND LEGISLATION:**

APPENDIX A: Algorithm for Assessing Appropriateness of the Medical Directive
APPENDIX B: Decision-Making Model Performing Additional Functions & Transferred Functions
Alberta Licensed Practical Nurses Association Standard of Practice Documents
Government of Nunavut TB Manual
Community Health Nursing Manual: Documentation Standards Policy
Community Health Nursing Manual: Transferred Functions
Community Health Nursing Manual: CHN Initiating X-Ray Requests
Community Health Nursing Manual: Requisitioning *Laboratory Studies*
Nunavut Formulary
Licensed Practical Nurses Act

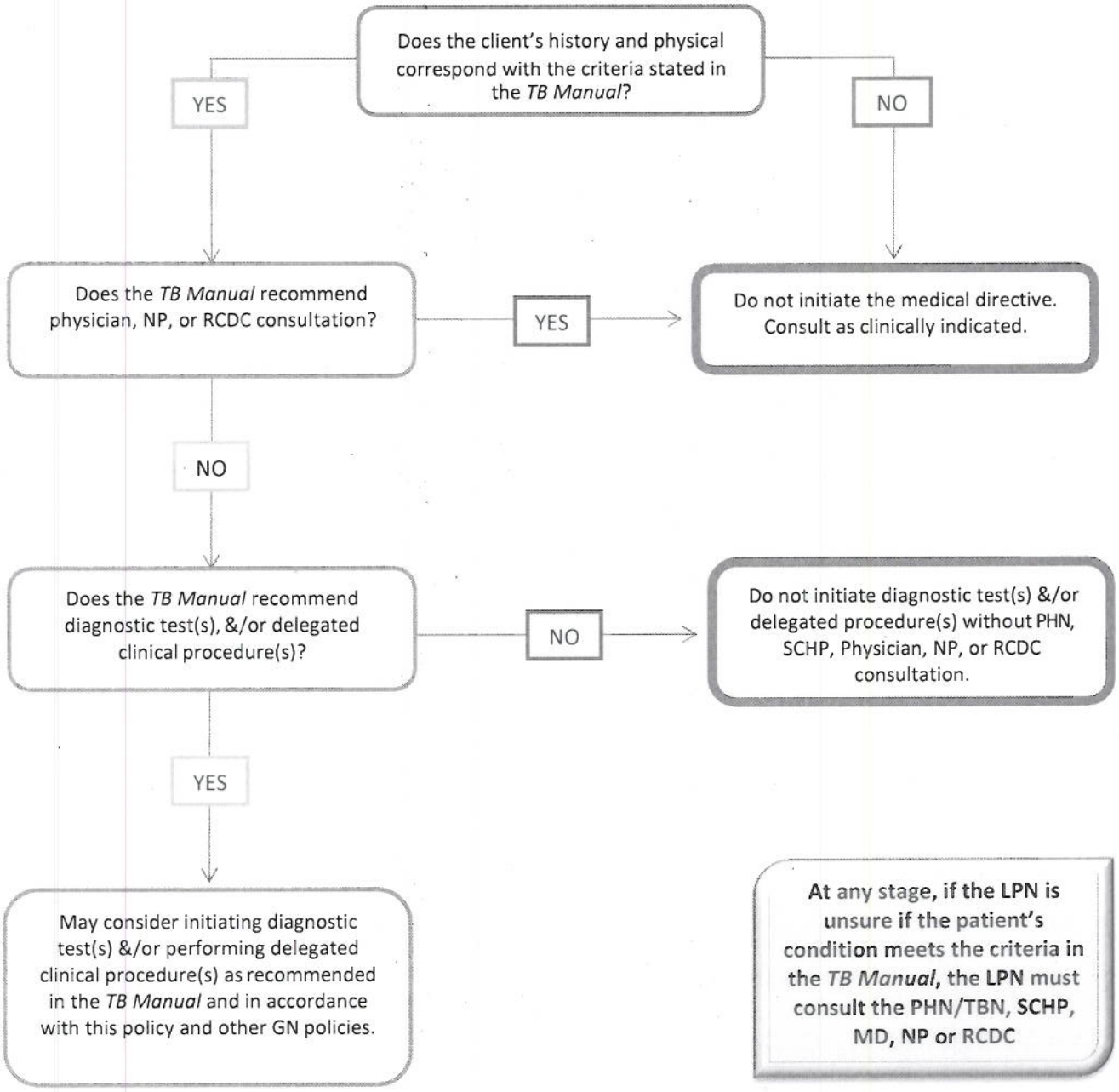
10. **REFERENCES:**

Alberta Licensed Practical Nurses Association Standard of Practice Documents
Government of Nunavut (2010). *Community Health Nursing Standards, Policies and Guidelines*
Government of Nunavut. *Tuberculosis Manual*. (2017)
Licensed Practical Nurses Act

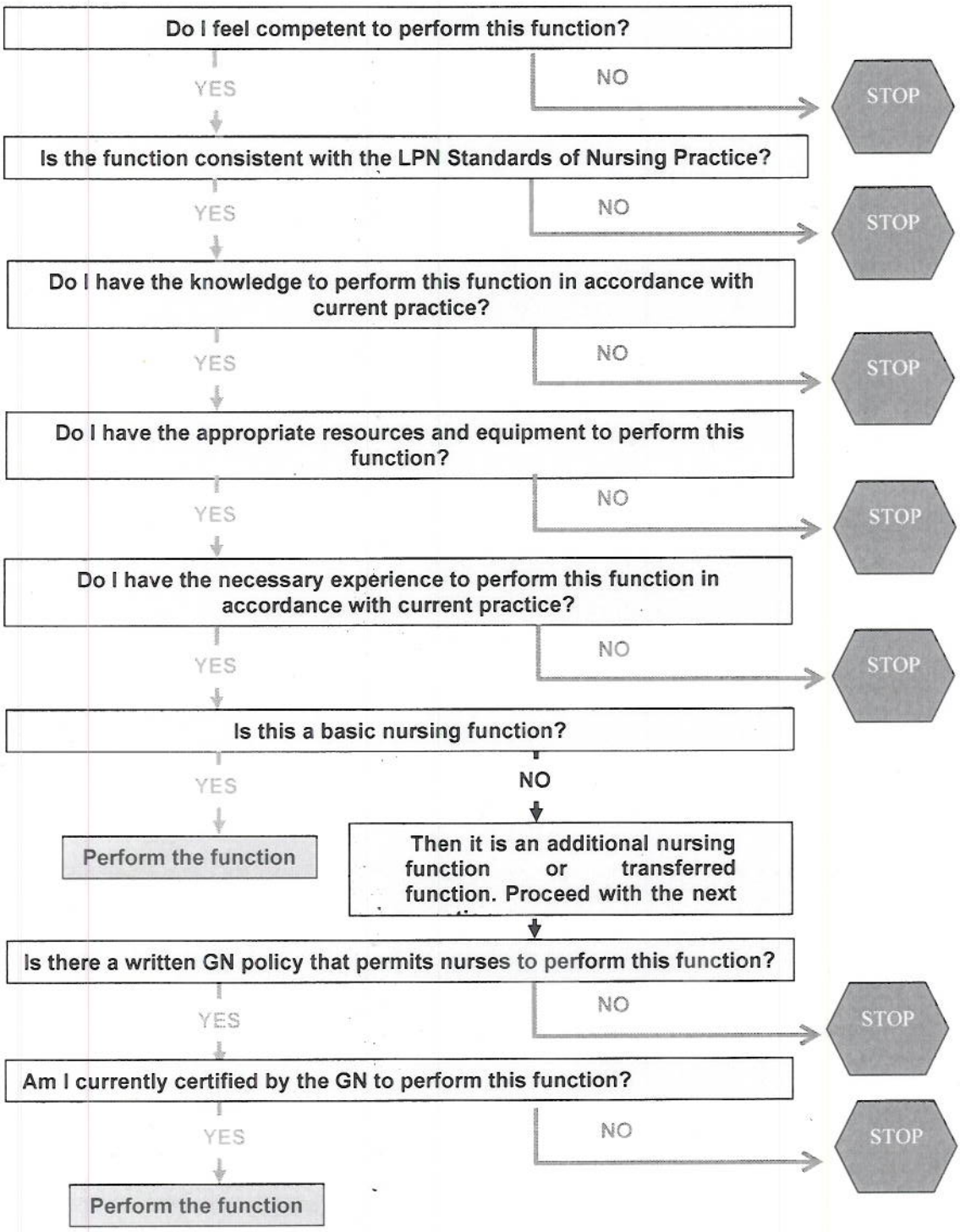
11. **APPROVALS:**

Approved By:	Date: 26-October - 2017
Dr. Kim Barker, Chief Medical Officer of Health – Department of Health	
Approved By:	Date: 26-October - 2017
Jennifer Berry, Chief Nursing Officer	

APPENDIX A: ALGORITHM FOR ASSESSING APPROPRIATENESS OF THE MEDICAL DIRECTIVE



APPENDIX B: DECISION-MAKING MODEL FOR PERFORMING ADDITIONAL FUNCTIONS AND TRANSFERRED FUNCTIONS



Adapted from RNANT/NU (2010). *Scope of Practice for Registered Nurses*, p. 9

Department of Health Government of Nunavut	Title **Infant - Telephone Triage and Infant Assessment (Age 0 – 12 Months)**		
NURSING POLICY, PROCEDURE AND PROTOCOLS		**SECTION:**	**POLICY NUMBER:**
Community Health Nursing		Clinical Practice	07-029-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
August 18, 2017	August 2020	07-006-00 Telephone Triage 07-007-00 Telephone Advice 07-008-00 Acutely Ill Infants	3
APPLIES TO:			
All Community Health Nurses and Nurse Practitioners			

1. BACKGROUND:

Community Health Nurses and Nurse Practitioners provide telephone triage services within the community to assess the severity of the client's symptoms and determine the appropriate plan of care. The health status of infants can quickly deteriorate, lending to the need that all ill infants require full assessments at the Health Centre to determine the infants' health status and appropriate plan of care.

2. POLICY:

ASSESSMENT:

2.1 All infants aged 12 months and under must be fully assessed in the clinic, whether it is during or after regularly scheduled clinic hours.

TELEPHONE TRIAGE:

2.2 Infants aged 12 months and under must be seen in the health centre within one hour of receiving a phone call from the parent/guardian. The timing of the visit to be determined by the urgency of the reported signs and symptoms.

i. If the parent/guardian declines to bring the infant to the health centre at the time of the call, he/she must be (1) offered the opportunity to call the Nurse-on-Call back and (2) offered an appointment at the health centre later that same day or the following calendar day.

2.3 Every telephone call received regarding an infant must be documented on the *Infant Telephone Triage Form* at the time the call is received. The only exception to this policy statement is when the nurse has the infant's chart in his/her possession at the time of the call and the information is written directly into the health record.

3. PRINCIPLES:

3.1 Telephone triage requires the nurse to assess a client's health concern without the advantage of a face-to-face interaction or hands-on inspection. The clinical decisions made by Registered Nurses during telephone triage require complex critical thinking, which shall largely be based on current evidence and best-practices. Nurses must also rely on their communication skills, knowledge of disease processes, and normal growth and development for all age groups in order to accurately understand the client's presenting symptoms.

3.2 All parents/guardians have a right to refuse to bring the infant to the health centre to be assessed. In these situations, the nurse will attempt to obtain as much information as possible over the phone to mitigate the risks associated with not immediately assessing the infant in the clinic.

3.3 The *Infant Telephone Triage Form* is a legal document and must be promptly secured in the health record.

4. DEFINITIONS:

Nurse: For the purpose of this policy, nurse refers to Community Health Nurses and Nurse Practitioners.

Telephone Triage: an assessment over the phone to assess a health condition of a client in order to determine the level of urgency for care and the overall plan of care.

5. PROCEDURE:

Telephone Triage:

5.1 When a call is received from a parent / guardian regarding an infant, the nurse shall use the *Infant Telephone Triage Form* to guide the telephone assessment, determine the urgency, and to record the details of the call.

NOTE: The triage form is only intended to provide guidance for a preliminary evaluation of the infant's health status to determine the urgency of receiving medical care. It is NOT intended to provide guidance for a full infant assessment.

5.2 The nurse will request that the parent/guardian bring the infant to the health centre within one hour of receiving the call. The decision to see the infant immediately versus safely postponing the clinic visit for one hour shall be based on the evaluation of the Infant's Airway, Breathing and Circulation status over the phone.

Note: In the event of a blizzard, safety considerations for the nurse and the client must be carefully evaluated. If the client's condition is determined to be non-urgent and it is not safe to travel to the health centre (e.g. zero visibility), the nurse must notify the SCHP and arrange appropriate follow up care (for example: follow up phone calls with the parent/caregiver at set intervals) until such time that the weather improves (e.g. visibility > 400m) or the client's condition changes and is now determined to be urgent or emergent. Follow local health centre protocols for travelling to the health centre in the event the client's condition is determined to be emergent or urgent, which includes notifying the SCHP of the situation before traveling to the health centre. Whenever the nurse is in doubt about the level of urgency for the client to be seen, the physician and supervisor are to be consulted.

5.3 If the parent/guardian declines to bring the infant to the health center, the nurse shall:

i. Obtain additional information regarding the infant's health status to support the development of an appropriate plan of care;
ii. Document details of the call on the triage form:
   - reason caller declined to attend health centre;
   - health status of the infant;
   - treatment plan;
   - date/time follow up appointment arranged
   - advice on when the parent/guardian should call the nurse on call back; and
   - any other relevant details discussed;
iii. Offer the caller an opportunity to call the nurse on call back at any time;
iv. Arrange an appointment for the infant to be assessed in the health centre later that day or on the next calendar day;
v. Complete, sign and date the *Infant Telephone Triage Form* at the time of the call and place in the infant's health record as soon as it is feasible to do so.

Assessment:

5.4 The assessment of the ill infant shall, at minimum, include ALL of the following:

1.	Undress the child down to his/her diaper.
2.	Address any airway, breathing or circulation issues first.
3.	Perform a full set of vital signs including temperature, heart rate, blood pressure, respiratory rate, oxygen saturation.
4.	Weigh the infant naked at <u>each</u> visit

5. Obtain a comprehensive history including: - past medical history and social history, - medications the infant has received (including antipyretics), - history of presenting illness, focusing on: when the illness started, if it's getting better or worse, if the infant is drinking, and voiding, and if there have been any changes in the level of alertness of the infant.
6. Perform a physical exam with particular focus on: - assessing hydration status (tears when crying, moist mucous membranes), - work of breathing, - fever status, - finding the focus: head and neck examination including looking in both ears and throat, respiratory exam (documenting work of breathing and breath sounds), cardiac exam, abdominal exam, dermatology exam and neurology exam including any signs of nuchal rigidity, and decreased level of consciousness. - Additional diagnostic tests may be required depending on the presenting concerns and initial assessment findings
7. Consult the physician on call for further advice (as per local protocols) for all concerns which arise from the assessment.

6. **RELATED POLICIES, PROTOCOLS AND LEGISLATION:**

Policy 06-001-00	Confidentiality
Policy 06-006-00	Health Records Management
Policy 06-008-00	Documentation Standards
Policy 06-009-00	Documentation Format

7. **REFERENCES :**

American Heart Association (2011) Pediatric Advanced Life Support Provider Manual

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

Department of Health Government of Nunavut Policy 07-027-00	TITLE **INFANT TELEPHONE TRIAGE FORM** **Age 0- 12 months**

ALL INFANTS (12 mths of age and younger) MUST BE ASSESSED AT THE HEALTH CENTRE

*** This Form is not to be used as an assessment of the infant but to establish URGENCY whether to see the child at the Health Centre immediately or within ONE hour ***

Name of Caller:	**Date**:	**Time**:	**Phone**:
Relationship of Caller to Patient:		**Location of Caller:**	
Name of Patient:	**Gender:** M / F	**Age**:	
Chief Complaint:			
Known Health Conditions:			

AIRWAY :			**CIRCULATION**		
Is the child breathing?	**Y**	**N**	Colour: ☐ **Normal** ☐ **Pale**		
Noisy Breathing?	**Y**	**N**	Urine Output : # wet diapers? _____ Last wet diaper? _____		
Is it worsening?	**Y**	**N**	Child crying /making tears?	**Y**	**N**
BREATHING			**DISABILITY**		
How is the infant's breathing? ☐ **Normal** ☐ **Fast** ☐ **Difficult**			Is the Child alert?	**Y**	**N**
Any blue colour around lips, hand or feet now?	**Y**	**N**	Responsive?	**Y**	**N**
Any previous episodes of blue colour around lips, hands or feet?	**Y**	**N**	Excessively sleepy?	**Y**	**N**
Using belly muscles while trying to breath?	**Y**	**N**	Irritable?	**Y**	**N**
Is the infant's head moving up & down when trying to breath?	**Y**	**N**	**Any other concerns?**		
Are the infant's nostrils moving in and out when trying to breath?	**Y**	**N**			

ASSESSMENT : Emergency: _____ Urgent (1 hour): _____ To Come to Clinic : Now _____ / within 1 hour_____

Other Comments : ☐ caller agreeable ☐ caller refused (check one)

If caller declines to bring child to health centre within one hour, DOCUMENT all advice given:

_____

_____

_____

_____

_____

_____

Signature of CHN _____ Print Name _____ Date_____ Time _____

COMPLETED FORM MUST be PLACED in Patient's Health Record

Department of Health Government of Nunavut	TITLE **Pediatric and Adult - Telephone Triage**		
NURSING POLICY, PROCEDURE AND PROTOCOLS		**SECTION:**	**POLICY NUMBER:**
Community Health Nursing		Clinical Practice	07-030-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
August 18, 2017	August 2020	07-006-00 Telephone Triage 07-007-00 Telephone Advice	6
APPLIES TO:			
All Community Health Nurses and Nurse Practitioners			

1. BACKGROUND:

Community Health Nurses and Nurse Practitioners provide telephone triage services within the community to assess the severity of the client's symptoms and determine the appropriate plan of care.

2. POLICY:

2.1 All clients who call regarding a health concern will be assessed on an individual basis utilizing the *Pediatric Telephone Triage Form* or the *Adult Telephone Triage Form* to establish the time frame in which the client will be assessed in the Health Centre.

2.2 **The following individuals** shall be offered to be seen at the Health Centre to have their presenting health concern fully assessed in the clinic immediately or within 4 hours based on the urgency of the presenting symptoms from the telephone triage:

1. All clients whose condition is determined to: a. Require resuscitation; b. Be emergent; or c. Be urgent
2. All clients age 65 and older;
3. All pregnant women;
4. All women up to two (2) weeks postpartum;
5. All clients who were discharged in the last 48 hour from a hospital or care facility;
6. All clients who had a surgical procedure under general anaesthetic within the previous ten (10) days
7. All clients who had an endoscopic procedure (gastroscopy or colonoscopy) within the previous three (3) days
8. All clients with complex medical condition(s)
9. All clients who had multiple visits or multiple calls to the Health Centre in the previous seventy-two (72) hours with the same presenting complaint(s)
10. All clients in custody of the RCMP when an Officer contacts the health centre regarding a health concern of a detainee.

2.3 Every telephone call received regarding a presenting health concern is to be documented on the appropriate *Telephone Triage Form* at the time the call is received. The only exception is when the nurse has the client's medical record in his/her possession at the time of the call and the information is written directly into the health record.

3. PRINCIPLES:

3.1 Telephone triage requires the nurse to assess a client's health concern without the advantage of a face-to-face interaction or hands-on inspection. The clinical decisions made by Registered Nurses during telephone triage require complex critical thinking, which shall largely be based on current evidence and best-practices. Nurses must also rely on their communication skills, knowledge of disease processes, and

normal growth and development for all age groups in order to accurately understand the client's presenting symptoms.

3.2 Telephone Advice Guidelines are included in Appendix A and provide examples of strategies to mitigate the risks associated providing advice over the phone.

3.3 All clients have a right to refuse to be seen at the health centre to be assessed. In these situations, the nurse will attempt to obtain as much information as possible over the phone to mitigate the risks associated with not being assessed in the clinic.

3.4 The *Telephone Triage Forms* are legal documents and must be promptly secured in the client's health record.

4. DEFINITIONS:

Nurse: For the purpose of this policy, nurse refers to Community Health Nurses and Nurse Practitioners.

Telephone Triage: an assessment over the phone to assess a health condition of the client in order to determine the level of urgency for care and the overall plan of care.

Resuscitation: When there are conditions that are threats to life or limb or there is an imminent risk of deterioration which requires aggressive interventions (Canadian Triage and Acuity Scale (CTAS, 2007)).
Examples include, but are not limited to (consult another care provider if uncertainly of the acuity status of a client):

- Cardiac arrest
- Active seizures
- Respiratory arrest
- Major trauma (shock)
- Shortness of breath (severe respiratory distress)
- Altered level of consciousness (Glasgow Coma Scale 3-9)
- Severe dehydration in pediatric client

Emergent: When there are conditions that are potential threat to life, limb or function, requiring rapid medical intervention (CTAS, 2007).
Examples include, but are not limited to (consult another care provider if uncertainly of the acuity status of a client):

- Chest pain with cardiac features
- Hypothermia
- Fever (Temperature > 38.5, appears septic; and/or infant less than 3 months with fever >38 C)
- Headache (sudden, severe)
- Bizarre paranoid behavior
- Depression/suicide (attempted suicide, clear plan)
- Chemical exposure to eye
- Shortness of breath (moderate respiratory distress)
- Abdominal pain (severe pain)
- Altered level of consciousness (Glasgow Coma Scale 10-13)
- Moderate dehydration in pediatric client

Urgent: When there are conditions that could potentially progress to a serious problem requiring emergency intervention (CTAS, 2007).
Examples include, but are not limited to (consult another care provider if uncertainly of the acuity status of a client):

- Seizures (resolved, normal level of alertness)
- Diarrhea (uncontrolled bloody diarrhea)
- Active labour; premature rupture of membrane; and/or preterm bleeding after 20 weeks gestation.
- Depression / suicide (suicidal ideation, no plan)
- Shortness of breath (mild respiratory distress)
- Abdominal pain

- Headache (moderate pain 4-7 / 10)
- Chest pain, non cardiac features (other significant chest pain)

5. PROCEDURE:

5.1 When a call is received from a client the nurse shall use the appropriate *Telephone Triage Form* (Pediatrics or Adults) to guide the telephone assessment, determine the urgency, and to record the details of the call.

NOTE: The triage form is only intended to provide guidance for a preliminary evaluation of the client's health status to determine the urgency of receiving medical care. It is NOT intended to provide guidance for a full client assessment.

5.2 After analyzing the assessment information obtained from the telephone triage and noting the **required client populations to be seen listed in policy statement 2.2,** the nurse will determine the appropriate follow up plan:

i. Arrange to see the client at the Health Centre immediately or within four hours of the call; or
ii. Offer an alternate appointment date / time; or
iii. Provide telephone advice only.

Note: In the event of a blizzard, safety considerations for the nurse and the client must be carefully evaluated. If the patient's condition is determined to be non-urgent and it is not safe to travel to the health centre (e.g. zero visibility), the nurse must notify the SCHP and arrange appropriate follow up care (for example: follow up phone calls with the client/parent/caregiver at set intervals) until such time that the weather improves (e.g. visibility > 400m) or the patient's condition changes and is now determined to be urgent or emergent. Follow local health centre protocols for travelling to the health centre in the event the patient's condition is determined to be emergent or urgent, which includes notifying the SCHP of the situation before traveling to the health centre. Whenever the nurse is in doubt about the level of urgency for the patient to be seen, the physician and supervisor are to be consulted.

5.3 When a client declines to come to the health centre or when an alternate date/time has been arranged, the nurse shall:

i. Obtain additional information regarding the client's health status to support the development of an appropriate plan of care;
ii. Offer the caller an opportunity to call the nurse on call back at any time
iii. Counsel the client on when he/she should call the nurse on call back;
iv. Arrange an alternate appointment date/time;
v. Complete, sign and date the *Telephone Triage Form* and secure in client's health record as soon as it is feasible to do so.

5.4 Details of the call are to be documented on the *Telephone Triage Form* at the time the call is received and secured in the client's medical record at the earliest opportunity.

6. RELATED POLICIES, PROTOCOLS AND LEGISLATION:

Appendix A:	Telephone Advice Guidelines
Appendix B:	*Pediatric Telephone Triage Form*
Appendix C:	*Adult Telephone Triage Form*
Policy 06-001-00	Confidentiality
Policy 06-006-00	Health Records Management
Policy 06-008-00	Documentation Standards
Policy 06-009-00	Documentation Format

7. **REFERENCES:**

Canadian Emergency Department (2007). Canadian Triage and Acuity Scale (CTAS).

National Emergency Nurses Affiliation (2002). Position Statement A-1-4.

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

Appendix A: Telephone Advice Guidelines

BACKGROUND:
It is within the scope of practice for a Community Health Nurses to provide telephone advice. The Department of Health supports the practice of providing telephone advice to clients by Registered Nurses.

Guidelines:

Common Hazards

The Registered Nurse must be aware of the most common hazards in giving telephone advice and attempt to eliminate these hazards. These include, but are not limited to:

Common Hazards	
▪ Using leading questions	▪ Using medical jargon
▪ Inadequate data collection	▪ Inadequate time to explore client's symptoms
▪ Jumping to conclusions	▪ Stereotyping callers or problems
▪ Failing to talk directly to the client	▪ Accepting client self-diagnosis and second guessing
▪ Overreacting and underreacting	▪ Nurse fatigue
▪ Language barriers	

Documenting Telephone Advice

Documenting the telephone call is a legal and professional obligation for the Registered Nurse who provides telephone advice to a client. The minimum requirements to be included in telephone contact documentation include:

Documentation	
▪ Date and time of the call	▪ Callers name, telephone number and address
▪ Information received from the caller	▪ Advice or information given by the nurse
▪ Referral and follow-up information	▪ Name of the nurse
▪ Client's name if different from caller	

The nurse may document the details of the telephone contact directly into the progress notes of the client's health record if immediately available. If the chart is not immediately available, such as when the nurse on call is fielding telephone calls outside the health centre, the nurse shall document the telephone conversation onto the appropriate *Telephone Triage Form*. At first opportunity, the form must be placed in the client's health record. Until such time, all forms must be kept secure while in the nurse's possession.

Risk Management

Providing telephone advice is a high risk activity. The following risk management strategies are designed for both the employee and employer and intended to reduce the incidence of injury to clients and the risk of potential liability:

Risk Management Strategies	
▪ When in doubt, see the client	▪ If a client calls seeking advice about the same problem more than once in the span of 3 days, then arrange for the client to be seen
▪ After reviewing care advice, ask the caller, "do you feel comfortable with this plan?" if the caller does not, schedule a call back in 1 hour or arrange to see the client. Remember telephone triage is point of entry into the health care system. Do not use triage as a method of limiting access. Instead use it as a method of improving access to primary care.	▪ Encourage callers to call back if the condition worsens. Callers should be given specific reasons to call back. At the least, the nurse should instruct the caller to call back if the "client becomes worse".

Appendix A: Telephone Advice Guidelines

▪ Establish policies and protocols for nursing staff regarding telephone triage and telephone advice	▪ Ensure nurses have appropriate training, skills and experience to provide telephone advice
▪ Establish a policy to protect patient confidentiality	▪ Provide adequate staffing
▪ Develop an appropriate documentation system, including safe management of all records	▪ Follow professional guidelines and standards
▪ Ongoing review and evaluation of protocols for relevancy and accuracy	▪ Conduct routine chart audits
▪ Report and follow-up unusual occurrences	

Communication Device

- Every attempt should be made to talk with clients using a land line.
- There are special circumstances when a land line is not possible, e.g. clients in outpost camps using hand radios and satellite phones.
  - ➢ Clients must be informed that the information discussed may not be confidential as others may be able to hear the conversation.
  - ➢ Obtain only as much information that is required to make a sound clinical judgment
  - ➢ Protect the client's identity and personal information as reasonably possible.

REFERENCES:

Canadian Nurses Association (2007). *Telehealth: The role of the nurse.* Ottawa, ON.

Canadian Nurses Protective Society (2008). *Info Law a Legal Information Sheet for Nurses: Telephone advice.* Ottawa, ON.

College of Nurses of Ontario (2009). *Telephone Practice Guideline*. Toronto, ON

Wilson, B. (2003). Telephone Advice. *Nursing BC, June, 27-28.*

Appendix B: Pediatric Telephone Triage Form

See separate document – note this form must be printed double sided

Appendix C: Adult Telephone Triage Form

See Separate document – note this form must be printed double sided

Department of Health Government of Nunavut Policy 07-030-00	**TITLE** **PEDIATRIC TELEPHONE TRIAGE FORM** **12 months to 12 years of age**

Infants 12 mths or younger TO BE SEEN AT THE HEALTH CENTRE - Use Infant *Telephone Triage Form*

Name of Caller:	**Date**:	**Time**:	**Phone**:
Name of Patient:	**Gender:** M / F	**Age / DOB**:	
Relationship of caller to patient:		**Location of caller:**	
Chief Complaint:			
Known Health Condition(s):			

FEVER:	No Concern ☐		**TRAUMA :**	No Concern ☐	
Temperature (if known): Feels hot ☐			Precipitating event?		
When did fever start?			Time occurred?		
Tylenol ☐ or Advil ☐ given?	**Y**	**N**	Bleeding?	**Y**	**N**
When? How much?			Bruising?	**Y**	**N**
Did it take the fever away?	**Y**	**N**	Swelling?	**Y**	**N**
Seizure activity?	**Y**	**N**	Movement?	**Y**	**N**
Hx of seizures?	**Y**	**N**	Weight Bearing?	**Y**	**N**
Immunization in last 24 hours?	**Y**	**N**	Pain? Intensity of Pain (1-10 Scale):	**Y**	**N**
On antibiotics or just finished? Reason:	**Y**	**N**	Location: Localized ☐ or Referred ☐		
RESPIRATORY :	No Concern ☐		**SKIN/MSK:**	No Concern ☐	
How is their breathing? Normal ☐ Fast ☐ Difficult ☐			Burn ☐ or Laceration ☐ Location:		
Cough?	**Y**	**N**	Rash? Location:	**Y**	**N**
Is it worsening?	**Y**	**N**	Known food related?	**Y**	**N**
Noisy Breathing?	**Y**	**N**	Known Medication related?	**Y**	**N**
Is it worsening?	**Y**	**N**	Itchy?	**Y**	**N**
Any blue colour around lips, hands or feet now?	**Y**	**N**	Colour Change?	**Y**	**N**
Any blue colour around lips, hands or feet before? How many times?	**Y**	**N**	Area warm to touch?	**Y**	**N**
Using belly muscles while trying to breath?	**Y**	**N**	Sensation changes?	**Y**	**N**
Head moving up & down when trying to breath?	**Y**	**N**	Changes to movement?	**Y**	**N**
Nostrils moving in & out when trying to breath?	**Y**	**N**	**GU:**	No Concern ☐	
Activity level:			Burning / Pain with voiding?	**Y**	**N**
Are they able to eat and drink as usual?	**Y**	**N**	Urgency?	**Y**	**N**
# wet diapers today? or # times voided today?			Odour?	**Y**	**N**
Foreign body?	**Y**	**N**	Fever?	**Y**	**N**
Ingested toxin?	**Y**	**N**	# wet diapers? # times voided?		
GI:	No Concern ☐		**NEURO :**	No Concern ☐	
Vomiting? # times in 24 hrs:	**Y**	**N**	Level of Consciousness: Alert ☐ Altered ☐		
Diarrhea? # times in 24 hrs:	**Y**	**N**	Stiff neck?	**Y**	**N**
Pain? Where:	**Y**	**N**	Headache?	**Y**	**N**
Eating / drinking? Usual for child ☐ Less ☐ More ☐			Vomiting? # of times today?	**Y**	**N**
# wet diapers today? or # times voided today?			Child seems floppy?	**Y**	**N**
Foreign body?	**Y**	**N**	Seizures?	**Y**	**N**
Ingested toxin?	**Y**	**N**	History of Seizures?	**Y**	**N**

***** ASSESSMENT CONTINUES ON BACK PAGE *****

Name of Patient:	**Age / DOB**:

Mental Health:					No Concern ☐
Current thoughts of self-harm/ suicide?	**Y**	**N**	Current thoughts of harming another person?	**Y**	**N**
Past thoughts of self-harm / suicide?	**Y**	**N**	Past thoughts of harming another person?	**Y**	**N**
Prior Suicide attempts?	**Y**	**N**	Recent trauma exposure?	**Y**	**N**
Substance use / abuse? Current ☐ Past ☐	**Y**	**N**	Victim of violence / abuse?	**Y**	**N**
School concerns?	**Y**	**N**	Any recent losses?	**Y**	**N**
Ever accessed mental health services?	**Y**	**N**	☐ Family services or ☐ law enforcement involvement?	**Y**	**N**

ASSESSMENT : (0-1hour) _____ Urgent (1-4 hours) _____ Non-urgent _____

Complete the next two sections if the patient is not being seen immediately at the health centre and advice is being provided

PRELIMINARY DIFFERENTIAL DIAGNOSES:

Intervention(s) and Advice Given:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Follow up Plan:

Caller advised to: Come to Clinic: Now ☐ next 4 HRS ☐ Time: _____ in AM ☐ Date / time:_____

(**Refer to *Pediatric and Adult Triage Policy* for list of all clients that must be assessed in clinic within 1-4 hours of the call)**

Additional details:

_____
_____
_____
_____
_____

Other Comments:_____
_____

CALLER'S RESPONSE TO PLAN:

☐ caller agreeable ☐ caller refused (provide additional details if refused)

Signature of CHN _____ Print Name _____ Date_____ Time _____

COMPLETED FORM MUST be PLACED in Patient's Health Record

Department of Health Government of Nunavut Policy 07-030-00	**TITLE** **ADULT TELEPHONE TRIAGE FORM** **Age 12 years and older**

Name of Caller:	**Date**:	**Time**:	**Phone**:
Name of Patient:	**Gender:** M / F	**Age / DOB**:	
Relationship of caller to patient:		**Location of caller:**	
Chief Complaint:			

History of Presenting Illness:

Onset and Duration of the Event: (When did it start? How long has this condition lasted? What was pt doing when it started?)

Severity / Character: (How bothersome is this problem? Does it interfere with daily activities or keep pt up at night? Pt description of symptoms– use pain scale when appropriate)

Is it similar to a past problem? ☐ Y ☐ N If so, what was done at that time?

Location/Radiation: (Is the symptom (e.g. pain) located in a specific place or radiate? Has this changed over time?)

Treatment to Date: (Has pt tried any therapeutic maneuvers? Did it make it better or worse?)

Pace of illness: (Is the problem getting better, worse, or staying the same? How quickly or slowly has it been changing?)

Are there any associated symptoms? (Has the pt noticed other symptoms around the same time as the dominant complaint?)

What does the pt think the problem is and/or what he/she is worried it might be?

Why today? (When the cc that has been long standing -Is there something new/different today compared to previous days when present?)

Mental Health: No Concern ☐

Current thoughts of self-harm/ suicide?	**Y**	**N**	Current thoughts of harming another person?	**Y**	**N**
Past thoughts of self-harm / suicide?	**Y**	**N**	Past thoughts of harming another person?	**Y**	**N**
Prior Suicide attempts?	**Y**	**N**	Recent trauma exposure?	**Y**	**N**
Substance use / abuse? Current ☐ Past ☐	**Y**	**N**	Victim of violence / abuse?	**Y**	**N**
☐ School concerns? Or ☐ Job Loss?	**Y**	**N**	Any recent losses?	**Y**	**N**
Homelessness	**Y**	**N**	☐ Family services or ☐ law enforcement involvement?	**Y**	**N**
Ever access mental health services?	**Y**	**N**	Other:		

Current Medications:

Allergy status: ☐ NKDA ☐ Known (specify):

***** ASSESSMENT CONTINUES ON BACK PAGE *****

Name of Patient:	**Age / DOB**:

Relevant Past Medical / Surgical History:

LMP: ☐ N/A ☐ Date: ☐ Post menopausal ☐ Not known ☐ Pregnancy previously confirmed

The following clients are to be seen in the health centre immediately or within 4 hours of the call
(based on the urgency of the presenting symptoms from the telephone triage)

☐ Condition is determined to: ☐ Require resuscitation ☐ Be emergent ☐ Be urgent	☐ ≥ Age 65
☐ Complex medical condition(s)	☐ In RCMP Custody
☐ Pregnant	☐ ≤ Two (2) weeks postpartum
☐ Discharged in the last 48 hour from a hospital or care facility	☐ Had a surgical procedure under general anaesthetic within the previous ten (10) days
☐ Had an endoscopic procedure (gastroscopy or colonoscopy) within the previous three (3) days	☐ Multiple visits or multiple calls to the Health Centre in previous seventy-two (72) hours with the same presenting complaint(s)

Complete the next two sections if the patient is not being seen immediately at the health centre and advice is being provided

PRELIMINARY DIFFERENTIAL DIAGNOSES:

Intervention(s) and Advice Given:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Follow up Plan:

Caller advised to: Come to Clinic: Now ☐ next 4 HRS ☐ Time: _____ in AM ☐ Date / time:_____

Additional details:

_____
_____
_____
_____

Other Comments:_____
_____

CALLER'S RESPONSE TO PLAN:

☐ caller agreeable ☐ caller refused (provide additional details if refused)

Signature of CHN _____ Print Name _____ Date_____ Time _____

COMPLETED FORM MUST be PLACED in Patient's Health Record

Department of Health Government of Nunavut	Medical Directives and Delegation Community Health Nursing	

TITLE:		SECTION:	POLICY NUMBER:
CHN Expanded Role: Diagnosing, initiating lab and x-ray tests and initiating drug treatment		Nursing Practice	07-031-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
July 2018	July 2020		5
APPLIES TO:			
Community Health Nurses			

1. **BACKGROUND:**

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

Community Health Nurses (CHN) are registered nurses who work in an expanded role through the execution of advanced nursing skills and medical directives to assess, diagnose, plan, initiate and evaluate care. This policy provides an authorizing mechanism in which CHNs may perform duties which are sanctioned to another regulated health care professional, examples which includes but is not limited to (e.g. physician, nurse practitioner, and pharmacist) without a direct order from that health care professional.

2. **MEDICAL DIRECTIVE:**

2.1 CHNs may (1) formulate and communicate medical diagnoses; (2) initiate lab and x-ray tests; and/or (3) perform delegated clinical procedures without a direct physician or nurse practitioner (NP) order as directed by one of the following resources:

a) The First Nations and Inuit Health Branch (FNIHB) *Clinical Practice Guidelines for Nurses in Primary Care – Adult Care*;

b) The FNIHB *Clinical Practice Guidelines for Nurses in Primary Care - Pediatric and Adolescent Care;*

c) Nunavut Prenatal Record and Guidelines for Completing Prenatal Record; or

d) Government of Nunavut (GN) Public Health Directive or Protocol issued by the office of the Chief Medical Officer of Health (CMOH);

e) GN Chronic Disease Management Protocols;

f) CHN Initiated X-Ray Medical Directive (Policy # 08-19-00)

g) Other GN approved policies, procedures, screening and management protocols and medical directives.

2.2 CHNs may initiate drug therapy without a direct physician or NP order in accordance with the Nunavut Formulary.

3. **LEGISLATIVE AND REGULATORY SUPPORTING DOCUMENTS:**
   - 3.1 Nursing act
   - 3.2 RNANTNU Standards of practice
   - 3.3 RNANTNU Scope of practice document
   - 3.4 CNA code of ethics
   - 3.5 Medical professions act

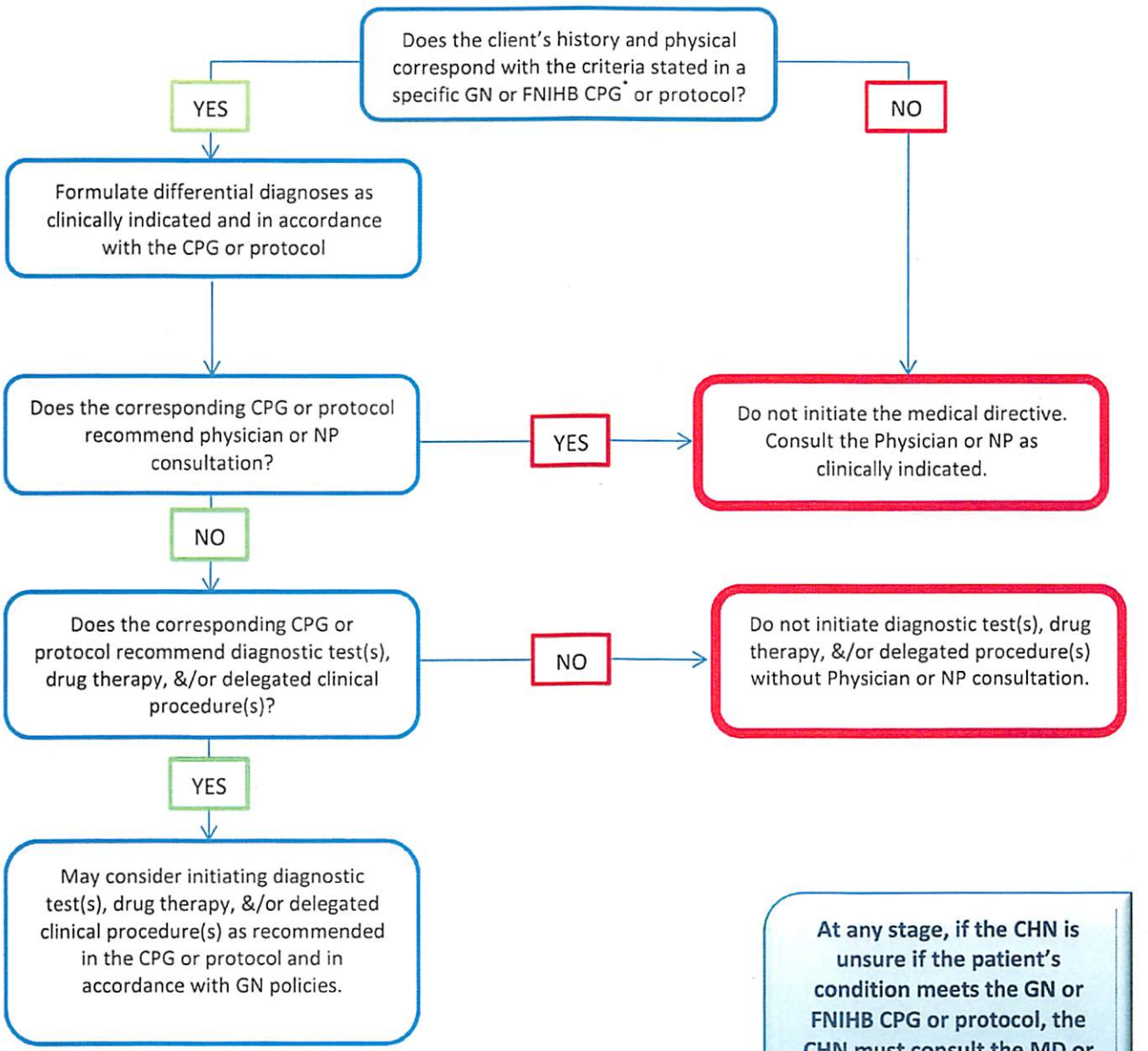
4. **AUTHORIZED IMPLEMENTERS:**
   - 4.1 CHN and Supervisor of Community Health Program who possess the knowledge, skill and judgment to do so. The CHN is required to demonstrate competency to implement this medical directive through the standard orientation process.
   - 4.2 Sub delegation is not permitted to another health care professional.

5. **PRINCIPLES:**
   - 5.1 CHNs are expected to practice within their own level of competence and seek guidance from their supervisor, physician or NP as needed. Decision making model is included in Appendix A to assist with the decision to perform additional skills and delegated functions.
   - 5.2 Guidelines do not replace clinical judgement. Management decisions must be individualized.

6. **CONTRAINDICATIONS:**
   Consult the physician or NP before enacting this medical directive when any of the following conditions exist:
   - 6.1 The CHN cannot confirm all conditions of this directive have been met.
   - 6.2 The patient's history or physical exam does not match the criteria set forth in a corresponding GN or FNIHB clinical practice guideline, policy, protocol or directive.
   - 6.3 The GN or FNIHB guideline, policy, protocol or directive recommends physician or NP consultation first.

7. **PROCEDURE:**
   - 7.1 The CHN references one of the resources stated in policy statement 2.1 and 2.2 to determine if the conditions of this directive have been met. The Algorithm in Figure 1 provides guidance to the CHN when determining if the medical directive is appropriate to enact.
   - 7.2 If the CHN determines that the conditions have not been met, then the physician or NP shall be consulted.
   - 7.3 The patient encounter is to be documented according to GN and RNATNU documentation standards.

FIGURE 1: Algorithm for Assessing Appropriateness of the Medical Directive



* CPG = Clinical Practice Guideline

8. RELATED POLICIES, PROTOCOLS AND LEGISLATION:

APPENDIX A: Decision-Making Model for Performing Additional Functions and Transferred Functions

Community Health Nursing Manual: CHN Initiated X-Ray Request Policy
Community Health Nursing Manual: Documentation Standards Policy
Community Health Nursing Manual: Transferred Functions Policy
Community Health Nursing Manual: Nursing Practice- Additional Nursing Functions
Community Health Nursing Manual: Transferred Functions
FNIHB Clinical Practice Guidelines for Nurses in Primary Care.
FNIHB Pediatric Clinical Practice Guidelines
Government of Nunavut Chronic Disease Management Protocols
Government of Nunavut Tb Manual
Nunavut Formulary

9. REFERENCES:

Health Canada (2011). *First Nations and Inuit Health Branch Clinical Practice Guidelines for Nurses in Primary Care – Adult Care*

Health Canada (2011). *First Nations and Inuit Health Branch Clinical Practice Guidelines for Nurses in Primary Care – Pediatric and Adolescent Care*

Government of Nunavut (2010). *Community Health Nursing Standards, Policies and Guidelines*

Government of Nunavut. *Tuberculosis Manual*.

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

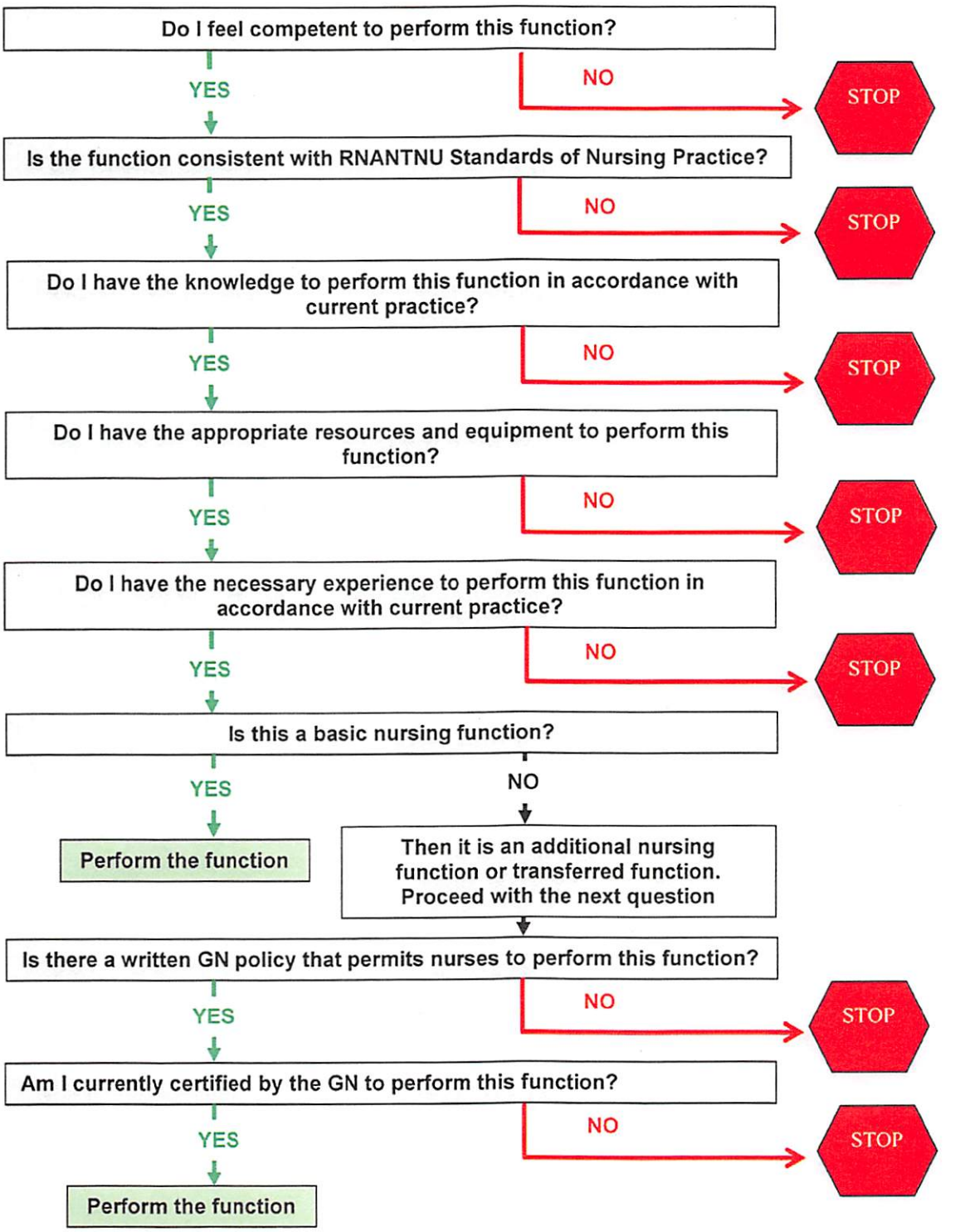
Registered Nurses Association of Northwest Territories and Nunavut (2010). *Scope of Practice for Registered Nurses*. Yellowknife: RNANTNU

Registered Nurses Association of Northwest Territories and Nunavut (2014). *Standards for the Practice of Registered Nurses and Nurse Practitioners*. Yellowknife: RNANTNU

10. APPROVALS:

Approved By: Colleen Stockley	Date: Aug 9/18
Colleen Stockley, Deputy Minister – Department of Health	
Approved By:	Date: August 08/ 2018
Jennifer Berry, Chief Nursing Officer	
Approved By:	Date: Aug. 9/ 18
Dr. Alison McCallum, Medical Chief of Staff, on behalf of the Medical Advisory Committee	

APPENDIX A: DECISION-MAKING MODEL FOR PERFORMING ADDITIONAL FUNCTIONS AND TRANSFERRED FUNCTIONS



RNANT/NU (2010). *Scope of Practice for Registered Nurses*, p. 9

Department of Health Government of Nunavut		Medical Directives and Delegation Public Health Nursing	
TITLE:		**SECTION:**	**POLICY NUMBER:**
Testing, diagnosing, and treating syphilis infections for public health nurses and community health nurses		Nursing Practice	07-032-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
October 1, 2018	October 2020		9
APPLIES TO:			
Public Health Nurses and Community Health Nurses who have completed training as specified in the directive			

1. **BACKGROUND:**

The rates of sexually transmitted infections (including chlamydia, gonorrhea, and syphilis) in Nunavut are higher than the rest of Canada. In particular, the territory has been experiencing a syphilis outbreak since 2012. Prior to that time there were 0-5 cases per year; from 2012 to 2017 there have been approximately 30-120 cases per year.

Public Health Nurses (PHN) and Community Health Nurses (CHN) in the territory can help to decrease the risk of transmission and possible complications of syphilis by supporting prompt diagnosis and treatment of syphilis.

PHNs and CHNs are expected to practice within their own level of competence and consult with their supervisor, a nurse practitioner (NP), or a physician as required. Interviewing cases and contacts and completing a physical assessment are within the RN scope of practice. Drawing blood is also within the RN scope of practice provided the nurse has acquired the appropriate competencies. Diagnosis and treatment are not within the RN regulated scope of practice and therefore, RNs require additional training and a medical directive to perform these functions.

2. **MEDICAL DIRECTIVE AND/OR DELEGATED PROCEDURE:**

This medical directive includes testing (2.1), diagnosing (2.2.), and treating (2.3). Please note that this directive is intended to be used by only a few nurses, with appropriate training and assessment as per this directive, in communities where there is ongoing transmission of syphilis.

Please see Section 6.4.1 Syphilis in the Nunavut Communicable Disease Manual for detailed clinical information.

2.1 **TESTING**: Public Health Nurses (PHN) and Community Health Nurses (CHNs) may order a blood test for syphilis for patients presenting to the clinic without a direct Physician or Nurse Practitioner (NP) order when any of the following conditions in Table 1 are met. In addition to the blood test, they may also collect a swab if clinically indicated; note, there is not darkfield microscopy in the territory but PCR testing may be possible through the National Microbiology Laboratory (NML).

2.1.1 The PHN or CHN may order bloodwork for syphilis, HIV and Hepatitis B without a physician or NP order when testing for *Chlamydia trachomatis* or *Neisseria gonorrhea*, as per recommendations from the *Canadian Guidelines on Sexually Transmitted Infections*.

Table 1: Inclusion Criteria for ordering blood test for syphilis

Syphilis
Female or Male
Lesion (chancre) or rash consistent with syphilis
Generalized symptoms or findings consistent with secondary or tertiary syphilis
Sexual contact with a person with known infection or compatible syndrome
Anyone diagnosed with gonorrhea or chlamydia
Patient self identifies at least 1 risk factor for STIs as outlined in the Government of Nunavut Communicable Disease Manual (GN CD Manual)
Patient request
As part of prenatal screening
Follow-up of individual previously diagnosed with syphilis

Nunavut Communicable Disease Manual, 2013

PRACTICE NOTE: If the patient reports any of the following, consult the MD or NP:

Female: Lower abdominal pain
Abnormal vaginal bleeding
Neurologic findings
Findings consistent with non-primary syphilis
Suspected sexual assault

Male: Testicular or epididymal pain
Neurologic findings
Findings consistent with non-primary syphilis (see Table 2 for more details)
Suspected sexual assault

2.2 **DIAGNOSIS**: PHN or CHN with appropriate training may communicate a diagnosis of syphilis infection or a negative result to the patient when a blood or microscopy test is done for *Treponema pallidum* (syphilis). This can only be done when the PHN or CHN has completed appropriate training as per this directive as the interpretation of syphilis serology and test results is complicated and depends on past exposure and treatment.

Table 2: Clinical manifestations of syphilis based on stage of infection

Syphilis		
Stage	**Incubation period**	**Clinical manifestations**
Primary	3 weeks (3 to 90 days)	Chancre, regional lymphadenopathy
Secondary	2 to 12 weeks (2 weeks to 6 months)	Rash, fever, malaise, lymphadenopathy, mucus lesions, condyloma lata, patchy or diffuse alopecia, meningitis, headaches, uveitis, retinitis
Latent	Early: < 1 year Late: ≥ 1 year	Asymptomatic
Tertiary:		
Cardiovascular syphilis	10 to 30 years	Aortic aneurysm, aortic regurgitation, coronary artery ostial stenosis
Neurosyphilis	<2 years to 20 years	Ranges from asymptomatic to symptomatic with headaches, vertigo, personality changes, dementia, ataxia, presence of Argyll Robertson pupil
Gumma	1 - 46 years (most cases 15 years)	Tissue destruction of any organ; manifestations depend on site involved
Congenital:		

Early	Onset <2 years	2/3 may be asymptomatic; fulminant disseminated infection, mucocutaneous lesions, osteochondritis, anemia, hepatosplenomegaly, neurosyphilis
Late	Persistence >2 years after birth	Interstitial keratitis, lymphadenopathy, hepatosplenomegaly, bone involvement, anemia, Hutchinson's teeth, neurosyphilis

2.3 **TREATMENT**: PHN and CHN may initiate and dispense drug treatment for syphilis without a direct physician or NP order when any of the following conditions in Table 3 apply. The physician or NP must be consulted prior to treatment for all children 16 years of age and younger, all pregnant individuals, and if penicillin-allergic.

Table 3: Inclusion Criteria for Initiating Drug Therapy

Treponema pallidum (syphilis)
A test is positive for syphilis infection as outlined in the diagnostic section of 6.4.1 Syphilis protocol in the Communicable Disease Manual.
Patient reports syndrome compatible with a syphilis infection (without waiting for test results) as outlined in Table 2 of this directive.
Diagnosis of syphilis infection in a sexual partner
Practice Note: Diagnosis of a syndrome according to standard criteria predicts the likelihood that a specific pathogen is present, leading to empiric treatment at the first visit rather than deferring treatment until there is microbiological confirmation (*Canadian Guidelines on Sexually Transmitted Infections,* 2006). The syndromic approach helps in controlling transmission and negative sequelae, particularly in a territory that has variable access to lab testing and variable rates of follow up.

3. Recipient Patients:

3.1 All male and female patients older than 16 years of age may receive counseling, testing, and treatment. The physician or NP must be consulted prior to treatment for all children 16 years of age and younger, all pregnant individuals, and if penicillin-allergic.

4. Authorized Implementers:

4.1 In order to enact this medical directive, the PHN or CHN is required to complete additional training in sexually transmitted infections including syphilis which has been approved by the Chief Medical Officer of Health (CMOH). Current authorized training includes: (1) training at a clinic (e.g. Edmonton, Ottawa, or as determined by CMOH) and (2) review the relevant chapters in the Nunavut Communicable Disease Manual and *the Canadian Guidelines on Sexually Transmitted Infections*. Completion of training will be tracked by the territorial Communicable Disease Consultant. The training will need to be re-certified every 5 years. The office of the CMOH will keep a written list of all those who are authorized implementers and each addition to the list will need to be signed off by the CMOH or DCMOH. In addition, periodic case audits and reviews may be conducted. Individuals using this directive are expected to review any questions with the Regional Communicable Disease Coordinators, and, where necessary, the territorial syphilis consultant.

4.2 See Appendix A for a decision-making flow chart to assist staff in deciding if they have the knowledge, skills, and ability to enact the directive.

4.3 Sub delegation is not permitted to another regulated or non-regulated health care professional who (1) are not listed in the directive/ delegation policy and (2) are not authorized to perform that procedure through other authorizing mechanisms like departmental policies, professional regulation acts and associations.

5. INDICATIONS AND CONTRAINDICATIONS:

The physician or NP must be consulted when any of these conditions exist:

5.1 **GENERAL:**

- 5.1.1 The patient's history or exam findings do not match the criteria stated in this directive
- 5.1.2 The patient reports neurological symptoms or symptoms consistent with secondary or tertiary syphilis as outlined in table 2.

5.2 **TREATMENT** - Specific:

- 5.2.1 The patient is younger than 16 years of age.
- 5.2.2 Patient has a contraindication (to the preferred treatment) as stated in the product monograph or CPS.
- 5.2.3 The nurse is unsure or uncomfortable about providing treatment.
- 5.2.4 The patient is pregnant.
- 5.2.5 The patient is penicillin-allergic.

6. PROCEDURE:

6.1 Prior to implementation of this directive, a patient assessment must be conducted. At minimum, assess: for fever, risk assessment (as outlined in the *Canadian Guidelines on Sexually Transmitted Infections*), history of presenting illness, medical /menstrual / breast feeding and social history, allergy status, current medications, previous STI test results, contact history, and immunization status. For any patient reporting sexual abuse, consult with MD/NP without delay and consider referral to mental health and victim services.

6.2 **TESTING**:

- 6.2.1 When the patient meets the conditions stated in medical directive statement 2.1, the PHN or CHN may order a blood test for syphilis
- 6.2.2 In addition to ordering bloodwork for syphilis, the nurse should consider ordering urine for chlamydia and gonorrhea and bloodwork Hepatitis B and HIV screening, as per *Canadian Guidelines on Sexually Transmitted Infections*.
- 6.2.3 Obtain verbal consent prior to collecting a specimen and initiating drug treatment – ensure the patient understands the mandatory reporting and contact tracing requirements associated with positive results.
- 6.2.4 The specimen is to be collected, labelled, handled, and transported as per relevant GN laboratory and Meditech policy and procedures.
    - Requisitioning through Medi-tech: Enter the PHN or CHN's Personal Identification Number in the signature line and enter the Medical Directive Number, and the PHN or CHN's full name with designation in the Comments field of the requisition module.

- Requisitioning on hard copies of the lab form: Enter the Medical Directive Number and the PHN/CHN's signature on the form.

6.2.5 The PHN/CHN is responsible and accountable for reviewing and following up on lab results once available. Every attempt shall be made to promptly notify the patient of the results once available and if the patient is lost to follow-up and had a positive test result, attempt follow-up by phone at least three times and by mail at least once.

- When HIV and Hepatitis B screening serology was ordered as part of this medical directive, all positive results must be referred to an physician or NP.
- If the PHN or CHN is unsure of the interpretation of any lab result, the regional Communicable Disease Consultant should be consulted.

6.2.6 The PHN/CHN is not authorized, through this medical directive, to assess, diagnose and treat HIV or Hepatitis B and thus physician or NP referral is required upon receipt of positive laboratory results. Consultation with the physician or NP should follow usual consultation practices already established locally.

6.2.7 When a positive syphilis test result is reported, the PHN/CHN will complete and submit the GN *Syphilis Report Form*, conduct case management and contact tracing in compliance with the CMOH-directed protocol in the CD manual and submit the *STI Contact Investigation Form* to the regional Communicable Disease Consultant within one week of diagnosis.

6.2.8 For children 16 years and younger, the physician or NP must be consulted, as there may be additional assessments, swabs and referrals required. NOTE: Mandatory reporting protocols are to be enacted when child abuse is suspected. Refer to *Appendix B: Age of Consent to Sexual Activity*.

6.3 **TREATMENT:**

PRACTICE POINT: For children whereby sexual abuse is suspected, a physician or NP must be consulted prior to initiating drug treatment.

6.3.1 When the patient meets the conditions stated in medical directive statement 2.3, the PHN or CHN may Initiate treatment as outlined in the Syphilis Protocol in section 6.4.1 of the Nunavut Communicable Disease Manual and provide patient information about the potential adverse effects of the prescribed treatment.

6.3.2 Any adverse events will be documented and reported to the physician or NP.

6.4 **COUNSELING:**

6.4.1 The PHN or CHN will provide health counselling information as outlined in the Nunavut Communicable Disease Manual.

6.4.2 Provide information about the conditions in which the patient should seek follow up medical care; and when to return for follow-up syphilis serology.

6.4.3 Offer the Hepatitis B vaccine, if eligible under the GN immunization schedule.

7. DOCUMENTATION:

7.1 The nurse is to document in accordance with RNANT/NU and GN documentation standards. At minimum, the following is to be documented:

7.1.1 The patient assessment findings and care plan;

7.1.2 The specific laboratory test(s), date and time ordered;

7.1.3 Medication treatment initiated and administered (include name of medication, dose, route, time of administration, and amount dispensed)

7.1.4 Patient counselling topics;

7.1.5 All other interventions conducted (including referrals and procedures); and

7.1.6 The Medical Directive Number.

7.2 For lab and other diagnostic test requisitions, the implementer must document the name and number of the directive on the requisition form, as well as the implementer's name as ordering provider.

8. Quality Monitoring:

8.1 Any staff that identifies unintended outcomes arising from implementation of this directive or needs clarification of this directive, are responsible to discuss with their supervisor.

8.2 The Department of Health will maintain a list of authorized implementers and may perform random audits.

9. Related Policies, Protocols and Legislation:

Nunavut Communicable Disease Manual. Chapter 6.4.1 Syphilis.

APPENDICES

Appendix A: Decision-Making Model for Performing Additional Functions and Transferred Functions

Appendix B: For more information on clinical guidance, please see Chapter 6.4.1 Syphilis in the Nunavut Communicable Disease Manual.

DOCUMENTS

- Government of Nunavut (2013). Nunavut Communicable Disease Manual. Chapters: 6.4.1 Syphilis; 6.2.1 Chlamydia; and 6.3.1 Gonorrhea. Available at: https://www.gov.nu.ca/health/information/manuals-guidelines.
- Nunavut Drug Formulary
- GN Community Health Nursing Administration Manual. Policy: Documentation Standards
- GN Community Health Nursing Administration Manual. Policy: Transferred Functions
- GN Community Health Nursing Administration Manual. Policy: Medication Administration – Nursing
- GN Community Health Nursing Administration Manual. Policy: Dispensing Medication
- GN Community Health Nursing Administration Manual. Policy: Laboratory Procedures
- Public Health Agency of Canada (2010). *Canadian Guidelines on Sexually Transmitted Infections* from http://www.phac-aspc.gc.ca/std-mts/sti-its/cgsti-ldcits/index-eng.php#toc
- Health Centre Lab Manual – Regional Specific

10. REFERENCES:

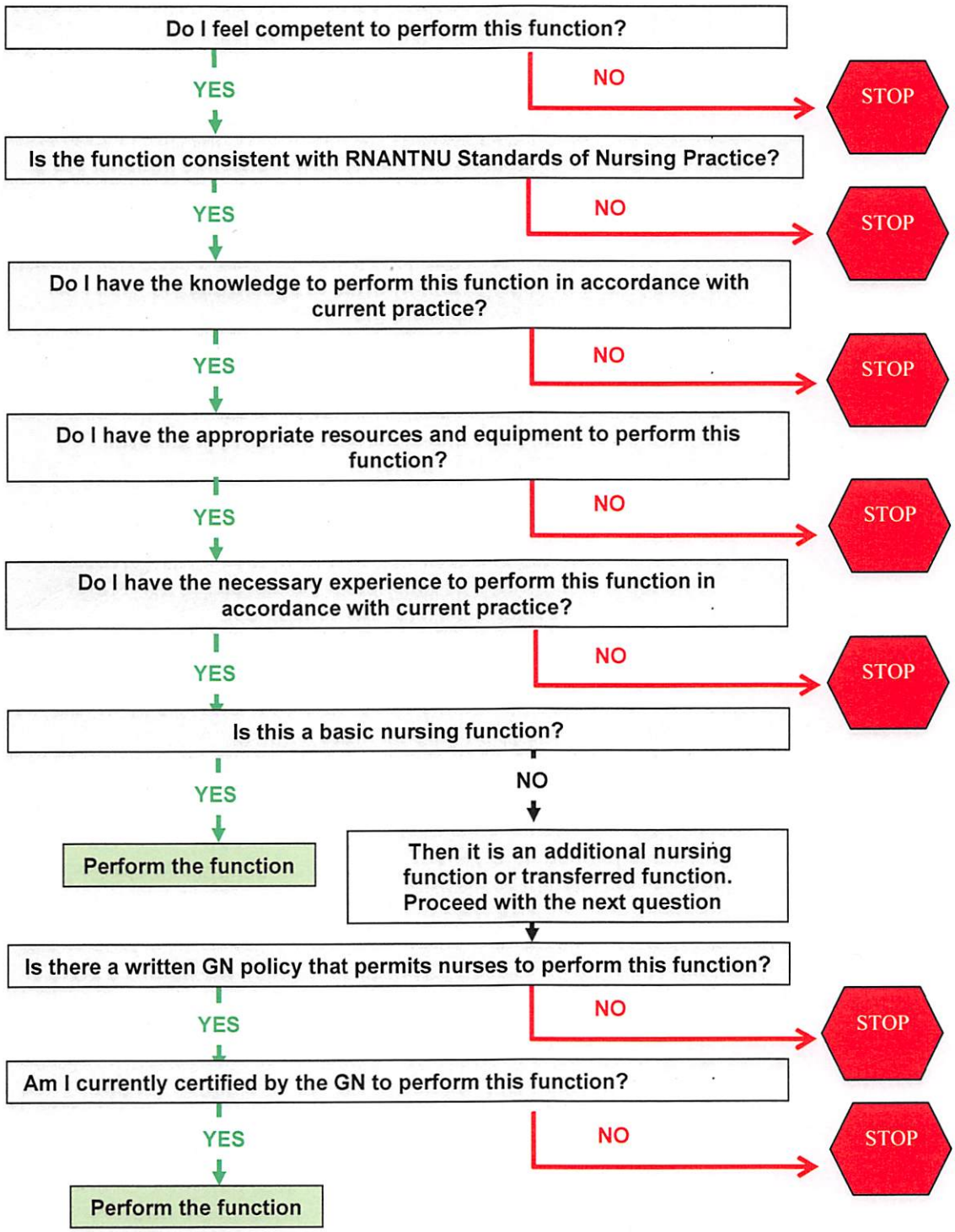
- Government of Nunavut (2013). Nunavut Communicable Disease Manual. Available at: https://www.gov.nu.ca/health/information/manuals-guidelines.
- Government of Nunavut (2010). Community Health Nursing Administration Manual.
- Public Health Agency of Canada (2010). *Canadian Guidelines on Sexually Transmitted Infections*. Available at: http://www.phac-aspc.gc.ca/std-mts/sti-its/cgsti-ldcits/index-eng.php#toc.

11. APPROVALS:

A directive, delegation or procedure may require approval from administrative authorities such as the Medical Advisory Committee.

Approved By:	Date: Nov 30/18
Colleen Stockley, Deputy Minister – Department of Health	
Approved By:	Date: Nov 29, 2018
Jennifer Berry, Chief Nursing Officer	
Approved By:	Date: Dec 3/18
Dr. Michael Patterson, A/Chief Medical Officer of Health	

APPENDIX A: DECISION-MAKING MODEL FOR PERFORMING ADDITIONAL FUNCTIONS AND TRANSFERRED FUNCTIONS



RNANT/NU (2010). *Scope of Practice for Registered Nurses*, p. 9

Appendix B:

For more detailed clinical guidance, please see Chapter 6.4.1 Syphilis protocol in the Nunavut Communicable Disease Manual (last updated in 2018).

It includes a 2-page decision support tool with information on staging, contact tracing, treatment, and follow-up.

Department of Health Government of Nunavut	Medical Directives and Delegation All Health Services	
TITLE:	**SECTION:**	**POLICY NUMBER:**
COVID-19: Nursing Assessment & Advice Protocol	Nursing Practice	07-033-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
March 20, 2020 / March 2023	N/A	
APPLIES TO:		
Registered Nurses and Licensed Practical Nurses		

1. **BACKGROUND:**

COVID-19 is a novel coronavirus that was first detected in Wuhan, China in late 2019. On March 11, 2020, the World Health Organization declared COVID-19 a pandemic. Coronavirus infections are diagnosed through health care professionals in consultation with public health teams and guidance based on symptoms and typically confirmed through laboratory testing. To address the need for urgent public health information, a COVID-19 Telephone Hotline has been developed. The Department of Health *COVID-19 Nursing Assessment & Advice Protocol* is intended to 1) provide standardized health information to the public; and 2) provide an authorizing mechanism for nurses to communicate standardized public health information related to eligibility and direction for COVID-19 screening, self-monitoring, self-isolation, and advice developed through the Chief Public Health Officer.

Guidelines do not replace clinical judgement; management decisions must be individualized. Registered Nurses and Licensed Practical Nurses are expected to practice within their own level of competence and seek guidance as required.

2. **MEDICAL DIRECTIVE AND/OR DELEGATED PROCEDURE:**
   - **2.1 Registered Nurses and Licensed Practical Nurses may determine COVID-19 screening eligibility and coordinate screening for Nunavummiut as outlined in the *COVID-19 Public Health Protocol***
   - **2.2 Registered Nurses and Licensed Practical Nurses may communicate advice related to COVID-19 outlined in the *COVID-19 Pubic Health Protocol***
   - **2.3 Registered Nurses may provide the information and screening listed in 2.1 and 2.2 via telephone interaction.**

3. **DEFINITIONS:**
   - 3.1 *Nurse* refers to registered nurse or licensed practical nurse.
4. **RECIPIENT PATIENTS**
   - 4.1 Nunavummiut of all ages
5. **AUTHORIZED IMPLEMENTERS:**
   - 5.1 Nurses employed by the Department of Health.
   - 5.2 Sub delegation is not permitted to another regulated or non-regulated health care professional who are not listed in this medical directive.
6. **CONTRAINDICATIONS TO THIS MEDICAL DIRECTIVE:**
   - 6.1 Health care workers inquiring about COVID-19 workplace practices must contact the Office of the Chief Public Health Officer (previously referred to as Chief Medical Officer of Health)

directly.

6.2 In the event a client or client caller reports any medical distress, the nurse is required to immediately direct them to seek medical attention in their community and document the advice given.

6.3 For telephone advice, callers not physically located in Nunavut must be advised to contact their local jurisdiction for advice. Registered Nurses' registration provides liability coverage for advice to clients in territory only.

7. **PROTOCOL:**

7.1 Refer to Appendix A for the *COVID-19 Public Health Protocol, including the Persons Under Investigation (PUI) Assessment Form*

8. **DOCUMENTATION:**

8.1 It is the nurse's responsibility to ensure documentation of telephone interaction is recorded in accordance with Department of Health *Documentation Standard*, and completion of the *COVID-19 Persons Under Investigation Assessment Form* including:

i. Date and time of call
ii. Name, telephone number, address of the client
iii. Information received
iv. Advise or information given, guided by the *PUI Assessment Form*
v. Referral and follow-up information
vi. Name and signature of the implementer, including designation
vii. Pertinent information related to call, such as the client's response

9. **RELATED POLICIES, PROTOCOLS AND LEGISLATION:**

Appendix A: COVID-19 Public Health Protocol
CHN Manual Policy: 06-088-00 Documentation Standard

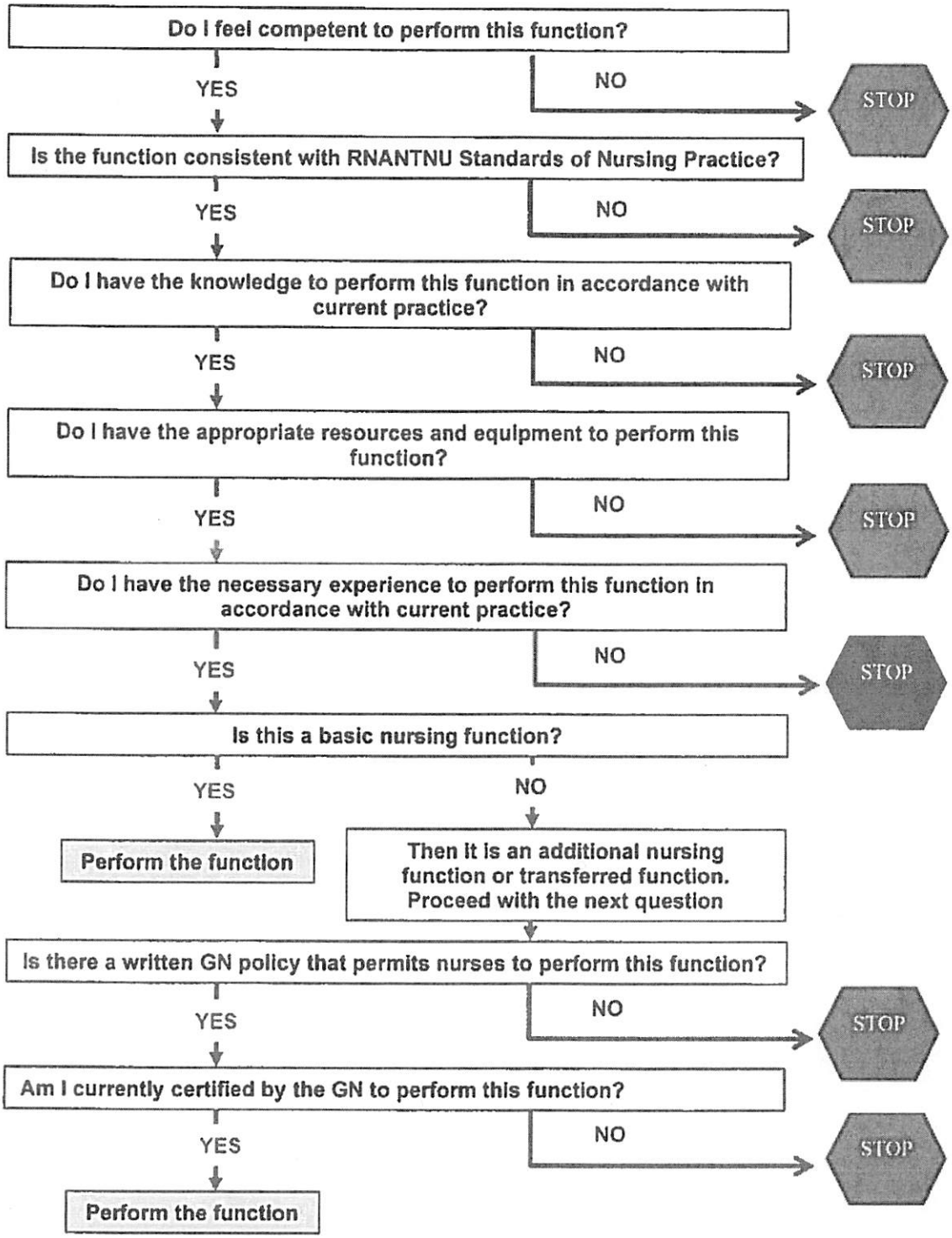
10. **REFERENCES:**

Canadian Nurse's Protective Society. Telephone Advice.
https://www.cnps.ca/index.php?page=111

11. **APPROVAL:**

Approved By: N/A	Date: N/A
Ruby Brown, Deputy Minister – Department of Health	
Approved By: [signature]	Date: March 24/20
Monique Skinner, Chief Nursing Officer	
Approved By: [signature]	Date: March 24/2020
Dr. Michael Patterson, Chief Public Health Officer	

APPENDIX A: DECISION-MAKING MODEL FOR PERFORMING ADDITIONAL FUNCTIONS AND TRANSFERRED FUNCTIONS



RNANT/NU (2010). *Scope of Practice for Registered Nurses*, p. 9

Department of Health Government of Nunavut	**Medical Directives and Delegation** **Community Health Nursing**	
TITLE:	**SECTION:**	**POLICY NUMBER:**
COVID-19 Laboratory Testing Authority	Nursing Practice	07-034-00

EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
March 30, 2020	March 2023		

APPLIES TO:
Nursing

1. BACKGROUND:

COVID-19 is a novel coronavirus that was first detected in Wuhan, China in late 2019. On March 11, 2020, the World Health Organization declared COVID-19 a pandemic. Coronavirus infections are diagnosed through health care professionals in consultation with public health teams and guidance based on symptoms, typically confirmed through laboratory testing. Through policy 07-031-00, Community Health Nurses are delegated the authority to initiate COVID-19 testing. To improve access to care and lower the risk of transmission, delegation to all Registered Nurses is needed. The *COVID-19 Laboratory Testing Authority* is intended to 1) provide an authorizing mechanism for Registered Nurses to initiate laboratory testing for COVID-19; 2) provide standardized public health criteria to guide the nurse in their decision to initiate testing; 3) provide a procedural outline; and 4) provide standardized guidance related to follow-up and mandatory reporting.

2. MEDICAL DIRECTIVE AND/OR DELEGATED PROCEDURE:

2.1 **Registered Nurses are permitted to initiate testing for COVID-19, according to the *COVID-19 Public Health Protocol* and requirements outlined in this medical directive.**

2.2 **Community Health Nurses already possess the delegated authority to initiate testing; however, they must follow the additional requirements outlined in this medical directive.**

3. Principles:

3.1 Nurses are expected to practice within their own level of competence and seek guidance from their supervisor, Physician, or Nurse Practitioner as needed.

3.2 Guidelines do not replace clinical judgement. Management decisions must be individualized.

4. RECIPIENT PATIENTS:

4.1 Nunavummiut of all ages

5. AUTHORIZED IMPLEMENTERS:

5.1 Registered Nurses who possess the knowledge, skills, and abilities to initiate the testing.

5.2 Sub delegation to initiate a test is not permitted to another regulated or non-regulated health care professional who (1) is not listed in the directive/ delegation policy and (2) is not authorized to perform that procedure through other authorizing mechanisms like departmental policies, professional regulation acts and associations.

5.3 Nurses are required to demonstrate competency to implement this medical directive through the standardized orientation process.

6. INDICATIONS AND CONTRAINDICATIONS:

6.1 The medical directive may be enacted when patient's history and symptoms match the testing criteria outlined in the *COVID-19 Public Health Protocol.*

6.2 To assess knowledge, skills, and abilities to enact this medical directive, see *Appendix A Decision-Making Model for Performing Additional Functions and Transferred Functions*

6.3 Nurses may only initiate testing by means of Nasopharyngeal (NP) swab.

6.4 Registered Nurses may not give orders to other nurses (ie. LPNs) to perform testing, as per scope of practice.

6.5 LPNs may receive orders from Nurse Practitioners and Physicians to perform testing.

Practice Point: LPNs may complete the PUI Form and determine eligibility for testing; if orders received from Nurse Practitioner or Physician, they may perform Nasopharyngeal swab.

7. DEFINITIONS:

Nurse: Registered Nurse (RN) or Licensed Practical Nurse (LPN)

8. PROCEDURE:

8.1 The nurse assesses the patient by completing the *Person Under Investigation (PUI) Assessment Form*, outlined in Appendix C of the *COVID-19 Public Health Protocol*

8.2 The nurse determines if COVID-19 testing is indicated through the *COVID-19 Healthcare Provider flowchart,* outlined in Appendix D of the *COVID-19 Public Health Protocol*

8.3 If the client meets testing criteria:

i. the nurse completing the *PUI Assessment Form* (if an LPN) immediately refers the client to a Registered Nurse who possesses the delegated authority to initiate testing for COVID-19, as listed in 2.1; or,

ii. the nurse completing the *PUI Assessment Form* (if an RN) initiates testing

8.4 **The Registered Nurse is required to submit the PUI Assessment Form for all patients to the Regional Communicable Disease Coordinator (RCDC) by email when testing is initiated. Forms for those not tested can be sent in batches at the end of the day directly to cdsurveillance@gov.nu.ca. In the case of computer issues, fax the form AND contact RCDC by phone to ensure receipt of information. The RCDC will in turn, forward the form to the Territorial Communicable Disease Specialist (TCDS) and Communicable Disease Surveillance team (cdsurveillance@gov.nu.ca), to ensure required outbreak management processes can occur.**

8.5 The nurse will explain the procedure to the client and/or family, including any potential adverse outcomes. Obtain verbal consent.

8.6 The nurse collects the specimen, according to the *COVID-19 Public Health Protocol*, listing the name of the person ordering/initiating the test. When collecting specimens, the approved procedural technique and personal protective equipment requirements must be followed.

8.7 The nurse completes all fields on the laboratory requisition (enter in Meditech where available) including, but not limited to:

i. A minimum of 2 patient identifiers.

ii. The name of the clinician initiating/ordering the test, clearly stated as the ordering provider.

iii. Date and time of collection clearly labelled on the specimen and requisition.

iv. Health Centre contact information and initiating/ordering clinician's contact information.

8.8 The Registered Nurse is accountable for providing timely follow-up of test results in accordance with CHN Manual policies *Acknowledgement of Diagnostic Test Results* and *Follow up of Abnormal Diagnostic Test Results*.

8.9 The Registered Nurse maintains a manual list of all tests they have initiated and are responsible for manually tracking test results. The RCDC will additionally be tracking pending investigations but is not the most responsible practitioner. The Registered Nurse initiating the test is the most responsible practitioner.

8.10 Reporting suspicious or confirmed cases of COVID-19 to Public Health is mandatory, see COVID-19 Public Health protocol for reporting requirements.

8.11 In the case that the Registered Nurse's employment ends, the list of investigations initiated must be handed over to the Supervisor of Health Programs and the RCDC to ensure follow-up.

8.12 Health centres, hospitals, screening clinics, or any other health programs are required to manually track COVID-19 specimens if they do not have processes in place to do this through Meditech. This is to ensure specimens are not lost in transit or there are issues that arise with lab processing.

Practice Point: Maintain a manual tracking binder in your facility for COVID-19 laboratory investigations; keep one section for pending requisitions and another section for completed/received results. This will additionally allow for tracking the amount of testing per community.

9. DOCUMENTATION:

9.1 Nurses must follow the *Documentation Standard* policy outlined in the CHN Manual

9.2 At minimum, the following must be document:

i. All related fields within the *COVID-19 Public Health Protocol's, PUI Form*
ii. If patient meets testing criteria, any consultations to initiate and perform the test (NP swab)
iii. Informed consent received from the client and tolerance of the test
iv. Follow-up instructions to the patient
v. Reference to this medical directive
vi. Documentation of communication to RCDC

10. RELATED POLICIES, PROTOCOLS AND LEGISLATION:

APPENDIX A: Decision-Making Model for Performing Additional Functions and Transferred Functions

Appendix B: COVID-19 Public Health Protocol
https://www.gov.nu.ca/sites/default/files/covid-19_public_health_protocol_march_23_2020_1.pdf

CHN Manual Policy: Acknowledgement of Diagnostic Test Results
CHN Manual Policy: Follow up of Abnormal Diagnostic Test Results
CHN Manual Policy: Documentation Standard
https://www.gov.nu.ca/health/information/manuals-guidelines

11. REFERENCES:

Government of Canada. (2020). https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection.html

World Health Organization. Coronavirus disease. https://www.who.int/emergencies/diseases/novel-coronavirus-2019/events-as-they-happen

Department of Health Government of Nunavut	**Medical Directives and Delegation** **Community Health Nursing**	
TITLE:	**SECTION:**	**POLICY NUMBER:**
COVID-19 Laboratory Testing Authority	Nursing Practice	07-034-00

EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
March 30, 2020	March 2023		

APPLIES TO:
Nursing

1. BACKGROUND:

COVID-19 is a novel coronavirus that was first detected in Wuhan, China in late 2019. On March 11, 2020, the World Health Organization declared COVID-19 a pandemic. Coronavirus infections are diagnosed through health care professionals in consultation with public health teams and guidance based on symptoms, typically confirmed through laboratory testing. Through policy 07-031-00, Community Health Nurses are delegated the authority to initiate COVID-19 testing. To improve access to care and lower the risk of transmission, delegation to all Registered Nurses is needed. The *COVID-19 Laboratory Testing Authority* is intended to 1) provide an authorizing mechanism for Registered Nurses to initiate laboratory testing for COVID-19; 2) provide standardized public health criteria to guide the nurse in their decision to initiate testing; 3) provide a procedural outline; and 4) provide standardized guidance related to follow-up and mandatory reporting.

2. MEDICAL DIRECTIVE AND/OR DELEGATED PROCEDURE:

2.1 **Registered Nurses are permitted to initiate testing for COVID-19, according to the *COVID-19 Public Health Protocol* and requirements outlined in this medical directive.**

2.2 **Community Health Nurses already possess the delegated authority to initiate testing; however, they must follow the additional requirements outlined in this medical directive.**

3. Principles:

3.1 Nurses are expected to practice within their own level of competence and seek guidance from their supervisor, Physician, or Nurse Practitioner as needed.

3.2 Guidelines do not replace clinical judgement. Management decisions must be individualized.

4. RECIPIENT PATIENTS:

4.1 Nunavummiut of all ages

5. AUTHORIZED IMPLEMENTERS:

5.1 Registered Nurses who possess the knowledge, skills, and abilities to initiate the testing.

5.2 Sub delegation to initiate a test is not permitted to another regulated or non-regulated health care professional who (1) is not listed in the directive/ delegation policy and (2) is not authorized to perform that procedure through other authorizing mechanisms like departmental policies, professional regulation acts and associations.

5.3 Nurses are required to demonstrate competency to implement this medical directive through the standardized orientation process.

6. INDICATIONS AND CONTRAINDICATIONS:

6.1 The medical directive may be enacted when patient's history and symptoms match the testing criteria outlined in the *COVID-19 Public Health Protocol.*

6.2 To assess knowledge, skills, and abilities to enact this medical directive, see *Appendix A Decision-Making Model for Performing Additional Functions and Transferred Functions*

6.3 Nurses may only initiate testing by means of Nasopharyngeal (NP) swab.

6.4 Registered Nurses may not give orders to other nurses (ie. LPNs) to perform testing, as per scope of practice.

6.5 LPNs may receive orders from Nurse Practitioners and Physicians to perform testing.

Practice Point: LPNs may complete the PUI Form and determine eligibility for testing; if orders received from Nurse Practitioner or Physician, they may perform Nasopharyngeal swab.

7. DEFINITIONS:

Nurse: Registered Nurse (RN) or Licensed Practical Nurse (LPN)

8. PROCEDURE:

8.1 The nurse assesses the patient by completing the *Person Under Investigation (PUI) Assessment Form*, outlined in Appendix C of the *COVID-19 Public Health Protocol*

8.2 The nurse determines if COVID-19 testing is indicated through the *COVID-19 Healthcare Provider flowchart,* outlined in Appendix D of the *COVID-19 Public Health Protocol*

8.3 If the client meets testing criteria:

i. the nurse completing the *PUI Assessment Form* (if an LPN) immediately refers the client to a Registered Nurse who possesses the delegated authority to initiate testing for COVID-19, as listed in 2.1; or,

ii. the nurse completing the *PUI Assessment Form* (if an RN) initiates testing

8.4 **The Registered Nurse is required to submit the PUI Assessment Form for all patients to the Regional Communicable Disease Coordinator (RCDC) by email when testing is initiated. Forms for those not tested can be sent in batches at the end of the day directly to cdsurveillance@gov.nu.ca. In the case of computer issues, fax the form AND contact RCDC by phone to ensure receipt of information. The RCDC will in turn, forward the form to the Territorial Communicable Disease Specialist (TCDS) and Communicable Disease Surveillance team (cdsurveillance@gov.nu.ca), to ensure required outbreak management processes can occur.**

8.5 The nurse will explain the procedure to the client and/or family, including any potential adverse outcomes. Obtain verbal consent.

8.6 The nurse collects the specimen, according to the *COVID-19 Public Health Protocol*, listing the name of the person ordering/initiating the test. When collecting specimens, the approved procedural technique and personal protective equipment requirements must be followed.

8.7 The nurse completes all fields on the laboratory requisition (enter in Meditech where available) including, but not limited to:

i. A minimum of 2 patient identifiers.

ii. The name of the clinician initiating/ordering the test, clearly stated as the ordering provider.

iii. Date and time of collection clearly labelled on the specimen and requisition.

iv. Health Centre contact information and initiating/ordering clinician's contact information.

8.8 The Registered Nurse is accountable for providing timely follow-up of test results in accordance with CHN Manual policies *Acknowledgement of Diagnostic Test Results* and *Follow up of Abnormal Diagnostic Test Results*.

8.9 The Registered Nurse maintains a manual list of all tests they have initiated and are responsible for manually tracking test results. The RCDC will additionally be tracking pending investigations but is not the most responsible practitioner. The Registered Nurse initiating the test is the most responsible practitioner.

8.10 Reporting suspicious or confirmed cases of COVID-19 to Public Health is mandatory, see COVID-19 Public Health protocol for reporting requirements.

8.11 In the case that the Registered Nurse's employment ends, the list of investigations initiated must be handed over to the Supervisor of Health Programs and the RCDC to ensure follow-up.

8.12 Health centres, hospitals, screening clinics, or any other health programs are required to manually track COVID-19 specimens if they do not have processes in place to do this through Meditech. This is to ensure specimens are not lost in transit or there are issues that arise with lab processing.

Practice Point: Maintain a manual tracking binder in your facility for COVID-19 laboratory investigations; keep one section for pending requisitions and another section for completed/received results. This will additionally allow for tracking the amount of testing per community.

9. DOCUMENTATION:

9.1 Nurses must follow the *Documentation Standard* policy outlined in the CHN Manual

9.2 At minimum, the following must be document:

i. All related fields within the *COVID-19 Public Health Protocol's, PUI Form*
ii. If patient meets testing criteria, any consultations to initiate and perform the test (NP swab)
iii. Informed consent received from the client and tolerance of the test
iv. Follow-up instructions to the patient
v. Reference to this medical directive
vi. Documentation of communication to RCDC

10. RELATED POLICIES, PROTOCOLS AND LEGISLATION:

APPENDIX A: Decision-Making Model for Performing Additional Functions and Transferred Functions

Appendix B: COVID-19 Public Health Protocol
https://www.gov.nu.ca/sites/default/files/covid-19_public_health_protocol_march_23_2020_1.pdf

CHN Manual Policy: Acknowledgement of Diagnostic Test Results
CHN Manual Policy: Follow up of Abnormal Diagnostic Test Results
CHN Manual Policy: Documentation Standard
https://www.gov.nu.ca/health/information/manuals-guidelines

11. REFERENCES:

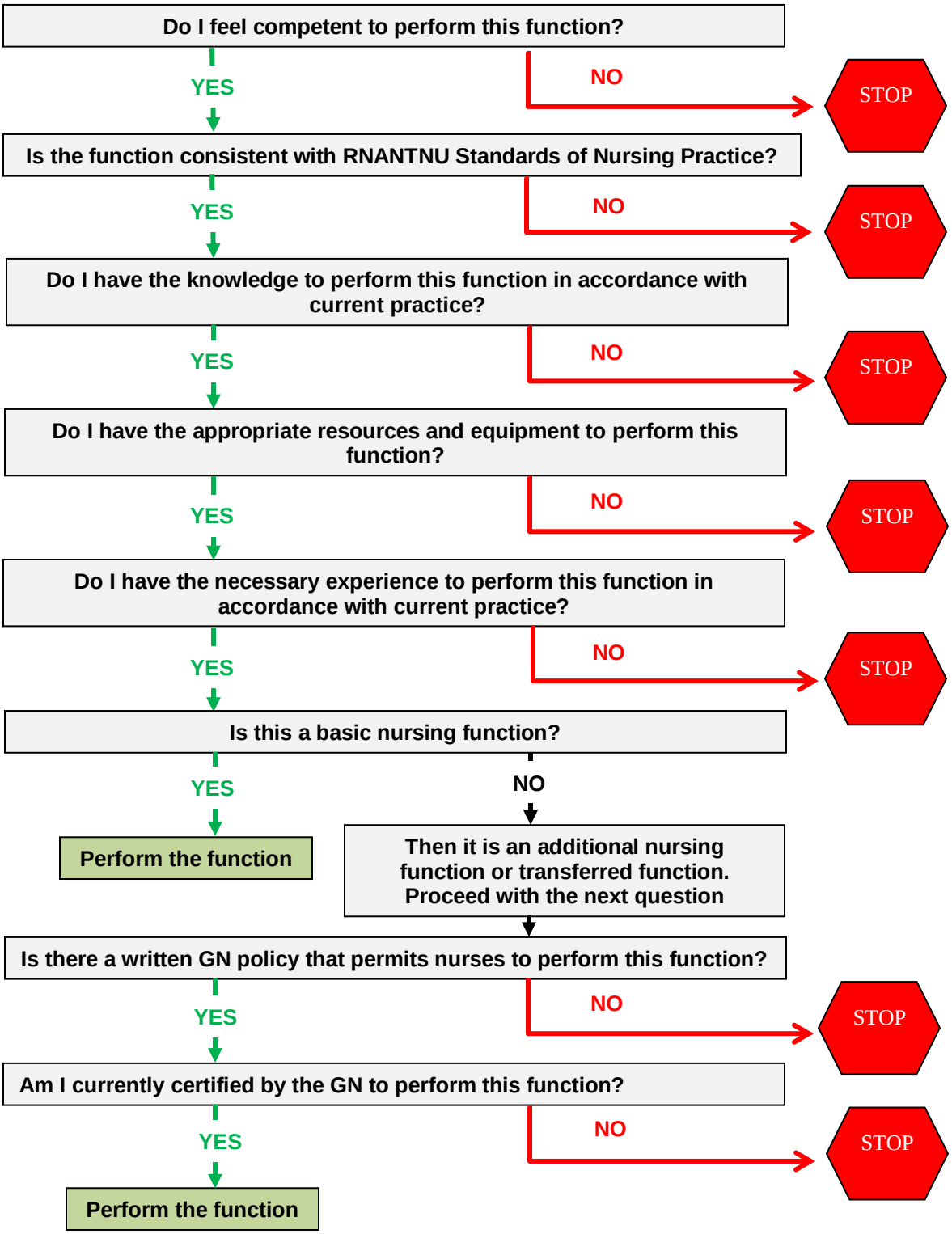
Government of Canada. (2020). https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection.html

World Health Organization. Coronavirus disease. https://www.who.int/emergencies/diseases/novel-coronavirus-2019/events-as-they-happen

12. APPROVALS:

Approved By: M Skinner	Date: April 2/20
Monique Skinner, Chief Nursing Officer	
Approved By:	Date:
Dr. Michael Patterson, Chief Public Health Officer, on behalf of the Medical Advisory Committee	
M Patterson	Date: April 2/20

APPENDIX A: DECISION-MAKING MODEL FOR PERFORMING ADDITIONAL FUNCTIONS AND TRANSFERRED FUNCTIONS



RNANT/NU (2010). *Scope of Practice for Registered Nurses*, p. 9

Coronavirus (COVID-19)

Special Precautions/Considerations

Precautions: Contact/Droplet

Reporting

Notifiable: Yes
Reporting: Immediate (as soon as suspected)

Please note that this is an emerging infection with rapidly evolving information. This is version 5 of the protocol. Information in this protocol was developed as of May 2020. Please update your health centre's communication binder with this version of this protocol and ensure to share new versions with anyone recently starting in a role. Updated versions will be circulated in the future. Although the COVID-19 response is requiring considerable resources at this time, we will also need to continue to be mindful of reporting and control of other communicable diseases (including TB and syphilis).

Infectious Agent	Coronavirus is a large family of viruses, of which 7 strains infect humans. COVID-19 is a novel coronavirus that was first detected in Wuhan, China in late 2019.
Clinical	
Clinical Presentation	COVID-19 is an acute respiratory illness. Symptoms include: • New or worsening Cough • Fever • Shortness of breath (in some cases) Symptoms may be mild or more acute and are similar to other respiratory viruses circulating during the winter months. Less common symptoms may include muscle aches, headache, sore throat, and congestion. Vulnerable populations may include older adults, those with underlying medical conditions (e.g. heart diseases, diabetes, chronic respiratory diseases, cancer), and those with a compromised immune system (e.g. from a medical condition or treatment). Please note that this information continues to evolve as we learn more about the virus and will be updated in future versions of this protocol.
Diagnostics	**Nasopharyngeal swabs** (e.g. flocked swabs, or FLOQSwab™) should be collected while maintaining DROPLET and CONTACT precautions (see Occupational Health section) and sent in Universal Transport Media (UTM) or Viral Transport Media. Other swab types may be used with specific collection guidance as communicated by Public Health Officer guidance (e.g. Aptima). The preferred site for specimen collection is the nasopharyngeal (NP)/deep nares. When NP/deep nares is not possible (e.g. in an infant) a throat swab may be considered. Please contact your RCDC for further information. Follow regional lab guidance related to storage, handling and shipment of lab specimens, as guidance may vary between region, testing facility and product(s) used.

	Work is being done on bringing testing capacity into territory but as of May 12, 2020 the testing flows are as follows: • Kitikmeot Region (health centres ship directly to DynaLife then Alberta Prov Lab in Edmonton) • Kivalliq Region (most (not all) health centres ship directly to Rankin Inlet Lab then National Microbiology Laboratory in Winnipeg) • Qikiqtaaluk Region (health centres ship directly to Iqaluit then Dynacare for furtherance to Hamilton Regional Laboratory Medicine Program). In-territory testing is being developed with some limited, potential availability in Rankin Inlet and Iqaluit at this time. All swabs tested through this process require Public Health Officer approval (please see separate protocol). This process will be in place until further notice (based on testing being validated and stable supply for testing in territory obtained). Even then, tests will continue to be sent to provincial lab partners for validation and confirmation. **Lower respiratory samples** (e.g. bronchoalveolar lavage, endotracheal suction, etc.) should only be collected under the guidance of the Public Health Officer on call. Samples are collected in sterile containers while adhering to AIRBORNE PRECAUTIONS. This is likely to evolve over time and please look for updates to this protocol and memo communications. **Follow guidance from the COVID-19 Healthcare Provider Flowchart (Appendix D) to determine eligibility for testing.** Physicians, Nurse Practioners, and Community Health Nurses may enter the test under current professional standards. All other nurses must refer to the COVID-19 Laboratory Testing Authority Medical Directive (policy #07-034-00). The decision to test may also be communicated by the TCDS or PHO directly. This guidance may be updated as the situation evolves. See Appendix A for NP swab procedure. In general, where feasible and an individual does not require care at a health centre or hospital, the following options are listed in order of preference: - Collecting sample at individual's home or isolated unit (preferred). Refer to Appendix B for guidance. - Collecting sample at a designated location with minimal traffic to the public or vulnerable populations. - Collecting sample within health center or community clinic setting. - Collecting sample in a rapid access clinic (RAC) or emergency department setting. **Serology:** Currently serological tests are being studied but are not available in this context to diagnose COVID-19. IgG and IgM are not routinely recommended, however may be used in the future to consider seroprevalence, population-based understanding, or other purposes under the direction of a PHO.
Treatment	Care is supportive. To date, there is no vaccine against or treatment for COVID-

	19. Research is occurring on developing these. It is possible that some patients will require medevac, which is arranged through the usual regional MD on-call protocols.
Pathogen	
Occurrence	COVID-19 is a novel virus and data on occurrence is continually being updated. For up-to-date information, including current rates of Canadian confirmed cases go to the Public Health Agency of Canada website: https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection.html On March 11, 2020 the World Health Organization declared COVID-19 a pandemic. **As of May 11, 2020, there are no confirmed cases of COVID-19 in Nunavut.**
Reservoir	Human. Possible animal sources of COVID-19 have not yet been confirmed.
Transmission	Most likely person-to-person by droplet spread. As droplets are released or shed from an infected person when they sneeze, cough or talk they can be propelled (generally up to 2 meters) through the air and deposited on the mouth or nose of people within this range. Droplets may also be deposited on objects and spread infection to those touching the surfaces and bringing the virus to their mucous membranes. The amount of time the virus can survive on a surface is unknown. Review infection prevention and control guidance below for both droplet and contact precautions. For aerosol generating procedures (e.g. intubation, bag-mask ventilation, nebulizer treatment), healthcare providers should follow airborne precautions (which includes a properly fitting N95 mask).
Incubation Period	The incubation period is not fully known at this time. The range is 1-14 days, with most common estimate being 5 days.
Communicability	Full information on the communicability of COVID-19 is not clear at this time. Infected individuals are likely most infectious early in the onset of symptoms, with lower infectivity towards the end of symptoms and as recovered. As of April 2020, the estimated period of communicability is 2 days before symptom onset through 10 days after symptom onset. Those with COVID-19 infection **must** remain on isolation until deemed non-infectious by the office of the CPHO. **All probable or confirmed cases require Public Health Officer approval to be removed from isolation.**
Susceptibility and Resistance	Unknown at this time. Given that it is a novel virus, more of the population is considered susceptible to COVID-19 infection, as individuals to not have immunologic memory from previous exposure.

Public Health Management

Testing and Reporting

HCPs should consider COVID-19 infection in those with:

- Fever; AND
- New or worsening cough or shortness of breath;

OR

- Fever; OR
- Cough (new or worsening);
- Shortness of breath (new or worsening);
- Sore throat;
- Nasal congestion;
- Headache

AND

- Exposure criteria including one of:
    - **Travel** outside the territory within 14 days of symptom onset.
    - **High or medium risk contact** to a confirmed or probable **case** of COVID-19 infection within 14 days prior to onset of illness.
    - Had high-risk (close) contact with a person with acute respiratory illness who traveled out-of-territory OR had contact with another case within 14 days prior to their onset of illness

*****Refer to Contact section for definitions of high and medium risk contacts.

Individuals who meet the above criteria will be considered Persons Under Investigation (PUIs) for COVID-19 infection. See more detail on case definitions below.

Testing criteria are broader than current case definitions. Refer to COVID-19 Healthcare Provider Flowchart (Appendix D) for further details.

Routine testing of asymptomatic individuals is not routinely recommended. Testing asymptomatic individuals may result in a false negative lab result which can lead to a sense of reassurance that may change compliance with the recommended public health measures (e.g. isolation precautions). Testing of asymptomatic individuals (e.g. contacts, cluster investigations) will only be done under the guidance of a PHO in specific investigations or for surveillance purposes.

All unexplained deaths in territory should be tested for COVID-19 infection in consultation with the coroner and PHO on call.

Reporting:

- If your patient presents to the health centre/clinic/hospital and meets the COVID-19 screening criteria outlined in the COVID-19 Healthcare Provider Flowchart (Appendix D) have the patient wear a surgical/procedure mask immediately if they're not already wearing one. Place the patient in a separate room with contact and droplet precautions.
    - **Complete the Person Under Investigation (PUI) Assessment Form (Appendix C), scan and email to RCDC (copying**

	CDsurveillance@gov.nu.ca) as soon as possible. ○ The individual covering CDsurveillance@gov.nu.ca will email all of these immediately to TCDS as they receive them as required; the TCDS may also receive them from the RCDC. • If your patient calls in and meets the COVID-19 screening criteria, but does not require immediate emergency medical care, have them self-isolate at home and complete the Person Under Investigation (PUI) Assessment Form over the telephone where possible. RCDC will advise on the collection of the swab and daily check-ins. This may include a public health nurse or other nurse going to the patient's home to collect a swab. If you are unsure if your client meets testing criteria (see Appendix D), please contact RCDC during business hours or the Public Health Officer on call for guidance after hours (3rd number at 867-975-5772).
Management of PUIs	Refer to appendix D for detailed guidance on testing, precautions, and monitoring required. All individuals who require isolation or self-isolation must remain so until advised as clear by RCDC, TCDS, or PHO. Communication of this decision may be made to a client by a delegated HCP. For a PUI client to be advised to be removed from isolation, all of the following requirements must be met: - Negative swab result; - Swab properly collected; - Swab collected while symptomatic; - No indication of freezing or sample issues; - No international or OOT travel in certain time frame; and - No known contact to a confirmed case in certain time frame. The RCDC should contact the TCDS if unsure about advising end of self-isolation. If all of the conditions above are not met, the individual cannot be cleared from isolation and please ask your RCDC to inform the TCDS to discuss with PHO. Unless otherwise advised, all OOT travelers and high-risk contacts of confirmed cases must remain on isolation for the full 14 days after arriving in territory or last unprotected exposure respectively, regardless of test result. Individuals who have isolated in a Government of Nunavut – run self-isolation hub and been cleared through that process do not need to repeat self-isolation in territory but should practice physical/social distancing and limit contact with others. Review indications for isolation, self-isolation and self-monitoring in the COVID-19 Healthcare Provider Flowchart (Appendix D) and ensure the patient is aware of the recommended precautions. Scripts are provided in Appendix G to advise the patient of required isolation procedures. Please provide anyone on isolation with an isolation fact sheet. Anyone advised to be on home isolation should remain so until otherwise advised by the RCDC, TCDS, or PHO. The use of isolation hubs in communities is not routinely recommended. Patients are recommended to isolate at home unless otherwise advised by the RCDC, TCDS, or PHO. Please note that daily HCP monitoring would typically be completed over the

	phone. For daily monitoring of asymptomatic PUIs (e.g. high-risk contacts of a case), a second PUI form should be completed and sent to RCDC if the individual develops symptoms.
Case	The best and safest place for most people to recover from COVID-19 infection (both for them and their community) is at home. If a change in location is being considered for either an individual with infection or a vulnerable member of the household for infection control and communicable disease purposes, this will be decided on a case-by-case basis with the Public Health Officer on-call. Public Health Monitoring of Cases: **All confirmed and probable cases require active daily monitoring by public health. Select Persons Under Investigation (PUIs) require monitoring as outlined in the Health Care Provider Flowchart (Appendix D).** Active daily monitoring includes having daily contact with the individual for symptom monitoring, to assess for symptom resolution, or to assess for progression of illness. Cases must be monitored using the Daily Monitoring Form (Appendix E) until they have been cleared from isolation by the RCDC.
Contacts	Please see definitions of persons under investigation (PUI), probable case, and confirmed case below. Probable and confirmed cases are treated the same for contact follow-up. Contacts of a probable or confirmed COVID-19 case are assessed based on high (close contact), medium (casual contact) and low (transient contact) level of risk. HIGH risk exposure (close contact of a case): • **Provided direct care** for the case (including health care workers, family members or other caregivers), without consistent and appropriate use of recommended personal protective equipment, OR • **Household member** who had other close physical contact with a case without consistent and appropriate use of recommended personal protective equipment • **Person who lived with or had other close prolonged contact** (e.g. intimate contact) within 2 metres with a case while the case up to 48 hours prior to symptom onset or while the case was symptomatic and not isolating • People who have been in direct contact with infectious body fluids of a case (e.g. was coughed or sneezed on) MEDIUM risk exposure (non-close contact of a case): • Provided direct care for the case, (including health care workers, family members or other caregivers) or who had other similar close physical contact with consistent and appropriate use of personal protective equipment OR • Who lived or otherwise had prolonged contact **but was not within 2 metres** of a case up to 48 hours prior to symptom onset or while the case was symptomatic and not isolating LOW risk exposure (only transient interactions): • Only transient interactions (e.g. walking by the case or being briefly in the same room) Please review and follow complete guidance from the Public Health Agency of

	Canada (PHAC) regarding the contact management of probable and confirmed cases. Available online at: https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals/interim-guidance-cases-contacts.html **Please use the COVID-19 Contact Tracing Form (Appendix F) for listing all contacts. All cases and all high/medium risk contacts of a confirmed or positive COVID-19 case should have contact tracing forms completed as per the flowchart in the appendix**. RCDC, TCDS, and PHO will advise on next steps for all COVID-19 cases (lab-confirmed).
Health Education	As with other respiratory illnesses such as influenza, the spread of COVID-19 can be minimized through respiratory etiquette, hand hygiene and environmental cleaning. Additional guidance regarding physical distancing >2 metres is also essential in minimizing spread. Please see the resources section for more information. Guidance for someone isolating at home (e.g. confirmed case) includes: ▪ Stay home until advised no longer required by RCDC, TCDS, or PHO ▪ Avoid contact with other people, particularly medically-vulnerable people or elders ▪ Separate room and sleeping arrangements where possible. ▪ Manage symptoms independently where possible. If caregiver required, designate one individual for that role. ▪ Stay 2m away from other individuals and no visitors. ▪ Avoid sharing unwashed dishes ▪ Clean high touch surfaces regularly ▪ Hand hygiene and respiratory etiquette For more detailed information refer to Isolating a Case in the Home or Co-living Setting guidance document.
Health Settings Management	
Infection Control Measures in Health Care Settings	Use droplet/contact precautions (consistent with national / international guidance). When triaging, suspect COVID-19 cases should be placed in a separate room away from other patients as soon as possible or separated by at least two meters from other people waiting if it is not possible to use another room. Individuals suspected to have COVID-19 should be instructed to put on a surgical/procedural mask (with ear loops) while they are in the clinic, if tolerated. Diligent hand hygiene using either liquid soap and water or 60-90% alcohol-based sanitizer, before and after patient contact/assessment and after contact with contaminated equipment. When handling linen and garbage, if it is soiled or at risk of being soiled, create a barrier by wearing gloves and gowns that cover exposed contact skin areas. Increased frequency of cleaning high-touch surfaces is significant in controlling the spread of microorganisms during a respiratory infection outbreak. Environmental cleaning products registered in Canada with a

	Drug Identification Number (DIN) and labelled as a broad-spectrum virucide are sufficient. All surfaces, especially those that are horizontal and frequently touched, should be cleaned at least twice daily and when soiled. See the Nunavut Housekeeping Procedures Manual for more detailed information on terminal cleaning recommendations. https://www.gov.nu.ca/health/information/housekeeping-procedures-manual
Occupational Health	Staff should wear a surgical/procedural mask, eye protection, gown and gloves when providing care to clients with suspected or confirmed COVID-19 infection. See Appendix for detailed information on donning and doffing Personal Protective Equipment. See the Infection Prevention and Control Manual for more detailed guidelines. https://www.gov.nu.ca/health/information/infection-prevention-and-control
Surveillance	
Case Definition	**Nunavut numbers for cases would be available here:** https://www.gov.nu.ca/health/information/covid-19-novel-coronavirus **Canada numbers for cases are available here:** https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection.html **Person under investigation (PUI)** A person with symptoms that include one or more of: • Fever (signs of fever) • Cough (new or worsening) • Shortness of breath (new or worsening) • Sore throat • Runny nose • Headache AND • Meets the exposure criteria below OR • Had close contact with a probable or confirmed case of COVID-19 Exposure criteria In the 14 days before onset of illness, a person who: • Returned to Nunavut from out of territory OR • Had close contact with a confirmed or probable case of COVID-19 OR • Had high-risk (close) contact with a person with acute respiratory illness who either a) had travelled out-of-territory within 14 days prior to their onset of illness OR b) had contact with a confirmed or probable case within 14 days prior to their onset of illness OR • Had laboratory exposure to biological material (e.g. primary clinical specimens, virus culture isolates) known to contain COVID-19.

	Probable **A person (who has had a laboratory test):** • with fever (over 38 degrees Celsius) or new onset of (or exacerbation of chronic) cough And • who meets the COVID-19 exposure criteria and in whom a laboratory diagnosis of COVID-19 is inconclusive. **Or** **A person (who has not had a laboratory test):** • With fever (over 38 degrees Celsius) or new onset of (or exacerbation of chronic) cough, And ○ Close contact [Footnote 2] with a confirmed case of COVID-19, Or ○ Lived in or worked in a closed facility known to be experiencing an outbreak of COVID-19 (e.g., long-term care facility, prison) Notes: • NAATs must be validated for detection of the virus that causes COVID-19. • Inconclusive is defined as an indeterminate test on a single or multiple real-time PCR target(s) without sequencing confirmation or a positive test with an assay that has limited performance data available. • An indeterminate result on a real-time PCR assay is defined as a late amplification signal in a real-time PCR reaction at a predetermined high cycle threshold value. This may be due to low viral target quantity in the clinical specimen approaching the limit of detection (LOC) of the assay, or may represent nonspecific reactivity (false signal) in the specimen. When clinically relevant, indeterminate samples should be investigated further in the laboratory (e.g. by testing for an alternate gene target using a validated real-time PCR or nucleic acid sequencing that is equally or more sensitive than the initial assay or method used) or by collection and testing of another sample from the patient with initial indeterminate result. **Confirmed** A person with laboratory confirmation of infection with the virus that causes COVID-19 performed at a community, hospital or reference laboratory (NML or a provincial public health laboratory) running a validated assay. This consists of detection of at least one specific gene target by a NAAT assay (e.g. real-time PCR or nucleic acid sequencing). Notes: • NAATs must be validated for detection of the virus that causes COVID-19. • Positive laboratory tests during early stages of testing (e.g. first 10 positive tests) at a non-reference laboratory require additional testing at a reference laboratory for confirmation. • Laboratory tests are evolving for this emerging pathogen, and laboratory testing recommendations will change accordingly as new assays are developed and validated.
Reporting Requirements and Forms	Lab confirmed COVID-19 infection is notifiable in Nunavut. Please report as outlined in the Person Under Investigation Assessment Form (Appendix C). Please note a few considerations, particularly when this occurs after hours. In

	addition to providing any immediate follow-up required, the Public Health Officer is expected to notify other PHOs involved as appropriate as well as the TCDS immediately by email. The TCDS will ensure the epidemiologists and RCDCs are notified. Roles and responsibilities include: - **Health care provider**: Notification to public health as outlined above and in Appendix C & D, care for individual, and providing education to the patient regarding self-monitoring, self-isolation and plan of care. - **RCDC**: Following up all PUI and cases, ensuring initial information is gathered, ensuring case report form is filled out and send to TCDS, and other functions - **TCDS**: coordinating and advising RCDCs, liaising with PHOs, ensuring PUI and case information sent to epidemiologists - **Epidemiologist**: maintaining accurate linelist, circulating linelist to outbreak team, flagging any missed follow-up noted, monitoring for national surveillance updates - **PHO, DCPHO, and CPHO**: as reviewed above. Please note that the Public Health Officer on call will typically be the Deputy Chief Public Health Officer or Chief Public Health Officer. Confirmed cases of COVID-19 require completion of the Public Health Agency of Canada COVID-19 case report form. RCDC, working with the epidemiology team, will ensure completion of the form and may require additional information to be provided by health care providers.
Tools	
Guidelines	Refer to the following online Government of Nunavut manuals available online at: **https://www.gov.nu.ca/health/information/manuals-guidelines** • Communicable Disease Manual • Infection Prevention and Control Manual • Housekeeping Procedures Manual
Materials & Resources	Appendix A - Nasopharyngeal Swab Procedure Appendix B – Home Swab Collection Guideline Appendix C – Person Under Investigation (PUI) Assessment Form Appendix D - COVID-19 Healthcare Provider Flowchart Appendix E – Daily Monitoring Form Appendix F – COVID-19 Contact Tracing Form Appendix G - Script for Explaining Isolation or Self-Isolation Instructions for isolating a case in the home or co-living setting About coronavirus disease COVID-19 Cleaning to Reduce the Risk of COVID-19 COVID-19 Isolation Managing Anxiety and Stress During Covid-19

	Social Distancing Washing Hands Poster Additional translated resources for the public can be found online at https://gov.nu.ca/health/information/covid-19-novel-coronavirus
Cross Reference	Not applicable

References

Public Health Agency of Canada. Coronavirus disease (COVID-19): For health professionals. Available online at: https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals.html#cg

Ontario Ministry of Health and Long-Term Care. Ontario Public Health Standards – Infectious Diseases Protocol, 2009. Available online at: http://www.health.gov.on.ca/english/providers/program/pubhealth/oph_standards/ophs/infdispro.html

World Health Organization. Q&A on coronaviruses (COVID-19). Available online at: https://www.who.int/news-room/q-a-detail/q-a-coronaviruses

Approval

Version 5 approved by Dr. Jasmine Pawa on May 12, 2020

Abbreviations: TCDS = Territorial Communicable Disease Specialist, RCDC = Regional Communicable Disease Specialist, OOT=out-of-territory, HCP=health care provider

Appendix A – NP Swab Procedure

Appendix B – Home Swab Collection Guideline

Appendix C – Person Under Investigation (PUI) Assessment Form

Appendix D - COVID-19 Healthcare Provider Flowchart

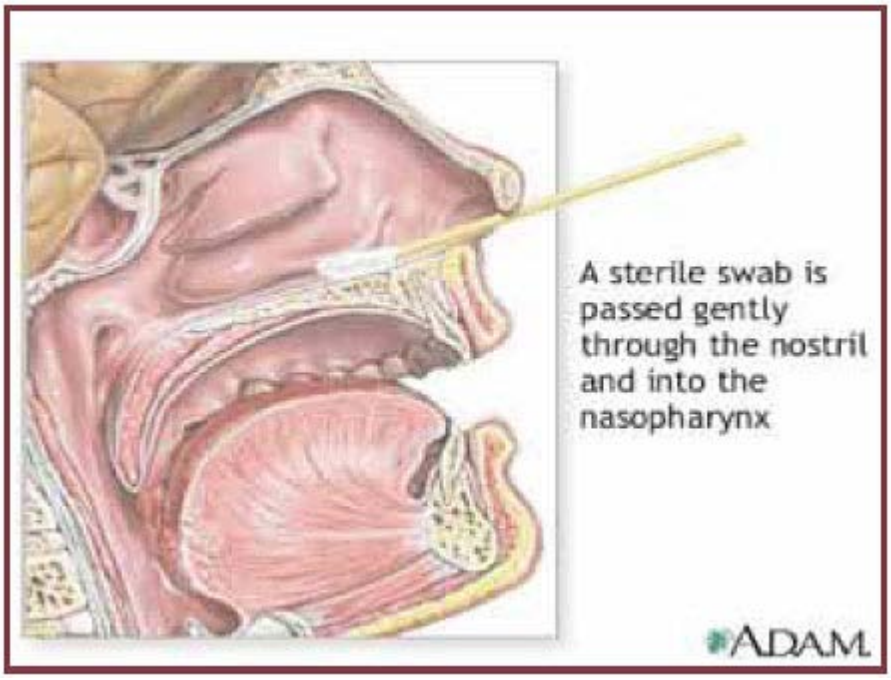
Appendix E – Daily Monitoring Form

Appendix F – COVID-19 Contact Tracing Form

Appendix G – Script for Explaining Isolation or Self-Isolation

Appendix A - Nasopharyngeal Swab Procedure

1. Use the swab supplied with the viral transport media.
2. Explain the procedure to the patient.
3. When you collect specimens, wear gloves and a mask. Change gloves and wash your hands between each patient.
4. If the patient has a lot of mucous in the nose, this can interfere with the collection of cells. Either ask the patient to use a tissue to gently clean out visible nasal mucous or clean the nostril yourself with a cotton swab (**not** the same swab you will be using to collect the specimen).
5. Estimate the distance to the nasopharynx; prior to insertion, measure the distance from the corner of the nose to the front of the ear; the swab should be inserted approximately half the length of this distance.
6. Seat the patient comfortably. Tilt the patient's head back slightly to straighten the passage from the front of the nose to the nasopharynx. This will make insertion of the swab easier.
7. Insert the swab along the medial part of the septum, along the floor of the nose, until it reaches the posterior nares; gentle rotation of the swab may be helpful (if resistance is encountered, try the other nostril, as the patient may have a deviated septum).
8. Cut the shaft of the swab with scissors or break in half, place in transport medium, recap and place in a specimen bag with the requisition to be sent to the laboratory.



Instructions for isolation of an individual with COVID-19 in the home or co-living setting

"Isolation" and "self-isolation" means:

- Not going out unless directed to do so (i.e. to seek medical care)
- Not going to school, work, or other public areas
- Not using public transportation (e.g. taxis)

The following steps should be followed by every household where a Person Under Investigation, or a positive case is isolating or self-isolating:

1. Limit Contact with Other People in the Household – Physical Distancing in the Home

Any person who is sick with COVID-19 should avoid being close to anyone else, including people who live in the same house. If possible, the person who is sick should have a room to themselves, and eat alone, and spend all day alone until they no longer have symptoms and the nurse or doctor says they are clear to come off isolation or self-isolation.

At all times – the person who is sick should be at least 2 meters apart from everyone else in the household. If the person requires a caregiver, then gloves, face protection and hand hygiene should be used.

If a separate room is not possible, ensure that shared spaces are well ventilated (e.g. windows open, as weather permits). If it is difficult to separate the person physically in their own room, hanging a sheet from the ceiling to separate the ill person from others may be considered. If the sick person is sleeping in the same room as other persons, it is important to maintain at least 2 metres distance from others (e.g. separate beds and have people sleep head-to-toe, if possible).

Visitors should not be allowed at any time, unless they are providing care or delivering supplies or food. Every effort should be made so that visitors can drop off supplies outside and have no contact with household members or enter the building of the sick person.

2. Avoid Sharing Personal Household Items

The individual should not share personal items with others, such as toothbrushes, towels, cloths, bed sheets and blankets, cigarettes, unwashed eating utensils, drinks, phones, computers, or other electronic devices. A garbage bin with garbage bags should be placed in the room where the sick person is.

3. Clean all high-touch surfaces

Disinfectants can kill the virus making it no longer possible to infect people. High-touch areas such as toilets, bedside tables and door handles should be disinfected daily. Rooms and shared spaces (such as bathrooms and kitchens) where sick people are recovering should be disinfected at least every day. High-touch electronics such as phones, computers and other devices may be disinfected with 70% alcohol (e.g. alcohol prep wipes) if they can withstand the use of liquids for disinfection. If objects in the house can not be disinfected, they should not be shared between the person who is sick and other people in the household.

If possible, an approved *hard surface disinfectant* with a **Drug Identification Number (DIN)** should be used. A DIN is an 8-digit number given by Health Canada that confirms the disinfectant product is approved and safe for use in Canada. When approved *hard surface disinfectants* are not available for household disinfection, a diluted bleach solution can used by following the instructions on the bottle or the instructions provided by the Government of Nunavut available on their website. Follow instructions for proper handling of household (chlorine) bleach.

4. **Be Safe When Doing Laundry and Throwing Out Garbage**.

Clothing, towels and bed sheets and non-medical masks belonging to the sick person can be washed together with other laundry, using regular laundry soap and hot water (60-90°C). Laundry should be completely dried. If someone other than the sick person is washing the clothes, then gloves, face protection and hand hygiene should be used.

Garbage bags from the room of the sick person should be tied up by either the sick person themselves or a caregiver who is using proper gloves, face protection and hand hygiene.

5. **All People in the Household Should Practice "hand hygiene"**

Hand hygiene means the practice of hand washing, or hand sanitizing and actions taken to maintain healthy hands and fingernails. It should be done regularly with soap and water for at least 20 seconds:

- Before and after preparing food;
- Before and after eating;
- After using the toilet;
- Before and after using a mask;
- Before and after using disposable or reusable gloves;
- Whenever hands look dirty.

Handwashing with plain soap and water is the preferred method of hand hygiene, because it can remove infection causing bacteria and viruses and it can clean visibly dirty hands.

If soap and water are not available, hands can be cleaned with an alcohol-based hand sanitizer (ABHS) that contains at least 60% alcohol, ensuring that all surfaces of the hands are covered (e.g. front and back of hands as well as between fingers) and rub them together until they feel dry. For visibly dirty hands, remove soiling with a wipe first, followed by use of ABHS.

When drying hands, disposable paper towels are preferred, but a dedicated reusable towel may be used and replaced when it becomes wet.

Avoid touching their eyes, nose, and mouth with unwashed hands because this is a main way to become infected with a virus or a bacteria.

6. Gloves

Disposable single use gloves should be worn when a household member is in direct contact with the sick person, cleaning surfaces or spaces where the sick person is, and handling things with body fluids, including dishes, cutlery, clothing, laundry, and garbage.

Reusable gloves are OK (the yellow and pink ones available at the stores); but they must be cleaned with soap and water then disinfected every time they are used.

You must also wash your hands before and after using gloves:

- Perform hand hygiene before putting on gloves;
- If your gloves become dirty or rips while giving care/cleaning the area of the sick person, remove them, wash your hands and put on new gloves. This will prevent you from spreading dirt around the room;
- Perform hand hygiene after removing gloves;
- Double-gloving is not necessary and does not provide extra safety.

When removing gloves be sure not to touch the outside of the glove (the dirty side). Make sure that you throw them into a garbage bin with a garbage bag that is dedicated to the sick person.

7. All people in the house should practice "Respiratory Etiquette"

"Respiratory etiquette" means paying attention to how you talk, breathe, cough and sneeze. By paying attention to these things you can help reduce the spread of the virus.

- Try to cough or sneeze into a tissue or Kleenex and throw it away into a garbage bin with a garbage bag OR
- Cough/sneeze into the bend of your arm
- Never cough or sneeze into your hand because your hand touches a lot of surfaces and may spread the virus quickly. If you accidentally cough/sneeze into your hand – be sure you wash your hands before touching anything else.

8. Masks and Homemade Masks/Barriers and Eye Protection

Medical masks (sometimes called surgical masks or procedure masks) provide some protection when trying to stop the virus from spreading from a sick person to someone who does not have the infection. When a sick person coughs, sneezes or breathes – they can release droplets of tiny liquid that have the virus in them. Physical barriers such as medical masks, homemade masks, or other barriers such as bandanas can stop the virus from spreading by someone who is infected with it.

Masks alone cannot stop the virus from spreading. "Respiratory etiquette" and hand hygiene are very important parts preventing the spread of the virus. Standing at least 2 meters apart (physical distancing) as much as possible will also stop the virus from spreading to people.

- When it is not possible to always stay 2 meters away from people, the sick individual should use either a mask or another barrier.

- If a healthy person must provide care to a sick person then the care giver should use a mask/barrier. Eye protection should be used with a mask or barrier, because the virus can enter through a person's eyes.

If masks/barriers aren't used properly they can increase the spread of a virus. Follow these steps to make sure you are using masks or other physical barriers properly:

1. Wash your hands before putting on a mask.
2. Hold the outside of the mask or barrier and put over the nose and the mouth. Make sure that the barrier is snug in place and will not fall off or need to be adjusted.
3. Once the mask is on – do not adjust it, lift it to speak or remove it and replace it. Part of stopping the virus from spreading is getting used to never touching your face. If you accidentally touch your face be sure to wash your hands immediately or as soon as possible.
4. To remove the mask/barrier: remove the loops of the mask or untie the barrier from behind. Make every effort to make sure the front of the mask does not touch your face or anywhere else.
5. Wash your hands after removing a mask/barrier.
6. If the mask becomes wet, dirty with mucus, or damaged it should be replaced. Follow steps 1-5.

All medical masks are "single use only" which means they must be thrown away once they are removed from the face.

All homemade barriers should be "single use only" as well. After one use place the barrier in a laundry basket or into a washer.

If you are using a homemade mask or barrier and you have trouble breathing, remove the barrier and breath normally. Homemade masks and barriers are not tested in laboratories to make sure they are safe to use. Sometimes the material can be too thick and cause you to not get enough oxygen.

9. Self-care while recovering

a) Treatment

There is no specific medicine/treatment for COVID-19. The individual with COVID-19 should rest, eat nutritious food, stay hydrated with fluids like water, and manage their symptoms. Over the counter medication can be used to reduce fever and aches. Vitamins and complementary and alternative medicines are not recommended unless they are being used in consultation with a licensed healthcare provider.

b) Monitor symptoms and temperature regularly

The individual should monitor their symptoms and immediately report worsening of symptoms to a health care provider. Daily monitoring is recommended as outlined in Appendix D – COVID-19 Healthcare Provider Flowchart.

The individual should monitor their temperature daily, or more frequently if they have a fever (e.g., sweating, chills), or if their symptoms are changing. Temperatures should be recorded and reported to healthcare providers doing the daily monitoring. If the sick person is taking

acetaminophen (e.g. Tylenol) or ibuprofen (e.g. Advil), the temperature should be recorded at least 4 hours after the last dose of these fever-reducing medicines.

c) Maintain a suitable environment for recovery

The environment should have good air exchange (by vents not fans) and free of tobacco or other smoke where possible. Airflow can be improved by opening windows and doors, as weather permits. Where possible, the sick person should have access to electronics to remain "socially connected" by social media, or other communication.

10. **Supplies for the Household If Possible**
    - Enough food for two weeks if possible;
    - Medical mask or homemade mask/barrier;
    - Disposable Gloves or reusable gloves;
    - Eye protection; Thermometer;
    - Fever-reducing medications;
    - Hand soap;
    - Alcohol based hand sanitizer containing at least 60% alcohol;
    - Tissues; Garbage bin with garbage bags;
    - Regular household cleaning products;
    - Approved hard-surface disinfectants that have a Drug Identification Number (DIN) or if an approved hard surface disinfectant is not available, bleach;
    - Alcohol (70%) prep wipes or cleaners suitable for cleaning high- touch electronics (e.g., phones);
    - Regular laundry soap;
    - Dish soap;
    - Disposable paper towels or hand towels for drying hands.

Adapted from the Public Health Agency of Canada guidance retrieved from:
https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals/interim-guidance-cases-contacts.html#app

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS **Community Health Nursing**		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Escalation of Medical Care		Nursing Practice	07-035-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
21/07/2020	07/2023	N/A	5
APPLIES TO:			
Community Health Nurses, Nurse Practitioners, and Physicians			

1. BACKGROUND:

1.1. The Department of Health (Health) provides patients with care as close to home as possible. When the patient needs exceed the services available at the health centre in their home community, the patient will be transferred to another centre with more robust resources providing that the patient is agreeable.

1.2. To protect the health and wellbeing of patients, limitations are placed on the length of time which a patient may remain at the health centre, and the number of repeat visits without improvement or diagnosis.

2. POLICY:

2.1. The nurse will consult with the community physician or physician on call to arrange patient transfer to an alternate care site whenever a patient has been at a health centre for 4 hours without evidence of clinical improvement. For greater clarity, patients may not be monitored in the health centre for greater than 4 hours. Transferring a patient to another health centre or third-party healthcare provider is done explicitly to allow for timely access to greater resources and supports for investigations, diagnosis, and treatment options.

2.2. A patient who has been seen twice for the same complaint must be seen by a different clinician on the third visit. The third visit will include a complete examination and investigations into alternate diagnoses in addition to a referral to or consultation with a physician or nurse practitioner.

2.3. A patient who has been seen three times for the same complaint **without** an effective treatment plan and/or diagnosis must be sent to a third-party healthcare provider by the most appropriate means of transportation given the patient's condition, including medevac. The transfer of the patient to a third-party healthcare provider is done explicitly to allow for timely access to greater resources and supports for investigations, diagnosis, and/or treatment options. This statement applies to all clinicians regardless of location of care within Nunavut.

3. PRINCIPLES:

3.1. Nunavummiut have a right to access equitable healthcare resources and supports regardless of

their home community. The delivery of these healthcare resources and supports may require travel to another centre.

3.2. Health provides Nunavummiut with care as close to home as possible. To ensure that the priority of receiving care as close to home as possible does not conflict with the need to provide all Nunavummiut with access to equitable healthcare resources and supports, patients may be required to receive evaluation, care, and/or treatment at a location other than their home community. Non-urgent/non-emergent treatment at a location other than a patient's home community will take place only when specific criteria are met as outlined in this policy.

3.3. Patients will be transferred between communities and referral sites using the most appropriate means of transportation given the patient's condition, including medevac.

3.4. To ensure that all Nunavummiut have access to the healthcare resources and supports needed, even in non-urgent/emergent situations, patients may be required to receive care away from home.

4. DEFINITIONS:

4.1. **Clinician:** Refers to Community Health Nurses (CHN), Nurse Practitioners (NP), and Physicians.

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

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

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

4.5. **Consultation:** A deliberation between clinicians in order to seek advice. The clinician initiating the consult remains the Most Responsible Person (MRP).

4.6. **Referral:** A referral is a request from one physician to another to assume responsibility for management of one or more patient either entirely or for a specified problem. A referral may be for a specified time period, until the resolution of a problem, or may be for ongoing care. It is the responsibility of the physician accepting the referral to maintain appropriate and timely communication with the referring physician and to seek approval from the referring physician for treating or referring the patient for any other condition that is not part of the original referral.

5. PROTOCOL:

5.1. Patients who have made three visits to a clinician for the same complaint without improvement or a confirmed diagnosis must be transferred to a third-party healthcare provider for evaluation and/or treatment if determined through consultation with the community physician or physician on call.

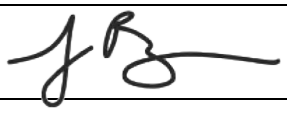
5.1.1. Physicians who have seen the same patient for 3 visits for the same complaint without improvement or a confirmed diagnosis must refer the patient for transfer to a third-party healthcare provider.

5.2. Patients who have been in the health centre for 4 hours without improvement will be transferred to a regional centre or third-party healthcare provider after consultation with a physician.

5.3. Patients who have been treated twice for the same complaint will be re-evaluated by a different clinician on their third visit for the same complaint, regardless of resolution/improvement between visits. A physician or nurse practitioner referral or consultation must be arranged at that time.

6. PRACTICE POINT:

6.1. An underlying mood disorder or other psychiatric origin of the illness, as well as a referral to Mental Health, should be considered for any patient who has been seen twice with vague or non-specific complaints **without** a diagnosis.

Approved By: 	Date: August 31, 2020
Jennifer Berry, Assistant Deputy Minister, Operations, Department of Health	
Approved By: 	Date: August 31, 2020
Monique Skinner, Chief Nursing Officer, Department of Health	
Approved By:	Date:
Francois de Wet, Chief of Staff, Department of Health	

Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS Community Health Nursing	
TITLE:	**SECTION:**	**POLICY NUMBER:**
Community Health Centre Protected Code Blue During the COVID-19 Pandemic	Nursing Practice	07-037-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
May 2020 / May 2023	N/A	9
APPLIES TO:		
Community Health Centres		

PLEASE NOTE: This is an emerging pandemic involving a novel virus. As new evidence is released, the information contained within this document may change.

1. **BACKGROUND:**
   The SARS-CoV-2 virus (COVID-19) currently causing a worldwide pandemic is transmitted primarily by droplet and contact means. Certain procedures performed during a code blue, known as 'aerosol-generating medical procedures' (AGMP), are believed to cause both a higher volume of infectious droplets as well as aerosolization of the virus, increasing risk of transmission. This protocol aims to provide specific risk reduction and infection prevention strategies to guide healthcare providers when performing resuscitation.

2. **DEFINITIONS:**
   - **2.1** Code Blue: Cardiopulmonary arrest.
   - **2.2** Aerosol: Small droplet of moisture that may carry microorganisms; may remain suspended in the air for periods of time, allowing inhalation of microorganisms.
   - **2.3** Aerosol-Generating Medical Procedures (AGMP): A procedure with the potential to generate a high volume of respiratory droplets and aerosols. Potential AGMP during a critical patient presentation and resuscitation within the health centre setting may include (but is not limited to):
     - **2.3.1** Nebulizer therapy
     - **2.3.2** High-flow oxygen therapy (nasal prongs at >6L/min)
     - **2.3.3** Open airway suctioning (including deep suctioning of nasopharynx and trachea; not including oral suctioning)
     - **2.3.4** Cardiopulmonary resuscitation (CPR)
       - i. Cardioversion and defibrillation **in the absence of bag-valve mask ventilation (BVM)** are not AGMP
       - ii. Other procedures associated with CPR including chest compressions **with** intubation and manual ventilation, are AGMP
       - iii. Chest compressions alone are not considered an AGMP
     - **2.3.5** Bag-valve mask ventilation
     - **2.3.6** Endotracheal intubation and extubation
     - **2.3.7** Insertion of any advanced airway

2.3.8 Non-invasive ventilation (CPAP, BiPAP)
2.3.9 Needle decompression

3. KEY PRINCIPLES:

3.1 Safety and protection of healthcare providers is priority.
3.2 Additional precautionary measures should be taken when delivering care to patients with suspected respiratory infection.
3.3 During the current pandemic, assume all respiratory and cardiac arrests are COVID-19 positive.
3.4 Ethical principles surrounding resource allocation, staff training, PPE availability and conservation, prognosis, and patient wishes must be taken into consideration.

4. RECIPIENT PATIENTS:

4.1 Patients presenting to the Community Health Centre, requiring resuscitation.

5. POLICY:

5.1 The Community Health Centre must apply the risk reduction and infection prevention strategies listed in 6.0 during a code blue.
5.2 The Community Health Centre must adapt the risk reduction and infection prevention measures outlined in Appendix A: *Community Health Centre Protected Code Blue Practical Guide.*

Note*: It is recognized that the resources and number of healthcare providers involved in a code blue will depend on staffing complement and availability. The roles and responsibilities outlined in Appendix A must be adapted to situation and setting, with emphasis on maintaining risk reduction and infection prevention strategies.*

6.0 RISK REDUCTION & INFECTION PREVENTION STRATEGIES:

6.1 AGMP should be performed in (order of preference):
6.1.1 Negative pressure room
6.1.2 Isolation room with door closed, or
6.1.3 Private room with door closed, or
6.1.4 COVID-19 cohort area, where all healthcare providers are wearing PPE
6.2 In the absence of a negative pressure room, every effort must be made for a code blue resuscitation to be performed in the health centre isolation room with the door closed.
6.3 It is mandatory for healthcare providers to don full Personal Protective Equipment (PPE) for droplet, contact and airborne precautions during a code blue resuscitation.
6.4 An observer should be assigned with donning and doffing of PPE.
6.5 Use disposable equipment when possible.
6.6 Double glove to allow removal of highly contaminated outer gloves.
6.7 Pay attention to limit exposure of contaminated equipment that have come into direct contact with the patient's face or secretions.
6.8 Use a drop bag to isolate highly contaminated equipment after any procedures, prior to disposal/cleaning of room.
6.9 Limit the amount of equipment entering the room to items that are deemed necessary; all supplies in the room are considered contaminated.
6.10 Avoid unnecessary entry/exit of the room by healthcare providers.
6.11 Bag-valve mask ventilation (BVM) is considered a highly aerosolized procedure. If BVM must be performed, use two-person, four-handed technique.

6.12 The door to the room should remained closed as much as possible.

6.13 Utilize a telephone with speaker phone function or baby monitor to communicate with staff outside of the room. This will a) minimize door opening b) aid with documentation; and c) assist with retrieval of equipment.

6.14 The use of personal cell phones is discouraged.

Note: Contact the Regional Director and/or Regional Clinical Educator for direction on isolation room set up.

7.0 PROCEDURAL GUIDE:

Outlined below in Appendix A: Community Health Centre Protected Code Blue Practical Guide.

8.0 RELATED POLICIES, PROTOCOLS AND LEGISLATION:

Department of Health, Qikiqtani General Hospital. April 2020. *Protected Code Blue in adults at Qikiqtani General Hospital during the COVID-19 pandemic.*

Department of Health, Qikiqtani General Hospital. April 2020. *Protected Code Blue in pediatric patients at Qikiqtani General Hospital during the COVID-19 pandemic.*

Community Health Centre Policy 10-003-06 Aerosol-Generating Medical Procedures in Patients with Known or Suspected COVID-19

Community Health Nursing Policy 06-008-00: Documentation Standards

Community Health Nursing Policy 06-008-01: Documentation Standards

Community Health Nursing Policy 10-005-00: Personal Protective Equipment

Department of Health Housekeeping Procedures Manual

9.0 REFERENCES:

1. Tran, K., Cimon, K., Severn, M., Pessoa-Silva, C.L., & Conly, J. (2011). Aerosol-generating procedures and risk of transmission of acute respiratory infections: A systemic review. *Canadian Agency for Drugs and Technologies in Health*. Retrieved from https://www.cadth.ca/media/pdf/M0023_Aerosol_Generating_Procedures_e.pdf

2. The Ottawa Hospital, Department of Critical Care. COVID-19 Quick reference guide. Retrieved from https://www.covidottawa.com/

Approved By:	Date: June 22, 2020
Ruby Brown, Deputy Minister – Department of Health	
Approved By: Monique Skinner Digitally signed by Monique Skinner DN: cn=Monique Skinner, o=Government of Nunavut, ou=Operations, email=mskinner@gov.nu.ca, c=CA Date: 2020.06.22 08:26:24 -06'00'	Date:
Monique Skinner, Chief Nursing Officer	
Approved By:	Date:
Francois de Wet, Chief of Staff – On behalf of the Medical Advisory Committee	

APPENDIX A:

COMMUNITY HEALTH CENTRE PROTECTED CODE BLUE PRACTICAL GUIDE

1. Team Roles & Preparation

Minimize number of people inside room. Roles should be assigned. Consider staffing compliment, job descriptions, and scope of practice.

Ideal Healthcare Providers Inside Room

a) Team Lead MD, 1st responder or most experience provider - may assist with BVM by bagging
b) Nurse x 4 if available

Ideal Healthcare Providers Outside of the Room

c) Nurse – backup in full airborne PPE
d) Nurse – Runner, documenter and PPE Observer if dedicated Observer not available
e) PPE Observer

2. Equipment Preparation

a) Cardiac monitor removed from arrest cart and brought into room
a) Portable suction
b) IV pump as needed
c) Oxygen Tank
d) Back board
e) Preparation Isolation supply of: Airway and Breathing Kit, Circulation Kit & Medication Kit OR Arrest cart outside of the room
f) **ARREST CART (SHOULD) REMAIN OUTSIDE ROOM DURING CODE**
Note: Contact Clinical Nurse Educator for isolation room set up and equipment preparation.

3. Situation Specific Procedure

Healthcare provider who witnesses an adult patient experiencing cardiac arrest, or becoming unresponsive:

a) Check for pulse for no more than 10 seconds
b) Verify code status if possible
c) Alert code blue to team
d) Leave room to properly don Airborne PPE
e) Cover nose and mouth with surgical mask, NRB mask up to 15 L/min, or piece of cloth while awaiting additional personnel
f) Return to room, if defibrillator available, apply pads to patient. If rhythm is shockable, you may deliver a shock, as this is not considered and AGMP
g) Start compressions as soon as 1st responder is in room in full PPE
h) Only ventilate patient with appropriate airway adjunct and when two experienced providers are available. With viral filter attached to BVM, perform 2-Person, 4-hand BVM.
i) Ensure door to room is closed

4. Roles & Responsibilities of Healthcare Providers Inside the Room

Team Lead:

a) Enters room in airborne and contact PPE
b) Assigns roles to team members
c) Obtain clinical history; if no physician present, call regional physician on call
d) Once airway obtained, assist with bagging patient using 2-person, 4-hand technique

First Nurse (Defibrillator/Monitor):

e) Returns to room after donning airborne and contact PPE
f) If cardiac monitor in room already, apply pads; follow ACLS guidelines; defibrillation in the absence of BVM is not an AGMP; therefore, may defibrillate at this point if indicated.
g) Initiate chest compressions if indicated without airway manipulation or BVM
h) Will switch roles with team members at each pulse check as per ACLS guidelines or physician direction, to maintain high quality CPR

Second Nurse (Circulation):

i) Brings Circulation Kit, Medication Kit, back board and cardiac monitor
j) Place backboard to improve compressions
k) Apply pads to patient and deliver a shock if shockable rhythm is present (not considered an AGMP) unless this has already been done by first nurse.
l) Obtain IV access
m) Cycle compressions and airway with first nurse at each pulse check

Third Nurse (Airway):

n) Brings Airway Kit & Breathing Kit
o) If no physician, apply oxygen at 15 L/min with a Non-Rebreather Mask
p) Insert oral airway and initiate 2-person, 4-Hand BVM; Team Lead can perform 'bagging'
q) If physician in community, patient may be intubated at this time; chest compressions are to be paused for intubation. (Note: Community Health Centre Guideline for COVID-19 Intubation is in development).
r) BVM increases aerosolization; use viral HEPA filter if available; use PEEP valve if available and indicated.
s) If using PEEP valve, set at 5 cm H20 and increase as ordered to improve oxygen saturation. Avoid PEEP in hypotensive patients; consult with physician for guidance.
t) Cycles compressions and airway

***Fourth &/or Fifth Nurse*:**

u) Cycles compressions and airway

5. Roles & Responsibilities of Healthcare Providers Outside the Room

Backup Nurse:

a) To don full PPE and wait outside the room to assist if necessary
b) May need to swap out for compressions or airway support

***Runner and PPE observer*:**

c) Retrieve extra equipment/meds as needed (Support staff may act as runner)
d) PPE observer remains outside room; ensures proper donning/doffing of PPE by all individuals entering room and prevents unnecessary personnel from entering or leaving the room
e) Documenter

6. Running the Code Blue

a) The Code Blue to be directed by Physician/Physician On-Call, following standard ACLS Guidelines.
b) Consider inserting an advanced airway if physician available in community (or a healthcare provider who has received training for advanced airway insertion such as LMA, KingLT, or Combitube) to decrease aerosolization in comparison to BVM.
c) Only Rankin Inlet has a ventilator at this time; if patient is intubated or has a supraglottic airway inserted, they require manual ventilation, which is an AGMP. Currently, there is no way to close the circuit in a community health centre setting.
d) If unable to insert advanced airway, the patient should be ventilated with oral or nasal airway and 2-person, 4-hand BVM technique.
e) Consider discontinuation of resuscitation if:
    - No improvement after 1-2 cycles of CPR after definitive airway is established
    - Severe COVID-19 related hypoxia that has deteriorated despite invasive mechanical ventilation.

7. Determining Appropriateness & Duration of Intervention

a) Decision to discontinue efforts is made by physician.
b) With patient historical factors and context of arrest in mind:
    I. Consider holding resuscitation for unwitnessed arrests in adults with suspected/confirmed COVID-19.
    II. Consider discontinuing resuscitation for adults after 1 cycle of CPR once a definitive airway is established with the following rationale:
        i. Purely hypoxic arrests should respond quickly to restoring oxygenation with a definitive airway.
        ii. Chance of survival for asystole and PEA that does not respond quickly to ACLS measures is poor.
        iii. If the patient is suffering from severe and progressive COVID-19 disease, resuscitative efforts are unlikely to change the course of this disease.
        iv. Prolonged resuscitative efforts increase ongoing risk of exposure to all healthcare providers involved in the code.

8. Further Treatments & Investigations

a) Diagnostic imaging should be avoided during code blue for patients with suspected/confirmed COVID-19.
b) Obtaining laboratory specimens should be avoided during code blue for patients with suspected/confirmed COVID-19.
c) Consider empiric needle decompression of chest if pneumothorax suspected (considered to be an AGMP).
d) Extra equipment should not be brought into room such as portable ultrasound, EKG machine if not necessary.

9. Documentation

a) Documentation is low priority, but still important.
b) Healthcare providers involved in the code blue can meet and reasonably recall events for documentation following the code.
c) Documenter, if available, should remain outside the door.
d) Follow Policy 06-008-00 *Documentation Standards* & 06-008-01 *Documentation Standard Guidelines* found in Government of Nunavut Community Health Nursing Manual.

e) Use of speaker function on telephone in isolation room or baby monitor, is suggested.
f)

10. Successful Code Blue During COVID-19 Pandemic

a) If patient has return of spontaneous circulation (ROSC), ongoing management must be provided while maintaining full airborne/contact/droplet precautions until patient is transferred to higher tertiary centre.
b) If ventilator available (closed circuit), patient can be removed from airborne precautions 4 hours after AGMP or resuscitation.
c) Any urgent investigations such as blood work should be carried out by those healthcare providers already in the room, whenever possible.
d) After successful code blue, ALL equipment and medication are to remain in the room for safe disposal and decontamination.
e) Garbage and linen may be removed as per isolation policy in housekeeping manual; however, equipment if possible, should stay in room until patient leaves room.
f) At least one designated RN to remain in room with patient to provide supportive care; may need to be relieved by another team member depending on transport time to higher level care centre.
g) Medevac to be arranged by regional physician; contact RCDC and/or CPHO; ensure transport team aware of precautions.
h) Disposition of patient would be decided by the regional physician on-call.
i) Documentation to be completed by Nurse who was designated to document; maintain documentation outside of room.
j) Once patient leaves, allow 4 hours to elapse before cleaning, according to housekeeping procedure (see Reference List).

11. Termination of Code Blue During COVID-19 Pandemic

a) After unsuccessful code blue, ALL equipment and medication are to remain in room for safe disposal and decontamination.
b) DO NOT extubate patient – leave ambu-bag, filter, and airway, in situ.
c) Housekeeping staff to perform a decontamination and disposal of room, 4 hours after patient removed from room.
d) Careful doffing of PPE must be done for all involved personnel, one at a time, with the designated observer ensuring proper processes followed.
e) If possible, staff involved in resuscitation/code blue should shower and change clothing.

12. Summary of Adjustments to CPR algorithms during COVID-19 pandemic

Reduce Provider exposure

a) Assume all patients are COVID-19 positive during an arrest
b) Don PPE before entering room/scene
c) Limit personnel involved

Prioritize oxygenation and ventilation strategies with lower aerosolization risk

d) Defibrillation can be performed early without airborne precautions for shockable rhythms
e) Before intubation, BVM can be used if it can be performed using 2 Person, 4 Handed approach
f) Viral HEPA Filter to be used
g) Consider passive oxygenation with a facemask as an alternative to bag mask ventilation when not immediately available

h) Intubate early with a cuffed tube, if possible, and connect to mechanical ventilator when able (applies to Rankin Inlet only)
i) Engage the Intubator with the highest chance of first-pass success
j) Pause chest compressions to intubate
k) Consider use of video laryngoscopy or LMA, if available

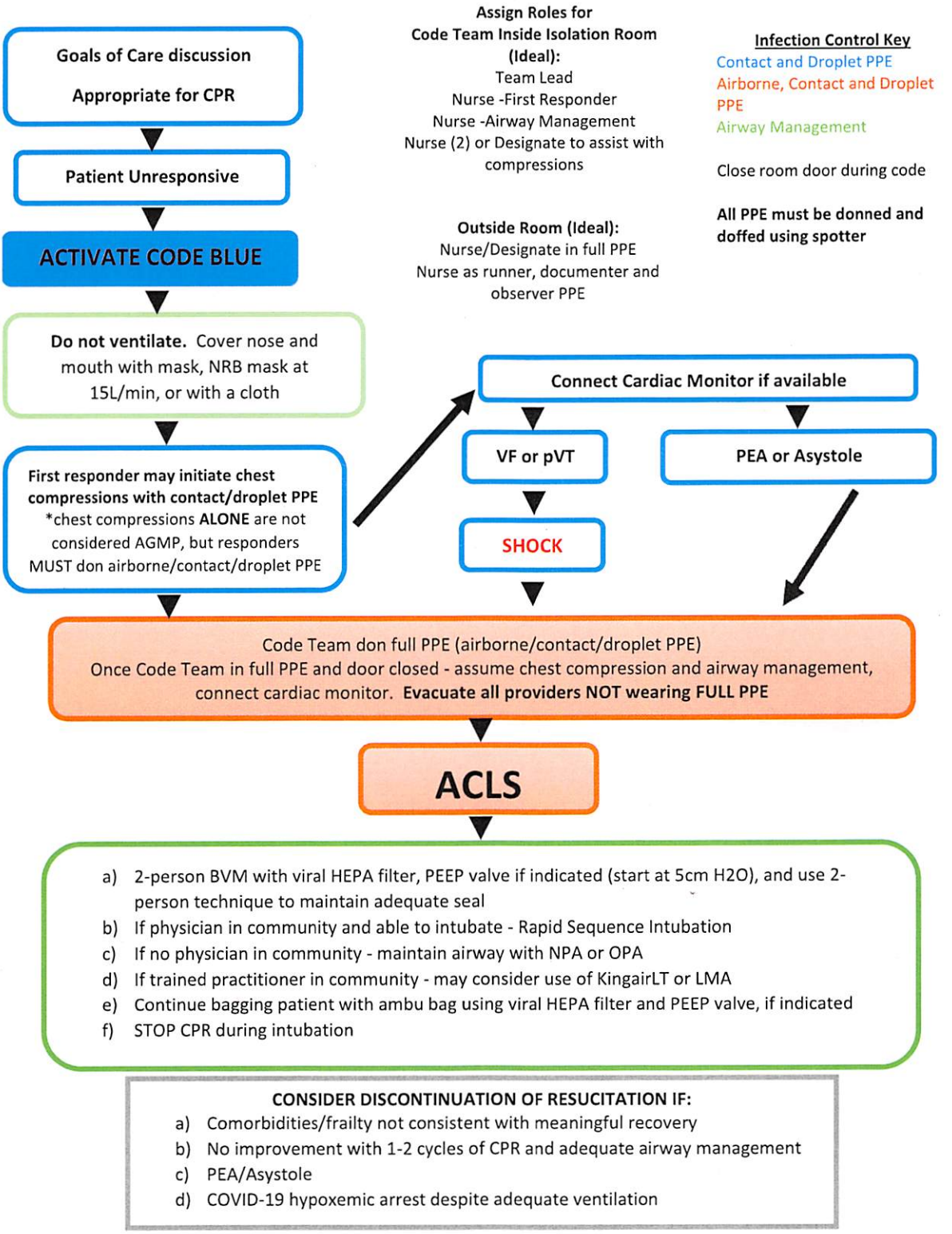
Consider Rescuer Appropriateness

l) Address Goals of Care in early course of illness, when possible
m) Consider discontinuation of CPR following 1-2 cycles with adequate ventilation

Pediatric Considerations

a) Equipment: Broselow Equipment Organizer outside of room – supplies brought in as needed
b) Medication: As directed by Physician
c) Defibrillation: Energy delivery as directed by Physician, based on weight
d) Running the Code Blue: Physician, or Physician on call and according to PALS Guidelines
e) Rescuer Appropriateness: Physician to determine appropriateness and duration of resuscitation

Community Health Centre Protected Code Blue During the COVID-19 Pandemic



Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS Community Health Nursing	
TITLE:	**SECTION:**	**POLICY NUMBER:**
Transfer of Person Requiring Medical Care from water vessel to shore within Nunavut during COVID-19 Pandemic	Nursing Practice	07-038-00
EFFECTIVE DATE: / **REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
June 23, 2020 / June 2023	N/A	5
APPLIES TO:		
Community Health Centres		

1. **BACKGROUND:**

The Government of Nunavut (GN) has placed specific limitations and restrictions on travel in to the Territory of Nunavut in response to the SARS-CoV-2 virus (COVID-19) global pandemic. These limitations and restrictions are in place specifically to minimize risks for Nunavummiut.

During the summer months goods are transported to Nunavut by ocean going vessels/sealifts. The ships provide an essential service by transporting goods into Nunavut from other jurisdictions.

Persons onboard the sea vessels/ships may need access to healthcare services at community health centres and/or the Qikiqtani General Hospital (QGH). This policy has been developed in consultation with Federal Health and Marine partners, as well as the GN Departments of Health (DH) and Community and Government Services (CGS) to provide guidance and direction on how to safely provide care for these individuals while ensuring the safety of Nunavummiut. It is assumed that the sea vessels/ships are not arriving directly from international water.

2. **POLICY:**
   - 2.1 It is the requirement that all communicable diseases be reported through existing standard operating procedures outlined in the Government of Nunavut Communicable Disease Manual and the COVID-19 Public Health Protocol.
     - 2.1.1 Department of Health staff will provide health care services to sealift re-supply vessel staff who develop an illness or are injured.
     - 2.1.2 All staff will take necessary precautions described in this protocol to reduce the risk of COVID-19 transmission once the ill or injured individual is brought ashore.

3. **PRINCIPLES:**
   - 3.1 Safety and protection of healthcare providers, and community members is priority.
   - 3.2 Additional precautionary measures should be taken when delivering care to patients with COVID-19 infection or communicable disease.
   - 3.3 During the current pandemic, assume that all out of territory travel/contact be considered high risk for COVID-19 transmission.
   - 3.4 All persons/patients seeking medical attention at Nunavut Health Centres or Hospital setting require screening for COVID-19.

4. **DEFINITIONS:**
   - 4.1 Nurse refers to Community Health Nurse (CHN) or Supervisor of Community Health Programs (SCHP).
   - 4.2 Person refers to anyone who has travelled or is travelling on a sea vessel/ship from out of territory for seasonal sealift deliveries to communities.
   - 4.3 Patient refers to any person from the sea vessel/ship that requires care at the health centre or hospital.
   - 4.4 Non-urgent refers to conditions that may be acute but non-urgent as well as conditions which may be part of a chronic problem with or without evidence of deterioration.
   - 4.5 Urgent refers to conditions that could potentially progress to a serious problem requiring emergency interventions.
   - 4.6 Emergent refers to conditions that are a potential threat to life, limb or function requiring rapid medical interventions and the use of condition specific controlled medical acts.
   - 4.7 Resuscitation refers to conditions that are considered threats to life or limb and have imminent risk of deterioration requiring immediate aggressive interventions.

5. **RECIPIENT PATIENTS:**
   - 5.1 All persons that require medical care in a community health centres or Qikiqtani General Hospital from out of territory sea vessels.

6. **PROTOCOL:**
   - 6.1 While a sea vessel is in transport, as soon as there is a potential or actual need for medical care; COVID-19 or otherwise, the vessel Captain should contact the Canadian Coast Guard Marine Communications and Traffic services (MCTS) as per usual protocol.
     - 6.1.1 The Vessel captain will notify MCTS if they contact the health centre or hospital directly.
   - 6.2 ***For minor injury or illness scenarios where COVID-19 is not suspected***
     - 6.2.1 The health centre or hospital at the closest port is contacted prior to disembarking to arrange for health screening.
     - 6.2.2 If vessel is at sea, the vessel captain will contact MCTS to flag medical issues. MCTS will contact the closest health centre for instructions.
     - 6.2.3 The patient must wear a non-medical mask to disembark the vessel.
     - 6.2.4 The patient being transported to the health centre is to restrict contact with community members. If a patient requires assistance getting to the Health Centre or Hospital-limit to 1 person from the ship to attend with the patient. The attendant is also required to wear a non-medical mask.
     - 6.2.5 Health centre staff will don appropriate PPE and place patient in designated isolation room/space.
     - 6.2.6 Patient is to be treated, then transported back to the ship and will restrict contact with community members enroute.
   - 6.3 ***For minor injury or illness scenarios where COVID-19 is suspected***
     - 6.3.1 Patient to wear a surgical mask and should be isolated immediately onboard, as per the vessel's COVID-19 contingency plans.
     - 6.3.2 Captain to contact the health centre for screening assessment of the patient over the phone.
     - 6.3.3 The nurse will then use the COVID-19 Healthcare Provider Flowchart and consult with the PHO on call to decide next steps (e.g. if swab needed).
     - 6.3.4 If swab is needed, the nurse is to follow the COVID-19 Protocol Appendix B. Home

Testing Guidance and obtain the swab at the sea vessel/ship, beach, or dock – which ever location is most suitable and presents the least risk of viral transmission.

6.3.5 The swab is to be tested in Iqaluit or Rankin Inlet using the GeneXpert for faster results and also sent to the southern testing facility, as per established local protocols.

6.3.6 Captain of the vessel is to instruct all persons to report symptoms consistent with COVID-19 as per the COVID-19 Public Health Protocol.

6.3.7 All persons on board the vessel reporting symptoms are to be assessed using the COVID-19 Healthcare Provider Flowchart and swabbed accordingly. Consult with Public Health Officer (PHO) on call for direction.

6.3.8 The PHO, nurse, and vessel captain should assess the situation together and determine next steps regarding isolation plans via conference call.

6.3.8.1 Operator may need to arrange and pay for a charter to send the swab to Iqaluit or Rankin Inlet for faster results with the GeneXpert. This decision will rest with the PHO on call and the Vessel Captain.

6.3.8.2 If the patient is not permitted to re-board, the vessel operator is responsible for arranging an aircraft charter as soon as possible out of community. Note: medical evacuation using GN emergency system is reserved for those who medically require transfer to another health facility for care and treatment. Therefore, the vessel operator will need to arrange alternate air charter service for this type of evacuation.

6.3.9 The captain or public health officer may request a secondary risk assessment and planning conference call to address concerns of a broader stakeholder group (PHAC, TC, CG, JFTN, PS NEM, Captain, operation and GN Health).

6.3.10 If there will be a delay in transport, the patient will need to be isolated at the expense of the vessel operator. The health centre may not have capacity to keep patient in health centre beyond 4 hours.

6.4 ***For emergent/resuscitation scenario where COVID-19 IS or is NOT suspected at Sea***

6.4.1 The Vessel Captain contacts MCTS to flag medical issues.

6.4.2 MCTS will connect with the Emergency Room Physician at QGH, where a decision will be made if the patient needs to come ashore, requires a sea medivac, and the level of urgency.

6.4.3 If the patient needs to come ashore for treatment, the ER physician will contact the Nurse on Call or SCHP of the nearest health centre to determine appropriate location to come ashore.

6.4.4 If a medivac from the vessel is warranted, MCTS will coordinate the medivac with the Joint Rescue Coordination Centre (JRCC) and the ER physician on call.

6.5 ***For emergent/resuscitation scenario where COVID-19 IS or is NOT suspected anchored at community:***

6.5.1 The Vessel Captain will call the health centre directly. Health centre to screen for COVID symptoms when feasible and safe to do so.

6.5.2 If life threatening condition – Do not delay transport. Someone from ship to call the health centre while patient is transported immediately to the health centre.

6.5.3 Health Centre staff to coordinate transport from the beach to the Health Centre (if non-ambulatory), limiting contact with community.

6.5.3.1 If patient needs assistance getting to the Health Centre – limit persons from the ship to attend with the patient. Everyone to wear nonmedical masks when disembarking.

6.5.3.2 Health Centre staff will don appropriate PPE, and isolate patient immediately in designated isolation room upon arrival to the Health Centre.

6.5.3.3 Patient treated and transported back to the ship, limiting contact with community.

6.5.3.4 If patient not able to continue with the vessel voyage due to medical reasons, a medevac is to be arranged by the Health Centre, while the patient remains isolated in the Health Centre.

6.6 ***For emergent/resuscitation scenario where COVID-19 is suspected:***

6.6.1 Patient to wear medical mask and be isolated immediately onboard, as per the vessel's COVID-19 contingency plans.

6.6.2 Captain to contact the health centre – screening and assessment to occur over the phone using the COVID-19 Health Care Provider Flowchart and consult to PHO on call. Do not delay transportation to health centre if a life-threatening condition.

6.6.3 Bring to Health Centre, limiting contact with community members. If person is non-ambulatory, the Health Centre will coordinate transport from the beach to the Health Centre.

6.6.4 If patient needs assistance getting to the Health Centre – limit the number of persons from the ship to attend with the patient – both patient and attendant(s) will need to wear a surgical mask when disembarking.

6.6.4.1 In addition to the medical mask, the attendant should also wear gloves and eye protection (goggles or face shield).

6.6.4.2 PPE should be changed after the patient has been transferred to the health centre staff and appropriately disposed of in a sealed bag. If the attendant is at the health centre, they need to perform hand hygiene and don a new medical mask before leaving the health centre to return to the vessel.

6.6.4.3 Transport staff should frequently clean their hands with an alcohol-based hand rub or soap and water and ensure that they clean their hands before putting on PPE and again after removing the PPE.

6.6.5 Health Centre staff will don PPE and isolate patient in designated isolation room immediately upon arrival at the Health Centre.

6.6.6 Captain of vessel to instruct all workers onboard to report if they have symptoms consistent with COVID-19 as per the COVID-19 Public Health Protocol to the nurse at the health centre. It is to be reported to PHO on Call and/or MCTS if at sea.

6.6.7 Conference call between the PHO, the Health Centre nurse, and the vessel Captain to assess the situation and determine next steps including a testing and isolation plan.

6.6.8 The PHO and Captain will decide if a secondary conference call is needed with broader stakeholders (PHAC, TC, CG, JTFN, PS NEM, Captain, operator and GN Health) when there is risk to vessel operations.

6.6.9 If swabbing is needed for additional persons, nurses to go to the vessel, beach, or dock to carry out the swabbing and contact tracing as per the COVID-19 Protocol Appendix B Home Testing Guidance

6.6.10 Persons to wear a mask when disembarking. Crew may have to rotate ashore for testing.

6.6.11 If patient not able to re-board vessel and requires ongoing medical care, patient to be isolated in the Health Centre and medevac arranged by the Health Centre.

6.6.12 If patient does not need medical monitoring, then the vessel operator is responsible for aircraft charter to evacuate person from the community.

6.6.13 Operator may need to arrange and pay for a charter to send the swab to Iqaluit or Rankin Inlet for faster results with the GeneXpert. Some ships may be outfitted with antigen tests.

7. **RELATED POLICIES, PROTOCOLS AND LEGISLATION:**

COVID-19 Public Health Protocol
Government of Nunavut Communicable Disease Manual

8. **REFERENCES:**

Approved By	Date
Ruby Brown, Deputy Minister – Department of Health	
Approved By	Date
Monique Skinner, Acting Chief Nursing Officer	