Nunavut

Agency Nurse Orientation Training Program

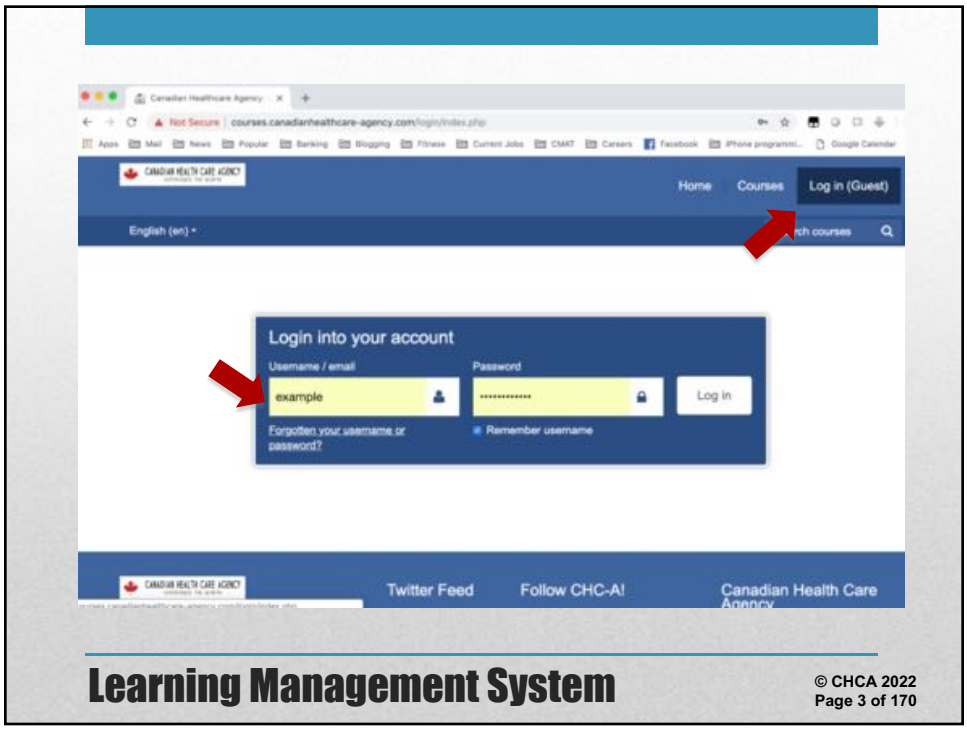
Created by Valerie Rzepka, NP

1

- Learning Management System
- Inuit Cultural Safety
- Team Communications and Patient Transportation
- Documentation
- Pharmaceuticals and Controlled Substances
- Laboratory Operations
- Immunizations
- Public Health and STBBI's
- Paediatrics
- Behavioural Health and Suicide Prevention
- Well woman Cervical Exam
- Prenatal Examination

Overview

2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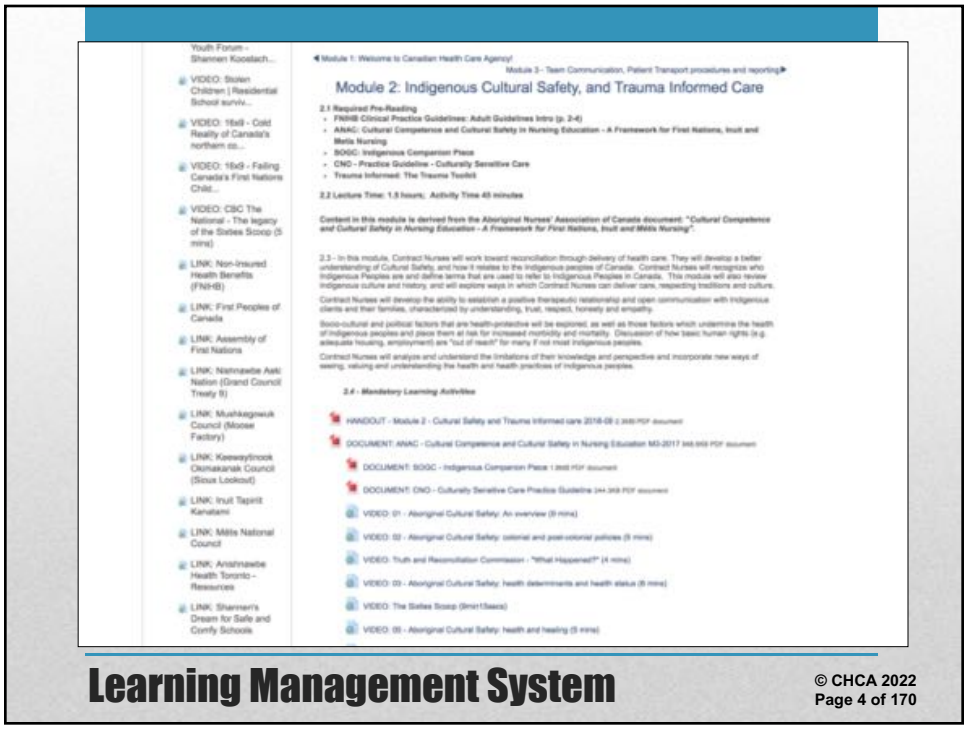
Page 3 of 170

3


Module 2: Indigenous Cultural Safety, and Trauma Informed Care
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Page 4 of 170

4

Inuit Cultural Safety

Drum Dancer: Peter Pitseolak

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EXPERIENCE THE NORTH

5

Video – Arctic Defenders

Arctic Defenders

6

Inuit ᐃᓄᐃᑦ (singular: Inuk)

- Inuit is defined as: "The People"
- Groups of culturally similar indigenous peoples inhabiting the Arctic and subarctic regions of Greenland, Canada, and Alaska (USA)
- There is no single Nunavut Inuit culture, just as there is no single non-Inuit culture. Interactions and practices need to acknowledge the diversity of Inuit and other cultures, locally, nationally and internationally.
- Live throughout most of Northern Canada in the territory of Nunavut, Nunavik in the northern third of Quebec, Nunatsiavut and NunatuKavut in Labrador, and in various parts of the Northwest Territories, particularly around the Arctic Ocean, in the Inuvialuit Settlement Region.
- Many individuals who would have historically been referred to as "Eskimo" find that term offensive, and/or forced upon them in a colonial way
- "Inuit" is now the most correct term for a large

sub-group of these people.

Inuit Terminology

7

Nunavut ᓄᓇᕗᑦ

- Means "our land" in Inuktitut.
- Territory separated officially from the Northwest Territories on April 1, 1999, via the Nunavut Act, and the Nunavut Land Claims Agreement Act
- Largest Land Claim agreement in history,
- Inuit now have an independent government – Capitol city Iqaluit.

Nunavut History

8


Grise Fiord
Resolute
Arctic Bay
Pond Inlet
Clyde River
Qikiqtarjuaq
Igloolik
Cambridge Bay
Taloyoak
Hall Beach
Kugaaruk
Kugluktuk
Gjoa Haven
Pangnirtung
Repulse Bay
Iqaluit
Cape Dorset
Kimmirut
Baker Lake
Coral Harbour
Rankin Inlet
Chesterfield Inlet
Whale Cove
Arviat
Churchill
Sanikiluaq
Nunavut – Common community names
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Page 9 of 170

9


KITIKMEOT
QIKIQTAALUK
Takurjuaq
Kugaaruk
Nunavut
Naujaat
Qamani'tuaq
Kangiqiniq
Tikiraqjuaq
KIVALLIQ
Arviat
Sanirajak
Pangnirtung
Igaluit
Kimmirut
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Page 10 of 170
Nunavut History – Inuktitut community names

10

- Of Canada's Indigenous languages, the Inuit language is one of the healthiest.
- The Inuit language, Inuktut, consists of several dialects, two of which are officially spoken in Nunavut: Inuktitut and Inuinnaqtun.
- This is the mother tongue of nearly 70% of the population of some 32,000.
- Instruction in Inuktut has been available up to Grade 3 since 2009, and by 2019 it was made available to all grades.

Nunavut – Official Languages

11

- Claims of early contact between the Inuit and Norse/Vikings is unclear and remains controversial
- First recorded European contact was made by English explorer Martin Frobisher in 1576 while searching for the Northwest Passage.
- Other explorers in search of the elusive Northwest Passage followed in the 17th century, including Henry Hudson, William Baffin and Robert Bylot.

Nunavut History – European Contact

12

- Prior to the arrival of European customs, the Inuit had no need of family names, and children were given names by the elders.
- "Eskimo Identification Tag System" was used by the Government of Canada in lieu of surnames and were similar to dog tags.
- Under the Eskimo Identification Tag System, each Inuit person was issued an individual number on a leather tag which was used to identify them in place of their given name.
- By the 1940s the record-keeping requirements of outside entities such as missions, traders and the government brought about change. In response to the government's needs, it decided on the disc number system.
- From the 1940s until the 1978, Inuit people in the Canadian Arctic were forced to wear these tags.

Nunavut History - Disc Numbers (ujamiit or e-numbers) © CHCA 2022 Page 13 of 170

13

- In 1953 and 1955, the RCMP moved approximately 92 Inuit from Inukjuak, in Northern Quebec and Pond Inlet, Nunavut to settle in Resolute and Grise Fiord on High Arctic islands.
- It has been argued that the Government of Canada ordered the relocations to establish Canadian sovereignty in the Arctic, and promised in Inuit improved living conditions, and assured plentiful wildlife.
- The relocated Inuit were dropped on the beach, with minimal supplies. They soon discovered that they had been misled, and endured hardships, the effects lingering for generations.
- 1980's a report was published: *The High Arctic Relocation: A Report on the 1953–55 Relocation.*
- The government paid compensation to those affected and their descendants. On August 18, 2010, in Inukjuak, QC, a formal apology was given on behalf of the Government of Canada for the forced relocation of Inuit to the High Arctic.

Nunavut History – Cold War and Forced Relocation © CHCA 2022 Page 14 of 170

14

- Sled Dogs were once used as the preferred method of transportation by Inuit in the Canadian Arctic. By the 1960s traditional working dog teams became increasingly rare in the North.
- Controversy surrounds the intentional killings of a debated number of Inuit sled dogs between 1950 and 1970 by the Royal Canadian Mounted Police. Estimates of the number of dogs killed range from 1,200 to 20,000.
- In some communities, elders have alleged that this destruction was conducted in order to intimidate the Inuit and to intentionally disrupt their way of life.
- A 2005 RCMP report concluded that dogs were indeed killed, but for public health purposes, but also acknowledged that the RCMP rarely followed ordinances that required dogs to first be captured and owners to be notified before killings, that owners had no recourse against unreasonable killings, and that the justification for killings were not always explained to the Inuit. The Qikiqtani Inuit Association denounced the report as "biased, flawed and incomplete."
- In August of 2019, a wide ranging apology to the Inuit of Baffin Island, including for the slaughter and forced decline of Inuit dogs.

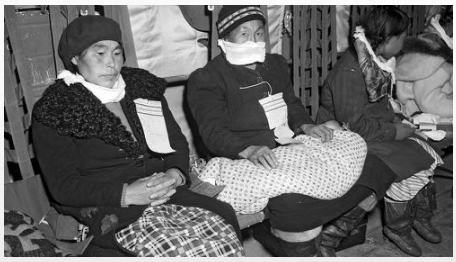
Nunavut History – RCMP Sled Dog Cull (qimmiijaqtauniq)

15

- Tuberculosis reached epidemic proportions in Canada and peaked among Inuit between the 1940s and 1960s
- Inuit were greatly affected due to the high incidence of TB, the lengthy separation of patients from families, and lack of information on the fate of their loved one.
- In the 1950s, at least 1/3 of the Inuit population was infected with tuberculosis.
- Due in part to a lack of medical facilities in the north, many Inuit were sent far from their home communities to sanitoria across Canada for treatment for an average of two-and-a-half years, but some stayed much longer
- Many Inuit patients were treated and returned home, however, many others died and were laid to rest near treatment facilities.
- To this day, many Inuit are still searching for information, including the whereabouts of their family member's grave. Others do not know the complete history of what happened to their family members during treatment.

Nunavut History - Tuberculosis

16



- Although TB has been nearly eliminated in non-Indigenous people born in Canada, it is a public health crisis in some First Nations, Inuit and Métis communities.
- Living conditions, health inequities, historical traumas, and stigma help sustain high incidence rates of active in some Indigenous communities.
- Populace incidence rates for 2016 :
- 0.6 per 100,000 among Canadian-born, non-Indigenous people;
- 23.8 per 100,000 among all First Nations people;
- 170.1 per 100,000 among Inuit;
- 2.1 per 100,000 among Métis people.

Tuberculosis – The Inuit Experience

17

- In the 1970s, the Canadian Government caused the forced sterilization of over 150 Inuit women, to reduce the “future burden” on the government.
- These women did not know that this was occurring and did not provide consent for this to occur.

Forced Sterilization

18

- Inuit across the north were surveyed for their opinions, findings of which were published in the *Inuit Use and Occupancy Study, 1973.* The study showed where the Inuit live today and where their ancestors lived. It also discussed how land is, and was, used.
- Negotiations between the Inuit (represented by the Tungavik Federation of Nunavut) and the Canadian Government began in 1976, continued throughout the 1980's. A plebiscite vote was held in April 1982 with the majority voting in favour of division, and the agreement was finally signed in May 1993.
- Inuit indicated that they did not want reserves under the Indian Act. Like other Canadians, they wanted to pay their taxes and enjoy a modern standard of living. Inuit also wanted to protect and promote their way of life, language and heritage.
- Negotiators worked to make Inuit rights and benefits clear. The Agreement recognizes the contributions of Inuit to Canada's history, identity and sovereignty in the Arctic.

Nunavut History – Nunavut Land Claims Agreement

19

- The term Inuit Qaujimajatuqangit refers to Inuit "Traditional Knowledge"
- Meant to encompass local and community based knowledge, ecological knowledge (both traditional and contemporary), which is rooted in the daily life of Inuit people, and has an important contribution to make to an impact assessment.
- The incorporation of traditional knowledge into government regulatory frameworks may also reflect a widespread concern regarding the social and economic sustainability of natural resource based livelihoods throughout the world.

Inuit Qaujimajatuqangit principles

20

The Nunavut Impact Review Board continues to be guided by the following Inuit Qaujimajatuqangit principles, as set out by the Government of Nunavut:

- ᐃᓄᖅᑲᑎᒪᔨᕐᓂᖅ - **Inuuqatigiitsiarniq**
  Respecting others, relationships and caring for people.
- ᑐᙵᓚᓐᓂᖅ - **Tunnganarniq**
  Fostering good spirit by being open, welcoming and inclusive.
- ᐱᔪᓯᓂᖅ - **Pijitsirniq**
  Serving and providing for family and/or community.
- ᐊᔨᖅᑎᒋᔭᓂᖅ - **Aajiiqatigiinniq**
  Decision making through discussion and consensus.
- ᐱᓕᒪᒃᑲᓂᖅ - **Pilimmaksarniq**
  Development of skills through observation, mentoring, practice, and effort.
- ᐃᑲᔪᖅᑎᒋᔭᓂᖅ - **Ikajuqtigiinniq**
  Working together for a common cause.
- ᖃᓄᖅᑐᓂᖅ - **Qanuqtuurniq**
  Being innovative and resourceful.
- ᐊᕿᑎᕋᔭᐅ ᑲᒪᓯᐊᓂᖅ - **Avatittinnik Kamatsiarniq**
  Respect and care for the land, animals and the environment.

Inuit Qaujimajatuqangit principles

21

- European explorers interacted with some Inuit villages in the 1600's, but did not significantly impact the Inuit lifestyle.
- In the 1800's, the whaling industry moved to the Arctic, and the Inuit lifestyle began to change. Whalers, merchants and fur traders, brought new tools and technology to the Inuit, as well as devastating diseases which wiped out entire camps.
- Inuit life is very different in the Canadian Arctic today.
- The advent of satellite technology has had a profound effect on isolated Inuit Arctic communities.
- While strong traditional values and ethics are woven into the fabric of many Nunavut communities, Inuit are now adapting and using home computers, cell phones, cable TV and Satellite based Internet.

Inuit Lifestyle

22

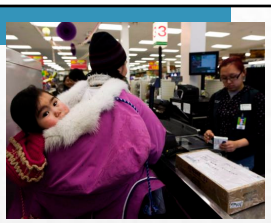
- Traditional life in the Arctic was semi-nomadic, moving from one place to another with the seasons to hunt caribou, muskox and seal, or fish for char and whitefish.
- Walking between summer and winter camps was the primary method of transport
- Kayaks (small boat) and Umiaks (larger boat) were used to hunt sea mammals - motor boats are more common now.
- Today most Inuit use snowmobiles to travel on the land, often towing a Qamutiik (sled)
- For 8-9 months of the year there is sufficient snow on the land and ice on the frozen ocean and lakes to make snowmobile travel practicable.
- During the 3-4 months of summer, many Inuit use ATV. The trade names of "Ski-Doo" and "Honda" are used interchangeably to refer to a snowmobile or ATV.
- Inter-community travel is usually by airplane. Aircraft are the vital link connecting many communities, transporting passengers, mail, supplies and groceries all year, weather permitting.



Inuit Lifestyle - Transportation

23





- The climate dictated when and where families would move. Camps would be established to hunt caribou. When an animal was caught, the camp shared the food equally. Sharing and interdependency were traits of the traditional Inuit economy.
- Within the camp there were different people with different skills (eg. Sewing, hunting) - no one individual had all the skills necessary, and the survival of the group was dependent on the skills and abilities of the individuals. Similarly if a hunter were injured, his family would be provided with food and care until he recovered
- Life has changed and Nunavut today has adopted a wage economy. The need for income to purchase groceries, pay mortgages, and buy boats, ATV's and Ski-Doos has encouraged many Inuit to take jobs with the Nunavut government and municipal governments. The Canadian dollar has become the medium of exchange.
- The centralization and urbanization of Canadian Inuit into 28 Nunavut communities ("Hamlets") has eroded traditional and cultural pursuits and values, but has facilitated the delivery of contemporary education, employment and health care.

Inuit Lifestyle - Economy

24

- Traditionally Inuit lived in small groups of several families. Relatives are obliged to share with each other. Virtually everyone became a relative, and decisions made by consensus. The size of the group depended on the hunting resources of the area.
- A household might consist of a wife and husband, unmarried children, an adopted child, and maybe someone's widowed mother or a widowed sister.
- Today Inuit live in 28 small communities throughout Nunavut. The home environment is generally heated with electricity.
- Many Inuit families live in social housing. It is estimated that 15% of Nunavut's population is waiting for public housing, and over 3,000 homes are needed to meet the need.
- It is reported that 39% of Inuit people live in crowded homes, 33% of the homes are in need of major repair, and 33% are in core housing need. Inuit people are 10 times more likely to live in crowded homes and 5 times more likely to live in homes in need of major repair than non-Indigenous people.
- Housing conditions contribute to many health and social issues for Inuit children and youth – including increased rates of infectious and respiratory illnesses.

Inuit Lifestyle – Social Organization

25

- Inuit Families are commonly united by marriage.
- The use of namesakes created yet another bond. Naming a child after a recently deceased person meant that the child belonged to two families: the original and that of the namesake.
- Children can also be made kin through custom adoption. Inuit adoption, however, creates more than just a bond between the adopted child and its new family. It creates a link between the new parents and the natural parents.
- Traditionally, the custom was for the grandparents to adopt the first-born child of a couple (usually on the father's side). This ensured all camps had a population of young people, and ensured the continuation of kinship bonds and vibrant communities.
- Custom adopted children always knew from a young age who their birth parents and birth family were. Inuit custom adoption is a centuries-old form of open adoption that ensured each child had a network of loving family and teachers throughout their lifespan.

Inuit Lifestyle – Kinship

26

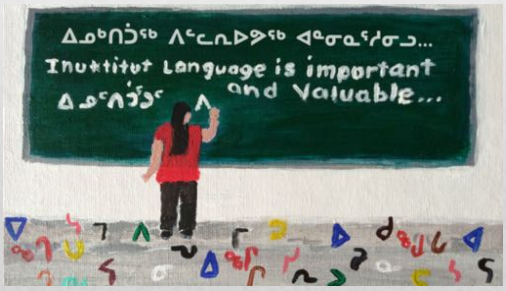
- In traditional Inuit households, children were treated with patience and gentleness, and in response, children were seldom unruly. Slapping and scolding were not regarded as acceptable
- Being patient was part of life and children learned this too. If a family was confined to the igloo because of a storm, children entertained themselves. After all, bad weather or sickness couldn't be controlled: one simply learned to live with it. Waiting was a part of life.
- Ajurnamat, the people would say: "it can't be helped."
- Child are carried/ packed in Amauti (Packing parka) often up to the age of 5 or 6.
- Education took place within the family and the community circle. By constant exposure to their parents and other adults in the community, children learned all they needed to live successfully.
- Inuit children today spend as much time in front of screens, as children anywhere in Canada. As of December, 2000, every Nunavut community is connected to the internet.

VIDEO – Inuit Amauti

Inuit Lifestyle – Child Rearing

27

- The Inuit of old did not have a written language, so skills and knowledge were passed down by word of mouth. After a successful hunt, for example, the details would be shared with the community.
- Schools throughout Nunavut now teach Canadian curriculum from K-12, with aspects of cultural immersion and inclusion.
- Inuktitut existed without written form until missionaries went North in the 18th and 19th centuries and introduced syllabics.
- But the Inuit possessed more than an oral language. They also maintained a non-verbal language that relied on body expression and other cues to display feelings. So, the Inuit learned to interpret human behaviour in the same manner they read animal behaviour.



Inuit also use many non-verbal communication methods

Video – Inuit yes and no

Inuit Lifestyle – Language

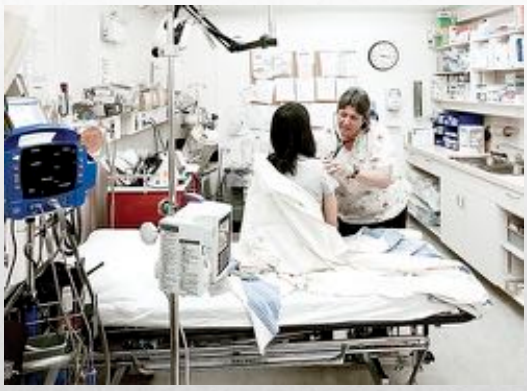
28

- Inuit children attend elementary schools and high school, and are subject to federal and territorial laws which are administered in every Nunavut community by the RCMP and municipal by-law officers.
- Today many Inuit read and write both English and Inuktitut. Middle aged and elderly Inuit are mainly unilingual in Inuktitut, or speak some English, while the younger Inuit are mainly bilingual.

Inuit Lifestyle – Education

29

- The Inuit were, by and large, a healthy people. Their diet was protein rich and provided all the necessary nutrients.
- With the coming of non-natives to the north, the Inuit were exposed to many diseases. Having little or no immunity to these foreign illnesses, the Inuit died by the hundreds.
- Today Inuit have health care provided by Nunavut Government.
- Each community has a Health Center, staffed by nurses and community health workers.
- Serious injuries are flown to Yellowknife, Winnipeg or Iqaluit by regular airplane or on a medievac in an emergency situation.



Inuit Lifestyle – Health

30

- Children spent a lot of time outside playing tag or hide and seek or pretending to hunt. There are other games for the young and old during the long, dark winter months,
- Games were also geared to enhance societal values. Feats of strength such as leg wrestling kept men in good physical shape. Other games such as arm-pulling tested men's endurance. The high-kick tested one's agility. In every aspect of the Inuit culture high value was placed on group achievement rather than self-achievement, and games were no exception.
- The Inuit were also great storytellers. The Inuit also maintained a large repertoire of legends, many of which their society's values and stimulated the imagination.
- Today Inuit enjoy volleyball, basketball, badminton, ice hockey, and curling. Most communities have a school gym, a community hall and an ice hockey rink with one or two sheets of curling ice available.

Inuit Lifestyle – Recreation

31

- The drum dance combined music, song, dance and story. It was performed by an individual or by a group, depending on the custom of the area. In the eastern arctic the drum (made of animal skin) could be a meter in diameter.
- It was held in one hand, with the wrist rotating the drum back and forth. As the drum was rotated, its rim was hit with a stick held in the other hand. The drum dancer, who could also be the drummer, moved rhythmically, acting out the imagery of the accompanying song, usually a personal story.
- Women in many northern communities, particularly in the eastern and central arctic practiced a form of singing called throat singing.
- Two women facing each other made guttural and resonant sounds through voice manipulation and breathing techniques. Often, the resulting sounds imitated the sounds of the north - the northern lights, the seashore, the wind - and evoked similar images.

Inuit Lifestyle – Music, Singing and Dance

32

Warning:

The next section contains subject matter which some participants may find disturbing.

33

Imagine being taken from your parents at the age of five. Being given a number instead of a name. Being punished for speaking the only language you know. Being cut off from your family.

Imagine being a parent, and being threatened with jail if you didn't give up your children. Imagine being cut off from your children for ten years.

What would it do to your family?

34

- While the Inuit residential school experience was unique, the broader themes of colonization and assimilation remain constant.
- The first government-regulated school for Inuit opened in 1951 in Chesterfield Inlet.
- After 1950, when Inuit became settlement based, almost all Inuit children were required to attend Residential Schools or federal hostels in order to receive a formal education.
- These schools were often far away from the new Inuit settlements which resulted in the separation of children and youth from their parents, kinship networks and traditional ways of life.
- Residential Schools for Inuit continued to open into the 1960s and by 1963, 3,997 Inuit children were attending these schools.
- In June 1964, 75% of Inuit children and youth aged six to 15 years were enrolled in the schools.

The Inuit Legacy of Residential Schools

35

- It is believed that at least 3,000 Inuit who attended Residential School are still alive today, and according to the Aboriginal Peoples Survey, almost half (44%) of those 44 to 54 years of age had a close family member who attended these schools.
- Inuit language, culture and spiritual beliefs were eroded because of the assimilation process.
- Traditional Inuit education was passed on from adults to children and intertwined practical skills with cultural values. Traditional Inuit skills included hunting, meat and pelt preparation, sewing, building igloos and navigating the land and water.
- The rich tradition of oral storytelling, music, dance and craft and a respect for the environment that were an integral part of Inuit knowledge and way of life was eroded as a result of the Residential School experience.
- Inuit were not considered Indians as defined and controlled by the Indian Act until 1939, due to a prior lack of interest in their lands. Once Inuit came under the control of the Indian Act, Inuit health, welfare and education was to become a responsibility of the federal government, although Canada was reluctant to take on this role.

Long-term and intergenerational effects of Residential Schools

36

- Between 1950 and 1960, the federal government undertook a major expansion of schooling in the North. After 1950, the federal government created a system of day schools and hostels under the direction of Northern Affairs, which led to a rapid and hostile transformation of traditional, land-based lifestyles and economies.
- The schools were not simply an extension of the already established southern residential school system.
- Travelling extreme distances to attend schools often resulted in separation from families for years. Often schools were only accessible by boat or plane and extremely far away from students' homes, which made contact with family members impossible.
- By 1964, the number of school-aged Inuit children attending residential schools had increased to over 75%.
- Day schools and small hostels in the eastern Arctic resulted in parents relocating on a year-round basis to be closer to their children. The western Arctic established large hostels that brought children from different regions and backgrounds together.
- The large and small hostels were distinct to the north. Small hostels were normally supervised by Inuit couples and housed 8–12 elementary aged children.

Long-term and intergenerational effects of Residential Schools

37

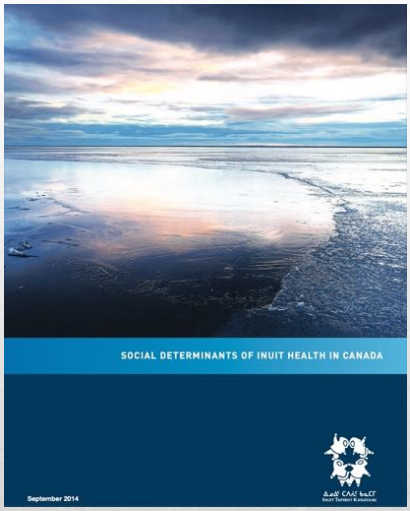
- For Inuit, the residential school system was but one facet of a massive and rapid sweep of assimilation that included:
  - the introduction of Christianity;
  - forced relocation and settlement;
  - the slaughter of hundreds of sled dogs eliminating the only means of travel for many Inuit;
  - the spread of tuberculosis and smallpox, and the corresponding mandatory southward medical transport;
  - the introduction of RCMP throughout the Arctic; and
  - other disruptions to the centuries-old Inuit way of life.
- Inuit children were made to feel ashamed of their traditional way of life, and many acquired disdain for their parents, their culture, their centuries old practices and beliefs and even for the food their parents provided.
- Due to impacts of colonization, conditions within communities had deteriorated to a point where some attributes of the schools seemed to be an improvement to new notions of poverty and famine that many were faced with.

Long-term impact of Residential Schools

38

The following eleven factors have been articulated as key social determinants of Inuit health:

- quality of early childhood development;
- culture and language;
- livelihoods;
- income distribution;
- housing;
- personal safety and security;
- education;
- food security;
- availability of health services;
- mental wellness; and
- the environment.



Social Determinants of Inuit Health in Canada

39

- The Inuit Child First Initiative ensures Inuit children (ages 0-18) have access to the essential government funded health, social and educational products, services and supports they need, when they need them.
- Tungasuvvingat Inuit offers service coordination to support applicants in accessing the Child First Initiative.
- All Inuit children, no matter where they live in Canada, can request funding through the Child First Initiative. They must be: *recognized by an Inuit land claim organization in Canada and they must be under the age of majority in their province/territory of residence.
- Items that could be funded under the Child First Initiative:
  - Addiction services
  - Cultural services from Elders
  - Mental health counselling and supports
  - Psychological assessments (autism, cognitive psychoeducational assessments),
  - Assessments and screenings (speech and language, nutritional assessment)
  - Medical supplies and equipment, assistive devices
  - Therapeutic services (behavioural therapy, physiotherapy, occupational therapy,
  - Land-based activities, specialized summer camps
  - Respite care programs based on cultural beliefs and practices
  - Tutoring services, Educational assistants, specialized school transportation

Tungasuvvingat Inuit

Email: childfirst@tiontario.ca

Inuit Child First Initiative

40

- **Non-Insured Health Benefits** (NIHB) program provides medically-necessary coverage for eligible First Nations and Inuit people in Canada under the Indian Act.
- Administered by Health Canada and covers benefit claims for items not covered by the provincial health insurance plan (eg. OHIP) or private insurance plans (eg. Employer benefits) such as:
  - Most prescription and some non-prescription drugs,
  - dental care,
  - vision care,
  - medical supplies and equipment,
  - short-term crisis intervention,
  - mental health counselling, and
  - medical transportation.

Canada
NON INSURED HEALTH BENEFITS

- In Canada, provinces and territories deliver health care services, which can be accessed by First Nations and Inuit people.
- Health care providers must submit cases to Health Canada for review to access all vision care, transportation, and counselling, most dental, medical supplies and equipment benefits, and for some drug benefits.

Non-Insured Health Benefits

41

Who is eligible for Non-Insured Health Benefits?

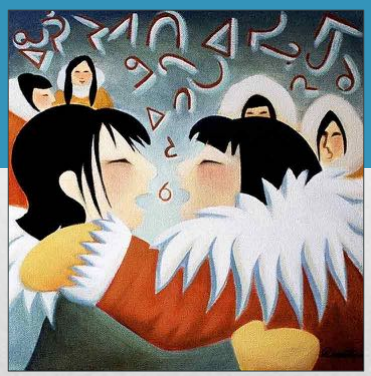
- An eligible client must be a resident of Canada and any of the following:
  - A First Nations person who is registered under the Indian Act (commonly referred to as a Status Indian)
  - An Inuk recognized by an Inuit land claim organization
  - An infant less than 1 year old whose parent is a registered First Nations person or a recognized Inuk
  - In order to be eligible for the dental program, kids must be registered with a Band number.
  - NEW! 24/7 online chat counselling service:

https://chat.fn-i-hopeforwellness.ca

Non-Insured Health Benefits

42

Team Communication, Medevac/ Schedevac Procedures



Throat Singing: Nathalie Parenteau

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EXPERIENCE THE NORTH

43

Nunavut Regions – Medevac Route Map

44

Arrival: Medical Driver picks up nurses from airport.

Keys: Upon arrival meet with Nurse in Charge (NIC), sign out keys and get apartment assigned. Apartments generally on 2nd floor of the clinic, sometimes in a separate location.

Narcotic Count in.

Phones: Front Desk Staff answers phones during clinic hours. Calls transferred to Nurse On Call after hours.

Your personal cell phone may work (Bell and Telus work. Rogers is hit and miss)

Internet for personal use is not provided – you may need to increase your data cap on your mobile device, or purchase a mobile stick from Qiniq.

Nursing Station 101

45

- Apartments furnished, appliances, dishes and linens provided. Laundry on site.
- Satellite or cable TV
- Need to supply your own toilet paper, paper towels, dish soap, laundry detergent etc. (available to purchase in community store)

Nursing Station 101

46

- Nunavut has a Territorially-run health care system.
- Through this system, the territory pays for the health services needed by patients.
- Anyone seeking care at the nursing station needs a Nunavut health card. (or other provincial health card)

Nunavut Health Care Card

47

All Consults require:

- 3 Patient Identifiers (Name, DOB, and Nunavut Health Card Number)
- History of presenting illness
- Review of Systems
- Treatment offered to date
- Recent Vital Signs
- Physical Assessment findings
- Working Diagnosis
- Collaborate and agree on plan of care.

Criteria for MD/NP Consult

48

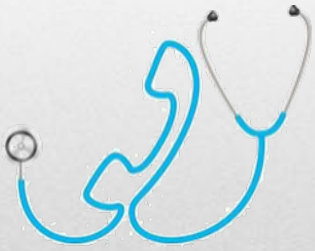
- Enter note into Meditech, consult with the scheduled NP.
- If no NP – the nurse will scan and email consultation to physician with a small chart review.
- Consulting physician – fill out Microsoft word form, providing basic health info, in brief SOAP note format. Send to community physician inbox (communitypager@gov.nu.ca).
- Page Physician who will retrieve note.

- Non-urgent/ Urgent – Email prior to contacting on-call physician/NP.
- Emergency/ Resuscitation – Phone on-call physician followed by email of on-call record as soon as clinical data has been collected, when reasonably possible, considering client needs and safety.
- Call backs should be expected within 30 minutes of receipt of the Community Call record.

Consultation

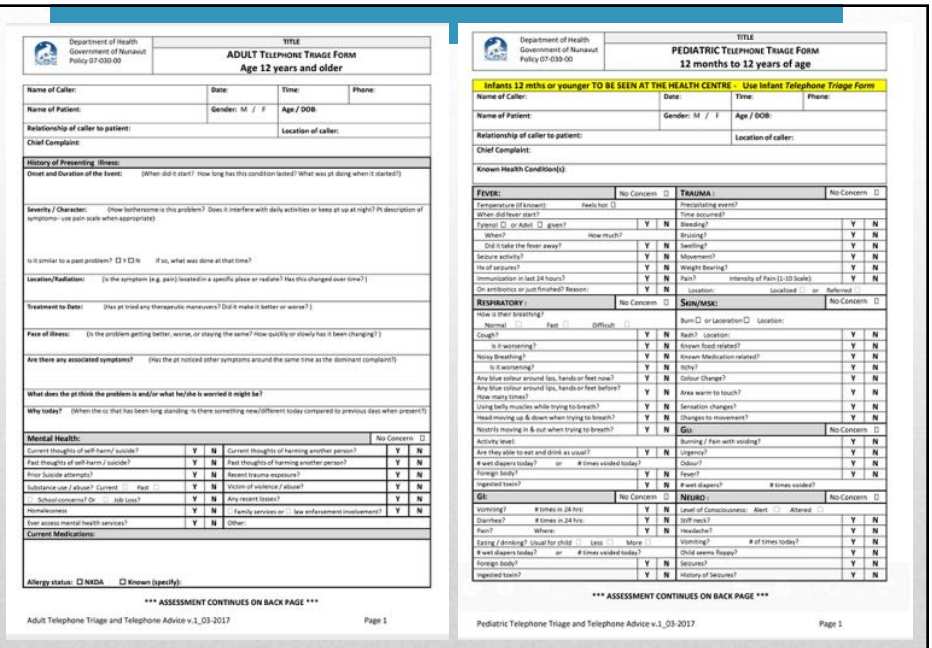
49

- Document telephone calls on paper form overnight, then register the patient, and enter the triage findings into the EMR chart.
- Triage Policy:
  - EMERGENCY (ALL AGES): CLIENT ADVISED TO COME TO THE HEALTH CENTRE IMMEDIATELY. IF ALREADY PRESENT, THE CLIENT MUST BE REFERRED IMMEDIATELY TO THE NURSE ON CALL.
    - Person has "just been in an accident"
    - Person collapsed
    - Unconscious
    - Seizures
    - Any breathing difficulty (client reported or witnessed)
    - Severe distress including chest pain or indigestion
    - Severe and uncontrolled bleeding
    - Looks or feels very unwell
    - Suspected poisoning or overdose
  - URGENT: REFER PROMPTLY TO THE NURSE ON CALL.
    - Severe abdominal pain
    - Eye injury or severe pain
    - Hemorrhage in pregnancy
    - Urine retention in elderly males
    - Allergic reaction – itchy rash, tongue swelling, breathing difficulties
    - Physical or emotional distress
    - Persistent vomiting and diarrhea (Infants less than 1 years old)



Telephone Triage Policy

50



Telephone Triage Policy - Forms

51

- Medevac Procedures differ depending on region, specifically in who initiates the medevac.
- Complete the Medical Travel Request form for each medevac and procedure.
- Each community has an escort policy – and a banned escort list – ask the SHP.

Medevac Procedure

52

Medevacs in a nutshell

Qikiqtaaluk Region

- MD initiates
- MD calls Keewaytin Air, then Keewaytin calls Nursing Station for report.
- Nurse arranges community ground transport

Kivalliq Region

- After consultation, MD will contact receiving hospital, confirms who will be the receiving MD.
- MD will let nurse know. Nurse then initiates medevac through Keewaytin

Kitikmeot Region

- Call Dispatch

Medevac Procedure

53

- Fill out medical travel request form
- Medical travel clerk will arrange.
- Sometimes if on call, and there's a scheduled flight in the morning, or weekend, you will need to call medical travel on-call.
- Always someone on call.

Schedevac Procedure

54

There are occasions when resources must be redirected due to a higher transport priority.

There are a number of factors that are taken into consideration when triage or redirect decisions are made. Some of these factors include:

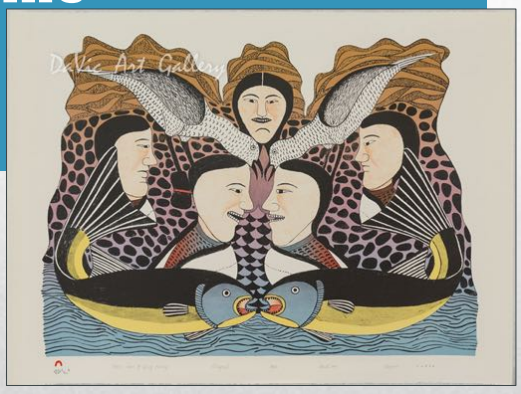
- Condition of your patient, and triage levels of patients in other communities
- Weather conditions
- Other resources that are responding
- Location
- Availability of Medevac resources

If redirected, every effort is made to advise the sending facility of the change and the estimated time of arrival.

Medevac Delays

55

Documentation and Telemedicine



Women Speak of Spring Fishing: Kenojuak Ashevak, RCA, OC

CANADIAN HEALTH CARE AGENCY
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56

57

MEDITECH
Medical Information Technology, Inc.

Documenting a Note from PCM

1. From the Patient's EMR:
   - Click "Select Visits"
   - Select your visit to add documentation
   - Click "Document
2. Use the Footer buttons to select "new"
3. Select the appropriate note category (i.e.: QI, GP Clinic note, QI GP Emergency Note etc.) or select the note category using the footer buttons Standards & Manage Features
4. Use the first line (approx. 20 characters) as your title/ diagnosis
5. When finished documenting (SOAP Format), select "ok" in the bottom right corner, enter your PIN to save.

REFER TO MEDITECH QUICK REFERENCE NOTES FOR MORE INFORMATION

58

Subjective: **A DESCRIPTION OF PRESENTATION FROM PATIENT'S PERSPECTIVE**

The patient's "STORY"

- Chief Complaint (CC): One brief statement in patient's own words
- History of Presenting Illness (HPI): Onset, progression, associated symptoms, alleviating factors
- Past Medical History (PMHx) : Any recent hospitalizations? Changes in your past medical Hx?
- Family History (FHx): Anyone ill at home? Any contributing factors from your family members health history?
- Social History (SHx): Work or school attendance? Do you use alcohol, cigarettes or drugs?
- Review of Systems (ROS): Head to toe symptom inquiry, reporting in the patient's own words.

Use words like:
•"Reports"
•"Denies"
•"Describes"

SOAP Charting: SUBJECTIVE

59

History of Present Illness (HPI): **OPQRST, AAA**

- Onset
- Progression
- Quality/Quantity
- Radiation
- Severity
- Timing
- Associative Symptoms
- Aggravating Factors
- Alleviating Factors

The HPI components are very important, and you may remember OPQRST as the way we take a history.

Onset, Progression and associated and alleviating factors, and of course the clients perception of the problem!!

Remember – this is the story from the patient's perspective!

Past Medical History:

- Significant past medical illnesses
- Surgeries
- Hospitalizations
- Major Trauma (MVA's)
- Childhood Illnesses
- Immunization Status
- Obstetrical History **TPAL**=**T**erm--**P**remature Births-**A**bortions-**L**iving Children
- GTPAL includes gravidity

SOAP Charting: SUBJECTIVE

60

Objective: **A DESCRIPTION OF ASSESSMENT FINDINGS FROM YOUR PERSPECTIVE**

your "OBSERVATIONS"

- Vital signs (V/S): Temperature, Pulse, Respirations, Blood Pressure, SPO_2
- Laboratory data: Random Blood Glucose (RBG), Hemoglobin (Hgb),
  - Other Lab findings: urinalysis (uDip), Pregnancy test (BHCG), ECG, Radiology results etc.
- Measurements: Weight in kg (done at every pediatric visit), Height, BMI, Snellen Eye Exam etc.
- Systemic documentation of physical exam findings as listed in Review of Systems (ROS).
  - Normal findings documented as "no remarkable findings", or N)
- Document IPPA
  - Inspection
  - Percussion
  - Palpation
  - Auscultation

Remember: Auscultation is done before Palpation in Abdomen Exam

OBJECTIVE

61

Assessment : **Your Primary Diagnosis statement, and any other differential diagnoses.**

1. What do you think is going on? (DIAGNOSIS)

2. What else could it possibly be? (DIFFERENTIAL DIAGNOSES)

- BRIEF STATEMENT listing medical diagnosis & pertinent differential diagnoses.
- Medical diagnosis for the purpose of the medical visit on the given date of the note

ASSESSMENT: Primary and Differential Diagnoses

62

Plan: **A DESCRIPTION OF FURTHER ASSESSMENTS, and PLAN OF CARE FROM YOUR PERSPECTIVE**

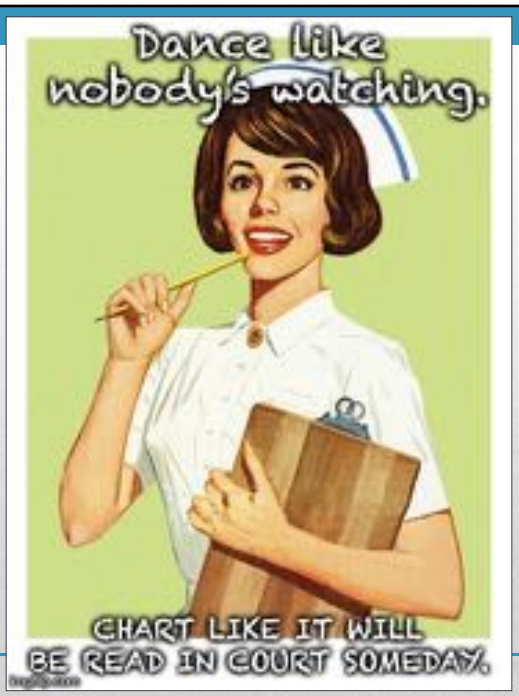
your "TREATMENTS and RECOMMENDATIONS"

- Use sub-headings!
- Additional Diagnostic Tests not yet done (e.g. x-ray, u/s, C&S)
- Any consultations made with MD/ NP, include their name, the time and method of consulting.
- Prescription fully written out
- Non-pharmacological treatments (eg. Increase fluids, perineal hygiene, fever mgmt)
- Any Health Teaching provided to the patient/ parent
- Referral, Monitoring, Follow-Up and/or Re-evaluation instructions

- ALWAYS include Follow-Up guidance – "Return to Clinic in 24 hours" etc.
- Signature, Printed Name and Professional Designation.
  - **IMPORTANT:** have a legible printed name if your signature if illegible; and sign the master signature sheet if one exists.

PLAN

63



64

Interpreter services should be utilized during the following types of encounters/procedures, including, but not limited to:

- Providing emergency medical services;
- Obtaining medical histories;
- Explaining any diagnosis and plan for medical treatment;
- Discussing any mental health issues or concerns (preferably not a family member);
- Explaining any change in regimen or condition
- Explaining any medical procedures, tests or surgical interventions
- Explaining client rights and responsibilities
- Explaining the use of restraints or seclusion
- Obtaining informed consent
- Providing medication instructions and explanation of potential side effects
- Explaining discharge plans
- Discussing issues at client and family care conferences and/or health education sessions
- Discussing Advance Directives
- Discussing end-of-life decisions
- Obtaining financial and insurance information

The name of the person interpreting for the client must be documented in the client's health record. If a friend or family member is interpreting for the client, her/his relationship to the client (i.e., wife, friend) must also be documented.

Using an Interpreter

65

Pharmaceuticals and Controlled Substances

Artist: Kenojuak Ashevak,
Title: Wisdom of the Elders

CANADIAN HEALTH CARE AGENCY
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66

- Registered nurses employed as a Community Health Nurse may implement drug therapy without a direct physician order only as directed by the Nunavut Formulary.
- Especially important to review patient's PMHx:
  - Medical condition for taking medication which may be a problem if you start a new medication for them?
  - Has the client been on this type of medication before?
  - Do they have a history of non-adherence?
  - Have they seen other health care professionals recently?
  - eg: Ibuprofen with history of Hypertension – retains sodium and can increase BP, worsen CHF

Prescribing Basics

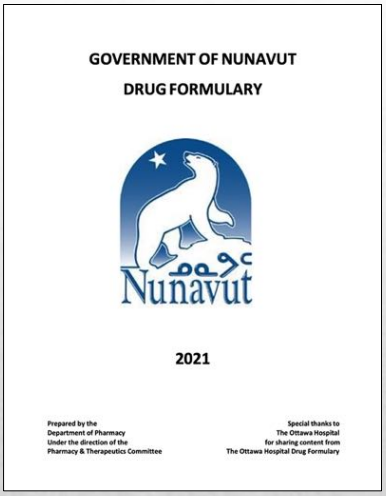
67

- The registered nurse is authorized to dispense medications, with or without a direct order from a medical practitioner or licensed dental professional, in accordance with the Nunavut Formulary.
- All pharmaceutical agents dispensed from a community health centre shall be done so according to policy. This includes pharmaceutical agents prepackaged by a retail or hospital pharmacy and dispensed through the health centre.
- In the community health setting all containers, in which medications are dispensed, shall be labeled in a standardized manner
- Labels must include the following information:
  - Manufacturer's pharmaceutical agent name
  - Strength
  - Frequency
  - Route
  - Duration
  - Amount dispensed
  - Client's name
  - Date dispensed
  - The initials of the registered nurse dispensing the pharmaceutical agent
  - Every effort shall be made to affix the completed label to the pharmaceutical agent container.

Prescribing Basics

68

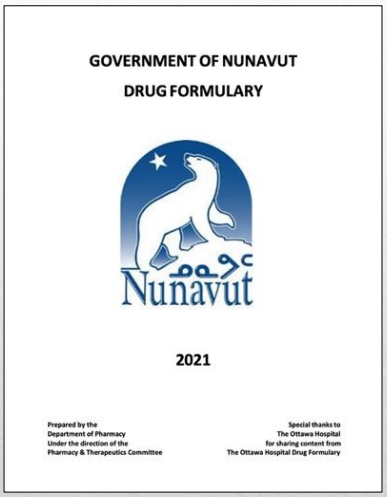
What is the Formulary?



- Standardized list of medications that should be stocked in nursing stations.
- Based on best available evidence including recent clinical practice guidelines, while considering the First Nations remote and isolated health service delivery context.
- **Medications listed in this Formulary supersede any drugs listed in any previous formularies or other applicable guidelines currently in use in all FNIHB facilities using a formulary**.
- The Formulary will be updated on an ongoing basis. These updates will attempt to include the most relevant medication options for practitioners.

Drug Formulary

69



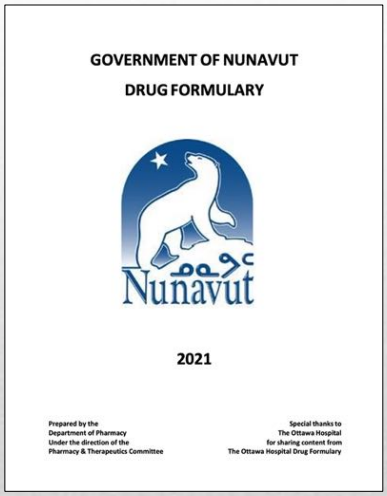
- The recommended Clinical Practice Guidelines are as follows:
  - First Nations and Inuit Health Branch (FNIHB) - Clinical Practice Guidelines for Nurses in Primary Care;
  - First Nations and Inuit Health Branch (FNIHB) - Pediatric Clinical Practice Guidelines for Nurses in Primary Care;
  - Clinical Practice Guidelines in the Drug-Related Policies and Guidelines section of the GN Drug Formulary;
  - Nunavut Communicable Disease Manual;
  - Anti-infective Guidelines for Community-acquired Infections [Ontario Anti-infective review panel];
  - Advances in Labour and Risk Management (ALARM) [SOGC];
  - Compendium of Therapeutic Choices (formerly known as Therapeutic Choices);
  - ACLS (Advanced Cardiovascular Life Support),
  - ENPC (Emergency Nursing Pediatric Course),
  - NRP (Neonatal Resuscitation Program),
  - TNCC (Trauma Nursing Core Course);

NOTE: The most recently published guidelines will supersede older guidelines.

Drug Formulary

70

What is the Drug Classification System?


GOVERNMENT OF NUNAVUT
DRUG FORMULARY

Nunavut

2021

Prepared by the
Department of Pharmacy
Under the direction of the
Pharmacy & Therapeutics Committee

Special thanks to
The Ottawa Hospital
for sharing content from
The Ottawa Hospital Drug Formulary

Drug Treatment code mnemonic:

Category A: **A**ll Drugs

Category B/B+: **B**y prescription only*

Category C: **C**ourse of Drug

Category D/D+: **D**ose of Drug

Drug Classification System

71

What does **Code A** indicate?

Code A ("All Drugs")

- CHN initiated, based on nurse assessment of patient (maximum duration ONE MONTH)
- GN medication stock coded as "A" may be dispensed by a CHN for up to a maximum of 30 days.
- If a patient is to be treated for more than 30 days, a prescription must be written, directed to a retail pharmacy, and delivered to the patient within the first 30 days.

"I'm not sure what these are, but take them for a couple of weeks and let me know how you feel."

Drug Classification System

72

What does Code B or B+ indicate?

Code B or B + ("By prescription only")

- Physician or Nurse Practitioner initiated, based on consultation with MD or NP (maximum duration TWO WEEKS)
- GN medication stock coded as "B" may be dispensed by a CHN for treatment that must be started immediately and for up to a maximum of 14 days.
- The physician or nurse practitioner must write a prescription at the time of consultation and direct it to a retail pharmacy for processing when:
  - Treatment can wait until the patient receives the medication from the retail pharmacy.
  - A medication is required for longer than 14 days.

Drug Classification System

73

What does Code B or B+ indicate?

Code B or B + ("By prescription only")

- In an emergency situation where an immediate urgent and critical health concern may seriously endanger or threaten the life, health or safety of the client and where immediate access to a physician/ dentist/ nurse practitioner is not available, CHNs are authorized to administer a maximum of one dose of a controlled substance, pending communication with a physician/dentist/nurse practitioner if the following criteria are present:
  - The CHN has the knowledge, skill and judgement to determine whether the client's condition warrants the use of a controlled substance;
  - The CHN knows the risks and benefits to the client; and 3. The CHN can reasonably predict the outcome.

Drug Classification System

74

What does Code C indicate?

Code C ("Course")

- CHN may initiate one course GN medication stock coded as "C" may be dispensed by a CHN for up to a maximum of 14 days.
- If the patient's symptoms recur, the condition does not resolve or first-line therapy fails, a physician must be consulted.
- If a patient is to be treated for more than 14 days, a prescription must be written, directed to a retail pharmacy, and delivered to the patient within the first 14 days.

Drug Classification System

75

What does Code D/ D+ indicate?

Code D ("Dose")

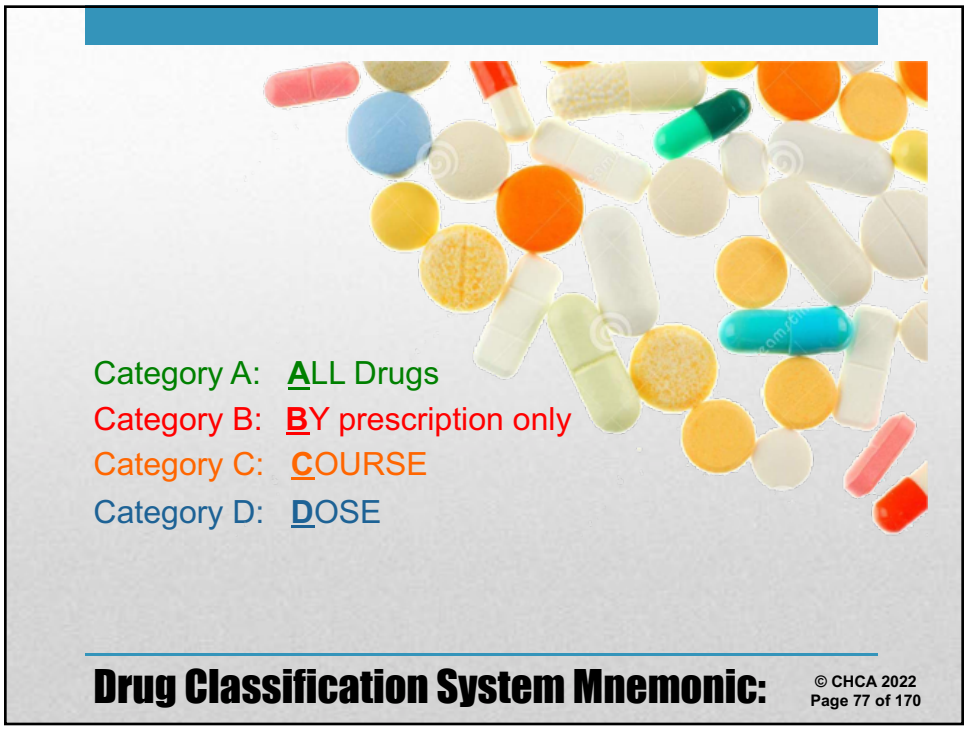
- CHN may initiate one dose GN medication stock coded as "D" may be dispensed by a CHN for ONE DOSE.
- The CHN must reassess the patient after the first dose and contact the MD if further treatment is required.

Code D+ ("Dose")

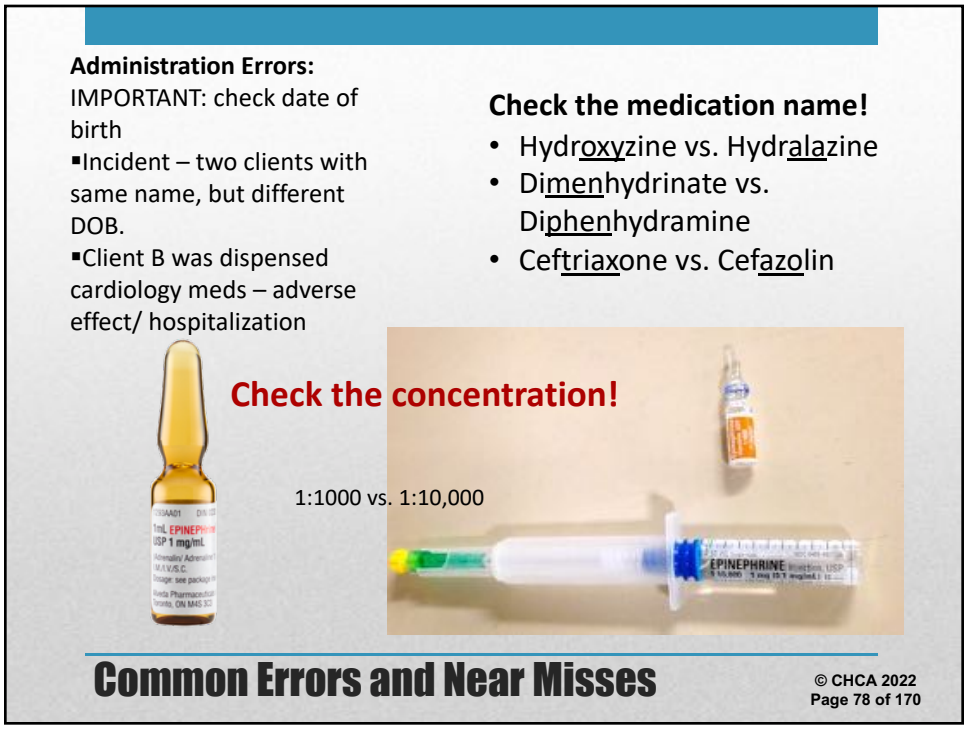
- CHN may provide up to eight (8) tablets one time only.
- If patient returns for the same condition, the CHN must consult with the MD or NP.
- Note: this code applies only to Tylenol #3 and Codeine 15 mg tablets.

Drug Classification System

76


Category A: ALL Drugs
Category B: BY prescription only
Category C: COURSE
Category D: DOSE
Drug Classification System Mnemonic:
© CHCA 2022
Page 77 of 170

77


Administration Errors:
IMPORTANT: check date of birth
▪Incident – two clients with same name, but different DOB.
▪Client B was dispensed cardiology meds – adverse effect/ hospitalization
Check the medication name!
• Hydroxyzine vs. Hydralazine
• Dimenhydrinate vs. Diphenhydramine
• Ceftriaxone vs. Cefazolin
Check the concentration!
1:1000 vs. 1:10,000
EPINEPHRINE
Common Errors and Near Misses
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Page 78 of 170

78

Controlled Substances Policy

CANADIAN HEALTH CARE AGENCY
EXPERIENCE THE NORTH

79

First Nations and Inuit Health Branch

POLICY AND PROCEDURES ON CONTROLLED SUBSTANCES FOR FIRST NATIONS HEALTH FACILITIES

Effective Date: July 2015

Cancels and Supersedes : August 2013

Office of Primary Interest : Office of Primary Health Care within the Population Health and Primary Care Directorate

Controlled Substances

80

- In a health centre setting, all controlled substances listed above must be counted and recorded, at a minimum, once weekly and when staff are leaving their positions and new staff are arriving.
- The count is to be performed by two (2) registered nurses (this includes CHNs and CPNs) except in a one-nurse health centre.
  - Note: Counts in health centres are not required on weekends or statutory holidays.
- The Supervisor of Community Health Programs (SHP) may recommend an increased frequency of narcotic counts at their health centre.
- This decision should be communicated to the Territorial Director of Pharmacy or designate and the Director of the health centre in a timely manner.
- All controlled substance counts must be recorded on the Controlled Substances Register in RED INK.

Controlled Substances - Count

81

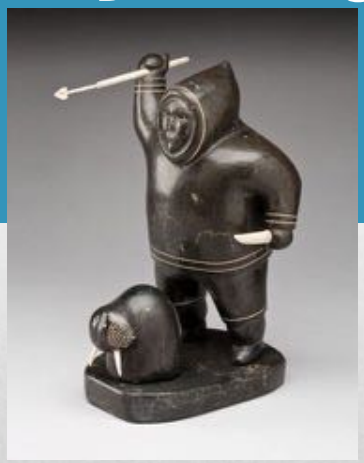
- If any controlled substances are wasted (partial ampoule used, patient refusing medication, medication dropped on floor), this fact must be recorded on the Controlled Substances Register and co-signed by a second nurse.
- In a health centre, this is mandatory during the operational hours at the health centre.
- A second signature is not required in one-nurse health centres or if a nurse would need to be called in after hours for an emergency situation.
- All wasted controlled substances must be safely disposed of in a securely located sharps container at the time of medication preparation.
- Reasonable attempts should be made to render the wasted drug unusable to eliminate the risk of intentional diversion. Ensure sharps containers are disposed of as per appropriate protocol when full.

**** WHEN POSSIBLE, HAVE A WITNESS FOR WASTAGE ****

Wastage of Controlled Substances

82

Laboratory and Diagnostics



Artist: Akeeaktashuk
Title: Hunter and Walrus

CANADIAN HEALTH CARE AGENCY
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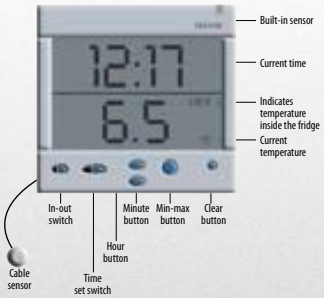
83

Vaccine Temperature Log Book

Month: January, 2011 Office/Facility: ABC Family Practice

Week 1	Mon		Tue		Wed		Thur		Fri		Sat		Sun	
Time	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Current Temp	5.8	7.0	3.4	5.6	5.7	6.8	3.2	5.3	5.3	5.2	7.0	6.5	6.0	6.7
Max Temp	6.8	6.5	6.0	6.8	6.7	7.1	10.4	6.9	6.3	6.4	5.6	5.2	4.5	5.5
Min Temp	3.4	3.5	2.9	3.3	3.4	4.0	2.5	3.0	-0.2	3.6	7.0	7.5	6.5	7.8
Initials	AB	AB	AA	AA	AA	AA	AA	AA	AA	AA	AB	AB	AB	AB
Week 2	Mon		Tue		Wed		Thur		Fri		Sat		Sun	



- Nurse on first call notes Maximum/Minimum temperatures twice daily: first thing in the morning, and at the end of the clinic day.
- Always reset your maximum/ minimum thermometer after recording the temperature readings.
- Out-of-Range temperatures – any temperature readings below +2ºC and/or above +8ºC must be reported to your public health unit immediately.

Vaccine Fridge Temperature Log

84

- Daily calibration of several instruments done
- Performed prior to the start of clinic day.
- Generally done or delegated by the 1st nurse on call for that day
- All HemoCue and Blood Glucose Monitors in the clinic can be done at the same time.
- Once per month, a lab sample sent for correlation. (note on req and sample "QA")
- Once per month, equipment should be cleaned.

Point of Care Quality Assurance

85

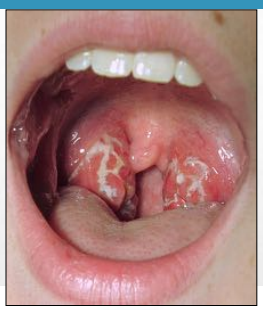
- Rapid Strep Throat Swabs
- i-Stat machine*
- Capillary Blood Glucose
- Urine Analysis
- Pregnancy Testing
- Hemoglobin
- Urine Drug Screening*
- H. Pylori
- Troponin*

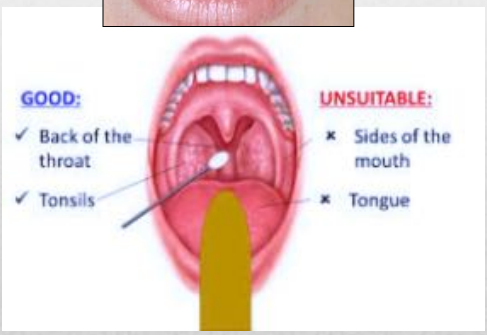
Point of Care Tests

86

- Test for the presence of Group A Streptococcal Pyrogenes
- Based on Clinical Findings*:
  - Sore Throat
  - Fever/ Malaise
  - Exudate on Tonsils
  - Absence of Cough
- Swab to obtain sample of exudate from both tonsils
- **IF NEGATIVE: send a standard charcoal swab for C&S to the lab for confirmation.**

* Can include, but not limited to these findings

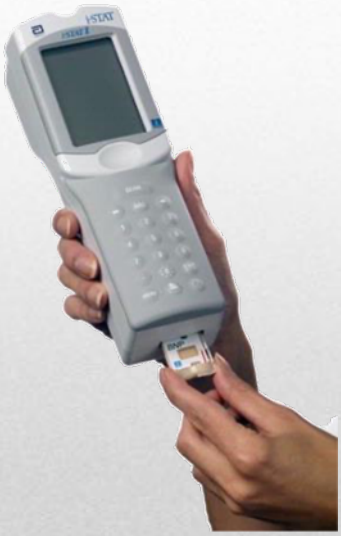




Point of Care Testing - Rapid Strep

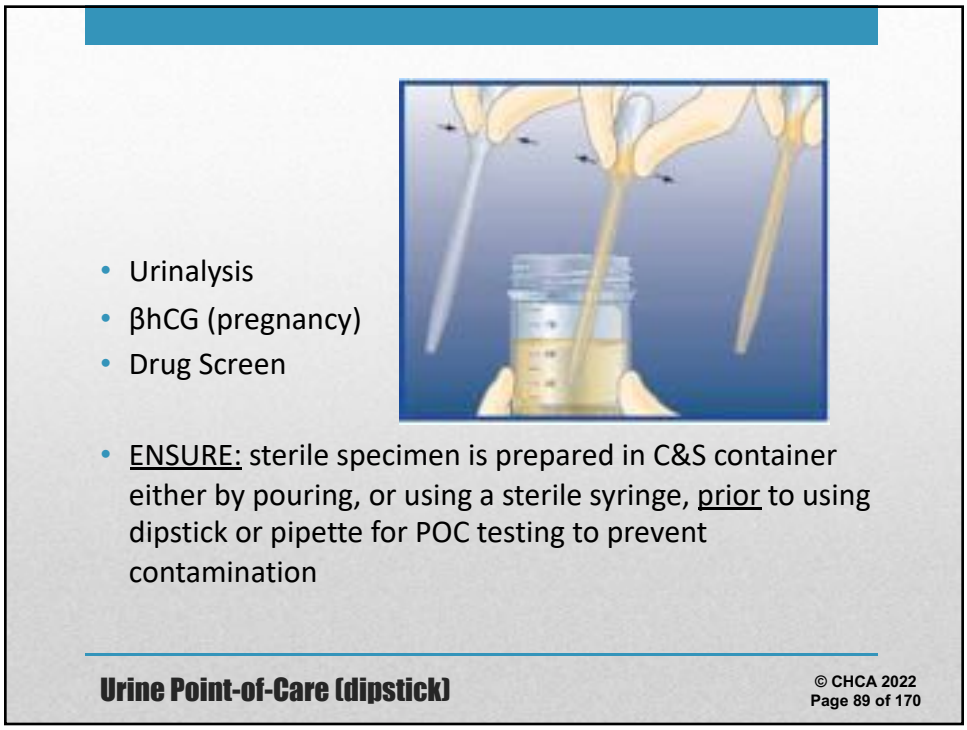
87

- Found in most Nursing Stations in Northern Ontario
- Requires additional Continuing Education training / certification
- MD/ NP Order required for testing
- Venous draw using Green Heparinized tube
- Cartridges are refrigerated
- Quality Control testing needs to be done daily



Point of Care Testing - iStat

88


• Urinalysis
• βhCG (pregnancy)
• Drug Screen
• ENSURE: sterile specimen is prepared in C&S container either by pouring, or using a sterile syringe, prior to using dipstick or pipette for POC testing to prevent contamination
Urine Point-of-Care (dipstick)
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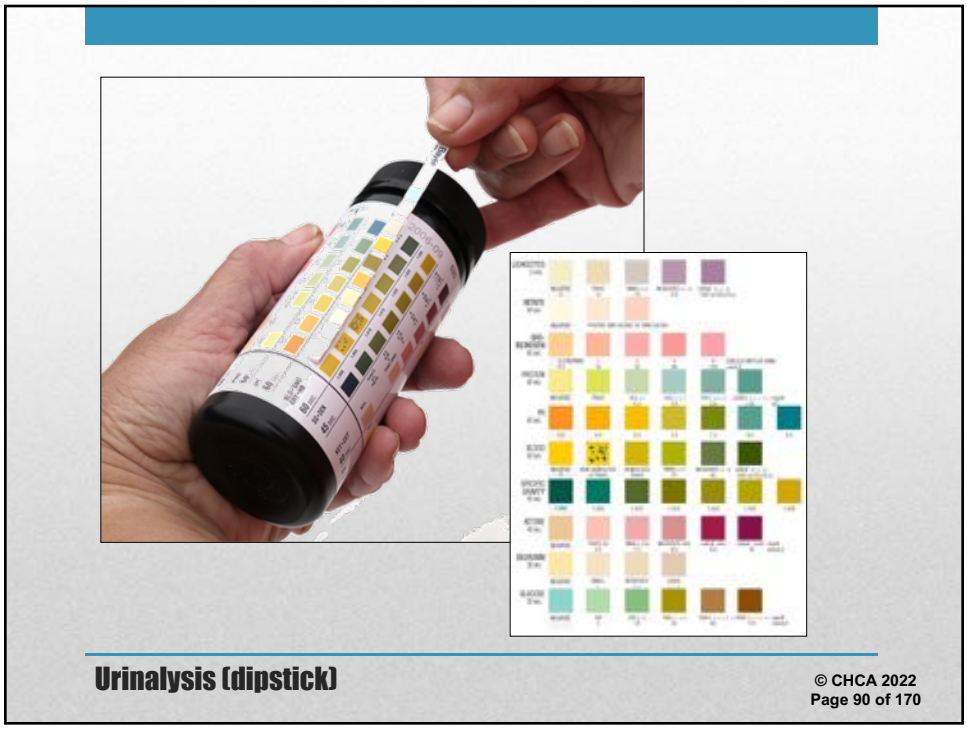
Page 89 of 170

89


Urinalysis (dipstick)
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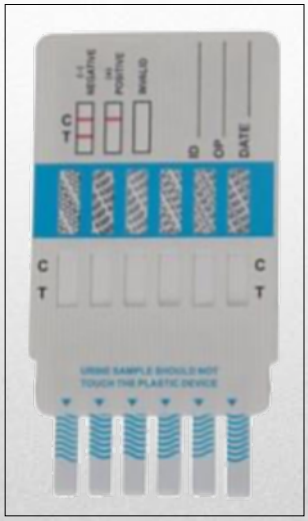
Page 90 of 170

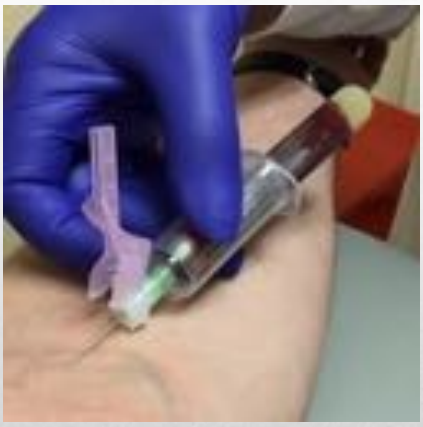
90



- **MUST have a MD/NP Order for Urine Drug Screen**
- Often part of community-based Suboxone program
- Tests for several substances:
  - Cocaine
  - Morphine
  - Bupropion
  - Benzodiazepines
  - Oxycodone
- Test results read opposite to a urine pregnancy test:
  - ONE line is positive
  - TWO lines is negative.

Urine Drug Screen

91



- Registered Nurses working as a community health nurse may initiate laboratory studies as per the FNIH Clinical Practice Guidelines for Nurses in Primary Care, Pediatric Clinical Practice Guidelines for Nurses in Primary Care, other territorial / national guidelines and/or in consultation with a physician or nurse practitioner.
- The name of the person ordering the laboratory tests shall ensure his/her name is entered on the lab requisition form.
- Only the person's name that is ordering the test should be entered. Do not include a physician's name when the physician did not specifically order that test.

Requisitioning Laboratory Studies

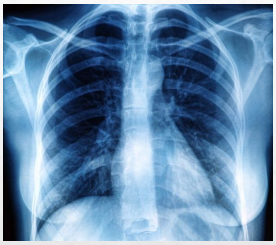
92

- Collecting post mortem samples is the responsibility of the Coroner.
- However, in accordance with the Coroners Act and the Coroners Forms Regulations, the Coroner may authorize the Registered Nurse to collect post mortem samples.
- The Coroner will use Form 11 of the schedule to authorize the nurse to obtain the samples.

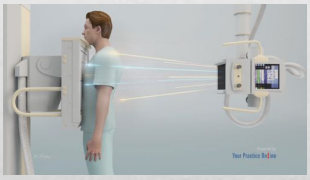
Post Mortem samples

93

- Basic radiography services are considered an essential part of the basic health care services that must be available in each community.
- As it is not feasible to have a certified medical radiation technologist in every community, Community Health Nurses, Nurse Practitioners and Basic Radiography Technicians are delegated the authority to perform basic radiography exams in certain circumstances including:
  - Chest (including ribs)
  - Extremities (excluding hips)



- Patients < 6 years of age: No x-rays in this age group are to be performed; exceptions may be made by a physician (only) in cases of trauma, intubation in the health centre, and TB work up.
- Patients 6 to 11 years of age: Physician or NP order required.
- Patients ≥ 12 years of age: Physician or NP order. CHN may also order an x-ray as authorized through the GN Policy: CHN Initiated X-ray Requests.



X-Rays

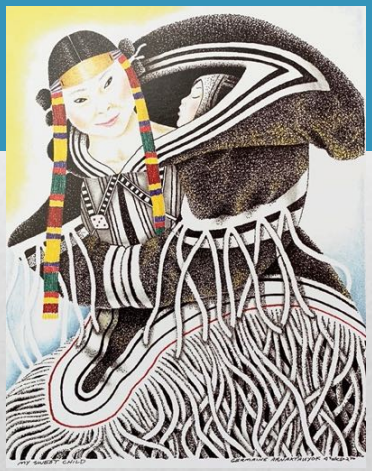
94

- MEDICAL DIRECTIVE: Community Health Nurses (CHN) may initiate a chest x-ray or extremity x-ray without a direct Physician or Nurse Practitioner (NP) order for children 12 years of age and older and when any of the following patient condition(s) apply:
  - Traumatic injuries of the extremities or clavicles when the x-rays are anticipated to have a direct and significant impact on the immediate management of the case;
  - Routine screening chest x-ray under TB surveillance protocols;
  - Diagnostic chest x-ray in periods of acute illness, as directed by the First Nations and Inuit Health Branch (FNIHB) Clinical Practice Guidelines or Department of Health (DH) protocols.
- PRACTICE NOTE: The practitioner must be aware that due to the equipment and resources available in the health centre setting, the films may be suboptimal and care must be exercised in using them for clinical decision making.
- RECIPIENT PATIENTS: Patients 12 years of age and older

X-Rays

95

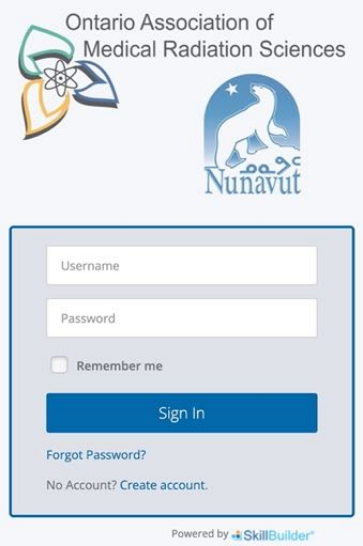
Paediatric and Adult Immunizations



Artist: Germaine Arnaktauyok
Title: My Sweet Child

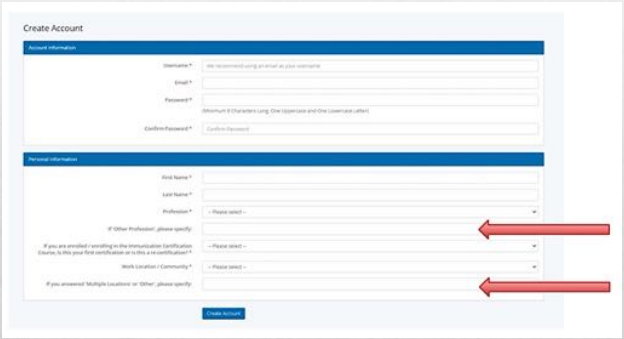
96

- Step 1 Go to: https://nunavuthealth.skillbuilder.co/sign-in
- Step 2: Click on "Create account"
- Step 3: Fill in the boxes with your answers and press "Create Account".
- All questions marked with * are mandatory. If you've answered "Other", "Multiple Locations" or "Not Applicable" to any of the questions, please specify in the correct boxes below



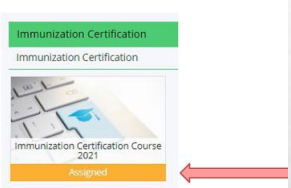
97

- Step 4: Follow prompts to check your email and confirm your account.
- You will receive an email from SkillBuilder Notifications [notifications@skillbuilder.co] with the subject heading "Account Created - Verify Account".
- If the email is not in your inbox, check your "Junk E-mail" or "Spam" folder.
- In the email, click on the link: Verify Your Account
- ***Please note - if you have any issues related to the online platform, you can contact the administrators directly using the help function on website.



98

- Step 5: Clicking on the link above will bring you back to the https://nunavuthealth.skillbuilder.co/sign-in website.
- Now you can Log in using the Username and Password you created.
- Step 6: Once logged in, you will be in the "My Dashboard" portion of the website. Click on the "My Learning Paths" circle:



- Step 7: From there you will see the Immunization Certification Course 2021. Click on the course.
- Step 8: Review the course outline for learning objectives on the 6 education modules.
- There is also a link to the Nunavut Immunization Manual online. You will notice that the icons are in yellow until the item has been completed, when they turn green.

Nunavut Immunization Certification Process

99

- Respiratory Syncytial Virus (RSV) is the most common cause of bronchiolitis and pneumonia in infants and young children.
- Synagis: a monoclonal antibody used to prevent severe disease caused RSV infection.
- Testing for RSV done by NP swab, reportable disease in Nunavut.

- Recommended for high-risk infants because of prematurity or another medical problem such as congenital heart disease.
- Synagis provides passive immunity, thus missed doses leave patients unprotected. Ensure all doses are administered on time for maximum protection.
- Does not interfere with the immune response to vaccines and can be administered at the same time as childhood vaccines.

Schedule:

- **Supplied in 50 mg vials of sterile powder for reconstitution with sterile water**
- **Given once monthly, during RSV season: January 1 to May 31**
- **Max 5 doses.**
- **Intramuscular injection**

Synagis (Palivizumab)

100

Nunavut Recommended Childhood Immunization Schedule
For more information on these immunizations, consult the immunization protocols in the Nunavut Immunization Manual

Vaccine Name	Age in Months								Age in Years		School Grade		
	0	1	2	4	6	9	12	15	18	2-3 Years	4-6 Years	Gr 6	Gr 9	Gr 12[5]
Bacille Calmette-Guérin (BCG)		✓												
Hepatitis B (HB)	✓	✓				✓								
Diphtheria, Tetanus, acellular Pertussis, Polio, Haemophilus influenzae Type B (DTaP-IPV-Hib)			✓	✓	✓				✓					
Pneumococcal conjugate 13 (Pneu-C-13)			✓	✓	✓			✓						
Rotavirus (RV)[1]			✓	✓	✓									
Measles, mumps, rubella, varicella (MMRV)							✓		✓					
Meningococcal C Conjugate (Men-C-C)							✓							
Pneumococcal Polysaccharide 23 (Pneu-P-23)										✓				
Diphtheria, Tetanus, acellular Pertussis, Polio (DTaP-IPV or Tdap-IPV)											✓			
Human Papillomavirus (HPV9)[2]												✓		
Tetanus, Diphtheria, acellular Pertussis (Tdap)												✓		
Varicella[3]												CU		
Meningococcal-C-ACYW													✓	
Influenza[4]														

1. Rotavirus vaccine dose series varies depending on which product is used. Review vaccine specific protocol for scheduling recommendations.
2. HPV9 is recommended for boys and girls. This is a 2 dose series (given at 0 and 6 months).
3. Catch-up for children who have only received 1 varicella containing vaccine (Varicella or MMRV), a 2nd dose of Varicella vaccine should be offered, ideally with 2nd dose of HPV vaccine.
4. Annual Influenza vaccine may be given after 6 months of age. Previously unvaccinated children <9 years of age require 2 doses of the vaccine, with an interval of 4 weeks. The 2nd dose is not needed if the child has received one or more doses of vaccine during a previous influenza season.
5. For all grade 12 students, ensure that the child has received all recommended vaccinations during childhood. Catch up vaccinations as necessary, according to the Nunavut Catch-up Schedule.

For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the Nunavut Catch-up Schedule.

This schedule is based on current recommendations from the Canadian Immunization Guide (CIG) and the National Advisory Committee on Immunization (NACI), found online at http://phac-aspc.gc.ca/publicat/cig-gci/index-eng.php
July 2021

Nunavut Routine Childhood Immunizations

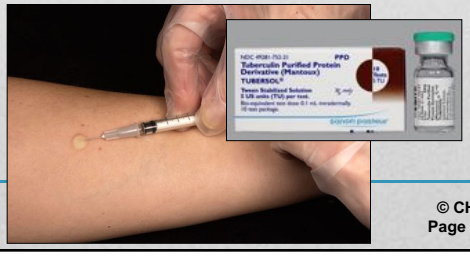
101

BCG

BCG vaccination is not currently being provided: pending review – Agency RNs are not certified to administer

TST

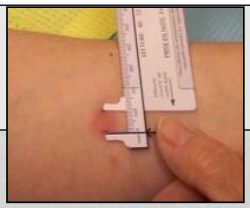
- The Tuberculin Skin Test (TST) or Mantoux test is a tool for screening for tuberculosis (TB) and for tuberculosis diagnosis.
- TST is given at 4-6 years old
- Two step test
- Check at 48-72 hours
- Measure induration only
- What is the work up if positive?



BCG vs. TST

102

TST Reaction Size	Situation When Result is Considered Positive
0 - 4mm	In general this is considered negative and no tx is indicated Child less than 5 years and high risk of TB infection
5 - 9mm	HIV infection Contact with infectious TB within the past 2 years Fibronodular disease on chest x-ray (healed TB but not previously treated) Organ transplantation (related to immune suppressant therapy) TNF alpha inhibitors Other immunosuppressive drugs e.g. corticosteroids End-stage renal disease
≥ 10mm	TST conversion (within 2 years) Diabetes, malnutrition Silicosis Hematologic malignancies



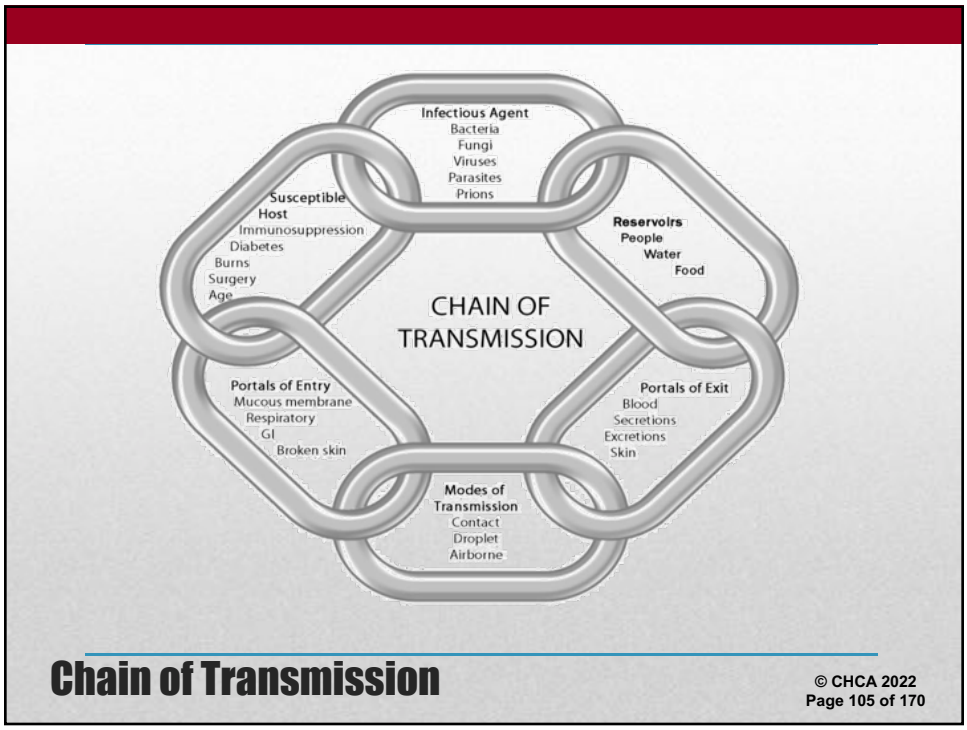
TST interpretation

103

Public Health: Communicable Diseases and Contact Tracing

CANADIAN HEALTH CARE AGENCY
EXPERIENCE THE NORTH

104


Infectious Agent
Bacteria
Fungi
Viruses
Parasites
Prions
Susceptible Host
Immunosuppression
Diabetes
Burns
Surgery
Age
Reservoirs
People
Water
Food
CHAIN OF TRANSMISSION
Portals of Entry
Mucous membrane
Respiratory
GI
Broken skin
Portals of Exit
Blood
Secretions
Excretions
Skin
Modes of Transmission
Contact
Droplet
Airborne
Chain of Transmission
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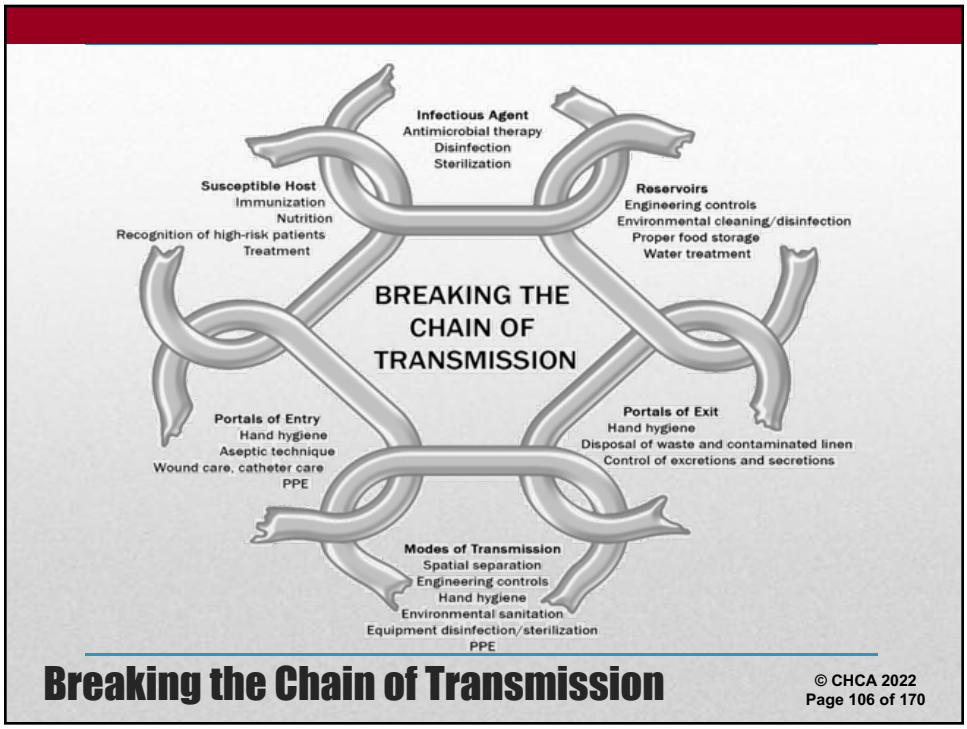
Page 105 of 170

105


Infectious Agent
Antimicrobial therapy
Disinfection
Sterilization
Susceptible Host
Immunization
Nutrition
Recognition of high-risk patients
Treatment
Reservoirs
Engineering controls
Environmental cleaning/disinfection
Proper food storage
Water treatment
BREAKING THE CHAIN OF TRANSMISSION
Portals of Entry
Hand hygiene
Aseptic technique
Wound care, catheter care
PPE
Portals of Exit
Hand hygiene
Disposal of waste and contaminated linen
Control of excretions and secretions
Modes of Transmission
Spatial separation
Engineering controls
Hand hygiene
Environmental sanitation
Equipment disinfection/sterilization
PPE
Breaking the Chain of Transmission
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Page 106 of 170

106

Communicable Disease Control and Management

Confirm Diagnosis	• Review lab slip • Review Appendix B (IDP) to confirm case definition and if reportable
Case Management	• Investigate history of the disease Counselling • Treatment of disease or symptoms if needed • Immunization or immunoglobulin
Contact Tracing	• Prepare list based on mode of transmission and incubation period • Recommend testing or treatment
Prevention Activities	• Community education Community immunization blitz • Targeted education Harm reduction
Outbreak Management	• Covered in subsequent presentation
Surveillance and Reporting	• Complete appropriate forms and submit to CD nurse • Monitor for increased cases in the community that may indicate an outbreak

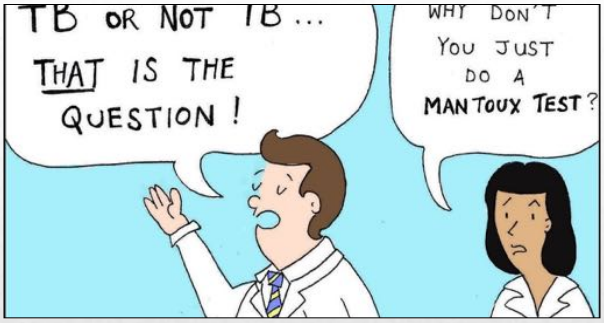
107

Causes:

- Mycobacterium tuberculosis bacterium

Symptoms:

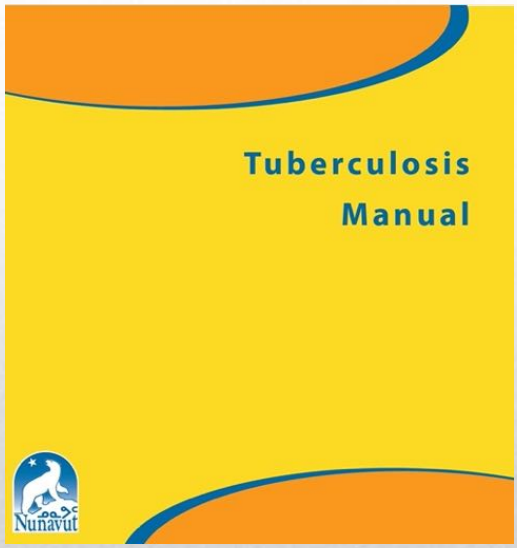
- Chronic cough, lasting ≥3 weeks
- Hemoptysis
- Fever
- Night sweats
- Fatigue
- Weight loss



- Spread by droplet (talking, singing coughing)
- Multiplies in the alveoli
- LATENT: Immune system builds a wall around the infection
- ACTIVE: Immune system unable to supress = transmissible.
- 10% of Latent infections will develop into active, often when health declines or with aging.

Tuberculosis

108



Tuberculosis

109

Latent Infection (LTBI)

- Primary infection but patient does not have active disease and cannot transmit the organism to others.
- The risk of active disease is high in certain groups of people with latent infection

Active Disease

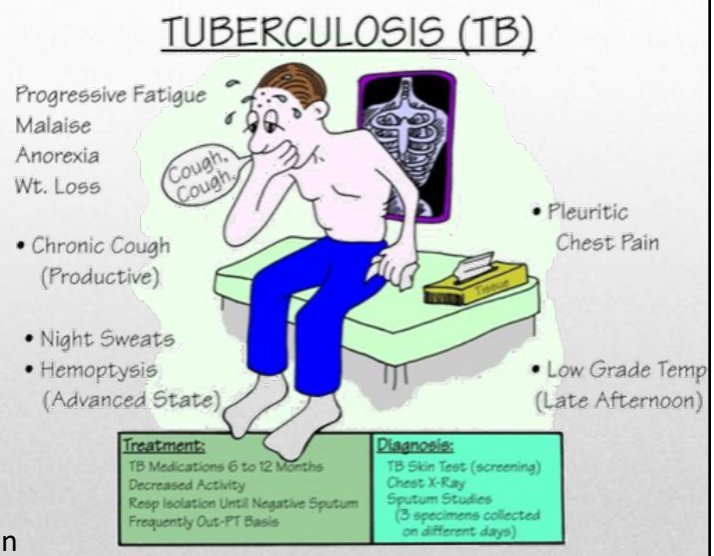
- The person has active disease and is contagious when they have high numbers of tubercle bacilli with involvement of the respiratory tract.

Tuberculosis – Latent vs Active

110

Differential Diagnoses:

- Chronic or subacute pneumonia
- Chronic obstructive pulmonary disease (COPD)
- Bronchiectasis
- Lymphoma or other malignancy
- Fungal infection



Tuberculosis

111

What are some of the contraindications for TST?

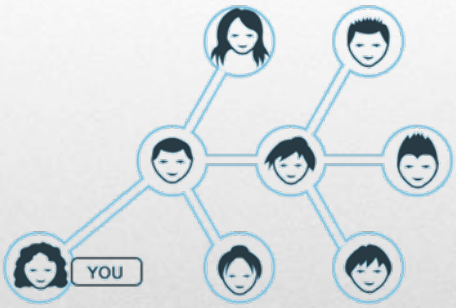
- Previous severe blistering reactions to the TST (Mantoux) test
- Documented positive TST result in the past that was read by a knowledgeable health care practitioner
- Client known to have active TB or has been treated in the past for active TB
- Extensive burns or eczema
- Client who has had a viral infection (such as measles or mumps) in the past month or who has received vaccination with a live-virus vaccine in the past month

Tuberculin Skin Test

112

Contact Tracing

- Assume the presenting client is the index case until proven otherwise
- Obtain a list of all contacts (for STI tracing, sexual partners in the past 3 months or more) when samples are collected
- If test results are positive, all contacts must be reported and tested appropriately
- Determined by mode of transmission
  - Eg: measles – airborne vs. STI.



Management

113

Paediatrics

Artist: Germaine Arnaktamyok

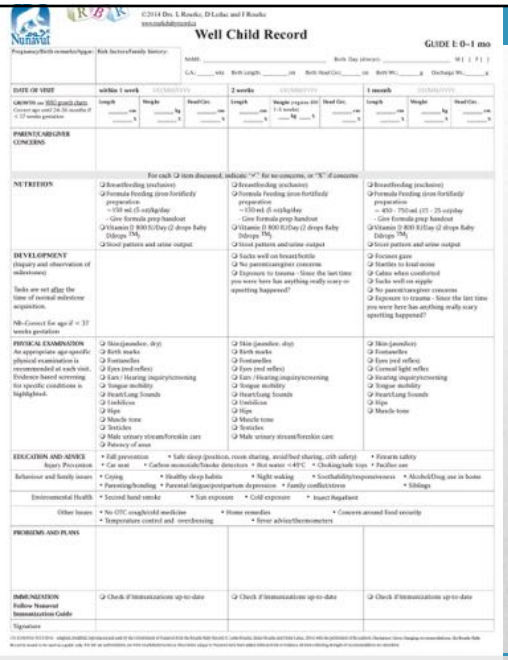
CANADIAN HEALTH CARE AGENCY
EXPERIENCE THE NORTH

114

Well child Record

- The Well-Child Record for infants and young children in Nunavut has been updated to better support primary care providers in assessing children's physical, cognitive and social development at regular visits.
- These visits are based on the immunization schedule for Nunavut and take place:
  - Within the first week 2 weeks
  - 1 month, 2 months, 4 months, 6 months,
  - 9 months, 12-13 months, 15 months, 18 months
  - 2-3 years 4-5 years (preschool)

115


Well Child Record

GUIDE I: 0–1 mo

www.rourkebabyrecord.ca

116

- **Guide I:** visits at up to one week, two weeks, and one month of age;
- **Guide II**: visits at two, four, and six months of age;
- **Guide III**: visits at nine, 12, and 15 months of age;
- **Guide IV**: visits at 18 months, two to three years, and four to five years of age.

1. **Guidelines/resources** dealing with growth monitoring, nutrition, physical examination, and education and advice issues excluding those on development, behaviour, immunization and infectious diseases.
2. **Guidelines/resources** dealing with development, behaviour, and parenting resources.
3. **Guidelines/resources** dealing with immunization and infectious diseases.

Rourke Guides & Resources

117

The '7' Areas	Rourke Components in Detail

7 assessment areas for EVERY VISIT in the first year of life

Height, Weight	Every visit: Birth-16 yrs old
Head Circumference	Every Visit: First 2 years of life
Eye Assessment	Every visit
Strabismus Assessment	Every visit: First year of life
Development Assessment	Every visit
Nutrition	Every visit
Parenting	Every visit

Rourke Guides & Resources

118

looksee
checklist by ndds

119

LOOKSEE Checklist (formerly NDDS)

120

- The **LOOK-SEE Guide** is designed to provide an easy-to-use method of recording the development and progress of infants and children. The LOOKSEE Guide provides a general overview (snap-shot) of the child's development on the day of screening.
- Most children will have mastered the given skills by each appropriate age. **If one or more "No" responses are marked**, a referral to MD/NP should be made
- Explores 13 developmental stages:
  - Vision
  - Hearing
  - Speech
  - Language
  - Communication
  - Gross and fine motor
  - Cognitive
  - Social/Emotional
  - Self-help

LOOKSEE Checklist (formerly NDDS)

121

Get Started

1 Choose the nearest age

Choose the checklist that matches your child's age. If your child falls between two ages, use the earlier age (if child is 4½ years old, use the 4 year checklist). If your child is 3 or more weeks premature, determine the appropriate checklist at **looseechecklist.com/premature**

2 Answer the questions

Answer the questions to the best of your ability. If you are not sure, try the question with your child. Any examples are only suggestions. You may use similar examples from your family experience. Language and communication items can be asked in the child's first language. Items marked with ** may not be common to all cultures.

3 Follow-up with a professional

If you answer "no" to any question or have any concerns about your child's development, follow-up with a health care and/or child care professional.

When you're done

Follow the parenting tips beside the checklist to help your child grow. These tips may be a bit more challenging than the checklist. If you have questions, contact a professional. The tips are organized into the following developmental areas:

Emotional | Fine Motor | Gross Motor | Social | Self-Help | Communication | Learning & Thinking

6 months

looksee checklist ndds

A checklist to monitor your child's development from 1 month to 6 years of age with tips to help them grow.

122

By six months of age, does your child:

- ○ ○ 1 Swipe at and reach for objects within view?
- ○ ○ 2 Turn head and look in the direction of a new sound?
- ○ ○ 3 Respond to own name?
- ○ ○ 4 Smile and babble when given adult attention?
- ○ ○ 5 Vocalize pleasure and displeasure? *squeal with excitement or grunt in anger*
- ○ ○ 6 Seem to respond to some words? *"daddy", "bye-bye"*
- ○ ○ 7 Make sounds while you are talking to him/her?
- ○ ○ 8 Roll from back to side?
- ○ ○ 9 Push up on hands when on tummy?**
- ○ ○ 10 Sit with support? *pillows*
- ○ ○ 11 Use hands to reach, grasp, bang, and splash?
- ○ ○ 12 Bring hands or toy to mouth?
- ○ ○ 13 Pat and pull at your hair, glasses, or face?
- ○ ○ 14 Sleep and feed at regular times?

* Examples are only suggestions. Use similar examples from your family experience.
** Item may not be common to all cultures.

6 MONTHS English looksee checklist'o ndds

Child's Name: _____
Birthdate: _____
Today's Date: _____

Try these tips to help your child grow:

I still like quiet time, so hug me, hold me, talk to me, sing to me, and read to me.

Comfort me when I am unhappy or fussy by rocking me, holding me close, or talking to me in a soft voice. Respond when I cry. Remember you can't spoil me.

Funny booties or colourful socks will encourage me to grab my feet. I may want to kick my legs and play with my feet.

Place toys in various positions and distances from me so I can reach out and grasp them. Say, "Get the ball".

I like objects of different colours, sizes, and textures to hold and squeeze so I can build my strength. Encourage me to use both hands.

Place me on my tummy and use a toy to encourage me to push up on my hands and try to reach up.

Encourage me to roll from my tummy to my back. I am learning how my body works and I want to explore my environment.

Show me the actions for "wave bye-bye" and "blow kisses" and I will learn to act them out myself.

Imitate sounds I make. My sounds may be changing to include more babbling. Try to get me to say them back to you as if we are having a conversation. I like it when you slow down and change your tone of voice ("Hiiii pretty baaaaby").

I enjoy it when you sing the same songs over and over again; *Itsy Bitsy Spider, This Little Piggy, Peek-a-boo and Pat-a-cake* are just some of my favourites.

When I'm not watching you, shake a rattle, squeeze a toy, or call my name from different parts of the room. This will help me to look in the direction of new sounds.

When I try to tell you something by looking, reaching, babbling, smiling, or crying, try to understand what I mean and say it with real words.

Help me to play. Prop me up in a corner of the couch or on the floor with support (blankets, pillows) and put some of my favourite toys within reach for me to play with. I may want to reach for the toys, but I'm still not too steady, so stay with me to keep me safe.

My body is growing—now is a good time to get information on what to feed me.

looksee 6 checklist'o ndds

123

Key Point:

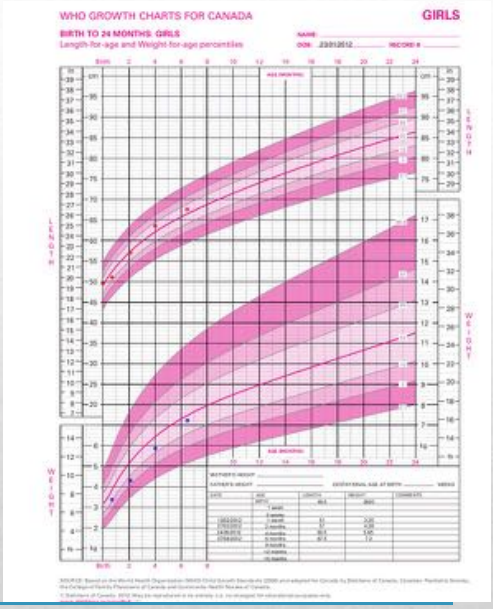
1. Healthy infants follow their curve
2. Healthy infants are proportionate

For example:

- If you measure a child at 3 months and she is in 75th percentile, but at 9 months she measures in the 50th percentile…

Question… what should you do?

- Crossing over 2 curves is a **red flag**
- You should explore the potential reasons for this change and refer the patient.



Tips For Measuring Growth – WHO Charts

124

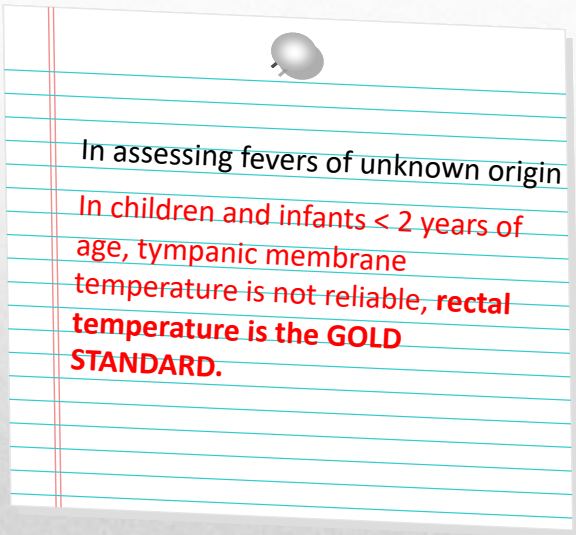
- The REVISED vitamin D supplementation policy for Nunavut is as follows:

Life stage	Year Round Dosage	Dosage Availability
Infants < 2years: receiving breast milk or formula	800 IU/Day	2 Baby Ddrops™
Children 2-18 years	400 IU/Day	daily multivitamin
Pregnant* and nursing women	1000 IU/Day	vitamin D supplement
Adults > 50 years	400 IU/Day	daily multivitamin

*in addition to the vitamin D in prenatal supplements

Vitamin D Supplementation

125



A Note on Fevers

126

Child and Family Services Act

- appears to be suffering from abuse and/or neglect
- Reasonable grounds
- Applied to children 16 and younger

Professional Duty to Report

127

Behavioural Health and Addictions

Artist: Ningeeuga Oshuitoq

CANADIAN HEALTH CARE AGENCY
EXPERIENCE THE NORTH

128

"balance between the mental, emotional, physical and spiritual health."

"the disparity between Aboriginal behavioural health and that of the rest of Canadians is of concern."

Provide specific information about client's
- Behaviour
- Thoughts
- Feelings

…and the relation of these factors to the client's
- Background
- Experiences
- Present circumstances

INTRODUCTION: Behavioural Health

129

- Most Communities have a Mental Health Nurse and/or Social Worker on site.
  - Case-manage patients on long-term psychiatric drugs
  - Assist in crisis counselling
  - Follow up with clients

Mental Health Nurse

130

BATHE

- **B**ackground: "what is happening in your life?"
- **A**ffect: "how do you feel about the situation?"
- **T**rouble: "what worries you the most?"
- **H**andling: "what resources do you have?"
- **E**mpathy: "your response is reasonable."

ASSESSMENT: Behavioural Health

131

HISTORY

- General description
- History of presenting problem
  - Chief concern
  - Difficulties or changes
  - Increased feelings
  - Somatic changes
  - Integrative patterns/client's perception
- Relevant History

ASSESSMENT: Behavioural Health

132

MENTAL STATUS EXAMINATION (MSE)

- Appearance
- Behaviour
- Speech
- Mood and Affect
- Thought processes
- Thought content
- Perception
- Cognition
- Insight and Judgment

ASSESSMENT: Behavioural Health

133

- Make a provisional diagnosis
- Determine need for emergency actions
  - Homicidal or violent impulses
  - Potential suicide
  - Inability to function independently
  - Acute psychotic symptoms
  - Delirium

"treatment goals should be identified and driven by clients."

ASSESSMENT: Behavioural Health

134

- **Consult**
  - Physician
  - Nurse Practitioner
  - Clinical Nurse Specialist
  - Psychiatrist
  - Counselor
  - Social Worker
  - behavioural health/wellness worker

- Hospitalization:
  - that decision is only made in consultation with a physician or nurse practitioner

ASSESSMENT: Behavioural Health

135

- Anxiety Disorders
- Mood Disorders
- Psychotic Disorders
- Family Violence
- Substance Misuse
- Cognitive Impairment

COMMON PROBLEMS

136

- Generalized anxiety disorder
- Obsessive compulsive disorder
- Panic disorder
- Post-traumatic stress disorder
- Social anxiety disorder
- Specific phobias

"…symptoms that persist, are of a greater intensity than expected, and impair daily functioning…"

Anxiety Disorders

137

GAD-7 Screening Questions[1,2]

During the last 2 weeks, how often have you been bothered by the following problems?

Problem	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
	Total each column:			
			Total score (Add columns 2,3,4):	

– Adapted from Spitzer et al[1]

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Calculate the patient's anxiety severity by assigning scores of 0, 1, 2 and 3 to the response categories of "not at all," "several days," "more than half the days," and "nearly every day," respectively.

The total score for the seven items ranges from 0 to 21. A score of 5-9 indicates mild anxiety, 10-14 indicates moderate anxiety, and 15-21 indicates severe anxiety.

Using the threshold score of 10, the GAD-7 has a sensitivity of 89% and a specificity of 82% for GAD (General Anxiety Disorder). It is moderately good at screening three other common anxiety disorders: panic disorder (sensitivity 74%, specificity 81%), social anxiety disorder (sensitivity 72%, specificity 80%), and post-traumatic stress disorder (sensitivity 66%, specificity 81%). When screening for individual or any anxiety disorder, a recommended cut point for further evaluation is a score of 10 or greater.

References: 1. Spitzer RL et al. A brief measure for assessing generalized anxiety disorder: The GAD-7. *Arch Intern Med* 2006;166:1092-7. 2. Kroenke K et al. Anxiety disorders in primary care: prevalence, impairment, comorbidity, and detection. *Ann Intern Med* 2007;146(5):317-25.

GAD-7 Questionnaire

138

- Major depressive disorder
- Seasonal affective disorder
- Postpartum depression
- Sub-syndromal/ minor depression
- Dysthymic disorder
- Bipolar I
- Bipolar II

Mood Disorders

139

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✔" to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING: 0 + _____ + _____ + _____
=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

PHQ-9 Questionnaire

140

"…can present as delusions, hallucinations, disorganized speech, bizarre behaviour, catatonia, withdrawal and social withdrawal."

"approximately 3% of Canadians experience some kind of psychosis in their life."

Psychotic Disorders

141

Positive Symptoms

- Hallucinations
- Delusions
- Thought disorder
- Disorganized behaviour
- Inappropriate affect

Negative Symptoms

- Slow thoughts
- Poverty of speech
- Lack of motivation
- Low energy
- Inability to gain pleasure
- Flat affect

Schizophrenia

142

- Physical Abuse
- Emotional or Psychosocial Abuse
- Neglect
- Financial Abuse
- Sexual Assault

"Most female victims support routine verbal screening for domestic violence."

Family Violence

143

Screen when:

- History of physical findings indicate violence
- A female is pregnant
- Presentation is after clinic hours
- Female with chronic abdominal or chest pain, headaches, and/or STIs
- Dependent older adults
- Initial clinic visit for new clients
- Well-child visits
- Preventative care visits for females < 12 years

Family Violence

144

History taking tips:

- states injuries are a result of trauma
- do not put down the abuser
- states that behaviour is unacceptable
- do not reassure the client that "everything will be alright"
- help client be objective
- verbalize client priorities
- encourage use of "I" messages with abuser
- assess for danger to children

Family Violence

145

- **Cannabis**
  - Marijuana, Hashish
- **Depressants**
  - Barbiturates, Benzodiazepines
  - ETOH
  - Opioid analgesic
  - Inhalants
- **Stimulants**
  - Amphetamines, Ritalin, Cocaine, Crack,
  - Caffeine, Tobacco
- **Hallucinogens**
  - LDS, Mescaline, Peyote

"Of Aboriginal people, 26.3% report substance misuse a concern."

Substance Misuse

146

C: Ever felt the need to **C**ut down or **C**hange your pattern of drinking or drug use?

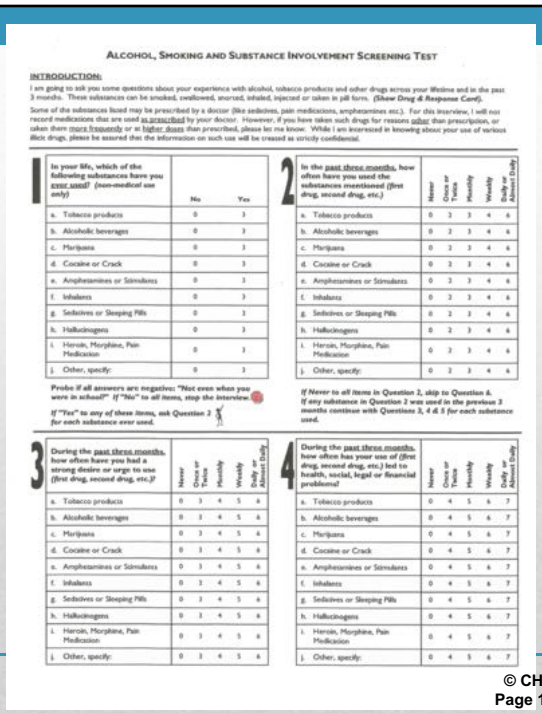
A: Ever been **A**nnoyed by others criticizing you drinking or drug use?

G: Ever felt **G**uilty about what has happened while you were drinking or using drugs?

E: Ever had a drinking or used drugs in the morning (**E**ye-opener) to help with a hangover or withdrawal symptoms?

CAGE-AID Tool

147



ALCOHOL, SMOKING AND SUBSTANCE INVOLVEMENT SCREENING TEST

INTRODUCTION:

I am going to ask you some questions about your experience with alcohol, tobacco products and other drugs across your lifetime and in the past 3 months. These substances can be smoked, swallowed, snorted, inhaled, injected or taken in pill form. *(Show Drug & Response Card).*

Some of the substances listed may be prescribed by a doctor (like sedatives, pain medications, amphetamines etc.). For this interview, I will not record medications that are used as prescribed by your doctor. However, if you have taken such drugs for reasons other than prescription, or taken them more frequently or at higher doses than prescribed, please let me know. While I am interested in knowing about your use of various illicit drugs, please be assured that the information on such use will be treated as strictly confidential.

1 In your life, which of the following substances have you ever used? (non-medical use only)

	No	Yes
a. Tobacco products	0	3
b. Alcoholic beverages	0	3
c. Marijuana	0	3
d. Cocaine or Crack	0	3
e. Amphetamines or Stimulants	0	3
f. Inhalants	0	3
g. Sedatives or Sleeping Pills	0	3
h. Hallucinogens	0	3
i. Heroin, Morphine, Pain Medication	0	3
j. Other, specify:	0	3

Probe if all answers are negative: "Not even when you were in school?" If "No" to all items, stop the interview.

If "Yes" to any of these items, ask Question 2 for each substance ever used.

2 In the past three months, how often have you used the substances mentioned (first drug, second drug, etc.)

	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products	0	3	4	5	6
b. Alcoholic beverages	0	2	3	4	6
c. Marijuana	0	3	4	5	6
d. Cocaine or Crack	0	3	4	5	6
e. Amphetamines or Stimulants	0	3	4	5	6
f. Inhalants	0	2	3	4	6
g. Sedatives or Sleeping Pills	0	2	3	4	6
h. Hallucinogens	0	2	3	4	6
i. Heroin, Morphine, Pain Medication	0	2	3	4	6
j. Other, specify:	0	2	3	4	6

If Never to all items in Question 2, skip to Question 6.
If any substance in Question 2 was used in the previous 3 months continue with Questions 3, 4 & 5 for each substance used.

3 During the past three months, how often have you had a strong desire or urge to use (first drug, second drug, etc.)?

	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products	0	3	4	5	6
b. Alcoholic beverages	0	3	4	5	6
c. Marijuana	0	3	4	5	6
d. Cocaine or Crack	0	3	4	5	6
e. Amphetamines or Stimulants	0	3	4	5	6
f. Inhalants	0	3	4	5	6
g. Sedatives or Sleeping Pills	0	3	4	5	6
h. Hallucinogens	0	3	4	5	6
i. Heroin, Morphine, Pain Medication	0	3	4	5	6
j. Other, specify:	0	3	4	5	6

4 During the past three months, how often has your use of (first drug, second drug, etc.) led to health, social, legal or financial problems?

	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products	0	4	5	6	7
b. Alcoholic beverages	0	4	5	6	7
c. Marijuana	0	4	5	6	7
d. Cocaine or Crack	0	4	5	6	7
e. Amphetamines or Stimulants	0	4	5	6	7
f. Inhalants	0	4	5	6	7
g. Sedatives or Sleeping Pills	0	4	5	6	7
h. Hallucinogens	0	4	5	6	7
i. Heroin, Morphine, Pain Medication	0	4	5	6	7
j. Other, specify:	0	4	5	6	7

ASSIST Tool

148

- **ASK** about use
- **ADVISE** them to quit
- **ASSESS** their willingness to make a quit attempt
- **ASSIST** them by arranging/providing counseling and pharmacologic treatment
- **ARRANGE** follow up

Five A's

149

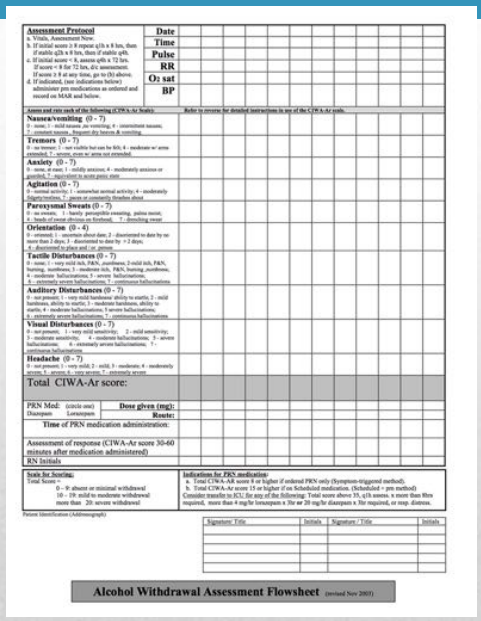
Clinical Institute Withdrawal Assessment for Alcohol-revised (CIWA-Ar)

- Severity of ETOH withdrawal
- Determine appropriate care
- Monitor client during detoxification

"complete on suspected ETOH withdrawal; who can talk and who have drank in the past 5 days."

Acute Alcohol Withdrawal

150



Alcohol Withdrawal Assessment Flowsheet

CIWA-A: Acute Alcohol Withdrawal Tool

151

- Verbal and Non verbal techniques
- De-escalation
- Security
- Physical restraints
- Pharmacological interventions

- In extreme danger – lock yourself in the pharmacy and call police.

Aggressive Behaviour

152

Suicide Prevention; Assessment and Treatment of the Suicidal Patient

Artist: Annie Pootoogook

CANADIAN HEALTH CARE AGENCY
EXPERIENCE THE NORTH

153

CHN Role in Suicide Prevention

- Teaching youth coping strategies, problem solving skills and life skills
- Reducing access to lethal means
- Ensuring adequate treatment for mental health
- Addressing determinants of health
- Family support
- Support groups for youth
- Increase awareness of mental health and suicide

154

Risk Factors

- Social isolation
- Major disruption in life
- Mental Illness
- Family History
- Substance abuse
- Peer teasing
- Poor school attendance
- Previous attempts

Protective Factors

- Good physical and mental health
- Strong problem solving, communication, conflict resolution abilities
- Positive family and friend relationships
- Positive attitude towards school

Risk Factors & Protective Factors

155

- Sudden change in behaviour
- Increased use of ETOH or drugs
- Recent loss of friend or family member
- Many mood swings, outbursts, irritability or aggression
- Feeling hopeless, worthless, in despair
- Giving away valued possessions, putting affairs in order
- Purchasing items to be used for suicide
- Having a plan for suicide
- Preoccupation with death
- Talking about suicide directly
- Threatening to die by suicide

Warning Signs

156

History

- BATHE
- Therapeutic relationship
- Assure confidentiality
- Suicidal ideation?
- "Does client have a plan?"
- Suicide risk assessment
- Triggers
- Previous attempts?
- Mood
- Substance use
- "Does client want help?"

Suicidal Behaviour: History

157

KNOW THE SIGNS

Suicide Is Preventable

- Asking questions during your assessment is important but understand how to ask questions to get the answers that will help with identifying patient at risk for suicide.
- Example:
  - Asking direct questions related to 'wanting to die' rather than 'wanting to commit suicide' are more appropriate among youth.
  - Ask: "Have you tried to die before?", "When was the last time you tried to die?", and "Have you tried to hurt yourself without wanting to die?"

Attempted Suicide: Ask Careful Questions

158

- Feasible; low burden- short administration time
- Assesses both behavioral and ideation: Uniquely addressing the need for a summary measure of suicidality
- Comprehensive measure that includes only the most necessary suicidality characteristics (low burden)
- Evidence-based (developed by leading experts)

VIDEO: CSSRS

Columbia-Suicide Severity Rating Scale

159

KEY QUESTIONS AREAS FOR SUICIDAL IDEATION

1) **Wish to be Dead**
   - Have you wished you were dead or wished that you could go to sleep and not wake up?
2) **Non-specific Active Suicidal Thoughts**
   - Have you actually had thoughts of killing yourself?

   ****If NO to #1 and #2, Suicidal Ideation Section completed**

   ****If NO to #1 and YES to #2, ask the following 3 questions**
3) **Associated Thoughts of Methods**
   - Have you been thinking about how you might do this?
4) **Some Intent**
   - Have you had these thoughts and had some intension of acting on them?
5) **Plan and Intent**
   - Have you started to work out or have worked out the details of how to kill yourself? Do you intend to carry out this plan?

Columbia-Suicide Severity Rating Scale

160

1. Safety First
2. Assess patient for any physical injuries and treat.
3. Choose the appropriate suicide risk assessment tool
4. Contact MD on-call for Medevac, call Nodin to send patient out and arrange escort.
5. Create a **SAFETY PLAN** if remains in the community.
6. Form 1 if patient refuses admission, with assistance of MD via video conference or if MD onsite.

Management of the Suicidal Patient

161

- Safety plans are proactive strategies, typically developed in collaboration with the clinician in advance of any crises, that serve to articulate what the client will do and who the client will contact when faced with suicidal urges.

- If I have thoughts of hurting myself, I will:
  1. Do the following activities to calm myself down/ comfort myself…
  2. Remind myself of my reasons for living…
  3. Call a friend or family member (Name: Phone #:)…
  4. Call a backup person if that one is not available…
  5. Call a care provider (psychologist, doctor)…
  6. Call my local crisis line (Phone #)…
  7. Go somewhere I am safe…
  8. Go to the emergency room of my nearest hospital…
  9. Feel that if I can't get to the hospital safely, call 911 and request transportation to the hospital. They will send someone immediately.

Safety Planning

162

Non pharmacological

- Educate about suicide
- Establish a written safety plan
- Crisis intervention services
- Family interventions
- Establish a treatment plan
- Verbal or written safety plan

Pharmacological

- Treat co-existing and/or misdiagnosed medical or psychiatric concerns
- Treat chronic medical conditions
- Tetanus vaccination
- Antibiotics
- Poison control instructions

Suicidal Behaviour

163

- Exhibiting destructive behaviours and is willing to attend counselling.
- Exhibiting Suicidal behaviours and is willing to attend counselling.
- Is a victim of Sexual Assault/physical abuse and is at imminent danger if remains in the community and is willing to attend counselling.
- Physical condition warrants further medical attention

Medevac Criteria for Admission of Suicidal Patient

164

Well Woman Exam

CANADIAN HEALTH CARE AGENCY
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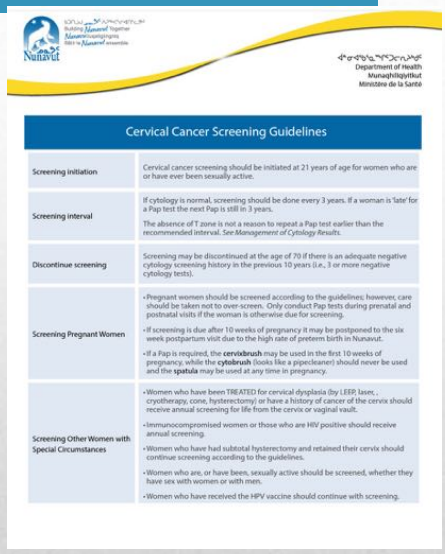
When do women start cervical screening?

- 21 yrs old as part of routine exam regardless of sexual activity
- If negative, then repeat pap smears are done every 3 yrs
- If positive – then depending on grade, different screening schedules.

When do women stop screening?

- At 70 years of age with three clear pap tests (no cervical abnormalities) in 10 years and no history of dysplasia.

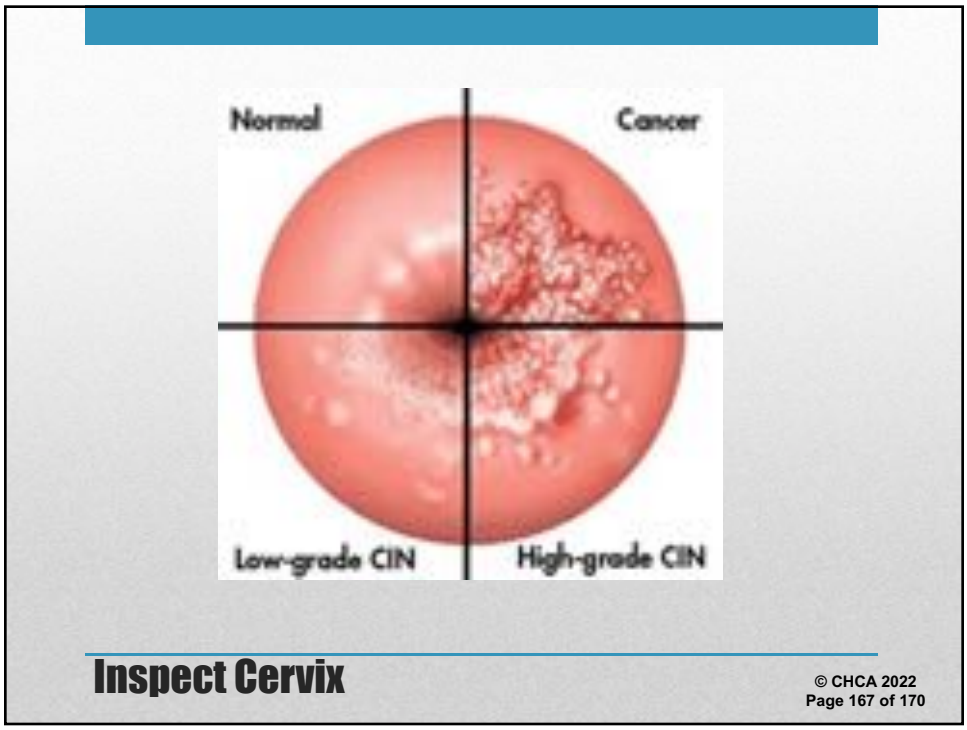

Department of Health
Munaqhiliqiyitkut
Ministère de la Santé

Cervical Cancer Screening Guidelines

Screening initiation	Cervical cancer screening should be initiated at 21 years of age for women who are or have ever been sexually active.
Screening interval	If cytology is normal, screening should be done every 3 years. If a woman is 'late' for a Pap test the next Pap is still in 3 years. The absence of T zone is not a reason to repeat a Pap test earlier than the recommended interval. *See Management of Cytology Results.*
Discontinue screening	Screening may be discontinued at the age of 70 if there is an adequate negative cytology screening history in the previous 10 years (i.e., 3 or more negative cytology tests).
Screening Pregnant Women	• Pregnant women should be screened according to the guidelines; however, care should be taken not to over-screen. Only conduct Pap tests during prenatal and postnatal visits if the woman is otherwise due for screening. • If screening is due after 10 weeks of pregnancy it may be postponed to the six week postpartum visit due to the high rate of preterm birth in Nunavut. • If a Pap is required, the **cervixbrush** may be used in the first 10 weeks of pregnancy, while the **cytobrush** (looks like a pipecleaner) should never be used and the **spatula** may be used at any time in pregnancy.
Screening Other Women with Special Circumstances	• Women who have been TREATED for cervical dysplasia (by LEEP, laser, , cryotherapy, cone, hysterectomy) or have a history of cancer of the cervix should receive annual screening for life from the cervix or vaginal vault. • Immunocompromised women or those who are HIV positive should receive annual screening. • Women who have had subtotal hysterectomy and retained their cervix should continue screening according to the guidelines. • Women who are, or have been, sexually active should be screened, whether they have sex with women or with men. • Women who have received the HPV vaccine should continue with screening.

Cervical Screening Guidelines

166


Normal
Cancer
Low-grade CIN
High-grade CIN
Inspect Cervix
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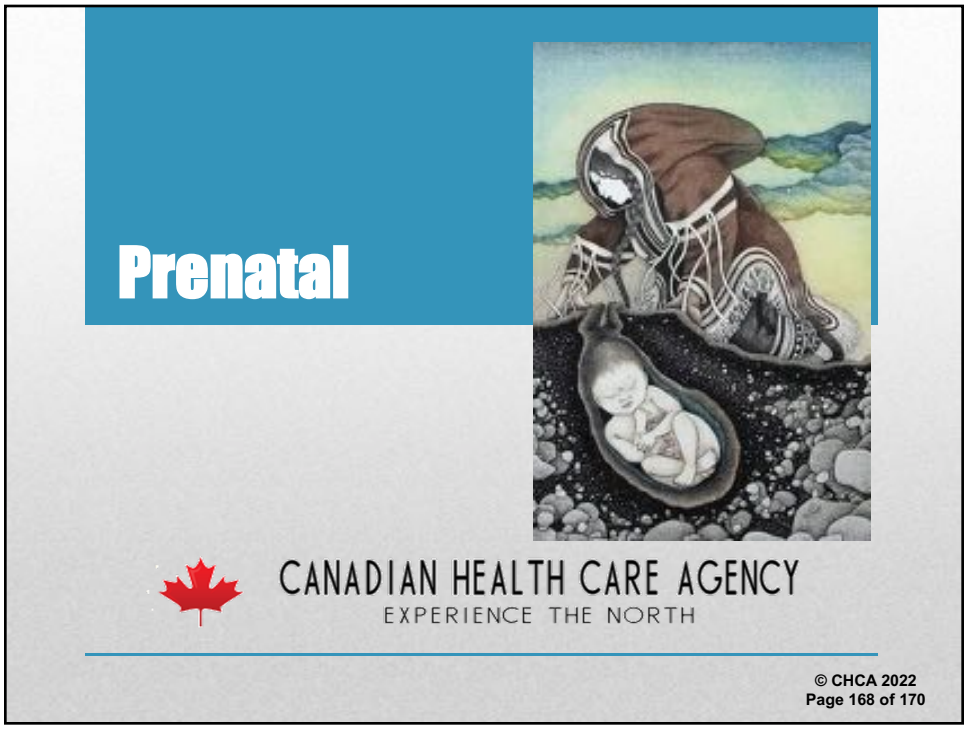
Page 167 of 170

167


Prenatal
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Page 168 of 170

168

- The Nunavut Prenatal Record supports the assessment and documentation of information about a pregnant woman's health and care in a structured and standardized manner.
- Part 1A and 2A Supplementary provides space for charting additional pregnancies and prenatal visits.
- Part 1B – Risk assessment guide and BMI table as well as Health Risk Classification According to BMI
- Part 2B – Edinburgh Perinatal Depression Scale and TWEAK Questionnaire/Scoring Guide
- Part 3 - Flow sheet for blood work, cultures and other recommendations for care.

Nunavut Prenatal Record

169

At 24-28 weeks gestation:

- CBC
- Ferritin
- Antibody/Indirect Coomb's on Rh negative women - if negative, consult for Rhogam order!
- 50 Gram, 1-hour OGTT
  - If necessary, proceed with 75 g OGTT, to make dx of gestational diabetes if values are:
    - Greater or equal to 5.3 mmol/L fasting, at one hour greater or equal to 10.6mmol/L and at two hours, greater or equal to 9.0 mmol/L

Subsequent Labs

170

- Nunavut Nursing Manuals, Guidelines and other information are available at:
- https://www.gov.nu.ca/health/information/manuals-guidelines

Summary

171