



NWT Clinical Practice Information Notice

Upon receipt, please file this notice in
Section C, Clinical Practice Information Binder for future reference.

The following clinical practice has been approved for use in the Northwest Territories Health and Social Services system, and has been distributed to:

☒	Hospitals	☒	Community Health Centres		Homecare		LTC		Pharmacists
☒	Doctor's Offices		Social Services Offices	☒	Public Health Units		Please list other(s):		

The information contained in this document is a Departmental:

	Policy	☒	Clinical Standard	☒	Protocol		Procedure		Clinical Practice Guideline
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Title: NWT Community Health Core Service Standards and Protocols

Effective Date: December 2020

Important: This is replacing an already existing CPI #35 - NWT Community Health Nursing Program Standards and Protocols (June 2003)

Statement of approved Clinical Practice:

The NWT Community Health - Core Standards mandate the core services delivered in NWT communities. Presently, these core services are predominantly delivered by CHNs and PHNs; however, any practitioner involved in any capacity, at any time, with the delivery of Community Health Care is expected to adhere to the Community Health Core Service Standards and Protocols. The NWT Community Health Core Service Standards and Protocols are issued to:

- Define the core (essential) services delivered, primarily by Community Health Nurses (CHN)/Public Health Nurses (PHN) and where applicable other Health and Social Services team members;
- Identify, and standardize, the minimum outcome, process and protocol for each core service delivered;
- Provide a framework for Health and Social Services Authorities to monitor and evaluate service delivery (create audit tools);
- Provide a framework for HSS to monitor and evaluate services.

Attachments:

- NWT Community Health Core Service Standards and Protocols

An electronic copy of this notice is also available on the Department of Health and Social Services public website at: <http://www.professionals.hss.gov.nt.ca/document-categories/clinical-practice-information-notices>.

Minister ☐ Deputy Minister ☐ Assistant Deputy Minister ☒ Chief Public Health Officer ☐

Geukotto

This clinical practice is approved. _____.

This clinical practice is approved. _____
(signature) (date)

Deputy Minister

☐

Chief Medical Health Officer

☐

December 2020

Department of Health and Social

CPI #162 (issued by
DHSS Senior Nursing
Consultant)

(signature) (date)

Minister

☐

Deputy Minister

☐

Chief Public Health Officer

☐

NWT Community Health Core Service Standards & Protocols – Quick Reference Guide

The NWT Community Health Core Service Standards & Protocols have been updated to reflect current evidence in health care practice, and to reflect the priorities, goals and objectives as laid out in the DHSS strategic plan, *Caring for Our People: Strategic Plan for the NWT Health and Social Services System 2017-2020*.

What are the standards and protocols?

The Standards mandate, describe and define the core services delivered in NWT communities.

The Standards identify the minimum expected outcomes and requirements for all community health services. The Standards provide a structure by which Community Health Centers develop, operationalize and deliver their services. Indicators have been included for use to assess and evaluate the quality of service delivery, resource management and operational performance and expected outcomes.

Why use the Standards and Protocols?

The Standards are developed with the intended outcome of optimizing client care and well-being for NWT residents.

- The Standards are a practice oriented framework that assists all health care practitioners involved in the delivery of health services to provide equitable and consistent interdisciplinary care for all NWT residents.
- The protocols guide and provide tools in the operationalization of the services, provide useful points for teaching and guidance, and links practitioners to resources for additional information.

Who uses the Standards and Protocols?

Community Health Care Providers use the Standards and Protocols to ensure NWT residents are at the center of care.

- Core services are predominantly delivered by CHNs and PHNs in NWT communities; however, other health care practitioners are expected to deliver services in keeping with the Standards and Protocols.
- All staff involved in the delivery of core services are required to adhere to the Standards and use the Protocols in the provision of lifespan appropriate assessment, prevention, care, teaching and guidance.

When to use the Standards?

Any interaction with a client is an opportunity to deliver elements from the Community Health Core Standards.

- The Standards are organized by lifespan and further divided by main topics and sub topics which are relevant to that specific lifespan. Clinical judgement and the client's lived experience will requisite the use of multiple sections to ensure health needs are being met.
- Use the Standards with every opportunity to become familiar with expected outcomes and services.

Example:

- A 12 year old states they have started menstruating. Simultaneous use of the Lifespan, Infant and Child Health Section and /or Adolescent Health section may be required to meet their health needs.
- A Community Health Center organizes a full day event to provide well-child visits. CHNs and CHRs conduct well child assessments, and deliver health promotion activities as per the Lifespan and Infant and Child Health section.

How do the Standards contribute to quality of care?

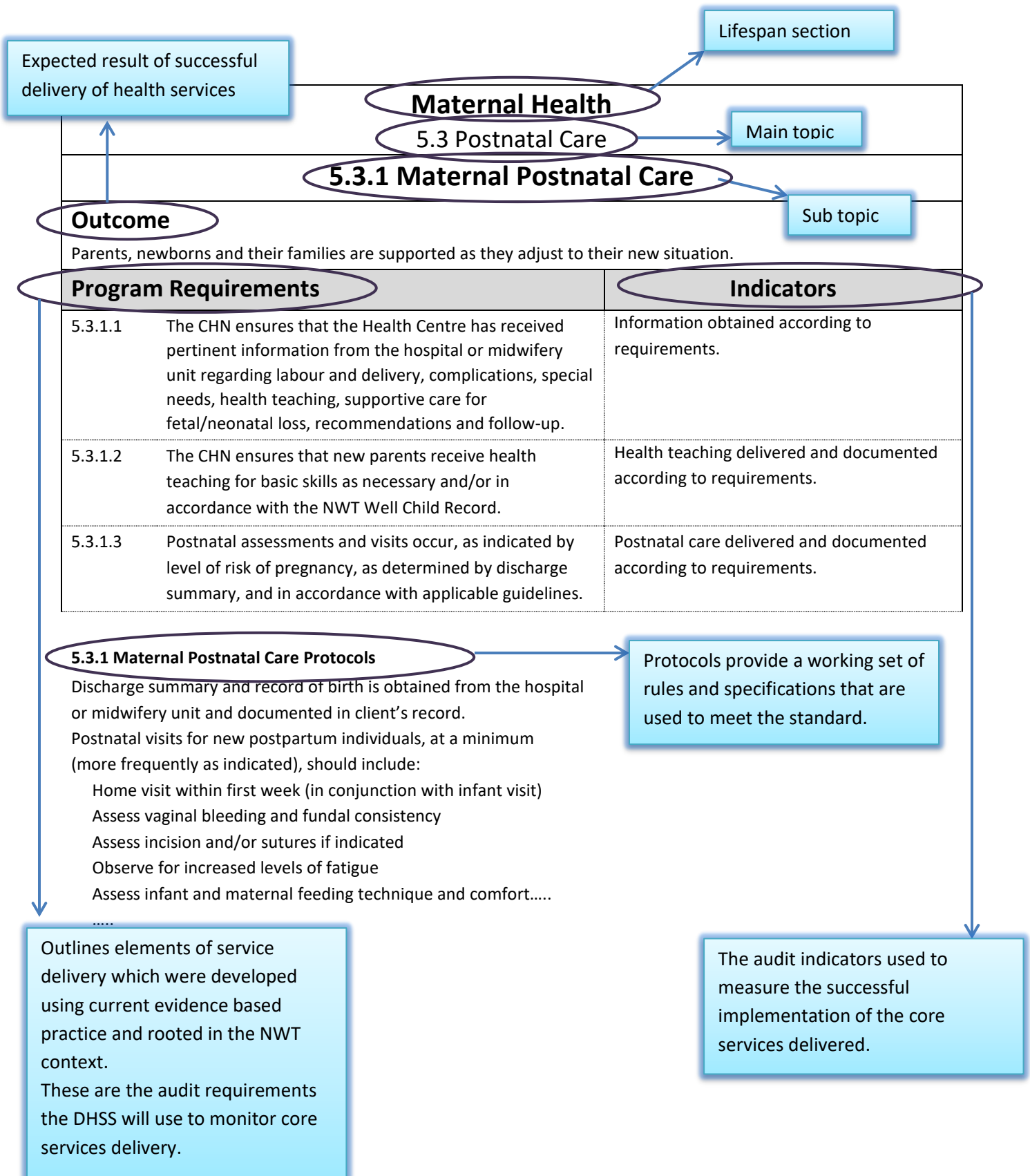
Just as in the nursing process, implementation of a care plan must be evaluated to determine if the interventions led to the expected outcomes.

- Health care services need to be monitored continuously to ensure that quality service is being delivered.
- These Standards and Protocols can be used to assess the successes and/or challenges associated with the quality of programs, service delivery and the operational systems in place.
- Health Centre audits and departmental evaluations inform the progression and evolution of health care in the NWT.
- The HSS will review audits and reports to conduct service delivery assessments and evaluations using the requirements and indicators which are outlined in each section of the Standards and Protocols.

Please see reverse for breakdown of a section of the Community Health Core Program Standards



Breakdown of a section of the Community Health Core Services Standards



NWT Community Health Core Service Standards and Protocols



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Chapter 0 Introduction

Health and Social Services Delivery in the Northwest Territories

Department of Health and Social Services

Mission

Through partnerships, provide equitable access to quality care and services and encourage our people to make healthy choices to keep individuals, families and communities healthy and strong.

Reporting to the Minister of Health and Social Services, the role of the Department of Health and Social Services (Department), is to promote, protect and to provide for the health and well-being of the people of the Northwest Territories. The Minister has overall responsibility for the health and social services system. The Department supports the Minister of Health and Social Services in carrying out this mandate by: setting the strategic direction for the system through the development of legislation, policy and standards; the establishment of approved programs and services; the establishment and monitoring of system budgets and expenditures; and the evaluating and reporting on system outcomes and performance.

Health and Social Services Authorities

The Department provides funding to three regional Health and Social Services Authorities: *Northwest Territories Health and Social Services Authority, Hay River Health and Social Services Authority and the Tlicho Community Services Agency*. The Authorities are responsible for the front line operational delivery of programs and services to citizens. Care is delivered in a variety of settings including community health centres, primary care clinics, public health units and hospitals.

System Priorities

The Department of Health and Social Services (DHSS) considers the Government of the Northwest Territories (GNWT) multi-year business plan (2020-2023) as the new Territorial Plan for the Health and Social Services system for the next 4 years. This includes a new strategic planning framework that sets the strategic direction, priorities, goals and objectives for the system. This is a quadruple aim Framework where strategic priorities and planned commitments and activities stem from each of the four aims. This planning framework's four aims provide a balanced approach and include a focus on:

- Health of the Population and Equity
 - focused on promotion, disease prevention and targeted access to programs and services for high-risk populations.

- Better Access to Better Services
 - focused on improving access, reducing wait times, strengthening cultural safety and creating a more robust system of supports in order to improve patient experience, promote equity, and avoid contributing to barriers to access for marginalized populations.
- Stable and Representative Workforce
 - focused on human resources planning to identify areas of demand, ensure appropriate job design and skill mix, and improve recruitment and retention practices in order to reduce high rates of turnover and reliance on locums.
- Quality Efficiency and Sustainability
 - focused on continued efforts to manage the growth in expenditures and maximize the return on all our investments. This may involve changes to the suite of services currently considered “core” and setting fiscal parameters for health planning.

Building a Culturally Respectful Health and Social Services System

The Department is committed to working collaboratively with partners to ensure all aspects of health and social services are culturally safe and respectful for clients throughout the territory. Throughout the Northwest Territories, the health and social services system works to provide quality services for all NWT residents – care that is respectful, responsive and accessible. A key part of this is making sure that all aspects of the health and social services system are culturally respectful and safe for everyone; particularly Indigenous peoples whose healthcare needs are often seen through a lens of racial discrimination. This also includes respecting Indigenous understandings of health and wellness and finding ways to accommodate traditional healing in our system. Cultural safety is a key part of reconciliation. The health and social services system has prioritized the delivery of culturally safe care and is working on implementation of a range of actions that advance cultural safety across all areas of the system, including system leadership, and policy design, traditional healing, staff training and performance measurement.

Community Health in the Northwest Territories

In the Northwest Territories, many citizens receive health and social services programming through their local community health centre. Community Health Nurses are the primary care providers in most Northwest Territories communities, working in an expanded nursing role with other health care and social services professionals. In addition to community, home care and public health services, these nurses provide treatment and emergency care services, X-ray, medical evacuation services and crisis management. Note: As Community Health Nurses are the primary care providers in most communities, the NWT Community Core Services Standards and Protocols have been written from the lens of the Community Health Nurse. However, any practitioner involved in any capacity, at any time, with the delivery of Community Health Care is expected to adhere to the Community Health Core Service Standards and Protocols.

NWT Community Health Nursing Roles

The delivery of community health programs are the responsibility of Community Health Nurses (CHNs) and Public Health Nurses (PHNs) in NWT. As registered nurses they practice in accordance with:

- The Code of Ethics for Registered Nurses (Canadian Nurses Association, 2017), and;
- Professional practice standards, competencies and scope of practice as regulated by the Registered Nurses Association of the Northwest Territories and Nunavut (RNANTNU, 2010a & 2010b), and;
- Applicable Federal and Territorial legislation.

CHNs and PHNs may have additional skills to support the demands and expectations of their diverse role described in employer job descriptions, policies, guidelines and procedures or protocols.

CHNs and PHNs embrace the tenets of Primary Health Care and are uniquely positioned in their role to contribute to the mission of the NWT Health and Social Services System as stated in the strategic plan for the system.

This means that NWT CHNs and PHNs:

- Provide individualized evidence-based health programs and services that consider the evolving needs, capacities and circumstances of each client/family with the goal of optimizing their wellness and quality of life.
- Focus on proactive 'upstream interventions' such as health promotion, injury/illness prevention and anticipatory guidance during health care encounters.
- Decrease the burden of chronic disease on the HSS system; optimizes the quality of life of the individual with chronic condition(s) and their family; promotes contemporary, evidence-based chronic disease management including, where appropriate, client self-management.
- Have access to other disciplines and teams to collaboratively address individual and community health and social services needs in a timely and effective manner.

- Respond to unscheduled, urgent or emergent health care needs.
- Work with other CHNs and PHNs, and under the guidance of their supervisors to enhance Primary Health Care services in the community.
- Encourage and support the involvement of community members in planning services that address community needs.
- Use available technology in all aspects of client care and program delivery, whenever possible.

For the purposes of this document, the term CHN will apply to CHNs and PHNs involved in delivery of Community Health Core Service Standards and Protocols.

Community Health Core Service Standards and Protocols

Purpose

The **NWT Community Health - Core Standards** mandate the core services delivered in NWT communities. Presently, these core services are predominantly delivered by CHNs and PHNs; however, any practitioner involved in any capacity, at any time, with the delivery of Community Health Care is expected to adhere to the Community Health Core Service Standards and Protocols.

The NWT Community Health – Core Service Standards and Protocols

- Describe and define the core (essential) services delivered in NWT community settings.
- Identify (and standardize) the minimum expected outcomes and standards for each core area including indicators for monitoring/evaluation.
- Provide a framework and protocols for Health and Social Services Authorities to implement, monitor and evaluate Community Health Nursing/Public Health Nursing Programs.
- Are evidence-based and anchored in best practice.

The Standards and Protocols are not a substitute for the use of professional and clinical judgment in the provision of quality care.

Administration

All staff involved in the delivery of community health care, especially CHNs and PHNs, will be introduced to the Community Health Core Service Standards and Protocols during their orientation by their Nurse-In-Charge or delegate. Revisions and/or updates will be brought to the attention of community health staff in a timely manner and this will be documented according to regional or health centre practice for sharing of information. All community health staff share the responsibility for identifying areas of deficit or discrepancy with regard to any Community Health Standards.

To ensure the Standards are kept up to date and remain relevant, this document will be routinely revised. Community Health Core Service Standards and Protocols remain in effect until reviewed and revised or removed from the Standards document.

Community Health Core Services

The core services meet the needs of clients and families throughout the lifespan (birth to death) and the illness/health continuum. The core services are designated by lifespan periods that correlate with ages and the normative expectations for cognitive, social, emotional and physical development milestones.

Community Health Core Service Standards and Protocols are subject to ongoing, monitoring, evaluation and quality improvement. This includes self-audit for professional growth.

Outcomes and indicators for each of the core services have been developed. Many outcomes and indicators are common through the lifespan and these are included in the Lifespan Health Section.

How to Use this Document:

The NWT Community Health Core Service Standards and Protocols establish operational benchmarks for the delivery of services by the Health Authorities. They provide the means to evaluate service delivery and organizational systems against best practice and accountability established by the Minister of Health and Social Services. The Standards and Protocols and the operational policies, within the authorities, that arise from them are to be adopted, and to be used to develop procedures from which they can be operationalized. Nurse In Charge (NIC)s, Nurse Managers and Regional Managers use these Standards and Protocols when planning service delivery in their respective practice area.

Quality services arise from continuous monitoring of operational performance, identification of needs and priorities and effective management of resources. Compliance with the Standards and Protocols must be assessed routinely through auditing mechanisms and, in the event that standards are not being met, corrective action must be taken to bring operations into compliance. The Standards in no way supersede any statutes or regulations. Compliance with the Standards and Protocols is mandatory however it is understood that not all standards are applicable in all practice settings. It is the expectation that decision makers will assess and identify within their operational plans, which standards will apply and the minimum standards are met. It is understood that current services will be incorporated, and augmented, within the context of the level of service and staffing model that is established for each health centre and/or public health unit.

The Protocols are a set of specifications, or tools, to ensure the Standards are met, however not each protocol will be implemented with each client interaction.

For example, the Greig Record would be used for a 9-year old girl presenting for her HPV vaccine. This is a protocol in the Lifespan health, however if during a system review overcrowding, weight loss and a chronic cough are identified, then the use of the TB Manual protocol will need to be initiated as well.

Important Note

There may be instances where a client's level of development dictates that standards from the Lifespan Health (to be used across all stages of growth and development), in combination with another area, would address their needs more appropriately. An assessment is critical to making a determination of which standards to use.

For example, a 9-year old girl with early onset puberty may need sexual health counseling in accordance with the Adolescent Health Standards; an adult with cognitive disabilities may require modifications to health education that correlates with their functional level rather than age; a pregnant adolescent requires care in accordance with Maternal Health; a middle aged person with complex chronic health conditions who is frail may require accommodations in treatment commonly associated with elder care. A plan of care is

developed, documented and communicated through organizational policies, usually in the electronic medical record (EMR).

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Chapter 1 Lifespan Health

The Lifespan Health Section contains standards applicable to all the age groups and must be used in conjunction with another section.

Lifespan Health 1.1 Health Promotion, Protection and Illness/Injury Prevention	
1.1.1 Lifespan Healthy Development	
Outcome Individuals and families are supported in making healthy life choices. Individuals have the knowledge, understanding, skills and attitudes to make healthy choices related to optimal physical, mental, including psychological, emotional, behavioural, social, and spiritual health, including but not limited to age and development appropriate adjustments e.g. exercise, screen time, sexuality, etc. CHNs will use holistic approaches to support individuals with the knowledge, skills and attitudes to achieve optimal health. Individuals will have the knowledge and resources to make healthy choices regarding nutrition and oral health.	
Standards	Indicators
1.1.1.1 The CHN delivers programs and services in culturally safe manners that respect each individual's culture, beliefs, values, religion and language. Individuals consent to participating in receiving services that are individualized and where privacy and confidentiality and individual choice is respected. When appropriate and opportune, the CHN incorporates the following in an age-specific and culturally-competent manner: a. screening assessments b. risk assessments c. health information d. anticipatory guidance e. preventative interventions	Individualized, up-to-date plans of care are in place and accessible to all CHNs. Plans of care are developed, documented and maintained in collaboration with the client/family/caregiver.
1.1.1.2 The CHN (under the guidance of the NIC or Regional Manager) uses available data to assess	Evidence of available data.

	community-level requirements for reducing the incidence of illness and injury, including requirements for at-risk groups. Examples of data sources include but are not limited to: • data on incidence of chronic disease • data on incidence of communicable diseases • immunization rates • Canadian Hospitals Injury Reporting and Prevention program.	
1.1.1.3	The CHN collaborates with community members, schools and/or professional colleagues on community needs assessments that identify issues that impact the health and well-being of the community and focus on promoting healthy choices and improving health (e.g.: community garden, activity/exercise promotion, etc.)	Evidence of CHN collaboration in community needs assessments.
1.1.1.4	The CHN participates in health education and healthy living activities (such as workshops, displays, radio shows or Elders' Tea).	Evidence of CHN participation in health education and healthy living activities.
1.1.1.5	The CHN acts as a resource for educators and the community regarding encouraging environments that are conducive to healthy sexual development. The CHN provides individualized, evidence-based, culturally safe sexual health education and advice that respects diversity and the clients' right to confidentiality, privacy and autonomy.	Evidence of CHN involvement in sexual health promotion activities. Sexual health discussions and education take place, as indicated.
1.1.1.6	The CHN provides individualized, culturally-safe nutritional care including: a. regular assessment of nutritional/macronutrient status b. identification of risk factors c. plan of care development d. health teaching and/or anticipatory	Nutritional care is delivered and documented in accordance with applicable guidelines, organizational policies and protocols.

	guidance referrals (including to Registered dietitians) as indicated.	
1.1.1.7	Referrals for nutritional (including Registered Dietitians) services are made as indicated. Referrals to oral health professionals and/or dentists are made as indicated.	Appropriate and timely referrals are sent as indicated. Plan of care is revised accordingly.
1.1.1.8	Oral health screening and preventative dental care are provided to individuals. CHN makes referrals to oral health professionals and/or dentists as indicated. All children will have a referral by the age 1.	Screening and preventative care documented in accordance with applicable guidelines, organizational policies and protocols. Appropriate and timely referrals are sent as indicated.
1.1.1.9	The CHN uses health encounters with individuals, when appropriate, to: a. promote positive body image b. assess the need for information c. provide guidance and resources for nutrition, body image and/or oral health.	Evidence of assessments, guidance, counseling and resources documented in accordance with applicable guidelines, organizational policies and protocols.
1.1.1.10	The CHN supports, facilitates and/or participates in activities conducive to the promotion of nutritional and oral health, and healthy body image for individuals.	Evidence of CHN involvement in health promotion activities.

1.1.1 Lifespan Healthy Development Protocols

Well Child Record:

<http://www.professionals.hss.gov.nt.ca>

Well Child Record User Guide and Resources: AGE: Birth to 5 years

Health and Social Services Professional's Website:

<http://www.professionals.hss.gov.nt.ca>

Grieg record and selected guidelines and resources:

<https://www.cps.ca/en/tools-outils/greig-health-record>

The Preventive Care Checklists and guiding documents are available at:

<https://www.cfpc.ca/en/home>

NWT Mental Health and Addictions Resource list:

<https://www.hss.gov.nt.ca/sites/hss/files/resources/mha-resource-list.pdf>

NWT Prenatal Record User Guide:

<http://www.professionals.hss.gov.nt.ca>

Culturally Safe Care

Aboriginal Cultural Awareness Training:

<https://www.fin.gov.nt.ca/en/services/diversit%C3%A9-et-inclusion/aboriginal-cultural-awareness-training>

Building a Culturally Respectful Health and Social Services System:

<https://www.hss.gov.nt.ca/sites/hss/files/resources/building-culturally-respectful-hss-system.pdf>

Community Wellness initiatives:

<https://www.hss.gov.nt.ca/en/services/community-wellness-initiatives>

Sexual Health

NWT Communicable Disease Manual:

<https://www.hss.gov.nt.ca/professionals/content/communicable-disease-manual-0>

Canadian Guidelines on Sexually Transmitted Infections:

<https://www.canada.ca/en/public-health/services/infectious-diseases/sexual-health-sexually-transmitted-infections/canadian-guidelines/sexually-transmitted-infections.html>

Assessments, screening and education and preventative interventions pertaining to sexual health are performed in accordance with the following guidelines:

<https://www.canada.ca/en/public-health/services/infectious-diseases/sexual-health-sexually-transmitted-infections/canadian-guidelines/sexually-transmitted-infections/canadian-guidelines-sexually-transmitted-infections-17.html>

Information on mandatory reporting and Age of Consent to sexual activity:

<https://www.justice.gc.ca/eng/rp-pr/other-autre/clp/faq.html>

NWT Guidelines for the Care of Survivors of Sexual Assault:

<https://www.hss.gov.nt.ca/professionals/sites/default/files/nwt-guidelines-care-survivors-sexual-assault.pdf>

Lifespan Health 1.1 Health Promotion, Protection and Illness/Injury Prevention	
1.1.2 Lifespan Prevention and Control of Communicable Disease	
Outcome All eligible people are immunized against vaccine-preventable diseases. Spread of communicable disease is prevented and controlled.	
Standards	Indicators
1.1.2.1 The required immunization competency program must be completed by all CHNs and PHNs prior to beginning immunization administration. The CHN proactively seeks opportunities to educate individuals and families about the importance of vaccination and immunizes individuals in accordance with the NWT Immunization Schedule. The CHN documents administered vaccines; and reports immunizations and refusals, in accordance with the <i>NWT Public Health Act, Immunization Regulations</i>.	Evidence of the immunization competency program completion. Immunizations administered according to the NWT Immunization Schedule. Documentation and reporting of administered immunizations in accordance with the <i>NWT Public Health Act, Immunization Regulations</i>.
1.1.2.2 The CHN reports adverse reactions to immunizations in accordance with the current <i>NWT Public Health Act, Immunization Regulations</i>.	Reports of adverse reactions to immunizations are provided to the Chief Public Health Officer within 24 hours of the assessment of the reaction.
1.1.2.3 The CHN reports communicable diseases to the Office of the Chief Public Health Officer as required by the current <i>NWT Public Health Act, Reportable Disease Control and Disease Surveillance Regulations</i> and in accordance with the <i>NWT Communicable Disease Manual</i>.	Required reports are completed and sent within prescribed timelines.

1.1.2.4 The CHN ensures that: a. Individuals with communicable diseases receive prompt and effective treatment, with consent; and b. Clients and/or families/caregivers receive written instruction on specific measures to control spread of infection, to minimize complications and to prevent recurrence.	Treatment administration in accordance with applicable guidelines, policies and protocols. Instructions given to the client and/or family/caregiver in accordance to applicable guidelines.
1.1.2.5 Screening, contact tracing and treatment are provided and reported in accordance with the <i>NWT Public Health Act, Reportable Disease Control Regulations, NWT Communicable Disease Manual, NWT TB Manual</i> and other applicable guidelines.	Screening and contact tracing reports are complete and submitted. Documentation of treatment and intervention for client and contact(s).

1.1.2 Lifespan Prevention and Control of Communicable Diseases

Protocols

Immunizations

CHNs actively offer immunizations throughout the lifespan.

For child and adolescent populations, CHNs work with school districts to optimize delivery of vaccination programs to this age-group in the school setting. CHNs also plan approaches to offer immunizations to children and adolescents who may not be in attendance at school.

Registered Nurses must complete the mandatory immunization competency program prior to beginning immunization administration:

The Education Program on Immunization Competencies (EPIC) modules can be accessed at:

<http://www.professionals.hss.gov.nt.ca/content/epic>

Immunizations are administered according to the NWT Immunization Schedule, and applicable Clinical Practice Information Notices, available at:

<http://www.professionals.hss.gov.nt.ca>

Information regarding immunizations can be found at:

<https://www.canada.ca/en/public-health/topics/immunization-vaccines.html>

<http://www.hss.gov.nt.ca/en/services/immunization-vaccination>

The Canadian Immunization Guide is available at:

<https://www.canada.ca/en/public-health/services/canadian-immunization-guide.html>

For more information on immunization facts and effective communication:

<https://www.canada.ca/en/public-health/services/publications/healthy-living/canadian-immunization-guide-part-1-key-immunization-information/page-5-communicating-effectively-immunization.html>

Mandatory reporting of adverse events following immunization:

<https://www.hss.gov.nt.ca/professionals/content/communicable-disease-manual-0>

Communicable Disease

NWT Communicable Disease Manual:

<https://www.hss.gov.nt.ca/professionals/content/communicable-disease-manual-0>

NWT TB Manual:

<https://www.hss.gov.nt.ca/professionals/content/nwt-tuberculosis-manual>

NWT HIV/AIDS Manual for Health Professionals:

https://www.hss.gov.nt.ca/professionals/sites/default/files/hiv_aids_manual_0.pdf

NWT Infection Control Manual:

<https://www.hss.gov.nt.ca/professionals/sites/default/files/infection-control-manual.pdf>

Sexual Health

NWT Communicable Disease Manual:

<https://www.hss.gov.nt.ca/professionals/content/communicable-disease-manual-0>

Canadian Guidelines on Sexually Transmitted Infections:

<https://www.canada.ca/en/public-health/services/infectious-diseases/sexual-health-sexually-transmitted-infections/canadian-guidelines/sexually-transmitted-infections.html>

Assessments, screening and education and preventative interventions pertaining to sexual health are performed in accordance with the following guidelines:

<https://www.canada.ca/en/public-health/services/infectious-diseases/sexual-health-sexually-transmitted-infections/canadian-guidelines/sexually-transmitted-infections/canadian-guidelines-sexually-transmitted-infections-17.html>

Information on mandatory reporting and Age of Consent to sexual activity:

<https://www.justice.gc.ca/eng/rp-pr/other-autre/clp/faq.html>

NWT Guidelines for the Care of Survivors of Sexual Assault:

<https://www.hss.gov.nt.ca/professionals/sites/default/files/nwt-guidelines-care-survivors-sexual-assault.pdf>

Lifespan Health	
1.1 Health Promotion, Protection and Illness/Injury Prevention	
1.1.3 Lifespan Prevention of Illness, Injury and Disability	
Outcome	
The incidence and severity of preventable injury, illness and disability are at or below National standards.	
Standards	Indicators
1.1.3.1 The CHN uses health encounters, as appropriate, to discuss safe behaviours, provide anticipatory guidance, and assess risk for intentional or unintentional injury, self-harm and suicide. The CHN provides culturally-safe, developmentally appropriate information.	Documented discussion about safety, anticipatory guidance and risk assessment when possible.
1.1.3.2 The CHN identifies individuals who may be in need of and benefit from therapeutic supports for example: • community counseling program • community social services, • mental health and addictions services, • On the Land programming, • peer support, • an elder in the community, • the NWT Help Line. With client consent, the CHN ensures that the identified supports are arranged.	Assessment of and identification of the need for therapeutic support. Support services and/or referral for support services is completed. Plan of care is revised accordingly.
1.1.3.3 The CHN collaborates with clients, families, Community Health Representatives, community schools, community members and organizations, identified helping professionals and other stakeholders to prevent illness, injury, and injury-related disabilities.	Evidence of collaboration to prevent illness, injury, and/or injury-related disability.

1.1.3 Lifespan Prevention of Illness, Injury and Disability Protocols

Age-specific topics for discussion are available at:

NWT Well Child Record: Age: Birth to 5 years

<http://www.professionals.hss.gov.nt.ca>

Grieg record and selected guidelines and resources - Age 6 to end of life:

<https://www.cps.ca/en/tools-outils/greig-health-record>

The Preventive Care Checklists and guiding documents are available at:

<https://www.cfpc.ca/en/home>

NWT Prenatal User Guide:

<https://www.hss.gov.nt.ca/professionals>

Injury Prevention:

<https://www.hss.gov.nt.ca/en/services/injury-prevention>

Lifespan Health		
1.1 Health Promotion, Protection and Illness/Injury Prevention		
1.1.4 Lifespan Harm Reduction		
Outcome		
Harm reduction strategies are employed based on identified community needs and available resources. Harm reduction is a public health approach aimed at reducing the adverse health, social and economic consequences of higher risk activities and focuses on maximizing safety and minimizing death, disease and injury associated with risky behaviours, while recognizing that the behaviour may continue despite the risks.		
Standards		Indicators
1.1.4.1	The CHN collaborates with community members and others to raise awareness about harm reduction in a manner that increases community acceptance, and reduces stigma and discrimination.	Evidence of collaboration with community members regarding harm reduction strategies.
1.1.4.2	The CHN collaborates with the community and other stakeholders to advocate for and explore and implement evidence-informed harm reduction strategies.	Evidence of discussions or implementation of harm reduction strategies.
1.1.4.3	In accordance with harm reduction principles, when the CHN identifies risky behaviours which the client may continue despite the risks, the CHN: a. Provides client centered care which recognizes client vulnerability and promotes health equity b. Provide education regarding ways to mitigate identified risks (seat belts, life jackets, safer sex) c. Provide appropriate supplies to mitigate risks (e.g. condoms/barriers, take home naloxone kit) d. Arrange referrals to appropriate supports (housing, addictions, mental health)	Documentation of interactions discussing harm reduction interventions and of supports/supplies being offered as needed and when available. Evidence of referrals being made to appropriate supports. Plan of care is revised accordingly.

1.1.4 Lifespan Harm Reduction Protocols

For topic specific information please refer to resources available at:
<https://www.hss.gov.nt.ca/en/resources>

Injury Prevention:
<https://www.hss.gov.nt.ca/en/services/injury-prevention>

Lifespan Health 1.2 Health Maintenance, Restoration and End of Life Care	
1.2.1 Lifespan Curative and Restorative Care	
Outcome Ill or injured clients are seen and treated in accordance with applicable guidelines. Clients who have been ill or injured regain optimal levels of health and wellbeing.	
Standards	Indicators
1.2.1.1 The CHN will assess every ill or injured clients who presents to the clinic: a. within a client and family centred care approach b. using a holistic approach (physical, developmental, emotional, social, spiritual needs) whenever possible c. through focused history and physical examination, and investigations according to applicable guidelines and approved decision support tools.	Client events are conducted and documented according to applicable guidelines, organizational policies and protocols.
1.2.1.2 The CHN provides interventions and treatments that: a. are based on assessment findings b. are in accordance with applicable clinical practice guidelines c. include consults/referrals, counselling and/or other therapeutic supports, and health teaching as necessary d. include preferences and capabilities of the client, family and/or caregiver whenever possible e. are congruent with relevant legislation, employer policy and scope of practice f. are evaluated and adapted as necessary.	Interventions and/or treatments are delivered and documented according to applicable guidelines, organizational policies and protocols.
1.2.1.3 In an emergency situation, the CHN: a. conducts a focussed history and physical of the client b. contacts, consults and collaborates with a physician/NP/midwife according to regional guidelines, to develop a plan of care to stabilize and/or transport the individual out of the community c. conducts regular, condition-sensitive reassessments for the time that the individual is under the CHN's care d. performs necessary investigations	Emergency events and transportation are managed and documented according to applicable guidelines, organizational policies and protocols.

	e. provides information, emotional reassurance and support to the client and family/caregiver f. involves family or caregivers in care delivery and decision making, with due consideration of the individual's health care needs.	
1.2.1.4	In accordance with Accreditation Canada and in keeping with organizational policy, the CHN will, conduct a medication reconciliation of all prescribed medications, over-the-counter medications, alternative or traditional remedies, and herbal supplements used by the client. At each visit when a medication is dispensed it is expected that the CHN would review the medication list with the client for accuracy. The CHN dispenses and documents medications in accordance with NWT Health Centre Formulary, organizational policies and applicable clinical practice guidelines, and minimizing interactions or contraindications with reconciled medications.	Medication reconciliations are completed. Medication dispensed and documented in accordance with applicable guidelines, organizational policies and protocols.
1.2.1.5	Where necessary, the CHN provides habilitation and rehabilitation interventions following illness or injury, in collaboration with the client, family and/or caregiver, and in accordance with expert advice/recommendations.	Interventions delivered as necessary. Plan of care is revised.

1.2.1. Lifespan Curative and Restorative Care Protocols

Every ill or injured client will be assessed including, but not limited to:

- history and physical examination
- medication review (and medication reconciliation, if being transferred to another facility)
- further assessments as warranted.

NWT Clinical Practice Guidelines for Primary Community Care Nursing:

<https://www.hss.gov.nt.ca/professionals/sites/professionals/files/resources/clinical-practice-guidelines-primary-community-care-nursing.pdf>

NWT Health Centre Formulary:

https://www.hss.gov.nt.ca/professionals/sites/default/files/nwt_health_centre_formulary_0.pdf

Lifespan Health 1.2 Health Maintenance, Restoration and End of Life Care		
1.2.2 Lifespan Home Care		
Outcome Whenever possible, clients who are unable to attend the community health centre for assessment and/or treatment receive necessary nursing services in their home.		
Standards		Indicators
1.2.2.1	In collaboration with or in the absence of a formal community-based Home Care program, the CHN will deliver nursing services to clients in their home that meet the physical, emotional and spiritual needs of the client and their family when operationally feasible, and are in accordance with <i>NWT Continuing Care Standards</i> .	Evidence of nursing services delivered in the home as necessary.
1.2.2.2	The CHN develops a plan of care in collaboration with the client and family/caregiver and in accordance with recommendations from other disciplines involved in the care, including community Home Care Workers if present. Treatment is evaluated and the care plan is revised as necessary.	Evidence of evaluation and care plan revision as necessary.

1.2.2 Lifespan Home Care Protocols

CHNs provide care in these situations according to individual needs, local resources, organizational policies, CHN scope of practice, and professional competence and, in collaboration with specialists.

Continuing Care Standards:

<https://www.hss.gov.nt.ca/professionals/sites/professionals/files/resources/continuing-care-standards.pdf>

Lifespan Health 1.2 Health Maintenance, Restoration and End of Life Care	
1.2.3 Lifespan Chronic Health Conditions	
Outcome Individuals with chronic health conditions are identified early, receive necessary treatment/care, and are able to achieve a ‘personal-best’ level of wellness and quality of life.	
Standards	Indicators
1.2.3.1 The CHN will conduct an assessment of every individual who is at risk for a chronic condition or who presents for maintenance of a chronic condition utilizing applicable NWT screening protocols and approved clinical protocols.	Assessments are completed and documented.
1.2.3.2 The CHN will consult with and/or refer to an NP, family physician, or specialist physician in accordance with applicable guidelines and/or policies.	Consults and/or referrals are completed as necessary.
1.2.3.3 The CHN collaborates on, promotes and delivers evidence-informed chronic disease management including self-management.	Chronic disease management delivered and documented.
1.2.3.4 Individuals with chronic conditions and their families/caregivers receive flexible, accessible, culturally safe and appropriate information, respectful of traditional beliefs, to build capacity in managing their health, minimizing complications and optimizing functioning.	Information shared according to requirements.
1.2.3.5 The CHN conducts regular monitoring of the plan of care to assess adherence (and rationale for non-adherence), complications, effectiveness, coping, and capacity.	Plans of care are revised as indicated.
1.2.3.6 The CHN conducts regular medication reviews and best possible medication history (BPMH) that includes an inventory of all prescribed medications, over-the-counter medications, alternative or traditional remedies, and herbal supplements used by the client.	Medication reviews are completed, revised and documented according to applicable guidelines, organizational policies and protocols.

paying particular attention to polypharmacy. The review will include the client and/or family/caregiver's adherence with prescribed medication regimen and assess each medication's appropriateness, side effects, effectiveness and known/potential interactions with other drugs that the client is taking. The CHN may make adjustments to the client's medication regimen in consultation with the physician, NP, client, family/caregiver, and pharmacist. A best possible medication history is conducted at least annually with clients with chronic disease.	
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1.2.3 Lifespan Chronic Health Conditions Protocols

Every person at risk for or with a chronic condition will be assessed including, but not limited to:

- history and physical examination
- medication review (and medication reconciliation, if being transferred or referred to another facility or practitioner)
- A best possible medication history is conducted at least annually with chronic disease clients
- further assessments as warranted.

NWT Resources for Chronic Disease Screening:

[http://www.professionals.hss.gov.nt.ca/content/chronic-disease-prevention-and-management:](http://www.professionals.hss.gov.nt.ca/content/chronic-disease-prevention-and-management)

NWT Cervical Cancer Screening Guidelines:

http://www.professionals.hss.gov.nt.ca/sites/default/files/page_95_nwt_cervical_cancer_screening_guidelines.pdf

NWT Type 2 Diabetes Screening and Diagnosis: Guidelines:

<https://www.hss.gov.nt.ca/professionals/sites/professionals/files/resources/cpi-148-nwt-type-2-diabetes-screening.pdf>

NWT Breast Cancer Screening Guidelines:

<http://www.professionals.hss.gov.nt.ca/sites/default/files/page-117-nwt-breast-cancer-screening-clinical-practice-guidelines.pdf>

NWT Colorectal Cancer Screening Guidelines:

http://www.professionals.hss.gov.nt.ca/sites/default/files/page_101_nwt_colorectal_screening_guidelines.pdf

NWT Chronic Kidney Disease Clinical Practice Guidelines:

<https://www.hss.gov.nt.ca/professionals/sites/professionals/files/resources/cpi-137-chronic-kidney-disease-clinical-practice-guidelines.pdf>

Lifespan Health 1.2 Health Maintenance, Restoration and End of Life Care	
1.2.4 Lifespan Palliative and End of Life Care	
Outcome Individuals with life-limiting illness and their families receive culturally-sensitive and compassionate palliative and end of life care.	
Standards	Indicators
1.2.4.1 The CHN provides care towards ensuring a comfortable death that meets the physical, emotional and spiritual needs and wishes of the client and their family and facilitates referrals or access to the required level of care.	End of life and palliative care delivered and documented. Evidence of referrals and/or facilitation of access/transfer to required level of care is documented.
1.2.4.2 Advance care planning (Living Wills, Advance Directives) and goals of care, including conversations about extraordinary measures and after life care, are reviewed with the client and family.	Advance care planning conversations are conducted and documented.
1.2.4.3 The CHN will provide any adult or elder seeking information and/or requesting medical assistance in dying with an Information Package as identified in the <i>“Medical Assistance in Dying – Interim Guidelines for the Northwest Territories”</i> .	Medical Assistance in Dying information is provided upon request and documented.
1.2.4.4 The individual’s death is pronounced, documented and communicated in accordance with NWT legislation, regulations, and policies.	Documentation and reporting is completed according to applicable guidelines, organizational policies and protocols.

1.2.4 Lifespan Palliative and End of Life Care Protocols

CHNs provide care in these situations according to individual needs, local resources, organizational policies, CHN scope of practice, and professional competence and, in collaboration with specialists.

Continuing Care Standards:

<https://www.hss.gov.nt.ca/professionals/sites/professionals/files/resources/continuing-care-standards.pdf>

Personal Directives:

<http://www.hss.gov.nt.ca/en/services/personal-directives>

Medical Assistance in Dying:

<http://www.hss.gov.nt.ca/en/services/medical-assistance-dying-aid>

NWT Help Line:

<http://www.hss.gov.nt.ca/en/services/nwt-help-line>

NWT Coroner's Act:

<https://www.justice.gov.nt.ca/en/files/legislation/coroners/coroners.a.pdf>

Palliative Approach to Care – Service Delivery Model for the NWT:

<https://www.hss.gov.nt.ca/sites/hss/files/resources/palliative-approach-care-service-delivery-model-nwt.pdf>

Lifespan Health 1.2 Health Maintenance, Restoration and End of Life Care	
1.2.5 Lifespan Bereavement Care	
Outcome Individuals, families and the community receive compassionate bereavement care.	
Standards	Indicators
1.2.5.1 CHNs provide culturally safe and age-appropriate bereavement care to siblings, parents/caregivers, extended family, and peer groups as necessary.	Bereavement care is provided and documented according to applicable guidelines, organizational policies and protocols.
1.2.5.2 The CHN considers the health and psychosocial status of those closest to the deceased and implements interventions/referrals to other community supports as necessary.	Interventions and/or referrals delivered and documented as necessary.

1.2.5 Lifespan Bereavement Care Protocols

CHNs provide care in these situations according to individual needs, local resources, organizational policies, CHN scope of practice, and professional competence and, in collaboration with specialists.

Continuing Care Standards:

<https://www.hss.gov.nt.ca/professionals/sites/professionals/files/resources/continuing-care-standards.pdf>

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Chapter 2 Infant and Child Health

The Infant and Child Health Section contains program standards applicable to children from birth to age 12; however, clinical judgment should determine if another section is more appropriate to use. To be used in conjunction with Lifespan Health.

Infant and Child Health 2.1 Health Promotion, Protection and Illness/Injury Prevention	
2.1.1 Infant and Early Childhood Health Screening, Risk Assessment, and Healthy Development	
Outcome Children birth to 5 years of age receive appropriate health screening and risk assessment. Children birth to 5 years of age at risk for or with identified conditions, receive interventions and referrals in accordance with the NWT Well Child Record and/or applicable guidelines. Parents/caregivers of children birth to 5 years, have the knowledge, skills and resources to provide for infant/child health and healthy development. The rights of children aged birth to 5 years to be protected from abuse are upheld through duty to report in cases where the cause of injury is abuse or suspected abuse. CHNs will use holistic approaches to support children birth to 5 years of age in seeking optimal physical, mental, social, and spiritual health.	
Standards	Indicators
2.1.1.1 In accordance with the NWT Well Child Record, the CHN provides age-specific and culturally safe: a. screening assessments b. risk assessments c. information about infant and child health d. resources for positive parenting e. information on healthy development f. anticipatory guidance for safety and reduction of risks. g. Others as per the Well Child Record	Assessments and information sharing are completed and documented according to applicable guidelines, organizational policies and protocols.
2.1.1.2 The CHN makes referrals to the appropriate provider or specialist per the NWT Well Child Record and/or to the Healthy Family Program as indicated.	Appropriate and timely referrals are sent as indicated. Plan of care is revised accordingly.
2.1.1.3 The CHN will monitor for signs and symptoms of abuse, maltreatment and neglect. In instances of abuse or suspected abuse, reports are made to child protection services in accordance with section 8 (1) of the NWT	Abuse and suspected abuse are reported according to legislation and appropriate guidelines, organizational policies and protocols.

<i>Child and Family Services Act.</i>		
2.1.1.4	The CHN supports, facilitates and/or participates in injury prevention and health promotion activities that support early childhood development and positive parenting.	Evidence of CHN involvement in injury prevention and health promotion activities.

2.1.1 Infant and Early Childhood Protocols

All infants and children, from age 0 – 5, are seen at prescribed intervals as identified on the NWT Well Child Record:

- Within 1 week of birth (typically a home visit)
- Age 1 month
- Age 2 months
- Age 4 months
- Age 6 months
- Age 12 months
- Age 18 months
- Age 3 years
- Age 4-5 years (school entry).

Assessment, screening, education and anticipatory guidance completed and documented on the NWT Well Child Record.

NWT Well Child Record:

https://www.hss.gov.nt.ca/professionals/sites/default/files/page-132-nwt-child-well-record_0.pdf

NWT Well Child Record User Guide and Resources:

<http://www.professionals.hss.gov.nt.ca>

NWT Growth Chart Standards:

<http://www.professionals.hss.gov.nt.ca/sites/default/files/page-126-nwt-child-growth-chart-standard.pdf>

Immunizations are administered according to the NWT Immunization Schedule, and applicable Clinical Practice Information Notices, available at:

http://www.professionals.hss.gov.nt.ca/sites/default/files/nwt_immunization_schedule.pdf

NTHSSA professional's link:

<http://www.professionals.hss.gov.nt.ca>

Infant and Child Health 2.1 Health Promotion, Protection and Illness/Injury Prevention	
2.1.2 School Age Health Screening, Risk Assessment, Healthy Development, and Active Living	
Outcome School age children (6-12 years of age) receive appropriate health screening and risk assessment. School age children (6-12 years of age) at risk for or with identified conditions, receive interventions and referrals in accordance with applicable guidelines. School age children have the knowledge, skills and resources to develop healthy habits and make healthy decisions. The school community is often an ideal setting for health promotion, protection and illness/injury prevention nursing interventions to take place. The rights of school age children to be protected from abuse are upheld through duty to report in cases where the cause of injury is abuse or suspected abuse. School age children (6-12 years of age) receive anticipatory guidance regarding healthy relationships CHNs will use holistic approaches to support children 6-12 years of age in seeking optimal physical, mental, social, and spiritual health.	
Standards	Indicators
2.1.2.1 When appropriate and opportune, the CHN incorporates the following into school age children’s visits, in an age-specific and culturally-competent manner: a. screening assessments b. risk assessments c. health information d. anticipatory guidance e. preventative interventions Use of the Greig Record or similar record is recommended.	Assessments and information sharing are completed and documented according to applicable guidelines, organizational policies and protocols.
2.1.2.2 School age children with developmental, physical or mental/emotional challenges are referred as required.	Appropriate and timely referrals are sent as identified. Evidence of collaboration with school system as appropriate. Plan of care is revised accordingly.

2.1.2.3	The CHN will monitor for signs and symptoms of abuse, maltreatment and neglect. In instances of abuse or suspected abuse, reports are made to child protection services in accordance with section 8 (1) of the <i>NWT Child and Family Services Act</i> .	Abuse and suspected abuse are reported according to requirement.
2.1.2.4	The CHN supports schools in taking actions so that school environments are conducive to making healthy choices. The CHN acts as a resource to educators by sharing knowledge and information.	Evidence of CHN participation in school activities that positively affect development, knowledge, health and well-being of students. CHNs involved in school-based health education are familiar with the NWT School Health Curriculum.
2.1.2.5	The CHN supports, facilitates and/or participates in injury prevention and health promotion activities in the school and/or community where adolescent populations can be accessed.	Evidence of CHN involvement in injury prevention and health promotion activities.
2.1.2.6	The CHN will provide education and anticipatory guidance around elements of developing healthy relationships.	Documentation of discussion as indicated.
2.1.2.7	The NIC and/or school nurse and the School Principal and/or staff meet within one month of the new school year to discuss and plan for a School Health Program. Included but not limited in the plan are: health activities (through regularly scheduled visits to the schools), provision of school-based immunizations as required, and other. The School Health Program plan should be determined based on needs identified through collaboration with the community, school officials and students, and the operational resources of the local health centre/public health unit. CHNs, in consultation with school teachers and/or the	Documentation of School Health Plan Documentation of needs assessment Documentation of specific plans of care

Principal, parents and/or guardians, should determine their involvement in the plan of care for students who are identified as being at risk or requiring additional supports at any time throughout the school year.	
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2.1.2 School Age Health Protocols

School age children (6-12 years of age) are assessed, screened, and provided with anticipatory guidance using the Greig Record or similar tool.

Grieg record and selected guidelines and resources:

<https://www.cps.ca/en/tools-ouils/greig-health-record>

Every visit should include:

- Head to toe systems review
- Other assessments as warranted, including but limited to vision and hearing screening
- Inquiry and assessment regarding psychosocial development
- Inquiry and assessment regarding nutrition (if concerns, include hemoglobin or other as needed)
- Growth parameters are measured and documented at every visit.
- Education and advice/anticipatory guidance regarding injury and illness prevention, health promotion, healthy relationships and decision making.

Immunizations are offered in this age group often as a School-based program. Nurses adhere to organizational policy regarding obtaining consent for immunization in the school setting.

Immunizations are administered according to the NWT Immunization Schedule (often as a School-based program), and applicable Clinical Practice Information Notices, available at:

http://www.professionals.hss.gov.nt.ca/sites/default/files/nwt_immunization_schedule.pdf

<https://www.hss.gov.nt.ca/professionals/sites/professionals/files/resources/cpi-144-nwt-immunization-schedule.pdf>

NWT Growth Chart Standards:

<http://www.professionals.hss.gov.nt.ca/sites/default/files/page-126-nwt-child-growth-chart-standard.pdf>

NWT Mental Health and Addictions Resource list:

<https://www.hss.gov.nt.ca/sites/hss/files/resources/mha-resource-list.pdf>

Injury Prevention:

<https://www.hss.gov.nt.ca/en/services/injury-prevention>

School-Based Nursing

A meeting between the NIC and/or school nurse and the School Principal and/or staff within one month of the new school year to discuss and plan for a School Health Program and to develop a plan for the school year's health activities and through regularly scheduled visits to the schools, including provision of school-based immunizations where required.

The School Health Program plan should be determined based on needs identified through collaboration with the community, school officials and students, and the operational resources of the local health centre/public health unit.

CHNs, in consultation with school teachers and/or the Principal, parents and/or guardians, should determine their involvement in the plan of care for students who are identified as being at risk or requiring additional supports at any time throughout the school year.

NWT School Health Program Curriculum

<https://www.ece.gov.nt.ca/en/services/curriculum-and-school-list/health-studies>

Infant and Child Health 2.1 Health Promotion, Protection and Illness/Injury Prevention	
2.1.3 Infant and Child Nutrition and Oral Health	
Outcome Infants, children and their families are supported to develop healthy nutrition patterns and good oral health.	
Standards	Indicators
2.1.3.1 The CHN encourages, and follows organizational policies, on promoting exclusive breastfeeding for the first six months of life, and is respectful and supportive of parental choice when infant feeding is discussed.	Infant feeding is discussed and documented according to applicable guidelines, organizational policies and protocols.
2.1.3.2 The CHN recommends Vitamin D supplementation for all infants and children under age 3, in accordance with NWT Vitamin D Supplementation Recommendations.	Evidence of discussion of Vitamin D supplementation is documented.
2.1.3.3 The CHN screens for anemia risk in all infants 6-18 months as appropriate, and recommends age-appropriate iron rich foods and/or iron fortified formulas in accordance with recommendations as per the NWT Well Child Record.	Screening, assessments and discussions are performed and documented according to applicable guidelines, organizational policies and protocols.
2.1.3.4 The CHN documents weight, height, head circumference (and other e.g.: head, chest abdomen, or thigh, as required) for all infants and children and makes timely referrals to the most appropriate provider (including Registered Dietitians) when there are identified issues with physical growth and development, in accordance with the NWT Well Child Record.	Growth parameters are measured and documented according to applicable guidelines, organizational policies and protocols. Appropriate and timely referrals are sent, as indicated. Plan of care is revised accordingly.
2.1.3.5 The CHN provides age-appropriate oral health guidance to reduce or prevent the incidence of childhood caries. The CHN will refer all infants and children to an oral health professional and/or dentist. Oral Health screening, risk screening, anticipatory	Oral health guidance given and documented according to applicable guidelines, organizational policies and protocols. Appropriate and timely referrals are sent as

guidance for reduction or oral health risks and referrals as per the Oral Health Standards.	indicated.
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2.1.3 Nutrition and Oral Health Protocols

NWT Well Child Record

https://www.hss.gov.nt.ca/professionals/sites/default/files/page-132-nwt-child-well-record_0.pdf

Refer to the NWT Well Child Record User Guide and resources

<http://www.professionals.hss.gov.nt.ca>

Food and Nutrition:

<http://www.hss.gov.nt.ca/en/services/food-and-nutrition>

Traditional Foods:

<http://www.hss.gov.nt.ca/sites/www.hss.gov.nt.ca/files/traditional-food-fact-sheets.pdf>

Baby Friendly Initiative NWT

<https://www.hss.gov.nt.ca/en/services/breastfeeding/baby-friendly-initiative>

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Chapter 3 Adolescent Health

*The Adolescent Health Section contains program standards applicable to people aged 13-18; however, clinical judgment should determine if another section is more appropriate to use.
To be used in conjunction with Lifespan Health.*

Adolescent Health 3.1 Health Promotion, Protection and Illness /Injury Prevention	
3.1.1 Adolescent Health Screening, Risk Assessment, Healthy Development and Active Living	
Outcomes Adolescents receive appropriate health screening and risk assessment. Adolescents at risk for, or with identified conditions, receive interventions and referrals according to applicable guidelines. The rights of adolescents to be protected from abuse are upheld through duty to report in cases where the cause of injury is abuse or suspected abuse. School age adolescents have the knowledge, skills and resources to be resilient and to make healthy choices for living. The school community is often an ideal setting for health promotion, protection and illness/injury prevention nursing interventions to take place. CHNs will use holistic approaches to support adolescents in seeking optimal physical, mental, social, and spiritual health. CHNs will support adolescents to have the knowledge, understanding, skills and attitudes to make healthy choices related to their sexuality and orientation, sexual activity, sexual risk behaviours and prevention of sexual health related complications.	
Standards	Indicators
3.1.1.1 When appropriate and opportune, the CHN incorporates the following into adolescents' visits, in an age-specific and culturally-competent manner: a. screening assessments b. risk assessments c. health information d. anticipatory guidance e. preventative intervention Use of the Greig Record or similar record is recommended.	Assessments, screening and information sharing are completed and documented according to applicable guidelines, organizational policies and protocols.
3.1.1.2 The CHN supports, facilitates and/or participates in injury prevention and health promotion activities in the school and/or community where adolescent populations	Evidence of CHN involvement in injury prevention and health promotion activities.

	can be accessed.	
3.1.1.3	The CHN facilitates referrals and timely access to resources such as: • specialists • community counseling program, • community social services, • mental health and addictions services, • On the Land programming, • peer support, • an elder in the community, • the NWT Help Line.	Evidence of assessment, referrals, and follow-up as indicated. Plan of care is revised accordingly.
3.1.1.5	The CHN acts as a resource to educators and the community towards encouraging environments that are conducive to healthy sexual development.	Evidence of CHN involvement in healthy relationship and sexual health promotion activities.
3.1.1.6	The CHN provides adolescents with individualized, culturally safe health education and information that respects diversity and the adolescent's right to confidentiality, privacy and autonomy for making decisions affecting their health. The CHN encourages parent/caregiver involvement in discussions pertaining to healthy relationships and healthy sexuality to the extent possible and while respecting adolescents' increasing decision making autonomy.	Discussions are documented according to applicable guidelines, organizational policies and procedures.
3.1.1.7	The CHN will monitor for signs and symptoms of abuse, maltreatment and neglect. In instances of abuse or neglect, reported or suspected, in adolescents up until their 19 th birthday, reports are made to child protection services in accordance with section 8 (1) of the <i>NWT Child and</i>	Evidence of documentation of concerns and reports in accordance with applicable NWT legislation, guidelines, organizational policies and protocols.

<i>Family Services Act.</i>	
3.1.18	The NIC and/or school nurse and the School Principal and/or staff meet within one month of the new school year to discuss and plan for a School Health Program. Included but not limited in the plan are: health activities (through regularly scheduled visits to the schools), provision of school-based immunizations as required, and other. The School Health Program plan should be determined based on needs identified through collaboration with the community, school officials and students, and the operational resources of the local health centre/public health unit. CHNs, in consultation with school teachers and/or the Principal, parents and/or guardians, should determine their involvement in the plan of care for students who are identified as being at risk or requiring additional supports at any time throughout the school year.
	Documentation of School Health Plan Documentation of needs assessment Documentation of specific plans of care

3.1.1 Adolescent Health Screening, Risk Assessment, Healthy Development and Active Living Protocols

Adolescents are assessed, screened, and provided with anticipatory guidance using the Greig Record or similar tool.

The Greig Record and guiding documents are available at:

<https://www.cps.ca/en/tools-outils/greig-health-record>

Every visit should include:

- Head to toe systems review
- Other assessments as warranted, including but not limited to vision and hearing screening
- Inquiry and assessment regarding psychosocial development

- Inquiry and assessment regarding nutrition (if concerns, include hemoglobin or other as needed)
- Inquiry and assessment regarding substance use
- Inquiry and assessment regarding sexual health where developmentally appropriate
- Growth parameters are measured and documented at every visit
- Education and advice/anticipatory guidance regarding injury and illness prevention, health promotion, healthy relationships, sexual health, decision making and consent.

Immunizations are offered in this age group often as a School-based program. Nurses adhere to organizational policy regarding obtaining consent for immunization in the school setting.

Immunizations are administered according to the NWT Immunization Schedule and applicable Clinical Practice Information Notices, available at:

http://www.professionals.hss.gov.nt.ca/sites/default/files/nwt_immunization_schedule.pdf

<https://www.hss.gov.nt.ca/professionals/sites/professionals/files/resources/cpi-144-nwt-immunization-schedule.pdf>

NWT Growth Chart Standards:

<http://www.professionals.hss.gov.nt.ca/sites/default/files/page-126-nwt-child-growth-chart-standard.pdf>

NWT Mental Health and Addictions Resource list:

<https://www.hss.gov.nt.ca/sites/hss/files/resources/mha-resource-list.pdf>

Injury Prevention:

<https://www.hss.gov.nt.ca/en/services/injury-prevention>

Assessments, screening and education and preventative interventions pertaining to sexual health are performed in accordance with the following guidelines:

<https://www.canada.ca/en/public-health/services/infectious-diseases/sexual-health-sexually-transmitted-infections/canadian-guidelines/sexually-transmitted-infections/canadian-guidelines-sexually-transmitted-infections-17.html>

Information on mandatory reporting and Age of Consent to sexual activity:

<https://www.justice.gc.ca/eng/rp-pr/other-autre/clp/faq.html>

NWT School Health Program Curriculum:

<https://www.ece.gov.nt.ca/en/services/curriculum-and-school-list/health-studies>

NWT Child and Family Services Act:

<https://www.justice.gov.nt.ca/en/files/legislation/child-family-services/child-family-services.a.pdf>

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Chapter 4 Adult and Elderly Health

The Adult and Elderly Health Section contains program standards applicable to most people over the age of 18 years; however, clinical judgment should determine if another section is more appropriate to use. To be used in conjunction with Lifespan Health.

Adult and Elderly Health 4.1 Health Promotion, Protection and Illness/Injury Prevention	
4.1.1 Adult and Elderly Health Screening, Risk Assessment, and Healthy Living	
Outcome All adults and elders receive age-appropriate targeted health screening and risk assessment. Adults and elders at risk or with identified health problems receive interventions and/or referrals in accordance with applicable guidelines. CHNs will use holistic approaches to support adults and elders in seeking optimal physical, mental, social, and spiritual health.	
Standards	Indicators
4.1.1.1 The CHN, in accordance with applicable guidelines, and in a culturally-safe manner, conducts: a. health screening assessments b. lifestyle risk assessments c. health information d. anticipatory guidance e. preventative intervention.	Assessments and information sharing are delivered and documented according to applicable guidelines, organizational policies and protocols.
4.1.1.2 The CHN facilitates referrals and timely access to resources such as: • specialists • community counseling program, • community social services, • mental health and addictions services, • On the Land programming, • peer support, • an elder in the community, • the NWT Help Line.	Evidence of assessment, referrals, and follow-up as indicated. Plan of care is revised accordingly.
4.1.1.3 In situations where criminal activity, violence or other forms of abuse are suspected or a risk is identified, the CHN will complete a full assessment of the victim/survivor and support them to report the incidence to Social Services and/or the RCMP in	Victim/survivor assessments are completed and documented. Evidence that the victim/survivor has been supported to report the incident.

	accordance with the client's wishes and applicable legislation, guidelines, policies and protocols.	
4.1.1.5	The CHN provides adults and elders with individualized, culturally safe health education and information that respects diversity.	Discussions are documented according to applicable guidelines, organizational policies and protocols.
4.1.1.6	The CHN supports, facilitates and/or participates in health promotion activities, in the health centre and/or in the community for adults and elders.	Evidence of CHN involvement in health promotion activities.

4.1.1 Adult and Elderly Health Screening, Risk Assessment, and Healthy Living Protocols

Average-risk adults and elders should be screened and assessed through an opportunistic head to toe systems review with focused testing that takes into account the client's unique risk factors, their age and their lifestyle and any social determinants of health which may compound well-being. CHNs are expected to use clinical judgement in determining what assessments/interventions are best for individual clients.

Every visit should include:

- Head to toe systems review
- Other assessments as warranted
- Inquiry and assessment regarding psychosocial health
- Inquiry and assessment regarding nutrition
- Inquiry and assessment regarding substance use
- Inquiry and assessment regarding sexual health
- Cancer risk screening
- Education and advice/anticipatory guidance regarding injury and illness prevention, health promotion, healthy relationships and sexual health.

According to Choosing Wisely Canada guidance, adults and elders should also be assessed:

- When they are sick
- When they have a symptom that could indicate illness
- To manage chronic conditions
- To check on the effects of a new medicine
- To help with risk factors such as smoking or obesity
- For maternal lifestyle issues like family planning

- For other reasons based on individual needs.

Adults and elders are assessed, screened, and provided with anticipatory guidance using the Preventive Care Checklist or similar tool.

The Preventive Care Checklists and guiding documents are available at:

<https://www.cfpc.ca/en/home>

Screening also offered in accordance with NWT Screening Clinical Practice Guidelines:

<http://www.professionals.hss.gov.nt.ca/content/chronic-disease-prevention-and-management>

Immunizations are administered according to the NWT Immunization Schedule, and applicable Clinical Practice Information Notices, available at:

http://www.professionals.hss.gov.nt.ca/sites/default/files/nwt_immunization_schedule.pdf

<https://www.hss.gov.nt.ca/professionals/sites/professionals/files/resources/cpi-144-nwt-immunization-schedule.pdf>

Assessments, screening and education and preventative interventions pertaining to sexual health are performed in accordance with the following guidelines:

<https://www.canada.ca/en/public-health/services/infectious-diseases/sexual-health-sexually-transmitted-infections/canadian-guidelines/sexually-transmitted-infections/canadian-guidelines-sexually-transmitted-infections-17.html>

Mental Health and Addictions Resource List:

<https://www.hss.gov.nt.ca/sites/hss/files/resources/mha-resource-list.pdf>

Injury Prevention:

<https://www.hss.gov.nt.ca/en/services/injury-prevention>

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Chapter 5 Maternal Health

The Maternal Health Section contains program standards applicable to planning to conceive and pregnant individuals, regardless of their age. To be used in conjunction with Lifespan Health.

Maternal Health 5.1. Preconception Care	
5.1.1 Preconception Health	
Outcome Individuals of child bearing age receive the necessary knowledge, skills and resources to prepare for conception and pregnancy.	
Standards	Indicators
5.1.1.1 The CHN provides individualized, culturally-safe health-teaching, screening and care toward ensuring best health in preparation and planning for conception and pregnancy.	Pre-conception teaching and care is delivered and documented according to applicable guidelines, organizational policies and protocols.
5.1.1.2 The CHN will refer individuals of child-bearing age who require further support to reach optimal health to necessary services as indicated.	Appropriate and timely referrals sent as indicated. Plan of care is revised accordingly.
5.1.1.3 The CHN supports, facilitates, and/or participates in health promotion activities for healthy pregnancies, healthy birth outcomes, and positive parenting.	Evidence of CHN involvement in health promotion activities.

5.1.1 Preconception Health Protocols

All individuals considering conception should be screened and assessed through an opportunistic head to toe systems review with focused testing that takes into account the client's unique risk factors, their age and their lifestyle and any social determinants of health which may compound well-being.

Individuals should be encouraged to care for their health for general well-being and in preparation for possible pregnancy.

Every visit should include:

- Head to toe systems review
- Other assessments and screening as warranted
- Inquiry and assessment regarding psychosocial health
- Inquiry and assessment regarding nutrition
- Inquiry and assessment regarding substance use

- Inquiry and assessment regarding sexual health
- Education and advice/anticipatory guidance regarding optimizing chronic medical conditions, nutrition, oral health, healthy body weight and body image, physical activity.

The Public Health Agency of Canada's *Family Centered Maternity and Newborn Care: National Guidelines* provide further information on preconception care in Chapter 2 of at the following location:
<https://www.canada.ca/en/public-health/services/publications/healthy-living/maternity-newborn-care-guidelines-chapter-2.html>

Maternal Health 5.2. Prenatal Care	
5.2.1 Pregnancy Choices	
Outcome Information on available options is offered to allow for informed decisions regarding the pregnancy. Options for pregnancy are provided and the client feels supported through access to resources to facilitate their decision making.	
Standards	Indicators
5.2.1.1 The CHN will, as necessary, provide advice/information about pregnancy outcome options (parenting, abortion and adoption). This information is provided in an open, supportive, respectful and culturally safe manner. Sufficient time will be provided for full consideration of the options. The pregnant individual is made aware that, regardless of their decision, they are encouraged to make choices that are best for them along the continuum of care; recognizing that their choice may change.	Discussions regarding pregnancy choices take place and are documented according to applicable guidelines, organizational policies and protocols. Plan of care is revised accordingly.
5.2.1.2 The CHN will facilitate client access to information and support regarding termination of pregnancy through the Northern Options for Women program. Clients can self-refer or the CHN can refer online. Assist clients in identifying social support network, and organize referrals to local counselling services as necessary.	Appropriate and timely referrals are sent as indicated. Documentation of discussion and referrals as indicated.
5.2.1.3 Clients can be referred to Social Services for information and support regarding adoption or custom adoption.	Appropriate and timely referrals are sent as indicated.

5.2.1 Pregnancy Choices Protocols

There are many complex reasons for planning to carry a pregnancy through to term, seeking abortion, seeking to adopt a child, or seeking to provide a child a different home other than the home into which the baby is born. The CHN supports individuals, their support persons and families by providing culturally safe and supportive care, assessments and screening and provide anticipatory guidance regarding individual choices in pregnancy.

Individuals seeking information about their options will be provided the following information:

- Parenting
<https://www.rightfromthestart.ca/>
<https://www.nthssa.ca/en/services/healthy-family-program>
- Abortion services
Referral to Northern Options for Women (NOW). Individuals can self-refer or be referred by the CHN/PHN.
<https://www.northernoptionsforwomen.com/>
- Adoption:
Referral to Child and Family Services Department of Health and Social Services :
<http://www.hss.gov.nt.ca/en/services/adoption>

Maternal Health

5.2. Prenatal Care

5.2.2 Prenatal Care for All Individuals

Outcome

All pregnant individuals receive care and support for healthy pregnancies.

Pregnant individuals have the knowledge, skills and resources necessary to understand the course of pregnancy and delivery; and to make healthy decisions for themselves and their baby.

All pregnant individuals with identified risk factors or complex/special needs receive appropriate care.

Those who develop pregnancy-associated conditions are supported in maintaining optimal health.

CHNs will use holistic approaches to support pregnant individuals in seeking optimal physical, mental, social, and spiritual health.

Standards		Indicators
5.2.2.1	In accordance with the NWT Prenatal Record, the CHN provides individualized and culturally-safe care including but not limited to: a. screening assessments b. risk assessments c. health information d. anticipatory guidance e. preventative interventions	Assessments and information sharing are completed and documented according to applicable guidelines, organizational policies and protocols.
5.2.2.2	Personal health and lifestyle information will be updated as necessary throughout the pregnancy.	Plan of care, as per the NWT Prenatal Record, is revised accordingly.
5.2.2.3	The CHN refers pregnant individuals with identified risk factors, and/or those with complex/special needs to a physician/NP, midwife, or specialist in accordance with applicable guidelines.	Appropriate and timely referrals are sent as indicated. The outcomes, recommendations, monitoring or follow-up are documented in the client prenatal record and plan of care.
5.2.2.4	The CHN monitors and/or intervenes on conditions in accordance with applicable guidelines and specialist advice.	Follow-up is completed and documented according to the requirement.
5.2.2.5	The CHN encourages partners, identified family members and support persons to take an active role in the pregnancy.	Documentation of discussion
5.2.2.6	The CHN makes arrangements for the transfer of prenatal individuals (for birth services) in accordance with plan of care and travel policy.	Plan of care updated accordingly.

5.2.2 Prenatal Care Protocols

Prenatal Visits

All pregnant individuals will be seen and provided care in accordance with the NWT Prenatal Record and the NWT Prenatal Record User Guide.

Care of the pregnant individual resumes once the pregnancy is identified, and an initial prenatal visit can be booked as per the NWT prenatal protocol:

- Head to toe systems review+
- Other assessments and screening as warranted (e.g.: urinalysis, weight, safety, etc.)
- Inquiry and assessment regarding psychosocial health
- Inquiry and assessment regarding nutrition
- Inquiry and assessment regarding substance use
- Inquiry and assessment regarding sexual health
- Education and advice/anticipatory guidance regarding optimizing chronic medical conditions, nutrition, oral health, healthy body weight and body image, physical activity.

NWT Prenatal Record:

<http://www.professionals.hss.gov.nt.ca>

Standard prenatal visit schedule is as follows:

- **Initial prenatal visit** should take place between 6 and 12 weeks gestation.
- **Regular prenatal visits** every 4 weeks until 28 weeks, then
- Every 2 weeks until 36 weeks, then;
- Every week until birth or until the individual leaves community for birth services.
- More frequent visits may be scheduled as clinical situations arise.

Prenatal Visit Physical examination and documentation:

- At each prenatal visit, examine measure and document: Gestation in weeks; Fundal height; Blood Pressure; Urine protein; weight; Fetal Heart Rate (FHR); Fetal Movement (FM); Presentation; next planned visit (in weeks)

Copies of the prenatal record and all lab results should be sent to the referral centre prior to a pregnant individual's appointment (physician, ultrasound, Northern Women's Health Program, birth services), and/or determined by the plan of care and following organizational procedures.

Maternal Sexual Health

Canadian Guidelines on Sexually Transmitted Infections – Specific populations – Pregnancy:

<https://www.canada.ca/en/public-health/services/infectious-diseases/sexual-health-sexually-transmitted-infections/canadian-guidelines/sexually-transmitted-infections/canadian-guidelines-sexually-transmitted-infections-41.html>

Supplementary statement for recommendations related to the diagnosis, management, and follow-up of Pregnant Women:

<https://www.canada.ca/en/public-health/services/infectious-diseases/sexual-health-sexually-transmitted-infections/canadian-guidelines/sexually-transmitted-infections/canadian-guidelines-sexually-transmitted-infections-12.html>

NWT Clinical Practice Information Notice – Enhanced Congenital Syphilis Screening:

<https://www.hss.gov.nt.ca/professionals/document/enhanced-congenital-syphilis-screening>

Medical Travel

Medical Travel Policy:

<https://www.hss.gov.nt.ca/en/services/d%C3%A9placement-pour-raisons-m%C3%A9dicales/medical-travel-policy>

Maternal Health 5.2. Prenatal Care	
5.2.3 Maternal Nutrition and Oral Health	
Outcome Pregnant individuals have the knowledge and resources to make healthy choices regarding nutrition and oral health during pregnancy.	
Standards	Indicators
5.2.3.1 The CHN provides ongoing assessments of each pregnant individual's nutritional status; and risk factors and provides nutrition information and resources as indicated in accordance with the NWT Prenatal Record. The CHN will complete and send referrals (including to Registered Dietitians) as indicated.	Nutritional assessments conducted and documented according to applicable guidelines, organizational policies and protocols. Plan of care revised accordingly.
5.2.3.2 The CHN recommends Vitamin D supplementation for all pregnant and lactating individuals, in accordance with NWT Vitamin D Supplementation Recommendations.	Recommendations made according to requirements.
5.2.3.3 The CHN screens for anemia in all pregnant individuals in accordance with the NWT Prenatal Record and makes recommendations for iron rich foods and/or iron supplementation as indicated.	Screening and recommendations completed and documented according to applicable guidelines, organizational policies and protocols.
5.2.3.4 Oral health screening is completed in accordance with the NWT Prenatal Record. Pregnant individuals are referred to oral health professionals and/or a dentist for a prenatal visit.	Oral health assessments completed and documented according to applicable guidelines, organizational policies and protocols. Documentation of referrals. Plan of care revised accordingly.
5.2.3.5 The CHN offers individualized, culturally safe oral health education and counseling to expectant mothers, in accordance	Information sharing according to requirement.

with the NWT Prenatal Record, to ensure they have the knowledge and resources to make healthy choices regarding oral health. The CHN ensures that expectant mothers are made aware of oral health services available in their community. The CHN conducts risk and oral screenings and refers to an Oral Health Professional as appropriate.	PNR reflects discussion and referrals
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5.2.3 Maternal Nutrition and Oral Health Protocols

All pregnant individuals will be seen and provided care in accordance with the NWT Prenatal Record and the NWT Prenatal Record User Guide.

NWT Prenatal Record:

<http://www.professionals.hss.gov.nt.ca>

Health Canada Recommendations Food Safety for Pregnant Women:

<https://www.canada.ca/en/health-canada/services/food-safety-vulnerable-populations/food-safety-pregnant-women.html>

Food and Nutrition:

<http://www.hss.gov.nt.ca/en/services/food-and-nutrition>

Traditional foods:

<http://www.hss.gov.nt.ca/sites/www.hss.gov.nt.ca/files/traditional-food-fact-sheets.pdf>

NWT Vitamin D Supplementation Recommendations:

<https://www.hss.gov.nt.ca/professionals/sites/default/files/page-122-vitamin-d-supplementation-recommendations.pdf>

Maternal Health 5.2 Prenatal Care	
5.2.4 Obstetrical Emergencies	
Outcome All obstetrical emergencies are managed in a timely and clinically appropriate manner and always in consultation.	
Standards	Indicators
5.2.4.1 In an emergency situation, the CHN: a. conducts a history and physical b. contacts the specialist, physician/NP or midwife on call and provides a complete report of the individual's and baby's health statuses, investigations performed, treatments that have been initiated and the effectiveness of those interventions c. collaborates with specialist, physician/NP or midwife to stabilize the individual and baby and/or transferring to a hospital for specialized care d. conducts regular reassessments as indicated by condition, and reports any changes e. prepares for transport and/or emergency delivery if necessary, including making additional contacts and/or enlisting additional help in the health centre.	Emergency events and transportation are managed and documented according to applicable guidelines, organizational policies and protocols.
5.2.4.2 The CHN takes several steps to avoid unexpected childbirth in the community including, but not limited to: a. educating individuals about the management of obstetrical risks and the reasons for the policy on hospital-based delivery b. counselling individuals on the early signs of labour and the steps to be taken should these occur c. identifying those who are at risk for premature	Evidence of documentation on plan of care recorded in NWT Prenatal Record.

delivery (teens, previous preterm delivery, and those with higher-risk pregnancies) and facilitating an appropriate birth services plan. Collaborating with professional and community resources to help meet the needs of families when pregnant individuals leave the community (often leaving small children and other dependent family members) for birth services.	
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5.2.4 Obstetrical Emergencies Protocols

The CHN contacts the specialist, physician/NP or Midwife on-call/in accordance with local processes for obstetrical emergencies.

NWT Clinical Practice Guidelines for Primary Community Care Nursing, Chapter 12 Obstetrics:

<https://www.hss.gov.nt.ca/professionals/tools/policies-and-guidelines-standards-and-manuals>

Maternal Health 5.3 Postnatal Care		
5.3.1 Maternal Postnatal Care		
Outcome Parents, newborns and their families are supported as they adjust to their new situation.		
Standards	Indicators	
5.3.1.1	The CHN ensures that the Health Centre has received pertinent information from the hospital or midwifery unit regarding labour and delivery, complications, special needs, health teaching, supportive care for fetal/neonatal loss, recommendations and follow-up.	Information obtained according to applicable guidelines, organizational policies and protocols.
5.3.1.2	The CHN ensures that new parents receive health teaching for basic skills as necessary and/or in accordance with the NWT Well Child Record.	Health teaching delivered and documented according to requirements.
5.3.1.3	Postnatal assessments and visits occur, as indicated by level of risk of pregnancy and, as determined by discharge summary.	Postnatal care delivered and documented according to requirements.

5.3.1 Maternal Postnatal Care Protocols

Discharge summary and record of birth is obtained from the hospital or midwifery unit and documented in client's record.

Postnatal visits for new postpartum individuals, at a minimum (more frequently as indicated), should include:

- Home visit within first week (in conjunction with infant visit)
 - Assess vaginal bleeding and fundal consistency
 - Assess incision and/or sutures if indicated
 - Observe for increased levels of fatigue
 - Assess infant and maternal feeding technique and comfort.
- Office visit at 3-4 weeks (in conjunction with infant visit)
 - Assess vaginal bleeding and fundal consistency
 - Assess incision and/or sutures if indicated
 - Observe for increased levels of fatigue
 - Screen for postpartum depression/anxiety (Edinburgh scale)
 - Assess infant and maternal feeding technique and comfort.
- Office visit at 6 weeks

- Assess vaginal bleeding
- Assess incision and/or sutures if indicated
- Observe for increased levels of fatigue
- Screen for postpartum depression/anxiety (Edinburgh scale)
- Inquire about infant feeding concerns
- Discuss and determine contraception choice.

Health teaching for new parents in accordance with the NWT Well Child Record and Well Child User Guide:
<http://www.professionals.hss.gov.nt.ca>

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Appendices

[Appendix A : Abbreviations and Glossary of Terms](#)

[Appendix B : Forms](#)

[Appendix C : References](#)

Appendix A:

Abbreviations:

CHN	Community Health Nurse
DHSS	Department of Health and Social Services
GNWT	Government of the Northwest Territories
HRHSSA	Hay River Health and Social Services Authority
NP	Nurse Practitioner
NTHSSA	Northwest Territories Health and Social Services Authority
TCSA	Tłıchǫ Community Services Agency
WHO	World Health Organization

Glossary of Terms:

Advance Care Planning	A process people can use to: think about their values and what is important to them with regard to their healthcare choices; explore medical information that is relevant to their health; communicate their wishes and values to their loved ones, substitute decision-maker and healthcare team; and record their healthcare choices and decisions in the event they can no longer speak for themselves. The process may involve discussions with their healthcare providers and people who are significant in their lives. Advance care planning may result in the creation of advance directives or a “living will”, which are a person’s formal or informal instructions about their future care and choice of treatment options. (Canadian Hospice Palliative Care Association, 2015)
Anticipatory Guidance	Information about normal expectations of an age group to provide support for coping with problems before they arise. It is a component of many health care encounters (e.g.: well-child check-ups in infancy).
Care Plan	The process of planning individualized care, based on episodic visits, disease specific or program area specific. This may be limited to the P:Plan in the SOAP note, or may extend to the inclusion of a formalized program.

Chronic Disease Management	An organized, proactive, multi-component, client-centered approach to healthcare delivery that involves all members of a defined population who have a specific disease entity (or a subpopulation with specific risk factors). Care is focused on, and integrated across the entire spectrum of the disease and its complications, the prevention of comorbid conditions, and relevant aspects of the delivery system. Essential components include identification of the population, implementation of clinical practice guidelines or other decision making tools, implementation of additional client-, provider-, or healthcare system-focused interventions, the use of clinical information systems, and the measurement and management of outcomes. (NHS, 2016).
Chronic Disease or Chronic Health Condition	A chronic disease is a human health condition or disease that is persistent or otherwise long-lasting in its effects. The term chronic usually applies when the course of the disease lasts more than three months. Common chronic diseases include arthritis, asthma, cancer, chronic obstructive pulmonary disease (COPD), depression, diabetes and HIV/AIDS. (Chowdhury, 2014).
Client	Any individual or family accessing health care services.
Client and Family Centered Approach	An approach that fosters respectful, compassionate, culturally appropriate, and competent care that responds to the needs, values, beliefs, and preferences of clients and their family members. Instead of doing to or for a client, the approach involves doing something with a client. (Accreditation Canada)
Cognitive Ability	The mental process of knowing, including aspects such as awareness, perception, reasoning, and judgement.
Culture	A dynamic process where meanings are created between people and shaped by historical and social contexts. Features to remember about culture include: • Most people identify with multiple cultures. • While people may identify with a certain culture, they might not participate in practices associated with that group • Culture is constantly evolving and adapting to peoples' experiences. (GNWT, HSS, 2016)
Cultural Awareness	The ability to recognize and appreciate diversity and the differences between people. (GNWT, HSS, 2016)
Cultural Sensitivity	Building on cultural awareness, cultural sensitivity recognizes the need to appreciate cultural differences and treat different cultural groups professionally and with respect. (GNWT, HSS, 2016)

Cultural Competence	Cultural competence is typically measured in the knowledge and actions of the staff/practitioner and reflects the process of building effective relationships with Indigenous clients, rather than the outcome or results. (GNWT, HSS, 2016)
Cultural Safety	“Is an outcome that is based on respectful engagement which recognizes and strives to address power imbalances inherent in the health and social services system. It results in an environment free of racism and discrimination where people feel safe receiving health care” (GNWT, HSS, 2016).
End of Life Care	Includes physical, spiritual and psychosocial assessment, and care and treatment delivered by health professionals and ancillary staff. It also includes support of families and carers, and care of the client’s body after their death.
Habilitation	The process of assisting an individual with achieving developmental skills when impairments have caused a delay or blocking of initial acquisition of these skills. Habilitation can include cognitive, emotional/social, fine motor, gross motor or other skills that contribute to mobility, communication, socialization, performance of activities of daily living and quality of life. (NHS, England, 2016)
Harm Reduction	Refers to policies, programs and practices designed to reduce the adverse health, social and economic harms associated with the use of psychoactive substances, and sexual activity. Harm reduction focuses on keeping people safe and minimizing death, disease, and injury associated with risky behaviours, while recognizing that the behaviour may continue despite the risks. It involves a range of non-judgmental approaches and strategies aimed at providing and enhancing the knowledge, skills, and supports for individuals, their families and communities to make informed decisions to be safer and healthier. (BC Harm Reduction Strategies and Services, December 2014)
Holistic	Holistic (health care) means consideration of the complete person, physically, psychologically, socially, and spiritually, in the management and prevention of disease. These different states should be managed together so that a person is treated as a whole. A holistic approach means that the health care provider is informed about a client’s whole life situation.
Indicator	An indicator provides a sign or a signal that something exists or is true. It is used to show the presence or state of a situation or condition. In the context of monitoring and evaluation, an indicator is a quantitative metric (or qualitative variable) that provides information to monitor performance, measure achievement and determine accountability. (adapted from GNWT, DHSS 2014)

Interdisciplinary Team	An interdisciplinary team is a consistent grouping of people from relevant clinical disciplines, ideally inclusive of the client, whose interactions are guided by specific team functions and processes to achieve team-defined favourable client outcomes. (Dubravko & Pandak, 2016)
Medication Reconciliation	An Accreditation Canada requirement and a formal process in which health care providers work together with clients, families, and caregivers to ensure accurate and comprehensive medication information is communicated consistently across transitions of care. Medication reconciliation requires a systematic and comprehensive review of all the medications a client is taking (known as a Best Possible Medication History (BPMH)) to ensure that medications being added, changed, or discontinued are carefully evaluated. It is a component of medication management and informs prescribers and enables them to make the most appropriate prescribing decisions for and with the client.
Palliative Care	Palliative care is an approach that improves the quality of life of clients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification, assessment and treatment of pain and other problems, physical, psychosocial and spiritual. (DHSS, 2015a).
Positive Parenting	An approach to parenting that encourages building a close relationship between parent and child; that emphasizes setting up consistent, clear boundaries for children; that promotes non-punitive consequences for negative behaviour. (Region of Waterloo Public Health, 2012)
Primary Care	Refers to the delivery of community-based clinical health care services. Primary care providers coordinate the care of individuals and enable equitable, timely access to other health care services and providers. The primary care sector focuses on preventing, diagnosing, treating and managing health conditions as well as promoting health. (CNA, 2015)
Primary Health Care	Primary health care is essential health care that is available to all people and families in the community by means they find acceptable, with their full participation, and at a cost that the community and country can afford. Primary health care addresses the main health problems in the community. It provides services to promote health, prevent disease, cure problems, and rehabilitate people, as needed.
Quality Improvement	A sustained effort to improve healthcare quality that incorporates repeated performance measurement and feedback to healthcare providers. (CIHI, 2012)

Rehabilitation	Rehabilitation is a personalized, interactive and collaborative process, reflecting the whole person. It enables an individual to maximize their potential to live a full and active life within their family, social networks, education/training and the workplace where appropriate. Rehabilitation can take place at any time across a life course or in a continuum and may include habilitation (the process of assisting an individual with achieving developmental skills when impairments have caused a delay or blocking of initial acquisition of these skills. Habilitation can include cognitive, emotional/social, fine motor, gross motor or other skills that contribute to mobility, communication, socialisation, performance of activities of daily living and quality of life), reablement (active process of an individual regaining the skills, confidence and independence to enable them to do the things for themselves, rather than having things done for them) and recovery (A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful and contributing life even with limitations caused by the illness). (NHS England, 2016)
Risk Factor	Any attribute, characteristic or exposure of an individual that increases the likelihood of developing a disease or injury. Some examples of the more important risk factors are overweight, unsafe sex, high blood pressure, tobacco and alcohol consumption, and unsafe water, sanitation and hygiene.
Self-Management	Refers to the measures that a client can take to manage and prevent the symptoms of his or her chronic disease in accordance with the participation of his or her health care team. Client self-management necessarily requires the culmination of a certain set of skills and behaviors that create confidence in dealing with a range of emotional, physical and physiological symptoms of their chronic disease. Self-management support is “the systematic provision of education and supportive interventions, by health care staff (and others), to increase clients’ skills and confidence in managing their health problems, including regular assessment of progress and problems, goal setting, and problem-solving support.” (Health Council of Canada, 2012)
Sexual Health	Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected,

	protected and fulfilled. (Decker et al., 2015)
Standards	Are developed through reviews of best evidence. Standards establish and promote quality services within the NWT context and these standards can be used to assess the quality of programs, service delivery and the operational systems in place. Policies should be developed and operationalized based on the standards that are outlined in this document. In delivering core services, health and social service boards are expected to adopt their own bylaws and standards. However, all board bylaws and standards must be consistent with all relevant federal and territorial legislation and regulations, Government of the Northwest Territories (GNWT) policies, directives and agreements, and departmental policies, directives, standards, guidelines and procedures. Health care services need to be monitored continuously to ensure that quality service is being delivered. Audits of the standards will be conducted to monitor for successes or challenges in meeting the Standards.

Appendix B

Forms

NWT Prenatal Record:

<http://www.professionals.hss.gov.nt.ca>

NWT Well Child Record:

<http://www.professionals.hss.gov.nt.ca>

Greig Forms: EMR or,

Grieg record and selected guidelines and resources:

<https://www.cps.ca/en/tools-outils/greig-health-record>

Adult assessment: EMR or,

The Preventive Care Checklists and guiding documents are available at:

https://portal.cfpc.ca/CFPC/Resources/EN/Periodic_Health_Examination/content_id_1184.aspx?WebsiteKey=94ad8c9d-31a6-4b04-b014-7de04c05f742

Appendix C:

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